OFFICE OF PHARMACY AFFAIRS (OPA)
340B REGISTRATION FORM FOR CHILDREN'S HOSPITAL OUTPATIENT FACILITIES USING MEDICARE COST REPORT

I. Hospital Information:

Hospital (Main Provider) Name: ____

Hospital (Main Provider) Medicare Provider Number: ______________________

Hospital (Main Provider) Address: ____

II. Hospital Outpatient Facilities Information:
Please complete Section IV and list outpatient facilities and all requested information.

Indicate the following regarding the list from Section IV of outpatient facilities:
Attached list includes new registrations for outpatient facilities to enroll in 340B? Yes ❐ No ❐

III. Certification:

I acknowledge that I am familiar with the Center for Medicare & Medicaid Services' guidelines concerning Medicare certification of hospital components as one cost center. Pursuant to those guidelines, I request that the attached list of qualifying outpatient facilities be added to the database of 340B covered entities. I have examined the list and certify that each outpatient facility is reimbursable on the covered entity's Medicare cost report and is an integral part of the aforementioned hospital under the Medicare provider number listed above. I further acknowledge that the main provider hospital and attached list of outpatient facilities are in compliance with 340B published guidelines regarding entity and patient eligibility. I confirm that I am fully authorized to bind the hospital and certify that the contents of any statement made or reflected in this document are truthful and accurate; I further acknowledge the hospital's responsibility to notify OPA immediately if there is a material change in the 340B eligibility of any facility.

IV. Authorized Signature:

The undersigned represents and confirms that he/she is fully authorized to bind the hospital and certifies that the contents of any statement made or reflected in this document are truthful and accurate; and that the hospital will comply with all requirements and restrictions of Section 340B of the Public Health Service Act and any accompanying regulations or guidelines including, but not limited to, the prohibition of duplicate discounts/rebates, and drug diversion. The undersigned further acknowledges the 340B Covered Entity's responsibility to contact OPA if there is a change in meeting any of these criteria.

____

Signature of Authorizing Official Date

____

Name & Title of Authorizing Official and Title Phone Email
(*please print or type)(e.g.CEO,CFO,COO)*

The quarterly deadlines for data submission to OPA are December 1 for the quarter beginning January 1; March 1 for the quarter beginning April 1; June 1 for the quarter beginning July 1; and September 1 for the quarter beginning October 1.

Submit original, signed form to: HRSA, Office of Pharmacy Affairs, 5600 Fishers Lane, Mail Stop 10C-03, Rockville, Maryland 20857

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project Is 0915-XXXX. Public burden is estimated to average XX minutes per respondent, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-33, Rockville, Maryland 20857.

IV. List of Outpatient Facilities:

NAME OF FACILITY **&** **FACILITY'S MEDICARE PROVIDER NUMBER/NPI** *(If Applicable)*	**STREET ADDRESS** **BILLING ADDRESS** *(if different)* **SHIPPING ADDRESS** *(if different)*	**340B CONTACT** *(Name, Title, Phone Number, Email Address)*	**If facility bills Medicaid for 340B drugs subject to a rebate, then you must submit all such MEDICAID PROVIDER NUMBER(S) and/or NPI** *(If Not Applicable, 'N/A')*

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