PPCN Pharmacist Provider FAQs and Application

What is PPCN?

PPCN was established in 1999 as a pharmacist network connecting clinical pharmacists to HealthMapRx™ program participants. PPCN, LLC is a North Carolina based company that contracts with employer groups to provide health related cost containment services and programs to their employees. Services include, but are not limited to:

- Chronic Condition Care Management programs
- Health and Lifestyle Coaching
- Claims Analysis and Medication Management Services
- Biometric Health Screening Events

What does PPCN expect of its Pharmacist Providers?

- Adherence to national standards of care, credentialing requirements and PPCN visit protocols
- Timely and accurate collection and electronic documentation of participant data and visit information
- Notify program coordinator regarding participant compliance issues or provider availability changes
- Routinely review and respond when necessary to program and provider updates as communicated from Program and Clinical Leadership.
- Upon request, serve as a liaison between PPCN and the employer sponsoring the program

Who is eligible?

Pharmacists must apply and be approved as a PPCN Provider prior to being considered for a Service Agreements. In general, approval is contingent upon the following:

- Licensed pharmacist in good standing with the State Board of Pharmacy in the state in which services are to be rendered (or in the primary state where provider practices)
- A Pharmacist that currently provides (or is interested in providing) clinical pharmacy services
- Meets one or more of the following credentialing requirements:
    - Has ACPE (or accredited equivalent) certification and experience in managing patients with the disease targeted by the program in which the provider will be participating
    - Has 2 or more ACPE accredited certifications in relevant disease states
    - One of the following Certificates: BCPS or CPP or CGP
    - Completed an ASHP accredited residency that focused on the targeted condition(s)
    - For Diabetes Management Programs, be currently recognized by the American Association of Diabetic Educators (AADE) as a Certified Diabetes Educator (CDE), has passed the NISPC Diabetes Exam, has a current Diabetes Management Certificate from an ACPE approved provider; or, has completed an Ambulatory Care Residency with sufficient concentration in Diabetes Management

For those who may NOT have achieved any of the above professional designations, PPCN's Clinical Leadership will review and take into consideration any other training or experience identified by the applicant that may be relevant in considering qualification. PPCN will also consider awarding "provisional" status to those who are in the process of obtaining qualifying training, experience, or certification.

What are the anticipated renewal requirements for providers in the network?

Ongoing renewal of qualification credentials may be required.

PPCN is dedicated to outcomes that meet or exceed national guidelines. Providers in the network will need to stay current with newly released national guidelines that relate to the protocols in their clinical practices, therefore, renewal requirements may apply with certain programs. Providers are expected to maintain proficiency with respect to professional standards of care in order to maintain patient referral status.

How do I apply?

***Step 1**:* Complete the attached application and fax or email along with a current resume or CV to PPCN. Background check will only be completed for approved applicants.

***Step 2**:* Upon approval, you will receive a Provider Practice Agreement (this is the contract between PPCN and you as the provider of clinical pharmacy services). If you agree with the terms of the agreement, sign it and return it to PPCN.

***Step 3**:* Where applicable, provide demographic information detailing your practice. It is important that this information be correct for you to receive patient assignments.

***Step 4**:* Attend (in person or remotely) program training with a member of PPCN's Clinical team.

Required Documents:

1. **Provider Application and Background Check (Pages 3-5) Completed and Signed**
2. **Current Resume or CV**
3. **Copy of Current Pharmacy License**
4. **Proof of Insurance**

Fax or Email to: Provider Recruitment

Fax: 888-429-2011

ron.devizia@emailmm.com

For Questions Call: 919-464-1348

802 Green Valley Rd Ste 106 Greensboro, NC 27408-7099
Email: ron.devizia@emailmm.com
Fax: 888-429-2011 Phone: 919-464-1348

CLEARLY PRINT OR TYPE ALL REQUESTED INFORMATION

NAME: _____ **SSN:** _____

NAME OF COLLEGE WHERE DEGREE ATTAINED: _____

PHARMACY LICENSE#: _____ **State** _____ **BCPS#:** _____ **CGP#:** _____

ASHP RESIDENCY: (type) _____**# OF YEARS IN CLINICAL PRACTICE:** _____

PLEASE PROVIDE THREE REFERENCES:

1) **NAME:** _____ **AFFLIATION:**_____

   Phone: _____ **Email:** _____

2) **NAME:** _____ **AFFLIATION:**_____

   Phone: _____ **Email:** _____

3) **NAME:** _____ **AFFLIATION:**_____

   Phone: _____ **Email:** _____

SELECT THE FOLLOWING:

_____ I will see participants at location(s) determined by PPCN _____ I will see participants at an alternate site.

Address/Description of Alternate Site: _____

- I can provide services to _____ (number) patients per month per protocol in my practice.
- I have professional liability insurance with _____

(Documentation page of policy to be included with application)

CERTIFICATES AND/OR EXPERIENCE

Section I:

I have completed the following ACPE (or equivalent) approved certificate programs: (Please list all that apply. You may be asked to submit copies of your certificates.)

Disease State ***Where certification received (i.e. AHEC)*** ***Date received*** ***Date of last renewal***

1._____

2._____

3._____

4._____

5._____

Section II:

I am currently providing clinical services in the following areas and would like PPCN to consider these in my provider application: (**Please circle/list all that apply**.) **Note:** You may be asked to submit case write-ups for final approval.

ASTHMA **DEPRESSION** **DIABETES** **HYPERTENSION** **HYPERLIPIDEMIA**

OTHER EXPERIENCE: (Please specify):

_____

_____

_____

PREFERRED CONTACT INFORMATION:

MAILING ADDRESS: _____

PHONE: _____

EMAIL: _____

FAX: _____

I understand, once approved, I will be required to provide supporting documents and sign a provider practice agreement before I will be assigned program participants. I am willing to represent PPCN in customer related activities such meetings or events as requested by PPCN leadership.

Signature: _____ **Date:** _____

CONFIDENTIAL

PPCN, LLC: Authorization for Background Check

Print Name: _____
(First) (Middle) (Last)

Former Name(s) and Dates Used: _____

Current Address Since: _____
(Mo/Yr) (Street) (City) (Zip/State)

Previous Address From: _____
(Mo/Yr) (Street) (City) (Zip/State)

Previous Address From: _____
(Mo/Yr) (Street) (City) (Zip/State)

Social Security Number: _____ Date of Birth: _____

Telephone Number: _____

Driver's License Number/State: _____

The information contained in this application is correct to the best of my knowledge. I hereby authorize PPCN LLC and their designated agents and representatives to conduct a comprehensive review of my background causing a consumer report and/or an investigative consumer report to be generated for employment and/or contract employment purposes. I understand that the scope of the consumer report/ investigative consumer report may include, but is not limited to the following areas: verification of social security number; current and previous residences; employment history, education background, character references; drug testing, civil and criminal history records from any criminal justice agency in any or all federal, state, county jurisdictions; driving records, birth records, and any other public records.

I further authorize any individual, company, firm, corporation, or public agency (including the Social Security Administration and law enforcement agencies) to divulge any and all information, verbal or written, pertaining to me, to PPCN LLC or its agents. I further authorize the complete release of any records or data pertaining to me which the individual, company, firm, corporation, or public agency may have, to include information or data received from other sources.

I hereby release PPCN LLC, the Social Security Administration, and its agents, officials, representative, or assigned agencies, including officers, employees, or related personnel both individually and collectively, from any and all liability for damages of whatever kind, which may, at any time, result to me, my heirs, family, or associates because of compliance with this authorization and request to release.

Signature: _____ **Date:** _____