

# HSN New Pharmacy Form

Please complete the fields below and send the form to [HSNHelpDesk@MassMail.State.ma.us](mailto:HSNHelpDesk@MassMail.State.ma.us)

**Note:** The setup process must be completed with MassHealth before this form can be completed in full.

Save this document as "Provider Name – Pharmacy Site Name – New Pharmacy Form Date" e.g. "ABC Hospital – South St Pharmacy – New Pharmacy Form 7.31.16"

Name of pharmacy site

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Address of pharmacy site

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Telephone number of pharmacy site

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Name of the primary contact  
(usually the pharmacy manager at the site)

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Telephone number of the primary contact

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Name of the 340B entity (community health  
center or hospital)

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Address of the 340B entity

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Telephone number of the 340B entity

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NPI # of the pharmacy

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NPI # of the 340B entity to which payment is  
sent

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MassHealth provider number of the  
pharmacy site (Provider ID/Service Location,  
10 characters)

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MassHealth provider number of the  
340B entity to which the payment is sent  
(Provider ID/Service Location, 10 characters)

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Effective date of the MassHealth provider  
number of the 340B pharmacy site  
(determined by MassHealth)

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