Department of Health and Human Services, Health Resources and Services Administration, Healthcare Systems Bureau
OMB No. 0915-0327; Expiration Date: XX/XX/20XX

Covered Entity Details

340B ID:

Entity Name:

Entity Sub-Division Name:

Medicare Provider Number:

Entity Type:

Employer Identification Number:

Grant Number:

Covered Entity Address

Street Address (PO Box Not Allowed) **Continue** **Undo**

***Address Line 1:**

Address Line 2:

***City:**

***State:** Select a State

***Zip:** -

☐ Billing Address Same as Street Address

Billing Address **Continue** **Undo**

***Organization Name:**

***Address Line 1:**

Address Line 2:

***City:**

***State:** Select a State

***Zip:** -

☑ Shipping Address Same as Street Address

Covered Entity Date Information

Registration Date:

Participating Approval Date:

Participating Start Date:

Termination Reason:

Termination Date:

The date the entity became ineligible:

Last date that 340B drugs were or will be purchased under this 340B ID:

Termination Comments:

Medicaid Billing

Medicaid Billing Information

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

NPI Number(s):

NPI Number

Contact Information

Authorizing Official

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

[ ] Make Primary Contact Information same as Authorizing Official

Primary Contact

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

Update Terminate Cancel

Black Lung Clinics Program Grantee/ Program Manager
Batch Certification 2015

NOTE: Recertification is not complete until you check the certification statement below and click the "Attest and Recertify" button.

Covered Entities

The number of rows returned: 1

Rows/Page: 200 Set

340B ID	Batch Name	Entity Name	Subdivision Name	Address	City	State	Zip	Status

Program Manager/Authorizing Official

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

Authorized Signature

☐ The undersigned represents and confirms that he/she is fully authorized to legally bind the covered entity and certifies that the contents of any statement made or reflected in this document are truthful and accurate. Failure to recertify may be grounds for removal from the 340B Program.

The undersigned further acknowledges the 340B covered entity's responsibility to abide by the following:

As an Authorized Official, I certify on behalf of the covered entity that:

(1) all information listed on the 340B Program database for the covered entity is complete, accurate, and correct;
(2) the covered entity meets 340B Program eligibility requirements;
(3) the covered entity will comply with all requirements of Section 340B of the Public Health Service Act and any accompanying regulations including, but not limited to, the prohibition against duplicate discounts and diversion (section 340B(a)(5)(A) and (B) of the Public Health Service Act;
(4) the covered entity maintains auditable records pertaining to compliance with the requirements described in paragraph (3) above, pursuant to section 340B(a)(5)(C) of the Public Health Service Act;
(5) if the covered entity uses contract pharmacy services, that the contract pharmacy arrangement will be performed in accordance with OPA requirements and guidelines;
(6) the covered entity acknowledges its responsibility to contact OPA as soon as possible if there is any change in 340B eligibility and/or breach by the covered entity of any of the foregoing; and
(7) the covered entity acknowledges that if there is a breach of the requirements described in paragraph (3) that the covered entity may be liable to the manufacturer of the covered outpatient drug that is the subject of the violation, and, depending upon the circumstances, may be subject to removal from the list of eligible 340B entities.

Please provide any additional information that may be helpful in reviewing this recertification request, and/or any requested changes to the entity's 340B record:

Attest and Recertify