

Corporation Pharmacy Enrollment Form

PLEASE PRINT CLEARLY.

Email the completed form to adap@health.state.ny.us 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 enrolled with one or more Medicare Prescription Drug Plans. Applying pharmacies should also be actively enrolled, or began the enrollment process, with New York State Medicaid.

Pharmacies eligible to purchase drugs under the Public Health Service (PHS) Section 340B discount program are required to notify the HIV Uninsured Care Programs of their participation in the 340B program within 30 days of approval by HRSA's Office of Pharmacy Affairs.

Do any of the pharmacies from this corporation participate in the 340B discount program? Yes No

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 5.1 unless otherwise specified. The HIV 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 HIV Uninsured Care Programs within 30 days of enrollment. Signature on this form constitutes acceptance and compliance with all HIV 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)

