

Pharmacy Provider Enrollment & Trading Partner Agreement

Attached is the Pharmacy Provider Enrollment & Trading Partner Agreement (MSA-1626) used by the Michigan Department of Community Health (MDCH) Pharmacy Benefits Manager (PBM), First Health Services Corporation (FHSC) to enroll pharmacies into the Fee-For-Service (FFS) Programs for Medicaid, Children's Special Health Care Services, Adult Benefits Waiver, Maternity Outpatient Medical Services, and *Plan First!*.

It is very important that you update your information with the National Council for Prescription Drug Programs (NCPDP). NCPDP is the clearinghouse that provides pharmacy contact information to FHSC and ultimately to MDCH. The web address for NCPDP is <https://www.ncpdponline.org>.

To receive Electronic Funds Transfer (EFT) payments you must complete the FHSC Electronic Funds Transfer (EFT) Authorization form. You must contact the FHSC Provider Enrollment Department at 804-965-7619 to obtain this form.

If you are an out-of-state/beyond borderland pharmacy requesting enrollment in the Michigan Medicaid Program, see additional enrollment information for out of state providers at www.michigan.fhsc.com >> Providers >> Provider Forms >> [Out of State Billing Information](#).

The effective date of enrollment for a pharmacy provider is the date you sign the Agreement (license permitting) should FHSC receive the **Agreement and all required documentation** within 30 days of the signature date. Effective dates for some pharmacy providers are determined by certification requirements or other approval dates. A pharmacy may request retroactive enrollment in writing. This request must contain a valid reason for retroactive enrollment. The retroactive written request must accompany this Agreement. Approval for retroactive enrollment is not a waiver for any claim(s) not submitted within the Michigan Medicaid Program billing guidelines.

You will be notified when your Agreement has been processed/approved via a fax form "Michigan Medicaid Provider Enrollment Confirmation" which will contain your Medicaid enrollment information.

If you have questions concerning enrollment, please contact the FHSC Provider Enrollment Department at (804) 965-7619 or (804) 965-7748 or via e-mail HWTune@fhsc.com.

**First Health Services Corporation
Michigan Medicaid – Provider Enrollment Department
4300 Cox Road
Glen Allen, VA 23060**

The Michigan Department of Community Health is an equal opportunity employer, services and programs provider.

Pharmacy Provider Enrollment & Trading Partner Agreement

Conditions and Provisions

IMPORTANT

- Trading Partner Provisions apply to all electronic billers.
- Either party, upon thirty (30) days written notice, may cancel this Agreement.

In applying for enrollment as a provider or trading partner with First Health Services Corporation (FHSC) (and programs for which the Michigan Department of Community Health (MDCH) is the fiscal intermediary), I represent and certify as follows:

1. The applicant and the employer certify that the undersigned have the authority to execute this Agreement.
2. Enrollment in the Medical Assistance Program does not guarantee participation in MDCH managed care programs nor does it replace or negate the contract process between a managed care entity and its providers or subcontractors.
3. All information furnished on this Pharmacy Provider Enrollment & Trading Partner Agreement is true and complete.
4. The providers and fiscal agents of ownership and control information agree to provide proper disclosure of provider's, owner's and other person's criminal convictions related to Medicare, Medicaid or Title XX involvement. [42 CFR 455.100]
5. The applicant and the employer agree to provide proper disclosure of any criminal convictions related to Medicare (Title XVIII), Medicaid (Title XIX), and other State Health Care Programs (Title V, Title XX, and Title XXI) involvement. [42 CFR 455.106 and 42 U.S.C. § 1320a-7]
6. Before billing for any pharmacy services that I render, I will read the Michigan Medicaid Provider Manual from the Michigan Department of Community Health (MDCH) and the First Health Claims Processing Manual. I also agree to comply with: 1) the terms and conditions of participation noted in the Manuals; and 2) MDCH's policies and procedures for the Medical Assistance Program contained in the manual, manual updates, provider bulletins and other program notifications.
7. I agree to comply with the provisions of 42 CFR 455.104, 42 CFR 455.105, 42 CFR 431.107 and Act No. 280 of the Public Acts of 1939, as amended, which state the conditions and requirements under which participation with MDCH is allowed.
8. I agree to comply with the requirements of Section 6032 of the Deficit Reduction Act of 2005, codified at Section 1902(a)(68) of the Social Security Act, which relates to the conditions and requirements of "Employee Education About False Claims Recovery."
9. I agree that, upon request and at a reasonable time and place, I will allow authorized state or federal government agents to inspect, copy, and/or take any records I maintain pertaining to the delivery of goods and services to, or on behalf of, a MDCH beneficiary. These records also include any service contract(s) I have with any billing agent/service or service bureau, billing consultant, or other healthcare provider.
10. I agree to include a clause in any contract I enter into which allows authorized state or federal government agents access to the subcontractor's accounting records and other documents needed to verify the nature and extent of costs and services furnished under the contract.
11. I understand that payment for services billed under my provider identification number will be made directly to me, unless Item 19 (below) applies.
12. I am not currently suspended, terminated, disbarred, or excluded from the Medical Assistance Program by any state or by the U.S. Department of Health and Human Services.
13. I agree to comply with all policies and procedures of the MDCH when billing for services rendered. I also agree that disputed claims, including overpayments, may be adjudicated in administrative proceedings convened under Act No. 280 of the Public Acts of 1939, as amended, or in a court of competent jurisdiction. I further agree to reimburse the Medical Assistance Program for all overpayments, and I acknowledge that the Medicaid Audit System, which uses random sampling, is a reliable and acceptable method for determining such overpayments.
14. I agree to comply with the privacy and confidentiality provisions of any applicable laws governing the use and disclosure of protected health information, including the privacy regulations adopted by the U.S. Department of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and Public Acts 104-191 (45 CFR Parts 160 and 164, Subparts A and E). I also agree to comply with the HIPAA security regulations, as applicable, for electronic protected health information (45 CFR Parts 160 and 164, Subparts A and C). I will abide

by the Trading Partner section of this Agreement, and the HIPAA regulations regarding electronic transactions and code sets, as applicable. (45 CFR Parts 160 and 162).

15. This Agreement shall be governed by the laws of the State of Michigan and applicable federal law including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
16. The provisions of this Agreement are severable. If any provision is held or declared to be illegal, invalid or unenforceable, the remainder of the Agreement will continue in full force and effect as though the illegal, invalid or unenforceable provision had not been contained in this Agreement.
17. Failure or delay on the part of either party to exercise any right, power, privilege, or remedy in this Agreement will not constitute a waiver. No provision of this Agreement may be waived by either party except in writing, signed by an authorized representative of the party making the waiver.

Pharmacy Provider – Employer/Employee Conditions

18. The **applicant** is employed by the business listed, now referred to as the “**employer**”, to provide Medical Assistance Program services to eligible beneficiaries at the service address listed.
19. The **employer** shall use the **applicant’s** Pharmacy provider identification number assigned at the service location when billing for pharmacy services provided by the applicant to eligible beneficiaries.
20. The **applicant**, as a condition of employment, agrees that the employer shall directly receive the payments made in his/her name by the MDCH for services billed and paid for eligible beneficiaries.
21. The **employer** and the **applicant** shall advise MDCH within thirty (30) days after any changes in the employment relationship.
22. The **employer** and the **applicant** agree to be jointly and severally liable for any overpayments billed and paid under Act No. 280 of the Public Acts of 1939, as amended, for services provided by the applicant to eligible beneficiaries.

Trading Partner Provisions

The MDCH/FHSC and its Trading Partner desire to facilitate the exchange of pharmacy transactions (“Transactions”) by electronically transmitting and receiving data in agreed formats in substitution for conventional paper-based documents.

1. Companion Documents; Standards; Other Documentation.

MDCH makes available certain inbound and outbound Electronic Data Interchange (EDI) transaction sets/formats and associated versions. From time to time during the term of this Agreement, FHSC may modify supported transaction sets/formats. In submitting Transactions to FHSC, Trading Partner agrees to conform to FHSC-issued provider publications and FHSC Payer Specifications as amended from time to time. The FHSC Payer Specifications for Michigan Medicaid, incorporated by reference herein, contain specific instructions for conducting each Transaction and as such supplement Implementation Guides issued under the Standards for Electronic Transactions mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended. The FHSC Payer Specifications for Michigan Medicaid are not intended to be complete billing instructions and do not alter or replace applicable pharmacy guides or other pharmacy provider billing publications issued by MDCH or by other third party payers. The Trading Partner agrees to comply with the requirements set forth in the applicable FHSC Payer Specifications for Michigan Medicaid. The Trading Partner, or its vendor or other authorized technical representative responsible for EDI software, will document Trading Partner information, data formats and related versions, trading partner identifiers, and other information MDCH requires to receive and transmit specific Transactions supported by FHSC.

2. Support.

As to software, equipment, and services associated with each party’s performance under this Agreement, the parties agree to provide support services sufficient for Transactions to be exchanged. Each party will assist the other in establishing and/or maintaining support procedures, and will complete appropriate problem determination procedures prior to contacting the other with a support related matter. The parties agree to use all commercially reasonable efforts to avoid and resolve performance and unavailability issues. Each party will perform remedial action as requested by the other to assist in problem resolution. Each party, at its own expense, shall provide and maintain the equipment, software, services, and testing necessary to effectively and reliably transmit and receive transactions.

3. Data Retention.

FHSC will log all Transactions for the purposes of problem investigation, resolution, and servicing. The Trading Partner is responsible for maintaining and retaining its own records of data submitted to FHSC on behalf of MDCH. Trading Partners who are pharmacy providers will ensure that electronic pharmacy claims submitted to FHSC can be readily associated and identified with the correct patient pharmacy records, and that these records are maintained in a manner that permits review and for the time period as may be required by MDCH or other third party payer responsible for claim payment.

4. Proper Receipt and Verification for Transactions.

Upon proper receipt of NCPDP Standard Transactions, the receiving party shall promptly and properly transmit a functional acknowledgement in return, unless otherwise specified. The functional and interchange acknowledgements must be accepted and reviewed, when applicable, to confirm the receipt of a Transaction. The ability to send or receive functional acknowledgements is applicable only to NCPDP Standard Transactions. Additionally, FHSC originated outbound Transactions must be accepted and reviewed, when appropriate, to obtain FHSC's response to specific inbound Transactions. The acknowledging party does not attest to the accuracy of the data contained in the transmission; rather, it only confirms receipt of the transmission.

5. Liability.

FHSC shall not be responsible to the Trading Partner nor anyone else for any damages caused by loss, delay, rejection, or any misadventure affecting such electronic information. In addition, FHSC shall be excused from performing any EDI service or function, in whole or in part, as a result of an act of God, war, civil disturbance, court order, labor dispute, or other cause beyond its reasonable control, including shortages or fluctuations in electrical power, heat, light, or air conditioning. FHSC's sole liability to the Trading Partner, or to any other person or entity in connection with FHSC's responsibilities under this Agreement, shall be to reprocess information supplied by the Trading Partner or duplicate information from a backup supplied by the Trading Partner upon FHSC's request, which shall be the sole remedy against FHSC for claimed damage or injury of any nature. FHSC shall not be liable for any indirect, special, or consequential damages arising out of any access, use, or any reliance upon, the EDI services MDCH/FHSC provides to the Trading Partner. FHSC assumes no responsibility for claims preparation, review, information accuracy, pricing, adjudication, payment, adjustment, accounting, reconciliation or any other matter related to the claims transmitted for delivery to other third party payers. The Trading Partner agrees to defend, indemnify, and hold harmless FHSC, its Trading Partners, officers, agents, employees, assigns and successors from and against any and all claims, losses, and actions, including all costs and reasonable attorney fees arising out of electronic Transactions the Trading Partner submits to FHSC on behalf of MDCH.

6. Standard Transactions.

All Standard Transactions, as defined by HIPAA, will be conducted by the parties using only code sets, data elements, and formats specified by the Transaction rules and instructions in the FHSC Payer Specifications for Michigan Medicaid. The parties agree that when conducting Standard Transactions, they will not change the definition, data condition, or use of a data element or segment in a standard, add data elements or segments to the maximum defined data set, use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specification(s), or change the meaning or intent of the HIPAA standards implementation specifications.

7. Testing.

All new Trading Partners will cooperate with FHSC upon request in testing processes prior to submission of production data. Existing Trading Partners will cooperate with FHSC upon request in testing processes for any changes in submission format prior to submission of production files. FHSC will notify the Trading Partner of the effective date for production data after successful testing.

8. Data and Network Security.

The parties agree to use reasonable security measures to protect the integrity of data transmitted under this Agreement and to protect this data from unauthorized access. The Trading Partner shall comply with FHSC data and network security requirements which may change from time to time, and as may be required by the HIPAA security regulations.

9. Automatic Amendment for Regulatory Compliance.

This Agreement will automatically be amended to comply with any final regulation or amendment to a final regulation adopted by the U.S. Department of Health and Human Services concerning the subject matter of this Agreement upon the effective date of the final regulation or amendment.

10. Miscellaneous.

Provisions 3 and 8 shall survive termination of this Agreement.

The Trading Partner will notify FHSC of any changes in Trading Partner information supplied including, but not limited to, the name of the service bureau, billing service, recipient of remittance file, or provider code at least 30 calendar days prior to the effective date of such change.

PHARMACY PROVIDER ENROLLMENT & TRADING PARTNER AGREEMENT

To be completed by FHSC Staff only		
Provider ID Number	Provider Type	Eligibility Begin Date / /
Group ID Number	Location Code	Eligibility End Date / /

NOTE: Review "Instructions" (page 8) for detailed information of this Agreement.

PROVIDER / APPLICANT INFORMATION					
1. Business Name of Pharmacy (Parent Company)			2. Doing Business As		
3. Applicant Name and Title		4. Phone Number () -		5. Fax Number () -	
Note: All identification numbers require a photocopy of documentation.					
6. State License Number		7. Tax ID Number/EIN Number		8. State Tax ID Number	
9. N.P.I. Number Applicant/Store		10. NCPDP Number		11. DEA Number	
12. Medicare Number					
13.A Classification of Pharmacy (Check one that applies.) <input type="checkbox"/> Chain (5 or more stores) <input type="checkbox"/> Independent (1 to 4 stores)					
13.B Pharmacy Business Type (Check all that apply.) <input type="checkbox"/> Community/Retail <input type="checkbox"/> Mail Order <input type="checkbox"/> Long Term Care <input type="checkbox"/> Veterans Health Administration <input type="checkbox"/> Home Infusion <input type="checkbox"/> Institutional Pharmacy <input type="checkbox"/> Managed Care Pharmacy <input type="checkbox"/> Clinic Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Military Pharmacy <input type="checkbox"/> Compounding Pharmacy <input type="checkbox"/> Indian Tribal/Urban Indian Health Services <input type="checkbox"/> Franchise <input type="checkbox"/> Government <input type="checkbox"/> Other (explain) -					
14. Business Type (Check all that apply.) <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Non-profit <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> 340B <input type="checkbox"/> Government					
SERVICE ADDRESS			BILLING ADDRESS		
15. Street Address (include suite number)			21. PO Box <u>or</u> Street Address (include suite number)		
16. City		17. State	18. Zip Code		
22. City		23. State	24. Zip Code		
19. Phone Number () - ext.		20. County		25. Phone Number () - ext.	
26. CORRESPONDENCE INFORMATION					
Contact Person Name			E-mail Address		Phone Number () - ext.
PO Box <u>or</u> Street Address (include suite number)			City		State Zip Code
If Trading Partner is a Provider who elects to receive an 835, and Trading Partner uses multiple submitters, Trading Partner must designate one recipient for all 835 electronic remittance advices.			Unique Receiver ID or Name		
27. AUDIT CORRESPONDENCE INFORMATION					
Audit Contact Name:			PO Box <u>or</u> Street Address (include suite number)		
Phone Number () - ext.			City		State Zip Code

The Michigan Department of Community Health is an equal opportunity employer, services and programs provider.

NOTE: Include a photocopy of ownership and control interest documents as required by 42 CFR 455.104.

28. Ownership Information. THIS IS REQUIRED. (List the individual owners. The owner's signature acknowledges agreement with the conditions and provisions of the "Pharmacy Provider Enrollment & Trading Partner Agreement". Use page 7 for additional ownership information.)								
Owner's Name		Date of Ownership		Percent Owned		Owner's Social Security Number		
Print Name and Title		/ /		%		- -		
Signature		Relationship to any owners (See instructions.)		Date Signed				
Print Name and Title		/ /		%		- -		
Signature		Relationship to any owners (See instructions.)		Date Signed				
29. Ownership Interest Information. List ownership interest in other entities reimbursable by Medicaid and/or Medicare. (List the individual owners. Use page 7 for additional ownership information.)								
Owner's Name			Owner's Name					
Entity Name			Entity Name					
Entity Mailing Address (PO Box <u>or</u> Street, including suite number)			Entity Mailing Address (PO Box <u>or</u> Street, including suite number)					
City		State	Zip Code		City		State	Zip Code
Entity Federal Tax Identification Number		Phone Number () -		Entity Federal Tax Identification Number		Phone Number () -		
30. MANAGING EMPLOYEE [as defined by 42 CFR 455.101 (c)]								
Print Name and Title			Managing Employee's Social Security Number		Date Signed			
			- -		/ /			
Signature								
BY SIGNING THIS AGREEMENT, I ASSERT THAT I HAVE READ AND AGREE TO THE PHARMACY PROVIDER ENROLLMENT & TRADING PARTNER AGREEMENT – CONDITIONS AND PROVISIONS. (Important: Facsimile signatures will not be accepted.)								
		31. Does any employee have Criminal Convictions relating to Title V, Title XVIII, Title XIX, Title XX or Title XXI? <input type="checkbox"/> NO <input type="checkbox"/> YES * * See "Instructions" for further details.						
32. Signature of Applicant				33. Date Signed				

Mail completed Agreement **and** required documentation to:

First Health Services Corporation
Michigan Medicaid - Provider Enrollment Department
4300 Cox Rd.
Glen Allen, VA 23060

USE THIS SHEET FOR ADDITIONAL OWNERSHIP INFORMATION. (MAKE PHOTOCOPIES AS NEEDED.)

28. (continued) Ownership Information. THIS IS REQUIRED. (List the individual owners. The owner's signature acknowledges agreement with the conditions and provisions of the "Pharmacy Provider Enrollment & Trading Partner Agreement".)

Owner's Name	Date of Ownership	Percent Owned	Owner's Social Security Number
Print Name and Title	/ /	%	- -
Signature	Relationship to any owners (See instructions.)		Date Signed
Print Name and Title	/ /	%	- -
Signature	Relationship to any owners (See instructions.)		Date Signed
Print Name and Title	/ /	%	- -
Signature	Relationship to any owners (See instructions.)		Date Signed
Print Name and Title	/ /	%	- -
Signature	Relationship to any owners (See instructions.)		Date Signed

29. (continued) Ownership Interest Information. List ownership interest in other entities reimbursable by Medicaid and/or Medicare. (List the individual owners.)

Owner's Name			Owner's Name		
Entity Name			Entity Name		
Entity Mailing Address (PO Box <u>or</u> Street, including suite number)			Entity Mailing Address (PO Box <u>or</u> Street, including suite number)		
City	State	Zip Code	City	State	Zip Code
Entity Federal Tax Identification Number	Phone Number () -		Entity Federal Tax Identification Number	Phone Number () -	
Owner's Name			Owner's Name		
Entity Name			Entity Name		
Entity Mailing Address (PO Box <u>or</u> Street, including suite number)			Entity Mailing Address (PO Box <u>or</u> Street, including suite number)		
City	State	Zip Code	City	State	Zip Code
Entity Federal Tax Identification Number	Phone Number () -		Entity Federal Tax Identification Number	Phone Number () -	

INSTRUCTIONS FOR THE PHARMACY PROVIDER ENROLLMENT & TRADING PARTNER AGREEMENT

PHOTOCOPIES OF THIS AGREEMENT MUST NOT BE USED TO REQUEST ENROLLMENT.

This Agreement is to be completed by all eligible providers who wish to receive payment for services provided under the programs for which the Michigan Department of Community Health serves as the fiscal intermediary.

An **original** Agreement must be submitted for **each** pharmacy provider rendering services. **NOTE: Photocopies of this Agreement (except page 7) will not be accepted.**

TYPE or PRINT in BLACK INK.

- Item 1:** Print the business name of the pharmacy (or the parent company name) that is licensed in Michigan.
- Item 2:** Print the name under which the pharmacy does business as.
- Item 3:** Print the name of the individual and the individual's title who is completing this Agreement.
- Item 4:** Print the phone number of the business listed in Item 2.
- Item 5:** Print the fax number of the business listed in Item 2.
- Item 6:** Print the state license number of the business listed in Item 2. A photocopy of the current state license **must** be submitted with this Agreement for in-state, out-of-state, newly licensed, and limited/temporary licensed pharmacies.
- Item 7:** Print the tax ID number/employer ID number (EIN) for the business listed in Item 2. A photocopy of the tax ID number/EIN number **must** be submitted with this Agreement.
- Item 8:** Print the state tax ID number. A photocopy of the pharmacy state tax ID number **must** be submitted with this Agreement.
- Item 9:** Print the NPI of the business listed in Item 2. A photocopy of the NPI **must** be submitted with this Agreement.
- Item 10:** Print the NCPDP number of the business listed in Item 2. Each pharmacy practice location must have its own unique NCPDP number. A photocopy of the NCPDP number **must** be submitted with this Agreement.
- Item 11:** Print the DEA number of the business listed in Item 2. A photocopy of the DEA number **must** be submitted with this Agreement.
- Item 12:** Print the Medicare number for the business listed in Item 2. A photocopy of the Medicare number **must** be submitted with this Agreement.
- Item 13A:** Check the appropriate box for the classification of pharmacy that best describes your primary business.
- Item 13B:** Check the appropriate box(es) for the classification of pharmacy that best describes your pharmacy business type.
- Item 14:** Check the appropriate box(es) for the business type. A list of 340B drugs and changes **must** be provided for exclusion from the rebate process. (Nonprofit organizations do not complete Items 28-29.)
- Items 15-20:** Print the street address (include suite number if applicable), city, state, zip code, phone number & extension, and county as the physical location of the business listed in Item 2.
- Items 21-25:** Complete these Items if you want checks, remittance advices, and IRS 1099 forms sent to an address other than the service address. Print the street address or P.O. Box address, city, state, zip code, and phone number.
- Item 26:** Complete this section if you want letters, bulletins, etc. from Michigan Department of Community Health (MDCH) sent to an address other than the service address. Print the contact person's name, e-mail address, phone number, street address or P.O. Box, city, state, and zip code. Print the Unique Receiver ID or Name that is assigned to the business identified in Item 7. **All providers** under that corporate Tax Identification Number (TIN)/EIN must indicate the same Unique Receiver ID or Name. **This Unique Receiver ID or Name will be the entity that receives the 835 Health Care Payment/Advice Transactions for providers under the same TIN/EIN.**
- Item 27:** Complete these Items if a Corporate Entity wants to receive notification on MDCH Audit Findings and Gross Adjustments for individual pharmacies.

INSTRUCTIONS FOR THE PHARMACY PROVIDER ENROLLMENT & TRADING PARTNER AGREEMENT

Item 28: Must be completed:

- a. Complete this Item for each individual having 5% or more ownership in the business identified in Item 2. Each individual owner must print his/her name and title, date of ownership, percentage owned, and social security number. A signature and date signed for each individual owner is also required. List the relationship to any person related to the owner or individual with a 5% or more controlling interest (i.e., spouse, parent, child, siblings, etc.). If additional space is needed, use Page 7. (Page 7 may be photocopied as needed to obtain the information and signature for each individual owner.) ***Facsimile signatures will not be accepted.***
- b. Complete this item if not applicable by printing "**No individual and/or entity meets this requirement**" in the *Print Name and Title* field. A confirmation signature and date from authorized individual listed in item 32.

Item 29: Must be completed:

- a. Complete this Item for each individual listed in Item 28 who also has ownership interest in other entities reimbursable by Medicaid and/or Medicare. If additional space is needed, use Page 7. (Page 7 may be photocopied as needed to obtain the information for each individual owner.)
- b. Complete this item if not applicable by printing "**No individual and/or entity meets this requirement**" in the *Owner's Name* field. A confirmation signature and date from authorized individual listed in item 32.

Item 30: The Managing Employee as defined in 42 CFR 455.101 (c), of the business listed in Item 2 **must complete this Item**. Print name, title, social security number, date signed and signature.

Item 31: Check the appropriate box if you have criminal conviction and sanctions relating to Title V, Title XVIII, Title XIX, Title XX, or Title XXI. Federal laws 42 CFR 455.106 and 42 U.S.C. § 1320a-7 require the State to collect criminal convictions information related to Medicare (Title XVIII), Medicaid (Title XIX), or other State Health Care Programs (Title V, Title XX or Title XXI) for any person who has ownership or control interest, or is a managing employee of the provider. If this applies, provide information and/or documentation on a separate page.

Items 32-33: The applicant (identified in Item 3) who can be held responsible for the business listed in Item 2 **must** sign and date this Agreement.

Retain a photocopy of the completed Pharmacy Provider Enrollment and Trading Partner Agreement for your records.

Mail the completed Agreement and required documentation to:

**First Health Services Corporation
Michigan Medicaid - Provider Enrollment Department
4300 Cox Rd.
Glen Allen, VA 23060**