ATTACHMENT B
PHARMACY CREDENTIALING FORM

Thank you for your continued interest in the WellDyneRx Pharmacy Network. Please complete this form in its entirety to ensure continued network participation. If you have any questions, please email them to RetailManager@netcardsystems.com.

PHARMACY INFORMATION

Pharmacy Legal Name: _____ Pharmacy DBA Name: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

NCPDP #/Chain Code(s): _____ NPI: _____

Pharmacy Permit #: _____ Expiration Date: _____

Pharmacy DEA #: _____ Expiration Date: _____

Medicaid Provider #: _____ Tax ID: _____

Medicare #: _____ Other #(s): _____

Contact Name: _____

Phone Number: _____ Fax: _____ Email: _____

Pharmacist in Charge: _____

License #: _____ Expiration Date: _____

PHARMACY OPERATIONS

Monday-Friday: _____ Saturday: _____ Sunday: _____ Holidays: _____

☐ Open 24 Hours ☐ Emergency Services Provided

Total Hours Open per Week: _____

Software Vendor: _____ Switch: _____ NCPDP Version: _____

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PHARMACY PAYMENT AND LIABILITY INSURANCE INFORMATION

Mailing Address: _____

City: _____ State: _____ Zip: _____

Liability Insurance Carrier: _____

Policy Number: _____ Expiration Date: _____

Amount per Occurrence: _____ Aggregate: _____

PHARMACY SERVICES AND TYPE

Pharmacy Type – Which description most closely describes the type of services provided by your pharmacy and approximately what percent of your business handles the following? (Note all that apply)

_____ % Retail	_____ % Specialty	_____ % Compounding
_____ % Clinic/Hospital	_____ % Mail Order	_____ % Long Term Care
_____ % Home Infusion	_____ % State/Federal	_____ % Indian Health Services

Services - (check all that apply)

- ☐ Emergency services provided after hours
- ☐ Closed Door
- ☐ Home Delivery
- ☐ Internet Service
- ☐ Drive-Up Window
- ☐ Handicap Access
- ☐ Electronic Billing
- ☐ Medication Adherence Program
- ☐ Auto Refill Reminder Program
- ☐ Balance Billing

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COMPLIANCE AND ATTESTATION

If you answer "Yes" to questions numbers 1 through 24 below, please provide a letter of explanation with details, settlement amount and dates with this form. Please answer all questions listed below. If any changes must be made, please cross out the error, initial and fill in the correct response.

1. Has the business entity, under any current or former business name or identity, had a felony conviction or a misdemeanor conviction, under Federal or State law, related to the delivery of goods or services to a Medicaid, Medicare, or State health care program?
   ☐ Yes ☐ No

2. Has the business entity, under any current or former business name or identity, had a felony conviction or a misdemeanor conviction, under Federal or State law, related to theft, fraud, breach of fiduciary duty, embezzlement, or other financial misconduct in connection with the delivery of health care services?
   ☐ Yes ☐ No

3. Has the business entity, under any current or former business name or identity, had a felony conviction or a misdemeanor conviction, under Federal or State law, related to interference with or obstruction of any investigation into any criminal offense?
   ☐ Yes ☐ No

4. Has the business entity, under any current or former business name or identity, had a felony conviction or a misdemeanor conviction, under Federal or State law, related to the unlawful manufacture, distribution, prescription, or dispensation of a controlled substance?
   ☐ Yes ☐ No

5. Has the business entity, under any current or former business name or identity, had a license to provide health care by any state licensing authority suspended or revoked, including the surrender of a license while a formal disciplinary proceeding was pending before a State licensing authority?
   ☐ Yes ☐ No

6. Has the business entity, under any current or former business name or identity, been excluded or suspended from participation in, or any sanction imposed by, a Federal or State health care program, or any disbarment from participation in any Federal procurement or non-procurement program?
   ☐ Yes ☐ No

7. Has the business entity, under any current or former business name or identity, been suspended from Medicaid or Medicare payment under any Medicare or Medicaid billing number?
   ☐ Yes ☐ No

8. Has the business entity, under any current or former business name or identity, knowingly employed a person who has had a license to provide health care by any state licensing authority suspended or revoked, including the surrender of a license while a formal disciplinary proceeding was pending before a State licensing authority?
   ☐ Yes ☐ No

9. Has the business entity employed a person who has a felony conviction or a misdemeanor conviction, under Federal or State law, related to theft, fraud, breach of fiduciary duty, embezzlement, or other financial misconduct in connection with the delivery of health care services?

   ☐ Yes ☐ No

10. Has the business entity, under any current or former business name or identity, knowingly employed a person who has a felony conviction or a misdemeanor conviction, under Federal or State law, related to interference with or obstruction of any investigation into any criminal offense?

    ☐ Yes ☐ No

11. Has the business entity, under any current or former business name or identity, knowingly employed a person who has a felony conviction or a misdemeanor conviction, under Federal or State law, related to the unlawful manufacture, distribution, prescription, or dispensation of a controlled substance?

    ☐ Yes ☐ No

12. Has the business entity, under any current or former business name or identity, knowingly employed a person who has, been excluded or suspended from participation in, or any sanction imposed by, a Federal or State health care program, or any disbarment from participation in any Federal procurement or non-procurement program?

    ☐ Yes ☐ No

13. Does the business entity employ any person with a physical or mental health problem that may affect the business entities' ability to provide health care?

    ☐ Yes ☐ No

14. Does the business entity employ any person with a history of chemical dependency or substance abuse?

    ☐ Yes ☐ No

15. Does the business entity employ any person who has had a professional license suspended or revoked?

    ☐ Yes ☐ No

16. Has the business entity, under any current or former business name or identity, been suspended or otherwise limited from participation in a pharmacy network?

    ☐ Yes ☐ No

17. Has malpractice coverage for the business entity ever been denied, involuntarily limited or revoked?

    ☐ Yes ☐ No

18. Has any malpractice carrier or similar insuring entity ever made an out-of-court settlement or paid a Judgment on a professional liability claim on the behalf of the business entity?

    ☐ Yes ☐ No

19. Has the business entity, directors, officers, agents or managing employees of the business entity ever been subject to the filling of a charge by the Department of Health and Human Services (HHS), or its designees?
☐ Yes ☐ No

20. Are there any individuals or organizations having a direct or indirect ownership or control interest of five percent (5%) or more in the entity that have been convicted of a criminal offense related to the involvement of such persons, or entities in any of the programs established by titles XVIII, XIX, or XX?
☐ Yes ☐ No

21. Are there any individuals or organizations having a direct or indirect ownership or control interest of five percent (5%) or more in the entity that have been convicted of a criminal offense related the breach of a fiduciary duty, or other financial misconduct?
☐ Yes ☐ No

22. Has the business entity contemplated filing for bankruptcy protection in the last five (5) years?
☐ Yes ☐ No

23. Are there any pharmacists currently employed that would not be covered by the company's malpractice insurance policy or their own malpractice insurance?
☐ Yes ☐ No

24. Are any of the pharmacies owned by this business entity unable to operate due to their license being suspended by a state, federal or territorial agency?
☐ Yes ☐ No

25. Is the business entity open a minimum of five (5) days per week / eight (8) hours per day?
☐ Yes ☐ No

26. Business entity holds and maintains a valid license to operate a pharmacy in the jurisdiction where business is conducted?
☐ Yes ☐ No

27. The business entity certifies that it complies with all applicable state and federal laws, regulations, and administrative guidance.
☐ Yes ☐ No

28. All employees of the business entity maintain valid professional licenses where applicable.
☐ Yes ☐ No

29. The business entity agrees to disclose any disciplinary actions or investigations taken against the business entity.
☐ Yes ☐ No

30. The Business entity maintains a training program for its employees regarding the dangers of fraud, waste, and abuse.
☐ Yes ☐ No

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MEDICAID AND MEDICARE

Conflict of Interest

The below initials confirm that the undersigned has policies and procedures in place to ensure ALL staff responsible for the administration or delivery of Medicaid and Medicare services have signed a conflict of interest statement, certification, or attestation at the time of hire and annually thereafter throughout the employment tenure.

Initial Here: _____

OIG and GSA Certification

The below initials confirm that the undersigned has policies and procedures in place to review the Office of Inspector General (OIG) and General Services Administration (GSA) exclusions material at the time of hire and annually thereafter throughout the employment tenure, to ensure ALL staff is not currently excluded from 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 Here: _____

Compliance Oversight

The below initials confirm that the undersigned has policies and procedures in place to promptly address and correct identified compliance deficiencies in accordance with CMS rules, regulations and guidance.

Initial Here:_____

Medicaid Participant

The below initials confirm that the undersigned is enrolled as a Medicaid provider in their residing State.

Initial Here:_____

Medicare Participant

The below initials confirm that the undersigned is enrolled as a Medicare provider in their residing State.

Initial Here:_____

SIGNATURE AND CERTIFICATION

I understand, and hereby acknowledge that the information provided within this Credentialing Form is true and accurate to the best of my knowledge. I authorize WellDyneRx to consult with and inspect all WelldyneRx/NetCard Related documents from individuals and organizations having information pertaining to the operation of this pharmacy. I hereby release from liability all individuals and organizations that provide information to NetCard Systems, its parent companies and subsidiaries in good faith and without malice related to the evaluation or verification of information contained in this form. I further agree to promptly notify WellDyneRx of any change to the information provided within this form.

Signature: _____ Date: _____

Print Name: _____

Title: _____

Upon completion, attach copies of the following documents along with your completed form:

1. Current State Pharmacy Operating license
2. Current Federal DEA license
3. Current Pharmacy (not Pharmacist) malpractice liability insurance policy certificate showing expiration dates and liability coverage or indicate self-insured.
4. Please fax back to (855) 404-0968 or mail to the address below:

   NetCard Systems
   7472 S Tucson Way, Ste 100
   Centennial, CO 80112