HSN NEW PHARMACY FORM

Please complete the fields below and send the form to HSNHelpDesk@massmail.state.ma.us as well as ryan.bettencourt@mass.gov and Jessica.robinson@mass.gov. All fields must be completed in full, and the pharmacy must be enrolled with MassHealth before the HSN set-up can be completed.

Entity Name: _____
(Hospital or CHC that owns or contracts with the dispensing pharmacy)

Entity Address: _____

Entity Contact Name & Job Title: _____

Entity Phone & Email Address: _____

Entity's NPI #: _____
(For HSN Use: New MMIS NPI)

Entity's MassHealth Provider Number (PID/SL) Where Payment should be Sent: _____
(For HSN Use: Pharmacy New MMIS Pay to Billing Number (do not enter Service Location letter in CMS2)

Is the Entity 340B Eligible: Yes ☐ No ☐

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New Pharmacy's Name: _____

Pharmacy's Address: _____

Pharmacy Contact Name & Job Title: _____

Pharmacy Contact Phone & Email: _____

Pharmacy's NPI: _____
(For HSN Use: National Provider Identification Number – Pharmacy)

Pharmacy MassHealth Provider Number: _____
(For HSN Use: New MMIS Provider ID)

Will the Pharmacy be Dispensing 340B Drugs? Yes ☐ No ☐

If Yes, will the Pharmacy Submit 340B Claims with Submission Clarification Code "20" and Basis of Cost Determination "08"? Yes ☐ No ☐

Pharmacy's Relationship to the Entity: Owned ☐ Contracted ☐

License Held by the Pharmacy: Clinic ☐ Retail ☐ (select all that apply)

Requested Effective Start Date of HSN Relationship: _____

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: _____

For Internal POPS Use:

Eligible for 004A: Yes ☐ No ☐

0004 ☐ 004A ☐ 0005 ☐ 0006 ☐ 0007 ☐

Approved by:

For Internal HSN Use:

Entity OrgID: _____ Pharmacy OrgID: _____

004A Exception: Yes ☐ No ☐

Approved by:

Print Form **Clear Form**