KEYSTONE
PHARMACY PURCHASING ALLIANCE, INC.

Membership Questionnaire

PLEASE PRINT LEGIBLY

Store Name/Trading As: _____

Corporate Name of Store: _____

Street Address: _____

City: _____ **State**: _____ **Zip**: _____ **County**: _____

Manager/Owner **9 digit**

Contact Name: _____ Title:_____

Please fill in all blocks below

Phone Number:	**Fax Number:**
E-Mail Address	**Pharmacy License #**
	Include a copy of Pharmacy License
DEA #	**NABP #**
Include a copy of DEA License	
Fed ID#/SS #	**NPI #**
Include W9 Form	

Primary Wholesaler: _____ **Account #** _____ **Secondary Wholesaler**_____ **Account #** _____

Generic Source: _____ **Account #** _____

Managed Care Membership (PSAO) _____ **Other Buying Group Affiliation**: _____

DME Accredited: Yes ☐ **No** ☐ **Size of store** _____**square feet**

Immunization Certified: Yes ☐ **No** ☐ **Annual Sales $**_____

Additional Pharmacies Owned: Yes ☐ **No** ☐ **NABP e-Profile #** _____

Close relationship with any Legislators: Yes ☐ **No** ☐ **If yes, List names** _____

Number of year's this Pharmacy has been in business with present owner _____

PLEASE FILL OUT A SEPARATE QUESTIONNAIRE FOR EACH STORE.

Dues are $750 a year with $250 taken from rebates due to you in March, July & November.

Part of your dues payment is used to pay your Pennsylvania Pharmacist Association (PPA) and National Community Pharmacist Association (NCPA) dues. Stores in other States can have their State Association Dues paid by Keystone. We also pay for HDS Verify for verifying DEA & NPI #'s – updated weekly (Value= more than $800/year)

MAIL TO: Keystone Pharmacy Purchasing Alliance – 2200 Michener St., Suite 10 Philadelphia, PA 19115

I understand that Keystone will be receiving administration fees on my behalf and that I will be informed yearly of these percentages on our website www.kpparx.com I understand that Keystone will be receiving information on my purchasing which will be kept in strict confidence. Members have an obligation to report rebates to Medicaid, Medicare, and/or a third party payer. This is the sole responsibility of the purchaser.

Authorized Signature of

Store Owner/Manager Signature _____ Date: _____

Please Print Name _____

KEYSTONE
PHARMACY PURCHASING ALLIANCE, INC.

Group Purchasing Program ***Pharmacy Application***

The _____ of _____
(Pharmacy) (City, State)

Herein after referred to as **"PHARMACY"** does hereby make application to Keystone Pharmacy Purchasing Alliance, Inc., Herein after referred to as "**KEYSTONE"**, a group purchasing alliance of community pharmacies, for membership in Keystone. Pharmacy does hereby acknowledge that Keystone is engaged in the business of negotiating for the purchase of pharmaceuticals and other merchandise from manufacturing firms, distributing firms, and drug wholesalers, hereinafter referred to as **"VENDORS"**, on behalf of member pharmacies.

PHARMACY does herby agree that if accepted as a participant in Keystone, it will abide by the following terms and conditions of membership:

1. **PHARMACY** shall maintain a valid permit to operate a pharmacy in the jurisdiction where **PHARMACY** engages in business, and agrees to provide reasonable evidence of such at the request of Keystone.
2. **PHARMACY** recognizes that Keystone shall provide Prime Vendor Wholesalers, and other **VENDORS**, to function as distribution sources for contractually and non-contractually awarded products.
3. **PHARMACY** understands that in order to remain a member in good standing, it must have their social security # or Federal EIN on file at the Keystone Office, and purchase at least 70% of its purchases from approved primary wholesaler vendors.
4. **PHARMACY** authorizes Keystone, or its designated agent, to negotiate and enter into agreements on its behalf for the purchase of services, pharmaceuticals and other merchandise.
5. **PHARMACY** understands Keystone shall notify **PHARMACY** of all contractually awarded products and services that are available for purchase under the Keystone membership. **PHARMACY** agrees to accept this information via regular mail, e-mail, telephone or fax.
6. **PHARMACY** authorizes Keystone or its designated agent, to obtain copies of all data in possession of the Prime Vendor Wholesalers, including but not limited to, those reflecting product velocity movement, inventory management, item sales analysis, and other data pertaining to Pharmacy, that are captured or generated by the Keystone designated Prime Vendor Wholesalers and other **VENDORS** with regard to participation in Keystone.
7. **PHARMACY** agrees to lend its name and product purchase information to Keystone in its request for special pricing from **VENDORS**.
8. **PHARMACY** understands that Keystone is responsible solely for negotiating agreements with **VENDORS,** and it is not a guarantor of cost savings to **PHARMACY.**
9. **PHARMACY** understands and agrees with this Agreement, and its obligations performed hereunder may be assigned directly or indirectly, by either party, with written agreement consent of the other party.
10. **PHARMACY** understands and agrees that Keystone, as a group purchasing organization, is required to comply with specific federal and state laws governing participation in the federal Medicare and state Medicaid programs and under those laws, must have a written agreement with **PHARMACY** in order for **PHARMACY** to purchase items and services under **VENDOR** contracts.
11. **PHARMACY** understands and agrees that Keystone must disclose the administration fee paid it, hereby indicating that such fees are three percent (3%) or less for goods or services purchased from that **VENDOR**, or if more than three percent (3%), the actual percentage or method of calculation of such payment.
12. **PHARMACY** understands and agrees that at the specific request of the **PHARMACY**, Keystone will provide an annual report of the % received from each vendor with respect to purchases made by, or on behalf of said **PHARMACY** and other Keystone members.
13. **PHARMACY** understands enrollment may be terminated at any time with thirty days written notice by either party.

ACCEPTED BY

_____

Signature-Owner/Manager State Pharmacy Permit Number DEA # Date

_____

Signature/Keystone President/CEO Date