DISCLOSURE FORM FOR PHARMACIES

Directions: Use this form if you are trying to enroll your **Pharmacy or Pharmacy chain**,in the CoverKids Pharmacy network, or if you are re-credentialing or re-contracting a **Pharmacy or Pharmacy chain**, or if there have been significant changes to the information required on this form, for example an ownership change, the addition of new managing employee or the change of your business location. [Note: Each pharmacy participating in Group Purchasing Organization (GPO) or Pharmacy Services Administration Organization (PSAO) MUST fill out its own form. The GPO or PSAO is NOT considered a chain pharmacy]

Please answer all questions as of the current date. If additional space is needed, please note on the form that the answer is being continued, and attach a sheet referencing the item number that is being continued. Return the original to the PBM at

Express Scripts
HQ2W02
8931 Springdale Ave
St Louis MO 63134
Fax: 1-800-899-1601

Return the original to Express Scripts at the address or fax numbers above. Additional information on the form may be accessed at the CoverKids website located on-line at http://www.coverkids.com/ and/or the Express Scripts website located on-line at www.**express-scripts**.com/services/**pharmacist**s/.

Please retain a copy for your files. Completely answer the applicable questions. If a question is not applicable please respond **N/A** for that question. ***NO QUESTIONS SHOULD BE LEFT BLANK***. The SSN must be provided. Tennessee Code Annotated § 4-4-125 creates an exception to the public records act by prohibiting state agencies from disclosing Social Security Numbers (SSN).

I. Identifying Information

Name of person Completing form	Phone number of person completing form

Pharmacy Corporate Name	Pharmacy DBA Name (if different from Corporate name)	Pharmacy Federal Tax Id number

Pharmacy NPI number If you are a small chain (10 or fewer stores) list each NPI. If a large chain give your chain code. (If you have one, if not indicate if applied for.)	Pharmacy NCPDP If you are a small chain (10 or fewer stores) list each NCPDP. If a large chain give your chain code. (If you have one, if not indicate if applied for.)	Pharmacy telephone Number

Pharmacy Address- Must include at least one street address. (Attach a separate sheet if needed).List all Pharmacy locations that you are trying to credential. [If you are a small chain, 10 or fewer stores, list each location. A large chain give main corporate address.]	City	State	Zip

II. OWNER OR CONTROL INFORMATION

Directions: An **"Owner"** is a person or business entity which owns 5% or more of the assets, stock or profits of the **Pharmacy or Pharmacy chain**. This 5% may be **Direct** ownership or **Indirect** ownership i.e, an individual might own 50% of a company that owns the actual **Pharmacy or Pharmacy chain** meaning their indirect ownership is 50%. In addition to ownership of stock, an **Owner** is also a person who owns a legal obligation like a mortgage or loan that is secured by the assets of the **Pharmacy or Pharmacy chain**. If your **Pharmacy** is a sole proprietorship list yourself as the 100% owner.

A person with **"Control**" is someone who directs the **Pharmacy or Pharmacy chain** and includes Directors, Trustees and Officers of Corporations and Partners in a Partnership. If the **Pharmacy or Pharmacy chain** is a non-profit entity, respond **N/A** in the column for % of ownership.

A **"Managing Employee"** is someone who makes the day to day decisions for the **Pharmacy or Pharmacy chain**. If the Pharmacy is a small chain (10 or fewer stores) the **Managing employee** would be the **Pharmacist in charge** for each store, if that person is not already listed as an **Owner** or a person with **Control**. If the

pharmacy is part of a large chain the **Managing Employee** would be the district and/or regional managers for the territory in which the pharmacy is located.

An **"Agent"** is an individual who has the legal ability to bind the **Pharmacy or Pharmacy chain,** i.e., the **Pharmacy or Pharmacy chain** may use an **Agent** to obtain contracts for it.

Please provide the following information for **Owners**, persons with **Control** interests, **Agents** and **Managing employees** of the **Pharmacy or Pharmacy chain**. Attach a separate sheet if needed.

A. Master List

Name	Address For *individuals* use Home address. For pharmacy *entities* that might have ownership interest use all street addresses (if more than one location), and P.O. Box address if any.)	City	St.	ZIP	DOB	SSN for individuals or Tax ID for business entities	% own er-ship	Title

B. Specific Questions

1) Is any person on the **Master List** related to another person on the **Master List** as a spouse, parent, child or sibling?

Yes ☐ No ☐ If "Yes", please provide the following information about the related persons:

Name of First related person	Name of Second related Person	Type of relation

2) Does any person or entity in the **Master List** have an **Ownership** or **Control** interest in any other health care provider?

Yes ☐ No ☐ If "Yes", please provide the following information about the other health care provider the person on the **Master List** has an interest in.

Name of other Pharmacy provider	Address	City	State	Zip	Tax I.D.

3) Have any of the individuals or entities on the **Master list** been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, CHIP, Tricare or the Title XX services program since the inception of those programs?

Yes ☐ No ☐ If "Yes", please provide the information requested below:

Name on Court records	SSN /TIN	Matter of the Offense	Date of the Conviction	Exclusion Period of the Offense if you were excluded by the Federal Office of the Inspector General(OIG)

4) Have any of the individuals or entities on the **Master List** ever been **Debarred** from participation in Federal Government contracts? **"Debarred"** means an individual is not allowed to participate in contracts paid for by the Federal government, whether or not those contracts are in the pharmacy area.

Yes ☐ No☐ If "Yes", is checked, provide the following information:

When you were debarred	Length of Debarment	Reason for Debarment

5) Has any person or entity on the **Master List** ever been **Excluded** from participation in Federal pharmacy programs (Medicare, Medicaid, CHIP or Tricare) in the past. "Excluded" means that a person or entity has been told by the Department of Health and Human Services, Office of the Inspector General (HHS, OIG) that they may no longer work for any federally funded pharmacy program.

Yes ☐ No☐ If "Yes", please supply the following information:

Name of Individual	Beginning date of exclusion or termination	End date of exclusion or termination	Reason for exclusion or termination

6) Has any person or entity on the **Master List** ever been **Terminated** from a State's Medicaid or CHIP programs for reasons having to do with Program Integrity (fraud or abuse)? **Terminated** means the person or Pharmacy lost the right to bill a State's Medicaid or CHIP programs for a cause related to fraud or abuse.

Yes ☐ No☐ If "Yes", please supply the following information:

State where practicing when terminated	Reason for termination	Date of termination

7) Has any person or entity on the **Master List** ever had Civil Monetary Penalties (CMPs) assessed against them? A CMP is a type of fine assessed against a person or Pharmacy by a governmental agency that manages a federal pharmacy program.

Yes ☐ No☐ If "Yes", please supply the following information:

Name Of Individual	State where practicing when CMP assessed	Reason for CMP	Amount of CMP	Date of CMP

8) Did anyone on the **Master List** obtain their **Ownership** interest 1) as a result of a transfer of ownership from someone who was about to be Excluded or Terminated from participation in a Federal pharmacy program, or was in fact Excluded or terminated from participation in a federal pharmacy Program and 2) where the original **Owner** is or was a member of the **current Owner's Immediate Family** or M**ember of** the current owner's H**ousehold**, at the time of the transfer of ownership? [**Immediate Family** is defined as a person's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother or stepsister; father, mother, daughter, son, brother or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild. **Membe**r **of Household** is, with respect to a person, any individual with whom they are sharing a common abode as part of a single family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of household.]

Yes ☐ No ☐ If "Yes", please supply the following information:

Name of original **Owner**	SSN or TAX ID of original **Owner**	Place of Transfer	Date of Transfer

9a) List any **Subcontractor** in which this **Pharmacy or Pharmacy chain** has a direct or indirect **Ownership** interest of at least a 5%. A **Subcontractor** is a person or company that this **Pharmacy or Pharmacy chain** has contracted with to do some of the **Pharmacy or Pharmacy chain** business functions related to providing pharmacy services, i.e., billing agent, or provide medical services i.e. a medical lab.

Name of Subcontractor	Address	City	State	Zip	Tax I.D.

9b) For each **Subcontractor(s)** listed in 9a above please provide the following information for the individuals with an **Ownership** or **Control** interest in the **Subcontractor(s).** See the Introduction section above for a definition of those terms. Attach a separate sheet if necessary.

Name	Address (for individuals use Home address, for business entities that might have ownership interest use business street address, and P.O. Box address if any.)	City	State	Zip	DOB	SSN for individ-uals or Tax ID for business entities	% of own er-ship	Title

9c) Is anybody in the list in 9b list related to any person in the **Master List** above?

Yes ☐ No☐ If "yes", please supply the following information about the related persons:

Name of First related person	Name of Second related Person	Type of relation

III. Business transactions

1) Please list the **Subcontractors** with whom you have done business over the last 5 years where the contract is worth at least 5% of your **Pharmacy or Pharmacy chain** total operating expenses *or* $25,000 *whichever is less*. Use a separate sheet if necessary. *Do not* include the Subcontractors listed in II.9a. in which you have an ownership interest. A **Subcontractor** is a person or company that this **Pharmacy or Pharmacy chain** has contracted with to do some of the **Pharmacy or Pharmacy chain** business functions related to providing pharmacy services, i.e., billing agent, or to provide medical services, i.e., a medical lab.

Name	Address	City	State	Zip

2) Does the **Pharmacy or Pharmacy chain** *wholly own* a **Supplier**? **Supplier** means an individual, agency, or organization from which the **Pharmacy or Pharmacy chain** *purchases goods and services* used in carrying out its responsibilities under Medicaid and CHIP (e.g., a commercial laundry, a manufacturer of hospital beds or a pharmacy.)

Yes ☐ No ☐ If "yes", supply the following information about the **Supplier:**

Name	Address	City	State	Zip	NPI	TIN

IV Signature

The State or Federal Medicaid/CHIP agency may refuse to enter into, renew, or terminate an agreement with a Pharmacy if it is determined that a Pharmacy did not fully, accurately, and truthfully make the disclosures required by this statement. Additionally, false statements or representations of the required disclosures may be prosecuted under applicable federal or state laws. 42 C.F.R. § 455.106. The signature below **MUST** be the written signature of an individual who can legally bind this **Pharmacy or Pharmacy chain**.

Name of Person (Printed)	Signature of Person	Title	Date