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____________________________________________________________________________________
(OUT 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_____________________________
**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**
- **Physical Address Line 2**

City/Town___________________________ State______________ Zip______________

- **Is the supplier’s mailing address the same as the supplier’s physical address provided in Question A?**
  - ☐ Yes ☐ No

**C. “Doing Business As” (DBA) Name**

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

- **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**

Telephone (include area code)_________________________  
E-Mail Address_________________________

- **Contact Person(s) First Name**
- **Last Name**
- **Title**

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**

Telephone (include area code)_________________________  
E-Mail Address_________________________

- **Contact Person(s) First Name**
- **Last Name**
- **Title**

Telephone (include area code)_________________________  
E-Mail Address_________________________

**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

Form CMS-10169A (07/09) EF (07/2009)
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)

<table>
<thead>
<tr>
<th>Location</th>
<th>Sanctions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

J. Accreditation Information
Is the location identified in Question A accredited by a Medicare approved accreditation organization?

<table>
<thead>
<tr>
<th>Location</th>
<th>Accreditation Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Area</th>
<th>Accreditation Issue Date and Expiration Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Location</th>
<th>Product Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charlotte-Gaston-Concord, NC-SC</td>
<td>Walkers &amp; Related Accessories</td>
</tr>
<tr>
<td></td>
<td>CPAP Devices, Respiratory Assist Devices, &amp; Related Supplies &amp; Accessories</td>
</tr>
<tr>
<td></td>
<td>Hospital Beds and Related Accessories</td>
</tr>
<tr>
<td></td>
<td>Complex Rehabilitative Power Wheelchairs &amp; Related Accessories (Group 2)</td>
</tr>
<tr>
<td>Cincinnati-Middletown, OH-KY-IN</td>
<td>Walkers &amp; Related Accessories</td>
</tr>
<tr>
<td></td>
<td>CPAP Devices, Respiratory Assist Devices, &amp; Related Supplies &amp; Accessories</td>
</tr>
<tr>
<td></td>
<td>Hospital Beds and Related Accessories</td>
</tr>
<tr>
<td></td>
<td>Complex Rehabilitative Power Wheelchairs &amp; Related Accessories (Group 2)</td>
</tr>
<tr>
<td>Cleveland-Elyria-Mentor, OH</td>
<td>Walkers &amp; Related Accessories</td>
</tr>
<tr>
<td></td>
<td>CPAP Devices, Respiratory Assist Devices, &amp; Related Supplies &amp; Accessories</td>
</tr>
<tr>
<td></td>
<td>Hospital Beds and Related Accessories</td>
</tr>
<tr>
<td></td>
<td>Complex Rehabilitative Power Wheelchairs &amp; Related Accessories (Group 2)</td>
</tr>
<tr>
<td>Dallas-Fort Worth-Arlington, TX</td>
<td>Walkers &amp; Related Accessories</td>
</tr>
<tr>
<td></td>
<td>CPAP Devices, Respiratory Assist Devices, &amp; Related Supplies &amp; Accessories</td>
</tr>
<tr>
<td></td>
<td>Hospital Beds and Related Accessories</td>
</tr>
<tr>
<td></td>
<td>Complex Rehabilitative Power Wheelchairs &amp; Related Accessories (Group 2)</td>
</tr>
<tr>
<td>Kansas City, MO-KS</td>
<td>Walkers &amp; Related Accessories</td>
</tr>
<tr>
<td></td>
<td>CPAP Devices, Respiratory Assist Devices, &amp; Related Supplies &amp; Accessories</td>
</tr>
<tr>
<td></td>
<td>Hospital Beds and Related Accessories</td>
</tr>
<tr>
<td></td>
<td>Complex Rehabilitative Power Wheelchairs &amp; Related Accessories (Group 2)</td>
</tr>
<tr>
<td>Miami-Fort Lauderdale-Pompano Beach, FL</td>
<td>Walkers &amp; Related Accessories</td>
</tr>
<tr>
<td></td>
<td>CPAP Devices, Respiratory Assist Devices, &amp; Related Supplies &amp; Accessories</td>
</tr>
<tr>
<td></td>
<td>Hospital Beds and Related Accessories</td>
</tr>
<tr>
<td></td>
<td>Complex Rehabilitative Power Wheelchairs &amp; Related Accessories (Group 2)</td>
</tr>
<tr>
<td>Orlando-Kissimmee, FL</td>
<td>Walkers &amp; Related Accessories</td>
</tr>
<tr>
<td></td>
<td>CPAP Devices, Respiratory Assist Devices, &amp; Related Supplies &amp; Accessories</td>
</tr>
<tr>
<td></td>
<td>Hospital Beds and Related Accessories</td>
</tr>
<tr>
<td></td>
<td>Complex Rehabilitative Power Wheelchairs &amp; Related Accessories (Group 2)</td>
</tr>
<tr>
<td>Pittsburgh, PA</td>
<td>Walkers &amp; Related Accessories</td>
</tr>
<tr>
<td></td>
<td>CPAP Devices, Respiratory Assist Devices, &amp; Related Supplies &amp; Accessories</td>
</tr>
<tr>
<td></td>
<td>Hospital Beds and Related Accessories</td>
</tr>
<tr>
<td></td>
<td>Complex Rehabilitative Power Wheelchairs &amp; Related Accessories (Group 2)</td>
</tr>
<tr>
<td>Riverside-San Bernardino-Ontario, CA</td>
<td>Walkers &amp; Related Accessories</td>
</tr>
<tr>
<td></td>
<td>CPAP Devices, Respiratory Assist Devices, &amp; Related Supplies &amp; Accessories</td>
</tr>
<tr>
<td></td>
<td>Hospital Beds and Related Accessories</td>
</tr>
<tr>
<td></td>
<td>Complex Rehabilitative Power Wheelchairs &amp; Related Accessories (Group 2)</td>
</tr>
</tbody>
</table>
## Section 1a. Location-Specific Questions

### L. Additional Physical Location Information

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

<table>
<thead>
<tr>
<th>Legal Business Name</th>
<th>DBA (if different)</th>
<th>Physical Address Line 1</th>
<th>(Street Name and Number)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Address Line 2</td>
<td>(Suite, Room, etc.)</td>
<td>City/Town</td>
<td>State</td>
</tr>
<tr>
<td>Toll Free Number</td>
<td>E-mail address:</td>
<td>NSC Number (for this location)</td>
<td>NPI Number (for this location)</td>
</tr>
</tbody>
</table>

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

- **Charlotte-Gastonia-Concord, NC-SC**
  - Oxygen Supplies & Equipment
  - Enteral Nutrients, Equipment, & Supplies
  - Mail-Order Diabetic Supplies
  - Standard Power Wheelchairs, Scooters, & Related Accessories
  - Walkers & Related Accessories
  - CPAP Devices, Respiratory Assist Devices, & Related Supplies & Accessories
  - Hospital Beds and Related Accessories
  - Complex Rehabilitative Power Wheelchairs & Related Accessories (Group 2)

- **Cincinnati-Middletown, OH-KY-IN**
  - Oxygen Supplies & Equipment
  - Enteral Nutrients, Equipment, & Supplies
  - Mail-Order Diabetic Supplies
  - Standard Power Wheelchairs, Scooters, & Related Accessories
  - Walkers & Related Accessories
  - CPAP Devices, Respiratory Assist Devices, & Related Supplies & Accessories
  - Hospital Beds and Related Accessories
  - Complex Rehabilitative Power Wheelchairs & Related Accessories (Group 2)

- **Cleveland-Elyria-Mentor, OH**
  - Oxygen Supplies & Equipment
  - Enteral Nutrients, Equipment, & Supplies
  - Mail-Order Diabetic Supplies
  - Standard Power Wheelchairs, Scooters, & Related Accessories
  - Walkers & Related Accessories
  - CPAP Devices, Respiratory Assist Devices, & Related Supplies & Accessories
  - Hospital Beds and Related Accessories
  - Complex Rehabilitative Power Wheelchairs & Related Accessories (Group 2)

- **Dallas-Fort Worth-Arlington, TX**
  - Oxygen Supplies & Equipment
  - Enteral Nutrients, Equipment, & Supplies
  - Mail-Order Diabetic Supplies
  - Standard Power Wheelchairs, Scooters, & Related Accessories
  - Walkers & Related Accessories
  - CPAP Devices, Respiratory Assist Devices, & Related Supplies & Accessories
  - Hospital Beds and Related Accessories
  - Complex Rehabilitative Power Wheelchairs & Related Accessories (Group 2)

- **Kansas City, MO-KS**
  - Oxygen Supplies & Equipment
  - Enteral Nutrients, Equipment, & Supplies
  - Mail-Order Diabetic Supplies
  - Standard Power Wheelchairs, Scooters, & Related Accessories
  - Walkers & Related Accessories
  - CPAP Devices, Respiratory Assist Devices, & Related Supplies & Accessories
  - Hospital Beds and Related Accessories
  - Complex Rehabilitative Power Wheelchairs & Related Accessories (Group 2)

- **Miami-Fort Lauderdale-Pompano Beach, FL**
  - Oxygen Supplies & Equipment
  - Enteral Nutrients, Equipment, & Supplies
  - Mail-Order Diabetic Supplies
  - Standard Power Wheelchairs, Scooters, & Related Accessories
  - Support Surfaces (Group 2 mattresses and overlays)
  - Walkers & Related Accessories
  - CPAP Devices, Respiratory Assist Devices, & Related Supplies & Accessories
  - Hospital Beds and Related Accessories
  - Complex Rehabilitative Power Wheelchairs & Related Accessories (Group 2)

- **Orlando-Kissimmee, FL**
  - Oxygen Supplies & Equipment
  - Enteral Nutrients, Equipment, & Supplies
  - Mail-Order Diabetic Supplies
  - Standard Power Wheelchairs, Scooters, & Related Accessories
  - Walkers & Related Accessories
  - CPAP Devices, Respiratory Assist Devices, & Related Supplies & Accessories
  - Hospital Beds and Related Accessories
  - Complex Rehabilitative Power Wheelchairs & Related Accessories (Group 2)

- **Pittsburgh, PA**
  - Oxygen Supplies & Equipment
  - Enteral Nutrients, Equipment, & Supplies
  - Mail-Order Diabetic Supplies
  - Standard Power Wheelchairs, Scooters, & Related Accessories
  - Walkers & Related Accessories
  - CPAP Devices, Respiratory Assist Devices, & Related Supplies & Accessories
  - Hospital Beds and Related Accessories
  - Complex Rehabilitative Power Wheelchairs & Related Accessories (Group 2)

- **Riverside-San Bernardino-Ontario, CA**
  - Oxygen Supplies & Equipment
  - Enteral Nutrients, Equipment, & Supplies
  - Mail-Order Diabetic Supplies
  - Standard Power Wheelchairs, Scooters, & Related Accessories
  - Walkers & Related Accessories
  - CPAP Devices, Respiratory Assist Devices, & Related Supplies & Accessories
  - Hospital Beds and Related Accessories
  - Complex Rehabilitative Power Wheelchairs & Related Accessories (Group 2)
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) Expiration Date (Month/Year)

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 any customer (including both 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.
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____________________________________________________________________________________________________

(Flat 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______________________________
**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)

**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.

<table>
<thead>
<tr>
<th>Contact Person(s) First Name</th>
<th>Last Name</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone (include area code)</td>
<td>E-Mail Address</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact Person(s) First Name</th>
<th>Last Name</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone (include area code)</td>
<td>E-Mail Address</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Contact Person(s) First Name</th>
<th>Last Name</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone (include area code)</td>
<td>E-Mail Address</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact Person(s) First Name</th>
<th>Last Name</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone (include area code)</td>
<td>E-Mail Address</td>
<td></td>
</tr>
</tbody>
</table>

**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:

<table>
<thead>
<tr>
<th>Location</th>
<th>Accreditation Area(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dallas-Fort Worth-Arlington, TX</td>
<td>Oxygen Supplies &amp; Equipment, Enteral Nutrients, Equipment &amp; Supplies, Mail-Order Diabetic Supplies, Standard Power Wheelchairs, Scooters, &amp; Related Accessories</td>
</tr>
<tr>
<td>Miami-Fort Lauderdale-Pompano Beach, FL</td>
<td>Oxygen Supplies &amp; Equipment, Enteral Nutrients, Equipment &amp; Supplies, Mail-Order Diabetic Supplies, Standard Power Wheelchairs, Scooters, &amp; Related Accessories</td>
</tr>
<tr>
<td>Orlando-Kissimmee, FL</td>
<td>Oxygen Supplies &amp; Equipment, Enteral Nutrients, Equipment &amp; Supplies, Mail-Order Diabetic Supplies, Standard Power Wheelchairs, Scooters, &amp; Related Accessories</td>
</tr>
<tr>
<td>Pittsburgh, PA</td>
<td>Oxygen Supplies &amp; Equipment, Enteral Nutrients, Equipment &amp; Supplies, Mail-Order Diabetic Supplies, Standard Power Wheelchairs, Scooters, &amp; Related Accessories</td>
</tr>
<tr>
<td>Riverside-San Bernardino-Ontario, CA</td>
<td>Oxygen Supplies &amp; Equipment, Enteral Nutrients, Equipment &amp; Supplies, Mail-Order Diabetic Supplies, Standard Power Wheelchairs, Scooters, &amp; Related Accessories</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Legal Business Name</th>
<th>DBA (if different)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical Address Line 1</th>
<th>(Street Name and Number)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical Address Line 2</th>
<th>(Suite, Room, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City/Town</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Toll Free Number</th>
<th>E-mail address:</th>
<th>NSC Number (for this location)</th>
<th>NPI Number (for this location)</th>
<th>TIN Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Charlotte-Gastonia-Concord, NC-SC
- Oxygen Supplies & Equipment
- Enteral Nutrients, Equipment, & Supplies
- Mail-Order Diabetic Supplies
- Standard Power Wheelchairs, Scooters, & Related Accessories
- CPAP Devices, Respiratory Assist Devices, & Related Supplies & Accessories
- Hospital Beds and Related Accessories
- Complex Rehabilitative Power Wheelchairs & Related Accessories (Group 2)

Cincinnati-Middletown, OH-KY-IN
- Oxygen Supplies & Equipment
- Enteral Nutrients, Equipment, & Supplies
- Mail-Order Diabetic Supplies
- Standard Power Wheelchairs, Scooters, & Related Accessories
- CPAP Devices, Respiratory Assist Devices, & Related Supplies & Accessories
- Hospital Beds and Related Accessories
- Complex Rehabilitative Power Wheelchairs & Related Accessories (Group 2)

Cleveland-Elyria-Mentor, OH
- Oxygen Supplies & Equipment
- Enteral Nutrients, Equipment, & Supplies
- Mail-Order Diabetic Supplies
- Standard Power Wheelchairs, Scooters, & Related Accessories
- CPAP Devices, Respiratory Assist Devices, & Related Supplies & Accessories
- Hospital Beds and Related Accessories
- Complex Rehabilitative Power Wheelchairs & Related Accessories (Group 2)

Dallas-Fort Worth-Arlington, TX
- Oxygen Supplies & Equipment
- Enteral Nutrients, Equipment, & Supplies
- Mail-Order Diabetic Supplies
- Standard Power Wheelchairs, Scooters, & Related Accessories
- CPAP Devices, Respiratory Assist Devices, & Related Supplies & Accessories
- Hospital Beds and Related Accessories
- Complex Rehabilitative Power Wheelchairs & Related Accessories (Group 2)

Kansas City, MO-KS
- Oxygen Supplies & Equipment
- Enteral Nutrients, Equipment, & Supplies
- Mail-Order Diabetic Supplies
- Standard Power Wheelchairs, Scooters, & Related Accessories
- CPAP Devices, Respiratory Assist Devices, & Related Supplies & Accessories
- Hospital Beds and Related Accessories
- Complex Rehabilitative Power Wheelchairs & Related Accessories (Group 2)

Miami-Fort Lauderdale-Pompano Beach, FL
- Oxygen Supplies & Equipment
- Enteral Nutrients, Equipment, & Supplies
- Mail-Order Diabetic Supplies
- Standard Power Wheelchairs, Scooters, & Related Accessories
- Support Surfaces (Group 2 mattresses and overlays)
- CPAP Devices, Respiratory Assist Devices, & Related Supplies & Accessories
- Hospital Beds and Related Accessories
- Complex Rehabilitative Power Wheelchairs & Related Accessories (Group 2)

Orlando-Kissimmee, FL
- Oxygen Supplies & Equipment
- Enteral Nutrients, Equipment, & Supplies
- Mail-Order Diabetic Supplies
- Standard Power Wheelchairs, Scooters, & Related Accessories
- CPAP Devices, Respiratory Assist Devices, & Related Supplies & Accessories
- Hospital Beds and Related Accessories
- Complex Rehabilitative Power Wheelchairs & Related Accessories (Group 2)

Pittsburgh, PA
- Oxygen Supplies & Equipment
- Enteral Nutrients, Equipment, & Supplies
- Mail-Order Diabetic Supplies
- Standard Power Wheelchairs, Scooters, & Related Accessories
- CPAP Devices, Respiratory Assist Devices, & Related Supplies & Accessories
- Hospital Beds and Related Accessories
- Complex Rehabilitative Power Wheelchairs & Related Accessories (Group 2)

Riverside-San Bernardino-Ontario, CA
- Oxygen Supplies & Equipment
- Enteral Nutrients, Equipment, & Supplies
- Mail-Order Diabetic Supplies
- Standard Power Wheelchairs, Scooters, & Related Accessories
- CPAP Devices, Respiratory Assist Devices, & Related Supplies & Accessories
- Hospital Beds and Related Accessories
- Complex Rehabilitative Power Wheelchairs & Related Accessories (Group 2)
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) __________________________

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).

Section 2b: Additional Network Member Information

O. Network Member’s Identifying Information
Provide the legal business name and physical address.

1. Legal Business Name

(Street Name and Number)

(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) __________________________
Supplier’s Legal Business Name ____________________________ Supplier’s Bidder No. ____________________________

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 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 ____________________________

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) ____________________________

P. Additional Information (Optional)
The space provided may be used if additional space is needed to fully respond to other questions on this form.
__________________________________________________________________________________________________________________________________________________________