

- Individual
- Partnership
- Corporation
- Limited Liability Company
- Limited Liability Partnership



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Application For \$50,000 DMEPOS Bond (Please Print or Type), for multiple locations complete supplement form

1. Bond Information	Amount of bond: \$	Effective Date:	Previous Bonding Co:	Reason for changing:
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2. BUSINESS INFORMATION	Business Name: (Must be exactly as Filed with Medicare/CMS)			Ph:
				F:
Bus. Address to be covered:		City:	State:	Zip code:
Date Business Formed:	No. of years in this business:	No. of years Licensed:	Fed tax ID #	No. of Owners, Partners or Members:
Are you an accredited DMEPOS provider? <input type="checkbox"/> YES <input type="checkbox"/> NO		Accredited Organization name:		
NPI No.:	NSC /PTAN No.:	Last Visit Date:	Accreditation Date:	
Medicare last audit date:	Any citations or problems? <input type="checkbox"/> YES <input type="checkbox"/> NO	How many years participating In Medicare?		
Est. Annual Medicare Receipts \$	Est. Next Year revenue\$	Last Year Annual Revenue \$		
Who are your primary customers?				
Percent of Business transacted through:	Storefront %	Home visits %	Mail order %	Internet %
Type of DMEPOS goods you supply:			Customized or off shelf?	
Warehouse Location:		<input type="checkbox"/> Own <input type="checkbox"/> Lease	Area of service:	
Name of Bank:	Name of Banker:	Bank Phone:	Years with bank:	
Explain Medicare billing process and experience:				
Formal line of credit?	Amount \$	Amount outstanding \$	How secured?	

3. Experience Information	Is the above <input type="checkbox"/> A new enrollee as a DMEPOS supplier? OR named company: <input type="checkbox"/> currently enrolled as a DMEPOS Supplier? How many years? _____			
Has the business or any of the owners or officers: (If you answered "Yes" to any you must provide explanation)				
a) Ever had a license suspended, revoked, or denied? <input type="checkbox"/> YES <input type="checkbox"/> NO		d) Ever been convicted of a crime? <input type="checkbox"/> YES <input type="checkbox"/> NO		
b) Been the subject of adverse action by CMS in the last ten years? (if yes please explain) <input type="checkbox"/> YES <input type="checkbox"/> NO		e) Have any outstanding collection items or liens? <input type="checkbox"/> YES <input type="checkbox"/> NO		
c) Have any pending litigation, lawsuits or judgments? <input type="checkbox"/> YES <input type="checkbox"/> NO		f) Ever caused claim to any surety company? <input type="checkbox"/> YES <input type="checkbox"/> NO		
		g) Ever failed in business or declared bankruptcy? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Is the applicant a pharmacy Licensed by a state board of Pharmacy to dispose prescription drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Pharmacy License No.:		Issuing State:	Date:	

4. Owners Information: List all Owners of the company (If additional Owners, please attach information on separate sheet)

A. Name:		Date of Birth:	SS#:	
Home Address:		City:	State:	Zip:
<input type="checkbox"/> Own <input type="checkbox"/> Rent	Equity in Home \$	Home Ph:	Cell:	Driver Lic:
Bus. Ownership %	Involved Full Time? <input type="checkbox"/> Y <input type="checkbox"/> N	Title:	Spouse Name:	
B. Name:		Date of Birth:	SS#:	
Home Address:		City:	State:	Zip:
<input type="checkbox"/> Own <input type="checkbox"/> Rent	Equity in Home \$	Home Ph:	Cell:	Driver Lic:
Bus. Ownership %	Involved Full Time? <input type="checkbox"/> Y <input type="checkbox"/> N	Title:	Spouse Name:	

5. General Notes: The undersigned applicant and indemnitor hereby request and apply for a Medicare bond and authorize LSJ Insurance Agency to submit this application on their behalf for approval and agree to the following: a) Authorize the surety bonding company to verify this information at any time, and obtain additional information from any source including credit report. b) Agree that if the application is approved to properly sign the Company's specific Indemnity agreement which becomes an integral part of this application and pay the premium due as a condition to issue the bond.

Agreed and signed this ____ day of _____, _____; **Applicant: by:** _____ / _____
Print name Sign here

E Mail: _____

Indemnitor: by: _____ / _____
Print name Sign here