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 21 No. 29 **December 2011**

TO: Fee-for-Service Providers of Pharmaceutical Services

SUBJECT: Form FD-70, Pharmacy Provider Certification Statement (Rev. 11/2008)

BACKGROUND: 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, must submit information 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.

ACTION: Pharmacy providers must complete and return the Pharmacy Provider Certification Statement and attach a copy of its valid pharmacy permit by **no later than January 15, 2012.** Please forward the documents to:

Molina Medicaid Solutions
P. O. Box 4804
Trenton, NJ 08650-4804
Attn: Form FD-70

ALL QUESTIONS ON FORM FD-70 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 January 15, 2012, **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, including a copy of the pharmacy's valid pharmacy permit, is received by Molina Medicaid Solutions (formerly Unisys).**

If pharmacy providers have any questions regarding this Newsletter, they may contact Molina Medicaid Solutions (formerly 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 FUTURE REFERENCE

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

PHARMACY PROVIDER CERTIFICATION STATEMENT FOR CALENDAR YEAR 2011

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 Rxs) 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 Molina Medicaid Solutions (formerly 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 24 hours/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 Molina Medicaid Solutions (formerly 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:

NAME	DEGREE	HOME ADDRESS	% OWNERSHIP
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