

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

To meet the eligibility requirements for a disproportionate share hospital to participate and be listed as an eligible covered entity under Section 340B(a)(4)(L) of the Public Health Service Act, this registration form must be completed and submitted according to the established deadlines that are published on the OPA website (www.hrsa.gov/opa).

A completed registration package must include:

- (1) This Basic registration information and compliance certification;
- (2) A copy of Worksheet E, Part A from the latest filed Medicare cost report (for the DSH adjustment percentage in II, A, below.);
- (3) A copy of Worksheet S-2 to demonstrate ownership type, and depending upon the hospital type the additional documentation described in II, D, below); and

All documentation described in 1-3 above is required to constitute a complete registration package. The entire package must be submitted on the same day to be considered complete. Incomplete packages will not be processed.

I. Hospital Information:

Hospital Name: _____

Medicare Provider Number: _____

Employer Identification Number: _____

Hospital Street Address (PO Boxes are not allowed): _____

City: _____ State: _____ Zip: _____

Hospital Billing Address (if different): _____

City: _____ State: _____ Zip: _____

Hospital Shipping Address (if different; PO Boxes are not allowed): _____

City: _____ State: _____ Zip: _____

II. Eligibility Criteria

Entity is a Disproportionate Share Hospital defined by section 1886(d)(1)(B) of the Social Security Act, and this status is recognized by CMS.

A. Disproportionate Share Adjustment Percentage: _____% based on
Medicare Cost Reporting Period: MM / DD / YYYY – MM / DD / YYYY
Filing Date: MM / DD / YYYY

B. Has the provider changed ownership during or since the end of the above cost reporting period?
 Yes Effective date of ownership change: MM / DD / YYYY
 No

C. Control Type per HCRIS

- | | |
|--|---|
| <input type="checkbox"/> 0 – Undetermined | <input type="checkbox"/> 8 – Governmental, City-County |
| <input type="checkbox"/> 1 – Voluntary Nonprofit, Church | <input type="checkbox"/> 9 – Governmental, County |
| <input type="checkbox"/> 2 – Voluntary Nonprofit, Other | <input type="checkbox"/> 10 – Governmental, State |
| <input type="checkbox"/> 3 – Proprietary, Individual | <input type="checkbox"/> 11 – Governmental, Hospital District |
| <input type="checkbox"/> 4 – Proprietary, Corporation | <input type="checkbox"/> 12 – Governmental, City |
| <input type="checkbox"/> 5 – Proprietary, Partnership | <input type="checkbox"/> 13 – Governmental, Other |
| <input type="checkbox"/> 6 – Proprietary, Other | |
| <input type="checkbox"/> 7 – Government, Federal | |

D. Hospital Classification

- Owned or Operated by State or Local Government
(Submit supporting documentation to verify State/Local Government ownership or operation) Please refer to the Office of Pharmacy Affairs website for a description and examples of acceptable documentation.

- Private, Non-Profit Hospital with State/Local Government Contract
(You must complete and attach State/Local Government Certification form (<ftp://ftp.hrsa.gov/bphc/pdf/opa/DSHGovtCert.pdf>) on the same day the registration form is submitted to the Office of Pharmacy Affairs. Please refer to the Office of Pharmacy Affairs website for a description and examples of acceptable documentation.)

Contract start date: MM / DD / YYYY

Contract end date: MM / DD / YYYY

- Check here if the entity's contract is valid until cancelled.

- Public or Private Non-Profit Hospital Formally Granted Governmental Powers, submit the following:

1. *The identity of the government entity granting the governmental power to the hospital;*
2. *A description of the governmental power that has been granted to the hospital and a brief explanation as to why the power is considered to be governmental; and*
3. *A copy of an official document issued by the government to the hospital that reflects the formal granting of governmental power.*

- Ineligible for-profit institution – **for-profit institutions are ineligible for registration**

- E. Government Ownership / Operation Certifying Official – *if owned or operated by state or local government or has a contract with the state or local government.*

Warning: The Government official must be able to certify that the hospital organization is owned or operated by a unit of state or local government, or that the hospital organization has a valid contract to provide health care services to low income individuals who are not entitled to benefits under Title XVIII of the Social Security Act or eligible for assistance under the State plan of Title XIX of the Social Security act, as appropriate.

The specified official will receive an e-mail from the Office of Pharmacy Affairs requesting this certification; he or she must respond within the next five calendar days. **If the Government Official does not confirm the hospital's status by the deadline, the registration will be deleted. It is the hospital's responsibility to ensure**

that the Government Official's email address is correct, and that he or she is available to respond within five calendar days.

Name: _____ Title: _____

Government Organization: _____

Phone: _____ Ext.: _____

E-mail: _____

III. Statutory Prohibition on Group Purchasing Organization Participation

Section 340B(a)(4)(L)(iii) of the Public Health Service Act, which is reiterated in the Statutory Prohibition on Group Purchasing Organization Participation Policy Release (2013-1), requires that the hospital not obtain covered outpatient drugs through a group purchasing organization or other group purchasing arrangement. This is a requirement for Disproportionate Share Hospitals, Children's Hospitals, and Free Standing Cancer Hospitals.

The authorizing official must certify that this hospital will not participate in a group purchasing organization or group purchasing arrangement for covered outpatient drugs as of the date of this listing on the OPA database. If drugs are purchased using a GPO for covered outpatient drugs while participating in the 340B Program, the covered entity understands that this violates program eligibility requirements and that the covered entity is obligated to inform OPA and may be required to repay manufacturers for the 340B discount received.

Yes, I Confirm

IV. Medicaid Billing Information

Will the covered entity dispense 340B purchased drugs to Medicaid patients AND subsequently bill Medicaid for those dispensed 340B drugs? Yes No

If "Yes", please provide the entity's Medicaid Provider Number(s) (MPN) and/or National Provider Identifier(s) (NPI) for each applicable entity location that bills Medicaid for 340B drugs. If you are unsure of the entity's MPN and/or NPI, please check with your State Medicaid agency. It is important that your Medicaid billing status and appropriate provider identifier number(s) are accurate in the OPA database and align with your billing practices in order to prevent Medicaid rebates on drugs that were purchased at the 340B discounted price.

Medicaid Provider Number(s) _____ and/or _____

National Provider Identifier(s) _____ and/or _____

All covered entities should notify OPA prior to any change in Medicaid billing status. For more information, please visit the HRSA website.

V. 340B Primary Contact and Authorizing Official Information:

Covered Entity Primary Contact Name
(Must be someone employed by the Covered Entity): _____

Title: _____

Phone: _____ Ext.: _____ Fax: _____

Email Address: _____

Covered Entity Authorizing Official

The Authorizing Official must be someone who can bind the organization into a contract, such as the President, Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, or Program Director. Forms that are signed by an individual that OPA determines is not an acceptable representative will not be processed. If you are in doubt regarding the acceptability of a signature, please contact the 340B Prime Vendor Program at 1-888-340-2787 or via email at ApexusAnswers@340bpvp.com prior to submission of your registration.

Covered Entity Authorizing Official Name: _____

Title: _____

Phone: _____ Ext. _____ Fax: _____

Email Address: _____

VI. Signed Agreement:

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. 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 and its outpatient facilities that:

- (1) all information listed on the 340B Program database for the covered entity will be complete, accurate, and correct;
- (2) the covered entity will meet all 340B Program eligibility requirements, including section 340B(a)(4)(L)(iii) of the Public Health Service Act when applicable, regarding the group purchasing organization prohibition - which states that the covered entity hospital does not obtain covered outpatient drugs through a group purchasing organization or other group purchasing arrangement;
- (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/rebates and diversion (section 340B(a)(5)(A) and (B) of the Public Health Service Act);
- (4) the covered entity will maintain 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.

In addition, I have read all applicable registration instructions and I am aware that my registration will not be reviewed if the required supporting documents are not submitted today.

Please provide any additional information that may be helpful in reviewing this registration for 340B eligibility:

Signature of Authorizing Official:

Date:

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 0915-0327. Public reporting burden for this collection of information is estimated to average 2.0 hours per response, including the time for reviewing instructions, searching existing data sources, 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 10C-26, Rockville, Maryland, 20857.