Form Approved
OMB No. 0938-1016

MEDICARE DMEPOS COMPETITIVE BIDDING PROGRAM

For CMS Use Only

Supplier Bidder No. Date Application Received

Competitive Bid Area (CBA)

Supplier's Identifying Information

Supplier's Legal Business Name Primary Supplier's Legal Business Name (if network)

FORM A: APPLICATION FOR DMEPOS COMPETITIVE BIDDING PROGRAM

NOTE: Please read all instructions completely. Suppliers with a single location or multiple locations must complete Section 1 -1a: Application for Suppliers. Networks, however, must complete Section 2-2b: Application for Networks.

Indicate how your Business Organization will be Bidding (choose only one):

- ☐ Supplier with a Single Location (Complete Section 1-1a)
- ☐ Supplier with Multiple Locations (Complete Section 1-1a)
- ☐ Network (Complete Section 2-2b)

Section 1: Application for Suppliers

Are you a Skilled Nursing Facility (SNF) or a Nursing Facility (NF) that is bidding as a specialty supplier that will provide competitively bid items only to its own residents? ☐ Yes ☐ No

A. Supplier's Identifying Information

Provide the legal business name and mailing address where correspondence will be sent to you by the Competitive Bidding Implementation Contractor (CBIC). This mailing address must match the mailing address on file with the National Supplier Clearinghouse (NSC) provided in Section 2.A.2 on the Medicare Enrollment Application Form CMS-855S.

Legal Business Name____
(NOT your billing agent, staffing company, or managing organization)

Mailing Address Line 1____
(Street Name and Number)

Mailing Address Line 2____
(Suite, Room, etc.)

City/Town__________________________ State__________ Zip__________

Telephone Number________________ Fax Number____________ E-mail____________

NSC and NPI Identification Number

Provide the NSC and NPI number specific to this business location

NSC Identification Number________________ NPI Identification Number__________

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.

TIN________________

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

B. Supplier's Physical Address

Is the supplier's mailing address the same as the supplier's physical address provided in Question A.? ☐ Yes ☐ No
If the answer is No, please complete the following information:

Physical Address Line 1____
(Street Name and Number)

Physical Address Line 2____
(Suite, Room, etc.)

City/Town______________________ State__________ Zip__________

C. "Doing Business As" (DBA) Name

Indicate the DBA name if different from the legal business name reported in Question A.

DBA (if applicable)____

DBA (if applicable)____

D. Establishment Information

Identify the two-letter abbreviation for the state in which your company was established or incorporated.

Established/Incorporated State__________

Indicate the length of time (number of months and years) this location has been in the business of furnishing DMEPOS items to any customer (including both Medicare and non-Medicare customers).

Months__________ Years__________ in business

E. 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__________________ Last Name__________________ Title__________
(PRINT)

Telephone (include area code)__________________ E-Mail Address__________________

Contact Person(s) First Name__________________ Last Name__________________ Title__________
(PRINT)

Telephone (include area code)__________________ E-Mail Address__________________

F. Key Personnel

Provide the name(s) and title(s)of the authorized official(s) or key personnel for the business organization.

Contact Person(s) First Name__________________ Last Name__________________ Title__________
(PRINT)

Telephone (include area code)__________________ E-Mail Address__________________

Contact Person(s) First Name__________________ Last Name__________________ Title__________
(PRINT)

Telephone (include area code)__________________ E-Mail Address__________________

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

G. Type of Business

Select the business type for the location identified by the NSC number in Question A. If "Other", briefly describe the supplier's type of business. Bidders must submit certain financial documentation based on the type of business identified in this response. Refer to Section III.C.1 of the Request for Bid (RFB) instructions for a list of required documents.

☐ Corporation (LLC, Professional Corporation, S Corp and C Corp) ☐ Municipality and State Owned
☐ Sole Proprietorship ☐Partnership ☐ Non Profit Organization

H. Service Delivery

For the location identified in Question A., how will you service beneficiaries in a CBA? (Check all that apply)

- ☐ Retail Location
- ☐ Mail Order
- ☐ Home Delivery

I. Sanctions

Indicate whether the location identified in Question A or any other location has been subject to any past or current legal actions, sanctions, including debarments?
(If yes, please see RFB instructions) ☐ Yes ☐ No

J. Accreditation Information

Is the location identified in Question A. accredited by a Medicare approved accreditation organization? ☐ Yes ☐ No

If the answer is yes, what is the name of the Medicare approved accreditation organization?

____

For which product specific area(s) are you accredited? ______________________________
Indicate your accreditation issue date and expiration date:

______________ ______________

Issue Date (Month/Year) (Current or Pending) Expiration Date (Month/Year) (Current or Pending)

If the answer is no, is accreditation pending for this location? ☐ Yes ☐ No
For which product specific area(s) is accreditation pending? ______________________________

K. Indicate the CBA(s) and the Product Category(s) for which this location is submitting a bid.

Charlotte N.C.
☐ Oxygen Supplies ☐ Walkers
☐ Enteral Nutrition ☐ CPAP
☐ Mail-Order Diabetic Supplies ☐ Hospital Beds
☐ Standard Power Wheelchairs

Cincinnati
☐ Oxygen Supplies ☐ Walkers
☐ Enteral Nutrition ☐ CPAP
☐ Mail-Order Diabetic Supplies ☐ Hospital Beds
☐ Standard Power Wheelchairs

Cleveland
☐ Oxygen Supplies ☐ Walkers
☐ Enteral Nutrition ☐ CPAP
☐ Mail-Order Diabetic Supplies ☐ Hospital Beds
☐ Standard Power Wheelchairs

Dallas/Ft. Worth
☐ Oxygen Supplies ☐ Walkers
☐ Enteral Nutrition ☐ CPAP
☐ Mail-Order Diabetic Supplies ☐ Hospital Beds
☐ Standard Power Wheelchairs

Kansas City
☐ Oxygen Supplies ☐ Walkers
☐ Enteral Nutrition ☐ CPAP
☐ Mail-Order Diabetic Supplies ☐ Hospital Beds
☐ Standard Power Wheelchairs

Miami
☐ Oxygen Supplies ☐ Walkers
☐ Enteral Nutrition ☐ CPAP
☐ Mail-Order Diabetic Supplies ☐ Hospital Beds
☐ Standard Power Wheelchairs ☐ Support Surf

Orlando
☐ Oxygen Supplies ☐ Walkers
☐ Enteral Nutrition ☐ CPAP
☐ Mail-Order Diabetic Supplies ☐ Hospital Beds
☐ Standard Power Wheelchairs

Pittsburgh
☐ Oxygen Supplies ☐ Walkers
☐ Enteral Nutrition ☐ CPAP
☐ Mail-Order Diabetic Supplies ☐ Hospital Beds
☐ Standard Power Wheelchairs

Riverside
☐ Oxygen Supplies ☐ Walkers
☐ Enteral Nutrition ☐ CPAP
☐ Mail-Order Diabetic Supplies ☐ Hospital Beds
☐ Standard Power Wheelchairs

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

Section 1a. Location-Specific Questions

L. Additional Physical Location Information

Provide the requested information for each location in your business organization. You must provide the unique NSC number that applies to each location.

Legal Business Name________________________ DBA (if different)________________________

Physical Address Line 1____

(Street Name and Number)

Physical Address Line 2____

(Suite, Room, etc.)

City/Town________________________ State______________ Zip______________

Toll Free Number______________ ______________ E-mail address:______________________

NSC Number (for this location)______________ NPI Number (for this location)______________ TIN Number______________

List the CBA(s) and product categories for which this location is bidding.

Charlotte N.C.

- ☐ Oxygen Supplies
- ☐ Walkers
- ☐ Enteral Nutrition
- ☐ CPAP
- ☐ Mail-Order Diabetic Supplies
- ☐ Hospital Beds
- ☐ Standard Power Wheelchairs

Cincinnati

- ☐ Oxygen Supplies
- ☐ Walkers
- ☐ Enteral Nutrition
- ☐ CPAP
- ☐ Mail-Order Diabetic Supplies
- ☐ Hospital Beds
- ☐ Standard Power Wheelchairs

Cleveland

- ☐ Oxygen Supplies
- ☐ Walkers
- ☐ Enteral Nutrition
- ☐ CPAP
- ☐ Mail-Order Diabetic Supplies
- ☐ Hospital Beds
- ☐ Standard Power Wheelchairs

Dallas/Ft. Worth

- ☐ Oxygen Supplies
- ☐ Walkers
- ☐ Enteral Nutrition
- ☐ CPAP
- ☐ Mail-Order Diabetic Supplies
- ☐ Hospital Beds
- ☐ Standard Power Wheelchairs

Kansas City

- ☐ Oxygen Supplies
- ☐ Walkers
- ☐ Enteral Nutrition
- ☐ CPAP
- ☐ Mail-Order Diabetic Supplies
- ☐ Hospital Beds
- ☐ Standard Power Wheelchairs

Miami

- ☐ Oxygen Supplies
- ☐ Walkers
- ☐ Enteral Nutrition
- ☐ CPAP
- ☐ Mail-Order Diabetic Supplies
- ☐ Hospital Beds
- ☐ Standard Power Wheelchairs
- ☐ Support Surf

Orlando

- ☐ Oxygen Supplies
- ☐ Walkers
- ☐ Enteral Nutrition
- ☐ CPAP
- ☐ Mail-Order Diabetic Supplies
- ☐ Hospital Beds
- ☐ Standard Power Wheelchairs

Pittsburgh

- ☐ Oxygen Supplies
- ☐ Walkers
- ☐ Enteral Nutrition
- ☐ CPAP
- ☐ Mail-Order Diabetic Supplies
- ☐ Hospital Beds
- ☐ Standard Power Wheelchairs

Riverside

- ☐ Oxygen Supplies
- ☐ Walkers
- ☐ Enteral Nutrition
- ☐ CPAP
- ☐ Mail-Order Diabetic Supplies
- ☐ Hospital Beds
- ☐ Standard Power Wheelchairs

Accreditation

Is the location identified in Question L. accredited by a Medicare approved accreditation organization?

☐ Yes ☐ No

If the answer is yes, what is the name of the Medicare approved accreditation organization?

____

For which product specific area(s) are you accredited? ________________________

Indicate your accreditation issue date and expiration date:

______________ ______________

Issue Date (Month/Year) (Current or Pending) Expiration Date (Month/Year) (Current or Pending)

If the answer is no, is accreditation pending for this location? ☐ Yes ☐ No

For which product specific area(s) is accreditation pending? ________________________

Supplier Business Information

Indicate the length of time (number of months and years) this location has been in the business of furnishing DMEPOS items to Medicare and non-Medicare customers.

Months__________ Years__________ in business

M. Additional Information (Optional)

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

MEDICARE DMEPOS COMPETITIVE BIDDING PROGRAM

For CMS Use Only

Supplier Bidder No.	Date Application Received
Competitive Bid Area (CBA)	
Supplier's Identifying Information	
Supplier's Legal Business Name	Primary Supplier's Legal Business Name (if network)

FORM A: APPLICATION FOR NETWORKS

NOTE: Please read all instructions completely. The primary network supplier must complete this application in order to bid on behalf of a network.

Indicate how your Business Organization will be Bidding (choose only one):

- ☐ Supplier with a Single Location (See Application for Suppliers)
- ☐ Supplier with Multiple Locations (See Application for Suppliers)
- ☐ Network

Section 2: Application for Networks

A. Primary Network Member Supplier's Identifying Information

Provide the legal business name and mailing address where correspondence will be sent to you by the Competitive Bidding Implementation Contractor (CBIC). This mailing address must match the mailing address provided in Section 2.A.2 on the Medicare Enrollment Application Form CMS-855S.

Legal Business Name____
(NOT your billing agent, staffing company, or managing organization)

Mailing Address Line 1____
(Street Name and Number)

Mailing Address Line 2____
(Suite, Room, etc.)

City/Town______________________ State______________ Zip______________

Telephone Number________________ Fax Number________________ E-mail Address________________

NSC and NPI Identification Number

Provide the NSC and NPI number specific to this business location

NSC Identification Number________________ NPI Identification Number__________

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.

TIN________________

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

B. Primary Network Supplier's Physical Address

Is the supplier's mailing address the same as the supplier's physical address provided in Section 2, Question A.? ☐ Yes ☐ No
If the answer is No, please complete the following information:

Physical Address Line 1____
(Street Name and Number)

Physical Address Line 2____
(Suite, Room, etc.)

City/Town________________________ State____________ Zip____________

C. "Doing Business As" (DBA) Name

Provide the DBA name if different from the legal business name reported in Question A.

DBA (if applicable)____

DBA (if applicable)____

D. Establishment Information

Identify the two-letter abbreviation for the state in which your company was established or incorporated.

Established/Incorporated State____________

Indicate the length of time (number of months and years) this location has been in the business of furnishing DMEPOS items to any customer (including both Medicare and non-Medicare customers).
Months____________ Years____________ in business

E. 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____________________ Last Name____________________ Title____________
(PRINT)
Telephone (include area code)____________________ E-Mail Address________________________

Contact Person(s) First Name____________________ Last Name____________________ Title____________
(PRINT)
Telephone (include area code)____________________ E-Mail Address________________________

F. Key Personnel

Provide the name(s) and title(s)of the authorized official(s) or key personnel for the business organization.

Contact Person(s) First Name____________________ Last Name____________________ Title____________
(PRINT)
Telephone (include area code)____________________ E-Mail Address________________________

Contact Person(s) First Name____________________ Last Name____________________ Title____________
(PRINT)
Telephone (include area code)____________________ E-Mail Address________________________

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

G. Type of Business

Select the business type for the location identified by the NSC number in Section 2, Question A. If "Other", briefly describe the supplier's type of business. Bidders must submit certain financial documentation based on the type of business identified in this response. Refer to Section III.C.1 of the Request for Bid (RFB) instructions for a list of required documents.

☐ Corporation (LLC, Professional Corporation, S Corp and C Corp) ☐ Municipality and State Owned
☐ Sole Proprietorship ☐Partnership ☐ Non Profit Organization

H. Service Delivery

For the location identified in Section 2, Question A., how will you service beneficiaries in a CBA? (Check all that apply)

- ☐ Retail Location
- ☐ Mail Order
- ☐ Home Delivery

I. Sanctions

Indicate whether the location identified in Question A or any other location has been subject to any past or current legal actions, sanctions, including debarments? (If yes, please see RFB instructions) ☐ Yes ☐ No

J. Accreditation Information

Is the location identified in Section 2, Question A. accredited by a Medicare approved accreditation organization? ☐ Yes ☐ No

If the answer is yes, what is the name of the Medicare approved accreditation organization?

For which product specific area(s) are you accredited? ______________________________
Indicate your accreditation issue date and expiration date:

______________	______________
Issue Date (Month/Year) (Current or Pending)	Expiration Date (Month/Year) (Current or Pending)

If the answer is no, is accreditation pending for this location? ☐ Yes ☐ No
For which product specific area(s) is accreditation pending? ______________________________

K. Indicate the CBA(s) and the Product Category(s) for which this location is submitting a bid.

Charlotte N.C.
☐ Oxygen Supplies ☐ Walkers
☐ Enteral Nutrition ☐ CPAP
☐ Mail-Order Diabetic Supplies ☐ Hospital Beds
☐ Standard Power Wheelchairs

Cincinnati
☐ Oxygen Supplies ☐ Walkers
☐ Enteral Nutrition ☐ CPAP
☐ Mail-Order Diabetic Supplies ☐ Hospital Beds
☐ Standard Power Wheelchairs

Cleveland
☐ Oxygen Supplies ☐ Walkers
☐ Enteral Nutrition ☐ CPAP
☐ Mail-Order Diabetic Supplies ☐ Hospital Beds
☐ Standard Power Wheelchairs

Dallas/Ft. Worth
☐ Oxygen Supplies ☐ Walkers
☐ Enteral Nutrition ☐ CPAP
☐ Mail-Order Diabetic Supplies ☐ Hospital Beds
☐ Standard Power Wheelchairs

Kansas City
☐ Oxygen Supplies ☐ Walkers
☐ Enteral Nutrition ☐ CPAP
☐ Mail-Order Diabetic Supplies ☐ Hospital Beds
☐ Standard Power Wheelchairs

Miami
☐ Oxygen Supplies ☐ Walkers
☐ Enteral Nutrition ☐ CPAP
☐ Mail-Order Diabetic Supplies ☐ Hospital Beds
☐ Standard Power Wheelchairs ☐ Support Surf

Orlando
☐ Oxygen Supplies ☐ Walkers
☐ Enteral Nutrition ☐ CPAP
☐ Mail-Order Diabetic Supplies ☐ Hospital Beds
☐ Standard Power Wheelchairs

Pittsburgh
☐ Oxygen Supplies ☐ Walkers
☐ Enteral Nutrition ☐ CPAP
☐ Mail-Order Diabetic Supplies ☐ Hospital Beds
☐ Standard Power Wheelchairs

Riverside
☐ Oxygen Supplies ☐ Walkers
☐ Enteral Nutrition ☐ CPAP
☐ Mail-Order Diabetic Supplies ☐ Hospital Beds
☐ Standard Power Wheelchairs

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

Section 2a: Location-Specific Questions for Primary Network Supplier

L. Additional Physical Location Information for Primary Network Supplier

Please provide the requested information for each location in your business organization. You must provide the unique NSC number that applies to each location. The primary network member should provide information for all of its locations first.

Legal Business Name________________________________ DBA (if different)______________________
Physical Address Line 1____
(Street Name and Number)
Physical Address Line 2____
(Suite, Room, etc.)
City/Town________________________________ State__________ Zip__________
Toll Free Number________________________________ E-mail address:______________________
NSC Number (for this location)__________ NPI Number (for this location)__________ TIN Number__________

List the CBA(s) and product category(s) for which this location is bidding.

Charlotte N.C.
- ☐ Oxygen Supplies
- ☐ Enteral Nutrition
- ☐ Mail-Order Diabetic Supplies
- ☐ Standard Power Wheelchairs
- ☐ Walkers
- ☐ CPAP
- ☐ Hospital Beds

Cincinnati
- ☐ Oxygen Supplies
- ☐ Enteral Nutrition
- ☐ Mail-Order Diabetic Supplies
- ☐ Standard Power Wheelchairs
- ☐ Walkers
- ☐ CPAP
- ☐ Hospital Beds

Cleveland
- ☐ Oxygen Supplies
- ☐ Enteral Nutrition
- ☐ Mail-Order Diabetic Supplies
- ☐ Standard Power Wheelchairs
- ☐ Walkers
- ☐ CPAP
- ☐ Hospital Beds

Dallas/Ft. Worth
- ☐ Oxygen Supplies
- ☐ Enteral Nutrition
- ☐ Mail-Order Diabetic Supplies
- ☐ Standard Power Wheelchairs
- ☐ Walkers
- ☐ CPAP
- ☐ Hospital Beds

Kansas City
- ☐ Oxygen Supplies
- ☐ Enteral Nutrition
- ☐ Mail-Order Diabetic Supplies
- ☐ Standard Power Wheelchairs
- ☐ Walkers
- ☐ CPAP
- ☐ Hospital Beds

Miami
- ☐ Oxygen Supplies
- ☐ Enteral Nutrition
- ☐ Mail-Order Diabetic Supplies
- ☐ Standard Power Wheelchairs
- ☐ Walkers
- ☐ CPAP
- ☐ Hospital Beds
- ☐ Support Surf

Orlando
- ☐ Oxygen Supplies
- ☐ Enteral Nutrition
- ☐ Mail-Order Diabetic Supplies
- ☐ Standard Power Wheelchairs
- ☐ Walkers
- ☐ CPAP
- ☐ Hospital Beds

Pittsburgh
- ☐ Oxygen Supplies
- ☐ Enteral Nutrition
- ☐ Mail-Order Diabetic Supplies
- ☐ Standard Power Wheelchairs
- ☐ Walkers
- ☐ CPAP
- ☐ Hospital Beds

Riverside
- ☐ Oxygen Supplies
- ☐ Enteral Nutrition
- ☐ Mail-Order Diabetic Supplies
- ☐ Standard Power Wheelchairs
- ☐ Walkers
- ☐ CPAP
- ☐ Hospital Beds

M. Accreditation Information for Locations Serving this CBA

Is the location identified in Section 2a, Question L. accredited by a Medicare approved accreditation organization? ☐ Yes ☐ No

If the answer is yes, what is the name of the Medicare approved accreditation organization?

____

For which product specific area(s) are you accredited? ________________________________
Indicate your accreditation issue date and expiration date:

__________________ __________________
Issue Date (Month/Year) Expiration Date (Month/Year)
(Current or Pending) (Current or Pending)

If the answer is no, is accreditation pending for this location? ☐ Yes ☐ No
For which product specific area(s) is accreditation pending?________________________________

N. Supplier Business Information

Provide the length of time (number of months and years) this location has been in the business of furnishing DMEPOS items to any customer (including Medicare and non-Medicare customers).
Months__________ Years__________ in business

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

Section 2b: Additional Network Member Information

O. Network Member's Identifying Information

Provide the legal business name and physical address.

1. Legal Business Name____
(NOT your billing agent, staffing company, or managing organization)

Physical Address Line 1____
(Street Name and Number)

Physical Address Line 1____
(Suite, Room, etc.)

City/Town______________________ State__________ Zip__________

Telephone Number______________ Fax Number______________ E-mail Address______________

NSC and NPI Identification Number
Provide the NSC and NPI number specific to this business location
NSC Identification Number______________ NPI Identification Number__________

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.
TIN______________

Accreditation
Is this location of the network member accredited by a Medicare approved accreditation organization? ☐ Yes ☐ No

If the answer is yes, what is the name of the Medicare approved accreditation organization?

____

For which product specific area(s) is this location accredited? ______________
Indicate the accreditation issue date and expiration date:

______________ ______________
Issue Date (Month/Year) Expiration Date (Month/Year)
(Current or Pending) (Current or Pending)

If the answer is no, is accreditation pending for this location? ☐ Yes ☐ No
For which product specific area(s) is accreditation pending?______________

Additional Network Member ______________________________

2. Legal Business Name____
(NOT your billing agent, staffing company, or managing organization)

Physical Address Line 1____
(Street Name and Number)

Physical Address Line 1____
(Suite, Room, etc.)

City/Town______________________ State__________ Zip__________

Telephone Number______________ Fax Number______________ E-mail Address______________

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

NSC and NPI Identification Number
Provide the NSC and NPI number specific to this business location
NSC Identification Number____________________ NPI Identification Number___________

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.
TIN____________________

Accreditation
Is this location of the network member accredited by a Medicare approved accreditation organization? ☐ Yes ☐ No

If the answer is yes, what is the name of the Medicare approved accreditation organization?

____

For which product specific area(s) is this location accredited? ______________________________
Indicate the accreditation issue date and expiration date:

____________________ ____________________
Issue Date (Month/Year) Expiration Date (Month/Year)
(Current or Pending) (Current or Pending)

If the answer is no, is accreditation pending for this location? ☐ Yes ☐ No
For which product specific area(s) is accreditation pending?______________________________

P. Additional Information (Optional)

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