

Tab 2-22

**340B PROGRAM ENROLLMENT LETTER FOR
DISPROPORTIONATE SHARE HOSPITALS (DSH)**

Acknowledgement that applicant 1) is owned or operated by a unit of State or local government, is a public or private non-profit corporation which is formally granted governmental powers by a unit of State or local government, or is a private non-profit hospital which has a contract with a State or local government to provide health care services to low income individuals who are not entitled to benefits under Title XVIII of the Social Security Act or eligible for assistance under the State plan under this Title; 2) has a disproportionate share adjustment percentage greater than 11.75 percent **AND** 3) will not obtain covered outpatient drugs through a group purchasing organization or other group purchasing arrangement.

I. Hospital Information:

Hospital Name: _____

Medicare Provider Number: _____

Disproportionate Share Adjustment Percentage _____%

- Based on most recently filed Medicare cost report FYE: ___/___/___

Public Hospital

(Submit supporting documentation required to verify State/Local Government ownership or operation)

Private Hospital with State/Local Govt. Contract

(Attach State/Local Government Certification form found at <ftp://ftp.hrsa.gov/bphc/pdf/opa/DSHGovtCert.pdf>)

Private Hospital granted governmental powers

(Submit supporting documentation required to verify formal delegation of power to DSH by State)

Hospital Address:

City: _____ State: _____ ZIP: _____

II. Medicaid Billing Information: *You **must** answer the following question regarding Medicaid billing.*

Do you intend to bill Medicaid for drugs purchased at 340B Drug Prices?

Yes No

If "Yes," your Pharmacy Medicaid Provider Number is required: _____

III. Hospital Contact Information: Please designate a person to serve as the hospital's point of contact for the 340B program.

340B Contact Name: _____

Title: _____

Phone: _____ Ext. _____ Fax: _____

Email Address: _____

IV. Signed Agreement:

The undersigned represents and confirms that he/she is fully authorized to bind the covered entity and certifies that the contents of any statement made or reflected in this document are truthful and accurate; and that the hospital will comply with all requirements and restrictions of Section 340B of the Public Health Service Act and any accompanying regulations or guidelines including, but not limited to, the prohibition on duplicate discounts/rebates, and drug diversion. The undersigned further acknowledges the 340B Covered Entity's responsibility to contact OPA if the hospital's status in regard to any of these criteria changes and the hospital is no longer eligible to participate in the 340B program.

Authorizing Official Name: *(please print or type)* _____

Title: _____
(CEO, CFO, COO)

Signature: _____ Date: _____

Phone: _____ Ext. _____ Email Address: _____

The quarterly deadlines for data submission to OPA are December 1 for the quarter beginning January 1; March 1 for the quarter beginning April 1; June 1 for the quarter beginning July 1; and September 1 for the quarter beginning October 1.

You may fax the completed forms to 301-594-4982, but you must also submit the original, signed form to: HRSA, Office of Pharmacy Affairs, 5600 Fishers Lane, Mail Stop 10C-03, Rockville, Maryland 20857