



GOOD NEIGHBOR PHARMACY PROVIDER NETWORK ATTESTATION FOR PARTICIPATION IN THE MEDICARE PART D PROGRAM

This Attestation was created by GNPPN to satisfy mandatory regulatory requirements related to recently released guidance from the Centers for Medicare and Medicaid Services "CMS" and Agreements and Addendums with PBM's/Payers signed on your behalf to participate in Medicare Part D Programs.

1. The pharmacy provides fraud, waste and abuse training to all employees and managers within 30-days of their date of hire and annually thereafter, who are directly or indirectly involved with the administration or delivery of Part D benefits programs.
2. The pharmacy has reviewed the DHHS OIG and General Services Administration (GSA) procurement and non-procurement lists for all new employees or contractors and will review at least once a year thereafter to ensure that any employee or contractor that assists in the administration or delivery of Part D benefits is not excluded from Federal healthcare programs. If an employee or contractor is on such lists, the pharmacy shall immediately remove the employee or contractor from any work related directly or indirectly to all Federal healthcare programs and will take appropriate corrective actions.
 - a. <http://exclusions.oig.hhs.gov/> - OIG List of Excluded Individuals/Entities Search
 - b. <http://www.epls.gov/> - GSA Excluded Parties List System
3. The pharmacy will provide a copy of attendance logs, training materials, and other evidence in support of compliance with points 1 and 2 for inspection and review upon request during a scheduled on-site audit or other review process.
4. The pharmacy will have a code of conduct policy and procedures in place to detect, prevent, and correct fraud, waste and abuse.
5. The pharmacy will require its managers, officers, and directors responsible for the administration or delivery of Part D benefits to sign a conflict of interest statement, attestation, or certification at the time of hire and annually thereafter certifying that the managers, officers, or directors are free from any conflict of interest in administering or delivering Part D benefits. This certification should state (1) that the individual has reviewed the organization's conflict of interests policy; (2) that the individual has disclosed any potential conflict of interests; and (3) that the individual has obtained management approval to work despite any conflicts or has eliminated the conflict.
6. The pharmacy has a record retention policy in place that complies with the ten-year record retention requirement.



7. The pharmacy tracks employee and manager attendance for any training conducted.
8. The pharmacy is aware of and follows the requirements for Medicare Part D sales and marketing activities.
9. The pharmacy posts or distributes notices at the counter instructing beneficiaries to contact their plans to obtain a coverage determination, formulary exception or tier exception if they disagree with information provided by the pharmacist.
10. The pharmacy agrees that in no event shall pharmacy attempt to collect an amount greater than the Cost Share Amount or charge any additional fee to a Beneficiary in connection with the purchase of a Covered Pharmaceutical Service covered by a Medicare Part D Plan.
11. The pharmacy dispensing home infusion agrees to provide delivery of home infusion drugs within 24 hours of discharge from an acute setting, or later if so prescribed.

Pharmacy understands that your ability to provide services to members with Medicare Part D Benefits is contingent upon compliance with all Centers for Medicare and Medicaid Services "CMS" guidance, rules and regulations as well as the terms and conditions outlined in this document.

PHARMACY HAS READ AND ATTESTS THAT IT AGREES AND IS IN COMPLIANCE WITH THE TERMS AND CONDITIONS SET FORTH ON THE ATTACHED PAGES.

FOR PHARMACY:

Pharmacy Name*

NCPDP#

NPI#

Authorized Signature

Printed Name of Authorized Person Signing

Title

Date

*Pharmacy owners with multiple GNPPN pharmacies may attach a separate sheet with the Pharmacy Name, NCPDP# and NPI#.



Please indicate method of education and training that your organization utilized to comply with CMS requirements:

SELECT ONE

Training and education provided by a Medicare Advantage and/or Part D Sponsor

Name of Program _____

LearnSomething

CVS/Caremark

MemberHealth (available November 2009)

Other _____ (please specify)

PLEASE FAX YOUR RESPONSE TO 845-483-1778