



**SCOTT AND WHITE HEALTH PLAN**

Application for Membership  
Prospective Pharmacy Providers

***Please read carefully before signing:***

All information submitted by me in this application is true to my best knowledge and belief. I fully understand that any misstatement or omissions from this application, significant or otherwise, may constitute cause for denial of my application.

In making this application for membership in Scott and White Health Plan, I acknowledge that I have the responsibility of reading the rules and the regulations of Scott and White Health Plan, and I agree to be bound by the terms thereof if I am granted membership. I agree to conduct my practice in accordance with high ethical standards.

By applying for membership in Scott and White Health Plan, I hereby signify my willingness to appear for interviews in regard to my application. I hereby authorize Scott and White Health Plan to consult with individuals, State or Federal Licensee=s, or Professional Organizations who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by a representative of Scott and White Health Plan of all documents that may be material to an evaluation of my professional qualifications and competence.

I hereby release from liability all representatives of Scott and White Health Plan for their acts performed in good faith and without malice in connections with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizational who provide information to Scott and White Health Plan in good faith and without malice concerning my professional competence, ethics, character and other qualifications, and I hereby consent of the release and exchange of information relating to any disciplinary action, suspension or curtailment of licensure to Scott and White Health plan.

I understand and agree that I, as an applicant have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

**Note: photocopies of a current Pharmacy License, DEA and DPS Certificates, and evidence of liability insurance must accompany Applications. If application is for multiple stores, documentation must be provided for each outlet to be considered.**

\_\_\_\_\_  
Owner’s Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



***It is requested that all information be filled in completely, including names, addresses and zip codes.***

***Only applicants who have a Texas License and who are in good standing with the Texas State Board of Pharmacy are eligible to apply.***

**Section I: Conditions of Participation**

Scott and White Health Plan (herein after referred to as AHealth Plan@) reserves the right to limit and number of providers enrolled in order to ensure a minimum familiarity with the program operations and to maximize its cost-efficiency potential. In order to be considered for participation, the potential provider must meet the following criteria:

1. The prospective provider must possess the ability to submit and receive claims data via an electronic system, which allows Areal time@, claims adjudication. Determination of a prospective provider=s ability to meet this standard resides with, and only with, Health Plan.
2. The prospective provider must maintain and use a patient profile system acceptable to Health Plan.
3. The prospective provider must maintain and use a patient counseling system acceptable to health plan.
4. Health Plan reserves the right to limit geographical access. In th8is case, health existing provider. In the case of multi-store prospective providers, Health Plan will not accept any prospective provider who has greater than thirty percent (30%) of its outlets within five miles of existing providers. Further health Plan will use the ratio of 1,000 members per provider in making its determination of need. Health Plan will make special consideration based on physical boundaries and hazards. However, the determination resides with, and only with, Health Plan.
5. Prospective provider must accept the current standard contract for Health Plan. This determination resides with and only with, the Health Plan and is based on the standard for the entire service area.



# SCOTT & WHITE HEALTH PLAN

## Texas Friendly

### Section II. Store Information

(Please type or Print)

\_\_\_\_\_  
Corporate or Name of Pharmacy Telephone Number

\_\_\_\_\_  
Telephone Fax Number E-Mail Address

Practice Status: Chain \_\_\_\_\_ Individual \_\_\_\_\_ Other \_\_\_\_\_ Number of Stores \_\_\_\_\_

Chief Pharmacist Name \_\_\_\_\_ Chief Pharm. License No. \_\_\_\_\_

List Names and License Numbers of all other Pharmacist=s employed by Pharmacy.

\_\_\_\_\_  
Pharmacist Name License Number

\_\_\_\_\_  
Pharmacist Name License Number

\_\_\_\_\_  
Pharmacist Name License Number

Type of Business: Corporation Sole Proprietorship Partnership

Principals Name (s) \_\_\_\_\_ Title \_\_\_\_\_

Principals Name (s) \_\_\_\_\_ Title \_\_\_\_\_

Principals Name (s) \_\_\_\_\_ Title \_\_\_\_\_

Liability Insurance Carrier: \_\_\_\_\_ Self Insured \_\_\_\_\_  
Name

Amount of Coverage \$ \_\_\_\_\_

Computer System:

Pharmacy Software Name \_\_\_\_\_

Transaction Switch: NDC ENVOY Other \_\_\_\_\_







# SCOTT & WHITE HEALTH PLAN

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### REFERENCES:

List references from two or more third party carriers or insurers who have worked extensively with you or have been responsible for professional observation of your work.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Telephone \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Telephone \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Telephone \_\_\_\_\_



*Texas Friendly*

**Section IV: Current Malpractice Information**

For the following questions, if any answer is AYes@, use separate sheet and explain. Please be as specific as possible with regard to procedures, names, dates and actions. In the context of this section, Ayou@ refers to the owner and chief pharmacist, or any employee pharmacist who is employed to practice pharmacy, and >you@ may also apply to the pharmacy or pharmacies.

1. Have you ever been rejected for membership or notified by  
Or requested to appear before any medical or pharmacy Society?  
NO YES
2. Have you ever been denied the privilege of taking an examination  
Administered by a U.S. State and/or Canadian provincial licensing Agency?  
YES NO
3. Have you ever, in any U.S. State, Canadian province and/or other  
Foreign country, been denied a license to practice or have you  
Ever had your pharmacy license restricted, revoked, suspended or  
Canceled?  
YES NO
4. Have you ever been requested to resign, withdraw, or otherwise  
Terminate your participation with a professional society or  
Association, corporation, health maintenance organization, or  
Other practice organization, either public or private, or has such  
Position(s) ever been canceled, revoke or censured?  
YES NO
5. Have you ever voluntarily surrendered a license issued to you  
By an U.S. State or Canadian province licensing agency?  
YES NO
6. Have you ever been notified or requested to appear before any  
U.S. State or Canadian province licensing or disciplinary agency?  
YES NO
7. Have you ever been notified or any charges or complaints filed  
Against you with any U.S. State or Canadian province licensing  
Or disciplinary agency?  
YES NO



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**Section IV: Current Malpractice Information, continued**

- 8. Are you now using, or have you ever used, alcohol (except Socially), narcotics, barbiturates, or other drugs affecting the Central nervous system, or other drugs which caused physical Or psychological dependence. YES NO
- 9. Have you now or ever had any chronic or debilitating physical Debilitating physical defect or emotional impairment? YES NO
- 10. Have you ever been treated for any mental illness, drug Addiction or alcohol problem? YES NO
- 11. Have you ever been denied a Drug Enforcement Admin- istration (DEA) registration certificate or been called before Or warned by the DEA? YES NO
- 12. Have you ever surrendered you state or federal controlled Substance registration (DEA or DPS) or had it restricted in Any way? YES NO
- 13. Have you ever been arrested, fined (over \$ 100), charged With or convicted of a crime (other than minor traffic violation), Indicted, imprisoned, or placed on probation? YES NO
- 14. Have you ever forfeited collateral for breach or violation of any Law, policy, regulation, or ordinance whatsoever, been Summoned into court as a defendant, or has any law suit (other than malpractice) been filed against you? YES NO
- 15. In the past ten (10) years, have there been or are there currently Any claims, settlements, or judgments against you? If yes, Please provide detailed information on a separate sheet, Including the plaintiff=s name, description of the incident(s), Date of the incident(s), your involvement, current disposition, And the amount of settlement. YES NO
- 16. Has your professional liability insurance ever been denied, Canceled, or not renewed? YES NO



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**Section IV: Current Malpractice Information, continued**

- 17. Have you ever been sanctioned by Medicare or Medicaid? YES NO
  
- 18. Have you now or ever had any condition or impairment  
 Which would interfere with your ability to practice pharmacy YES NO  
 Or which poses a potential risk to the health of your customers?

**Section V: Patient Profile Ability**

Please provide a detailed explanation of your patient profile capability and how this is integrated into your daily practice. Please provide examples of your system (Print screen for electronic system).

**Section VI: Patient Counseling Capability**

Please provide a copy of your standards for patient counseling . Please provide a detailed explanation regarding how patient counseling is incorporated into your practice.

**Section VII: Special Services**

Please list any special services you offer that you feel the Health Plan should be aware of:

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**SCOTT & WHITE  
HEALTH PLAN**

*Texas Friendly*

For Scott and White Health Plan Use Only

Date presented to Credentialing Committee:

\_\_\_\_\_

\_\_\_\_\_ Approved      \_\_\_\_\_ Disapproved

Reason Disapproved:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Approved with the following Conditions/additions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Committee Chair or Designee

\_\_\_\_\_  
Date