Form Approved
OMB No. 0938-1016

MEDICARE DMEPOS COMPETITIVE BIDDING PROGRAM

For CMS Use Only

Supplier Bidder No.	Date Application Received

FORM A: APPLICATION

Item #1: Application for Suppliers

Please read the instructions completely.

Competitive Bid Area (CBA)

Indicate Supplier Type (pick no more than one)

❑ Individual Supplier with a Single Location ❑ Primary Network Supplier

❑ Supplier with Common Ownership and Multiple Locations

Are you a specialty supplier? ❑ Yes ❑ No

Product Category

Select each product category for which the supplier or network is submitting a bid. (Product categories to be supplied later, for example.)

❑ Product Group 1 ❑ Product Group 2 ❑ Product Group 3

A. Supplier's Identifying Information

Provide the legal business name and mailing address as reported to the IRS. Mailing address is the address where the IRS Form 1099 is to be mailed for this supplier.

Supplier's Legal Business Name

Mailing Address (Street)

City	State	ZIP Code

Telephone Number *(Include Area Code)*	E-Mail Address	Fax Number *(Include Area Code)*

B. Supplier's Business Information

Indicate the length of time the supplier completing this form has been supplying DMEPOS items in the CBA.

Length of Time Supplying DMEPOS Items in the CBA

Years Months

C. Supplier's Primary Physical Address

If the supplier's primary physical address is not the same as the mailing address, indicate the supplier's complete physical address.

Physical Address(es)

City	State	ZIP Code

D. Tax Identification Number

Provide the Tax Identification Number (TIN) issued by the IRS to the supplier completing this form. If a sole proprietor, social security number may be used.

Tax Identification No. (TIN)

Supplier's Legal Business Name	Supplier Bidder No.

E. NSC and NPI Identification Number

Provide the NSC and NPI number specific to this business location.

NSC Identification Number	NPI Identification Number

F. Service Type

How will you service beneficiaries in a CBA? Check all that apply:

❑ Retail Location
❑ Mail Orders
❑ Home Delivery

G. DBA – "Doing Business As" Name

Provide the "doing business as" (DBA) if different from the legal business name reported in item A.

Doing Business As (DBA) *(If applicable)*

Doing Business As (DBA) *(If applicable)*

H. Additional Physical Location Information

Provide all additional names and related information for the additional physical location(s) in which the supplier does business, within the CBA.

1. Name of Business	Telephone Number	NSC Number	NPI Number	TIN Number

Physical Address

City	State	ZIP Code

2. Name of Business	Telephone Number	NSC Number	NPI Number	TIN Number

Physical Address

City	State	ZIP Code

I. Accreditation Information for Locations Serving this Competitive Bid Area

Indicate the name(s) of the Medicare-approved organization(s) you are accredited by, or anticipate accreditation from, and provide the accreditation's issue and expiration dates. Indicate product specific area(s) you are accredited (i.e. oxygen, general DME).

1. Legal Business Name	Zip	Product Specific Area(s)

Accrediting Organization	Status ❑ Yes ❑ No ❑ Pending	Issue Date *(month/year)* (Current or Expected)	Expiration Date *(month/year)* (Current or Expected)

2. Legal Business Name	Zip	Product Specific Area(s)

Accrediting Organization	Status ❑ Yes ❑ No ❑ Pending	Issue Date *(month/year)* (Current or Expected)	Expiration Date *(month/year)* (Current or Expected)

Supplier's Legal Business Name	Supplier Bidder No.

J. Type of Business

Select type of business. If "Other," briefly describe the supplier's type of business. Definitions are provided in the Glossary.

❑ Business Corporation ❑ Sole Proprietorship ❑ General Partnership ❑ Joint Venture
❑ Professional Corporation ❑ Franchise ❑ Publicly Traded Company
❑ Other_____

K. Establishment Information

Enter the two-letter abbreviation for the state in which the supplier completing this form is established or incorporated. Also provide the date established or incorporated. If incorporated at a previous time, in another state, please provide the state and date.

Established/Incorporated		Previously Established/Incorporated	
State	Date *(mm/dd/yyyy)*	State	Date *(mm/dd/yyyy)*

L. Contact Person

Provide the name(s) of the contact person who should be contacted to answer questions regarding the supplier's bid.

Contact Person(s) First Name PRINT	Last Name	Title
Telephone *(include area code)*	E-Mail Address	
Contact Person(s) First Name PRINT	Last Name	Title
Telephone *(include area code)*	E-Mail Address	

M. Financial Information

1. Credit rating and score (See instructions)
2. Required Financials (See instructions)

Supplier's Legal Business Name	Supplier Bidder No.

N. Sanctions

Have you been subject to past or current sanctions? ❑ Yes ❑ No

(If yes, please see instructions.)

O. Key Personnel

Please include a list of names and current titles of key personnel of your company.

Name	Title
Name	Title
Name	Title
Name	Title
Name	Title

P. Additional Information (Optional)

The space provided may be used if additional room is needed to fully respond to other questions on this form.

Supplier's Legal Business Name	Supplier Bidder No.

Item #2: Application for Networks

(A) Enter the primary supplier's NSC and NPI numbers. The NSC and NPI numbers must be specific to the supplier's location – not the corporate number.

NSC Number	NPI Number

(B) Enter the primary supplier's legal business name.

Primary Supplier's Legal Business Name

(C) List the network members with their NSC and NPI numbers.

Member Legal Business Name	NSC Number	NPI Number
Member Legal Business Name	NSC Number	NPI Number

(D) Do network members have a signed legal contract? ❑ Yes ❑ No

If yes, please provide a copy along with other hardcopy documents required for bidding. Your bid will not be considered complete without a copy of the contract.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1016. The time required to complete this information collection is estimated to average 10 hours per response, including the time to review instructions, search existing data resources, gather the the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Blvd. Baltimore, Maryland 21244.