TB Recertification

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 De			
	340B ID:		
Entity Name: Entity Sub-Division Name: Medicare Provider		Entity Type: Employer Identification Number:	
	Number:	Grant Number: Nature of Support:	Direct Funding (dollars received from CDC or an intermediate organization) In-Kind products or services (see note below; must have been purchased with section 317 funds) None Note: In-kind contributions may be in the form of real property, equipment, supplies and other expendable property, and goods and services directly benefiting and specifically identifiable to the project or program.
Covered Entity Ad			
Street Address (PO B	ox Not Allowed)		Continue Un
*Address Line 1:			
Address Line 2:			
*City:			
*State:	Select a State ▼・		
*Zip:	-		
	ddress Same as Street Address		
Billing Address			Continue Und
*Organization Name:			
*Address Line 1:			
Address Line 2:			
*City:			
*State:	Select a State ▼		
*Zip:	-		
☐ Shipping	g Address Same as Street Address		
Shipping Address (PC	Box Not Allowed)		
New Shipping Addre	ess		Continue Undo
*Organization Name:			
*Address Line 1:			
Address Line 2:			
*City:			
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*State:	Select a State	▼			
*Zip:					
vered Entity Dat	te Information				
	Registration I	Date:	Participating Start Date:		
Ī	Participating Approval I	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 Comm	nents:			
edicaid Billing—					
edicaid Billing In	formation				
You must answer t	he following question reg	garding Medicaid Billing	g:		
Will you bill Medica	aid for drugs purchased at 340B dru	ug price? C Yes No			
ontact Information	on				
Authorizing Offici Nam					
Titl	e:				
	one: Ext:				
Ema	II:				
Make Primary Conta	ct Information same as Authorizing	official			
Primary Contact					
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		Update Ten	minate Cancel		

February 20, 2015 6:52 AM ET

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NOTE:		ication is not complete un e "Attest and Recertify" b	til you check the certification	n statement bo	elow and			
overed	Entities	;						
e number of	rows returne	d: 1		Rows/Page: 200	Set			
40B ID	Batch Name	Entity Name	Subdivision Name	Address	City	State	Zip	Statu
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		- (A. II. 11. A. OFF. 11.						
ogram	n Manage	er/Authorizing Official						
		me:						
	Т	itle: Phone: Ext:						
	En	nail:						
	ed Sign							
			authorized to legally bind the covered entity and e grounds for removal from the 340B Program.	certifies that the conte	nts of any stateme	ent made or reflec	ted in th	is
		further acknowledges the 340B covered ent	ity's responsibility to abide by the following:					
The		Turtiler acknowledges the 546B covered ent	ity s responsibility to ablue by the following.					
	ŭ	0001111 116 1116 611	and the same of th					
	ŭ	Official, I certify on behalf of the covered en	tity that:					
As a	an Authorized all information	n listed on the 340B Program database for th	he covered entity is complete, accurate, and cor	rrect;				
As a (1) a (2) t	an Authorized all information the covered e	n listed on the 340B Program database for the ntity meets 340B Program eligibility requirer	he covered entity is complete, accurate, and cor		ulations including,	but not limited to	o, the pr	ohibition
As a (1) a (2) t (3) t agai	an Authorized all information the covered e the covered e inst duplicate	n listed on the 340B Program database for the ntity meets 340B Program eligibility requirer ntity will comply with all requirements of Se discounts and diversion (section 340B(a)(5)	he covered entity is complete, accurate, and comments; ction 340B of the Public Health Service Act and (A) and (B) of the Public Health Service Act;	any accompanying regu				
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