Medicaid Provider ID: _____
or, Application Tracking Number (ATN)

0 1 0 0

Medicaid Pharmacy Point Of Service
Vendor Certification And Claim Submission Authorization Form

This form must be completed by pharmacies that will submit claims electronically through a Point of Service (POS) device.

This Pharmacy Point of Service Agreement (hereinafter AGREEMENT), is made and entered into by and between: _____ (herein after called PROVIDER) and
(Provider Name)
the Florida Agency for Health Care Administration (herein after called AGENCY), acting in its own right as the agency responsible for administering the Medicaid Program (Title XIX).

In consideration of the mutual promises and covenants contained herein and other good and valuable consideration, the parties hereto agree as follows:

1. This Agreement is in addition to the Provider Enrollment Application between the Agency and Provider, including, but not limited to the right of the Agency or its representatives to perform audit functions or the requirement that the Provider maintain the original prescription on file.
2. Provider shall submit to the Agency, through the fiscal agent (hereinafter called Agent), for Florida Medicaid, via a Point of Service (POS) device, claims for prescriptions dispensed to Florida Medicaid recipients.
3. The Provider shall safeguard the Medicaid program against abuse in its utilization of claims entry through the POS system.
4. The Provider shall correctly enter the claims data, monitor the data and certify that the data entered is correct.
5. The Provider shall reverse any claim adjudicated and then not dispensed to a Medicaid recipient. Claim reversals are limited in their use by Medicaid policy.
6. The Provider shall allow the Agency access to claims data and assure that transmission of claims data is restricted to authorized personnel to preclude erroneous payment by the Agent resulting from carelessness or fraud.
7. The Provider shall allow the Agency or any of its designees and representatives of the Office of the Medicaid Fraud Control Unit to review and copy all records.
8. The Provider shall abide by all Federal and State statutes, rules, regulations and manuals governing the Florida Medicaid program and those conditions as set out in the State of Florida, Agency for Health Care Administration Medicaid Provider Agreement entered into previously.

In addition, the provider does hereby appoint _____ , using
(Telecommunication Switch Vendor)
_____ , _____ , as their agent,
(System Name) *(System Certification Number)*
for the provider and in their name, to submit Medicaid claims electronically to Florida Medicaid via the Point of Service medium for processing. The provider does hereby agree to indemnify and hold the aforementioned agent harmless from any and all liability resulting from claims submitted by them for the provider's account.

IN WITNESS WHEREOF, the undersigned affirms that he or she is the Medicaid provider indicated above or, if the provider is an entity, is an authorized signer for the entity. That he or she has caused this request to be duly executed and does, under the penalty of perjury, swear or affirm that the foregoing is true and correct.

_____ _____
(Print Name of Authorized Signer) *(Title)*

_____ _____
(Signature of Authorized Signer) *(Date)*

Statement of Notary

"SWORN AND SUBSCRIBED by the above-signed party, who is (check one) __ personally known to me, or __ produced positive identification (ID type and number) _____."

_____
(Notary Public Signature)
My commission expires: _____