Express Scripts
One Express Way
Attention: NetSpec, Mail Stop HQ 2W02
St. Louis, MO 63121
Email: NetSpec@express-scripts.com

EXPRESS SCRIPTS

PROVIDER VERIFICATION FORM

Please make ONLY the corrections or additions to sections that need updating. Section D and signature line are MANDATORY in order to have your updates recorded in our system. Please print clearly or type.

SECTION A: PROVIDER INFORMATION

NPI #:	Medco* Account # (if applicable)	NCPDP #:
Pharmacy Name/D.B.A. or Dispensing prescriber name:		
Corporate Name:		
Physical Street Address:		
City: State: Zip:	Pharmacy Phone #:	Secure Fax #:
Mailing address:		
City: State: Zip:		
Remit-to Address:		
City: State: Zip:	Phone Number:	
Provider agrees to hold Express Scripts and Sponsors harmless for any payments made by Express Scripts to a third party if Provider designated such third party to receive payments and statements on behalf of Provider.		
List all pharmacist's names and license #'s (attach separate sheet if necessary):		
Pharmacist-in-charge:	R.Ph. license #:	Pharmacist NPI #:
Pharmacist name:	R.Ph. license #:	Pharmacist NPI #:
Pharmacist name:	R.Ph. license #:	Pharmacist NPI #:
Contact Name:	Email address:	
Phone #:	Provider Website:	

SECTION B: PROFESSIONAL PRACTICE SETTING(S): (Indicate the anticipated percent of Rx volume in each setting to equal 100%).

☐ Retail/Community ____%	☐ LTC facility ____%	☐ Clinic____%	☐ Government owned ____%
☐ Home infusion ____%	☐ Assisted Living Facility (ALF) ____%	☐ University Health System Phcy ____%	
☐ Tribal Authority/Urban Indian ____%	☐ Mail order ____%	☐ Specialty ____%	
☐ Dispensing Prescriber ____%	☐ _____ ____% (Other)	☐ On-site nursing home ____%	
☐ Hospital outpatient clinic____%	☐ Compounding ____%		

☐ What percentage of prescriptions are mailed or shipped via common carrier? ____%

SECTION C: Business Information

DEA #:	State Board of Pharmacy License #:	Federal Tax ID #:
Medicare Part B supplier ID #:	Effective date:	
List all Provider's Medicaid #'s issued by specific state:		
State: _____ Medicaid #: _____	State: _____ Medicaid #: _____	
Is Provider open to the general public? ☐ Yes ☐ No	Does retail pharmacy have a store front with signage? ☐ Yes ☐ No	
Is Provider on-site of a nursing home? ☐ Yes ☐ No		

** Medco Health Solutions, Inc. ("Medco") is a wholly-owned subsidiary of Express Scripts Holding Company ("Express Scripts").*

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SECTION C: Business Information (Continued):

Computer software vendor: Switch vendor: Electronic claims submission in NCPDP vD.0 (mandatory)? ☐ Yes ☐ No
Insurance carrier:
Liability insurance – minimum required insurance amount of $1,000,000 / $3,000,000 ☐ Yes ☐ No
☐ e-Prescribing enabled ☐ Open 24 hours ☐ Emergency services ☐ Handicap access ☐ TTY (hearing impaired)

Please complete the following regarding Hours of Operation:

Weekdays:	Saturdays:	Sundays:	Holidays:
_____ a.m. to _____ p.m.	_____ a.m. to _____ p.m.	_____ a.m. to _____ p.m.	_____ a.m. to _____ p.m.

☐ Minority owned / operated business ☐ Woman owned / operated business ☐ Small business

Other pharmacy information: (This section is required. Enter N/A if not applicable.)

Provide NCPDP #, NPI #, pharmacy name and address for any pharmacy in which owners have a financial interest:	
NCPDP #	Pharmacy Name:
NPI #	Pharmacy Address:
NCPDP #	Pharmacy Name:
NPI #	Pharmacy Address:
NCPDP #	Pharmacy Name:
NPI #	Pharmacy Address:

SECTION D: Attestation:

Has any disciplinary action been taken, or is there any pending sanction by a regulatory agency or government agency, including but not limited to exclusion or debarment under any state or federal health care program, any state board of pharmacy, or the Centers for Medicare and Medicaid Services (CMS) for Title XVIII (Medicare) or Title XIX (Medicaid), against applicant, owner or staff pharmacist(s) in the past five (5) years?

☐ Yes ☐ No

If yes, please describe action, provide agency name and attach applicable documentation:

I certify I have checked all employees against the federal and state government exclusion lists annually.

I certify I will not bill to or charge to Express Scripts any prescriptions or claims handled, prescribed or dispensed by individuals on any state or federal exclusion list.

I certify that training by pharmacy staff meets CMS requirements and is conducted upon hire and annually. Training logs available upon request.

I certify that we provide eligible members with the CMS notice "Medicare Prescription Drug Coverage and Your Rights" upon receipt of a point-of-sale notification to do so.

Pharmacy represents and warrants that the information contained herein is true and accurate.

List all owners' names (please print)

Owner Name:	Owner Title:	Date of ownership:
Owner Name:	Owner Title:	Date of ownership:
Owner Name:	Owner Title:	Date of ownership:

Authorized signature:	Date:
Print name:	Title: