

Pharmacy Enrollment Form

Please print clearly. Fax the completed form to (518) 459-2749.

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:

The Uninsured Care Programs (ADAP) will not be obligated to pay claims submitted more than 90 days after delivery of services. All claims MUST be submitted through Point of Sale using NCPDP 5.1 unless otherwise specified. Signature on this form constitutes acceptance and compliance with the Uninsured Care Programs Pharmacy Provider requirements as 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: _____		