CAQH PROVIEW ACCOUNT
GUIDE FOR COMMUNITY PHARMACISTS

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In the State of Tennessee, pharmacists are recognized as providers and may be credentialed and contracted with third party payers to bill medical insurance for pharmacy services. The first step in this process requires completion of your **CAQH ProView Profile**. This profile is free, but requires several pre-requisite steps, including obtaining an **Individual NPI Number** and a **CAQH Provider ID**.

Please use the step-by-step instructions below to help guide you through preparation and completion of your CAQH ProView Profile.

You may assign another individual at your practice site to complete this process on your behalf. This is called a **credentialing contact**. The credentialing contact will need to collect all necessary information in order to accurately complete your profile. The **CAQH ProView Profile Template** will help you or your credentialing contact collect all necessary information to complete the profile. It is your responsibility to review the profile and complete the attestation prior to final submission.

BEFORE YOU BEGIN

1. **Obtain necessary pre-requisite ID numbers** (See “Getting Started” instructions on page 2)

2. **Gather Required Documents and/or Information:**
   - ☐ NPI Number (See “Getting started” instructions below)
   - ☐ Personal Information (e.g., name, contact info, SSN, demographics)
   - ☐ Practice Location Information (e.g., legal name, EIN, contact info)
   - ☐ Pharmacist Licensure Information (e.g., state(s), number, expiration)
   - ☐ Education (e.g., program information, start and end dates)
   - ☐ Professional Training (e.g., program information, start and end dates)
   - ☐ Completion of Cultural Competency Training (See Appendix)†
   - ☐ Board Certification (e.g., initial certification date and expiration)
   - ☐ BLS/ACLS/PALS Certification(s) (e.g., certificate number, certification date, expiration)
   - ☐ Copy of Current Professional Liability Insurance Policy*
   - ☐ Employment history for past 10 years (including start and end dates, explanation of gap dates)
   - ☐ Medicaid Number (See Appendix)†
   - ☐ Medicare Number (See Appendix)†

3. **Determine who will complete the ProView Profile**
   - ☐ Pharmacist Provider
   - ☐ Credentialing Contact – *If an individual at your practice site is selected to be a credentialing contact on behalf of the pharmacist, the pharmacist should complete the CAQH ProView Profile Template included in this document.*

*If you do not carry a Personal Professional Liability Policy and are covered under your employer’s policy, you will need to upload BOTH the COI from the insurance company AND a statement from your employer on company letterhead stating that you are covered.

†This item is not required in order to complete and submit CAQH ProView Profile. However, third party payers (including Medicaid and Medicare) may require it in order to complete the credentialing process.

GETTING STARTED – 20 MINUTES (TOTAL)

≥ 24 HOURS PRIOR: Obtain Individual NPI number

1. Visit https://nppes.cms.hhs.gov/#/ and select CREATE or MANAGE AN ACCOUNT
2. Follow Steps to create Identity & Access Management System (I&A) user ID and password
3. Return to NPPES and use I&A user ID and password to sign-in
4. Follow instructions to create your individual provider ID
5. Record below:

I&A User ID: ______________________________ NPI: ______________________________________
I&A Password: ____________________________

Register for CAQH Provider ID and create CAQH ProView Account

6. Visit https://proview.caqh.org/PR/Registration to register for **CAQH Provider ID**

   NOTE: Community Pharmacists should make the following selections:
   NUCC Grouping: Pharmacy Service Providers
   Provider Type: Pharmacist

7. Check email for **CAQH Provider ID** and click internal link to register for **CAQH ProView Account**

   NOTE: If you do not have a DEA, UPIN, or TIN number: leave field blank

8. Log-in to ProView Account https://proview.caqh.org/Login/Index?ReturnUrl=%2f
9. Record below:

CAQH Provider ID: __________________________ CAQH ProView Username: _____________________________
CAQH ProView Password: ______________________________

Tip: If you are registering multiple pharmacists at your practice site, use the CAQH ProView Practice Manager Module to reduce data entry redundancy: https://proview.caqh.org/Login?Type=PM

COMPLETING PROFILE – 2 HOURS (TOTAL)

Instructions: You must select 'Save' or 'Save & Continue' at the bottom of each screen. If you return at a later time to make edits, be sure to save it again.

The CAQH ProView Profile is comprised of 12 sections. We have provided tips for answering questions, based on your role as a community pharmacist.

NOTE: Once your profile is complete, each time you make a change, you will need to 'Review & Attest' to changes after each log in/log out.

CAQH PROVIEW ACCOUNT TEMPLATE

***Denotes required field**

SECTION 1: PERSONAL INFORMATION

PRACTICE INFORMATION	***NUCC Grouping:** Select *"Pharmacy Service Providers"*
	***Provider Type:** Select *"Pharmacist"*
	***Practice Setting:** Select *"Inpatient/Outpatient or Outpatient Only"*
	***Primary Practice State:**
	Additional Practice State(s):
PERSONAL INFORMATION	***First Name:** Middle Name: ***Last Name:** Suffix:
	Other Name(s):
	Street Address (Home or Mailing):
	City: State: Zip Code: Country:
CONTACT INFORMATION	***Primary Email:** Additional Email:
	Home Phone: Cell Phone: Fax Number:
PERSONAL ID NUMBERS	***Social Security Number:**
	***Individual NPI:**
	Foreign National Identification Number (FNIN) (If applicable):
	Unique Physician Identification Number (UPIN): *This section is not applicable to pharmacists.*
DEMOGRAPHICS	***Gender (Select One):** Male / Female / Unknown
	***Birth Date:**
	Race/Ethnicity (Select One): American Indian or Alaska Native / Asian / Black or African American / Hispanic or Latino/a Native Hawaiian or Other Pacific Islander / Prefer Not to Say / White/Caucasian / Other
	Birth City: Birth State: Birth Country:
LANGUAGE	Non-English Languages Spoken by Provider:

SECTION 2: PROFESSIONAL IDS

PROFESSIONAL LICENSE	***State:**
	***Currently Practicing (Select One):** Yes / No
	***License Number:** License Type: Leave Blank
	License Status (select one): If you have an active pharmacy license, Select *"Active"*

	Issue Date (MMDDYYYY): ***Expiration Date (MMDDYYYY):**
	Additional State(s): Please provide complete information for all states:
DEA REGISTRATION	***Do you have a DEA registration (Select One):** Select *"No"* (for most pharmacists)
	If NO: **Check the box:** Select "*I do not prescribe controlled substances*" **Reason for not having DEA Registration:** Select "I don't have a DEA due to my provider type"
	If YES: ***DEA Number:** ***State:** Issue Date (MMDDYYYY): ***Expiration Date (MMDDYYYY):**
CDS	*This section is not applicable to pharmacists.*
MEDICAID	In order to bill for pharmacy services under Medicaid, you must have a Medicaid Number (i.e., TennCare ID). Please see the Appendix for instructions to obtain your Medicaid Number. If you do *not* have a Medicaid number, skip this section. ***Medicaid Number:** ***State:**
	Additional State(s):
MEDICARE	In order to bill for pharmacy services under Medicare, you must have a Medicare Number (i.e., PTAN). Please see the Appendix for instructions to obtain your Medicare Number. If you do *not* have a Medicare number, skip this section. ***Medicare Number:** ***State:**
	Additional State(s):
ECFMG	*This section is not applicable to pharmacists.*
USMILE	*This section is not applicable to pharmacists.*
WORKERS COMP.	Workers Compensation Number (if applicable):

SECTION 3: EDUCATION & PROFESSIONAL TRAINING

EDUCATION	***Education Type:** Select *Professional School*
	***State:** County: Country:
	***Professional School:**
	***Degree:**
	Area of Training / Course of Study / Major:
	***Start Date (month/year):** ***End Date (month/year):**
	***Did you graduate (or will you graduate within 90 days) from this school (Select One):** Yes / No

PROFESSIONAL TRAINING

Please enter information about your internship, residency, or other training programs. Please be as specific as possible when entering contact information as it will be used by your authorized health plans/organizations to verify your training.

If you do *not* have additional professional training, skip this section.

***Training Type (Select One):**

Internship (*not IPPE/APPE*) / Residency / Fellowship / Continuing Medical Education / Faculty Positions or Academic Appointments

***Institution/Hospital Name:** Affiliated University:

State: County: Country:

Institution Email Address:

*** Start Date (month/year):** ***End Date (month/year):**

Type of Program (Select One): Straight / Transitional / Rotating / 5th Pathway / Other Specialty:

***Did you graduate (or will you graduate within 90 days) from the training program at this institution (Select One):** Yes / No
***Completion Date (MMYYYY):**

Additional Training(s): List all information for each additional training program.

CULTURAL COMPETENCY

Cultural Competency Training is required training by many third-party payers. The Tennessee Pharmacists Association (TPA) provides this training. Please see the Appendix. If your pharmacy is accredited for DMEPOS, you should have an annual training form that documents this training in your employee file. Your employer should be able to provide you with the copy.

***Have you completed cultural competency training?** Yes / No

SECTION 4: SPECIALTIES

PRIMARY SPECIALTY

***Do you have any specialties (Select One)?** Select *"Yes"*

***Primary Specialty:** Select *"Pharmacist"*

***Are you board certified (Select One)?** Yes / No

If YES:
***Name of Certifying Board (check one):**

- ☐ Board of Pharmaceutical Specialties
- ☐ National Association of Boards of Pharmacy
- ☐ National Institute for Standards of Pharmacist Credentialing
- ☐ Other, Not List

Street Address:

City: State: Zip Code:

County: Country:

***Initial Certification Date (MMDDYYYY):** ***Expiration Date (MMDDYYYY), if applicable:**

Are you listed in the American Board of Medical Specialties (Select One): Yes / No

Do you wish to be listed in the directory under this primary specialty?
Select directories that you would like to be listed under:

- ☐ HMO
- ☐ PPO
- ☐ POS

SECONDARY SPECIALTY

Additional Specialty: List all information for secondary specialty:

CERTIFICATIONS

Do you have any certifications (Select One): Yes / No

If YES:
Select any certifications you have:

	Certification	State	Number	Certification Date (MMDDYYYY)	Expiration Date (MMDDYYYY)
☐	Qualified Autism Service Provider (QASM)	N/A			
☐	Cardio-Pulmonary Resuscitation (CPR)				
☐	**Basic Life Support (BLS)**				
☐	Advanced Cardiac Life Support (ACLS)				
☐	Advanced Life Support in OB (ALSO)	N/A	N/A	N/A	
☐	Health Care Provider (CoreC)	N/A	N/A	N/A	
☐	Advanced Trauma Life Support (ATLS)				
☐	Neonatal Advanced Life Support (NALS)				
☐	Neonatal Resuscitation Program (NRP)	N/A	N/A	N/A	
☐	Pediatric Advanced Life Support (PALS)				
☐	Anesthesia Permit	N/A	N/A	N/A	N/A
☐	Other:				

TCN

This section is not applicable to pharmacists.

PROFESSIONAL ASSOCIATIONS

Please list any professional associations for which you are a member. If you are not a member of a professional association, skip this section.

Association	*Start Date (MMYYYY)	*End Date (MMYYYY)

OTHER INTERESTS

Provide additional areas of professional practice interest, activities, procedures, diagnoses, or populations:

SPECIAL EXPERIENCE, SKILLS AND TRAINING

Please select one or more special experience, skills and training that apply from the list below:

Patient populations

- ☐ Adolescents
- ☐ Children
- ☐ Children in the care or custody of DCF
- ☐ Child Welfare
- ☐ Homelessness
- ☐ Lesbian, Gay, Bisexual, Transgender Issues
- ☐ Youth Affiliated with DYS

Behavioral Conditions

- ☐ Anger issues
- ☐ Anxiety
- ☐ Attention Deficit/Hyperactivity Disorder (ADHD)
- ☐ Bipolar Depression
- ☐ Gender Dysphoria
- ☐ Geriatric Behavioral Health
- ☐ Obsessive Compulsive Disorder (OCD)
- ☐ Serious Mental Illness
- ☐ Sleep Disorders
- ☐ Substance Abuse
- ☐ Trauma

Additional Experience, Skills or Training

- ☐ Autism Spectrum Disorders
- ☐ Chronic Illness
- ☐ Co-occurring Disorders
- ☐ HIV/AIDS
- ☐ Other

Physical Conditions

- ☐ Blindness or Visual Impairment
- ☐ Deafness or Hard-of-hearing
- ☐ People with Disabilities
- ☐ Physical Disabilities

Therapeutic Methods and Tools

- ☐ Dialectical Behavioral Therapy (DBT)
- ☐ Group Therapy
- ☐ Marriage and Family Therapy
- ☐ Medical Illness and Therapy
- ☐ Medication Management and Therapy
- ☐ Neuropsychological Testing (adolescents)
- ☐ Neuropsychological Testing (children)
- ☐ Play Therapy
- ☐ Postpartum Depression and/or Psychosis
- ☐ Psychological Testing (adolescents)
- ☐ Psychological Testing (children)

SECTION 5: PRACTICE LOCATIONS

PRACTICE LOCATIONS

Please add practice location information for each practice at which you currently, or will in the near future, see patients, fill in for other providers, read tests, or provide other services. If you do not practice at a location that appears in the list, please click Edit to update your status.

Make sure to enter all group/practice information in the Employment Information section of your profile.

***Practice Location Name** (Public name that patient would reference if calling to make an appointment):

***Street Address:**

***City:** ***State:** ***Zip Code:**

County: ***Country:**

Practice Location Email Address (Public):

Practice Location Website:

PHONE

***Public Phone Number (for Patient Appointments):** Ext:

Fax Number:

BUSINESS IDENTIFIERS

Legal Business Name (as it appears on W-9):

***Tax ID:** ***Type of Tax ID (Select One):** Group / Individual

ORGANIZATION

Organization NPI number:

Type of Practice:

- ☐ Corporation
- ☐ Group
- ☐ Group Primary Care
- ☐ Group/Single/Clinic
- ☐ Home Based
- ☐ Hospital Based
- ☐ Individual
- ☐ Multispecialty Group
- ☐ Multispecialty Group/Other
- ☐ Partnership
- ☐ Single specialty group
- ☐ Solo Practice
- ☐ Solo Primary Care
- ☐ Solo Specialty Care
- ☐ Teaching or Research
- ☐ Urgent Care
- ☐ Other

Subspecialty: Select *"Pharmacist"*

Type of Service Provided: Leave blank

Please provide a narrative description of your clinical practice, including any special interests:

PRACTICE OFFICE HOURS

List Pharmacy Office Hours (Mon-Sun), including Start Time and End Time:

ACCESSIBILITY	Please indicate how this location is accessible, according to the Americans with Disabilities Act (ADA) Standards: Select all that apply: ☐ Exterior building ☐ Interior building ☐ Wheelchair access to exam room ☐ Exam table/scale/chair ☐ Gurneys & stretchers ☐ Other access for people with disabilities ☐ Portable lifts ☐ Radiologic equipment ☐ Signage & documents ☐ Parking ☐ Restroom ☐ Staff at this location receive ADA compliance training Please specify how this location accommodates people who have intellectual, cognitive or hearing disabilities: Select all that apply: ☐ Accommodations for people with intellectual/cognitive disabilities ☐ Teletypewriter (TTY) or Telecommunications Device for the Deaf (TDD) ☐ American Sign Language ☐ Mental/Physical Impairment Services ☐ Other disability services Please specify how this location is accessible by public transportation: Select all that apply: ☐ Bus ☐ Subway ☐ Regional Train ☐ Other Transportation Additional Accommodations: Select all that apply: ☐ This location provides childcare services ☐ This location meets all state and local fire, safety, and sanitation requirements
LANGUAGES	Non-English Language(s) spoken by office personnel: Non-English Language(s) spoken by interpreters:

SECTION 6: HOSPITAL AFFILIATIONS

Admitting Privileges	*This section is not applicable to pharmacists.*
Non-Admitting Privileges	Add if you are affiliated with a hospital, but you cannot admit. This may be called "courtesy" or "consulting" privileges at some hospitals. Please also enter in pending non-admitting hospital affiliations. ***State:** Country: ***Hospital Name:** Non-Admitting Affiliation Status: ***Please describe the non-admitting affiliation**: ☐ Active ☐ Inactive ☐ Pending Start Date:

SECTION 7: CREDENTIALING CONTACTS

CREDENTIALING CONTACT

If someone else at your practice site will be handling third party credentialing on your behalf, please list their contact information here:

Name:

Street:

City: State: Zip Code:

Phone Number:

Fax Number:

Email Address:

Is this individual your Primary Credentialing Contact (Select One): Yes / No

Location Type (check one):

- ☐ Hospital Affiliation
- ☐ Practice Location

Additional Credentialing Contact(s):

SECTION 8: PROFESSIONAL LIABILITY INSURANCE

INSURANCE COVERAGE

Please complete this section for your primary professional liability insurance policy. If you do not carry a Personal Professional Liability Policy and are covered under your employer's policy, you will need to upload BOTH the COI from the insurance company AND a statement from your employer on company letterhead stating that you are covered. Make sure that the "amount" of professional liability coverage matches what is listed on your policy. If it does not match, your CAQH ProView Profile will be rejected.

***Policy Number**

Covered Practice Location: (If you have multiple practice locations, select the location where this policy covers you):

***Current Effective Date (MMDDYYYY):** ***Current Expiration Date (MMDDYYYY):**

Original Effective Date (MMDDYYYY):

***Carrier/Self Insured Name:**

***Street Address:**

***City:** State: Zip Code:

Country:

Phone Number: Ext:

Fax Number:

***Do you have unlimited coverage with this insurance carrier (Select One):** Yes / No

Type of Coverage:

- ☐ Occurrence
- ☐ Claims made
- ☐ Individual
- ☐ Shared

***Amount of coverage per occurrence:** $

If you have changed your coverage within the last ten years, did you purchase tail and/or nose (prior occurrence/acts) coverage (Select One): Yes / No

***Individual Coverage (Select One):** Yes / No

***Self-insured (Select One):** Yes / No

Institution Affiliation:

Additional Policies: List information for additional policies.

FTCA COVERAGE

This section does not apply to most pharmacists practicing in a community pharmacy.

The Federal Tort Claims Act (FTCA) provides liability coverage for providers that offer services through entities that are supported by the Health Resources and Services Administration (HRSA). FTCA-eligible entities include:

- Federally Qualified Health Centers
- Indian Health Services
- Community Health Centers
- Migrant Health Centers
- Health Care for the Homeless Centers
- Public Housing Primary Care Centers

Are you a covered entity under FTCA (Select One): Yes / No

SECTION 10: EMPLOYMENT INFORMATION

EMPLOYMENT INFORMATION

Please list your current employment and all relevant employment history for the past 10 years. Relevant experience includes all work performed as a health professional.

***Practice/Employer Name:** Department/Specialty:

***Street Address:**

***City:** State: Zip Code:

Country:

Phone Number: Ext:

Fax Number:

***Start Date (MMYYYY)** *** End Date (MMYYYY)**

***Is this your current employer (Select One):** Yes / No

	***Additional Employment Record(s):** List all employment records (like above) for the past 10 years of work as a health professional:
GAP RECORDS	Health plans and other organizations often require gap records to explain academic training/leave. You must document any gaps in employment longer than 6 months (e.g., jobs unrelated to your professional, family leave, illness) within the past 10 years. Include pertinent dates and details.
MILIATRY	***Are you currently on active military duty (Select One)?** Yes / No Are you currently in the Reserves or National Guard (Select One)? Yes / No

SECTION 11: PROFESSIONAL REFERENCES

PROFESSIONAL REFERENCES	Please list any professional references that you would like to have on your profile including contact information (optional).

SECTION 12: DISCLOSURE

Instructions: If you do not believe a question is applicable to you, you should answer the question "No". You are required to enter malpractice case history information if applicable.

1. Has your license, registration or certification to practice in your profession ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board?
   - ☐ Yes - If Yes, please provide an explanation:
   - ☐ No

2. Has there been any challenge to your licensure, registration or certification?
   - ☐ Yes - If Yes, please provide an explanation:
   - ☐ No

3. Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?
   - ☐ Yes - If Yes, please provide an explanation:
   - ☐ No

4. Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?
    - ☐ Yes - If Yes, please provide an explanation:
    - ☐ No

5. Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?
    - ☐ Yes - If Yes, please provide an explanation:
    - ☐ No

6. Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?
    - ☐ Yes - If Yes, please provide an explanation:
    - ☐ No

7. Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?
    - ☐ Yes - If Yes, please provide an explanation:
    - ☐ No

8. Have any of your board certifications or eligibility ever been revoked?
    - ☐ Yes - If Yes, please provide an explanation:
    - ☐ No

9. Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?
    - ☐ Yes - If Yes, please provide an explanation:
    - ☐ No

10. Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?
    - ☐ Yes - If Yes, please provide an explanation:
    - ☐ No

11. Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs?
    - ☐ Yes - If Yes, please provide an explanation:
    - ☐ No

12. Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offence or sexual misconduct?
    - ☐ Yes - If Yes, please provide an explanation:
    - ☐ No

13. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?
    - ☐ Yes - If Yes, please provide an explanation:
    - ☐ No

14. Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?
    - ☐ Yes - If Yes, please provide an explanation:
    - ☐ No

15. Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?
    - ☐ Yes - If Yes, please provide an explanation:
    - ☐ No

16. Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?
    - ☐ Yes - If Yes, please provide an explanation:
    - ☐ No

17. Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?
    - ☐ Yes - If Yes, please provide an explanation:
    - ☐ No

18. Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?
    - ☐ Yes - If Yes, please provide an explanation:
    - ☐ No

19. Have you ever had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years? If yes, provide information for each case.
    - ☐ Yes – if Yes, must provide full case history for each claim (see screenshot below)
    - ☐ No

Malpractice Case Entry

Remove

* Date of Occurrence: Select date
* Date Claim Filed: Select date
* Claim Status: --Select--
Insurance Carrier Name: --Select-- ☐ Other (Not Listed)
Street 1
Street 2
City
State: --Select--
ZIP Code
Phone Number
Policy Number
Settlement Amount
Resolution Method: --Select--
* Description of Allegations
* Were you the primary defendant? ○ Yes ○ No
Number of Co-defendants
* Your involvement in the case
* Description of alleged injury to patient
Did the alleged injury result in death? ○ Yes ○ No
To the best of your knowledge, is this case included in the National Practitioner Data Bank (NPDB)? ○ Yes ○ No

20. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?
    - ☐ Yes - If Yes, please provide an explanation:
    - ☐ No

21. In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offence or sexual misconduct?
    - ☐ Yes - If Yes, please provide an explanation:
    - ☐ No

22. Have you ever been court-martialed for actions related to your duties as a medical professional?
    - ☐ Yes - If Yes, please provide an explanation:
    - ☐ No

23. Are you currently engaged in the illegal use of drugs? (Currently means sufficiently recent to justify a reasonable belief that the use of drug may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. Illegal use of drugs refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. 812.22. It does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the controlled Substances Act or other provision of Federal law. The term does include, however, the unlawful use of prescription controlled substances.)
    - ☐ Yes - If Yes, please provide an explanation:
    - ☐ No

24. Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?
    - ☐ Yes - If Yes, please provide an explanation:
    - ☐ No

25. Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?
    - ☐ Yes - If Yes, please provide an explanation:
    - ☐ No

26. Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?
    - ☐ Yes - If Yes, please provide an explanation:
    - ☐ No

APPENDIX

Cultural Competency Training

- Required for contracting by many third-party payers
- If your pharmacy is accredited for DMEPOS, you should have an annual training for this training in your employee file. Your employer should be able to provide you with the copy
- The Tennessee Pharmacists Association offers Cultural Competency Training
    - https://www.tnpharm.org/ce-and-events/cultural-competency-in-pharmacy-training-module/
    - $20.00
    - Training Length: 30 minutes

Medicaid Number (TennCare ID)

- Required for contracting with Medicaid as a provider
- Visit https://pdms.tenncare.tn.gov/ProviderPersonRegistration/Process/Register.aspx
- Free
- Registration Time: 2 minutes
- Time to receive: Up to 2 weeks

Medicare Number (PTAN)

- Required for contracting with Medicare as a provider
- Currently Free of Charge (there is usually a fee)
- Registration Time: 45 minutes
- Time to receive: Up to 12 weeks
- PTAN Types:
    - There are multiple PTAN types, each have different "scopes" for billing
    - You must register for a **Pharmacy** or **Mass Immunizer** PTAN
    - Your pharmacy's DMEPOS PTAN will not work for COVID-19 billing
- APhA has outlined Medicare's 24-hour expedited phone process for the **Mass Immunizer** PTAN
    - https://www.pharmacist.com/sites/default/files/audience/APhACOVIDReimbursementforAdmin_1220_web.pdf
    - 24-Hour expedited process must be followed by full application within 30-days in order to receive permanent number
- To obtain your PTAN (Pharmacy or Mass Immunizer), visit: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/Become-a-Medicare-Provider-or-Supplier