OFFICE OF PHARMACY AFFAIRS (OPA)
340B PROGRAM REGISTRATION FOR DISPROPORTIONATE SHARE HOSPITALS

To meet the eligibility requirements for a children's hospital to buy discounted outpatient drugs under Section 340B of the Public Health Service Act, this registration form must be completed and signed. Incomplete forms will not be processed.

I. Hospital Information:

Hospital Name: ____
____

Medicare Provider Number: _______________

Hospital Street Address: ____

____

City: ____ State: _________ ZIP: ___________

Hospital Billing Address (if different): ____

____

City: ____ State: _________ ZIP: ___________

Hospital Shipping Address (if different): ____

____

City: ____ State: _________ ZIP: ___________

II. Eligibility Criteria

A. Disproportionate Share Adjustment Percentage: ______% based on
Medicare Cost Reporting Period: ___/___ - ___/___

B. Type of Hospital

a) If Owned or Operated by State or Local Government, check here ❒
(Submit supporting documentation to verify State/Local Government ownership or operation)

b) If a Private, Non-Profit Hospital with State/Local Government Contract, check here ❒
(Attach State/Local Government Certification form (ftp://ftp.hrsa.gov/bphc/pdf/opa/DSHGovtCert.pdf)

c) If a Public or Private Non-Profit Hospital Formally Granted Governmental Powers, check here ❒
(Submit supporting documentation to verify formal delegation or power to hospital by State/Local Government)

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.

III. Medicaid Billing Information: *You **must** answer the following question regarding Medicaid billing.*

Will you bill Medicaid for drugs purchased at 340B Drug Prices?
Yes ❒ No ❒

If "Yes," please provide the Pharmacy/Clinic Medicaid Provider Number(s) and/or National Provider Identifier(s) (NPI) (*please include the number(s) and State*):

Medicaid Provider Number(s) ______________________ and/or ____________________________

National Provider Identifier(s) ______________________and/or_____________________________

If you bill Medicaid for pharmaceuticals that may be subject to a payment of a Medicaid rebate to a state, you must submit to OPA the pharmacy/clinic Medicaid number and/or NPI which is used to bill Medicaid for outpatient drugs. If you are unsure of your pharmacy Medicaid number and/or NPI, please check with your State Medicaid agency. It is important that your Medicaid billing status is accurate in the 340B database to prevent Medicaid rebates on drugs that were sold to a covered entity at a discounted 340B price. If you bill at an all-inclusive rate, which includes pharmaceuticals, or if you do not bill Medicaid, state N/A (Not Applicable). You should notify OPA prior to any change in your Medicaid billing status. For more information, go to: http://www.hrsa.gov/opa/medicaidexclusion.htm

IV. Designated 340B Contact Information:

340B Contact Name: ____

Title: ____

Phone: ______________________ Ext. __________ Fax: _____________

Email Address: ____

V. Signed Agreement:

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
(please print or type) (e.g.: CEO, CFO, COO)

______________________ __________ ____________________________________
Phone: Ext. Email Address:

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