

# Request to Become a THMP Participating Pharmacy

Please fill out all information and fax to THMP at 512-989-4003.

Pharmacy Legal Name: \_\_\_\_\_  
(as registered with the Secretary of State)

Pharmacy DBA Name: \_\_\_\_\_

Pharmacy License #: \_\_\_\_\_

Pharmacist in Charge (PIC): \_\_\_\_\_

PIC License Number: \_\_\_\_\_

Pharmacy E-Mail: \_\_\_\_\_

Other Staff Pharmacist(s): \_\_\_\_\_

Pharmacy Physical Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Pharmacy Mailing Address: \_\_\_\_\_

(if different from above) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

N.A.B.P. #: \_\_\_\_\_ Medicaid Vendor #: \_\_\_\_\_

Pharmacy Classification: \_\_\_\_\_ Federal Employer ID/Tax ID #: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Authorized Representative: \_\_\_\_\_  
(please print clearly)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_