KERN HEALTH SYSTEMS
PHARMACY APPLICATION

☐ Initial Application ☐ Recredentialing ☐ Additional Location

CORPORATE IDENTIFICATION INFORMATION	
Legal Business Name: (As reported to the IRS)	Federal Tax Identification Number (TIN):
Doing Business As (DBA) Name: (If applicable)	National Provider Identifier (NPI) for facility being credentialed:
Corporate Address:	Length of time in business with this Name and Tax ID: _____ Years _____ Months

PHARMACY INFORMATION SITE #1 ***Address must be a street address, not a Post Office box.***

NABP Number:			
Pharmacy Name:			
Address Line:			
City:	State:	Zip:	County:
Phone:	( )	Fax:	( )
Pharmacy Permit Number:		Permit Expiration:	
DEA Number:		DEA Expiration:	

Services provided at this location:
☐ Compounding ☐ DME ☐ Home Infusion ☐ Enteral Feeding ☐ TPNs ☐ Delivery

PHARMACY HOURS:

	SUN	MON	TUES	WED	THURS	FRI	SAT
Open AM							
Close PM							

PHARMACY INFORMATION SITE #2 ☐ ***Not Applicable or*** ☐ ***Additional Sites on Separate Sheet***

NABP Number:			
Pharmacy Name:			
Address Line:			
City:	State:	Zip:	County:
Phone:	( )	Fax:	( )
Pharmacy Permit Number:		Permit Expiration:	
DEA Number:		DEA Expiration:	

Services provided at this location:
☐ Compounding ☐ DME ☐ Home Infusion ☐ Enteral Feeding ☐ TPNs ☐ Delivery

PHARMACY HOURS:

	SUN	MON	TUES	WED	THURS	FRI	SAT
Open AM							
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CREDENTIALING CONTACT INFORMATION			
Credentialing Contact Name:			
Mailing Address:			
City:	State:	Zip:	Phone:
Fax:		Email:	

STAFFING ATTESTATION	
Select the method(s) the facility uses to verify the identity, license, certification, and criminal background of the individuals rendering services for your organization?	
☐ Credentialing procedures are performed internally. ☐ Credentialing procedures are outsourced/delegated to: ☐ On-line directory with the appropriate state and/or federal licensure or certification board ☐ Background check agency, contracted organization or vendor	
☐ No process please explain	***Explanation:***

MEDI-CAL & MEDICARE STATUS **Kern Health Systems requires all providers to be enrolled with the Department of Health Care Services Medi-Cal Fee-For-Service Program. <u>Each location</u> will be verified for current enrollment status by location in order to participate in the KHS Network.**		
1. Is this facility participating in the Medi-Cal program?	☐ Yes	☐ No
Medi-Cal Number:	Date of initial Certification:	
2. Is this facility participating in the Medicare program?	☐ Yes	☐ No
Medicare Number:	Date of initial Certification:	

Medi-Cal Enrollment

Kern Health Systems requires all Pharmacy locations to be enrolled with the Department of Health Care Services Medi-Cal Fee-For-Service Program. Each location will be verified for current enrollment status by location.

Liability Information

Kern Health Systems requires all contracted pharmacies to carry adequate professional liability coverage. The following minimums must be adhered to by all pharmacies:
Professional (Malpractice) $1,000,000 per occurrence / $3,000,000 annual aggregate
General Liability $1,000,000

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Disclosures/Attestation Questions:

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Please provider written explanation for any questions answered "Yes", *Except #10 - #8 & #9 provide copies of certificate of insurance coverage.			
1.	Has your Pharmacy(s) ever been disciplined by any state licensing or other authorizing agency, or has the organization or its branch locations ever voluntarily surrendered any license or certification while under investigation, or are there any actions or investigations currently under way which would lead to one of these outcomes?	☐ Yes	☐ No
2.	Has your Pharmacy(s) ever been the subject of an investigation or ever been terminated, suspended, sanctioned, assessed a penalty/fine or otherwise restricted from participating in any private or public program, including but not limited to, Medicare, Medicaid/Medi-Cal, military, and State Department of Health Programs?	☐ Yes	☐ No
3.	Has this Pharmacy(s), under current, former name, or business identity, ever had it accreditation revoked or suspended?	☐ Yes	☐ No
4.	Does your Pharmacy(s) or any of its authorized representatives currently have any pending or settled legal actions?	☐ Yes	☐ No
5.	At any time, has any third party payer ever revoked, reduced, denied, or suspended your Pharmacy(s) participation due to inappropriate utilization management, quality of concerns, or any other reason?	☐ Yes	☐ No
6.	Has any managing employee or person with an ownership or controlling interest in this Pharmacy(s) been excluded, sanction or debarred from participation in any government health care program?	☐ Yes	☐ No
7.	Has your Pharmacy(s) liability insurance coverage, for any reason, been denied, cancelled, restricted/limited, not renewed, or initially refused upon application?	☐ Yes	☐ No
8.	Is your Pharmacy(s) covered by Commercial General Liability insurance in the amount of $1million per occurrence? (*Provide copy)	☐ Yes	☐ No
9.	Is your Pharmacy(s) covered by Professional Liability insurance in the amount of $1million per occurrence and $3million aggregate as a covered facility/organizational policy (not individual-only policy)? (*Provide copy)	☐ Yes	☐ No
10.	Does your Pharmacy(s) comply with State and Federal handicap access standards?	☐ Yes	☐ No

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Attestation and Release of Information

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Release of Information:

As part of the application process and for the purpose of verifying any information provided on this application, I the undersigned, authorized agent of the facility/organization listed below, grant Kern Health Systems permission to contact any individual, institution, facility or agency identified on, or relative, to the evaluation of this application for the purposes of credentialing or recredentialing.

I, further understand, as an authorized agent of the facility/organization, that I and the facility/ organization have the burden of producing adequate information for the proper evaluation of the organization's competence, character, and ethics in resolving doubts about such qualifications.

I hereby grant permission for Kern Health System Representatives to conduct on-site and medical record reviews as necessary. I agree that this facility/organization will participate in and support Kern Health System's quality improvement and utilization review programs.

Release from Liability:

I, the undersigned, a duly authorized agent of the facility/organization, hereby release from any and all liability Kern Health Systems (KHS or Health Plan name: Kern Family Health Care), its respective agents and employees, for acts performed in good faith in connection with evaluating this facility/organization's credentialing and recredentialing applications. I also release from any and all liability all individuals and organizations who in good faith, at any time, provider KHS with information concerning this application.

I also herby attests to the correctness and completeness of this application and agree to notify KHS of any changes to information provided herein in accordance with timely notification as outlined in the contractual agreement.

Attestation:

I understand and hereby attest, and certify, that all information submitted on this application is true, accurate, and complete to the best of my belief and knowledge. I fully understand that any falsifications, misstatements in or omissions from the application, whether intentional or not, may constitute cause for denial from participation from the KHS Health Plan.

Signature: _____ Date: _____

Print Name: _____ Title: _____