



### 340B PARTICIPANT CHANGE FORM



OMB No. 0915-XXXX; Expiration Date: XX/XX/XXXX

If your facility is already participating in the 340B Program, please submit this form for updates to your existing profile. For assistance, call the Pharmacy Services Support Center (PSSC) at 1-800-628-6297. **Email the completed form to the Office of Pharmacy Affairs at [opastaff@hrsa.gov](mailto:opastaff@hrsa.gov).** You will be notified when the change has been made. To expedite the process, the "Covered Entity Authorizing Official" for your organization, should submit the change and the appropriate 340B ID number must be included. If it is submitted by someone else, a significant delay may occur and it may hamper your organization's purchase of 340B drugs until the matter is resolved.

<b>340B Covered Entity Name:</b> As listed on <a href="#">HRSA OPA's public Web site</a>	
<b>340B ID:</b> As listed on <a href="#">HRSA OPA's public Web site</a>	

#### Complete only information that is to be changed

<b>New Entity Name:</b>	
<b>New Entity Sub-Division Name:</b>	
<b>New Physical Address:</b>	
<b>New Physical Address City, State, Zip:</b>	
<b>New Ship To Address:</b>	
<b>New Ship To City, State, Zip:</b>	
<b>New Bill To Address:</b>	
<b>New Bill To City, State, Zip:</b>	
<b>Remove/Add/Revise Medicaid # or NPI #:</b> <i>(to be used only if billing Medicaid for 340B drugs)</i>	Indicate Remove/Add/Revise
<b>New Authorizing Official:</b> <i>(must be a senior managing official who can sign on behalf of an organization such as the CEO/CFO)</i>	
<b>New Authorizing Official Title:</b>	
<b>New Authorizing Official Phone #:</b>	
<b>New Authorizing Official E-mail Address:</b>	
<b>New Contact Person:</b>	
<b>New Contact Title:</b>	
<b>New Contact Phone #:</b>	
<b>New Contact Fax #:</b>	
<b>New Contact E-mail Address:</b>	

<b>Contract Pharmacy Information:</b> <i>(to be used only for correcting Existing Contract Pharmacy Contact Information)</i>	<i>The section below is to notify OPA only of corrections to the existing Contract Pharmacy Contact Information.</i>  <i>All new Contract Pharmacy Arrangements must submit a <a href="#">Contract Pharmacy Services Self-Certification Form</a> found at: <a href="http://www.hrsa.gov/opa/contracted.htm">http://www.hrsa.gov/opa/contracted.htm</a></i>
<b>Contract Pharmacy Contact Person:</b>	
<b>Contract Pharmacy Contact Title:</b>	
<b>Contract Pharmacy Phone #:</b>	
<b>Contract Pharmacy Fax #:</b>	
<b>Contract Pharmacy Email Address:</b>	

<b>Comments:</b>	
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**SUBMIT FORM TO :::::::::::::::::::::> [opastaff@hrsa.gov](mailto:opastaff@hrsa.gov)**  
**Update of this information is subject to approval and verification by the Office of Pharmacy Affairs.**

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.