

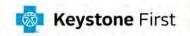


Coverage by Vista Health Plan, an independent licensee of the Blue Cross and Blue Shield Association

Application: Pharmacist Tobacco Cessation

Name:										
Legal Entity N	lame:									
Group NPI (10	characters), if app	licable:			_					
Group/Solo T	IN/EIN # (9 characte	rs):								
Contact Name	ə:			Contac	t Emai	l:				
services. Pharm	ia Department of Hun nacists must be Medic armacy will bill with th y address".	aid Enrolled as Typ	oe 37 –Toba	cco Cess	ation C	ounselo	r and wil	l be the rende	ring practitione	er on the
•	Pharmacy Name	Street Address	Bldg # and/or Ste #	City	State	Zip Code	County	Telephone w/ Area Code	Fax Number w/ Area Code	Email
Pharmacy Location 1										
Pharmacy Location 2										
Pharmacy Location 3										
Pharmacy Location 4										

^{*} Enrollment in the PA Medical Assistance Program is required in our Medicaid Product. If you are not enrolled and do not have PPID we cannot enroll you for participation. If you need to enroll, please call the Department of Human Services at 1-800-537-8862.





Coverage by Vista Health Plan, an independent licensee of the Blue Cross and Blue Shield Association

Application: Pharmacist Tobacco Cessation

Pharmacist Information:

First Name	Last Name	MI	Degree	Specialty	Individual NPI # (10 characters)	PPID #*	Pharmacy Location (Insert Practice #)

Submit this completed form via email to: provider.contracting@keystonefirstpa.com or fax to 215-863-5472

^{*} Enrollment in the PA Medical Assistance Program is required in our Medicaid Product. If you are not enrolled and do not have PPID we cannot enroll you for participation. If you need to enroll, please call the Department of Human Services at 1-800-537-8862.