Pharmacy Network Participation Request Form

Pharmacy Information Date: _____

Pharmacy DBA Name: _____

Pharmacy Legal Name: _____

☐ Independent ☐ Chain ☐ PSAO NPI: _____ NCPDP: _____

Chain/PSAO Name: _____ Chain/PSAO code: _____

Pharmacy Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Tax ID: _____

Pharmacy Owner Name: _____

Primary Contact Name: _____ Title: _____

Primary Contact Email: _____

Pharmacy Type and Services
(Please provide percentage to describe type of services that apply to your pharmacy)

_____ Retail
_____ Mail Order
_____ Specialty
_____ Compounding
_____ Long Term Care
_____ Home Infusion
_____ Clinic
_____ Outpatient Hospital
_____ DME
_____ Indian Health Services
_____ 340B
_____ Other (please explain) _____

Please submit Pharmacy Network Participation Request Form using one of the options below.

- Fax: (855) 404-0968
- Email: RetailManager@netcardsystems.com or PharmacyInfo@welldyne.com
- Mail: NetCard Systems at WellDyne
  P.O. Box 4517
  Englewood, CO 80155

For additional information or questions please contact our pharmacy network team at (866) 813-3743.