



COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

1570 Grant Street, Denver, CO 80203-1818 • (303) 866-2993 • (303) 866-4411 Fax • (303) 866-3883
John W. Hickenlooper, Governor • Susan E. Birch MBA, BSN, RN, Director

Dispensing Fee Attestation Worksheet

The Colorado Department of Health Care Policy and Financing (the Department) reimburses outpatient pharmacies for both the costs related to acquiring a drug from a wholesaler or manufacturer and the costs related to dispensing the drug to a Medicaid client. There are six distinct dispensing fees which are based upon a billing pharmacy's total prescription volume or whether the billing pharmacy is a rural pharmacy or a state run pharmacy. The dispensing fees and their requirements are as follows:

Requirements	Dispensing Fee
0 – 59,999 TAPV :	\$13.40
60,000 – 89,999 TAPV :	\$11.49
90,000 – 109,999 TAPV :	\$10.25
110,000 + TAPV :	\$ 9.31
Rural Pharmacy :	\$14.14
State Run Pharmacy :	\$ 0.00

TAPV = Total Annual Prescription Volume

This form is intended to establish a dispensing fee for any new pharmacy enrolling as a Medicaid provider. A new pharmacy must complete this worksheet stating their total prescription volume for the previous twelve (12) months before any claims will be paid by the Department. If a new pharmacy has been open for less than one year, the pharmacy should include the total prescription volume for the months the pharmacy has been open.

The attestation worksheet can be found on the second page of this document. A new pharmacy should complete every field to the best of their ability and email the letter to the Department at Colorado.SMAC@HCPF.state.co.us with the subject header 'Attestation Worksheet'.

This document must be completed and sent to the Department before any Medicaid claims will be paid. All claims submitted will be denied until this process is completed.

If you have any questions or concerns, please email Colorado.SMAC@HCPF.state.co.us.



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Pharmacy Information

Name of Pharmacy :
Street Address :
City :
State :
Zip Code :
Medicaid ID :
Telephone No. :
Fax No. :

Total Annual Prescript Volume

Please list the total number of prescriptions dispensed in the last 12 months. If the pharmacy has been open for less than 12 months, please list the total number of prescriptions dispensed for the months the pharmacy has been open.

Total Prescriptions :
Date Range :

Prescription Volume Breakdown

Please list the approximate percentage of prescriptions dispensed for each classification.

Medicaid : % **Medicare :** %
Other 3rd Party : % **Cash :** %

Preparer's Signature

I hereby attest that the information in the survey herein is complete and accurate to the best of my knowledge. I understand that whoever knowingly and willfully makes or causes to be made a false statement or representation on the reports may be prosecuted under applicable State laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate, or where the entity already participates, a termination of a Primary Contractor's contract with the Colorado Department of Health Care Policy and Financing.

- For electronic submission, check box, type full name, and date as acceptance that information provided is complete and accurate to the best of your knowledge.

Signature :
Print/Type Name :
Title/Position :
Date :
Phone Number :
Email Address :