340B COVERED ENTITY CHANGE FORM

1a. Covered Entity Name:		1b. 340B ID:
1c. Authorizing Official Name:		
Title:	Phone:	Email:

Section 2: Covered entity changes. Complete applicable fields **only** if reporting a change.

2a. Covered Entity Name:		2b. Covered Entity Sub-Division:
2c. Grant number (if applicable):		2d. Employer Identification Number:
2e. Authorizing Official Name:(see instructional page for more information)		
Title:	Phone:	Email:

☐ Check here if the change in Authorizing Official is applicable to all sites listed under the parent/child tab of the covered entity.

2f. New Authorizing Official Statement (see instructional page for more information):

☐ By checking this box, I declared that I am now the covered entity Authorizing Official. As such, I have the legal authority to bind the covered entity to 340B Program requirements and am fully aware of my responsibility to ensure the covered entity I represent remains compliant with 340B Program requirements.

2g. Section 2 Remarks:

Section 3: Entity Termination (complete only if requesting entity termination)

3a. Request covered entity termination - see instructional page for more information about entity terminations

☐ Check here if you wish to terminate this entity from the 340B Program. Use the remarks section to specify termination of certain child sites by providing each 340B ID, or state that the termination request should apply to all related child sites.

The information you provide below may be made available to manufacturers and the public. If 340B drugs were purchased after losing or terminating eligibility, HRSA urges entities to work with affected manufacturers regarding possible repayment.

a. Requested termination date:

b. Reason for termination:

- ❒ DSH percentage below statutory minimum
- ❒ For-profit conversion
- ❒ Loss of qualifying grant/support
- ❒ Site closure
- ❒ Other - stop here and e-mail ApexusAnswers@340bpvp.com for additional guidance

c. Date the entity became ineligible:

d. What is the last date that 340B drugs were or will be purchased under this 340B ID?

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e. Please provide a brief description of the reason for termination and how the effective date was determined:		
f. Has the contact information for the Authorizing Official for this entity changed?	☐ Yes ☐ No If yes, update the contact information below	
g. Authorizing Official Name:		
Title:	Phone:	Email:
3b. Section 3 Remarks:		

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Section 4: Contract Pharmacy Information. Complete only if reporting a change/update.

4a. Contract Pharmacy address update. (*Address updates to contract pharmacies that have a DEA registration number will occur automatically if the DEA number for that contract pharmacy has not changed. Please wait at least 7 days if a change was reported to DEA before submitting a change request to update a contract pharmacy address.)*		
Name of contract pharmacy:	**Change to**	
Address line 1		
Address line 2:		
City, State, Zip Code:		
4b. New Contract Pharmacy Representative Name:(see instructional page for more information)		
Title:	Phone:	Email:
4c. Section 4 Remarks:		

Medicaid Billing Information

At this site, will the covered entity bill Medicaid fee-for-service for drugs purchased at 340B prices? Yes ❒ No ❒

If the answer is yes, please provide the state(s) and associated billing number(s) listed on the claims to bill Medicaid fee-for-service for particular states that you plan to bill for 340B drugs in the space(s) below (this could include numbers for the state your hospital is located in and any out-of-state Medicaid agencies your hospital plans to bill for 340B drugs). All numbers you plan to use to bill Medicaid fee-for-service should be provided and may include the billing provider's national provider identifier (NPI) only, state assigned Medicaid number only, or both the NPI and state assigned Medicaid number. Do not list a state for which the covered entity will not bill Medicaid fee-for-service for drugs purchased at 340B prices.

HRSA exports the Medicaid billing information listed in this site's 340B OPAIS record to generate the quarterly Medicaid exclusion file (MEF). HRSA requires the information on the MEF be accurate and complete for every registered site in the 340B OPAIS, and that covered entities follow any additional state Medicaid requirements in order to prevent duplicate discounts.

While this site may request a change to its 340B OPAIS record at any time, the Medicaid fee-for service billing practice at this site, must match the quarterly MEF.

State	State Assigned Medicaid Number	NPI

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

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Authorizing Official Signature (Change request forms MUST be signed by the Authorizing official in all cases)

By signing, I represent and confirm that I am fully authorized to bind the covered entity and certify that the contents of any statement made or reflected in this document are truthful and accurate. The covered entity will comply with all of the requirements and restrictions of section 340B of the Public Health Service Act, including, but not limited to, the prohibitions on duplicate discounts and drug diversion.

Print name: _____

Signature: _____ ***Date:*** _____