MEDICARE DME For CMS Use Only	POS COMPETITIVE BIDDIN	GPROGRAM
Supplier Bidder No	Date Applica	tion Received
Competitive Bid Area (CBA)		
Supplier's identifying information		
Supplier's Legal Business Name	Primary Sup	plier's Legal Business Name (if network)
FORM A: APPLICATION FOR DMEP	POS COMPETITIVE BIDDING PR	OGRAM
NOTE: Please read all instructions comple Section 1 -1a: Application for Suppliers. I		
Indicate how your Business Organi □ Supplier with a Single Location (0 □ Supplier with Multiple Locations (□ Network (Complete Section 2-2b)	Complete Section 1-1a) (Complete Section 1-1a)	nly one):
Section 1: Application for Suppliers	s	
Are you a Skilled Nursing Facility (Supplier that will provide competitive. A. Supplier's Identifying Information Provide the legal business name and mailing Implementation Contractor (CBIC). This mail	vely bid items only to its own re on address where correspondence will be s	esidents?
Clearinghouse (NSC) provided in Section 2.A	A.2 on the Medicare Enrollment Application	on Form CMS-855S.
	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 NSC Identification Number		
Tax Identification Number Provide the Tax Identification Number (TIN) is security number may be used. TIN	issued by the IRS to the supplier complet	ting this form. If a sole proprietor, social
Form CMS-10169A (04/07) EF (04/2007)		

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ed to answer questions regarding the supplier's bid. ast Name Title
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ast Name Title
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ast Name Title
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it. Indicate the ODA	s, and the r r	oddot oategory(s) ioi	Willon this it	ocation to ocasimizing .	a Dia.
Charlotte N.C.		Cincinnati		Cleveland	
	□ Walkers	☐ Oxygen Supplies	□ Walkers	☐ Oxygen Supplies	□ Walkers
	☐ CPAP	☐ Enteral Nutrition	☐ CPAP	□ Enteral Nutrition	☐ CPAP
☐ Mail-Order Diabetic Supplies	☐ Hospital Beds	☐ Mail-Order Diabetic Supplies	☐ Hospital Beds	■ Mail-Order Diabetic Supplies	☐ Hospital Beds
☐ Standard Power Wheelchairs		☐ Standard Power Wheelchairs		☐ Standard Power Wheelchairs	
<u>Dallas/Ft. Worth</u>		Kansas City		<u>Miami</u>	
,g	□ Walkers	☐ Oxygen Supplies	□ Walkers	☐ Oxygen Supplies	☐ Walkers
	☐ CPAP	□ Enteral Nutrition	☐ CPAP	□ Enteral Nutrition	☐ CPAP
□ Mail-Order Diabetic Supplies	☐ Hospital Beds	☐ Mail-Order Diabetic Supplies		☐ Mail-Order Diabetic Supplies	
☐ Standard Power Wheelchairs		☐ Standard Power Wheelchairs		☐ Standard Power Wheelchairs	□ Support Surf
Orlando		Pittsburgh		Riverside	
Oxygen Supplies	□ Walkers	☐ Oxygen Supplies	☐ Walkers	Oxygen Supplies	□ Walkers
☐ Enteral Nutrition	☐ CPAP	☐ Enteral Nutrition	☐ CPAP	☐ Enteral Nutrition	☐ CPAP
☐ Mail-Order Diabetic Supplies	☐ Hospital Beds	☐ Mail-Order Diabetic Supplies	☐ Hospital Beds	☐ Mail-Order Diabetic Supplies	☐ Hospital Beds
☐ Standard Power Wheelchairs		□ Standard Power Wheelchairs	•	☐ Standard Power Wheelchairs	
Form CMS-10169A (04/07) EI	F (04/2007)				
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Supplier's Legal Business Name		Supplier's Bidder No.
Section 1a. Location-Specific Qu	estions	
L. Additional Physical Location I	nformation	
	i location in your business organization. You	must provide the unique NSC number
that applies to each location.	riocation in your business organization. Tou	must provide the anique 1400 hambor
Logal Business Name	DBA (if different)	
Physical Address Line 1		
Physical Address Line 1	(Street Name and Number)	
Physical Address Line 2	(0 ii 0	
City/Town	(Suite, Room, E.s.,	7 ín
Toll Free Number	F-mai: address:	
NSC Number (for this location)	Siw-eE-maii address:NPI Number (for this location)	TIN Number
List the CBA(s) and product categories for		
- · · · · · · · · · · · · · · · · ·	-	
Charlotte N.C. ☐ Oxygen Supplies ☐ Walkers ☐ Enteral Nutrition ☐ CPAP ☐ Mail-Order Diabetic Supplies ☐ Hospital Reds	<u>Cincinnati</u>	<u>Cleveland</u>
☐ Oxygen Supplies ☐ Walkers ☐ CPAP	☐ Oxygen Supplies ☐ Walkers ☐ Enteral Nutrition ☐ CPAP	☐ Oxygen Supplies ☐ Walkers ☐ Enteral Nutrition ☐ CPAP
☐ Mail-Order Diabetic Supplies ☐ Hospital Beds	☐ Mail-Order Diabetic Supplies ☐ Hospital Beds	☐ Mail-Order Diabetic Supplies ☐ Hospital Bed
☐ Standard Power Wheelchairs	☐ Standard Power Wheelchairs	☐ Standard Power Wheelchairs
<u>Dallas/Ft. Worth</u>	Kansas City	<u>Miami</u>
☐ Oxygen Supplies ☐ Walkers ☐ Enteral Nutrition ☐ CPAP	☐ Oxygen Supplies ☐ Walkers	☐ Oxygen Supplies ☐ Walkers
☐ Enteral Nutrition ☐ CPAP ☐ Mail-Order Diabetic Supplies ☐ Hospital Beds	☐ Enteral Nutrition ☐ CPAP ☐ Mail-Order Diabetic Supplies ☐ Hospital Beds	☐ Enteral Nutrition ☐ CPAP ☐ Mail-Order Diabetic Supplies ☐ Hospital Bed
☐ Standard Power Wheelchairs	☐ Standard Power Wheelchairs	☐ Standard Power Wheelchairs ☐ Support Surf
Orlando	Pittsburgh	Riverside
	□ Oxygen Supplies □ Walkers	
☐ Oxygen Supplies ☐ Walkers ☐ Enteral Nutrition ☐ CPAP	☐ Oxygen Supplies ☐ Walkers ☐ CPAP	☐ Oxygen Supplies ☐ Walkers ☐ CPAP
 □ Mail-Order Diabetic Supplies □ Hospital Beds □ Standard Power Wheelchairs 	 ☐ Mail-Order Diabetic Supplies ☐ Hospital Beds ☐ Standard Power Wheelchairs 	 □ Mail-Order Diabetic Supplies □ Hospital Bed □ Standard Power Wheelchairs
□ Yes □ No	credited by a Medicare approved accreditation he Medicare approved accreditation organization	
For which product specific area(s) are you	accredited?	
Indicate your accreditation issue date and		
		<u> </u>
Issue Date (Month/Year)	Expiration Date (Month/Year	·)
(Current or Pending)	(Current or Pending)	
If the answer is no, is accreditation pendir For which product specific area(s) is accreditation.		☐ Yes ☐ No
Supplier Business Information	•	
Indicate the length of time (number of more Medicare and non-Medicare customers.	nths and years) this location has been in the	business of furnishing DMEPOS items to
Months ir	n business	
M. Additional Information (Option The space provided may be used if additional additional information (Optional Information (Optiona	nal) onal space is needed to fully respond to othe	er questions on this form.
Form CMS-10169A (04/07) EF (04/2007)		
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MEDICARE DMEPOS COMPETITIVE BIDDING PROGRAM For CMS Use Only Supplier Bidder No. Date Application Received Competitive Bid Ares (CBA) Supplier's Identifying Information 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-85SS. Legal Business Name (NOT your billing agent staffing company, or managing organization) Mailing Address Line 1 (Street Name and Number) Mailing Address Line 2 (Sulte, Room, etc.) City/Town State Zip Telephone Number Fax Number Fax Number Fax Number NSC and NPI Identification Number NSC Identification Number		Later the second se		77 - 11 - 12 - 13 0 PE (\$ 151 1 1 1 1 1 1 1
Supplier Bild 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 Multiple Location (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 was 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 Fax Number Fax Number NPI Identification Number NPI Identification Number NPI Identification Number NPI Identification Number Tax Identification Number NPI Identification Number Tax Identification Number Tax Identification Number NPI Identification Number NPI Identification Number NPI Identification Number				
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Supplier's Legal Business Name	For CMS Use Only			
Supplier's Legal Business Name				
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Supplier's Legal Business Name	Competitive Bid Area (CBA)			
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Legal Business Name			e mailing address provided in Section	n 2.A.2 on the
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Mailing Address Line 2	Legal Business Name			
Mailing Address Line 2		(NOT your billing agent, staffing compa	any, or managing organization)	
Mailing Address Line 2	Mailing Address Line 1			
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.		(Street Name and	Number)	<u> </u>
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.	Mailing Address Line 2			
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,		(THY) issued by the INS to the su	pplier completing this form. If a sole	proprietor, social
Form CMS-10169A (04/07) EF (04/2007)	Form CMS-10169A (04/07) EF (04/2007)			

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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) 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 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 succontact Person(s) First Name (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 (PRINT) Telephone (include area code) E-Mail Address Contact Person(s) First Name (PRINT) Telephone (include area code) E-Mail Address Contact Person(s) First Name (PRINT) E-Mail Address E-Mail Address E-Mail Address Contact Person(s) First Name (PRINT) E-Mail Address E-Mail Address E-Mail Address		(Street Name and Number)	sical Address Line 1
City/Town			sical Address Line 2
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 appli		(Suite, Room, etc.)	
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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 any customer (including both Medicare and non-Medicare customers). Months		name reported in Question A.	
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 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 sufficient to the name(s) of the contact person who should be contacted to answer questions regarding the sufficient to the name(s) First Name			(if applicable)
Identify the two-letter abbreviation for the state in which your company was established or incorporated.			(if applicable)
Indicate the length of time (number of months and years) this location has been in the business of furnishing any customer (including both Medicare and non-Medicare customers). Months	1 .	our company was established or incorp	
any customer (including both Medicare and non-Medicare customers). Months			ablished/Incorporated State
Provide the name(s) of the contact person who should be contacted to answer questions regarding the su Contact Person(s) First Name (PRINT) Telephone (include area code) Contact Person(s) First Name (PRINT) Telephone (include area code) 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 (PRINT) Telephone (include area code) (PRINT) Telephone (include area code) (PRINT) Telephone (include area code) (PRINT) Last Name (PRINT) Last Name Last Name (PRINT) Last Name Last Name Last Name Last Name Last Name Last Name	ishing DMEPOS items		customer (including both Medicare and non-Medicar
Telephone (include area code)			vide the name(s) of the contact person who should be tact Person(s) First Name
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	_	E-Mail Address	
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Contact Person(s) First Name Last Name (PRINT)	Title	Last Name	vide the name(s) and title(s)of the authorized official(stact Person(s) First Name(PRINT)
(PRINT) Telephone (include area code) E-Mail Address			
relephone (include area code)		Last Name	(PRINT)
	-		spriorie (include area code)

supplier's type of business	. Bidders must s		mentation base	estion A. If "Other", briefly d d on the type of business ide required documents.	
☐ Corporation (LLC, Profe☐ Sole Proprietorship		tion, S Corp and C Corp) □ Partnership □	Municipality and Non Profit Orgar		
H. Service Delivery For the location identified i Retail Location Mail Order Home Delivery	n Section 2, Que	estion A., how will you servic	e beneficiaries i	n a CBA? (Check all that ap	pły)
		Question A or any other loca dease see RFB instructions)		bject to any past or current l	egal actions, I Yes □ No
J. Accreditation Info		stion A. accredited by a Med	icare approved a	accreditation organization?	⊐ Yes □ No
If the answer is yes, what i	is the name of th	e Medicare approved accre	ditation organiza	ition?	
For which product specific Indicate your accreditation					
Issue Date (Month/Year) (Current or Pending)			ite (Month/Year) or Pending)	_	
If the answer is no, is accr For which product specific					□ Yes □ No
K. Indicate the CBA	(s) and the P	roduct Category(s) fo	r which this l	ocation is submitting	a bid.
Charlotte N.C.		Cincinnati		Cleveland	
 □ Oxygen Supplies □ Enteral Nutrition □ Mail-Order Diabetic Supplies 	□ Walkers□ CPAP□ Hospital Beds	☐ Oxygen Supplies ☐ Enteral Nutrition ☐ Mail-Order Diabetic Supplies	□ Walkers□ CPAP□ Hospital Beds	☐ Oxygen Supplies ☐ Enteral Nutrition ☐ Mail-Order Diabetic Supplies	□ Walkers□ CPAP□ Hospital Beds
☐ Standard Power Wheelchairs		☐ Standard Power Wheelchairs		 Standard Power Wheelchairs Miami 	
Dallas/Ft. Worth ☐ Oxygen Supplies	☐ Walkers	Kansas City ☐ Oxygen Supplies	□ Walkers	Oxygen Supplies	□ Walkers
 □ Enteral Nutrition □ Mail-Order Diabetic Supplies □ Standard Power Wheelchairs 		 ☐ Enteral Nutrition ☐ Mail-Order Diabetic Supplies ☐ Standard Power Wheelchairs 	☐ CPAP☐ Hospital Beds	 □ Enteral Nutrition □ Mail-Order Diabetic Supplies □ Standard Power Wheelchairs 	
Orlando	□ Maluese	Pittsburgh	□ Mallings	Riverside	□ Walkers
 □ Oxygen Supplies □ Enteral Nutrition □ Mail-Order Diabetic Supplies □ Standard Power Wheelchairs 		 □ Oxygen Supplies □ Enteral Nutrition □ Mail-Order Diabetic Supplies □ Standard Power Wheelchairs 	□ Walkers□ CPAP□ Hospital Beds	 □ Oxygen Supplies □ Enteral Nutrition □ Mail-Order Diabetic Supplies □ Standard Power Wheelchairs 	☐ CPAP
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Section 2a: Location-Specific Questions for Primary Network Supplier

L. Additional Physical Location Information for Primary Network Supplier

				n. You must provide the uni rmation for all of its locations	
Legal Business Name			DBA (if different)		
Physical Address Line 1					
Physical Address Line 2		(Street Name a	nd Number)		
Physical Address Line 2		(Suite, Ro			
City/Town	1	(Cano, 115)	State	Zip	
Toll Free Number			E-mail address:		
NSC Number (for this locat	ion')	NPI Number (for this	s location)	Zip	
	category(s) to	or which this location is biddi	ing.	Clavaland	
Charlotte N.C.	D 184-11	Cincinnati ☐ Oxygen Supplies	T MAKE HERE AT	Cleveland	□ 18(allean
☐ Oxygen Supplies ☐ Enteral Nutrition	LI Walkers	☐ Oxygen Supplies ☐ Enteral Nutrition	□ Walkers □ CPAP	☐ Oxygen Supplies☐ Enteral Nutrition	□ Walkers□ CPAP
☐ Mail-Order Diabetic Supplies □	☐ Hospital Beds	☐ Mail-Order Diabetic Supplies		☐ Mail-Order Diabetic Supplies	
Chandred Davis Mile adalasis	_ 1.00p 2000	☐ Standard Power Wheelchairs		☐ Standard Power Wheelchairs	
Dallas/Ft. Worth	F	Kansas City		Miami	
	☐ Walkers	Mansas City ☐ Oxygen Supplies ☐ Enteral Nutrition	□ Walkers	□ Ovvgen Supplies	□ Walkers
☐ Oxygen Supplies☐ Enteral Nutrition	□≀CPAP	☐ Enteral Nutrition	□ CPAP	☐ Enteral Nutrition	☐ CPAP
□ Mail-Order Diabetic Supplies 1	□ Hospital Beds	Mail-Order Diabetic Supplies	i □ Hospital Beds	■ Mail-Order Diabetic Supplies	
☐ Standard Power Wheelchairs		☐ Standard Power Wheelchairs	S	□ Standard Power Wheelchairs	□ Support Surf
<u>Orlando</u>		<u>Pittsburgh</u>		<u>Riverside</u>	
☐ Oxygen Supplies ☐ Enteral Nutrition	□ Walkers	□ Oxygen Supplies	□ Walkers	☐ Oxygen Supplies☐ Enteral Nutrition	□ Walkers
☐ Enteral Nutrition	☐ CPAP	Pittsburgh ☐ Oxygen Supplies ☐ Enteral Nutrition ☐ Mail Order Plabatic Supplies	☐ CPAP	□ Enteral Nutrition	☐ CPAP
☐ Mail-Order Diabetic Supplies☐ Standard Power Wheelchairs	☐ Hospital Beds	 ☐ Mail-Order Diabetic Supplies ☐ Standard Power Wheelchain 	s ⊔ ⊓ospitai beus	 ☐ Mail-Order Diabetic Supplies ☐ Standard Power Wheelchairs 	
For which product specific	area(s) are you	he Medicare approved accr accredited?			
Indicate your accreditation	issue date and	l expiration date:			
Issue Date (Month/Year)		Expiration D	ate (Month/Year)	-	
(Current or Pending)			t or Pending)		
15 th		fo- this lass time 0			
If the answer is no, is accre For which product specific					□ Yes □ No
N. Supplier Busines: Provide the length of time any customer (including Months Years	(number of more edicare and no	nths and years) this location n-Medicare customers).	i has been in the l	business of furnishing DMEI	POS items to
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٥.,		1:	Didde-	NIA
อน	DD	iler s	Bidder	INO.

Section 2b: Additional Network Member Information

O. Network Member's Identifying Information

Provide the legal business name ar	nd physical address.			
Legal Business Name	(NOT your billing agent, staffing o	company, or managing	organization)	-
Physical Address Line 1		e and Number)		
	(Street Name	anu wumber,		
Physica! Address Line 1	(Suito E	Room, etc.;		
City/Town		State	Zip	
Telephone Number	Fax Number		E-mail Address	
NSC and NPI Identification Number of NSC Identification Number NSC Ide	specific to this business location	fication Number		
Tax Identification Number Provide the Tax Identification Numl security number may be used. TIN	ber (TIN) issued by the IRS to the	e supplier completi	ing this form. If a sole	proprietor, social
Accreditation Is this location of the network mem	,		•	□ Yes □ No
If the answer is yes, what is the nar	me of the Medicare approved ac	creditation organiz	ation?	
For which product specific area(s) Indicate the accreditation issue dat			<u> </u>	
Issue Date (Month/Year) (Current or Pending)		Date (Month/Year ent or Pending))	
If the answer is no, is accreditation For which product specific area(s)				☐ Yes ☐ No
Additional Network Member				_
2. Legal Business Name	(NOT your billing agent, staffing	company or managing	organization)	
		company, or managing	Organization)	
Physical Address Line 1	(Street Nam	e and Number)		
Physical Address Line 1				
-	(Suite,	Room, etc.)		
City/Town		State	Zip	
Telephone Number	Fax Number		E-mail Address	
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Supplier's Legal Business Name	Sup	oplier's Bidder No.
NSC and NPI Identification Number Provide the NSC and NPI number specification Number		
Tax Identification Number Provide the Tax Identification Number (TI security number may be used. FIN	IN) issued by the IRS to the supplier completing this form. If	a sole proprietor, social
Accreditation s this lenation of the network member ac	ccredited by a Medicare approved accreditation organization	? ☐ Yes ☐ No
f the answer is yes, what is the name of	the Medicare approved accreditation organization?	
or which product specific area(s) is this ndicate the accreditation issue date and	location accredited?expiration date:	
ssue Date (Month/Year) (Current or Pending)	Expiration Date (Month/Year) (Current or Pending)	
f the answer is no, is accreditation pendi For which product specific area(s) is acci		□ Yes □ No
	·	
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