MEDICARE DMEPOS COMPETITIVE BIDDING PROGRAM

For CMS Use Only	
Supplier Application No.	Date Application Received

FORM A: APPLICATION

Item #1: Application for Suppliers

Please read the instructions completely.

Competitive Bid Area (CBA)	ZIP Codes

Only one Form A needs to be submitted within a CBA regardless of number of bids submitted within that CBA.

A. Supplier's Identifying Information

Provide the legal business name and mailing address as reported to the IRS. Mailing address is the address where the IRS Form 1099 is to be mailed for this supplier.

Supplier's Legal Business Name

Mailing Address (Street)

City	State	ZIP Code

Telephone Number *(Include Area Code)*	E-Mail Address	Fax Number *(Include Area Code)*

B. Supplier's Business Information

Indicate the length of time the supplier completing this form has been doing business in the CBA.

Length of Time Doing Business

Years Months

C. Supplier's Primary Physical Address

If the supplier's primary physical address is not the same as the mailing address, indicate the supplier's complete physical address.

Physical Address(es)

City	State	ZIP Code

D. 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.

Tax Identification No. (TIN)

E. NSC and/or NPI Identification Number

Provide the NSC and/or NPI number specific to this business location.

NSC Identification Number	NPI Identification Number

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Supplier's Legal Business Name

F. DBA – "Doing Business As" Name

Provide the "doing business as" (DBA) if different from the legal business name reported in item A.

Doing Business As (DBA) *(If applicable)*

Doing Business As (DBA) *(If applicable)*

G. Additional Physical Location Information

Provide all additional names and related information for the additional physical location(s) in which the supplier does business.

1. Name of Business	NSC Number	NPI Number	TIN Number
Physical Address			
City	State	ZIP Code	
2. Name of Business	NSC Number	NPI Number	TIN Number
Physical Address			
City	State	ZIP Code	

H. Accreditation Information for Locations Serving this Competitive Bid Area

Indicate the name(s) of the Medicare-approved organization(s) you are accredited by, or anticipate accreditation from, and provide the accreditation's issue and expiration dates. Indicate product specific area(s) you are accredited (i.e. oxygen, general DME).

1. Legal Business Name	Zip	Product Specific Area(s)	
Accrediting Organization	Status ❑ Yes ❑ No ❑ Pending	Issue Date *(month/year)* (Current or Expected)	Expiration Date *(month/year)* (Current or Expected)
2. Legal Business Name	Zip	Product Specific Area(s)	
Accrediting Organization	Status ❑ Yes ❑ No ❑ Pending	Issue Date *(month/year)* (Current or Expected)	Expiration Date *(month/year)* (Current or Expected)

I. Product Category

Select each product category for which the supplier or network is submitting a bid. (Product categories to be supplied later, for example.)

❑ Product Group 1 ❑ Product Group 2 ❑ Product Group 3

J. Type of Business

Select type of business. If "Other," briefly describe the supplier's type of business. Definitions are provided in the Glossary.

❑ Business Corporation ❑ Sole Proprietorship ❑ General Partnership ❑ Joint Venture
❑ Professional Corporation ❑ Other_____

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K. Establishment Information

Enter the two-letter abbreviation for the state in which the supplier completing this form is established or incorporated. Also provide the date established or incorporated. If incorporated at a previous time, in another state, please provide the state and date.

Established/Incorporated		Previously Established/Incorporated	
State	Date *(mm/dd/yyyy)*	State	Date *(mm/dd/yyyy)*

L. Authorized Official

Provide the name(s) of the authorized official(s) who should be contacted to answer questions regarding the supplier's bid.

Authorized Official(s) First Name PRINT	Last Name	Title
Telephone *(include area code)*	E-Mail Address	
Authorized Official(s) First Name PRINT	Last Name	Title
Telephone *(include area code)*	E-Mail Address	

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Supplier's Legal Business Name

Bank References

List the supplier's primary banks or other financial institutions with which it does business. Include the supplier's line of credit with the institution, account number(s), contact name and telephone number.

1. Institution Name | Line of Credit (if any, in dollars)

Account No.	Contact Person	Telephone Number (include area code)

2. Institution Name | Line of Credit (if any, in dollars)

Account No.	Contact Person	Telephone Number (include area code)

3. Institution Name | Line of Credit (if any, in dollars)

Account No.	Contact Person	Telephone Number (include area code)

Financial Information

The following financial information is required. Please see "Financial Evaluation for Ensuring Capacity" under Instructions – Program Overview.

1. Reviewed Financial Reports (Balance Sheet, Income Statement, Cash Flow Statement) must be submitted by all suppliers who meet the definition of a small supplier as defined by the Small Business Administration (SBA). Small suppliers are defined by the SBA as businesses having less than $6 million in annual receipts. (A reviewed financial statement consist of inquiries of institution management by an outside, independent, certified public accountant and includes analytical procedures applied to the financial data. It is less in scope than an audited statement and does not have an "opinion" regarding the financial statement.)
2. Audited Financial Reports (Balance Sheet, Income Statement, Cash Flow Statement) must be submitted by all suppliers who do not meet the definition of a small supplier as defined by the SBA. (An audited financial statement is certified by an outside, independent, certified public accountant in accordance with standards established by GAAP.)
3. Credit rating and score from past two years from one of the three major credit bureaus
   ❑ Experia ❑ Equifax ❑ Trans Union

I HEREBY CERTIFY that I have examined the accompanying financial statement and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from books and records that we have prepared in accordance with GAAP.

Authorized Official PRINT	Title	Date
Authorized Official SIGNED	Title	Date

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Past or Pending Investigations

Please provide a brief explanation of any past or pending, if known, investigations, legal actions, or matters subject to arbitration involving the applicant, subcontractors, and any entities under legal arrangement (including parent firm). Information provided must include: 1) circumstances; 2) status (pending or closed); and 3) if closed, details concerning any resolution and any monetary damages.

Key Personnel

Please include a list of names and current duties of key personnel of your company. Provide resumes for these individuals that include work history, education and industry accomplishments.

Name	Duties	Resumé Attached
Name	Duties	Resumé Attached ❑ YES ❑ NO
Name	Duties	Resumé Attached ❑ YES ❑ NO
Name	Duties	Resumé Attached ❑ YES ❑ NO
Name	Duties	Resumé Attached ❑ YES ❑ NO
Name	Duties	Resumé Attached ❑ YES ❑ NO

Additional Information (Optional)

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

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Item #2: Application for Networks *(to be completed by Network Primary Supplier only)*

Only one bid per product category will be accepted from a network. Network member suppliers will not be allowed to bid separately from their network. Member suppliers are not allowed to join more than one network. Networks must have legal contracts in place with network member suppliers in order to be eligible to bid.

The primary supplier will submit claims, bill Medicare and receive reimbursement on behalf of all network members.

(A) Enter the primary supplier's NSC and NPI numbers. The NSC and NPI numbers must be specific to the supplier's location – not the corporate number.

NSC Number	NPI Number

(B) Enter the primary supplier's legal business name.

Primary Supplier's Legal Business Name

(C) List the network's member suppliers with their NSC and NPI numbers.

Member Legal Business Name	NSC Number	NPI Number
Member Legal Business Name	NSC Number	NPI Number

(D) Are network's signed, legal contracts between members attached? ❑ Yes ❑ No
If no, the network is ineligible to submit a bid.

Certifying Statement

I have read the contents of this application. 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 424.5. 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 of falsification of any information contained in this application 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 approval of a contract supplier for DMEPOS.

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-xxxx. The time required to complete this information collection is estimated to average xx xxxx 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.

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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.cC. § 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.

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