

Corporation Pharmacy Enrollment Form

Please Print Clearly and Fax Completed Form to 518-459-2749

PHARMACY CORPORATION NAME: _____

Corporate Address: _____

City: _____ State: _____ Zip:

FEDERAL TAX ID #: -

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

Corporate Contact Person: _____
(First and Last Name)

Email Address: _____

ENROLLED PHARMACY LIST:

Please complete the attached form or provide a list of all individual pharmacies enrolling as an ADAP Pharmacy Provider. The list should detail the same information as on the attached form.

MEDICARE PRESCRIPTION DRUG PLAN AFFILIATIONS:

Effective January 1, 2006 - All enrolled ADAP Pharmacies are required to participate with one or more Medicare Part D Prescription Drug Plans. ADAP participants who are eligible for Medicare Part D must enroll in a Medicare Part D Pharmacy Drug Plan (PDP) or a Medicare Advantage Prescription Drug Plan (MA-PD). Pharmacies providing service to participants will need to verify Medicare Part D plan enrollment and submit claims to the Medicare plan before submitting claims to ADAP. The Program will coordinate benefits with Medicare Prescription Drug Plans (PDP).

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 unless otherwise specified.

Signature on this form constitutes acceptance and compliance with NYS Uninsured Care Programs Pharmacy Provider requirements as detailed in the NYS Uninsured Care Programs Pharmacy Provider Manual for the Pharmacy Corporation and all affiliated individual Pharmacies.

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

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

