Return To: Computer Sciences Corporation
PO Box 4610
Rensselaer NY 12144-4610

SUPERVISING PHARMACIST AGREEMENT

Supervising Pharmacist:

_____

Last Name (Print) **First** **M.I.**

_____

License/Registration Number

Pharmacy Information:

Pharmacy Name: _____

Address: _____

_____

_____

_____ _____

Pharmacy License/Registration Number **National Provider Identifier (NPI)**

_____

NYS Medicaid Provider ID #

I agree to assume the responsibilities, as defined by State and Federal Laws, as the Supervising Pharmacist of _____
Pharmacy Name
National Provider Identifier (NPI)/MMIS Provider # _____, effective as of _____.

I agree to notify the State Pharmacy Board and the NYS Department of Health, Bureau of Enrollment, of any change of my Supervising Pharmacist status.

_____ _____

Signature of Supervising Pharmacist **Date Signed**

Pharmacy Owner:

I understand enrollment of a Supervising Pharmacist is a precondition for NYS Medicaid reimbursement.

_____

Owner's Name (PRINT)

_____

Owner's Signature (SIGNATURE STAMPS ARE NOT PERMITTED) **Date Signed**

Passport size photo affixed to a separate 8 ½" x 11" sheet of paper **with supervising pharmacist's name, social security number and name of pharmacy.**