Forms required for pharmacy participation in the Medicaid/CHIP Vendor Drug Program are online at TxVendorDrug.com/providers/.

03/2016: Text highlighted in yellow indicates common deficiencies currently being seen on submitted applications.

A. General Instructions

- All pharmacies that are currently contracted with the Vendor Drug Program (VDP) must complete this application and submit it in order to meet the federal requirements outlined in the Affordable Care Act.
- All fields should be completed either with the correct answer or a "NA" on the questions that do not apply. Applications could be returned if information is incomplete, incorrect, or missing.
- Applicants must also include the VDP Pharmacy Provider Agreement and all other required documents. (Applicants are often not sending in the signed provider agreement with their completed application. Applicants should submit both simultaneously.)
- If HHSC returns an application for missing, incorrect, or incomplete information, the applicant will be required to re-submit the entire application and include the requested information. For this reason, applicants should retain a copy of the completed application.
- The completed application must be sent to and received by HHSC on or **before June 17, 2016**, in order to meet the federal deadline of September 24, 2016 for reenrollment. Applications received **after June 17, 2016**, may not be processed before the September 24 deadline, resulting in disenrollment and payment disruption.

B. Required Documentation

The following documents must be included in order for HHSC to process your application:

- A complete VDP Pharmacy Provider Enrollment Application to include the signed signature page with the individual that has signature authority (refer to Section 13).

2. A notarized statement indicating which individual has the authority to sign the Application.
   - The statement must specify the person's position within the organization (refer to Section 13).
3. Texas Comptroller of Public Accounts Application for Payee Identification Number (Form AP-152).
4. Texas Comptroller of Public Accounts Direct Deposit Authorization (Form 74-176).
5. Child Support Certification Form. (Please ensure Section II is completed for each person with a minimum 25% ownership interest in the business entity.)
6. Lobbying Certification Form. (Please ensure the question noted at the bottom portion of the document is completed. That is often missed and required.)
7. Certification regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion for covered contracts form. (Applicants are not fully completing this form. The questions in the middle of the document and at the bottom are often missed and are required.)
8. VDP Electronic Remittance Advice Authorization Agreement Form
   - Participation is optional. Include the form in the packet with "NA" marked at the top if you do not want to participate.
9. VDP Eligibility Verification Portal (EVP) Access Form
   - Participation is optional. Include in packet with "NA" marked at the top if you do not want to participate.
10. Texas HHSC Vendor Information Form. (Applicants are not including this form. It is required.)
11. IRS FEIN (Federal Employee Identification Number) Verification Letter.

12. Assumed Name (Doing Business As) Certificate. (Applicants are not including this form. It is required if the applicant has a DBA.)
13. Application fee, if applicable.

C. Specific Fields on Application

1. Application (Page 1)

- **Date**: Enter the date the application is filled out or completed.
- Check one of the following boxes:
  - **New Pharmacy**: if your pharmacy is requesting enrollment for the first time in the Medicaid/CHIP Vendor Drug Program.
  - **Re-enrollment/Vendor#**: if your pharmacy is reenrolling in the VDP. Provide your pharmacy's current six-digit vendor number. All pharmacies that re-enroll will be assigned a new six-digit vendor ID number.
  - **Change of Ownership/Vendor#**: if you need to change the currently-listed information/ownership for your pharmacy. Provide your pharmacy's current six-digit vendor number.

2. Applicant (Page 1)

- **Name of Pharmacy**: list the name of the pharmacy. If the pharmacy has a "Doing Business As" (DBA), include the DBA in this field. If the pharmacy does not have a DBA, include the Legal Contractor Name in this field. If the pharmacy has a DBA name, a copy of the assumed name certificate from the county clerk's office or the Secretary of State, as applicable, in the appropriate county must be submitted with the completed application.
- **Legal Contractor Name**: indicate the legal name of the pharmacy. This response may be the same response provided in "Name of Pharmacy."
- **Telephone**: provide the telephone number for the pharmacy.
- **Fax**: provide the fax number for the pharmacy.
- **Email**: provide the electronic mail (e-mail) address for the pharmacy or a contact e-mail address for the pharmacy.
- **Pharmacy Physical Address**: provide the address where the pharmacy is physically located.
- **Pharmacy Business Address**: provide the address that will be receiving the pharmacy notifications, policy, and payment information.
- **Pharmacy Billing Address**: provide the address used for billing purposes.
- **Federal Employer ID Number (FEIN)**: provide your pharmacy's 9-digit FEIN from the Internal Revenue Service (IRS) Confirmation Letter. A copy of the confirmation letter must be submitted with the completed application. This number is required.
- **State Comptroller's Tax ID**: provide the State Comptroller's Tax ID number. This number is obtained from the Texas Comptroller's Office. This number is required.
- **Primary Taxonomy Code**: provide the primary taxonomy code for this application. Choose the correct taxonomy code for your pharmacy from the 10-digit codes below and include it in this field. This code is required.
  - Suppliers/Pharmacy: 333600000X

- Suppliers/Pharmacy, Clinic Pharmacy: 3336C0002X
- Suppliers/Pharmacy, Community/Retail Pharmacy: 3336C0003X
- Suppliers/Pharmacy, Compounding Pharmacy: 3336C0004X
- Suppliers/Pharmacy, Home Infusion Therapy Pharmacy: 3336H0001X
- Suppliers/Pharmacy, Institutional Pharmacy: 3336I0012X
- Suppliers/Pharmacy, Long-term Care Pharmacy: 3336L0003X
- Suppliers/Pharmacy, Mail Order Pharmacy: 3336M0002X
- Suppliers/Pharmacy, Managed Care Organization Pharmacy: 3336M0003X
- Suppliers/Pharmacy, Nuclear Pharmacy: 3336N0007X
- Suppliers/Pharmacy, Specialty Pharmacy: 3336S0011X

- **Pharmacy License Number**: provide the current and valid Texas State Board of Pharmacy (TSBP) license number for the pharmacy. The license number is five digits.
- **State**: list the state in which the current and valid pharmacy license was issued.
- **National Provider Identifier (NPI)**: provide your pharmacy's 10-digit NPI obtained from the National Plan Provider Enumeration Systems. The NPI is required for submitting pharmacy claims.
- **National Council of Prescription Drug Program (NCPDP) number**: provide the 7-digit NCPDP number for the pharmacy. The NCPDP can be found on the NCPDP website if you do not know the pharmacy's number.
- **Out of state pharmacy**: check this box if the pharmacy's physical location is more than 30 miles from a Texas border. In addition, provide a written statement attached to the completed application describing the additional benefit(s) or service(s) the pharmacy can provide to a recipient in Texas.

3. Applicant Enrollment Contact (Page 1)

(Applicants are leaving this blank. Applicants must include at least 1 contact person.)

The pharmacy must provide information for at least a primary and secondary point of contact. HHSC will contact this person if there is a question about the application.

- **Contact name**: first and last name.
- **Title**: provide that contact's title in the pharmacy or their role with the pharmacy.
- **Telephone**: provide the telephone number for that pharmacy contact.
- **Email**: provide the email address for the pharmacy contact.
- **Federally Qualified Health Center**: indicate either "Yes" or "No". (If "Yes" then the pharmacy does not qualify for reimbursement through this enrollment.)

4. Program Participation (Page 4)

Pharmacy providers must be enrolled in Medicaid in order to participate in any other VDP programs. The Applicant should identify any of the other VDP programs that they **do not want** to participate in. The other VDP programs include the Children's Health Insurance Program (CHIP), Children with Special Health Care Needs (CSHCN) Services Program, Kidney Health Care (KHC) program, and the Texas Women's Health Program (TWHP).

5. Application Fee (Page 5)

The Affordable Care Act requires all pharmacy providers to pay an application fee to offset the cost of the required background checks. For calendar year 2015, that amount is $553.00. For calendar year 2016, that

amount is $554.00. An application fee must be provided for each store location. For example, if a chain pharmacy has 10 stores, the chain will need to pay $554.00 for each of the 10 locations.

Pharmacies may not have to pay an application fee if the pharmacy as already paid in another state or for Medicare.

- **Medicaid programs in other states**: an application fee is not required if the pharmacy is enrolled in and has paid the application fee for enrollment as a pharmacy in another state's Medicaid program. The Applicant must submit proof of payment (such as a receipt) to another state's Medicaid program when submitting this application.
- **Medicare enrollment**: to avoid the cost of the Texas Medicaid VDP enrollment application fee, a pharmacy participating in Medicare can submit the receipt of the application fee if the fee paid was for enrollment.

New guidance from CMS allows a pharmacy to use proof of payment of an enrollment application fee as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) provider in Medicare, or Medicaid (in another state or in Texas), to avoid the cost of the VDP enrollment application fee.

6. Applicant's Legal Entity and Ownership Information (Page 2)

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. All fields MUST be completed or the application will be deemed incomplete and returned to the applicant.

6.1. Type of Entity

Select which type of business organization best describes your pharmacy. Only select one type of entity. If you're unsure, please contact the Texas Comptroller's Office or check your current contract with VDP. You must provide the documents listed below associated with your ownership type. If not all required documents are submitted, the application will be deemed incomplete and the application will be denied.

Required documentation that must be included with each application:

6.1.1. Sole proprietorship

1. Assumed name certificate from the County Clerk's office if a "Doing Business As" (DBA) name is provided and differs from the legal contractor name. If your pharmacy does not have a DBA, this documentation is not required.

6.1.2. Partnership (General Partnership, Limited Partnership)

1. Assumed name certificate from the Secretary of State's office if a "Doing Business As" (DBA) name is provided and differs from the legal contractor name. If your pharmacy does not have a DBA, this documentation is not required.
2. A copy of the partnership agreement, or a written statement that no written partnership agreement exists.
3. An organizational structure chart showing all individuals or organizations holding ownership interests in the partnership.

4. A statement of which partner is responsible for any amounts owed to VDP if the pharmacy ceases business or stops accepting Medicaid.
5. For partnerships with corporations or limited liability companies (LLC) as partners, refer to Corporation or LLC sections for additional required documents.

6.1.3. Corporation

1. Assumed name certificate from the Secretary of State's office if a "Doing Business As" (DBA) name is provided and differs from the legal contractor name. If your pharmacy does not have a DBA, this documentation is not required.
2. Board of Directors Resolution (note: must be notarized, original signatures required).
3. Either:
   A. Certificate of Incorporation (Texas).
   B. Certificate of Authority to do Business in Texas (foreign corporations). *
4. Certificate of Account Status. *
5. An organizational structure chart showing all individuals and/or organizations holding ownership interests in the corporation.
   * Request a copy from the Texas Comptroller at 800-252-5555.

6.1.4. Limited Liability Company (LLC)

1. Assumed name certificate from the Secretary of State's office if a "Doing Business As" (DBA) name is provided and differs from the legal contractor name. If your pharmacy does not have a DBA, this documentation is not required.
2. Certificate of Account Status.*
3. Articles of Organization OR Certificate of Formation.
4. Certificate of Organization or Certificate of Filing.
5. An organizational structure chart showing all individuals and/or organizations holding ownership interests in the company.
6. For LLC with corporations or partnerships, see Corporation or Partnership sections for additional required documents.
   * Request a copy from the Texas Comptroller at 800-252-5555.

6.2. Individuals with at least 5% ownership: all Applicants, except for Sole Proprietors, must include an organizational chart with the completed application, and the information in the organization chart should match the information provided in this section of the application. Provide actual percentages of ownership for each person/entity listed.

6.3. Individuals identified in 6.2 that share a familial relationship: any and all familial relationships must be listed here.

6.4. Individuals from subsection 6.2 having **or previously having** controlling interest in a business(s) with a Medicaid contract or Medicaid provider agreement. Any and all individuals meeting this criterion must be listed here.

6.5. Provide the name, address, and FEIN for the applicant's headquarters or home office. (Applicants are not completing this section. This section should be completed.)

7. Sanctions and Exclusions (Page 3)

Answer “Yes” or “No” in sections 7.1 through 7.11. All questions must be answered. If an answer is “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). The applicant must disclose information requested regardless of how long ago it occurred. Information should be provided for all owners, principals, managing employees, and the Pharmacist In Charge (PIC). (Applicants are not including copies of board orders. Applicants must include these if they have board orders for the pharmacy and any pharmacists associated with the store.)

8. List of Pharmacists Responsible for Providing Pharmaceutical Services (Page 5)

Complete information for all applicable pharmacists in sections 8.1 through 8.8. If the pharmacist does not have an NPI, enter “NA”. Add additional pages if necessary. All information is required and should be accurate and current.

9. Source of Purchase Information (Page 5)

All information in boxes 9.1 through 9.11 must be completed. For 9.6, please refer to http://www.hrsa.gov/opa/ for information regarding Public Health Service.

10. Type of Pharmacy (Page 6)

Answer "Yes" or "No" for questions 10.1-10.6 and 10.8-10.10. If answer is "Yes" then provide all required information in the box provided. For question 10.11, choose only one of the three types: (A) specialty pharmacy, (B) long-term care pharmacy, or (C) retail/community pharmacy. In order to select A., the applicant must meet all three criteria described in A. (Applicants are leaving 10.11 blank or are checking more than one box. Check the box that most closely describes your pharmacy. Choose only one.)

11. Delivery Incentive (Page 7)

Answer either “Yes” (the applicant certifies that they meet the minimum conditions) or “No” (the pharmacy does not want to obtain delivery incentives).

12. Other Medicaid Options (Page 7)

- If you are interested in participating as a durable medical equipment (DME) provider/supplier, please contact the Texas Medicaid & Healthcare Partnership (TMHP) at 1-800-925-9126.
- If you are interested in the Comprehensive Care Program (CCP), please contact the Texas Medicaid & Healthcare Partnership (TMHP) at 1-800-925-9126.

13. Applicant's Signature (Page 8)

Notarization required. (Applicants are not including the applicant's signature and/or the notary's seal. Both are required.)

14. Board of Directors Resolution (Page 9)

Notarization required. The Board of Directors Resolution must be submitted by any entity with a governing board.

Note: failure to complete, sign, notarize, and provide documents could deny your application.

C. Specific Fields in Appendices

1. Principal/Subcontractor Information (A)

All fields must be completed either with the correct answer or a "NA" on the questions that do not apply to the Principal or Subcontractor. Mark the boxes that are applicable and fill out the corresponding section. Answer "Yes" or "No". If "Yes" is answered to any of the questions, fully explain in details. Include date, state incident occurred, agency taking action, program affected. (Attach additional sheets if necessary). (Applicants are not providing the information in Appendix A for the Pharmacist in Charge (PIC), Entity, and/or Owner/Officers/Board Members. These are required, if applicable. The following information is often missing and is required: Social Security Numbers, Date of Birth, Driver's license numbers, State and Expiration dates, and Effective date of your role in the provider organization. These are required, if applicable. Applicants often leave the question, "Do you have one or more professional licenses, accreditations, or certifications?" blank. Yes or no should be checked.)

2. Application Fee Deposit Form (B)

- Applicant must submit the completed Application Fee Deposit Form and payment in the form of paper check, money order, or cashier's check, when submitting this application.
- Fee is required for each pharmacy you are enrolling.
- Complete the following fields and attach payment.
- See #5 on this document for more information about the application fee requirements.
- Appendix B is not required if proof of payment from Medicare or another state's Medicaid program is submitted with the application.

3. Checklist (C)

Use the checklist to ensure the application packet is complete and all required information and supporting documents are included. You do not need to submit the checklist with your application.