elixir

Pharmacy Network Enrollment Request Form – Retail Pharmacies

1. Ensure Part I and II of your pharmacy's NCPDP profile is up-to-date with the most current information.
   a. In addition to this form, Puerto Rico pharmacies are required to provide their current Pharmacy License Certification of good standing from the Puerto Rico Department of Health.
2. Complete all fields on this form and return to Provider Relations via email: providerenrollment@elixirsolutions.com.
3. Once the completed form is received, Provider Relations will review this form and Part I and II of your pharmacy's NCPDP profile for credentialing.
4. You will receive an email response back stating whether your pharmacy has met the conditions to participate in the Elixir Pharmacy Network or not.
5. If you are an independent pharmacy and pass credentialing, you will be sent a Participating Provider Agreement (PPA) for signature.
6. Once Elixir has received the signed PPA from your pharmacy, please allow 7-10 business days before you are able to process claims.

Pharmacy Information

NCPDP:

Pharmacy Legal Name:

Does your pharmacy transmit claims electronically in accordance with NCPDP standards? ☐ Yes ☐ No

Ownership information:

1. Does your pharmacy ship prescriptions to members? ☐ Yes (if yes, please provide the list of states you ship to) ☐ No
2. Has this pharmacy previously operated under a different NCPDP? ☐ Yes NCPDP: ☐ No
3. Has this pharmacy undergone a change of ownership? ☐ Yes Date: ☐ No
4. If this pharmacy changed ownership, please provide an explanation of the change. (Include if the current owner(s) had any ownership previously and from whom the ownership transferred, and what %)

Other Pharmacies Owned:

1. Does your pharmacy own or share common ownership with any other pharmacies? ☐ Yes ☐ No
2. If yes, please provide the pharmacy name and NCPDP:

Percentage of Business Filled for Members In State vs. Out of State: In State: % Out of State: %

Pharmacy Type and Percentage of Business (must add up to 100%):

Community Retail	%	Long Term Care	%
Mail Order (*does not include local delivery service or shipping within the state where the pharmacy is located*)	%	Home Infusion Therapy	%
Specialty	%	Compounding	%
DME	%	Non-Pharmacy Dispensing	%
Indian Health Service/ Tribal/Urban Indian Health (ITU)	%	Institutional	%
Parenteral and Enteral Nutrition	%	Clinic	%
Managed Care Organization	%	Department of Veterans Affair	%

Nuclear	%	Military/U.S. Coast Guard	%
Oxygen Equipment	%	Nursing Facility Supplies	%
Customized Equipment	%	Dialysis Equipment	%

Certification

By signing this form, I certify that I have legal authority to act as an agent or representative of the Pharmacy for the purposes of completing this form and certify that all information contained in the form and in the Pharmacy's NCPDP profile (Part I and II) is accurate and complete. I further agree that the information on the Pharmacy's NCPDP profile will be maintained so that it remains accurate and complete at all times. I understand that if any discrepancies are discovered with the information provided on the form or contained in the Pharmacy's NCPDP Profile that the Pharmacy and any other facilities under the same ownership, may be denied, terminated or suspended from access to the Elixir Pharmacy network and may be subject to an audit as outlined in 42 C.F.R. § 423.504.

I agree that the electronic signature provided in the "Signature" field below is the legal equivalent to my manual signature for the purposes of the Form.

Signature:____

Name and Title (Print):______________________________________

Email:____

Phone Number:____

Date:____