New York State Department of Health
UNINSURED CARE PROGRAMS
Empire Station, PO BOX 2052, Albany, NY 12220
Phone: 1-800-542-2437 Fax: 518-459-2749

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 Public Health Services (PHS) Section340B 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 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)
**Corporation Pharmacy Enrollment Form**

**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>
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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 [ ]

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