



TO: Providers of Pharmaceutical Services

SUBJECT: Form FD-70, Pharmacy Provider Certification Statement

BACKGROUND: Each participating Medicaid and/or PAAD pharmacy provider must submit his/her total prescription volume annually to the Division of Medical Assistance and Health Services (DMAHS) to determine the basis of payment for reimbursement of legend drug claims submitted. The total shall include all prescriptions filled, both new and refills, for private patients, Medicaid, PAAD, and all other third party carriers, (see FD-70, Section I) including nursing facility recipients.

To qualify for optional increments to the basic dispensing fee, information relevant to 24-hour emergency service, patient consultation, and impact allowance is required. (See FD-70, Section II)

ACTION: Each pharmacy provider must mail a completed Pharmacy Provider Certification Statement (Form FD-70) no later than **January 31, 1992**. Please return the completed form to:

Unisys
CN 4804
Trenton, NJ 08650
ATTN: Form FD-70

ALL QUESTIONS ON THE FORM FD-70 MUST BE ANSWERED OR IT WILL BE RETURNED TO YOU FOR INCLUSION OF MISSING INFORMATION.

Failure to submit the Form FD-70 will automatically place the pharmacy provider in the maximum regression (discount) category and in the basic dispensing fee category without qualifying for any increments. Changes cannot be effective until a properly completed Form FD-70 is received by Unisys.

Any pharmacy provider who has been in business less than one year will have his/her prescription volume projected for the entire year to determine his/her appropriate regression category.

If you have any questions regarding this Newsletter, please telephone Unisys at (800) 776-6334. In the local Trenton area: (609) 587-1955.



PHARMACY PROVIDER CERTIFICATION STATEMENT

Pharmacy Name _____ Provider ID # _____
Address _____ Telephone() _____

Section I. ANNUAL CERTIFICATION OF TOTAL PRESCRIPTION VOLUME FOR 1991

Prescriptions Filled: New _____ + Refills _____ = TOTAL*

*Total: Include all third party and non-third party Rx's.
Combine totals for both regular and LTCF numbers, if applicable.

Section II. FEE INCREMENTS ADDED TO BASIC DISPENSING FEE

1. 24-Hour Emergency Service Availability..... \$0.11

Provider certifies availability of 24 hours/day 365 days/year prescription service.
Yes No

If yes, service availability made known by:

Sign in store window Sign at prescription counter

Other Note: If other is checked a complete description of how
available must be given.

Telephone number for this service is ()
Telephone number for this service must be a local call. If telephone number is not
given, FD-70 will be returned.

2. Patient Consultation..... \$0.08

Provider agrees to monitor all Medicaid and PAAD patient profiles for drug
interactions, contraindications and adverse reactions. Provider will attempt to
discuss therapy with the patient with emphasis on compliance and proper utilization of
prescription. The pharmacist shall exercise good professional judgment at all times.
Yes No

NOTE: If provider discontinues any of the above services, he/she must notify Unisys
CN 4804, Trenton, N.J. 08650 in writing within 72 hours of such discontinuance
and must immediately cease adding the increments to the basic dispensing fee.

Each of the above claimed increments is subject to audit. If the New Jersey
Medicaid Program determines that the provider has an error rate of 5% or more
for either increment, the New Jersey Medicaid Program will recover the total
reimbursement paid for that increment, plus interest, retroactive to the date
of this agreement.

3. Impact Allowance..... \$0.15

This provider has a combined Medicaid/PAAD prescription volume (including LTCF Rx's)
equal to or greater than 50% of the total Rx volume & qualifies for "Impact Allowance"
Yes No

NOTE: If conditions for earning impact allowance change, provider must notify Unisys,
CN 4804 Trenton, N.J. 08650 in writing within 30 days of change and must
immediately cease adding the increment to the basic dispensing fee.

If the New Jersey Medicaid Program determines that the provider has not met the
impact allowance requirements, the New Jersey Medicaid Program will recover the
total reimbursement paid for this increment, plus interest, retroactive to the
date of this agreement.

Section III. OWNERSHIP DISCLOSURE STATEMENT

- 1. Chain Store (4 or more stores). ___Yes ___No
- 2. Do you or does your organization have any legal or professional relationships with any other health care organizations or facilities? ___Yes ___No

If yes, list all such relationships on a separate page.

- 3. Does any person in your organization own or have an interest in or any relationship with any other corporation, partnership or other organization providing services under the New Jersey Medicaid Program? ___Yes ___No

If yes, explain on a separate page.

- 4. Indicate the Legal Status of your organization:

___Sole Proprietor ___Partnership ___Non-Profit Corporation
 ___For Profit Corporation ___Government ___Other(If so, specify)

- 5. List names, home addresses, professional degree and percentage of ownership of individual(s) for:

All partners, directors, officers and/or stockholders as applicable.

	NAME	DEGREE	HOME ADDRESS	% OWNERSHIP
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

I HAVE THOROUGHLY READ THE PHARMACY PROVIDER CERTIFICATION STATEMENT AND AGREE TO THE TERMS AND CONDITIONS SET FORTH HEREIN; I UNDERSTAND THAT THE MAXIMUM CHARGE TO THE NEW JERSEY MEDICAID PROGRAM FOR A MEDICAID OR PAAD PRESCRIPTION FOR A COVERED LEGEND DRUG, MAY NOT EXCEED THE LOWEST OF THE FOLLOWING:

- A. Cost plus dispensing fee as outlined in the New Jersey Medicaid Pharmacy Manual.
- B. Usual and customary and/or posted or advertised charge.
- C. Average of other third party prescription plan charges or agreements.

THE MAXIMUM CHARGE TO THE NEW JERSEY MEDICAID PROGRAM FOR A COVERED NON-LEGEND PRODUCT, MAY NOT EXCEED THE LOWEST OF THE FOLLOWING:

- A. The manufacturer's published suggested selling price to the consumer.
- B. The usual and customary retail price charged to other persons in the community.

Legal Signature of Principal: _____ Date: _____
 Print Name: _____ Title: _____
 Pharmacy Name: _____

NOTE: All of the above statements are subject to audit and review by Division personnel, its contractors, or other state & federal agencies.

AFFIX
PHARMACY LABEL
HERE