

Pharmacy/ Pharmacist Credentialing Application

WASHINGTON STATE HEALTH CARE AUTHORITY (HCA) PROGRAM

INSTRUCTIONS

Thank you for your interest in joining the MEDICATION PATHFINDER Network for purpose of taking part in the Washington State Health Care Authority (HCA) Program. To avoid delays and ensure a timely response to your request, please complete this application in its entirety. If you have questions, please go to <http://www.medicationpathfinder.com/write2MTM.php> and send your questions electronically.

1. Complete **Sections 1 - 6** of this document.
2. Complete and sign the Software License and Support Agreement for Washington State Health Care Authority Medication Therapy Management (MTM) Program.
3. Complete and sign the Medication Pathfinder Network Provider Agreement for Medication Therapy Management.
4. Mail the completed application and the original of the above noted documents to:

**Medication Pathfinder
Clinical Support Services
701 Seneca Street, Suite 310
Buffalo, NY 14210**

1. **MTM Model Type (choose one)**

I am the administrator of a multi-store pharmacy chain authorizing store pharmacists to provide MTM Services by agreement of the corporate entity.

I anticipate providing MTM Services under the NPI of a single (chain or independent) pharmacy.

Our MTM consulting group will be providing MTM Services under the NPI of individual pharmacists servicing a multi-store pharmacy chain or academic institution (i.e., "centralized MTM model").

I anticipate providing MTM Services as a consulting pharmacist under my own NPI number.

Other _____.

2. **General Contact Information**

First Name: _____ Last Name: _____

Pharmacy / Business Name: _____

Legal Name, if different than above: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

3. **Billing Information**

First Name: _____ Last Name: _____

Pharmacy / Business Name: _____

Legal Name, if different than above: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Federal ID Tax Number: _____

4. **MTM Pharmacist Participants (choose one)**

Store-Level Participation

Store Name / Number: _____

Address: _____ City: _____

Zip Code: _____ NPI Number: _____

Store Name / Number: _____

Address: _____ City: _____

Zip Code: _____ NPI Number: _____

Store Name / Number: _____

Address: _____ City: _____

Zip Code: _____ NPI Number: _____

(Continue on separate page, if needed)

Pharmacist-Level Participation (Consultant or Centralized Services Pharmacists)

First Name: _____ Last Name: _____

Address: _____ City: _____

Zip Code(s)*: _____ NPI Number: _____

Washington State Pharmacist License Number: _____

First Name: _____ Last Name: _____

Address: _____ City: _____

Zip Code(s)*: _____ NPI Number: _____

Washington State Pharmacist License Number: _____

**Zip codes in locations where face-to-face MTM services will be provided.*

(Continue on separate page, if needed)

5. Location Features

A. Which description(s) most closely describes the organization from which you anticipate providing MTM services?

- | | |
|---|---|
| <input type="checkbox"/> Community Pharmacy (Independent) | <input type="checkbox"/> Pharmacy Consultant (Office Based) |
| <input type="checkbox"/> Community Pharmacy (Chain) | <input type="checkbox"/> Pharmacy Consultant (Home Calls) |
| <input type="checkbox"/> Physician Office | <input type="checkbox"/> Other (please specify _____) |
| <input type="checkbox"/> Clinic Facility | _____ |
| <input type="checkbox"/> Hospital | _____ |

B. Do you currently have a private counseling area to provide MTM Services?
(This is an HCA requirement.)

- Yes, in a community pharmacy location**
- Yes, in a clinic location**
- Yes, in a home visit setting**

6. Licensure/ Certification/ Malpractice

A. Has the pharmacy or any pharmacist intending to provide MTM been involved in a malpractice suit within the past five years?

- Yes** **No** (If Yes, please clarify on an attached sheet.)

B. Has any malpractice carrier made an out-of-court settlement or paid a judgment of professional liability claim on behalf of the pharmacy or pharmacist intending to provide MTM within the past five years?

- Yes** **No** (If Yes, please clarify on an attached sheet.)

C. Has the pharmacy or any pharmacist intending to provide MTM been convicted of a felony in the last five years?

- Yes** **No** (If Yes, please clarify on an attached sheet.)

STATEMENT OF CERTIFICATION & SIGNATURE

All information provided in or in connection with this application is complete and accurate to the best of my knowledge. I agree the Medication Pathfinder, its representatives, employees and agents shall not be liable for any act or omission related to the evaluation or verification of information contained in this application. I further agree to promptly notify Medication Pathfinder of any change to the information provided with this application.

Signature: _____ **Date:** _____

Title: _____