TEXAS
Health and Human
Services Commission

Vendor Drug Program Pharmacy Enrollment Form
Access for Weekly Payment Files

Instructions: complete all applicable fields and return by fax (866-780-2185) **or** email (Pharmacy.MoveIT@tmhp.com). Notice of Confidentiality: if you choose to send this document via email, please note you may be sending protected health information (PHI). Please electronically encrypt your information prior to sending.

Classification (please identify):
☐ Independent Pharmacy ☐ Chain Pharmacy/Corporate Headquarters

PROVIDER INFORMATION	
NPI Number (required):	
Legal Name:	
Provider DBA Name:	
Business Address:	
City, State, and ZIP:	
Telephone:	**Fax:**
Email:	
CONTACT INFORMATION	
Contact Name:	
Contact Title:	
Business Address:	
City, State, and ZIP:	
Telephone:	**Fax:**
Email:	
ADDITIONAL CONTACT INFORMATION	
Contact Name:	
Contact Title:	
Business Address:	
City, State, and ZIP:	
Telephone:	**Fax:**
Email:	
☐ Is the above “additional contact” a Service bureau/Third party reconciler? **Service bureau/Third Party Company Name:**	