APPLICATION FOR LICENSURE AS A HOME MEDICAL EQUIPMENT SERVICE PROVIDER

State Form 52525 (R5 / 4-17)

Approved by State Board of Accounts, 2017

INDIANA BOARD OF PHARMACY
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2067
E-mail: pla4@pla.IN.gov
www.pla.IN.gov

INSTRUCTIONS:

1. *The fee for this application is $150.00, payable to the Indiana Professional Licensing Agency, in accordance with 856 IAC 1-39-7.*
2. *Completed application and fees should be mailed to the address listed in the upper right hand corner of this form.*
3. *All fees are non-refundable and non-transferable.*
4. *Please refer to the instructions on our website, www.pla.in.gov, for the licensing requirements.*

FOR OFFICE USE ONLY

Application fee	Date paid (*month, day, year*)	Receipt number

License number	Date of issue (*month, day, year*)

DO NOT WRITE ABOVE THIS LINE

DOCUMENTATION

Attach copies of the following items to this application:

1. Medicare provider number _________________ (verification letter)
2. Medicaid provider number _________________ (verification letter)
3. Verification of each accreditation *(if applicable)*
4. Proof of insurance

APPLICANT INFORMATION

Type of application

☐ New Store
☐ Change of Location *(Provide current Indiana license number.)* ____________________
☐ Change of Ownership *(Provide current Indiana license number.)* ____________________

Legal name of business	Indiana Home Medical Equipment (HME) licencse number

Address of principal facility (*number and street*)	City	State	ZIP code	County

If change of location, previous address (*number and street*)	City	State	ZIP code	County

Telephone number	Fax number
( )	( )

E-mail address	Website (*if applicable*)

Principal mailing address (*number and street*)	City	State	ZIP code	County

National Provider Identification (NPI) number	Medicare Identification (NSC) number	Medicaid number

TYPE OF OWNERSHIP

☐ Sole proprietorship ☐ Limited liability corporation ☐ Other ____________________
☐ Partnership ☐ Corporation ____________________

ALL TRADE / BUSINESS NAMES USED BY THE ENTITY

FACILITY LICENSES / CREDENTIALS *(ex: Pharmacy, FDA, CDL, etc.)*

Type	Number	Date of expiration (*month, day, year*)
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OFF-SITE STORAGE FACILITIES

Number of off-site storage facilities or warehouses under the above listed ownership: ____________
List the address of each facility (*attach additional sheets, if necessary*).

Address of facility (*number and street, city, state and ZIP code*)	County
Address of facility (*number and street, city, state and ZIP code*)	County
Address of facility (*number and street, city, state and ZIP code*)	County
Address of facility (*number and street, city, state and ZIP code*)	County

CONTACT PERSON (*Individual completing application*)

Name of contact person	Title
Telephone number ( )	E-mail address

ACCREDITATION / CERTIFICATION (*Required for all Medicare providers after 01/01/07*)

Type	Date of expiration (*month, day, year*)

SERVICES PROVIDED (*Check all that apply*)

- ☐ Oxygen & oxygen delivery systems
- ☐ Ventilators
- ☐ Respiratory disease management devices
- ☐ Continuous positive airway pressure (CPAP) devices
- ☐ Electronic & computerized wheel chairs & seating systems
- ☐ Manual wheelchairs
- ☐ Apnea monitors
- ☐ Transcutaneous electrical nerve stimulators
- ☐ Low air loss cutaneous pressure management devices
- ☐ Sequential compression devices
- ☐ Feeding pumps
- ☐ Home phototherapy devices
- ☐ Infusion delivery devices
- ☐ Distribution
- ☐ Distribution of medical gasses to end users for human consumption
- ☐ Hospital beds & accessories
- ☐ Nebulizers
- ☐ Continuous Passive Motion (CPM) machines
- ☐ Patient lift devices
- ☐ Defibrillators
- ☐ Other similar equipment as adopted by the Board: ______________________________________
____
____

If oxygen is checked above Do you transfill oxygen? ☐ Yes ☐ No	If yes, please provide FDA number.
If oxygen is checked above Do you carry over 1,000 pounds? ☐ Yes ☐ No	If yes, please provide DOT number.

QUESTIONS

If your answer is "Yes" to any of the following, explain fully in a sworn affidavit, including all related details, and provide copies of all relevant arrest or court documents. Describe the event including the location, date and disposition. Falsification of any of the following is grounds for permanent revocation of the license or permit issued pursuant to this application.

1. Has the applicant, or any of the applicant's employees or associates ever been excluded from Medicare participation? ☐ Yes ☐ No
2. Has the applicant, or any of the applicant's employees or associates had a disciplinary action taken by the federal or state government of any license(s) held by any employee or associate? ☐ Yes ☐ No
3. Has the applicant, or any of the applicant's employees or associates, ever been convicted of a felony that has not been expunged by a court? ☐ Yes ☐ No
4. Is any action pending on any of the above? ☐ Yes ☐ No

AFFIDAVIT

I do solemnly swear or affirm, under the penalties of perjury, that I am the person authorized to sign this application for licensure and that the statements made are true and correct in all respects.

Signature of contact person	Date signed (*month, day, year*)
Title of contact person	