



# Medical Equipment Provider Questionnaire

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. YEARS IN BUSINESS	13. HOURS OF OPERATION	14. FEDERAL TIN _____ - _____	
15. WHAT ARE YOUR DELIVERY HOURS (IF DIFFERENT FROM HOURS OF OPERATION)?			16. DO YOU OFFER ON-CALL SERVICES? <input type="checkbox"/> Yes <input type="checkbox"/> No
17. REQUIRED TO HAVE A STATE LICENSE TO PROVIDE SERVICES? <input type="checkbox"/> Yes <input type="checkbox"/> No			
18. CERTIFICATIONS HELD (ATTACH CURRENT COPY OF EACH CERTIFICATE)			
19. DO YOU HAVE PROCESSES IN PLACE TO VERIFY CURRENT LICENSURES AND CERTIFICATIONS? <input type="checkbox"/> Yes <input type="checkbox"/> No			
20. DO YOU SUBCONTRACT ANY OF YOUR SERVICES? <input type="checkbox"/> Yes <input type="checkbox"/> No			
21. IF YES, WHAT SERVICES AND WHO CREDENTIALS THESE SUBCONTRACTORS?			
22. DO YOU SERVICE/REPAIR DME EQUIPMENT? <input type="checkbox"/> Yes <input type="checkbox"/> No			
23. IF YES, WHAT ITEMS ARE YOU CAPABLE OF SERVICING/REPAIRING IN-HOUSE?			
24. WHAT ITEM(S) DO YOU SUPPLY FROM YOUR IN-HOUSE INVENTORY? (Check all that apply)			
<input type="checkbox"/> BEDS	<input type="checkbox"/> GRAB BAR INSTALL	<input type="checkbox"/> ADLs	<input type="checkbox"/> REHAB SEATING/POSITIONING
<input type="checkbox"/> POWERCHAIRS	<input type="checkbox"/> BATH AIDS	<input type="checkbox"/> COLD THERAPY	<input type="checkbox"/> SPECIALTY MATTRESSES
<input type="checkbox"/> O&P	<input type="checkbox"/> SOFT GOODS	<input type="checkbox"/> GAME READY	<input type="checkbox"/> INFUSION/IV THERAPY
<input type="checkbox"/> DYNAMIC SPLINTS	<input type="checkbox"/> LIFT CHAIRS	<input type="checkbox"/> EMS	<input type="checkbox"/> RESPIRATORY PRODUCTS
<input type="checkbox"/> WHEELCHAIRS	<input type="checkbox"/> LIFTS	<input type="checkbox"/> BARIATRIC DME	<input type="checkbox"/> MONITORS/PUMPS
<input type="checkbox"/> BRACING	<input type="checkbox"/> TRACTION	<input type="checkbox"/> CPMs	<input type="checkbox"/> STATIC PROGRESSIVE SPLINTS
<input type="checkbox"/> OTHER (Please list):			

**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