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| **NEW ACCOUNT APPLICATION** | |
| **Company Website** | Enter your website address. |
| **Contact Name Person completing the form** | Enter Contact person name here. |
| **Billing Name** | Enter Full Name here. |
| **Billing Address** | Enter your Billing Address here. |
| **Buyer Contact Name** | Enter Full Name here. |
| **Buyer Email Address** | Enter valid Email address here. |
| **Buyer Telephone Number** | Enter phone number here. |
| **Accounts Payable Contact Name** | Enter Full Name here. |
| **Accounts Payable Phone Number** | Enter phone number here. |
| **Accounts Payable Email Address** | Enter valid Email address here. |

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| **Please fill in the ID below if applicable** |
| **340B ID (PHS Only):** Enter 340B ID here. |
| **The Billing and Shipping Addresses need to match the approved 340B set up on the Office of Pharmacy Affairs website** [**http://opanet.hrsa.gov/OPA/default.aspx**](http://opanet.hrsa.gov/OPA/default.aspx) |
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| **TRADE REFERENCES** | | | | | |
|  | **Name of the Supplier** | **Address** | **Telephone** | **Account** | **Email** |
| **Manufacturer** | Enter Supplier Name. | Enter Address here. | Enter Phone number here. | Enter Account number here. | Enter valid Email address. |
| **Wholesaler** | Enter Supplier Name. | Enter Address here. | Enter Phone number here. | Enter Account number here. | Enter valid Email address. |

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| **TYPE OF PRODUCT TO BE PURCHASED** |
| |  |  | | --- | --- | | **Estimated Annual Purchases ($)** | Enter Amount here. |   **☐Diabetes Growth Hormone Hemostasis Hormone Therapy**  **Devices** |

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| **SHIPPING LOCATION DETAILS** | | |
| **Type of Business** |  |  |
| **Other (Please specify)** | Please specify if Other. | Please specify if Other. |
| **Shipping Location Name** | Enter Name here. | Enter Name here. |
| **Shipping Address**  **\* Please provide each shipping point if multiple locations apply** | Enter Shipping Address | Enter Shipping Address |
| **Is the Location Owned by Billing Company?** | Choose an item. | Choose an item. |
| **Receiving Department Contact Name** | Enter Contact Name | Enter Contact Name |
| **Receiving Department Telephone Number** | Enter phone number | Enter phone number |
| **Receiving Department Email Address** | Enter valid email address. | Enter valid email address. |
| **DQSA Email Address**  **Responsibility for LOT TRACEABILITY** | Click here to enter text. | Click here to enter text. |
| **LICENSES/IDENTIFIERS**  **Please include a copy of your DEA Certificate and/or Pharmacy License** | | |
| **State License Number \*\* attach .pdf copy of current license.** | Enter valid SLN here. | Enter valid SLN here. |
| **DEA Number \*\* attach .pdf copy of current license.** | Enter valid DEA Number here. | Enter valid DEA Number here. |
| **Health Industry Number (HIN)** <http://www.hibcc.org/> | Enter HIN here. | Enter HIN here. |
| **State Licenses must be provided for the Contract Pharmacy and the Covered Entity for all 340B Contract Pharmacy account requests.** | | |
| **For information regarding the Health Industry Number (HIN), please refer to the website provided above.** | | |
| **SHIPPING LOCATION DETAILS** | | |
| **Type of Business** |  |  |
| **Other (Please specify)** | Please specify if Other. | Please specify if Other. |
| **Shipping Location Name** | Enter Name here. | Enter Name here. |
| **Shipping Address**  **\* Please provide each shipping point if multiple locations apply** | Enter Shipping Address | Enter Shipping Address |
| **Is the Location Owned by Billing Company?** | Choose an item. | Choose an item. |
| **Receiving Department Contact Name** | Enter Contact Name | Enter Contact Name |
| **Receiving Department Telephone Number** | Enter phone number | Enter phone number |
| **Receiving Department Email Address** | Enter valid email address. | Enter valid email address. |
| **DQSA Email Address**  **Responsibility for LOT TRACEABILITY** | Click here to enter text. | Click here to enter text. |
| **LICENSES/IDENTIFIERS**  **Please include a copy of your DEA Certificate and/or Pharmacy License** | | |
| **State License Number \*\* attach .pdf copy of current license.** | Enter valid SLN here. | Enter valid SLN here. |
| **DEA Number \*\* attach .pdf copy of current license.** | Enter valid DEA Number here. | Enter valid DEA Number here. |
| **Health Industry Number (HIN)** <http://www.hibcc.org/> | Enter HIN here. | Enter HIN here. |
| **State Licenses must be provided for the Contract Pharmacy and the Covered Entity for all 340B Contract Pharmacy account requests.** | | |
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