eMedNY

Free-Standing
Pharmacy Revalidation Application
Quick Reference Guide

CORRESPONDENCE: (indicate where letters and claims forms, if any, should be sent) – PO Box not acceptable		
Attention:	Street Address	Suite / Department/ Floor
City	State	Zip Code (9 digit)
County (if in New York)	Telephone Number (w/ extension)	Fax Number
PAY TO ADDRESS: (indicate where checks & remittance statements should be sent until EFT and e-Remits are in place):		
Attention:	Street Address or PO Box	Suite / Department/ Floor
City	State	Zip Code (9 digit)
County (if in New York)	Telephone Number (w/ extension)	Fax Number
CORPORATE ADDRESS: (indicate where Annual Tax Documents (Form 1099) should be sent)		
Attention:	Street Address or PO Box	Suite / Department/ Floor
City	State	Zip Code (9 digit)
County (if in New York)	Telephone Number (w/ extension)	e-Mail Address - **REQUIRED**

PAGE 3

- Service Address: List the address where the actual pharmacy is located. If you have more than one pharmacy (branch/store) enrolled, then you will need to complete one application per NPI.
- Towards the bottom of the page, you will need to fill in the name and NPI of the Supervising Pharmacist. If s/he is not enrolled in New York Medicaid, s/he will need to enroll for your revalidation application to process.

If the Applicant is a Pharmacy, Laboratory or a Portable X-Ray provider, please provide the Name and NPI of the Supervising Pharmacist, Laboratory Director or Supervising Physician, respectively.

PLEASE NOTE: If this individual is not actively enrolled in the NY Medicaid Program, s/he must complete the appropriate enrollment form found at www.eMedNY.org.

Name:	NPI:

Free-Standing
Pharmacy Revalidation Application
Quick Reference Guide

PAGE 4

- Section 1 of the Disclosure of Ownership and Control is on this page. For the "Disclosing Entity/Applicant", complete the pharmacy information including Name, NPI and FEIN (Tax ID).

DISCLOSURE OF OWNERSHIP AND CONTROL

Completion is required by 42 CFR Part 455.104. ***Failure to provide the information requested will cause the application to be returned.*** **Click here to review definitions and policy found at 18NYCRR, Section 504.1 before completing this form. {If additional space is needed, copy form; all entries must be on the form}.**

SECTION 1:

Disclosing Entity / Applicant (Entity named on page 2 of this application)

Entity Name	
FEIN	NPI (if exempt, leave blank)

Ownership in Applicant (per 42 CFR, Part 455.104(b)(1)(i) – (Entities and/or Individuals) Copy this page to report additional owners.

Name of Individual or Entity	Title (if individual)	Date of Birth (if individual) (MM/DD/YYYY)
Address (**Home Address** if Individual; Primary Address if Corporation) – **Street**		City, State & Zip Code (9 digit)

SSN (for individual)	FEIN (for entity)	% of Ownership (if none, put 0%)	NPI or NY Medicaid ID (if none, write None)

For Individuals Only: If you are related* to another person with an ownership or control interest in the Applicant, complete the following:

Name of other Owner: _____ Relationship to other Owner (parent, child, sibling, spouse): _____

For Corporations Only: Use the space below to report other business addresses (per 42CFR, Part 455.104(b)(1)(i)):

1)_____ 2)_____ 3)_____

- For the ownership in applicant, you will need to fill in the following information based on how your business is set up.
  - If you have a direct owner or owners, you will need to list each owner on this page. If there are more than 2, you will need to copy the page to report the information. eMedNY and DOH will not accept attachments for this.

Free-Standing
Pharmacy Revalidation Application
Quick Reference Guide

- If this is a public company and divided into shares, all shareholders owning more than a 5% stake must be listed on this page. eMedNY and DOH will not accept attachments for this part of the form.
- If there is no direct owner (example - you are a non-profit organization), then you can put 100% in the business information (Pharmacy Name, FEIN, Address etc.) area.
- Owners must provide their home address, social security number, and date of birth. If the information is not provided, the application will be returned.

Ownership in Applicant (per 42 CFR, Part 455.104(b)(1)(i) – (Entities and/or Individuals) Copy this page to report additional owners.

Name of Individual or Entity	Title (if individual)	Date of Birth (if individual) (MM/DD/YYYY)

Address (**Home Address** if Individual; Primary Address if Corporation) – **Street**	City, State & Zip Code (9 digit)

SSN (for individual)	FEIN (for entity)	% of Ownership (if none, put 0%)	NPI or NY Medicaid ID (if none, write None)

For Individuals Only: If you are related* to another person with an ownership or control interest in the Applicant, complete the following:

Name of other Owner: _____

Relationship to other Owner (parent, child, sibling, spouse): _____

For Corporations Only: Use the space below to report other business addresses (per 42CFR, Part 455.104(b)(1)(i)):

1) _____ 2) _____ 3) _____

PAGE 5

- Complete Sections 2, 3 and 4 **if** they apply to you.
- Section 5 (Agents and Managing Employees) must be completed. In this section, report all those who exercise operational or managerial control, or directly or indirectly conduct the day-to-day operations, of the provider. These individuals must provide their home address, social security number, and date of birth. If the information is not provided, the application will be returned. At a minimum, the Supervising Pharmacist must be reported in this section.
- If you have more than 3 agents or managing employees, then you can continue completing this section on page 6. If not, leave the page blank and submit the blank page with the application. If you have more to report and need more than the eight slots offered on this page, copy the page and fill it in accordingly. Remember, eMedNY and DOH will not accept attachments for these forms.

eMedNY

Free-Standing
Pharmacy Revalidation Application
Quick Reference Guide

SECTION 5:

Agents, Managing Employees & Those with a Control Interest – Including, but not necessarily limited to, the following: Facility Administrator, all Members of the Board of Directors, Managing Employees, Compliance Officer, Laboratory Director, Supervising Pharmacist *(although unusual, if None, indicate **NONE** in the first "Name" field below).* Include familial relationship to the Applicant (spouse, parent, child, sibling), if any.

Name			Association type (see instructions)
Home Address	City & State		Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	
Name			Association type (see instructions)
Home Address	City & State		Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	
Name			Association type (see instructions)
Home Address	City & State		Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	

{If additional space is needed, copy form; all entries must be on the form}

Agents, Managing Employees & Those with a Control Interest – (continued)

Name			Association Type (see instructions)
Home Address	City & State		Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	

Free-Standing
Pharmacy Revalidation Application
Quick Reference Guide

PAGE 7

- Check yes or no to the questions asked.
- If you answer "Yes" to questions 1-4 on this page, you must download, print and complete the Prior Conduct Questionnaire from www.emedny.org.

SECTION 6:

Respond to these questions on behalf of:
1. the Applicant
2. all individuals and entities identified in Sections 1 & 5
3. any entity in which the Applicant has a 5% or more ownership

1. Have any of the individuals/entities (1, 2 and 3) been terminated, denied enrollment, suspended, restricted by Agreement or otherwise sanctioned by the Medicaid Program in New York or in any other State, Medicare, or any other governmental or private medical insurance program?
☐ Yes ☐ No

2. Have any of the individuals/entities (1, 2 and 3) ever been convicted of a crime related to the furnishing of, or billing for, medical care or supplies or which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals in any State?
☐ Yes ☐ No

3. Have any of the individuals/entities (1, 2 and 3) ever had their business or professional license or certification, or the license of an entity in which they had an ownership interest over 5% ever been revoked, suspended, surrendered, or in any way restricted by probation or agreement by any licensing authority in any State?
☐ Yes ☐ No

4. Is there currently pending any proceedings that could result in the above stated sanctions for the individuals/ entities (1, 2 and 3)?
☐ Yes ☐ No

NOTE: If you answered "Yes" to any of the questions above, you must complete and submit the "Prior Conduct Questionnaire" available at www.emedny.org.

5. Has there been a change of ownership or control within the last 12 months to any of the entities (1, 2 and 3)?
☐ Yes ☐ No
If "Yes", provide:
NY Medicaid ID or NPI _____
Date of Ownership Change _____ (MM/DD/YYYY)

6. Do you anticipate a change of ownership within the next 12 months to any of the above entities (1, 2 and 3)?
☐ Yes ☐ No
If "Yes", when do you anticipate the ownership change will occur: _____ (MM/DD/YYYY)

7. Does the Applicant/Provider have any unpaid balances owed to the NY Medicaid Program related to this Business or another entity owned by the Applicant? ☐ Yes ☐ No

- If yes, indicate amount $_____
- If yes, has payment been arranged? ☐ Yes ☐ No If yes, attach verification of arrangement. If no, this enrollment will be reviewed by the OMIG

Free-Standing
Pharmacy Revalidation Application
Quick Reference Guide

PAGE 8

- The signature must be original; no stamps.
- Your application requires additional documents. Make sure you that you submit the following:
  - ☐ A copy of the IRS Assignment Letter (The letter that assigned the Tax ID to the business.)
  - ☐ A copy of the Certificate from the New York State Board of Pharmacy
  - ☐ A copy of the Pharmacy's DEA Certificate
  - ☐ The Pharmacy Information Request Form
  - ☐ If the Supervising Pharmacist has changed, send the PIN Request Form
  - ☐ The Supervising Pharmacist Agreement Form
  - ☐ If you are out of state, the Out of State Pharmacy Application
  - ☐ If you are out of state *and* a Competitive Bidder with *Medicare*, a copy of your status needs to be included
  - ☐ The application fee of **$560**. This must be a check or money order made out to the "New York State Department of Health." Make sure to include your NPI or Tax ID on the check/money order. The fee may not be required. See direction for "Medicare Fee Payment" on www.emedny.org.

- Once all forms are completed and ready, mail everything to the address on page 2 of the enrollment form. This address is listed as:

  eMedNY
  PO Box 4603
  Rensselaer NY 12144-4603

- The application will be reviewed for completeness and inclusion of required forms then submitted for review.

- Please note that there is no set timeframe for how long it will take to process the application. If more information is needed you will be contacted by the DOH. You may bill as normal in the interim.

- If you have any questions not addressed in this reference guide, please call eMedNY at 800- 343-9000.