PHARMACY INFORMATION REQUEST

If you are only seeking enrollment for Medicare crossover (co-pay and deductibles) claims only, check the 'yes' box below and sign this form on page 4. If you check the 'yes' box, you do not need to complete this form.

☐ Yes

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.

Are you presently open? ☐ Yes ☐ No

If yes, when did you open? __/__/__ (M M D D Y Y)

If no, when you anticipate opening? __/__/__ (M M D D Y Y)

1. List the name of the owner(s) of the business and their social security number(s) and percentage of ownership. **The names must match the names given on question #5 of the Disclosure of Ownership and Control Form.** 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 and their social security numbers and any NYS Medicaid Program provider numbers or professional licenses held.

Last Name, First Name	Social Security Number	% of Ownership	Medicaid Number/NPI/ Professional License

2. Leasehold arrangements:

   a. Indicate whether rent is paid in equal monthly or yearly installments. **You must attach a signed copy of the current lease.** _____

   b. Submit a description of any other payments to be made as, or in lieu of, rent to the owner of the property.

   c. Provide the name and address of the owner(s) of the building(s) to be used by the business.

Last Name, First Name (or Corporation Name)	Address

d. Provide the name and address to whom the rent is paid.

e. If rent is paid to a corporation or partnership, list the names of the officers, directors, principal stockholders, partners and any NYS Medicaid Program provider numbers, National Provider Identifiers or professional licenses held.

Last Name, First Name	**Medicaid Number/NPI/ Professional License**

3. If the business location was previously a place at which NYS Medicaid pharmacy services were rendered, list the NYS Medicaid Provider Number/National Provider Identifier(s) of the prior owner(s).

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

5. Estimate the dollar value of the pharmaceutical stock and medical supplies currently on hand. Please attach a detailed list of your current inventory. (If there has recently been an ownership change, submit all supplier invoices or inventories from previous owners that verify stock on hand.)

6. Estimate the percentage of business that will be billed to the NYS Medicaid Program. _____%

7. 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 of all personnel authorized to sign corporate checks against those accounts.

Person(s) Authorized to Sign Checks

8. 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.**

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

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

10. Indicate the days and corresponding hours the pharmacy will be open.

Monday	_____ to _____	Friday	_____ to _____
Tuesday	_____ to _____	Saturday	_____ to _____
Wednesday	_____ to _____	Sunday	_____ to _____
Thursday	_____ to _____		

11. Indicate which services your pharmacy provides and how they are provided.

a. Free delivery. **Please specify** any limitations. a. _____

b. Emergency service: b. _____

After hours phone number _____

After hours beeper number _____

c. Health counseling (e.g. blood pressure checks, diabetic care, etc.) **Please be specific.** c. _____

d. Multilingual counseling. **Please identify** the language(s) spoken and indicate which pharmacist or supervising pharmacist speaks the language(s) listed. d. _____

e. Multilingual labeling. **Please specify** the language(s). e. _____

f. Compound prescriptions. f. _____

g. Private consultation area. **Please describe.** g. _____

h. Patient information leaflets. **(Please attach a copy).** h. _____

i. Drug and allergy monitoring. **Please explain.** i. _____

j. How does your establishment provide access to the handicapped (ramps, passage, parking, etc.)? j. _____

Identify any additional circumstances or services which you offer that significantly improve health services to your clients other than those listed above.

_____

_____

_____

_____

12. Explain how your customers are made aware of the services your pharmacy provides.

13. Of your total pharmacy revenue, what percentage is provided by mail order or delivery (i.e. Fed Ex, UPS, US Mail, etc.)?

a. Identify the types of medication or supplies that you provide by mail order or delivery.

b. How do you provide these services to your customers?

c. Where do the customers that receive these services reside?

14. Provide the name and telephone number of the accountant for the business.

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

16. a. Are you an out of state provider of pharmacy services interested in participating in the NYS Medicaid Program? ☐ Yes ☐ No

b. Is this application for a single occasion for one NYS Medicaid Program recipient? ☐ Yes ☐ No

c. If yes, please provide the first date of service for this recipient. __/__/__/__/__/__ (M M D D Y Y)

Owner's Name (Print): _____

Owner's Signature: _____ Date Signed: _____
(Signature Stamps Are Not Permitted)

Application Prepared by (Print): _____

Telephone Number: _____