

**Provider information**

Legal Name (as it appears on tax ID form)		Federal Tax ID Number	
<input type="text"/>		<input type="text"/>	
Doing Business As		NPI Number	
<input type="text"/>		<input type="text"/>	
Street Address	City	State	Zip
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Telephone Number	Fax Number	E-mail address	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

**Type of Pharmacy**

- |  |                                       |                                      |
|--|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Home Therapy                | <input type="checkbox"/> Independent  | <input type="checkbox"/> Small Chain |
| <input type="checkbox"/> Nursing Facility            | <input type="checkbox"/> Professional | <input type="checkbox"/> Other       |
| <input type="checkbox"/> Tobacco Cessation Counselor | <input type="checkbox"/> Large Chain  |                                      |

**Pharmacist in Charge**

Name	
<input type="text"/>	
License Number	License Issued From
<input type="text"/>	<input type="text"/>

**Note:** Out of state pharmacies that mail to Nebraska must have a Nebraska pharmacy license. A copy of the license must be attached to form MC-19, Nebraska Service Provider Agreement.

**Signatures and Dates**

I certify that the above information is true, accurate, and complete.

_____ Provider/Agency Representative Signature (Stamped Signature not accepted)	_____ Date
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