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

overed Entity Details 340B ID:	
Entity Name: Entity Sub-Division Name: Medicare Provider Number:	Entity Type: Employer Identification Number: Grant Number: Site ID:
Covered Entity Address	
treet Address (PO Box Not Allowed)	Continue Un
*Address Line 1:	
Address Line 2:	
*City:	
*State:	
*Zip:	
Billing Address Same as Street Address	
illing Address	Continue Und
Organization Name:	
*Address Line 1:	
Address Line 2:	
*City:	
*State: ▼	
*Zip:	
Shipping Address Same as Street Address	
Alternative Methods	
hipping Address (PO Box Not Allowed)	
New Shipping Address	Continue Unde
*Organization Name:	
*Address Line 1:	
Address Line 2:	
*City:	
*State: Select a State	
*Zip:	
Covered Entity Date Information	
Registration Date:	Participating Start Date:
	• -

		Termination Date:					
	date the entity became ineligible:						
	Last dat	e that 340B drugs were or will be purchased under this 340B ID:					
Termination Comments:							
edicaid Billing edicaid Billing Information							
	ing question regarding Medicaid Billing:						
	purchased at 340B drug price? O Yes I No						
,							
ontact Information							
Authorizing Official							
Name: Title:							
Phone:	Ext:						
Email:							
Make Primary Contact Information	n same as Authorizing Official						
Primary Contact							
Name: Title:							
Phone:	Ext:						
Email:							
	Update Terminate Cano	zel					
		····					
larch 06, 2015 11:20 AM ET	ApexusAnswers@340bpvp.com 1-888-340-2787	OMB Number: 0915-0327, Expiration: XX/XX/2					

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Consolidated Health Center 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											
	Rows/Page: 200 - Set										
340B ID	Batch Name	Entity Name	Subdivision Name	Address	City	State	Zip	Status			
Program	Manage	r/Authorizing Official									
	N	ame:									
		Title:									
	Pł	none: Ext:									
	E	mail:									
Authorize	ed Signa	ture									
				covered entity and certifies that the contents	s of any statement made	or reflect	ed in this	5			
docur	ment are truth	ful and accurate. Failure to recertify	may be grounds for removal from the	he 340B Program.							
The u	Indersigned fu	urther acknowledges the 340B cover	red entity's responsibility to abide by	/ the following:							
As an	Authorized (Official, I certify on behalf of the cove	ared entity that:								
As an	Authonized	Sincial, i certify on benail of the cove	area entity that.								
		listed on the 340B Program databas									
				40B(a)(4)(L)(iii) of the Public Health Service ot obtain covered outpatient drugs through a							
	asing organiz			or obtain covered outpatient drugs through a	group purchasing organ		i ouiei g	nonh			
•	5 5		s of Section 340B of the Public Hea	Ith Service Act and any accompanying regula	ations including, but not l	imited to	, the pro	hibition			
-		liscounts/rebates and diversion (sec				()(5)(0)					
	e covered en h Service Act;		taining to compliance with the requi	irements described in paragraph (3) above, p	pursuant to section 340B	(a)(5)(C)	of the F	UDIIC			
	,		es, that the contract pharmacy arra	angement will be performed in accordance w	ith OPA requirements an	d guideli	nes;				
. ,		tity acknowledges its responsibility t	to contact OPA as soon as possible	if there is any change in 340B eligibility and/	or breach by the covered	d entity o	f any of	the			
5	oing; and	titu advaculadaas that if there is a l	areach of the requirements describe	ed in paragraph (3) that the covered entity m	any ha liabla ta tha many	facturar	of the cr	word			
				es, may be subject to removal from the list o		Indecturer		wereu			
		,,,,,,,	,	,,,	·						
		and distance in the Course of the State of the	halafal ta matanta ata arrente		- the early 1 0 100						
Please	e provide any	additional information that may be	neiprul in reviewing this recertificat	ion request, and/or any requested changes t	to the entity's 340B recor	a:					
I											
					Attes	t and F	Recerti	fy			

March 06, 2015 11:26 AM ET

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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 .05 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-03I, Rockville, Maryland, 20857.