PROVIDER CREDENTIALING AND VERIFICATION TO THE PARTICIPATING PHARMACY AGREEMENT

Please take the following steps to apply for access to the EnvisionRx Pharmacy Network

**Step One:** Complete the application below. Please ensure all applicable fields are populated, incomplete submissions will not be accepted.

**Step Two:** Return your submitted application. Submissions can be returned via

- **Fax:** 330-405-8094
- **Email:** providerenrollment@envisionrx.com

*A coversheet is provided on the final page of this packet for your use.*

**Pharmacies located in Puerto Rico must submit enrollment applications to Breyes@envisionrx.com for review prior to submitting to providerenrollment@envisionrx.com.**

**Step Three:** Please include the following documentation with your application for consideration.

- Envision Rx Provider Contract Application and Credential Verification
- W9
- Photo of store front (including signage)
- Photo of Pharmacy dispensing area

The following current Licensure and Certifications are required with submission

- State Pharmacy License
- Medicare ID award
- State Medicaid Enrollment Notice (*for all states Medicaid authorized*)
- DEA Certificate
- Copy of Professional Liability Insurance Certificate
- Sterile Compounding Certification (if applicable)
- Board of Equalization Permit (CA Only)
- Pharmacist-in-Charge State License and additional pharmacist/technicians
- Federal Tax ID Certificate

*This is only an application for participation and does not guarantee access into the Network.*

Please allow 10-15 business days for the processing of your submitted application. If approved, a Participating Provider Agreement packet will be emailed to you at the address designated on your application. Please allow at least 30 days before you are able to process prescription claims. If denied, you will be notified via email and will have an opportunity to appeal. Appeals should be submitted to credentialingappeals@envisionrx.com. To check the status of your application *after 15 business days*, email your request to providerenrollment@envisionrx.com; include in the subject line your NCPDP number and “Contract Application Status”.
Network Access request (select all that apply):
Commercial:  Medicare:  Preferred Network:  Medicaid:  Dispensing Physician:  

General Provider Information

NCPDP #:  NPI #:  Chain Code #:  
Provider Legal Name:  Store #:  
Provider DBA Name:  
Physical Address:  Building/Suite #:  
City:  County:  State:  Zip:  
Date Opened/Acquired:  
(Must be completed)

Have you had a change of ownership in the last year? Yes  No  
If yes, is there a Power of Attorney (POA) in place? Yes  No  
(If yes, include a copy of POA with enrollment application)
Did the new owner obtain a new NPI and NABP? Yes  No  
If yes, include copy of NCPDP notice which reflects effective date of new NCPDP

Contact Information

Mailing Address:  Building/Suite #:  
City:  State:  Zip:  
Telephone #:  Fax #:  
Owner’s Legal Name:  Email:  
Primary Contact:  Email:  
After Hours Phone Number:  
* By providing a fax number and/or email address, you are giving permission to Rx Options, Inc., to contact you via fax and/or email.

Identification Numbers

Medicare ID #:  Federal Tax ID:  
Medicaid ID #:  State:  
Is your pharmacy contracted for Medicaid? Yes  No  
If yes, which states:  
Please include supporting documentation affirming all states contracted to participate in Medicaid
**Pharmacy Operations**

Does your pharmacy provide emergency Rx services? Yes____________ No____________

If yes please provide emergency phone number:______________________________

**Hours of Operations**

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
</table>

24 Hour Pharmacy: Yes_____ No____________

If no, list your Hours of Operation:

**Location description**

(check option that applies)

<table>
<thead>
<tr>
<th>Free Standing</th>
<th>Grocery Store</th>
<th>Strip Mall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic</td>
<td>Hospital</td>
<td>Medial Office</td>
</tr>
</tbody>
</table>

**Provider Class**

(Select one)

<table>
<thead>
<tr>
<th>Independent</th>
<th>PSAO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chain</td>
<td>Franchise</td>
</tr>
<tr>
<td>Hospital/Clinic</td>
<td>Government/Federal</td>
</tr>
</tbody>
</table>

**Provider Type**

(Select one)

<table>
<thead>
<tr>
<th>Retail</th>
<th>Clinic Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mail Order</td>
<td>Home Infusion</td>
</tr>
<tr>
<td>Long Term Care</td>
<td>VA Hospital</td>
</tr>
<tr>
<td>Dispensing Physician</td>
<td>Indian Health</td>
</tr>
<tr>
<td>DME</td>
<td>Other:</td>
</tr>
</tbody>
</table>

**Services**

(Check all that apply)

<table>
<thead>
<tr>
<th>Compounding</th>
<th>Open 24 Hours</th>
<th>Assisted Living</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-Prescriptions</td>
<td>Flu Shots/Vaccines</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Drug Dependency</td>
<td>TTY (Text Telephone)</td>
<td>Specialty Drugs</td>
</tr>
<tr>
<td>Translation Services</td>
<td>Delivery</td>
<td>340B</td>
</tr>
<tr>
<td>Hospice</td>
<td>Nuclear Meds</td>
<td>Other</td>
</tr>
</tbody>
</table>

**Languages Spoken**

(Check all that apply):

<table>
<thead>
<tr>
<th>English</th>
<th>Vietnamese</th>
<th>German</th>
<th>French</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spanish</td>
<td>Chinese</td>
<td>Arabic</td>
<td>Creole</td>
</tr>
<tr>
<td>Japanese</td>
<td>Farsi</td>
<td>Armenian</td>
<td>Other:</td>
</tr>
</tbody>
</table>
Facility Liability Insurance Information

Insurance Carrier: __________________________ Policy #: __________________________

Policy Effective Date: __________________________ Policy Expiration Date: __________________________

Each Occurrence Limit: __________________________ General Aggregate Limit: __________________________

(Minimum requirement is $1M) (Minimum requirement is $3M)

Attach a current copy of your Certificate of Liability Insurance to this application. Any application received without a Certificate of Liability Insurance will not be reviewed or considered for participation in the Network.

Facility State License Information

Rx Options, Inc. will verify all state licenses using primary source verification and may review license history including all disciplinary actions. ** Any application received without a Certificate of Liability Insurance will not be reviewed or considered for participation in the Network. **

Facility State License Number: __________________________

Issue Date: __________________________ Expiration Date: __________________________

Additional States Licensed: __________________________

Facility DEA Certificate Information

Rx Options, Inc. will verify the facility’s DEA certificate using primary source verification. Rx. Options, Inc. does not allow providers into the Network without an active DEA certificate.

DEA Registration Number: __________________________

Issue Date: __________________________ Expiration Date: __________________________

Schedules (check those listed on certificate) 2 _____ 2N _____ 3 _____ 3N _____ 4 _____ 5 _____

Member Access

Please answer questions 1-5. If you answer “No” to any question, please explain. Please attach additional pages if necessary.

1. Is this facility open-door, where prescriptions are filled for all walk-in customers without restrictions? Yes_______ No_______

2. Is this facility able to transmit claims electronically in accordance with standards established by the National Council for Pharmacy Drug Program (NCPDP)? Yes_______ No_______

3. Is the Pharmacist-In-Charge (or Pharmacy Manager) a certified pharmacist employed by this facility? Yes_______ No_______

4. Does this facility provide secure access to staff-only areas? Yes_______ No_______

5. Is this facility compliant with applicable access standards related to the Americans with Disabilities Act of 1990 (or its successor) and able to accommodate individuals with physical and non-physical disabilities, including but not limited to: wheelchair accessibility, ample handicapped parking, clear display of signage and way finding, availability of public transportation to the facility and, where applicable, waiting room furnishings? Yes_______ No_______
Please answer questions 6-10. If you answer “Yes” to any question, please explain. Please attach additional pages if necessary.

6. Does your facility use pharmacists employed through an agency or are your pharmacists responsibilities outsourced to another company/agency? Yes______ No______

If “Yes”, list the name of the company/agency

7. Does the owner of your facility currently own or has previously owned any other pharmacies within the EnvisionRx pharmacy network? Yes______ No______

If “Yes”, list pharmacy Name(s) and NCPDP number(s) below:

Pharmacy Name: _____________________________ NCPDP #: __________________
Pharmacy Name: ____________________________ NCPDP #: __________________

8. Will the Pharmacy disclose any disciplinary actions or investigations taken against the Pharmacy? Yes______ No______

9. Other than the name listed, has another business or trade name ever been or is currently being used by Participating Pharmacy(ies)? Yes______ No______

If yes, what was the Participating Pharmacy’s previous NCPDP#? __________________________

10. Are there any owners of the pharmacy that are licensed physicians/ prescribers? Yes______ No______

11. Has Participating Pharmacy(ies) ever been denied a permit or pharmacy license in any state, or had its permit or license revoked or suspended? Yes______ No______

If yes, please explain on a separate sheet of paper.

12. Has the Participating Pharmacy(ies) or any of its present owners, employees or officers ever been charged with a criminal offense involving government business or has the Participating Pharmacy(s) or any of its present owners, employees or officers ever been convicted of federal or state drug or pharmacy service-related law convictions? Yes______ No______

If yes, please explain on a separate sheet of paper.

13. Has Participating Pharmacy(ies) been named in any professional liability judgements or settlements in the past 5 years? Yes______ No______ If yes, please explain on a separate sheet of paper.

14. Has the pharmacy(ies) malpractice coverage been denied or cancelled within the past 5 years? Yes______ No______ If yes, please explain on a separate sheet of paper.

15. Are there any employees currently employed by the pharmacy who would not be covered by the company’s malpractice insurance or their own insurance policy? Yes______ No______

If yes, please explain on a separate sheet of paper.

16. Under the current ownership, has this facility or any other previously owned facility ever been disciplined by a State Board of Pharmacy, government entity or any other regulatory authority within the past five (5) years? Yes______ No______
17. Have any of the owners, managers, pharmacists or pharmacy technicians been disciplined by a State Board of Pharmacy, a government entity, or any other regulatory authority within the past five (5) years? Yes____ No____

18. Under the current ownership, has this facility or any owner, manager, pharmacist or pharmacy technician been the subject of a civil lawsuit or criminal prosecution for fraud, deceit, deception, or a similar offense involving moral corruption? Yes____ No____

19. Has the Participating Pharmacy(ies) ever been the subject to any outstanding regulatory or disciplinary action by either State, Federal, Government or civil entities or disciplinary action in front of the State Board of Pharmacy? Yes____ No____
   If yes, please explain on a separate sheet of paper.

20. Has Participating Pharmacy(ies) had one or more public agreements or transactions (Federal, state, or local) terminated for cause or default? Yes____ No____
   If yes, please explain on a separate sheet of paper.

21. Is Participating Pharmacy(ies) under any restrictions of practice as imposed by the State Board of Pharmacy? Yes____ No____
   If yes, please explain on a separate sheet of paper.

22. What is the most recent date that Participating Pharmacy(ies) was inspected by the State Board of Pharmacy? (mm/dd/yyyy) ________________

23. Has Participating Pharmacy(ies) ever been terminated by a third party payor, prescription benefit management organization, managed care organization or other similar organization(s)? Yes____ No____
   If yes, please explain on a separate sheet of paper.

24. Has Participating Pharmacy(ies) been excluded from participation for a Federal program, including but not limited to, Medicare, Medicaid, federal health care programs or federal behavioral health care programs pursuant to Title XI of the Social Security Act, 42 U.S.C. section 1320a-7 and other applicable federal statutes? Yes____ No____
   If yes, please explain on a separate sheet of paper.

25. Has Participating Pharmacy(ies) ever been listed by a governmental agency as debarred from work with that agency, proposed for debarment from a governmental agency, or suspended from any government work, or otherwise precluded from participating in any Federal program? Yes____ No____
   If yes, please explain on a separate sheet of paper.

26. Has the DEA registration of the Pharmacy ever been suspended or revoked? Yes____ No____
   If yes, please explain on a separate sheet of paper.
Immunization Services

Primary Certified Immunization Pharmacist (CIP):

Additional CIP(s):

Immunization certification effective/expiration:

Accreditation Authority:

Immunization Attestation: Initial each Attestation item to affirm compliance with requirements

- All administering PICs attest to the meeting of all State Board of Pharmacy requirements
- My state board allows for pharmacists to administer immunization without formal training or certification
- I accept assignment to administer immunizations to Medicare Patients
- I am certified to administer immunizations to children
- My pharmacy administers immunizations to adults, 18 and older, only
- I can provide copies of all applicable PIC certifications upon request
- I can provide copies of all applicable pharmacy certifications upon request

*Please note that pharmacies in Puerto Rico requesting to administer vaccines must be in compliance with the Commonwealth of Puerto Rico, all pharmacies must comply with the Department of Health regulations as defined in (Article 9.06 Vaccine) regarding on-site immunizations including certification requirements for the pharmacist as an immunizer. Please include your Department of Health Certificate with the application along with the Immunizer Pharmacist credentials.

Mail Order

1. Does this facility utilize mail order? Yes__________No__________

Please list all of the states in which your pharmacy is licensed to provide Mail Order prescription services:

<table>
<thead>
<tr>
<th>STATE</th>
<th>LICENSE#</th>
<th>EXPIRATION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Is your pharmacy licensed in each state that it will mail covered prescription services, including compliance with any non-resident pharmacy requirements? Yes_________No_________

Please list each state(s) that pharmacy mails or intends to mail prescription drug products

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

*Classification definitions per NCPDP
Required Signature

The undersigned hereby authorizes EnvisionRx and its designated agents to review any and all records that it reasonably deems necessary within its credentialing procedures.

Further, the undersigned represents and warrants that any and all information provided to EnvisionRx in connection with its credentialing process is true, accurate and complete, and it has not failed to state any facts or provide any documents that may be material to EnvisionRx in connection with its credentialing process. Potential participating pharmacies have the right to review the information obtained from any outside primary source and the right to correct erroneous information submitted by another party.

By signing this Exhibit C, Participating Pharmacy(ies) agrees that all locations are bound by the terms and conditions of this Agreement.

Provider Name: (Please print) ___________________________ NCPDP: ___________________________

Name of Owner/ Authorized Agent: (Please print) ________________________________________________

Signature: ___________________________ Date: ___________________________

Operational Assessment

1. Are you a 340B provider? (As defined by 42 U.S.C §256b (a)(4))
   Yes ______ No _______
   (ATTACHED COPY OF THE 340(b) PHARMACEUTICAL PURCHASING WAIVER, IF APPLICABLE)

   340 ID Number: ___________________________

   Entity Type: __________________________________________

   Start date: ___________________________

2. Is the pharmacy able to participate in external audits and grievance procedures?
   Yes ______ No _______ If No, please explain on a separate sheet of paper.

3. Switch Link Check One:
   Relay Health_____ Emdeon_____ eRx_____ Freedom_____ DataRx_____ QS1_____ Other ___________

4. Is this facility able to transmit claims electronically in accordance with standards established by the National Council for Pharmacy Drug Program (NCPDP)?
   Yes ______ No _______ If No, please explain on a separate sheet of paper

5. Can your pharmacy software receive the following NCPDP messages? (check all that apply):
   Duplicate Therapy___________ Drug Interactions ___________________________
   All messages returned in the additional message field 526- FQ____________________

6. Does your pharmacy offer delivery service? Yes ______ No _______

7. Does your pharmacy ship or mail prescriptions? Yes ______ No _______ If yes what % ___________

8. Does your pharmacy provide durable medical equipment? Yes _______ No __________
   If yes, is it: Full line: ______ or Limited: _______ DMEPOS certification number: ___________

9. Will the pharmacy maintain patient profiles, prescription, and signature logs as required by applicable State, Federal and U.S. territorial laws, and advise members that their signature acknowledges their receipt of prescriptions and allow release of any and all claim information?
   Yes _______ No ________
10. Does your pharmacy provide special packaging of prescriptions that are required for skilled and/or assisted living facilities? Yes______No_______

11. Does your pharmacy have a policy to destroy and/or return expired medications on the shelf? Yes______No_______

12. Does your pharmacy routinely dispense written drug information with its prescriptions? Yes______No_______ If yes, attach a sample of your drug information to this application.

13. Are you willing to comply with EnvisionRx therapeutic, generic sampling and formulary programs? Yes______No_______

Compounding

14. Does your pharmacy compound medication? Yes______No_______

If yes, what percent of your business is devoted to compounding? ________________________________

When was your Compounding Pharmacy inspected? ________________________________

Is the pharmacy equipped with facilities, tools, and stocks of drugs sufficient to permit prompt compounding and dispensing of medications? Yes______No_______

15. Does your pharmacy perform Sterile Compounding? Yes______No_______

16. Is pharmacy accredited, certified and/or licensed for sterile compounding? Yes______No_______

If yes, by what organization? ________________________________

17. Does your pharmacy have a: Clean Room ______ Oven ______ Hood ______

18. Is your pharmacy a: Sterile, Low and Medium Compounding ________________________________

Sterile, High Compounding ______ Non-Sterile Complex Compounding ________________________________

Non-Sterile Basic Compounding ________________________________

19. Does the pharmacy have policy and procedure reflecting that USP 795(Non sterile compounding) USP 797 (Sterile Compounding) guidelines are in place? Yes______No_______

If yes indicate all that apply: USP 795________ USP 797________________

20. Does pharmacy have an area for aseptic compounding of sterile preparations that meets current USP<797> standards? Yes______No_______

21. Have pharmacy location facilities and Compounded Drugs been independently tested/inspected for sterility? Yes______No_______ If yes, please provide copy of the inspection/testing report.

22. Are all sterile compounds prepared in a barrier isolator which has been certified as ISO 5 by an independent contractor? Yes______No_______

If yes, please identify the independent contractor: ________________________________

23. Are all bulk, raw chemical ingredients used by pharmacy in Compound Drugs purchased from FDA-registered manufacturing facilities? Yes______No_______
24. Are all bulk, raw, chemical ingredients used by the pharmacy in Compounded Drugs approved by the FDA? Yes_______ No_______ If no, please explain________________________

25. Does pharmacy compound only patient-specific prescriptions written by a prescriber (not batch of non-patient specific medications) Yes_______ No_______

26. Does the pharmacy engage in anticipatory compounding? Yes_______ No_______

27. Does your pharmacy have areas set aside for patient consultation? Yes_______ No_______

28. If you have more than one Participating Pharmacy Location, would you like to be set up for central payment? Yes_______ No_______

29. Payment Information Format: (Select One)
   Paper Remittance_________________________ Electronic ANSI 835_________________________

30. Does your pharmacy perform vaccinations/immunization administration? (i.e. flu shots)?
    Yes_______ No_______

31. Is the pharmacy easily accessible and open to the general public? Yes_______ No_______

32. Do you coordinate with Medicare Part B? Yes_______ No_______

33. Does the pharmacy have any offshore activity that involves the use of PHI (i.e. call center claims reconciliation, etc) Yes_______ No_______
   If Yes, please explain on a separate sheet of paper.

34. Is the pharmacy able to comply with OBRA 90 rules and regulations? Yes_______ No_______

**Medicare Attestations**

Conflict of Interest: Please initial to confirm that the undersigned has policies and procedures in place to ensure that ALL staff responsible for the administration or delivery of Part D services has signed a conflict of interest statement, certification, or attestation at the time of hire, and annually thereafter throughout their employment.

_______ (initial)

OIG and GSA Certification: Please initial to confirm that the undersigned has policies and procedures in place to review the Office of the Inspector General (OIG) and General Services Administration (GSA) exclusions material at the time of hire and monthly thereafter throughout their employment to ensure that ALL staff is not currently excluded from any Federal health care programs. Should a staff member be identified on the list(s), the staff member will be immediately removed from any and all work relating to a Federal health care program.

_______ (initial)
Check here if not applicable. Percentage of business for LTC. 

Please list all of the states in which your pharmacy is licensed to provide Long Term Care prescription services.

<table>
<thead>
<tr>
<th>STATE</th>
<th>LICENSE#</th>
<th>EXPIRATION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

[Include a separate document with all additional active state licensures if number exceeds the space above]

*Classification definitions per NCPDP

1. Comprehensive Inventory and Inventory Capacity Yes No
2. Special Packaging Yes No
3. IV Medications Yes No
4. Compounding/Alternative Drug Composition Yes No
5. Pharmacist On-Call Service Yes No
6. Delivery Service Yes No
7. Emergency Boxes Yes No
8. Emergency Log Books and Services Yes No
9. Does your Pharmacy or group of Pharmacies collect cost sharing for LIS eligible beneficiaries? Yes No
10. Distribution or Consulting Yes No

**Low-Income Subsidy Cost-Sharing Certification:**

I hereby attest that the undersigned pharmacy does not collect cost sharing charges for LIS-eligible beneficiaries, and that any statements of such cost sharing charges submitted by the pharmacy to EnvisionRx are appropriate, owed and payable. The pharmacy agrees to notify Solutions within 30 days of changes to the collection of cost sharing charges for LIS-eligible beneficiaries.

1. Does your pharmacy understand waiving member copays is against the pharmacy contract and/or pharmacy manual? Yes No
2. Does your Pharmacy or group of Pharmacies collect cost sharing for LIS eligible beneficiaries? Yes No Please initial here to confirm your agreement.
Home Infusion State Licensure

Not applicable ________

Percentage of business for HI__________________________

Per CMS [42 CFR §423.120(a)(4)], a Home Infusion pharmacy must meet the minimum requirements as defined below:

(i) Are capable of delivering home-infused drugs in a form that can be administered in a Clinically appropriate fashion.

(ii) Are capable of providing infusible Part D drugs for both short-term acute care and long-term chronic care therapies.

(iii) Ensure that the professional services and ancillary supplies necessary for home infusion therapy are in place before dispensing Part D home infusion drugs.

(iv) Provide delivery of home infusion drugs within 24 hours of discharge from an acute care setting, or later if so prescribed.

My Pharmacy location meets the minimum requirements listed above from CMS and is indeed a Home Infusion pharmacy

Please list all of the states in which your pharmacy is licensed to provide Home Infusion prescription services to Medicare Part D beneficiaries:

State: ____________________________________________________________

License # _________________________________

Exp. Date: ________________________________

[Include a separate document with all additional active state licensures if number exceeds the space above]
Contact Information:

**Contracting Contact:** (Third Party Contracting/primary contact)

Name: ____________________________________________________________

Address: __________________________________________________________________

City: __________________________ ST: ______ Zip code: _______________________

Phone: ______________________ Fax: ______ Email: _________________________

**Credentialing Contact:** (Request for updating all pharmacy credentialing information)

Name: ____________________________________________________________

Address: __________________________________________________________________

City: __________________________ ST: ______ Zip code: _______________________

Phone: ______________________ Fax: ______ Email: _________________________

**Operations Contact:** (for chain pharmacy adds/deletes/updates)

Name: ____________________________________________________________

Address: __________________________________________________________________

City: __________________________ ST: ______ Zip code: _______________________

Phone: ______________________ Fax: ______ Email: _________________________

**Audit Contact:** (for discussing audits and audit issues)

Name: ____________________________________________________________

Address: __________________________________________________________________

City: __________________________ ST: ______ Zip code: _______________________

Phone: ______________________ Fax: ______ Email: _________________________

**Electronic Remittance Contact:**

Name: ____________________________________________________________

Address: __________________________________________________________________

City: __________________________ ST: ______ Zip code: _______________________

Phone: ______________________ Fax: ______ Email: _________________________

**Help Desk Contact:** (chain or PSAO support line for pharmacies)

Phone: ______________________ Email: ________________________________
ENVISIONRx CONTACT INFORMATION

Pharmacy Help Desks

Please see member card for information regarding the number to call for questions or issues. When member card is not available: call EnvisionRx Customer Service at 1-800-361-4542. The EnvisionRx Customer Service call center can be reached 24 hours a day, seven days a week.

The pharmacy help desk is available to assist you with the following: Claims processing issues, billing and payment inquiries, formulary questions, prior authorizations, plan and group information, and general inquiries

Provider Services

The EnvisionRx Provider Services Department hours of operation are Monday through Friday 8:30 am – 5:00 pm EST. We are available to assist you with the following:

- For all Pharmacy Contracting inquiries go to: PharmacyContracting@envisionrx.com
- For all MAC Disputes contact: Macdisputes@envisionrx.com
- For payment questions contact: PharmacyAccountingIssues@envisionrx.com

  ✓ The EFT and ERA form link https://www.envisionrx.com/pdf/PayRemit.pdf

- For updates to pharmacy information for currently contracted pharmacies and affiliations please update NCPDP as appropriate

EnvisionRx Website

EnvisionRx makes every effort to keep pharmacies informed and up-to-date on the latest operational information, procedures and requirements for EnvisionRx on our website located at: www.envisionrx.com.

Compliance Hotline reports go directly to our Compliance Department vendor voicemail box for assessment and investigation of the reported issue. Some examples of reportable fraud include forgery, suspicious claims, pharmacy and/or doctor shopping, identity theft, kickbacks and drug diversion. If you suspect a possible compliance concern please contact the EnvisionRx Compliance Hotline

  Telephone: 1-866-417-3069 Or
  Report Online: myethicsline.envisionrx.com
All information provided above, in connection with the credentialing of this facility is complete and accurate to the best of my knowledge. I understand this application does not guarantee participation in the Network. I understand Rx Options, Inc. will use a variety of sources, including primary sources, to verify the contents of this application and will inspect all documents from individuals and organizations having information pertaining to the operation of this facility. If any discrepancies are found with the information provided in this application, I understand that this facility and any other facilities under the same ownership, may be denied, terminated or suspended from access to the Network and may be subject to an audit as outlined in 42 C.F.R. § 423.504. Furthermore, I certify that all application content and supporting documents submitted, whether intentionally or negligently, are authentic and not fraudulent, and that no information has been withheld either intentionally or negligently. If any such misrepresentations and/or fraud is discovered, facility shall be liable under all applicable federal and state laws for such act, including but not limited to the Federal False Claims Act 31 U.S.C. §§ 3729 – 3733, civil tort laws in any and all jurisdictions in which the facility conducts business, and criminal penalty where applicable pursuant with the Office of Inspector General. I agree that Rx Options, Inc., its representatives, employees and agents shall not be liable for any act or omission related to the evaluation or verification of the information provided. I further agree to notify Rx Options, Inc. within 10 (ten) business days, of any change in the information provided.

I understand and agree that a photocopy of this authorization will be as valid as the original.

Signature: ___________________________ Date: ___________________________

Printed Name: ___________________________ Title: ___________________________
Network Application EnvisionRx Fax / Mail / Email

To: EnvisionRx  
Attn: Credentialing Department  
Date: ____________________________  

(Please Print Clearly)  
Pharmacy Name: ____________________________  
Pharmacy Contact: ____________________________________________  
NCPDP: ____________________________ NPI: ____________________________  
Phone: ____________________________ Email: ____________________________  

# of Pages: ____________________________ of ____________________________  

Pharmacies located in Puerto Rico must submit enrollment applications to Breyes@envisionrx.com for review prior to submitting to providerenrollment@envisionrx.com.  

Required application documents included:  

- Envision Rx Provider Contract Application and Credential Verification  
- W9  
- Photo of store front (including signage)  
- Photo of Pharmacy dispensing area

Applicable Licensure included:  

- State Pharmacy License  
- Medicare ID award Notice  
- Medicaid Provider Notice (for all states Medicaid authorized)  
- DEA Certificate  
- Copy of Current Professional Liability Insurance Certificate  
- Sterile Compounding Certification  
- Board of Equalization Permit (CA Only)  
- Pharmacist-in-Charge State License and additional pharmacist/technicians  
- Federal Tax ID Certificate

Comments: ____________________________  

_____________________________  

_____________________________  

_____________________________