

MEDICARE DMEPOS COMPETITIVE BIDDING PROGRAM

| For CMS Use Only | |
|----------------------|---------------------------|
| Bidder No. | Date Application Received |
| Competitive Bid Area | |

| Supplier's Identifying Information | |
|------------------------------------|--|
| Supplier's Legal Business Name | Primary Supplier's Legal Business Name (if applicable) |

FORM B: BIDDING SHEET FOR _____

**Individual Form MUST be submitted for each Product Category. Primary Supplier Completes for Network.
Information supplied must be aggregate information for the Network.**

- 1)** What was the total revenue collected for this product category in this CBA by the supplier or network during the past calendar year? All subsequent questions must be answered for the same calendar year. Estimates are acceptable.
- \$0–\$250,000
 \$250,000–\$500,000
 \$500,000–\$750,000
 \$750,000–\$1 million
 \$1 million–\$3 million
 \$3 million–\$6 million
 \$6 million–\$10 million
 More than \$10 million

What percentage of the total revenue for this product category was collected from Medicare? Estimates are acceptable.

- 0% – 10%
 11% – 20%
 21% – 30%
 31% – 40%
 41% – 50%
 51% – 60%
 61% – 70%
 71% – 80%
 81% – 90%
 91% – 100%

- 2)** What was the total number of customers served in this CBA for this product category by the supplier or network during the past calendar year? Estimates are acceptable.
- 0 – 25
 26 – 50
 51 – 75
 76 – 100
 101 – 300
 301 – 500
 501 – 750
 751 – 1000
 More than 1,000

What percentage of the total customers for this product category were Medicare beneficiaries? Estimates are acceptable.

- 0% – 10%
 11% – 20%
 21% – 30%
 31% – 40%
 41% – 50%
 51% – 60%
 61% – 70%
 71% – 80%
 81% – 90%
 91% – 100%

- 3)** Indicate the counties in this CBA you currently serve for the product category. (If you do not serve an entire county, please indicate the zip codes you currently do not serve in these counties for this product category.)

| | |
|--|--|
| | |
| | |

What percentage of the total geographic area in these counties are you currently serving Medicare beneficiaries? _____

| | |
|--|--|
| | |
| | |

- 4)** The codes listed below are the HCPCS codes, based on CMS data, that are the top three codes in terms of volume for this product category. Please list by HCPCS Code the number of units provided to total customers, and to Medicare beneficiaries in this CBA during the last calendar year.

| | | |
|---------------------------------|---------------------------------|---|
| HCPCS Code | No. of Units Provided Generally | No. of Units Provided to Medicare Beneficiaries |
| To be completed by CBIC. | | |
| HCPCS Code | No. of Units Provided Generally | No. of Units Provided to Medicare Beneficiaries |
| HCPCS Code | No. of Units Provided Generally | No. of Units Provided to Medicare Beneficiaries |

5a) Indicate for the product category the percentage increase in Medicare business compared to your current Medicare business for this product category that you or your network would be capable of providing that would be applicable for all codes during a projected 12 month period for this CBA.

5b) If you plan to expand under the Competitive Bid Program, please discuss your expansion plan. Please consider the following when addressing the scope of your expansion plan. If additional space is required, please expand under item #7.

| | Current | Expansion Plan |
|--|---------|----------------|
| Staff (manpower) | _____ | _____ |
| Financing (funding levels) | _____ | _____ |
| Facilities (square footage, facility) | _____ | _____ |
| Inventory Control (method of tracking inventory) | _____ | _____ |
| Distribution Methods (vehicles, mail order) | _____ | _____ |
| Other | _____ | _____ |

5c) If you plan to expand through the use of subcontractors, to meet the goals of your expansion plan, identify the legal entities with which you anticipate entering into a subcontracting agreement in order to furnish DMEPOS items if awarded a competitive bid contract.

| Legal Name | Expected Function |
|------------|-------------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

5d) Please provide copies of signed letters of intent to sign an agreement with each subcontractor noted above that:

- Clearly identify the parties;
- Describe the functions/services to be performed by the subcontractor;
- Contain language clearly indicating that the subcontractor has agreed to supply items/functions/services;
- Contain anticipated length of agreement;
- Are signed by an authorized official of each party;
- Contain language obligating the subcontractor to abide by State and Federal privacy and security requirements, including the privacy provisions stated in the regulations for this program.

6) Are you submitting a bid in any other CBA for any product category? Yes No
If yes, please indicate product category/CBA.

Product Category

CBA

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

7) Optional (additional information):

| | |
|--------------------------------|---------------------|
| Supplier's Legal Business Name | Supplier Bidder No. |
|--------------------------------|---------------------|

Please sign and attach certification to financial statements.

Certifying Statement Applies to All Information Submitted Electronically or Hard Copy.

I have read the contents of this application. I hereby certify that I have examined the accompanying financial statements and I certify that they are a true, correct and complete statement that can be substantiated from our books and records. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete to the best of my knowledge, and I authorize the CBIC to verify this information. I agree to notify the CBIC in writing of any changes that may jeopardize my ability to meet the qualifications stated in this application prior to such change or within 30 days of the effective date of such change. I understand that such a change may result in termination of the approval. I also certify that I have read, understand, meet and will continue to meet all supplier standards as outlined in 42 CFR 424.57. If I become aware that any information in this application is not true, correct or complete, I agree to notify the CBIC of this fact immediately. I agree that if my program meets the minimum qualifications and is Medicare-approved, I will abide by the requirements contained in the Regulation and Section IV of this RFB and provide the services outlined in my application. Neither I, nor the owner, director, officer or employee of the (Supplier) or other organizations on whose behalf I am signing this certification statement, or any contractor retained by the company of any of the aforementioned persons, currently is subject to sanctions under the Medicare or Medicaid program, or disbarred, suspended or excluded under any other Federal agency or program, or otherwise prohibited from providing services to CMS or other Federal agencies. I understand that in accordance with 18 U.S.C. 1001, any omission, misrepresentation or falsification of any information contained in this application and all required attachments and supplemental information or contained in any communication supplying information to CMS or the CBIC to complete or clarify this application may be punishable by criminal, civil, or other administrative actions including revocation of approval, fees, and/or imprisonment under Federal law. I further certify that I am an authorized official of the (Supplier) that is applying for a DMEPOS competitive bidding contract within a specified CBA.

If I am a member of a network, I also certify that I cannot independently service the entire CBA.

| | |
|---|----------------|
| Authorized Official Supplier Name (First, Middle, Last, Jr., Sr., etc.) PRINT | Title/Position |
| Signature | Date |

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 14 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.

PUBLIC ADDRESS ANNOUNCEMENT FORM

Penalties for Falsifying Information on this Enrollment Application

This section explains the penalties for deliberately furnishing false information to gain enrollment in the Medicare program.

1. 18 U.S.C. § 1001 authorizes criminal penalties against an individual who, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry.

Individual offenders are subject to fines of up to \$250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to \$500,000 (18 U.S.C. § 3571). Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against any individual who, “knowingly and willfully,” makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program.

The offender is subject to fines of up to \$25,000 and/or imprisonment for up to five years.

3. The Civil False Claims Act, 31 U.S.C. § 3729, imposes civil liability, in part, on any person who:
 - a.) knowingly presents, or causes to be presented, to an officer or any employee of the United States Government a false or fraudulent claim for payment or approval:
 - b.) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or
 - c.) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

The Act imposes a civil penalty of \$5,000 to \$10,000 per violation, plus three times the amount of damages sustained by the Government.

4. Section 1128A(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency... a claim... that the Secretary determines is for a medical or other item or service that the person knows or should know:
 - a.) was not provided as claimed; and/or
 - b.) the claim is false or fraudulent.

This provision authorizes a civil monetary penalty of up to \$10,000 for each item or service, an assessment of up to three times the amount claimed, and exclusion from participation in the Medicare program and State health care programs.

5. The government may assert common law claims such as “common law fraud,” “money paid by mistake,” and “unjust enrichment.”

Remedies include compensatory and punitive damages, restitution, and recovery of the amount of the unjust profit.