

# 340B PARTICIPANT CHANGE REQUEST

Change Request with tabs for each section that can be modified.

**HRSA** Office of Pharmacy Affairs **340B Participant Change Request**

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PED393302-00 - CHILDREN'S HOSPITAL OF PITTSBURGH OF UPMC

Details Addresses Medicaid Contacts

**Covered Entity Details** [Edit](#)

340B ID: PED393302-00

Entity Name: CHILDREN'S HOSPITAL OF PITTSBURGH OF UPMC Entity Type: Children's Hospital

Entity Sub-Division Name:

Medicare Provider Number: 393302

Continue Cancel

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Covered Entity Details section is default view.

Details Addresses Medicaid Contacts

**Covered Entity Details** [Edit](#)

340B ID: PED393302-00

Entity Name: CHILDREN'S HOSPITAL OF PITTSBURGH OF UPMC Entity Type: Children's Hospital

Entity Sub-Division Name:

Medicare Provider Number: 393302

Grant Number:

Covered Entity Details section in edit view.

**Covered Entity Details** [Continue](#) [Undo](#)

\*340B ID: PED393302-00

\*Entity Name: CHILDREN'S HOSPITAL OF PITTSBURGH OF UPMC

Entity Sub-Division Name:

Entity Type: Children's Hospital

Grant Number: (if known/applicable)

Medicare Provider Number: 393302 (only required for hospital entity types)

**Covered Entity Address section.**

Details **Addresses**

**Covered Entity Address** [Edit](#)

**Main Address (PO Box Not Allowed)**

4401 PENN AVENUE  
PITTSBURGH, PA 15224

Billing Address Same as Main

**Billing Address**

Hospital Billing Service  
55 Duvall Street  
Temple, PA 99999

Shipping Address Same as Main

**Shipping Address (PO Box Not Allowed)**

**Shipping Address 1**

HC PHARMACY CENTRAL-PROCUREMENT  
3175 E. CARSON STREET  
PITTSBURGH, PA 15203

**Covered Entity Address section in edit view.**

**Covered Entity Address** [Continue](#) [Undo](#)

**Main Address (PO Box Not Allowed)**

\*Address Line 1:

Address Line 2:

\*City:

\*State:  ▼

\*Zip:  -

Billing Address Same as Main

**Billing Address** [Continue](#) [Undo](#)

Organization Name:

\*Address Line 1:

Address Line 2:

\*City:

\*State:  ▼

\*Zip:  -

Shipping Address Same as Main

**Shipping Address (PO Box Not Allowed)** [Add](#)

**Shipping Address 1** [Continue](#) [Undo](#)

Organization Name:

\*Address Line 1:

Address Line 2:

\*City:

\*State:  ▼

\*Zip:  -

Medicaid Billing Information section in view.

Details | Addresses | **Medicaid** | Contacts

### Medicaid Billing Information Edit

You must answer the following question regarding Medicaid Billing:

Will you bill Medicaid for drugs purchased at 340B drug price?  Yes  No

**Medicaid Number(s):**

Medicaid Number	State
1007347990059	PA

**NPI Number(s):**

NPI Number
1164426896

Medicaid Billing Information in edit view.

Medicaid Billing Information Continue Undo

You must answer the following question regarding Medicaid Billing:

Will you bill Medicaid for drugs purchased at 340B drug price?  Yes  No

**Medicaid Exclusion Tutorial**

**Medicaid Number(s):** Add

Medicaid Number	State		
1007347990059	PA	<a>Edit</a>	<a>Delete</a>

**NPI Number(s):** Add

NPI Number		
1164426896	<a>Edit</a>	<a>Delete</a>

Contact Information section in view.

Details	Addresses	Medicaid	Contacts
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**Contact Information** [Edit](#)

**Authorizing Official**

**Name:** LAUREL RAGLAND  
**Title:** CFO  
**Phone:** 412-692-3152 **Ext:**  
**Email:**

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Make Primary Contact Information same as Authorizing Official

**Primary Contact** [Edit](#)

**Name:** JEFFREY GOFF  
**Title:** DIRECTOR OF PHARMACY  
**Phone:** 412-692-6242 **Ext:**  
**Email:**

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**Signed By Official**

**Name:**  
**Title:**  
**Phone:** **Ext:**  
**Email:**  
**Signed By Date:** 11/13/2009

Contact Information section in edit view.

Details	Addresses	Medicaid	Contacts
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**Contact Information** [Continue](#) [Undo](#)

**Authorizing Official**

**\*Name:**   
**\*Title:**   
**\*Phone:**  **Ext:**   
**Email:**

---

Make Primary Contact Information same as Authorizing Official

**Primary Contact** [Continue](#) [Undo](#)

**\*Name:**   
**\*Title:**   
**\*Phone:**  **Ext:**   
**Email:**

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**Signed By Official**


**Name:**  
**Title:**  
**Phone:** **Ext:**  
**Email:**  
**Signed By Date:** 11/13/2009

## Comments textbox (Optional)

Comments:

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## Authorize and Submit screen – **verbiage to be provided by OPA.**

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**Requestor Signature**

By checking this box, I represent and confirm that I am fully authorized to bind the covered entity and certify that the contents of any statement made or reflected in this document are truthful and accurate. The covered entity will comply with all of the 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 on duplicate discounts/rebates, and drug diversion. The covered entity acknowledges its responsibility to contact OPA as soon as reasonable possible if there is any material change in the 340B eligibility and/or material breach by the covered entity.

**Requestor**

\*Name:

\*Title:

\*Organization:

\*Phone:  Ext.

\*Email:

Remarks:

To apply these exact changes to more Outpatient sites, enter the 340B IDs of all the sites in the Remarks field. Also, include other relevant comments for OPA to review

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