OFFICE OF PHARMACY AFFAIRS (OPA)
340B REGISTRATION FORM FOR CHILDREN'S HOSPITAL OUTPATIENT FACILITIES USING PROVIDER-BASED STATUS

I. Hospital Information:

Hospital (Main Provider) Name: _____

Hospital (Main Provider) Medicare Provider Number: _____

Hospital (Main Provider) Address: _____

II. Hospital Outpatient Facilities Information:

Please complete Section IV and list outpatient facilities and all requested information.

Indicate the following regarding the list from Section IV of outpatient facilities:
Attached list includes new registrations for outpatient facilities to enroll in 340B? Yes ○ No ○

III. Certification:

I acknowledge that I am familiar with the sections of the Federal provider-based regulations and that each outpatient facility on the attached list complies with the requirements in 42 CFR 413.65(d) and (e). I agree to provide verification of meeting the provider-based criteria for each facility upon request from OPA. I further acknowledge that the main provider hospital and attached list of outpatient facilities are in compliance with 340B published guidelines regarding entity and patient eligibility. I confirm that I am fully authorized to bind the hospital and certify that the contents of any statement made or reflected in this document are truthful and accurate; I further acknowledge the hospital's responsibility to notify OPA immediately if there is a material change in the 340B eligibility of any facility and/or if there is a formal determination that a facility included in this attestation is no longer eligible for provider-based status and fails to meet the criteria in 42 CFR 413.65(d) or in the case of off-campus facilities, 42 CFR 413.65(e).

IV. Authorized Signature:

The undersigned represents and confirms that he/she is fully authorized to bind the hospital 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 of duplicate discounts/rebates, and drug diversion. The undersigned further acknowledges the 340B Covered Entity's responsibility to contact OPA if there is a change in meeting any of these criteria.

_____

Signature of Authorizing Official Date

_____

Name & Title of Authorizing Official and Title
(*please print or type)(e.g.CEO, CFO, COO)*

_____ _____ _____

Phone Extn. Email

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.

Submit original, signed form to: HRSA, Office of Pharmacy Affairs, 5600 Fishers Lane, Mail Stop 10C-03, Rockville, Maryland 20857

Revision date 7/29/2009

IV. List of Outpatient Facilities:

NAME OF FACILITY	**FACILITY'S MEDICARE PROVIDER NUMBER/ NPI** *(If Applicable)*	**STREET ADDRESS**	**BILLING ADDRESS** *(if different from facility's street address)*	**SHIPPING ADDRESS** *(if different from facility's street address)*	**340B CONTACT** *(Name, Title, Phone Number, Email Address)*	**If facility bills Medicaid for 340B drugs subject to a rebate, then you must submit all such MEDICAID PROVIDER NUMBER(S) and/or NPI** *(If Not Applicable, 'N/A')*

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