



Medicare Provider Group Registration Form

Pharmacy Name _____ Phone Number _____
Location Address _____ City/State/Zip _____
Mailing Address (if different) _____

Region/County _____

- Sign me up for HME Cluster Group
- Sign me up for 3rd Party HME Contracts

I currently supply the following Medicare Part B Product categories:

- Oxygen Supplies and Equipment
- Standard Power Wheelchairs, Scooters and accessories
- Complex Rehab Power Wheelchairs and accessories
- Hospital Beds and accessories
- Enteral Products and accessories
- Continuous Rehabilitative Airway Pressure Devices, Respiratory Assist Devices and accessories
- Walkers and accessories

I currently supply the following HME products and services:

- Diabetic Strips and Supplies
- Diabetic Shoes and Inserts
- Nebulizers
- Manual Wheelchairs
- Bathroom Safety
- Basic Mobility (Canes/Crutches)
- Wound Care or Med/Surg Supplies
- Ostomy Products
- Home Infusion Therapy
- Women’s Health Products
- Pain Management
- Compounding
- Injectibles

Accreditation Status

- I am Accredited by _____
- I am implementing Accreditation standards with _____
- I need help with Accreditation
 - I currently provide rental equipment or want/expect to
 - I do not expect to provide rental medical equipment

Payment Option

Medicare Provider Group Fee is \$750.00.
Make Check Payable to HME Solution, Inc. and mail to the PO Box listed at the bottom of the page OR
FAX Form with Credit Card Information to (888) 228-4867 for immediate registration

Card Holder Name _____ Card Number _____
Card Type _____ Expiration Date _____ Security Number _____
Billing Address _____

Approval Signature _____

HME Solution Inc. P.O. Box 17675 Holladay UT 84117 (888) 228-4867