Health Net®
Pharmaceutical Services

PHARMACY NETWORK PARTICIPATION REQUEST FORM

Instructions to Provider:

This form allows pharmacies to request participation in the Health Net network.
Please type or print legibly.
Please note that completion of the nomination form does not guarantee acceptance in the Health Net pharmacy network.
Your nomination will be reviewed and a contract will be sent to you upon receipt of this form.

PHARMACY INFORMATION

Pharmacy Name		
Pharmacy DBA (if applicable)		
Mailing Address		
Phone		Fax
First Name	MI	Last Name
NCPDP		NPI

Contract Type Requested:

- ☐ Retail
- ☐ 340(B)
- ☐ LTC (Medicare D Only)
- ☐ Indian/Tribal
- ☐ Home Infusion (Medicare D Only)
- ☐ Mail Order (Medicare D Only)

PLEASE RETURN THIS FORM TO:

Health Net Pharmaceutical Services
PO Box 3530
Rancho Cordova, CA 95741-3530

Fax: 1-800-206-7011

If you have any questions, please call 1-800-968-9004 or send an email to RxNetwork@healthnet.com