

Please complete form and send to Network Relations Department.  
 Phone: (407) 585-8306 Fax: (407) 585-8406  
 1280 Upsala Road • Sanford, FL 32771

1. LEGAL COMPANY NAME		
2. D/B/A NAME (IF APPLICABLE)		
3. PHYSICAL ADDRESS Street		Suite #
City	State	Zip
* LIST ADDITIONAL LOCATIONS ON SEPARATE PAGE *		
4. REMIT-TO ADDRESS Street		Suite #
City	State	Zip
5. PHONE	6. ALTERNATE PHONE	
7. FAX	8. EMAIL	
9. WEBSITE	10. CONTACT PERSON & TITLE	
11. COUNTIES SERVED	12. OFFICE HOURS OF OPERATIONS	
13. YEARS IN BUSINESS	14. FEDERAL TIN _____ - _____	
15. REQUIRED TO HAVE A STATE LICENSE TO PROVIDE SERVICES? ___ Yes ___ No		
16. TYPE OF PROVIDER ___ Agency ___ Registry ___ Other: _____		
17. CERTIFICATIONS HELD (ATTACH CURRENT COPY OF EACH CERTIFICATE)		
18. DO YOU HAVE PROCESSES IN PLACE TO VERIFY CURRENT LICENSURES AND CERTIFICATIONS? ___ Yes ___ No		
19. DO YOU SUBCONTRACT ANY OF YOUR SERVICES? ___ Yes ___ No		
20. IF YES, WHAT SERVICES AND WHO CREDENTIALS THESE SUBCONTRACTORS?		
21. DO YOU HAVE CAREGIVERS ON STAFF THAT CAN DO THE FOLLOWING? (Check all that apply)		
___ HOURLY SERVICES →	___ RN	___ LPN ___ HHA/CNA
___ VISIT SERVICES (2 HOURS OR LESS) →	___ RN	___ LPN ___ HHA/CNA
___ WOUND CARE	___ WOUND VACS →	___ BlueSky Medical ___ KCI
___ INFUSION/IV THERAPY	___ 24 HOUR/LIVE-IN AIDE	___ HOMEMAKER/COMPANION CARE
___ PHYSICAL THERAPY	___ OCCUPATIONAL THERAPY	___ SPEECH THERAPY
___ SPEAK A FOREIGN LANGUAGE: _____		
___ OTHER: _____		

**I attest that the information on this application is correct and complete. I agree to notify Total Medical Solutions within 30 days of any changes to the information contained herein.**

\_\_\_\_\_  
 signature

\_\_\_\_\_  
 print name

\_\_\_\_\_  
 date