CHANGE HEALTHCARE

Wyoming Department of Health
Medicaid Pharmacy Updates

PHARMACIST & MANAGING/DIRECTING EMPLOYEE

F. 307.426.4169 | M. PO Box 21719, Cheyenne, WY 82003

***Fax or mail form to CHC**

PHARMACY INFORMATION

Pharmacy Name: _____

National Provider Identifier (NPI): _____

Physical Address: _____
Street Address

_____
City *State* *ZIP Code*

PHARMACIST & MANAGING/DIRECTING EMPLOYEE INFORMATION

This information must be completed for the Pharmacist in Charge and for **each person** who is an agent or managing/directing employee in the pharmacy specified above. Please make copies of this page for the Pharmacist in Charge, Managing/Directing employee, etc., as needed.

***If any of the following information changes, please notify CHC at PBA_wyprovider@changehealthcare.com or 877-205-8083 as soon as the change occurs.**

Effective Date of Change: ____/____/____

Select title: ☐ Pharmacist in Charge ☐ Managing/Directing Employee ☐ Other: _____

Name (first, middle initial, last): _____

License #: _____ SSN: _____ Date of Birth: ____/____/____

State, Country, County of Birth: _____
State *Country* *County (only required if born in U.S.)*

Has this person ever been sanctioned, debarred, suspended, excluded or convicted of a criminal offense related to Medicare, Medicaid or any other State or Federal health care program? If yes, select all that apply and attach any applicable documentation. YES ☐ NO ☐

☐ Sanctioned ☐ Debarred ☐ Suspended ☐ Excluded ☐ Convicted

CONTACT INFORMATION

Contact Name: _____ Contact Title: _____

Contact Phone #: (____) ____-____ Contact Email: _____@_____.____

I certify that the above information is true and correct to the best of my knowledge.

_____ _____
Signature *Date*

_____
Address

_____
City *State* *Zip Code*