

OMB Approval No. 0938-0685

2. Supplier Identification			
This section is to be completed with information specifically related to the business location of the supplier submitting this application. Furnish the following information: the supplier's legal business name and address as reported to the IRS for issuance of IRS Form 1099, the type of business this supplier operates as, the type(s) of products and services this supplier will furnish, and information about the supplier's liability insurance.			
A. Supplier IRS Identification Information		<input type="checkbox"/> Change	Effective Date: _____
Furnish the supplier's legal business name (as reported to the IRS). A copy of the IRS CP-575 or other correspondence issued by the IRS showing the TIN for this business MUST be submitted.			
1. Legal Business Name as Reported to the IRS		Tax ID Number	
2. 1099 Mailing Address Line 1 (Street Name and Number)		Former Tax ID Number (if changed)	
1099 Mailing Address Line 2 (Suite, Room, etc.)			
1099 Mailing Address City	1099 Mailing Address State	1099 Mailing Address ZIP Code + 4	
B. Type of Business for this Supplier			
The supplier must meet all Medicare requirements for a DMEPOS supplier. Submit copies of all required licenses, certifications, and registrations with this application.			
1. Type of Supplier (Check all that apply):			
<input type="checkbox"/> Medical Supply Company	<input type="checkbox"/> Optician	<input type="checkbox"/> Physician	
<input type="checkbox"/> Medical Supply Company with Registered Pharmacist	<input type="checkbox"/> Optometrist	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Medical Supply Company with Respiratory Therapist	<input type="checkbox"/> Home Health Agency		
<input type="checkbox"/> Medical Supply Company with Orthotics Personnel	<input type="checkbox"/> Skilled Nursing Facility		
<input type="checkbox"/> Medical Supply Company with Prosthetics Personnel	<input type="checkbox"/> Intermediate Care Nursing Facility		
<input type="checkbox"/> Orthotics Personnel	<input type="checkbox"/> Nursing Facility (Other)		
<input type="checkbox"/> Prosthetics Personnel	<input type="checkbox"/> Pharmacy		
<input type="checkbox"/> Medicare + Choice Organization	<input type="checkbox"/> Grocery Store		
<input type="checkbox"/> Managed Care Plan (non-Medicare + Choice)	<input type="checkbox"/> Department Store		
	<input type="checkbox"/> Occupational Therapist/Physical Therapist		
2. Which of the above is the <u>primary</u> type of business for the business location of the enrolling supplier?			
C. Products and Services to be Furnished by this Supplier			
1. Check here <input type="checkbox"/> if this supplier is a physician and skip to Section D.			
2. Indicate all <u>primary</u> and secondary products and services furnished by this supplier by circling the letter "P" or the letter "S" next to the appropriate product or service.			
P S Enteral Nutrition	P S Optician	P S Oxygen	
P S Durable Medical Equipment	P S Other (Specify): _____	P S Parenteral Nutrition	
P S Prosthetics	P S Diabetic Equipment and Supplies	P S Drugs/Pharmaceuticals	
P S Orthotics	P S Dialysis Equipment and Supplies	P S Diabetic Footwear	
D. Liability Insurance Information			
Note: All DMEPOS suppliers <u>must</u> submit a copy of their liability insurance policy or evidence of self-insurance with this application.			
Name of Insurance Company			
Insurance Policy Number	Date Policy Issued (MM/DD/YYYY)	Expiration Date of Policy (MM/DD/YYYY)	
Insurance Agent's Name: First	Middle	Last	Jr., Sr., etc.
Agent's Telephone Number () () ()	Agent's Fax Number (if applicable) () () ()	E-mail Address (if applicable)	
E. Incorporation Information			
Is this DMEPOS supplier business incorporated? <input type="checkbox"/> YES <input type="checkbox"/> NO			