



Wisconsin Association of
Medical Equipment Services

WAMES Membership Application

- Confidential -

I. Contact Information

Company name of applicant _____

Contact Name & Title _____

Address _____

City _____

State _____

Zip _____

Telephone _____

Fax _____

Email address _____

Company web site address _____

II. Are you a subsidiary or franchise of another company? ___ yes ___ no If yes, please give the following information:

Parent company name _____

President and/or CEO _____

Mailing address of parent company: City _____ State _____ Zip _____

III. Please complete this form and submit it with your check payable to:

Wisconsin Association of Medical Equipment Services (WAMES)
PO Box 389, Wild Rose, WI 54984

or pay by Visa or MasterCard below:

Credit Card Number _____ Exp date _____

Signature _____

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Type of business (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> sole proprietor (owner) | <input type="checkbox"/> manufacturer |
| <input type="checkbox"/> regional chain | <input type="checkbox"/> national chain |
| <input type="checkbox"/> pharmacy | <input type="checkbox"/> distributor |
| <input type="checkbox"/> hospital based | <input type="checkbox"/> nursing home |
| <input type="checkbox"/> HMO | <input type="checkbox"/> franchise |

My company's top revenue producers in ranking order are:

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> DME | <input type="checkbox"/> oxygen |
| <input type="checkbox"/> PEN | <input type="checkbox"/> disposables |
| <input type="checkbox"/> rehabilitation | <input type="checkbox"/> other: |

Classes of Membership

Regular - A sole proprietorship, partnership, firm or corporation currently engaged in the retail/wholesale, rental or distribution of any type of medical equipment, products, services, or suppliers for home use in the care and treatment of patients. All organizations who bill Part B for their Medicare patients qualify to be a Regular Member. A Regular Member shall have full voting rights.

Associate - A person, partnership, firm or corporation not otherwise qualified for regular membership that engages through manufacturing, wholesale or otherwise in a business that supports or enhances a regular member's health care business.

Dues Classification

In accordance with the descriptions outlined above, our company is in the following category (please check one):

I. Regular Membership:

- | <u>Dues</u> | <u>Membership Category</u> |
|----------------------------------|---|
| \$595 <input type="checkbox"/> | Regular Member, Net Revenue of less than \$1,000,000 |
| \$795 <input type="checkbox"/> | Regular Member, Net Revenue between \$1,000,000 - \$3,000,000 |
| \$995 <input type="checkbox"/> | Regular Member, Net Revenue between \$3,000,000 - \$7,000,000 |
| \$1,095 <input type="checkbox"/> | Regular Member, Net Revenue over \$7,000,000 |

II. Associate Membership: Bronze \$595.00 Silver \$895.00 Gold \$1,395.00

- Do you Bill Part B for Medicare patients? yes no (If yes, you qualify to be a Regular Member)
- Has your company ever been convicted of any health care crime? yes no
- Has your company ever been convicted of a felony under Federal or State Law? yes no
- Has any family and/or household member(s) of the applicant who has ownership or control interest in the enrolling business or entity ever been convicted, assessed, or excluded from the Medicare program due to fraud, obstruction of an investigation, or a controlled substance violation? yes no If yes, please furnish the information below:
First name _____ Last name _____ Middle _____ Jr., Sr., etc _____ Relationship _____

e. Check below if the applicant has ever had any of the following adverse legal actions imposed by the Medicare, Medicaid or any other federal agency or program. For each checked, include the date the adverse legal action was imposed. Check all that apply or the "none of these" box. Attach copy of adverse legal action notification.

- | | | |
|--|---|---|
| 1. <input type="checkbox"/> Administrative Sanction(s) | 2. Health Care Related: | 3. None of these <input type="checkbox"/> |
| <input type="checkbox"/> Program exclusion(s) _____ | <input type="checkbox"/> Criminal fine(s) _____ | |
| <input type="checkbox"/> Suspension of payment(s) _____ | <input type="checkbox"/> Restitution order (s) _____ | |
| <input type="checkbox"/> Civil monetary penalty(s) _____ | <input type="checkbox"/> Pending civil judgment(s) _____ | |
| <input type="checkbox"/> Assessment(s) _____ | <input type="checkbox"/> Judgment(s) pending under the False Claims Act _____ | |
| <input type="checkbox"/> Program Debarment(s) _____ | | |

- Does the application have any outstanding criminal fines? yes no Restitution orders? yes no
- Does the applicant, under any name or business identity, have any outstanding overpayments with Medicare, Medicaid or any other federal program? yes no If yes, under what federal program? _____
If yes, under what name? _____

Certification

I certify that the information submitted in this application is true, complete and correct to the best of my knowledge and belief and further agree to comply with the WAMES Code of Ethics and Federal, State and Local Regulations.

Authorized signature _____ Date _____

**Authorization of Disclosure and Release of Information
Wisconsin Association of Medical Equipment Services**

In connection with my application for membership to the Wisconsin Association of Medical Equipment Services (hereinafter known as "WAMES"), I authorize WAMES and/or Fidelitec, LLC, to investigate and retrieve information relating to my past activities for purposes of such investigation from all relevant individuals and organizations, including but not limited to government agencies, companies, law enforcement agencies, and consumer reporting agencies, to supply any and all information concerning my background, and release the same from any liability resulting in providing such information. The information received may include, but is not limited to, criminal records, civil records, and related court offenses. I understand that I have the right to request additional information about these inquiries and any subsequent reports. This additional information will be provided to me upon written request to Fidelitec, LLC, 245 Horizon Drive, Suite 107, Verona, WI 53593.

I hereby certify that all the statements and answers made by me, both verbal and in writing, including statements on this form are true and complete to the best of my knowledge, and I understand that any false statements and/or answers or omissions of information and on this form will be sufficient cause for cancellation of my application or dismissal, if I have been granted membership. I understand that by furnishing my birth date below, WAMES and/or Fidelitec, LLC, are using that information for the sole purpose of verifying identification as part of the criminal records check and the birth date is not part of my application for membership. I release all parties for all liability for any damage that may result from furnishing information, including this disclosure of my date of birth and this authorization to WAMES and/or Fidelitec, LLC.

I authorize that a photocopy or fax of this authorization be accepted with the same authority as the original; and that this authorization be in effect throughout my consideration for membership and, if granted by WAMES, this authorization remain in effect throughout my membership.

Print Name (First, Middle Initial, Last)

Signature Date

Street City State Zip

SOCIAL SECURITY NUMBER _____

BIRTH DATE (MONTH/DAY/YEAR) _____

DRIVER'S LICENSE NO. _____

STATE _____ EXPIRES _____