Pharmacy Contract Request Form

Humana

Inquiry type *(select one)*

- ☐ New pharmacy contract
- ☐ Change of pharmacy address/phone/fax/email
- ☐ Change of pharmacy ownership **(provide previous owner and NCPDP in comments section)**
- ☐ Other **(specify in comments section)**

Pharmacy NCPDP		Pharmacy NPI		
Pharmacy DBA name		Pharmacy legal name		
Pharmacy physical address	City	State	ZIP code	County
Pharmacy phone number		Pharmacy fax number		
Pharmacy contracting contact name		Pharmacy owner		
Pharmacy mailing address	City	State	ZIP code	County
Tax Identification Number (TIN)		Medicaid ID **(list additional in comments)**		State
Email address **(contract will be sent to this email address)**				

Pharmacy type

1. Is the pharmacy a walk-in, full-service retail pharmacy open to the general public? _____**Y** _____**N**
2. Does the pharmacy or an affiliate of the pharmacy offer same-calendar-day prescription drug home delivery? _____**Y** _____**N**
   ** If yes, please explain in detail on a separate sheet of paper.*
3. Does the pharmacy or an affiliate of the pharmacy offer delivery of prescription drugs by any common carrier or U.S. Postal Service, offer non-same-calendar-day delivery services, and/or deliver drugs by any method across state lines? _____**Y** _____**N**
   ** If yes, please explain in detail on a separate sheet of paper.*
4. Is the pharmacy a long-term care (LTC)-only pharmacy? _____**Y** _____**N**
5. Is the pharmacy a specialty pharmacy (regularly dispensing drugs that require special handling, storage, administration, extensive patient education and clinical support, such as hemophilia products, IVIG and limited distribution drugs)? _____**Y** _____**N**
6. Is the pharmacy owned and/or operated by an entity that is entitled to acquire drugs at a discount (pursuant to the 340B Program established under Section 340B of the Public Health Service Act as amended)? _____**Y** _____**N**

Please indicate approximately what percentage of the pharmacy is composed of the following services:

_____Retail	_____Walk-in specialty	_____Home infusion
_____Compounding	_____Mail-order specialty	_____340B
_____LTC	_____Mail-order traditional	_____Indian Tribal Urban
_____Physician dispensing	_____Hospice	_____ Diabetic supplies

Numbers above must add up to 100%

Additional information required

1. Is the pharmacy independently owned? _____**Y** _____**N**
2. When does/did the pharmacy begin dispensing medications? (MM/DD/YYYY) _____/_____/_____
3. Does the pharmacy have any ownership or interest in pharmacies that have been or are currently part of the Humana network, or is the pharmacy owned by or under common control with any such pharmacies? _____**Y** _____**N**
   * *If yes, please explain in detail on a separate sheet of paper.*
4. Does the pharmacy have more than one store location? _____**Y** _____**N**
   * *If yes, please attach other pharmacy name(s) and NCPDP(s) on a separate sheet of paper.*
5. If the pharmacy is associated or owned by a physician/group practice, is that physician/group practice currently participating in Humana's medical provider network? _____**Y** _____**N**
6. What was the most recent date the pharmacy was inspected by the state board of pharmacy? _____
7. Is the pharmacy owned by a sole proprietorship? _____**Y** _____**N**
   * *If yes, please attach the DBA records (if applicable).*
8. Is the pharmacy owned by a partnership? _____**Y** _____**N**
   * *If yes, please attach the DBA records (if applicable), a copy of the partnership agreement or written statement that no written partnership exists, and the Organizational Structure Form.*
9. Is the pharmacy owned by a corporation or limited liability company? _____**Y** _____**N**
   * *If yes, please attach the DBA records (if applicable), a copy of the certificate of incorporation, a copy of the articles of organization or formation, and the Organizational Structure Form. Please list the state where originally incorporated or organized.*

Comments:

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Organizational Structure Form

Please provide the following information for each person or entity with an ownership interest in this pharmacy.

	Full legal name of person/entity with ownership interest	Address	Ownership percentage of pharmacy	Social Security number (SSN) or TIN	If an individual person is listed, designate role (corporate officer/ director or leadership positions)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

For each entity identified above (Entity 1), please provide the following information for each person or entity (Entity 2) with an ownership interest in Entity 1. For entities with multiple layers in the organizational structure, please complete additional tables until only individuals are named.

	Entity name	Full legal name of person/entity with ownership interest	Address	Ownership percentage	SSN	Designate role: director or leadership position
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

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For each person or entity with an ownership interest listed on any table above who also has an ownership interest in another pharmacy, please provide the following information. If no such relationship exists, please indicate this with an "N/A."

	Pharmacy name	Pharmacy NCPDP	Legal entity name	TIN	Ownership interest percentage in pharmacy
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

To ensure an applicant pharmacy's business and pharmacy practices comply with Humana standards and requirements, Humana may, at the discretion of its credentialing and contracting representative, request additional documentation. An applicant's failure to respond fully, in a timely manner and to Humana's satisfaction may result in denial of the pharmacy's contracting request.

I hereby represent that all information submitted herein is true, complete and accurate to the best of my knowledge and consent to the release of such information as may be necessary to verify my professional credentials and qualifications. I understand that falsification of any of these answers shall result in rejection of this application or immediate termination of the pharmacy with Humana. Furthermore, I or the pharmacy will indemnify Humana for any liability incurred, including, but not limited to, legal fees incurred by Humana as a result of my falsification of information. I understand that any falsification will be reported to the applicable state board(s) of pharmacy. I represent I have the authority necessary to bind the applicant pharmacy identified herein. I attest that the electronic signature provided in the "Signature (required)" field below is the legal equivalent to my manual signature for the purposes of this Pharmacy Contract Request Form.

_____ _____

Pharmacy owner name ***(required)*** Date

_____ _____

Signature ***(required)*** Date

Please complete and fax to 866-449-5380 or email to
PharmacyContractRequest@humana.com.