KERN HEALTH SYSTEMS

Pharmacist Services (AB 1114)
KHS - Request Form

***NOTE: Individual Pharmacist must be actively enrolled and approved in DHCS Medi-Cal ORP before applying for participation in the AB1114 designated services**

FURNISHING PHARMACIST: (FIRST, LAST, DEGREE)		**PHARMACIST INDIV NPI #:**	
PHARMACIST LICENSE #:		**ORP ENROLLED:**	☐ YES ☐ NO *See Note
PHARMACY LEGAL NAME:		**PHARMACY TIN:**	
PHARMACY GROUP NPI:		**PHARMACY LOCATION:**	

REQUIREMENTS:	**ATTESTATION:**
1. Eligibility – I understand this is a benefit for Medi-Cal Fee-for-Service beneficiaries including Medi-Cal Managed Care Plan beneficiaries such as Kern Family Health Care members?	☐ YES ☐ NO
2. Billing Provider (Pharmacy) – I understand my billing provider must be enrolled by Medi-Cal FFS as a Pharmacy Provider (not the pharmacist)?	☐ YES ☐ NO
3. Furnishing Pharmacist – I attest, as an individual furnishing pharmacist, I am enrolled as a Medi-Cal ordering, referring and prescribing provider (ORP)?	☐ YES ☐ NO
4. Reimbursement & Billing – I attest, that my billing provider (Pharmacy) is able to bill ASC X12N 837 electronic claims submission. I further understand I may not submit claims on a Pharmacy claim Form or on a Compound Drug Pharmacy Claim Form for these services?	☐ YES ☐ NO **KHS Payer ID 77093** **KHS acceptable clearinghouses:** **Office Ally, SSI, Relay Health, Change Healthcare**

5. ELIGIBLE SERVICES (Medical Provider Manual (Pharmacist Services)

I attest that the eligible services will be provided consistent with the requirements outlined in the Business and Professions Code and California Code of Regulations, I possess the education/training and can provide the necessary documentation for these services:

ONLY CHECK THOSE THAT APPLY

☐ YES	**Furnishing travel medications (BPC § 4052(a) (10) (A) (3) and 16 CCR 1746.5)**
☐ YES	**Furnishing naloxone hydrochloride (BPC § 4052.01 and16 CCR §1746.3)**
☐ YES	**Furnishing self-administered hormonal contraception (BPC § 4052.3 and 16 CCR §1746.1).**
☐ YES	**Initiating and administering immunizations (BPC § 4052.8 and 16 CCR §1746.4)**
☐ YES	**Providing tobacco cessation and furnishing nicotine replacement therapy (BPC § 4052.9 and 16 CCR §1746.2).**
☐ YES	**Furnishing HIV Pre-Exposure and Post-Exposure Prophylaxis (BPC § 4052.02 & 4502.03)**

6. AUDITING REQUIREMENTS:

- **Pharmacist providing the service will retain proof of successful completion of any required certification, training or continuing education.**
- **Pharmacy will retain all required documentation of patient, physician or other provider interactions.**

☐ YES ☐ NO

7. MEDICAL RECORDS DOCUMENTATION

- **I understand and attest to the DHCS Medical Record documentation requirements; the record storage and security requirements; and that the record must be complete, legible and concise.**

☐ YES ☐ NO

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Release of Information:

I, furnishing pharmacist, grant Kern Health Systems permission to contact any individual, institution, facility or agency identified, to evaluate the information provided or requested in support of my request to provide Pharmacist Services pursuant to AB 1114. I, further understand, that I have the burden of producing adequate information for the proper evaluation upon request from KHS, or DHCS if requested, to validate my qualifications, and resolve any doubts about my qualifications.

I hereby grant permission for Kern Health System Representatives to conduct on-site and medical record reviews as necessary. I agree that I, the furnishing pharmacist and my pharmacy will participate in and support Kern Health System's quality improvement and utilization review programs.

Release from Liability:

I, the undersigned, hereby release from any and all liability Kern Health Systems (KHS or Health Plan name: Kern Family Health Care), its respective agents and employees, for acts performed in good faith in connection with evaluating my qualifications. I also release from any and all liability all individuals and organizations who in good faith, at any time, provide KHS with information concerning this application.

I also herby attest to the correctness and completeness of this request and agree to notify KHS of any changes to information provided herein in accordance with timely notification as outlined in the contractual agreement.

Attestation:

I understand and hereby attest, and certify, that all information submitted on this form is true, accurate, and complete to the best of my belief and knowledge. I fully understand that any falsifications, misstatements in or omissions from the form, whether intentional or not, may constitute cause for termination from participation from the KHS Health Plan Pharmacist Eligible Services.

Signature: _____ Date: _____

Print Name: _____

Credentialing Office Use Only:

☐ Pharmacist License Verified In good Standing: ☐ YES ☐ NO / Date Verified: _____ Initials: _____

☐ Pharmacist ORP Verified In good Standing: ☐ YES ☐ NO / Date Verified: _____ Initials: _____

☐ Pharmacy FFS Verified In good Standing: ☐ YES ☐ NO / Date Verified: _____ Initials: _____