Pharmacy Provider Information Request Form
Category of Service 0441, 0445, 0451, 0452, 0453

Form Instructions

1. This form may be downloaded and completed electronically, and must be mailed with the application and other required documents.
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, 0445, 0451, 0452, and 0453.

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 drug and diabetic supply inventory.

   Documents attached: ☐Yes ☐No

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 (including inventory), 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 two (2) months or since the pharmacy opened, whichever is more recent
- ☐ 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 the inside of the pharmacy and the other side of any other internal doors or internal windows, or rooms
- ☐ Photographs of the patient pickup area (dispensing area), counseling area, vaccination area (if applicable)
- ☐ Photographs of the pharmacy preparation area and compounding area
- ☐ Photographs of the following inventory: medication, diabetic supplies, other durable medical equipment, and medical/surgical supplies, if applicable. **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 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, including the inside of the cabinet or safe.

☐ 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

☐ Signed copy of the current lease

☐ Detailed list of your current inventory (Question 6)

☐ Wholesaler drug purchase summary for each wholesaler for last two (2) months or from the date of opening, whichever is more recent

☐ A statement identifying the persons who will be authorized to sign NYS Medicaid Program claims, including original examples (wet) 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, inventory, 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 (refer to 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.**