Pharmacy Provider Enrollment Application

1. Application

Date 11/28/2018

☒ New Pharmacy ☐ Re-enrollment | Vendor # _____

☐ Change of Ownership | Vendor # _____

2. Applicant

Name Of Pharmacy (Doing Business As)		
ABC Pharmacy		
Legal contractor name		
ABC Pharmacy, Inc		
Telephone	**Fax**	**Email**
512-111-1111	(512) 222-2222	This email is required so we can contact you in relation to the application

Pharmacy Physical Address	City	State	Zip
555 Oakwood Way	Austin	TX	78701
Pharmacy Business Address	**City**	**State**	**Zip**
555 Oakwood Way	Austin	TX	78701
Pharmacy Billing Address	**City**	**State**	**Zip**
555-Oakwood Way	Austin	TX	78701

Federal Employer ID Number (FEIN)	State Comptroller's Tax ID	Primary Taxonomy Code	Pharmacy License Number	State	National Provider Identifier (NPI)	NCPDP Number
00-0000000	32000000000	336C00000X	12345	Tx	1111111111	222222

☐ Out of state pharmacy (physical location is more than 50 miles from Texas border).

3. Applicant Enrollment Contact

Contact Name #1	Title
John Doe	Owner
Telephone	Email
(512) 123-4567	Email address of the contact person
Contact Name #2	Title
Telephone	Email

Is the pharmacy a Federally Qualified Health Center?	☐ Yes ☒ No	FQHCs are reimbursed by a total encounter rate for all services under the Veterans Health Care Act of 1992. Please refer to hrsa.gov/opa/ for information regarding FQHC and the 340B Drug Pricing Program.

STOP! If the above response is "Yes" then
the pharmacy does not qualify for reimbursement through this enrollment.

4. Program Participation

Enrollment in Medicaid is a prerequisite for participation in any program administered by VDP. If a Provider's participation in Medicaid is terminated, the Provider's participation in all other VDP programs will also be terminated. Unless the applicant opts-out of a VDP program, the applicant will be automatically enrolled in Medicaid, CHIP, CSHCN, KHC, and HTW**.** If you do NOT want to participate in one of the aforementioned VDP Programs, you can opt-out by writing the name (or the acronym) of the program in this line:

_____

WARNING! IF YOU WROTE THE NAME OR ACRONYM OF A VDP PROGRAM IN THE LINE ABOVE, YOU WILL <u>NOT</u> BE ENROLLED IN SAID PROGRAM.

5. Application Fee

An application fee is not required and will not be accepted if the Applicant is enrolled in and has paid the application fee for Medicare, or another state's Medicaid program. If the Applicant claims that the Applicant is not required to pay the application fee in Texas, the Applicant must submit proof of payment to Medicare or another state's Medicaid program when submitting this application. The Applicant should select only <u>one</u> of the following:

☐ Applicant attests that the Applicant is not required to pay the application fee in Texas, at the business address stated in "Applicant" (Section 2).

☐ Applicant is required to pay the application fee in Texas and is submitting the application fee by paper check, money order, or cashier's check with this application. Cash will not be accepted. (Refer to Appendix "Application Fee Deposit Form" for further instruction)

6. Applicant's Legal Entity and Ownership Information

Complete this section in accordance with the Applicant's legal entity and the corresponding ownership information. All individuals and entities identified in this section are required to complete the "Principal/Subcontractor Information" (**Appendix A**) which must be submitted with this application.

6.1. Type of Entity (select only one):

☐ Sole Proprietorship ☐ General Partnership ☐ Limited Partnership ☒ Corporation
☐ Limited Liability Company ☐ Government Agency or Entity ☐ Professional Association

6.2. Identify individuals who have at least 5% ownership and are a sole proprietor or owners, partners, officers, directors, or Principals (including Creditors with a security interest in a debt that is owed by an Applicant if the creditor's security interest is protected by at least 5% of the property). (Add additional pages if necessary.)

	Name/Company Name	Address + City + State + ZIP	Position	% Ownership or Security Interest	FEIN
1.	John Doe	555 Oakwood Way Austin, Texas 78701	Managing Officer	100.00%	123-45-6789
2.	ABC Pharmacy, Inc	555 Oakwood Way Austin, Texas 78701	Owner	100.00%	00-0000000
3.				0.00%	
4.				0.00%	
5.				0.00%	

6.3. Please indicate any of the individuals identified in 6.2 that share a familial relationship (spouse, parent, child, or sibling).

	Name	Has a relationship as	Name
1.			
2.			
3.			
4.			
5.			

6.4. If an individual listed in 6.2 has or had ownership or controlling interest in a business(es) with a Medicaid contract or Medicaid provider agreement, list the legal name of said business(es).

	Name of Business	Address	Person(s) with Ownership/Control	NPI
1.				
2.				
3.				
4.				
5.				

6.5. Please provide the name, address, and FEIN number of the Applicant's corporate headquarters/home office.

Name	Address	City	State	ZIP	FEIN
ABC Pharmacy, Inc	555 Oakwood Way	Austin	Tx	78701	00-0000000

7. Sanctions and exclusions

7.1. Are there any individuals or organizations having a direct or indirect ownership or control interest of five percent or more in the Applicant that have been convicted of a criminal offense related to the involvement of such persons, or organizations, in any of the programs established by Titles XVIII, XIX, or XX?	☐ Yes ☒ No
7.2. Has the Applicant ever been sanctioned in any state or federal program?	☐ Yes ☒ No
• If **Yes** then fully explain the details, including date, the state where the incident occurred, the agency taking the action, and the program affected (attach additional sheets if necessary). *"Sanction" is defined as recoupment, payment hold, imposition of penalties or damages, contract cancellations, exclusion, debarment, suspension, revocation, or any other synonymous action*.	
7.3. Is the Applicant's professional license or certification currently revoked, suspended or otherwise restricted?	☐ Yes ☒ No

7.4. Has the Applicant ever had the Applicant's professional license or certification revoked, suspended, or otherwise restricted?	☐ Yes ☒ No
7.5. Is the Applicant currently, or have the Applicant ever been, subject to a licensing or certification board order?	☐ Yes ☒ No
7.6. Has the Applicant voluntarily surrendered the Applicant's professional license or certification in lieu of disciplinary action? (*The Applicant may be subject to a license or certification verification/status check with the Applicant's licensing or certification board.)*	☐ Yes ☒ No
• If **Yes** was answered to any of these questions, fully explain the details, including date, the state where the incident occurred, name of the board or agency, and any adverse action against the Applicant's license (attach additional sheets if necessary).	
7.7. Has the Applicant ever enrolled in or applied to any other State's Medicaid or CHIP program?	☐ Yes ☒ No
7.8. Is the Applicant currently or has the Applicant ever been subject to the terms of a settlement agreement, corporate compliance agreement or corporate integrity agreement in relation to any state- or federally-funded program?	☐ Yes ☒ No
7.9. Does the Applicant currently have any outstanding debt in relation to any state- or federally-funded program?	☐ Yes ☒ No
• If **Yes** was answered to any of these questions, fully explain the details, including date, the state where the incident occurred, and name of the board or agency (attach additional sheets if necessary).	
7.10. Is the Applicant currently charged with or has the Applicant ever been convicted of a crime (excluding Class C misdemeanor traffic citations)? To answer this question, use the federal Medicaid /Medicare definition of "Convicted" in 42 CFR. § 1001.2 as described below, and which includes deferred adjudications and all other types of pretrial diversion programs. The Applicant may be subject to a criminal history check. "Convicted" means that: (a) A judgment of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether: (1) There is a post-trial motion or an appeal pending, or (2) The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed; (b) A Federal, State or local court has made a finding of guilt against an individual or entity; (c) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity, or (d) An individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.	☐ Yes ☒ No
7.11. Have any pharmacists on staff ever been sanctioned by Texas State Board of Pharmacy (TSBP)? If **Yes**, please submit a copy of your TSBP board order with this application.	☐ Yes ☒ No

8. List of Pharmacists Responsible For Providing Pharmaceutical Services

Add additional pages if necessary.

8.1. Pharmacist In Charge	DOB	License Nbr.	State	NPI
Jane Doe	01/01/1977	67489	Tx	
8.2. Staff Pharmacist	DOB	License Nbr.	State	NPI
8.3. Staff Pharmacist	DOB	License Nbr.	State	NPI
8.4. Staff Pharmacist	DOB	License Nbr.	State	NPI
8.5. Staff Pharmacist	DOB	License Nbr.	State	NPI
8.6. Staff Pharmacist	DOB	License Nbr.	State	NPI
8.7. Staff Pharmacist	DOB	License Nbr.	State	NPI
8.8. Staff Pharmacist	DOB	License Nbr.	State	NPI

9. Source of Purchase Information

Please indicate your sources of purchase of pharmaceutical products by answering the following questions.

9.1. Primary wholesaler	9.2. Secondary wholesaler
This is the company from which your purchase drugs	This is the company from which your purchase drugs

9.3. % Direct purchased from manufacturer	9.4. List companies with whom you have direct accounts
0	

9.5. Co-op or buying group

9.6. Is your pharmacy eligible as a Public Health Entity Buy (subsection 340B Veteran's Health Care Act 1992).	☐ Yes ☒ No

Please refer to hrsa.gov/opa/ for information regarding Public Health Service.

9.7. For chain pharmacies: how many pharmacies do you have? (Five [5] or more stores with the same ownership arrangements are considered a chain.)			
9.7.1. In Texas:		9.7.2. In the United States:	

9.8. Do you have a warehouse?	☐ Yes ☐ No
9.9. Do you have an agreement with your wholesaler to house or store the drugs for you?	☐ Yes ☐ No
9.9.1. If yes, who owns the product while stored?	☐ Pharmacy ☐ Wholesaler
9.10. Do you have one contract/agreement with the wholesaler to serve all of your locations?	☐ Yes ☐ No
9.11. Do you allow your pharmacies to make spot purchases outside of the existing wholesaler contract/agreement?	☐ Yes ☐ No

10. Type of Pharmacy

10.1. Is the pharmacy located within a hospital?	☐ Yes ■ No
If **Yes**, please provide name of hospital and a letter detailing what type of services provided, and recipients served.	
10.2. Is the pharmacy located within a medical clinic?	☐ Yes ■ No
If **Yes**, please provide name of medical clinic and a letter detailing what type of services provided, and recipients served.	
10.3. Is the pharmacy located within an MHMR Hospital Clinic?	☐ Yes ■ No
If **Yes**, please provide name of MHMR Hospital Clinic and a letter detailing what type of services provided, and recipients served.	
10.4. Is the pharmacy a central fill location?	☐ Yes ■ No
If **Yes**, please provide name of host pharmacy.	
10.5. Is the pharmacy a remote fill location?	☐ Yes ■ No
If **Yes**, please provide name of host pharmacy.	
10.6. Does the pharmacy have subcontractors for the intent of filling or dispensing prescriptions?	☐ Yes ■ No
If **Yes**, please provide name of subcontractors.	
10.7. What percentage of your prescriptions do you deliver by mail?	0%
10.8. Is this a closed door pharmacy? If **Yes**, please provide a letter detailing what type of services provided, and recipients served.	☐ Yes ■ No
10.9. Does this pharmacy exclusively dispense to a particular type of customer (e.g. home health care recipients, or patients with a specific chronic condition?	☐ Yes ■ No
If **Yes**, please specify customer/specialty.	
10.10. Does this pharmacy receive public funds other than Medicaid and Medicare? If **Yes**, please provide name of payers and percentages.	☐ Yes ■ No
10.11. Choose one from the following:	
A. Does the pharmacy meet all of the following criteria? (1) The expected total Medicaid claims for specialty drugs (as described in 1 TAC §354.1853), exceeds or would exceed 10 percent of the pharmacy's total Medicaid claims per year; (2) The pharmacy obtains or is expected to obtain volume-based discounts or rebates on specialty drugs from manufacturers or wholesalers; (3) The pharmacy delivers or is expected to deliver at least 80 percent of dispensed prescriptions by shipment through the U.S. Postal Service or other common carrier to customers or healthcare professionals (including physicians and home health providers.	☐ Yes ■ No
B. Does the pharmacy meet the following criteria? (1) The expected total Medicaid claims for prescription drugs to residents of long term care facilities exceeds or would exceed 50 percent of the pharmacy's total Medicaid claims per year.	☐ Yes ■ No
C. Does the pharmacy operate as a community retail facility, e.g., an independent pharmacy, a supermarket pharmacy, a chain pharmacy or a mass merchandiser pharmacy having a state license to dispense medications to the general public?	■ Yes ☐ No
10.12. Who is your software company for the online submission of pharmacy claims?	
Name of Software Company	
10.13. What company serves as your switch service bureau? If unknown, contact your software company.	
Name of Switch Bureau	

10.14. What are the days of the week and the hours of operation for the pharmacy (e.g. Mon-Fri, 8:00 a.m. to 5:00 p.m.?)			
Mon-Fri 9a-5p, Sat 9a-12p, Closed Sun			
10.15. Is the pharmacy presently open?	☐ Yes ■ No	10.16. If no, by what date do you expect to open?	01/01/2019
10.17. Do you own the building in which your business is located?			☐ Yes ■ No
10.18. Do you lease the building in which your business is located?			■ Yes ☐ No
10.19. Are you located in a building that includes other healthcare providers authorized to write prescriptions? If **Yes**, provide the following information.			☐ Yes ■ No

Name of individual or Entity	Telephone Number:

Address (number, street)	City	State	ZIP Code

11. Delivery Incentive

VDP will pay a delivery incentive in the amount stated in the Medicaid State Plan for each prescription that is paid by HHSC. This delivery incentive will not be paid for over-the-counter (OTC) drugs – even if those OTC drugs are prescribed as a benefit under a VDP Program – nor will be it paid for a recipient residing in a nursing home or other similar group facilities. Conditions for payment of the delivery incentive are:

- The pharmacy must advertise to VDP Recipients the availability of the no-charge prescription service;
- The pharmacy must display the VDP-approved delivery sign in a prominent place in the store (e.g., window, door). VDP will provide the delivery sign to the pharmacy.
- Delivery must be made to Recipients in the same manner and degree as to the general public.

The deliver incentive only applies to filled prescriptions for which HHSC pays the claims. Delivery fees in managed care are governed by the contracts between the managed care organizations and the Pharmacy Provider.

■	Yes, the Applicant certifies that the Applicant meets the minimum conditions for payment of the delivery incentive, wants to obtain delivery incentives, and acknowledges that HHSC reserves the right to suspend and recoup all of the delivery incentive payments if a program review or audit indicates the Provider is not complying with all of the delivery incentive requirements.
☐	No, this pharmacy does not want to obtain delivery incentives.

12. Other Medicaid Opportunities

This application does not enroll a pharmacy as a Medicaid durable medical equipment (DME) provider or as part of the Medicaid Comprehensive Care Program (CCP). Pharmacy staff that want to learn more about providing these services to children or adults should visit txvendordrug.com/providers.

13. Applicant's Signature

The Applicant or Applicant's duly authorized representative (Representative) must personally review each copy of the Application and certify to the validity and completeness of the information. The Principal(s)'s and Subcontractor(s)'s information is part of the Application and the Representative signing this Application certifies that the information is true and accurate. The Representative also certifies that the Applicant complies with the state and federal requirements to participate as a Provider in the VDP Programs that the Applicant is applying for.

Signature _____ Printed Name _____

Title _____ Date _____

State of _____ County of _____

Before me, the undersigned authority, on this day personally appeared

_____

known to me to be the person(s) whose name(s) is (are) subscribed to the foregoing instrument and who, being duly sworn by me, states that the above and foregoing information supplied in the instrument, including all attached information related to Principals and Subcontractors is complete, true and correct. The undersigned authority also certifies that he/she had the authority to submit this Application on behalf of the Applicant and to enter into Agreements with HHSC on behalf of the Applicant.

Sworn to and subscribed before me, this _____ day of _____, in the year _____.

Notary Public in and for _____

County of _____

_____

Notary Signature

14. Board of Directors Resolution

For corporations only

On the _____ day of _____ , in the year _____ ,
at a meeting of the Board of Directors present, the following resolution was adopted:

BE IT RESOLVED that the Board of Directors of the above corporation does hereby authorize

_____

and his/her successors in office to negotiate an agreement or agreements with HHSC and to execute said agreement or agreements on behalf of the Applicant for the purpose of participating in VDP, and further we do hereby give him/her the power and authority to execute any and all documents incident to this transaction in VDP and, in addition, authority to do any and all things necessary to implement, maintain, amend or renew said agreements to assure continued participation in VDP.

The above resolution was passed by a majority of those present and voting in accordance with the By-laws and Articles of Incorporation.

I certify that the above and foregoing constitutes a true and correct copy of a part of the minutes of a meeting of the Board of Directors of

_____

Held on the _____ day of _____ , in the year _____ .

_____
Secretary signature

State of _____ County of _____

Before me, the undersigned authority, on this day personally appeared

_____

known to me to be the person(s) whose name(s) is (are) subscribed to the foregoing instrument and who, being duly sworn by me, states that the above and foregoing information supplied in the instrument, including all attached information related to Principals and Subcontractors is complete, true and correct. The undersigned authority also certifies that he/she had the authority to submit this Application on behalf of the Applicant and to enter into Agreements with HHSC on behalf of the Applicant.

Sworn to and subscribed before me, this _____ day of _____ , in the year _____ .

Notary Public in and for _____

County of _____

_____
Notary Signature