

**If you cannot complete one of the mandatory fields (\*), please contact a GeriMed representative at** **info@gerimedgso.com**

GeriMed Representative\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Address\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Phone\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Name\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Owner/President\*: ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacist In-Charge\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Director of Operations\*: ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Purchasing Agent\*: ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DEA #\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Global Location Number (GLN): ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tax ID Number\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State Pharmacy License Number\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current GPO/PSAO Affiliation\*: ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_

Retail Buying Group: ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Wholesaler\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Wholesaler Rep Name\*: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rep Email Adress\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rep Phone Number\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LTC Account #\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Wholesaler: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Wholesaler Rep Name: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rep Email Adress: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rep Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LTC Account #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NCPDP Number\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI Number\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this pharmacy under the same ownership of any other pharmacies currently a member of GeriMed or ComboMed?\*

* No
* Yes, list Group Name\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NCPDP #\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dispensing Software Company\*: ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your pharmacy use a reconciliation vendor?

* No
* Yes, please list the name of reconciliation vendor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you working with PharmaComplete?

* No
* Yes

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Bed Type** | **SNF** | **ALF** | **Group Home** | **Intermediate Care (ICF-IID)** | **Chronic Psych** | **LTC Pharmacy****at Home** | **Hospice** | **Correctional** | **Other** |
| Patient Number\* |  |  |  |  |  |  |  |  |  |
| Number of Facilities |  |  |  |  |  |  |  |  |  |

**Must provide a minimum of 25 Patient number for at least one LTC setting or 50 Patients if only servicing LTC at Home, or the application will not be processed. \*** You may include the number of facilities for these patients.

Total Number of Patients\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Total Number of Facilities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If ‘Other’, please explain setting: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently dispensing Long-Acting Antipsychotic Injections (LAIs)\*?

* No
* Yes

If yes, how many patients do you service on a monthly basis? \* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you dispensing or are you interested in dispensing sublocade?

* No
* Yes

How did you hear about GeriMed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide the following required information. **If you cannot, please contact a GeriMed representative at** **info@gerimedgso.com**

* **DEA Certification Copy**
* **PIC License**
* **State Registration**
* **Liability Insurance**
* **List of Long Term Care Facilities Serviced (Include: Facility name, address, phone number and number of patients serviced at each facility)**

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