Pharmacy Contract Request Form

Humana.

Inquiry Type *(select one)*

- ☐ New Pharmacy Contract
- ☐ Change of Pharmacy Address/Phone/Fax
- ☐ 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
Pharmacy Phone Number	Pharmacy Fax Number
Pharmacy Contracting Contact Name	Pharmacy Owner
Pharmacy Mailing Address	City State Zip
Tax ID	Medicaid ID ***(list additional in comments)*** State
Email Address ***(contract will be sent to this email address)***	

Pharmacy Type

1. Are you a walk-in full service retail pharmacy open to the general public? _____**Y** _____**N**
2. Are you an LTC only pharmacy? _____**Y** _____**N**
3. Are you a Specialty pharmacy *(dispensing drugs that require special handling, storage, administration, extensive patient education and clinical support such as Hemophilia products, IVIG, limited distribution drugs regularly)*? _____**Y** _____**N**

Please indicate approximately what percentage of your business is comprised of the following services:

_____ Retail	_____ Walk In Specialty	_____ Home Infusion
_____ Compounding	_____ Mail Order Specialty	_____ 340B
_____ Long Term Care	_____ Mail Order Maintenance	_____ Indian Tribal Urban (ITU)
_____ Physician Dispensing	_____ Diabetic Supplies	

Numbers above must add up to 100%

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Additional Information Required

1. Is this pharmacy independently owned? _____**Y** _____**N**
2. When does/did the above pharmacy open for business? *(MM/DD/YYYY)* ____ /____ /____
3. Do you currently have or have you previously had any ownership or interest in pharmacies that have been or are currently part of the Humana Pharmacy network? _____ **Y** _____**N**
   If Yes please explain, in detail, on a separate sheet of paper.
4. Do you own 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. Is the associated physician and/or physician group practice part of the medical network? _____**Y** _____**N**

Comments:

To ensure an applicant pharmacy's business and medical 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 my participation with Humana. Further, I 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 attest that the electronic signature provided in the "Signature (Prepared by)" 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 (Prepared by) ***(REQUIRED)*** Date

Please Complete and Fax to (866) 449-5380 or Email PharmacyContractRequest@humana.com