New York State Department of Health
HIV UNINSURED CARE PROGRAMS
Empire Station • PO BOX 2052 • Albany, NY 12220
Phone: 1-800-542-2437 or 1-844-682-4058
Fax: 518-459-7429

Pharmacy Enrollment Form

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

NPI NUMBER: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]   NABP NUMBER: [ ][ ][ ][ ][ ][ ][ ]

FEDERAL TAX ID Number: [ ][ ] - [ ][ ][ ][ ][ ][ ][ ]   NYS MEDICAID NUMBER: [ ][ ][ ][ ][ ][ ][ ][ ]

Pharmacy Corporation Name: ______________________________

Pharmacy (**DBA**) Name: ______________________________

Street Address: ______________________________

City: ____________________ State: ______ Zip: [ ][ ][ ][ ][ ] - [ ][ ][ ][ ]

Store Phone: ([ ][ ][ ]) [ ][ ][ ] - [ ][ ][ ][ ]   Fax: ([ ][ ][ ]) [ ][ ][ ] - [ ][ ][ ][ ]

Pharmacy Contact Person: ______________________________
(First and Last Name)

Pharmacy Email Address (**required**): ______________________________

Secondary Email Address (optional): ______________________________

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 have begun the enrollment process to participate in New York State Medicaid.

Is the Pharmacy actively enrolled in NYS EPIC? Yes ☐ **No** ☐

Does the Pharmacy participate with at least one Medicare Part D Plan? Yes ☐ **No** ☐

Is the pharmacy enrolled in or applied to participate in NYS Medicaid? Yes ☐ **No** ☐

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

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 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 a Pharmacy Provider Manual from the HIV Uninsured Care Programs (ADAP) within 30 days of enrollment. Signature on this form constitutes acceptance and compliance with all HIV Uninsured Care Programs (ADAP) pharmacy provider requirements listed above, which are further detailed in the Pharmacy Provider Manual.

Signature: ______________________________ Date Signed: ______________
(Pharmacy Owner / Corporate Officer Required)

(ADAP OFFICE USE ONLY)

Information Taken By: ____________________	*EPIC Verified:* *Y* [ ] *N* [ ] *Spoke to:* ____________
Pharmacy Packet Sent: *Y* [ ] *N* [ ] *Date:*	*EPIC Effective Date:*