Request for **Pharmacy Medicare Enrollment Exemption**

The New York State (NYS) Medicaid program requires Medicare enrollment for pharmacies enrolling in Medicaid to ensure that Medicaid Dual-Eligible members receive drugs and supplies from Medicaid providers enrolled in accordance with federal and State laws and regulations. The three types of Medicare enrollment discussed in this document include CMS-460 *Medicare Participating Physician or Supplier Agreement*, CMS-855B Medicare enrollment for clinics/group practices and other suppliers, and CMS-855S Medicare enrollment for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers.

Pharmacies that choose to enroll in the CMS-460 *Medicare Participating Physician or Supplier Agreement* agree to accept assignment for all their Medicare claims, including those not subject to Medicaid payment. This Medicare enrollment is optional. However, all pharmacy providers enrolled in Medicaid are still required by federal law to submit claims and accept assignment for Medicare-covered services provided to Medicaid Dual-Eligible members, regardless of CMS-460 enrollment status.

Pharmacy applicants applying for category of service (COS) 0441 are generally required to have CMS-855B (Supplier Type – Pharmacy) and CMS-855S (Supplier Type – Pharmacy). Refer to section *2.0 General Guidelines of the NYRx Pharmacy Manual Policy Guidelines* found here: https://www.emedny.org/ProviderManuals/Pharmacy/, which outlines each pharmacy type by description with the corresponding expected services and Medicare-type enrollment required at the time of application submission. Additional information regarding pharmacy enrollment can be found in the Pharmacy Guidelines using the above link.

This form provides pharmacy applicants the opportunity to clarify and confirm the necessity for an exemption from a type of Medicare enrollment. **Pharmacies that do not have or maintain CMS-855B and CMS-855S enrollment, where required, do not meet enrollment criteria and enrollment may be denied or terminated.** Pharmacies that do not comply with the Medicare enrollment requirement are subject to audit, recovery, and Medicaid provider termination.

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This form is required when the pharmacy applicant is missing "**Supplier Type – Pharmacy**" Medicare enrollment per the *Pharmacy Manual Policy Guidelines* at the time of a new application, revalidation, or reinstatement submission.

If submitting this form as an update and not as part of a new enrollment application, please mail it to:

eMedNY
PO Box 4603
Rensselaer NY 12144-4603

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Instructions: For each part below, select the statements that correspond to your pharmacy's business situation.

Pharmacy Name _____ Provider ID # _____ NPI #_____

**Be advised that a response of not enrolled to one or more Medicare types will require further review by the Pharmacy Policy Unit. If it is determined that additional Medicare enrollment is required for your business model to enroll or remain enrolled with the New York State Medicaid Program, the processing of your application may be impacted and delayed.**

**Part 1:**

☐ This pharmacy is enrolled as a **CMS-855B Supplier Type – Pharmacy** provider (Medicare enrollment for clinics/group practices and certain other suppliers). This pharmacy is dispensing drugs administered by a practitioner in a long-term care facility, practitioner's office, or home setting; or is dispensing drugs covered by National Government Services (NGS) enrollment that are self-administered; or is dispensing and administering vaccines.

☐ This pharmacy is not enrolled as a **CMS-855B Supplier Type - Pharmacy** provider. This pharmacy is not dispensing drugs administered by a practitioner in a long-term care facility, practitioner's office, or home setting; and is not dispensing drugs covered by National Government Services (NGS) enrollment that are self-administered; and is not dispensing/administering vaccines that require this Medicare enrollment.

**Note that applicant pharmacies seeking enrollment for COS 0441 are not eligible for Medicaid enrollment without active 855B enrollment where required.*

**Part 2:**

☐ This pharmacy is enrolled as a **CMS-855S Supplier Type- Pharmacy** provider: *Generally required for pharmacy enrollment* (Medicare enrollment for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers).

☐ This pharmacy is not enrolled as a **CMS-855S Supplier Type - Pharmacy** provider**.** This pharmacy does not dispense Medicare Part B drugs or supplies as allowed by **CMS-855S** enrollment. For example, this pharmacy does not dispense diabetic supplies, nebulizer drugs, oral anticancer or antiemetic drugs to any patients of the pharmacy.

**Note that applicant pharmacies seeking enrollment for COS 0441/0442 are not eligible for Medicaid enrollment without active 855S enrollment where required.*

**Part 3***:*

If the pharmacy indicated above that it does **not** have CMS-855B and/or CMS-855S enrollment use the section below to provide rationale on how the pharmacy meets enrollment criteria as described in the *Pharmacy Manual Policy Guidelines*. (Attach additional pages if necessary.)

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**Part 4:**

**All applicants and currently enrolled pharmacy providers must note that to obtain and maintain New York State Medicaid enrollment, pharmacies must have and retain CMS Medicare enrollments appropriate for the services provided. This form must be updated whenever the pharmacy adds or removes services requiring Medicare enrollment. Failing to promptly inform the Department of any changes to the pharmacy's Medicare status may result in termination from the New York State Medicaid Program.**

I hereby attest that the information contained in this document is correct and true, and I have the authority to sign this document on behalf of the named pharmacy provider. The pharmacy agrees to **accept** Medicare claims assignment and submit Medicare claims for **all Medicare-covered services** on behalf of a Medicaid member.

Pharmacy Name: _____

Pharmacy NPI: _____

Signature of Owner or Board Member: _____

Print name of Owner or Board Member: _____

Date: _____