Blue Cross Blue Shield Blue Care Network of Michigan

Pharmacy Contract Request Form

Requestor's first/last name	Requestor's phone number	Date requested

Michigan Pharmacy Locations:

1. Commercial Business: Complete this form and return to: Email: PharmacyNetworkAdmin@bcbsm.com OR Fax: (877) 357-1118.
   - **NOTE:** Blue Cross and BCN will no longer be accepting applications for ***new*** pharmacies as of October 1, 2018. For a new pharmacy, the pharmacy contract request form will need to be completed and emailed to PharmacyNetworkAdmin@bcbsm.com. Any pharmacy contract request forms received for new pharmacies, on or after October 1, 2018 will not be processed.
   - Blue Cross and BCN will continue to process ***change of ownerships requests*** until December 31, 2018. Pharmacies that are or will be undergoing a change of ownership with an effective date prior to December 31, 2018, will need to complete the pharmacy contract request form and email it to PharmacyNetworkAdmin@bcbsm.com.

2. Medicare Part D Business **EFFECTIVE** 01/01/2018: For questions regarding participation in Express Scripts' Medicare network, call 1 (888) 571-8182.

Out of Michigan Pharmacy Locations: **Contact** Express Scripts at (800) 922-1557.

Check one ☐ New pharmacy ☐ Change of ownership	NCPDP	NPI	Effective/opening date
Legal business name		Pharmacy DBA (doing business as) name	
Pharmacy street address		Pharmacy city	Pharmacy ZIP code
Pharmacy phone number		Pharmacy fax number	

Provide full First/Middle/Last names of ALL owners (including Stockholders, Shareholders, Silent Partners, etc.). (If not enough room, provide on additional pages.)

Do the owners own or hold stock in any other pharmacies? Check one ☐ Yes ☐ No	If Yes, please list all pharmacies owned both inside and outside of Michigan (include NCPDP). (If not enough room, provide on additional pages.)

Address to mail contract if different from Pharmacy Address: Please include contact person First/Last name

For additional questions or issues related to contracting, please email: PharmacyNetworkAdmin@bcbsm.com

Note: BCBSM's Pharmacy Network Administration team will contact you within three to five business days of receiving your request form.

The application and contracts must be signed by the same person. If the person who signs is not the owner, additional documentation must be submitted giving that person authorization to sign on behalf of the pharmacy.

BCBSM may add your pharmacy to its network dependent upon pharmacy meeting all requirements along with receiving a fully completed contract package. Missing or incomplete information may delay processing.

BCBSM Internal Use Only

Reviewer initials	Form sent (date/time)	Form received (date/time)	Date/time contract mailed	Date contract received

M*: ☐ Ltr ☐ APP ☐ MAC ☐ HQ and S. Doc (prn)	F: ☐ NCPDP ☐ NPI ☐ Ltr ☐ App pg 1 ☐ DB	Select one: ☐ I ☐ R ☐ C