



PHARMACY CREDENTIALING APPLICATION

INSTRUCTIONS

Thank you for your interest in joining the CIGNA Healthcare's Pharmacy Network. To avoid delays and ensure a timely review and response to your request, please complete this application in its entirety and provide all of the required documents listed below. If you have any questions please email them to PharmacyNetworkOperations@CIGNA.COM.

1. Complete sections I-IV and V-VI (if applicable). Be sure to sign sections III-IV and V-VI (if applicable).
2. Attach copies of the following documents along with your completed application:
 - i. Description (1-2 paragraphs) of the **primary and ancillary services offered to the community**
 - ii. Current **State Pharmacy Operating license**
 - iii. Current **Federal DEA license**
 - iv. Current **Pharmacy (not Pharmacist) malpractice liability insurance policy certificate** showing expiration dates and liability coverage (general aggregate must be a minimum of \$2,000,000) or indicate if self-insured.
3. Mail the completed application and above noted documents to the following location (**faxed applications will not be accepted**):

**CIGNA Pharmacy Network Operations
Attn: Network Support Administrator B5PHR
900 Cottage Grove Rd
Hartford, CT 06152**

4. Please allow for 10 business days to review your credentialing application. If approved, we will fax or email you 2 copies of the Participating Pharmacy Agreement and supporting contracting documents. If denied you will be notified by mail.

I. GENERAL INFORMATION *(Please type or print legibly)*

Legal Name: _____ DBA Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

NCPDP#: _____ NPI#: _____ Email Address: _____

Contact Name: _____ Phone Number: _____ Fax Number: _____

Pharmacy Owner Name: _____ Phone Number: _____

II. PHARMACY TYPE

1. 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/Open _____ % Long Term Care (Complete **Section VI.** below)
_____ % Specialty _____ % Home Infusion (Medicare Only -also complete **Section VII.**)
_____ % Compounding _____ % 340B Safety Net (Medicare Only)
_____ % Clinic/Hospital _____ % Indian Tribal Urban / Indian Health Services (Medicare Only)
_____ % Mail Order (Medicare only) _____ % State / Government owned/operated (Medicare Only)

2. Is your pharmacy physically accessible to the general public?
Yes _____ **No** _____ (If **No**, please clarify)

3. Is there a patient waiting area adjacent to where prescriptions are dispensed and sold?
Yes _____ **No** _____ (If **No**, please clarify)

4. Are the prescriptions hand delivered to the members?
Yes _____ **No** _____ (If **No**, please clarify)

5. Can you provide services to all members?
Yes _____ **No** _____ (If **No**, please clarify)

6. Can your pharmacy provide a majority of covered services to our members?
Yes _____ **No** _____ (If **No**, please clarify)

7. Is your pharmacy located within a hospital, skilled nursing facility, nursing home or other type of facility?
Yes _____ **No** _____ (If **Yes**, please clarify)

8. Do you provide mail order services outside of your state?
Yes _____ **No** _____ (If **Yes**, please clarify)

9. Are you interested in participating in Medicare Part D?
Yes _____ **No** _____ (If **Yes**, please complete section V. with the mandatory initials.)

10. Are you interested in participating in 90 day at retail program?
Yes _____ **No** _____

11. Are you interested in participating in Worker's Compensation Program?
Yes _____ **No** _____

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III. STATE LICENSURE/CERTIFICATION/MALPRACTICE

1. Pharmacies are required to maintain signature logs (paper, electronic or Medication Administration Record (MAR) for all prescriptions and required to advise Members that their signatures acknowledge receipt of prescriptions and allow for the release of any and all information supporting that claim.

Indicate your agreement and compliance with this requirement by initialing here. _____

Initial Here

2. Has your pharmacy DEA registration number or operating license ever been suspended or revoked?
Yes _____ **No** _____ (If **Yes**, please clarify)
3. Has the pharmacy or any pharmacist employed by the pharmacy been involved in a malpractice suit within the past five years?
Yes _____ **No** _____ (If **Yes**, please clarify)
4. Has any malpractice carrier made an out-of-court settlement or paid a judgment of professional liability claim on behalf of your pharmacy within the past five years?
Yes _____ **No** _____ (If **Yes**, please clarify)
5. Has your pharmacy's malpractice coverage been denied or canceled in the past five years?
Yes _____ **No** _____ (If **Yes**, please clarify)
6. Has the pharmacy or any pharmacist employed by the pharmacy been convicted of a felony within the past five years?
Yes _____ **No** _____ (If **Yes**, please clarify)
7. Has your pharmacy been expelled or suspended from service reimbursement from Medicare / Medicaid or been signed in an Enforcement Bureau Judgment by the state within the Past five years?
Yes _____ **No** _____ (If **Yes**, please clarify)
8. Are there any employees currently employed by the pharmacy who would not be covered by the company's malpractice insurance policy or their own malpractice insurance policy?
Yes _____ **No** _____ (If **Yes**, please clarify)
9. I hereby attest that the undersigned pharmacy participates in a **Quality Assurance Program**, if mandated by state law. If a Quality Assurance Program is **NOT** mandated, your Pharmacy has **formal written procedures for preventing and handling prescription errors**.

Indicate your agreement and compliance with this requirement by initialing here. _____

Initial Here

IV. CERTIFICATION & SIGNATURE

All information provided in or in connection with this application is complete and accurate to the best of my knowledge. I understand that this application does not entitle me to participation in the CIGNA HealthCare National Retail Pharmacy Network. I authorize CIGNA HealthCare to consult with and inspect all documents from individuals and organizations having information pertaining to the operation of this pharmacy. I agree that CIGNA HealthCare, 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 CIGNA HealthCare of any change to the information provided with this application.

Signature: _____ Date: _____

Title: _____

Sign Here

Reminder: Please complete the following sections **V. Additional Medicare Requirements** and **VI. Additional LTC Requirements** (if applicable) and **VII. Home Infusion State Licensure** (if applicable)


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V. ADDITIONAL MEDICARE REQUIREMENTS (if applicable)

Conflict of Interest Certification

I hereby attest that the undersigned entity has policies and procedures in place to ensure our managers, officers and directors responsible for the administration or delivery of Part D benefits sign a conflict of interest statement, attestation, or certification at the time of hire and annually thereafter certifying that the manager, officer or director is free from any conflict of interest in administering or delivering Part D benefits.

Indicate your agreement to this by initialing here _____




Initial Here

OIG and GSA Exclusion Review Process Certification

I hereby attest that the undersigned entity has policies and procedures in place to review the Office of Inspector General (OIG) and General Services Administration (GSA) exclusions lists upon initially hiring and annually thereafter to ensure that any employee or manager responsible for administering or delivering Part D benefits is not excluded from Federal health care programs. Additionally, if an employee is identified to be on such lists, that employee will immediately be removed from any work related directly or indirectly to all Federal health care programs and the entity will take appropriate corrective actions.


Indicate your agreement to this by initialing here _____



Initial Here

Medicare Part D Vaccine Administration Amendment will be included in your contract, unless you initial here that you are NOT interested in participating in this Program.

Indicate that you decline to participate in the Vaccine Administration Program here _____



Initial Here

VI. ADDITIONAL LTC REQUIREMENTS (if applicable)

As defined by the Medicare Prescription Drug Benefit Plan Final Rules, long term care (LTC) facilities include skilled nursing facilities as defined under Title XVIII of the Social Security Act (the Act), or a medical institution or nursing facility for which Medicaid makes payment throughout a month as defined under Title XIX of the Act.

Performance and Service Criteria for Network LTC pharmacies (NLTCPs) (Provided or contracted by your pharmacy, through an in network pharmacy provider)

- | | | | |
|---|-----------|----------|-------------|
| 1. Comprehensive Inventory and Inventory Capacity | Yes _____ | No _____ | Other _____ |
| 2. Pharmacy Operations and Prescription Orders | Yes _____ | No _____ | Other _____ |
| 3. Special Packaging | Yes _____ | No _____ | Other _____ |
| 4. IV Medications | Yes _____ | No _____ | Other _____ |
| 5. Compounding /Alternative Drug Composition | Yes _____ | No _____ | Other _____ |
| 6. Pharmacist On-call Service | Yes _____ | No _____ | Other _____ |
| 7. Delivery Service | Yes _____ | No _____ | Other _____ |
| 8. Emergency Boxes | Yes _____ | No _____ | Other _____ |
| 9. Emergency Log Books | Yes _____ | No _____ | Other _____ |
| 10. Misc. Reports, Forms and Prescription Ordering Supplies | Yes _____ | No _____ | Other _____ |

Low-income Subsidy Cost Sharing Certification

I hereby attest that the undersigned pharmacy(ies) do not collect cost sharing charges for LIS-eligible beneficiaries, and that any statements of such cost sharing charges submitted by the pharmacy(ies) to CIGNA Pharmacy Management are appropriate, owed and payable. The pharmacy agrees to notify CIGNA Pharmacy Management within 30 days of changes to the collection of cost sharing charges for LIS-eligible beneficiaries.

Do you collect cost sharing charges (i.e. copays) for LIS-eligible beneficiaries? Yes _____ No _____

Indicate your agreement to this by initialing here _____



Initial Here

VII. Home Infusion State Licensure (if applicable)

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# _____, expiration date _____; state _____, license# _____, expiration date _____;
state _____, license# _____, expiration date _____; state _____, license# _____, expiration date _____.

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