

STD-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 Details**

<p><b>340B ID:</b></p> <p><b>Entity Name:</b></p> <p><b>Entity Sub-Division Name:</b></p> <p><b>Medicare Provider Number:</b></p>	<p><b>Entity Type:</b></p> <p><b>Employer Identification Number:</b></p> <p><b>Grant Number:</b></p> <p><b>Nature of Support:</b></p> <p><input type="checkbox"/> Direct Funding (dollars received from CDC or an intermediate organization)</p> <p><input type="checkbox"/> In-Kind products or services (see note below; must have been purchased with section 318 funds)</p> <p><input type="checkbox"/> None</p> <p><small>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.</small></p>
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**Covered Entity Address**

**Street Address (PO Box Not Allowed)** [Continue](#) [Undo](#)

\*Address Line 1:

Address Line 2:

\*City:

\*State:

\*Zip:  -

Billing Address Same as Street Address

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

\*Organization Name:

\*Address Line 1:

Address Line 2:

\*City:

\*State:

\*Zip:  -

Shipping Address Same as Street Address

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

**Covered Entity Date Information**

<b>Registration Date:</b>	<b>Participating Start Date:</b>
<b>Participating Approval Date:</b>	<b>Termination Reason:</b>
	<b>Termination Date:</b>

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
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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

**Sexually Transmitted Diseases 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**