



**COMMONWEALTH OF VIRGINIA**  
 Virginia Department of Health Professions  
*Prescription Monitoring Program*

**Perimeter Center**  
 9960 Mayland Drive, Suite 300  
 Henrico, Virginia 23233  
 Phone: (804) 367-4514  
 Fax: (804) 527-4470  
 Email: [pmp@dhp.virginia.gov](mailto:pmp@dhp.virginia.gov)  
 Website: [www.dhp.virginia.gov](http://www.dhp.virginia.gov)

**APPLICATION TO REGISTER AS AN VIRGINIA MEDICAID MANAGED CARE AUTHORIZED AGENT  
 CLINICAL DESIGNEE TO RECEIVE INFORMATION FROM THE PRESCRIPTION MONITORING  
 PROGRAM**

**Please provide the information requested below. (Print or Type) Use full name not initials**

Name:		Provide Virginia License # from the Department of Health Professions: License #: _____	
Work Address		City	
State Virginia	Zip Code	Work Area Code and Telephone Number	
Fax Number:	Email Address:	Date of Birth:	
Name of Managed Care Organization (MCO):		Name of MCO Physician or Pharmacist Supervisor: Printed Name:	

**Signature of MCO Physician or Pharmacist Supervisor:**

I hereby attest that I am eligible to receive reports under §54.1-2523 (C-9) of the Code of Virginia from the Prescription Monitoring Program.  
 Sign Here and below:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**AFFIDAVIT**

(To Be Completed By Applicant Before a Notary Public)

(Printed Name) \_\_\_\_\_ certifies that he is the person referred to in this application for registration with the Prescription Monitoring Program and that the information provided is factual and complete.

\_\_\_\_\_  
 Signature of Applicant

**Subscribed and sworn to me, a notary public in and for the Commonwealth of Virginia at large, on this**  
**\_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_. My commission expires on \_\_\_\_\_, \_\_\_\_\_**

\_\_\_\_\_  
**Signature of Notary Public**

I hereby attest that \_\_\_\_\_ is approved for access to the Prescription Monitoring Program and is an employee of \_\_\_\_\_ entitled to receive reports from the Prescription Monitoring Program pursuant to §54.1-2523 (C-9) of the Code of Virginia (See below for language).

Department of Medical Assistance Services Approval Designee:

Title: \_\_\_\_\_ Printed Name: \_\_\_\_\_

Signature of Designee: \_\_\_\_\_ Date: \_\_\_\_\_

Subscribed and sworn to me, a notary public in and for the Commonwealth of Virginia at large, on this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_. My commission expires on \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
Signature of Notary Public

Registration as an agent authorized to receive reports shall expire on June 30 of each even-numbered year or at any time as the agent leaves or alters his current employment or otherwise becomes ineligible to receive information from the program.

**For Department Use Only**

Date Received:

Director or Designee Signature:

Date Completed:

*(Effective July 1, 2017)*  
**§54.1-2523 Paragraph C**

9. Information about a specific recipient who is a member of a Virginia Medicaid managed care program to a physician or pharmacist licensed in the Commonwealth and employed by the Virginia Medicaid managed care program or to his clinical designee who holds a multistate licensure privilege to practice nursing or a license issued by a health regulatory board within the Department of Health Professions and is employed by the Virginia Medicaid managed care program. Such information shall only be used to determine eligibility for and to manage the care of the specific recipient in a Patient Utilization Management Safety or similar program. Notice shall be given to recipients that information may be requested by a licensed physician or pharmacist employed by the Virginia Medicaid managed care program from the Prescription Monitoring Program.