Comprehensive Audit Prevention Services, L.L.C.

PARTICIPATING PROVIDER PROFILE ADDENDUM

(All information is required for CAPS enrollment)

☐ **Updated/Renewal**
☐ **New**

Pharmacy DBA Name: _____

Corporate Name: _____

_____

Street Address City State Zip

_____

Mailing Address City State Zip

_____

Billing Address City State Zip

Pharmacy Phone # (_____) _____ - _____ Pharmacy Fax # (_____) _____ - _____

Owner: _____ Pharmacist In Charge: _____

Email address: _____ Website Address: _____

NCPDP# _____ NPI # _____

STAFF INFORMATION (check main point of contact)

☐ Pharmacist: _____

☐ Pharmacy Technician: _____

☐ Pharmacy Technician: _____

Do you have three (3) or more pharmacies being covered by this agreement? If yes, Please list applicable chain code(s): _____ ☐ Yes ☐ No

Is this pharmacy an open-door retail pharmacy where you will fill prescriptions for all walk in customers without restrictions? ☐ Yes ☐ No

Do you maintain patient profiles? ☐ Yes ☐ No
If yes, are they electronic? ☐ Yes ☐ No

Is this pharmacy equipped to submit claims electronically in the most current NCPDP format? ☐ Yes ☐ No

Has the pharmacy ever changed names? If yes, when? _____ ☐ Yes ☐ No
Please include any previous name(s):_____
_____

Has the pharmacy ever undergone a change in ownership? If yes, when?_____ ☐ Yes ☐ No
Please include previous owner's name(s):_____
_____

PHARMACY INFORMATION

Is your pharmacy affiliated with any PSAO(s) (Pharmacy Services Administrative Organization(s)?

☐ Yes ☐ No

If yes, name of PSAO(s): ☐ APNS ☐ United ☐ Access ☐ Good Neighbor

Other: _____

Are you a member of APCI? ☐ Yes ☐ No

How did you hear about Comprehensive Audit Prevention Services (CAPS)?

_____

Enrollment:

I authorize American Pharmacy Cooperative, Inc. (APCI) to deduct any funds from my account to pay the monthly enrollment fee for *Comprehensive Audit Prevention Services (CAPS).* It is my desire to participate in CAPS and my signature below is confirmation of participation for membership which will renew automatically on a monthly basis from the date below.

_____	_____
Signature	Signature
_____	Jessica Cain CPhT
Print Name	Print Name
_____	_____
Date	Date

Comprehensive Audit Prevention Services, L.L.C.