# New York State
Elderly Pharmaceutical Insurance Coverage (EPIC)

# PHARMACY PROVIDER AGREEMENT

***PHARMACY IDENTIFICATION (all information must be provided):***

Pharmacy Name _____ d/b/a _____

Business Address (street, city, state, zip) _____ Phone (  ) _____

Corporate Address (street, city, state, zip) _____ Phone (  ) _____

National Provider Identifier (NPI) _____ NCPDP # _____

NYS Pharmacy Registration # _____ Medicaid Provider # _____

Federal Tax ID # _____ Resident State Pharmacy Registration # (if not NYS) _____

Software Vendor _____ Vendor's Phone Number (  ) _____

Type of Pharmacy: ☐ Independent ☐ Chain ☐ Clinical ☐ Mail Order ☐ Specialty ☐ Other

This agreement made by and between the NYS Elderly Pharmaceutical Insurance Coverage program (hereafter EPIC) and _____ (hereafter the Provider) sets forth the terms and conditions governing participation in the EPIC. The parties to this Agreement, intending to be legally bound, agree as follows:

**Provider Responsibilities**:

A. The Provider agrees to participate in EPIC and to comply with all Federal and New York State laws generally and specifically governing participation in EPIC. The Provider agrees to be knowledgeable of and to comply with applicable rules, regulations, rate, and fee schedules promulgated under such laws and any amendments thereto.

B. The submissions by or on behalf of the Provider of any claim to EPIC shall constitute certification by the Provider that:
   1. the service or items were actually provided by the Provider to the person identified as an EPIC participant; and
   2. the claim represents the lower charge from the options listed below:
      a. usual or customary charge of the pharmacy for such drug
      b. pharmacy's charge to the general public at the time of purchase, taking into consideration any quantity and promotional discounts.

C. The Provider agrees to submit all non-reimbursed claims for all covered purchases made by participants in the deductible plan to be credited toward their annual deductible. The Provider agrees to accept as full payment from the participant for such non-reimbursed claims that amount allowed under the same pricing methodology as for reimbursed claims. This is equivalent to the amount EPIC would reimburse them for the claim plus the required EPIC co-payment. The Provider certifies that the total amount collected from participants for non-reimbursed claims will not exceed the EPIC allowed amount.

D. The Provider shall not waive or reduce in whole or in part the co-payment except as described in the law.

E. The Provider understands that EPIC is defined in law as "the payer of last resort", and agrees to bill as the primary payer any other prescription insurance coverage an EPIC participant may have and which the Provider is aware of. The Provider further agrees to reimburse EPIC any additional monies received from third party insurers for payment of prescriptions or services previously reimbursed by EPIC.

F. The Provider agrees to prepare and maintain contemporaneous records demonstrating its right to receive payment under EPIC and to keep for a period of three years from the date services or supplies were furnished all information regarding claims for payment submitted by, or on behalf of, the Provider and to furnish such records and information, upon request, to EPIC or agents and designees.

G. The Provider will not illegally discriminate in the provision of services on the basis of handicap, race, color, religion, national origin, sex, or age.

H. The Provider will permit audits of all claims approved by EPIC. EPIC and their agents will perform such audits.

I. The Provider represents that the information submitted in or with this agreement to participate in EPIC and from which this contract ensued is true, accurate and complete. The Provider agrees further that such representation shall be a continuing one and that the Provider shall notify EPIC, in writing, within fifteen (15) days of its occurrence, if any fact arises or is discovered subsequent to the date of the agreement which affects the truth, accuracy or completeness of such representation.

J. The Provider agrees to submit claims for payment electronically, using the EPIC online point of sale (POS) claim system and to accommodate the complete receipt of EPIC claim responses in conformance with the current EPIC payer specifications, and any revisions that may occur from time to time.

K. This agreement is specific to the Provider and may not be assigned by the Provider without prior written approval from EPIC.

**Effective Date and Terms of the Agreement:**
The effective date of this Agreement shall be the date on which the Agreement is approved and dated by EPIC and shall remain in effect until terminated by either party. Termination of this contract shall not relieve the Provider of the obligations to retain records and make restitution of overpayments for services or items furnished prior to termination.

**Termination of Agreement:**
A. The Provider, upon thirty (30) days' advance written notice to EPIC, may terminate this Agreement.
B. The Provider's participation in EPIC may be terminated, suspended or restricted. The Provider must be given written notice of the action at least fifteen (15) days prior to its effective date, stating the reason for the action, the effective date, the effect of the action upon the Provider's participation in EPIC, the earliest date on which participation may be reinstated, and the requirements for requesting an administrative hearing to challenge the action.

**Disputes:**
All questions or disputes arising between the parties hereto with respect to payment made pursuant to this Agreement shall be referred to the Director of EPIC after a good faith effort on the part of the Provider and EPIC fails to resolve the dispute. Settlement of disputes under this provision must occur prior to any final payment to the Provider.

***Certification:***
I agree to the terms of this agreement, and hereby certify, to the best of my knowledge, that the above provided information is true and correct.

_____

**Signature of Provider, Owner or Authorized Agent** **Date**

_____

**Name of Authorized Representative (Printed or Typed)** **Title**

*Please return this completed Pharmacy Provider Agreement, Disclosure of Ownership Statement, and Electronic Funds Transfer Authorization Agreement to:* ***NYS EPIC Program, P.O. Box 15018, Albany, NY 12212 – 5018.***

# New York State

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## DISCLOSURE OF OWNERSHIP STATEMENT

1. Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations on a separate attachment.

    a. Are there any individuals or organizations having direct or indirect ownership or controlling interest of 5 percent or more in the pharmacy that have been convicted of a criminal offense related to the involvement of such persons or organizations in either the Medicare, Medicaid, or EPIC Programs?
    Yes ☐ No ☐

    b. Are there any directors, officers, agents, or managing employees of the pharmacy who have either been convicted of a criminal offense related to their involvement in the Medicare, Medicaid, or EPIC Programs?
    Yes ☐ No ☐

2. List names and addresses for individuals, or Employer Identification Numbers (EINs) for organizations having direct or indirect ownership or a controlling interest in the pharmacy. List any additional names and addresses on a separate attachment. If more than one individual is reported and any of these persons are related to each other, this must be reported on a separate attachment.

    a. Name_____ Address_____ EIN_____

    b. Name_____ Address_____ EIN_____

    ***Note: If the pharmacy is a corporation, list names, addresses of the directors, and EINs for corporations on a separate attachment.***

3. Has there been a change in ownership or control within the last year? Yes ☐ No ☐
    a. If yes when? _____

4. Do you anticipate any change of ownership or control within the year? Yes ☐ No ☐
    a. If yes when? _____

5. Is this pharmacy chain affiliated? Yes ☐ No ☐
    a. If yes, list name and address of Corporation, and EIN.

    b. Name_____ Address_____ EIN_____

**WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION ON THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN A DENIAL OF ENROLLMENT OR, WHERE THE PHARMACY ALREADY PARTICIPATES, SUSPENSION OR TERMINATION OF PARTICIPATION IN THE NEW YORK STATE EPIC PROGRAM.**

_____

**Signature of Provider, Owner or Authorized Agent** **Date**

_____

**Name of Authorized Representative (Printed or Typed)** **Title**

# New York State

Elderly Pharmaceutical Insurance Coverage (EPIC)

## Electronic Funds Transfer
## AUTHORIZATION AGREEMENT

National Provider Identifier (NPI) _____ NCPDP # _____

Pharmacy Name _____ Contact Name _____

Business Address (street, city, state, zip) _____

Contact Phone (  ) _____ Contact Fax (  ) _____

E-Mail Address _____

***Depository Bank Information: Please note that the account you designate must be your pharmacy's account, as we are unable to credit third party accounts.***

**Name of Bank** _____

**Bank Account Number**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

**ABA Routing Number (9 digits)**

Checking ☐ Savings ☐

***Certification of Authority:***

I certify that I am authorized to act on behalf of the above-named pharmacy and account, and hereby authorize the Elderly Pharmaceutical Insurance Coverage (EPIC) and the depository/bank financial institution named above (DEPOSITORY) to initiate credits against said account, and to also initiate, if necessary, debit entries and adjustments for any entries credited in error. This authorization is to remain in full force and effect until EPIC has received written notification from me of its termination in such time and manner as to afford EPIC and DEPOSITORY a reasonable opportunity to act on it.

_____

**Signature of Provider, Owner or Authorized Agent** **Date**

_____

**Name of Authorized Representative (Printed or Typed)** **Title**

**835 ELECTRONIC REMITTANCE ADVICE AGREEMENT**
**TO RECEIVE X12 835 ELECTRONIC TRANSACTIONS**

This is to certify that _____of
(Name of Pharmacy location submitting healthcare claims **and NPI Number**)

_____ _____
(Street Address) (City)

_____ _____ on the _____ day of _____, 20____,
(State) (Zip Code)

agrees to the following conditions for the receipt of 835 electronic remittance advice transactions from Prime Therapeutics Management (Prime), LLC on behalf of the State of _____ Pharmacy Management Program.

**Section 1: The Parties agree, in regard to any Electronic Transactions between them:**

(1) The only electronic transactions authorized and agreed to in this agreement are the transmission by Prime to Partner of 835 remittance advices for pharmacy claims processed by Prime on behalf of the State of _____Pharmacy Management Program.

(2) The electronic transactions shall comply with the requirements of HIPAA. Prime may, at its sole discretion, change any definition, data condition, or use of a data element or segment in the transactions, as long as doing so, is not a violation of HIPAA or other applicable law.

(3) It is agreed that upon the successful implementation of the 835 transactions, partner will receive all remittance advices from Prime via the 835 electronic transactions.

(4) The pharmacy or chain center certifies that they have a fully executed Electronic Data Interchange CONFIDENTIALITY Agreement on file with the State of _____ Pharmacy Management Program.

(5) The chain center will promptly notify the State of _____ Pharmacy Management Program of the names of providers either added to the chain center or discontinued from service (not applicable to independent pharmacies)

(6) The agreement may be terminated on thirty days' written notice by either party.

(7) This agreement will become effective when executed by both parties and may be amended only in writing, similarly executed.

(8) It is agreed that upon the successful implementation of the 835 transactions, partner will receive all remittance advices from Prime via the 835 electronic transactions.

**Section 2: General Terms and Conditions**

(1) Each party will implement and maintain appropriate policies and procedures, and mechanisms to protect the confidentiality and security of PHI transmitted between the parties.

(2) This agreement is entered into solely between, and may be enforced only by the State of _____ Pharmacy Management Program and Prime Therapeutics. This agreement shall not be deemed to create any rights in third parties or to create any obligations of Prime Therapeutics or partner to any third party.

(3) Each party shall maintain the confidentiality of PHI as required by law. This provision shall survive termination of this agreement.

(4) This agreement constitutes the entire agreement between the parties and contains a total integration of the rights and obligations of both parties with respect to the subject matter contained herein. This agreement may only be modified by amendment, which must be in writing and signed by both parties.

(5) If any part, term, or provision of this agreement shall be held illegal, unenforceable, or in conflict with any law of a federal, state, or local government having jurisdiction over this agreement, the validity of the remaining portion or portions shall not be affected thereby.

**Section 3: This agreement shall be governed by the laws of the Commonwealth of Virginia. The undersigned hereby agrees to the terms and conditions of this Compliance and Confidentiality Agreement.**

_____ _____
(Signature) (Date)

_____
(Print Name)

Company Name and Address

_____

_____

Company NPI_____

**Section 4: Contact Information for Login and Password Owner (this entity will pull the 835 transmissions, may be chain center or third-party agency)**

_____ _____
(Contact Name) (Contact Telephone)

Company Name, if different from above: _____

Company Address, if different from above: _____ Email address: _____

**Mail or Fax Completed 835 Electronic Remittance Advice Agreement Form to:**
**Prime Therapeutics Management**
15 Cornell Road
Suite 2201
Latham, New York 12110
Fax: 888-656-4156

For questions, please call the Provider Helpline: 1-800-634-1340

 