



State of New Jersey
Department of Human Services
Division of Medical Assistance & Health Services
and
Department of Health & Senior Services
Division of Senior Benefits and Utilization Management

Newsletter

Volume 20 No. 04

January 2009

TO: Providers of Pharmaceutical Services – **For Action**
Health Maintenance Organizations – **For Information Only**

SUBJECT: Revised Form FD-70, Pharmacy Provider Certification Statement

BACKGROUND: Newsletter Volume 19, No. 58 notified participating NJ FamilyCare/Medicaid pharmacy providers and, on behalf of the Department of Health and Senior Services (DHSS), Pharmaceutical Assistance to the Aged and Disabled (PAAD), Senior Gold, AIDS Drugs Distribution Program (ADDP) and Cystic Fibrosis (CF) pharmacy providers, that information must be submitted annually to the Division of Medical Assistance and Health Services (DMAHS) in order to obtain optional dispensing fee increments in addition to the basic dispensing fee. To qualify for these optional increments to the basic dispensing fee, information relevant to 24-hour emergency service and impact allowance is required. (See Form FD-70, Section I.) This information is used to determine appropriate dispensing fees for pharmacy claims submitted to the State for payment consideration, as described in N.J.A.C. 10:51-1.7 and 8:83C-1.

- **Newsletter Volume 19, No. 58 requested that participating pharmacies complete the FD-70 Pharmacy Provider Certification Statement revised in November 2009. Newsletter Volume 19, No.58 is being rescinded by the Division of Medical Assistance and Health Services and DHSS.**
- **Pharmacies are required to complete a former version of the FD-70 Certification Statement, revised in November 2008 (see attachment).**
- **Unisys has been instructed to disregard the November 2009 version of the FD-70 Certification Statement received from pharmacies for calendar year 2009.**
- **The FD-70 response deadline has been extended to accommodate this change.**

ACTION: Pharmacy providers must complete and return the Pharmacy Provider Certification Statement (Revised 11/2008) and attach a copy of its valid pharmacy permit **no later than February 15, 2010.** Please forward the documents to:

Unisys
P. O. Box 4804
Trenton, NJ 08650-4804
Attn: Form FD-70

ALL QUESTIONS ON FORM FD-70 (REVISED 11/2008) MUST BE COMPLETED. INCOMPLETE FORMS WILL BE RETURNED TO THE PHARMACY PROVIDER FOR COMPLETION.

NOTE: If any pharmacy provider fails to complete and return the Pharmacy Provider Certification Statement by February 15, 2010, the State will automatically assign the basic dispensing fee, without the optional increments, to that pharmacy. No changes to the assigned basic dispensing fee will become effective until a properly completed Pharmacy Provider Certification Statement (Revised 2008), including a copy of the pharmacy's valid pharmacy permit, is received by Unisys.

The State apologizes for any inconvenience caused by this change in requirements. If pharmacy providers have any questions regarding this Newsletter, they may contact Unisys Provider Services at 1-800-776-6334.

If pharmacy providers have any questions regarding PAAD, ADDP, CF or Senior Gold, they may contact the DHSS Pharmacy Consultant at 1-866-854-1596.

RETAIN THIS NEWSLETTER FOR YOUR RECORDS



**STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
AND
DEPARTMENT OF HEALTH AND SENIOR SERVICES**

PHARMACY PROVIDER CERTIFICATION STATEMENT FOR CALENDAR YEAR 2009

Pharmacy Name _____ Provider ID # _____
 Address _____ E-Mail Address _____
 _____ Telephone (____) _____

SECTION I. FEE INCREMENTS ADDED TO BASIC DISPENSING FEE

1. Impact Allowance..... \$0.15

This provider has a combined NJ FamilyCare/Medicaid/PAAD/ADDP/CF/Senior Gold prescription volume (including LTCF Rx) equal to or greater than 50% of the total Rx volume and qualifies for "Impact Allowance". **ONLY PRESCRIPTION CLAIMS SHALL BE COUNTED WHERE THE ABOVE PROGRAMS WERE PRIMARY PAYERS.**

Actual Percentage: _____ Yes _____ No

Note: If conditions for earning the impact allowance change, the provider must notify Unisys, in writing, at P.O. Box 4804, Trenton, NJ 08650-4804, within 30 days of change, and must immediately cease adding the impact allowance increment to the basic dispensing fee. If the State determines that the provider has not met the impact allowance requirements, the State shall recover the total reimbursement for this increment, retroactive to the date of this Statement.

2. 24-Hour Emergency Service \$0.11

Provider certifies that 24hours/day, 365 days/year emergency prescription service is provided at this specific location. _____ Yes _____ No

If yes, identify below the method used by the provider to post notice of open pharmacy hours 24 hours/day, 365 days/year.

_____ Window Sign _____ Prescription Counter Sign

_____ Other **Note:** If "Other" is checked, please attach a complete description of the notification method used by the provider to notify beneficiaries of this service.

24-Hour Emergency Service Telephone Number (____) _____

To qualify for the 24 hours/day, 365 days/year increment, the 24 hour emergency service must be for the actual pharmacy which will be providing the beneficiary this service. Failure to provide the 24 hour emergency service telephone number will result in the return of this form.

Note: If the provider discontinues 24-hour emergency service at this specific location, the provider must notify Unisys, in writing, at P.O. Box 4804, Trenton, NJ 08650-4804 within 72 hours of this decision, and must immediately cease adding the increment to the basic dispensing fee.

SECTION II. OWNERSHIP DISCLOSURE STATEMENT

1. _____ Pharmacy Name

Chain Pharmacy ___ Yes ___ No

If yes, please indicate the number of pharmacies operating in the State of New Jersey: ____

2. Does any person in the provider organization currently own or have an interest in or any relationship with any other corporation, partnership, or other organization providing services under the NJ FamilyCare/Medicaid, PAAD, ADDP, CF or Senior Gold? _____ Yes _____ No

If yes, please explain such affiliations on a separate page and attach to the Certification Statement.

3. Indicate the legal status of the provider organization below.

___ Sole Proprietor ___ Partnership ___ Non-Profit Corporation

___ For-Profit Corporation ___ Government ___ Other (Specify) _____

List names, professional degrees, home addresses, and percentage of ownership for all partners, directors, officers, and/or stockholders, as applicable:

	<u>NAME</u>	<u>DEGREE</u>	<u>HOME ADDRESS</u>	<u>% OWNERSHIP</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

I HAVE READ THE PHARMACY PROVIDER CERTIFICATION STATEMENT AND AGREE TO THE TERMS AND CONDITIONS SET FORTH HEREIN. I UNDERSTAND THAT THE MAXIMUM CHARGE TO THE STATE OF NEW JERSEY FOR ALL NJ FAMILYCARE/MEDICAID, PAAD, ADDP, CF AND SENIOR GOLD PRESCRIPTIONS FOR COVERED DRUGS AND RELATED PHARMACEUTICAL PRODUCTS/DEVICES SHALL NOT EXCEED THE PRICING POLICIES OF THE STATE AS DESCRIBED IN N.J.A.C. 10:51-1.7 AND N.J.A.C. 8:83C-1.

Legal Signature of Principal: _____ Date: _____

Print Name: _____ Title: _____

Pharmacy Name: _____

Pharmacist in Charge: _____ License Eff. Date: _____ License Exp. Date: _____

NOTE: ALL STATEMENTS IN THIS CERTIFICATION ARE SUBJECT TO AUDIT AND REVIEW BY THE NEW JERSEY DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES (DMAHS) AND/OR THE NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES (DHSS), THEIR CONTRACTORS, OR OTHER STATE AND FEDERAL AGENCIES.

AFFIX
PHARMACY LABEL
HERE