

## MEDICARE DMEPOS COMPETITIVE BIDDING PROGRAM

For CMS Use Only

Supplier Bidder No.

Date Application Received

Competitive Bid Area (CBA)

### Supplier's Identifying Information

Supplier's Legal Business Name

Primary Supplier's Legal Business Name (if network)

### FORM B: BIDDING FORM

One Form B MUST be submitted for each product category and CBA. Information supplied must be aggregate for all locations and for all network member locations that will be providing this product category in this CBA. References to a business organization includes: suppliers with a single location, suppliers with multiple locations, and networks. If the business organization is a network, the primary supplier must complete this form on behalf of the network.

**1) From the options below select** the total revenue that your business organization collected for this product category in this CBA for the past calendar year. A product category includes Healthcare Common Procedure Code System (HCPCS) codes for items that are related. For a list of all codes included in a product category see the Bidding Information Chart titled "Estimated Capacity and Bid Amount Worksheet" see [www.dmecompetitivebid.com/bic](http://www.dmecompetitivebid.com/bic). All subsequent questions must be answered for the same calendar year. *If you are submitting a bid for multiple locations that share common ownership or for a network, select the total revenue for all locations in this CBA.*

Estimates are acceptable.

- \$0–\$250,000       \$250,001–\$500,000       \$500,001–\$750,000       \$750,001–\$1 million  
 \$1,000,001 –\$3 million       \$3,000,001 –\$6 million       \$6,000,001 –\$10 million       More than \$10 million

Select the percentage of the total revenue that was collected from Medicare for this product category for the past calendar year. Estimates are acceptable.

- 0% – 10%       11% – 20%       21% – 30%       31% – 40%       41% – 50%  
 51% – 60%       61% – 70%       71% – 80%       81% – 90%       91% – 100%

**2) From the options below select** the total number of customers that your business organization furnished items in this product category in this CBA during the past calendar year. *If you are submitting a bid for multiple locations that share common ownership or for a network, select the total number of customers for all locations in this CBA.*

Estimates are acceptable.

- 0 – 25       26 – 50       51 – 75       76 – 100       101 – 300  
 301 – 500       501 – 750       751 – 1000       More than 1,000

Of the total customers for this product category, what percentage were Medicare beneficiaries? Estimates are acceptable.

- 0% – 10%       11% – 20%       21% – 30%       31% – 40%       41% – 50%  
 51% – 60%       61% – 70%       71% – 80%       81% – 90%       91% – 100%

**3)** Indicate the counties in this CBA where you currently furnish this product category; include Medicare and non-Medicare customers.

_____	_____
_____	_____
_____	_____

Indicate the percentage of the total geographic area (all counties) where you currently furnish items in this product category to Medicare beneficiaries? The total percentage may not exceed 100%.

\_\_\_\_\_

**4a)** The HCPCS codes listed below represent the top codes that account for approximately 80% of the allowed charges for this product category. Indicate the number of units that your business organization has furnished to all customers, both Medicare and non-Medicare, in this CBA during the past calendar year. In the next column, indicate the number of units provided only to Medicare beneficiaries in this CBA during the past calendar year. If your business organization has not provided the item, indicate "0" in the appropriate column. Please refer to the Bidding Information Chart titled "Estimated Capacity and Bid Amount Worksheet" at [www.dmecompetitivebid.com/bic](http://www.dmecompetitivebid.com/bic) for the definition of "Unit" for each item.

HCPCS Code	Total Units Provided To All Customers	Total Units Provided to Medicare Beneficiaries
HCPCS Code	Total Units Provided To All Customers	Total Units Provided to Medicare Beneficiaries
HCPCS Code	Total Units Provided To All Customers	Total Units Provided to Medicare Beneficiaries

**4b)** Indicate the percentage increase in Medicare business that you would be capable of providing for this product category in this CBA during a projected 12-month period. The percentage increase may exceed 100%.

**4c) Manufacturer and Model Information—**

Listed below are the top HCPCS codes for the product category in this CBA in terms of allowed charges. Identify the manufacturer(s), model name(s), and model number(s) of all products that you will make available to Medicare beneficiaries in the CBA. You must provide information for each HCPCS code in order for your bid to be complete.

If a contract is awarded, the information entered on this screen will be displayed to the public in the online Medicare Supplier Directory located at <http://www.medicare.gov>.

HCPCS CODE	Manufacturer	Model Name	Model Number

**5a)** If you plan to expand your business under the Competitive Bidding Program, please discuss the following items of your expansion plan. If additional space is required, see questions 7 for additional information.

Staff (manpower)

Current: \_\_\_\_\_

Expansion Plan: \_\_\_\_\_

Financing (funding levels):

Current: \_\_\_\_\_

Expansion Plan: \_\_\_\_\_

Facilities (square footage, facility):

Current: \_\_\_\_\_

Expansion Plan: \_\_\_\_\_

Inventory Control (method of tracking inventory):

Current: \_\_\_\_\_

Expansion Plan: \_\_\_\_\_

Distribution Methods (vehicles, mail order):

Current: \_\_\_\_\_

Expansion Plan: \_\_\_\_\_

Other:

Current: \_\_\_\_\_

Expansion Plan: \_\_\_\_\_

**5b)** If you plan to expand your business through the use of subcontractor(s), identify the entities with which you anticipate entering into a legal agreement and their expected function. If you plan to expand using subcontractor(s), a copy(s) of the signed letter of intent to enter into an agreement with the subcontractor(s) must be submitted along with the other required hardcopy documents. Please note that "subcontracting arrangements" must be in compliance with Supplier Standards and subcontractor(s) can only perform services allowed under these standards. For certain functions subcontractors are required to be accredited by a CMS approved accreditation organization.

Legal Name of Subcontractor

Expected Function

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# **FORM B: BIDDING SHEET**

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## **Supplier's Identifying Information**

Supplier's Bidder No.

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Supplier's Legal Name (from page 1)

Primary Supplier's Legal Business Name (if applicable)

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## **Bid Sheet Information:**

Provide the total estimated capacity and your bid price for each HCPCS code listed for this product category.

- HCPCS –Healthcare Common Procedure Code System. This is a standardized coding system that is used primarily to identify products, supplies, and services.
- Product Class- A combination of codes for which a single bid is required.
- Item Description – Short narrative description of each HCPCS code. For long description go to [www.dmecompetitivebid.com](http://www.dmecompetitivebid.com).
- Type of Bid (Rental or Purchase) – The bidding form indicates whether your bid amount for the item (identified by the HCPCS code) should be submitted as either for the purchase of a new item or as a monthly rental. In most cases you will submit a bid amount that represents a purchase of the item. Even though an item is routinely paid for on a rental basis, it does not necessarily mean the bid amount should be for a monthly rental payment.
  - If “Purchase” is indicated, enter a bid amount for total purchase of the item.
  - If “Rental” is indicated, enter a bid price for one month’s rental of the item.It is very important that you review your bid amount and ensure it was entered correctly.
- Product Weight – Indicates the relative market importance of each item to the overall product category.
- Fee Schedule – Indicates the fee schedule amount for this CBA. You must provide a bid price that is less than or equal to the fee schedule amount.
- Total Estimated Capacity – Indicates the number of units per HCPCS code that you estimate you can provide throughout the entire CBA for one (1) year. To determine the capacity for each HCPCS code, calculate the number of units that you currently furnish on a yearly basis and add any additional number of units or capacity you would be capable of providing annually at the start of the contract period. It is anticipated that suppliers will be capable of sustaining the same level of estimated capacity throughout the entire contract period. Please refer to the Bidding Information Chart titled “Estimated Capacity and Bid Amount Worksheet” at [www.dmecompetitivebid.com/bic](http://www.dmecompetitivebid.com/bic) for the definition of “Unit” for each item.
- Bid Price- Indicate your bid price for this item. You must submit a bona fide bid for each HCPCS code. The amount submitted should be rational, feasible, and supportable. If requested, you must be able to provide supporting documentation, such as a manufacturer’s invoice, that verifies you can provide the item to the beneficiary for the bid amount. The bid amount you submit for each HCPCS code should include the cost of furnishing the item throughout the CBA (except for SNFs and NFs that elect to participate as specialty suppliers) for the duration of the contract.

**Note:** Columns E & G are to be completed by your business organization.

<b>A HCPCS Code</b>	<b>B Item Description</b>	<b>C Bid Type Rental or Purchase</b>	<b>D Product Weight</b>	<b>E Total Estimated Capacity</b>	<b>F Fee Schedule</b>	<b>G Bid Price</b>
TO BE COMPLETED BY CBIC	TO BE COMPLETED BY CBIC	TO BE COMPLETED BY CBIC	TO BE COMPLETED BY CBIC		TO BE COMPLETED BY CBIC	

**Please sign and attach certification to financial statements.**

**Certifying Statement Applies to All Information Submitted Electronically or Hardcopy.**

I have read the contents of this application. I hereby certify that I have examined the completed application and accompanying financial statements and I certify that they are true, correct, and complete statements that can be substantiated from our books and records. 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 Competitive Bidding Implementation Contractor (CBIC) to verify this information. I also certify that I will adhere to the terms of the competitive bidding contract if awarded a contract.

I agree to notify the CBIC in writing of any changes that may affect the contract and/or my ability to carry out the terms of the contract, prior to such change or within 30 days of the effective date of such change. I understand that I may be in breach of contract if any such change results in my failure to carry out the terms of the contract.

I also certify that I have read, understand, meet, and will continue to meet all supplier standards and quality standards as outlined in 42 CFR § 424.57 and 424.58. 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 I am a Medicare enrolled supplier and meet the basic eligibility requirements of the DMEPOS Competitive Bidding Program.

I understand that in accordance with 18 U.S.C. §1001, any omission, misrepresentation, or falsification of any information contained in this application and all required attachments and supplemental information or contained in any communication supplying information to CMS or the CBIC 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 this organization that is submitting a bid in the DMEPOS Competitive Bidding Program.

**NOTE TO NETWORKS:** Networks are required to submit this certification page from the primary network supplier's authorized official. The network must also submit the Network Certification Page in addition to this certifying statement along with the package of hardcopy documents. Failing to submit all of these documents will disqualify the network's bid.

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Authorized Official Supplier Name (First, Middle, Last, Jr., Sr., etc.)  
PRINT

Title/Position

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Signature

Date

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Supplier's Legal Business Name

Supplier's Bidder No.

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## **NETWORK CERTIFICATION PAGE**

The primary network supplier and the authorized official for each individual network member must sign a hardcopy of this certification page(s) and submit it, along with the other required hardcopy documents to the CBIC.

By signing this certification, I further certify that I meet the definition of a small supplier and that I joined the network because I was unable independently to furnish all items in the product category for which the network is submitting a bid to beneficiaries throughout the entire geographic area of the Competitive Bidding Area.

Network Member Name (First, Middle, Last, Jr., Sr., etc)

Title/Position

PRINT

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SIGNATURE

Date

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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 14 hours per response, including the time to review instructions, search existing data resources, gather 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.

## 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.C. § 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.