Corporation
Pharmacy Enrollment Form

PLEASE PRINT CLEARLY.
Email the completed form to adap@health.ny.gov OR fax to (518) 459-7429

PHARMACY CORPORATION NAME: __________________________________________

FEDERAL TAX ID #: ___________ - ___________ NPI NUMBER: ___________ - ___________

Corporate Address: _______________________________________________________

City: ___________________________ State: _______ Zip: ___________ - ___________

Remittance Address: (if different from above)

City: ___________________________ State: _______ Zip: ___________ - ___________

Phone #: (_______) ________-_________ Fax #: (_______) ________-_________

Corporate Contact for Pharmacy Enrollment: ________________________________

(First and Last Name)

Email Address (required): _________________________________________________

ENROLLING THE INDIVIDUAL PHARMACIES:

All licensed New York State pharmacies are eligible to enroll as ADAP providers if actively enrolled in the New York State Elderly Pharmaceutical Insurance Coverage (EPIC) program and are enrolled with one or more Medicare Prescription Drug Plans. Applying pharmacies must also be actively enrolled with New York State Medicaid.

Pharmacies eligible to purchase drugs under Public Health Services (PHS) Section 340B may not use 340B stock for New York ADAP participants.

Complete the attached form OR provide a list of all individual pharmacies enrolling as an ADAP Pharmacy Provider under this corporation. The list should detail the same information as on the attached form.

Pharmacies MUST maintain active enrollment with Medicaid and EPIC to remain eligible as ADAP pharmacy providers. All claims MUST be submitted through Point of Sale using NCPDP D.0 unless otherwise specified. The Uninsured Care Programs (ADAP) will not be obligated to pay claims submitted more than 90 days after delivery of services. All enrolled pharmacy providers will receive an ADAP Pharmacy Provider Manual from the Uninsured Care Programs within 30 days of enrollment. Signature on this form constitutes acceptance and compliance with all Uninsured Care Programs’ pharmacy provider requirements listed above, which are further detailed in the ADAP Pharmacy Provider Manual.

Signature: ___________________________ Date Signed: ___________

(Pharmacy Owner /Corporate Officer Required)
Corporation Pharmacy Enrollment Form

PHARMACY CORPORATION NAME:

* PLEASE PRINT CLEARLY - Attach Separate List if Necessary *

<table>
<thead>
<tr>
<th>Pharmacy (DBA) Name:</th>
<th>NABP #</th>
<th>NPI #</th>
<th>NYS MEDICAID #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Street Address: ____________________________

City: ____________________________ State: _______ Zip: __________

Store Phone #: (______) _______ - __________ Fax #: (______) _______ - __________

Pharmacy Contact Person: ____________________________ (First and Last Name)

Does this Pharmacy participate with at least one Medicare Part D Plan? Y [   ] N [   ]

Is the Pharmacy actively enrolled in NYS EPIC? Y [   ] N [   ]

---

<table>
<thead>
<tr>
<th>Pharmacy (DBA) Name:</th>
<th>NABP #</th>
<th>NPI #</th>
<th>NYS MEDICAID #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Street Address: ____________________________

City: ____________________________ State: _______ Zip: __________

Store Phone #: (______) _______ - __________ Fax #: (______) _______ - __________

Pharmacy Contact Person: ____________________________ (First and Last Name)

Does this Pharmacy participate with at least one Medicare Part D Plan? Y [   ] N [   ]

Is the Pharmacy actively enrolled in NYS EPIC? Y [   ] N [   ]

---

<table>
<thead>
<tr>
<th>Pharmacy (DBA) Name:</th>
<th>NABP #</th>
<th>NPI #</th>
<th>NYS MEDICAID #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Street Address: ____________________________

City: ____________________________ State: _______ Zip: __________

Store Phone #: (______) _______ - __________ Fax #: (______) _______ - __________

Pharmacy Contact Person: ____________________________ (First and Last Name)

Does this Pharmacy participate with at least one Medicare Part D Plan? Y [   ] N [   ]

Is the Pharmacy actively enrolled in NYS EPIC? Y [   ] N [   ]