Instructions for Completing the Pharmacy Immunization Administration Deeming Form

Field Number	Field Name	Description
Field 1	**Existing Texas Provider Identifier (TPI):** *(9-digit)*	If you are already enrolled in Texas Medicaid or Children with Special Health Care Needs (CSHCN) Services Program, enter your existing 9-digit TPI.
Field 2	**National Provider Identifier (NPI):** *(10-digit)*	Enter your 10-digit NPI. If you are unable to obtain an NPI, please write N/A in the field and skip Field 4.
Field 3	**Provider name:**	Enter the name of the provider wishing to enroll.
Field 4	**Taxonomy code available for selection:** *(10-digit)*	Enter your primary taxonomy code. Skip this field if you entered N/A in Field 2. If you are a pharmacy group provider, include the appropriate taxonomy code.
Field 5	**Physical address:**	Enter your physical address including city, state, and ZIP + 4. This cannot be a P.O. Box.
Field 6	**Accounting/mailing address:**	Enter your accounting/mailing address including city, state, and ZIP + 4 if it is different than your physical address.
Field 7	**Medicare information:**	If applicable, providers must attach a copy of their Medicare enrollment letter or Remittance Advice Notice (MRAN) and a copy of their Medicare mass immunization designation letter. These documents must be dated within four weeks of the application submission date.
Field 8	**Legal name according to the IRS:** Must match the legal name field on the W-9.	Enter your legal name as reported to the IRS. It must match the information submitted on the W-9.
Field 9	**Federal Tax ID number:**	Enter your 9-digit Federal Tax ID number. It must match the information submitted on the W-9.
Field 10	**Provider signature:**	The original signature of the provider or an authorized representative of the provider is required. The signature of all performing providers is required.
Field 11	**Date:** MM/DD/YYYY	Enter the date this form was signed.
Field 12	**Printed name:** first, midle, and last	Print the name of the person signing the form.
Field 13	**Date of birth:** MM/DD/YYYY	Enter the date of birth of the provider wishing to enroll.
Field 14	**Social Security Number:**	Enter the Social Security Number of the provider wishing to enroll.

Texas State Health-Care Pharmacy Deeming Form

Pharmacies requesting to be deemed as an administrator of immunizations or vaccinations for the Texas Medicaid program may complete and submit this form to update their provider enrollment file. Print or type all of the information on this form. Mail the completed form and the additional required documentation to the address at the bottom of the page.
Reference: TAC, Title 22, Part 15, Chapter 295, Rule §295.15

1. Existing Texas Provider Identifier (TPI): *(9-digit)*	**2. National Provider Identifier (NPI):** *(10-digit)*

3. Provider name:

4. Taxonomy code available for selection: *(10-digit)*

5. Physical address:

Number	Street	Suite	City	State	ZIP+4

Telephone number:	**Fax number:**	**Provider business e-mail:**

6. Accounting/mailing address:

Number	Street	Suite	City	State	ZIP+4

Telephone number:	**Fax number:**

7. Medicare information:

- ☐ Copy of your Medicare enrollment letter or Remittance Advice Notice (MRAN) that is not older than four weeks from the application submitted date *(if applicable)*
- ☐ Copy of your Medicare mass immunization designation letter *(if applicable)*
- ☐ Completed W-9 – Request for Taxpayer Identification Number and Certification

8. Legal name according to the IRS: Must match the legal name field on the W-9.	**9. Federal Tax ID number:**

I certify that the information I have supplied in this document constitutes true, correct, and complete information. I agree to inform HHSC or its designee, in writing, of any changes or if additional information becomes available. I understand that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and/or state law. Fraud is a felony, which can result in fines or imprisonment. I understand that any falsification or misrepresentation that, if known, would have resulted in a denial of the application will result in all paid services declared as an overpayment and subject to recoupment. I also understand that other administrative sanctions may be imposed that includes payment hold, exclusion, debarment, contract cancellation, and monetary penalties. I also understand that the enrollment period will be effective for 180 days from the enrollment date. Accordingly, in order to continue Medicaid, participation beyond the enrollment period, a completed Texas Medicaid Provider Enrollment application must be submitted.

10. Provider signature:	**11. Date:** MM/DD/YYYY

12. Printed name: first, midle, and last

13. Date of birth: MM/DD/YYYY		**14. Social Security Number:**	

Mail the completed form and required documentation to:

Texas Medicaid &Healthcare Partnership
Provider Enrollment
P.O. Box 200795
Austin, Texas 78720-0795

Effective date: 10/01/09

Owners, Partners, Officers, Directors, and Principals

Identify sole proprietor or owners, partners, officers, directors, and principals [as defined in Principal Information Form (PIF-2)] of the applicant by providing, social security number, date of birth, driver's license # and state, and list the percentage of ownership, if applicable. Total ownership should equal 100%. As it relates to owners, include all individuals with 5% or more ownership in the company, whether this ownership is direct or indirect.

1	**Name:**		**Title:**	**Percentage Owned:**
	Social Security Number:	**Date of birth:** MM/DD/YYYY	**Drivers license number/State issuer:**	
2	**Name:**		**Title:**	**Percentage Owned:**
	Social Security Number:	**Date of birth:** MM/DD/YYYY	**Drivers license number/State issuer:**	
3	**Name:**		**Title:**	**Percentage Owned:**
	Social Security Number:	**Date of birth:** MM/DD/YYYY	**Drivers license number/State issuer:**	
4	**Name:**		**Title:**	**Percentage Owned:**
	Social Security Number:	**Date of birth:** MM/DD/YYYY	**Drivers license number/State issuer:**	

Group Practice *Required if enrolling as a Group Practice*

Indicate the enrollment type requested by selecting one of the following:

☐ **Adding additional performing provider(s) to an existing group.** (*Indicate Group TPI below.*)

☐ **Enrolling a new group with performing provider(s).**

Group 9-digit Texas Medicaid TPI :	**Group Medicare number:** *(if applicable)*

Certification Statement

I certify that the information I have supplied in this document constitutes true, correct, and complete information. I agree to inform HHSC or its designee, in writing, of any changes or if additional information becomes available. I understand that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and/or state law. Fraud is a felony, which can result in fines or imprisonment. I understand that any falsification or misrepresentation that, if known, would have resulted in a denial of the application will result in all paid services declared as an overpayment and subject to recoupment. I also understand that other administrative sanctions may be imposed that includes payment hold, exclusion, debarment, contract cancellation, and monetary penalties. I also understand that the enrollment period will be effective for 180 days from the enrollment date. Accordingly, in order to continue Medicaid, participation beyond the enrollment period, a completed Texas Medicaid Provider Enrollment application must be submitted.

1.	**Name:**		**Date of birth:** MM/DD/YYYY	**Social Security Number:**
	Professional license number:	**Professional license initial issue date:** MM/DD/YYYY	**Pharmacist certification issue date:** MM/DD/YYYY	**Medicare number:**
	Taxonomy code:	**NPI number(s):**	**Signature (ceritification statement):**	
2.	**Name:**		**Date of birth:** MM/DD/YYYY	**Social Security Number:**
	Professional license number:	**Professional license initial issue date:** MM/DD/YYYY	**Pharmacist certification issue date:** MM/DD/YYYY	**Medicare number:**
	Taxonomy code:	**NPI number(s):**	**Signature (ceritification statement):**	
3.	**Name:**		**Date of birth:** MM/DD/YYYY	**Social Security Number:**
	Professional license number:	**Professional license initial issue date:** MM/DD/YYYY	**Pharmacist certification issue date:** MM/DD/YYYY	**Medicare number:**
	Taxonomy code:	**NPI number(s):**	**Signature (ceritification statement):**	
4.	**Name:**		**Date of birth:** MM/DD/YYYY	**Social Security Number:**
	Professional license number:	**Professional license initial issue date:** MM/DD/YYYY	**Pharmacist certification issue date:** MM/DD/YYYY	**Medicare number:**
	Taxonomy code:	**NPI number(s):**	**Signature (ceritification statement):**	