

# Pharmacy Enrollment Form

Please print clearly. Fax the completed form to (518) 459-7429.

NPI NUMBER:

NABP NUMBER:

FEDERAL TAX ID Number:  -

NYS MEDICAID NUMBER:

Pharmacy Corporation Name: \_\_\_\_\_

Pharmacy (DBA) Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip:

Store Phone #: (  )  -  Fax #: (  )  -

Pharmacy Contact Person: \_\_\_\_\_  
 (First and Last Name)

Primary Email Address: \_\_\_\_\_

Secondary Email Address: \_\_\_\_\_

Is this Pharmacy actively enrolled in NYS EPIC?

Yes [ ] No [ ]

Does this Pharmacy participate with MOST of the Medicare Part D Plans in New York State?

Yes [ ] No [ ]

If No, Please list this Pharmacy's Medicare Prescription Drug Plan Affiliations:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

All licensed New York State pharmacies are eligible to enroll as ADAP providers if actively enrolled in the New York State Elderly Pharmaceutical Insurance Coverage (EPIC) program; enrolled with one or more Medicare Prescription Drug Plans; actively enrolled, or begun the enrollment process, with New York State Medicaid; and able to submit claims electronically through Point of Sale. Pharmacies must maintain active enrollment with Medicaid and EPIC to remain eligible as ADAP pharmacy providers. All claims MUST be submitted through Point of Sale using NCPDP 5.1 unless otherwise specified. The Uninsured Care Programs (ADAP) will not be obligated to pay claims submitted more than 90 days after delivery of services. All enrolled pharmacy providers will receive a Pharmacy Provider Manual from the Uninsured Care Programs (ADAP) within 30 days of enrollment. Signature on this form constitutes acceptance and compliance with all Uninsured Care Programs (ADAP) pharmacy provider requirements listed above, which are further detailed in the Pharmacy Provider Manual.

Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_  
 (Pharmacy Owner /Corporate Officer Required)

(ADAP OFFICE USE ONLY)			
Information Taken By: _____	Date: _____	Medicaid: Y [ ] N [ ]	EPIC: Y [ ] N [ ]
Pharmacy Packet Sent: Y [ ] N [ ]	Supervisor Verification: _____		