Pharmacy Provider Information Request Form
Category of Service 0441

Form Instructions

1. This form may be downloaded and completed electronically.
2. If additional room is needed to provide a complete response to any question, include the information on a separate page and attach it to this form. Be sure to indicate the corresponding question number on your attachment.
3. Applicants that do not check Yes below must answer every question. Any questions left blank, including failure to provide the required attachments, may result in the denial of the application pursuant to NYCRR Title 18 §504.5 (a)(1).
4. All questions related to this form must be directed to omig.enrollment@omig.ny.gov.

If you are only seeking enrollment for Medicare crossover claims (copays and deductibles), check the 'Yes' box below, sign this form on page 4, and submit the form with your application. You do not have to answer the questions that follow this section.

☐ Yes. Please note that this means that Medicaid claims may only be submitted for Medicare copays and deductibles. All other claims will be denied.

If the 'Yes' box above was not checked, the following information must be provided to process your enrollment application. Failure to submit required information may result in your application being returned to you and will delay the enrollment process. Attach additional sheets when necessary.

This form should only be completed by pharmacy providers enrolling under category of service 0441.

1. Does the applicant pharmacy submit and accept Medicare claims assignment for all Medicare covered services claims? ☐Yes ☐No

2. Date the pharmacy opened and began dispensing medications:

   ___/___/___/___/___/___

   M M D D Y Y

3. List the name of the owner(s) of the business, their Social Security number(s), and their percentage of ownership. The names must match the names listed under Section 1 of the Disclosure of Ownership and Control section of the Business Enrollment Form (EMEDNY-436701). List any New York State (NYS) Medicaid Program provider numbers, National Provider Identifiers (NPI) or professional licenses held by the owners. If a corporation or partnership, list the names of the officers, directors, principal stockholders, partners; their Social Security numbers; and any NYS Medicaid Program provider numbers or professional licenses held. The names must match the names listed under Section 5 of the Disclosure of Ownership and Control section of the Business Enrollment Form (EMEDNY-436701).

Last Name, First Name	Social Security Number	Percent of Ownership	NPI or NYS Medicaid ID Number or Professional License Number	License Type (Pharmacy, Medical, Dental, etc.)

4. List the name and license number of each pharmacist. State the days and hours of the week the pharmacist will be working.

Name	Title	License Number	Days of the Week Worked	Hours of the Week Worked

5. Indicate the days and corresponding hours the pharmacy will be open. *Pharmacy Manual Policy Guidelines, Section II General Guidelines.*

	Hours of Operation		Hours of Operation
Monday		Friday	
Tuesday		Saturday	
Wednesday		Sunday	
Thursday			

6. Please attach a detailed list of your current inventory.

   Documents attached: ☐Yes ☐No

   (If there has recently been an ownership change, submit all supplier invoices or inventories from previous owners that verify stock on hand.)

7. Was the business location previously a place at which NYS Medicaid pharmacy services were rendered? ☐Yes ☐No

   a. If yes, list the National Provider Identifier (NPI) or NYS Medicaid Number of the prior owner(s):

      _____

   b. Enclose copies of any promissory notes, sales agreements and any other relevant documents pertaining to the sale, if applicable.

      Documents attached: ☐Yes ☐N/A

8.

   a. Identify the name, address, and account number(s) of the bank(s) to be used by the business.

Name of Bank	Address	Account Number

   b. Provide the names and Social Security numbers of all personnel authorized to sign corporate checks against those accounts.

Person(s) Authorized to Sign Checks	Social Security Number

   c. Attach a statement identifying the persons who will be authorized to sign NYS Medicaid Program claims and provide original examples of their signatures. Signature stamps, photocopies, etc., are not acceptable.

      Signed statement attached: ☐Yes ☐No

   d. Provide the name, address, email, and telephone number of the attorney for the business.

Name	Address	Email Address	Telephone Number

Certification

I certify, to the best of my knowledge and belief, that all information contained in and attached to this *Pharmacy Provider Information Request form* is complete and accurate. I understand that failure to provide complete and accurate information may result in denial of enrollment.

By signing below, I acknowledge that I have read and agree to comply with the *New York State Medicaid Fee-for-Service Program Pharmacy Manual Policy Guidelines* found on eMedNY.org. I understand that failure to comply will result in denial of enrollment.

Owner's Name (Print): _____

Owner's Signature: _____ Date Signed _____

Form Prepared By (Print): _____

Telephone Number: _____Email Address: _____

Pharmacy Provider Information Request Form
Completeness Checklist

If applicable, please make sure all the following documents are attached. Failure to do so may result in denial of the application pursuant to New York Codes, Rules, and Regulations Title 18 § 504.5 (a)(1).

Please note that no protected health information should be sent electronically. All questions related to the attachments listed below must be directed to omig.enrollment@omig.ny.gov. All photographs should be sent directly to omig.enrollment@omig.ny.gov at the time the form is submitted. Please ensure the NPI number of the applying entity is included in all emails.

For all applicants:

- ☐ Names and titles of all staff who have keys to the pharmacy
- ☐ Names and titles of all staff who have keys to secure areas and/or lock boxes containing controlled substances
- ☐ Certificate of Incorporation
- ☐ Issued Stock Certificates
- ☐ Controlled Substance Order Forms for the last six (6) months or since the pharmacy opened (whichever is longer)
- ☐ Photographs of the outside of the pharmacy (include signage and business hours)
- ☐ Photographs of the inside of the facility (inside and outside of pharmacy area). If pharmacy is located inside a retail space, please include photos illustrating the method in which the pharmacy is secured.
- ☐ Photographs of medication in inventory on shelves. Please ensure all inventory on shelves is included.
- ☐ Photographs of hot and cold faucets that provide running water inside the pharmacy
- ☐ Photograph of medication refrigerator, the inside of the refrigerator, and a close-up photo of the thermometer inside showing its temperature
- ☐ Photographs of prescription drugs (inventory on the shelf), and durable medical equipment and medical surgical supplies, if applicable
- ☐ Photographs of the sanitary facility (bathroom)
- ☐ Photographs of the basement, if applicable
- ☐ Photographs of all licenses as they are displayed in the pharmacy
- ☐ Photographs of the location where controlled substances are kept
- ☐ Copies of entire daily log pages for the last two (2) weeks, as well as the daily summary pages, per-day, for the last two (2) weeks

☐ The pharmacy's process/procedure for removing drugs from stock, including invoices.

☐ Signed copy of the current lease

☐ Detailed list of your current inventory (Question 6)

☐ Invoices for the last six months or from the date of opening

☐ A statement identifying the persons who will be authorized to sign NYS Medicaid Program claims and provide original examples of their signatures (Question 8c) *Signature stamps, photocopies, etc., are not acceptable*

☐ A copy (front and back) of the most recent canceled rent check

If applicable:

☐ Copies of promissory notes, sales agreements, and any other relevant documents pertaining to the sale if the business location was previously a place at which NYS Medicaid pharmacy services were rendered (Question 7b)

☐ **For pharmacy providers located outside of New York State or its bordering states, contracts with homecare agencies, adult homes, nursing homes, or any other facilities must be included**