

Application for Community Health Centers (CHC) to Provide 340B-Priced Drugs to MassHealth Members

Important information

1. A 340B entity must be registered on the OPA Web site.
2. As used herein, the term “Clinic Pharmacy” refers to a pharmacy that can dispense drugs to the clinic’s patients only. A “Retail Pharmacy” refers to a pharmacy that can dispense drugs to the general public, and is licensed by the MA Board of Pharmacy.
3. Before submitting claims, the applicant’s pharmacy must successfully complete a test with MassHealth’s pharmacy claims processor.
4. To participate in the Health Safety Net (HSN), you must contact them directly. To register with the HSN, contact Marie.Vitello@state.ma.us.

Option A – CHC-owned Clinic Pharmacy

Provide information about the clinic pharmacy owned by the 340B-covered entity (CHC):

Name of the 340B-covered entity (CHC):

MassHealth pharmacy provider no. and service location (provider type 40):

If you do not have a MassHealth pharmacy provider number, you must submit a completed application for one to Provider Enrollment and Credentialing.

Pharmacy NPI:

Contact name:

Contact telephone no.:

Contact e-mail address:

Pharmacy license no.:

DEA no.: NCPDP no.:

Tax ID no.:

Option B – CHC contracting with a pharmacy or a CHC-owned Retail Pharmacy

Provide information about the 340B-covered entity (CHC):

Name of 340B-covered entity (CHC):

Contact name:

Contact telephone no.:

Contact e-mail address:

MassHealth provider no. and service location (provider type 20):

NPI:

Tax ID of CHC:

Provide information about the contract pharmacy.

Name of contract pharmacy:

Contact name:

Contact telephone no.:

Contact e-mail address:

MassHealth pharmacy provider no. of contract pharmacy and service location (provider type 40):

Provider's Attestation, Signature, and Date [340B-covered entity]

I certify under the pains and penalties of perjury that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I also certify that I am the provider or, in the case of a legal entity, duly authorized to act on behalf of the provider. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Provider's signature (signature and date stamps, or the signature of anyone other than the provider or a person legally authorized to sign on behalf of a legal entity, are not acceptable):

Printed legal name of provider:

Printed legal name of individual signing (if the provider is a legal entity):

Date: