Texas Vendor Drug Program
Pharmacy Provider Enrollment Application

Pharmacy Provider Enrollment Application

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DOCUMENT HISTORY LOG

STATUS	REVISION	EFFECTIVE	DESCRIPTION
Revision	1.4	Oct. 19, 2018	• Updated links to VDP website • Updated form numbers • Removed references to the formerly-required form, “Texas HHSC Vendor Information Form”
Revision	1.3	Dec. 10, 2016	• II. Instructions o Modified the application fee information • 2 Applicant o Modified state border distance to align with 1 TAC §352.17(b)(6) • Appendix B o Modified the application fee information
Revision	1.2	Jan. 8, 2016	• II. Instructions o Updated with 2016 application fee. • Appendix B o Updated with 2016 application fee.
Revision	1.1	Nov. 12, 2015	• Instructions o Modified Application Fee Information language for clarification purposes. • 6.5 o Modified to make this question applicable to all Applicants (as opposed to only chain pharmacies) • Appendix A o Modified the definition of "A Principal of the o Applicant" – removed fifth bullet o Modified child support requested data
Baseline	1.0	Oct. 30, 2015	Initial publication.

Pharmacy Provider Enrollment Application

Refer to the application instructions on the VDP website for help with completing the application.

I. Introduction

Thank you for your interest in becoming a provider for the Texas Vendor Drug Program (VDP). Your participation is vital to the successful delivery of VDP program services, and we welcome your application. The VDP Pharmacy Provider Enrollment Application ("Application") must be completed in its entirety as outlined in the instructions and will be reviewed by the Texas Health and Human Services Commission (HHSC).

HHSC will notify the Applicant once the Application is approved. The Applicant cannot submit claims for prescriptions until HHSC notifies the Applicant that the Applicant is authorized to do so.

Affordable Care Act

In compliance with the Patient Protection and Affordable Care Act (ACA), all Applicants are subject to ACA screening procedures when enrolling for the first time or when reenrolling providers. All Applicants must be screened upon submission of the Application, including, but not limited to:

- Applications for providers are new to Texas Medicaid.
- Applications for currently-enrolled providers that must periodically revalidate their enrollment in Texas Medicaid.

For the statutory provisions for these requirements refer to:

- Code of Federal Regulations (CFR) Title 42, Ch. IV, Part 455, Subpart E-Provider Screening and Enrollment
- Texas Administrative Code (TAC) Title 1, Part 15, Chapter 352

Provider Revalidation

In compliance with ACA, all contracted providers are required to revalidate their enrollment at least every three to five years depending on provider type. Providers will be notified that they are required to revalidate before their revalidation deadline. The ACA screening criteria applies during revalidation. Providers that do not revalidate their enrollment by the designated date will be disenrolled and will no longer receive reimbursement from Texas Medicaid.

Contact Information

For questions regarding VDP, including completing this application, please visit our website at txvendordrug.com.

II. Instructions

The Application can be completed to enroll in any program administered by VDP. Enrollment in Medicaid is a prerequisite for participation in any program administered by VDP, including pharmacy managed care. The Applicant must be enrolled in VDP prior to providing outpatient prescription services to managed care recipients.

If at any time during the enrollment process the information submitted on the Application changes, the Applicant must notify HHSC and submit the updated information. This includes changes in the list of pharmacists working at the pharmacy. Failure to update the Application in a timely manner may result in a delay of processing or denial of this application.

The Applicant should only submit the completed pages of the Application and any additional required forms and attachments. Do not submit the instruction pages of this Application as they are for your reference only.

Application Fee Information

In accordance with ACA and 42 CFR 455.460, certain providers are subject to an application fee for all applications, including, but not limited to:

- Initial applications for new enrollment
- Applications received in response to re-enrollment

If the Applicant is claiming 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.

If the Applicant is required to pay the application fee, the Applicant must submit the completed Application Fee Deposit Form and payment in the form of a paper check, money order, or cashier's check, when submitting this application. The payment is to be made out to HHSC.

Application fee may change each calendar year. Please refer to the Vendor Drug Program website for the current application fee at txvendordrug.com/providers/pharmacy-enrollment.

Pharmacy Provider Enrollment Application

Application Process

To complete this application process, the following documents must be completed and returned for processing:

1. A complete pharmacy application
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 (CPA Form AP-152)
4. Texas Comptroller of Public Accounts Direct Deposit Authorization (CPA Form 74-176)
5. Child Support Certification (HHS Form 1903)
6. Certification Regarding Federal Lobbying (HHS Form H2047)
7. Pharmacy Provider Enrollment Agreement (HHS Form 1341)
8. Pharmacy Eligibility Verification Portal Access (HHS Form 1317)
9. IRS FEIN (Federal Employee Identification Number) Verification Letter
10. Application fee, if applicable

Ownership Types

The following additional documents must be completed and returned for processing for each ownership type.

A. 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.

B. 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.
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.

C. 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.
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.*

D. 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.
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.*

Permanent Out of State Pharmacies

If Applicant is as an out-of-state permanent pharmacy (independent of type of legal entity), the Applicant must also submit a statement detailing the additional benefit(s) or service(s) it can provide to a Recipient.

Ownership Changes

If Applicant changes ownership (independent of entity type), the Applicant must also provide the following forms:

1. Pharmacy Ownership Transfer Affidavit (HHS Form 1332)
2. A list of pharmacy affiliates affected by this change as applicable.

III. Definitions

Applicant means the individual or entity identified in Section 2of this Application.

Application means this Vendor Drug Program Pharmacy Provider Enrollment Application Form.

Agreement means the HHSC Pharmacy Provider Agreement that is sent to the Applicant after the Application is approved.

C**HIP** means the Children's Health Insurance Program administered in accordance with Title XXI of the Social Security Act**.**

CMS means the United States Centers for Medicare & Medicaid Services.

CSHCN means the Children with Special Health Care Needs program administered in accordance with Title V of the Social Security Act.

Covered Drug means the term as explained in Section 354.1831 of Title 1 of the Texas Administrative Code.

Date of Service means the date the Provider prepares, packages, compounds and/or labels the Covered Drug.

HHSC means the Texas Health and Human Services Commission.

HHSC Confidential Information means any communication or record (whether oral, written, electronically stored or transmitted, or in any other form) provided to or made available to the Provider electronically or through any other means that consists of or includes any or all of the following:

a) Protected Health Information in any form, including without limitation, Electronic Protected Health Information or Unsecured Protected Health Information;
b) Sensitive Personal Information defined by Texas Business and Commerce Code Chapter 521;
c) Federal Tax Information;
d) Personally Identifiable Information;
e) Social Security Administration Data, including without limitation, Medicaid information; and
f) All information designated as confidential under the constitution and laws of the State of Texas and of the United States, including the Texas Health & Safety Code and the Texas Public Information Act, Texas Government Code, Chapter 552.

KHC means the Kidney Health Care Program administered in accordance with Texas Health and Safety Code, Chapters 42 and 1001.

Manual means the Texas Vendor Drug Program Pharmacy Provider Procedure Manual issued by HHSC.

Medicaid means the Medical Assistance Program administered in accordance with Title XIX of the Social Security Act.

National Council of Prescription Drug Program (NCPDP) number means the seven-digit number assigned to every licensed pharmacy and qualified Non-Pharmacy Dispensing Sites (NPDS) in the United States by the National Council for Prescription Drug Programs.

OIG means the HHSC Office of Inspector General.

Principal means owners with a direct or indirect ownership or control interest of 5 percent or more; corporate officers and directors, limited and non-limited partners, and all shareholders of a provider entity (including a professional corporation, professional association, or limited liability company); all managing employees or agents who exercise

operational or managerial control or who directly or indirectly manage the conduct of day-to-day operations of the pharmacy business, this includes the pharmacist in charge; all individuals, companies, firms, corporations, employees, independent contractors, entities or associations who have been expressly granted the authority to act for or on behalf of the provider; all individuals who are able to act on behalf of the provider because their authority is apparent.

Program Requirements means the VDP requirements included in the Manual, Index, and all federal and state laws, rules, regulations, policies, and procedures governing VDP, as amended or modified. This includes all notices, bulletins, and information packages issued by HHSC concerning VDP.

Pharmacy Provider or **Provider** means a provider of outpatient pharmacy services enrolled in the Medicaid program.

Recipient means a person eligible to receive benefits under any of the programs administered by VDP.

SAO means the Texas State Auditor's Office.

Switch service bureau means the vendor that receives and transfers claims from pharmacies to Medicaid.

Healthy Texas Women (HTW) means the state program administered by HHSC as authorized by Health and Safety Code, Chapter 31 and Subchapter B of Chapter 39 of Title 25 of the Texas Administrative Code (formerly the Texas Women's Health Program, or TWHP).

Vendor Drug Program (VDP) means the Texas Vendor Drug Program, an outpatient drug program administered by HHSC for Medicaid, CHIP, CSHCN, KHC, and HTW.

Refer to the application instructions on the VDP website for help with completing the application.

Pharmacy Provider Enrollment Application

1. Application

Date

☐ New Pharmacy ☐ Re-enrollment | Vendor # _____

☐ Change of Ownership | Vendor # _____

2. Applicant

Name Of Pharmacy (Doing Business As)				
Legal contractor name				
Telephone	Fax	Email		
Pharmacy Physical Address		City	State	Zip
Pharmacy Business Address		City	State	Zip
Pharmacy Billing Address		City	State	Zip

Federal Employer ID Number (FEIN)	State Comptroller's Tax ID	Primary Taxonomy Code	Pharmacy License Number	State	National Provider Identifier (NPI)	NCPDP Number

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

3. Applicant Enrollment Contact

Contact Name #1	Title
Telephone	Email
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 NOT 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 one 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.				0.00%	
2.				0.00%	
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

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
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

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

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?	
10.13. What company serves as your switch service bureau? If unknown, contact your software company.	

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.?)			
10.15. Is the pharmacy presently open?	☐ Yes ☐ No	10.16. If no, by what date do you expect to open?	
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.

Print and sign this page.

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

Save document as...	Saves this entire document on your local computer/network.
Reset Application	Clears/resets user-entered fields of only the Application (sections 1-13 above).
Print Application	Prints only the Application (sections 1-13 above).

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

Print Application Prints only the Application and Board of Director Resolution (sections 1-14 above).

Pharmacy Provider Enrollment Application

Refer to the application instructions on the VDP website for help with completing the application.

Appendix A | Principal/Subcontractor Information

A separate copy of this form must be completed in full for each Principal or Subcontractor of the Applicant.

A Principal of the Applicant is defined as follows:

- All owners with a direct or indirect ownership or control interest of 5 percent or more.
- All corporate officers and directors, all limited and non-limited partners, and all shareholders of a provider entity (including a professional corporation, professional association, or limited liability company).
- All managing employees or agents who exercise operational or managerial control or who directly or indirectly manage the conduct of day-to-day operations of the pharmacy business; this includes the pharmacist in charge.
- All individuals, companies, firms, corporations, employees, independent contractors, entities or associations who have been expressly granted the authority to act for or on behalf of the provider.

A Subcontractor of the Applicant is defined as follows:

- An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
- An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies

All fields must be completed with the correct answer that applies to the Principal or Subcontractor.

Mark the boxes that are applicable:

☐ Person ☐ Entity	☐ Principal ☐ Subcontractor

If **Entity** then complete the following fields:

Legal name as shown on the W9 IRS form			
Company			
Address as shown on the W9 IRS form	City	State	Zip

Do you conduct business under an assumed name?

☐ No ☐ Yes If yes, provide name:	

If **Person** then complete the following fields:

Last Name	First Name & Middle Initial	Maiden Name
Identify any other alias, name, or forms of your name ever used		

The following information must be completed by all 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) and Subcontractors. For additional names or addresses, attach pages as necessary.

Pharmacy Provider Enrollment Application

Physical address	City	State	Zip
Accounting/billing address	City	State	Zip
Previous physical address	City	State	Zip
Previous accounting/billing address	City	State	Zip

If your accounting address is different than your physical address, indicate your relationship to the accounting address:

☐ Billing agent ☐ Management company ☐ Employer ☐ Self

☐ Other; explain:

DOB	Gender	Social Security Number	Federal tax id number
	☐ M ☐ F		

Specialty of practice (i.e., pediatrics, general practice, etc.)	Medicare intermediary (if applicable)
Medicare provider number (if applicable)	Medicare effective date (if applicable)

Driver's license number	State	Expiration date

Your title/position in the Applicant organization for which enrollment is being sought:
Your duties to the Applicant organization (attach additional sheets if necessary):
Your role in the Applicant organization. Examples are Accountant, Agency, Attorney, Banker, Bookkeeper, Business, Care Giver, Consultant, Contractual, Corporate Officer, Director, Doctor, Elected Official, Employee, Employer, Government Official, Individual (Contracted), Individual (Fiscal Agent), Limited Partner, Managing Employee, Medical Director, Non-Limited Partner, Nurse, Official, Owner (Direct), Owner (Indirect) Parent, Recruiter, Representative, Shareholder, Subcontractor, or Unknown (attach additional sheets if necessary).

Effective date of your role in the provider organization	
Do you have a relationship with a separate provider?	☐ Yes ☐ No

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Do you have one or more professional licenses, accreditations, or certifications?
☐ No ☐ Yes If yes, provide the following information:

1	Professional Licensing or Certification Board	License Accreditation Cert. Issuer	License Accreditation Cert. Nbr.
	Licensing State	Issue Date	Expiration Date
2	Professional Licensing or Certification Board	License Accreditation Cert. Issuer	License Accreditation Cert. Nbr.
	Licensing State	Issue Date	Expiration Date
3	Professional Licensing or Certification Board	License Accreditation Cert. Issuer	License Accreditation Cert. Nbr.
	Licensing State	Issue Date	Expiration Date
4	Professional Licensing or Certification Board	License Accreditation Cert. Issuer	License Accreditation Cert. Nbr.
	Licensing State	Issue Date	Expiration Date

Have you ever been sanctioned in any state or federal program? "Sanction" is defined as recoupment, payment hold, imposition of penalties or damages, contract cancellations, exclusion, debarment, suspension, revocation, or any other synonymous action.	☐ Yes ☐ No
• If **Yes**, 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).	
Is your professional license or certification currently revoked, suspended or otherwise restricted?	☐ Yes ☐ No
Have you ever had your professional license or certification revoked, suspended, or otherwise restricted?	☐ Yes ☐ No
Are you currently, or have you ever been, subject to a licensing or certification board order?	☐ Yes ☐ No
Have you voluntarily surrendered your professional license or certification in lieu of disciplinary action? (You may be subject to a license or certification verification/status check with your 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 your license (attach additional sheets if necessary).	

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Are you currently or have you 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
Do you 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).	
Are you currently charged with or have you 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 C.F.R. § 1001.2 as described below, and which includes deferred adjudications and all other types of pretrial diversion programs. You 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
Have you been arrested for a crime but not yet charged?	☐ Yes ☐ No
Is there an outstanding warrant for arrest?	☐ Yes ☐ No
• If **Yes**, fully explain the details, including date, the state and county where the conviction occurred, the cause number(s), and specifically what you were convicted of (attach additional sheets if necessary).	
Are you currently subject to court ordered child support payments?	☐ Yes ☐ No
Are you a citizen of the United States?	☐ Yes ☐ No
• If **No**, provide the country of which you are a citizen.	
If you are not a citizen of the United States, do you have a legal right to work in the United States?	☐ Yes ☐ No
• If **Yes**, attach a copy of your United States Permanent Resident Card, visa, or other documentation demonstrating your right to reside and work in the United States.	

Reset Appendix A Clears/resets user-entered fields of only Appendix A (above).

Print Appendix A Prints only Appendix A (above).

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Appendix B | Application Fee Deposit Form

In accordance with ACA and 42 CFR 455.460, certain providers are subject to an application fee for all applications, including, but not limited to:

- Initial applications for new enrollment
- Applications received in response to re-enrollment

If the Applicant is required to pay the application fee, the Applicant must submit the completed Application Fee Deposit Form and payment in the form of a paper check, money order, or cashier's check, when submitting this application. Payment should be made out to the Texas Health and Human Services Commission (HHSC). Please include "ACA Pharmacy Enrollment Fee" in the memo line of the check.

Application fee may change each calendar year. Please refer to the HHSC website for the current application fee at txvendordrug.com/providers/pharmacy-enrollment.

Complete the following fields and attach payment.

Name Of Pharmacy (Doing Business As)
National Provider Identifier (NPI)
Check Number

For Internal Use

ACA PHARMACY ENROLLMENT FEE	R106	529200770

Print Appendix B Prints only Appendix B (above).

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Pharmacy Provider Enrollment Application

Appendix C | Checklist

To assist in the timely processing of the Application packet, the Applicant should use this checklist to ensure the application packet is complete and all required information and supporting documents are included. Failure to submit all required information and documents will result in delayed processing or denial of application. This checklist is for your reference and does not need to be returned with this Application to HHSC.

☐	1. Verify that the Application is completed in full.
☐	2. Verify that the Application has been signed and the notarized statement indicating which individual has the authority to sign the Application is included. The statement must specify the person's position within the organization.
☐	3. Verify that the address on the Application is the same as the address in National Plan and Provider Enumeration System (NPPES).
☐	4. Verify that all pharmacists listed on the Application are listed on the Texas State Board of Pharmacy website.
☐	5. Verify that the Federal Employer Identification Number (FEIN) is correct and registered.
☐	6. Verify that the Application contains the correct NCPDP Number, NPI Number, Pharmacy License Number, and State Tax ID Number.
☐	7. Verify that the Principal/Subcontractor Information (**Appendix A**) is completed in full for each Principal, Subcontractor, and Creditor of the Applicant.
☐	8. Submission of the IRS FEIN Verification Letter
☐	9. Completion of “Texas Comptroller's Application for Payee Identification Number” (CPA-AP-152)
☐	10. Completion of “Texas Comptroller's Direct Deposit Authorization” (CPA-74-176)
☐	11. Completion of “Child Support Certification” (HHS-1903)
☐	12. Completion of “Certification Regarding Federal Lobbying” (HHS-H2047)
☐	13. Completion of “Pharmacy Eligibility Verification Portal Access” (HHS-1317)
☐	14. Completion of “Pharmacy Electronic Remittance Advice Agreement” (HHS-1316)
☐	15. Completion of the “Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion for Covered Contracts” (HHS-H2046)
☐	16. Submission of application fee and completed Application Fee Deposit Form (**Appendix B**) (if applicable).