PHARMACY PROVIDER NETWORK PARTICIPATION REQUEST FORM

Dear Pharmacy Provider,

Thank you for your interest in joining the PharmPix Pharmacy Network. Please complete the information requested in this form and send it by email or fax to our Retail Network Contracting Department for review. If by email, please send to retailnetwork@pharmpix.com. If sending the document by fax, send to (787) 522-1580.

Pharmacy Name:		
Please check one:	**Chain** □	**Independent** □
NCPDP Number or Chain Code:		
Pharmacy Address:		
City:	**State:**	**Zip Code:**
Mailing Address:		
City:	**State:**	**Zip Code:**
Contact Person:		
Contact Phone:		
Contact Fax:		
Contact e-mail:		

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