



Addition of Product Categories Application

List product line additions

Facility Information

Facility Name		Doing Business As (DBA)			
Street Address					Suite Number
City		State		Zip Code	Country
Email			Fax Number		
Telephone Number			Mobile Number		
CMS Provider # (PTAN)		National Provider Identifier # (NPI)		Employer Identification # (EIN)	
National Association Board of Pharmacy # (NABP) <i>If applicable</i>			Drug Enforcement Agency # (DEA) <i>If applicable</i>		

Posted Business Hours: Indicate AM/PM and if the facility closes for lunch.

	Closed	Open Time	Close Time	Closed for Lunch	Lunch Start Time	Lunch End Time
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
Sunday						

Have there been changes to your Certified/Licensed Personnel? Yes No

If you answered yes to the above question please indicate these changes below and submit supporting documentation:



Owner/Corporate Officer Signature

By signing this affidavit, I attest to personal knowledge of the accuracy of all information provided to BOC. I agree to notify BOC in writing of changes to ownership, corporate structure, location, or provision of services/equipment. I grant permission to BOC and its authorized representatives to inspect my facility during business hours and without prior notification, and I agree to maintain ongoing compliance with BOC's policies and standards, as well as standards set forth by the Centers for Medicare/Medicaid Services (CMS); I understand my responsibility to maintain continued compliance, even as these policies and standards are updated. I understand that non-compliance with this affidavit may result in denial or revocation of accreditation.

Print Owner/Corporate Officer Name

Signature Owner/Corporate Officer

Date

Product Line Change Fee

On-Site Survey Fee (required for any product categories not listed below) **\$1,455**

For the product categories listed below there is only a \$150 administrative fee **if you have already paid for a full DME accreditation.** (No survey required)

- | | |
|---|---|
| <ul style="list-style-type: none"> ▪ Blood Glucose Monitors and Supplies-Mail Order (DM06) ▪ Blood Glucose Monitors and Supplies-Non Mail Order (DM05) ▪ Canes and Crutches (M01) ▪ Commodes/Urinals/Bedpans (DM02) ▪ Enteral Nutrients (PE03) ▪ Lymphedema Compression Treatment Items (S04) | <ul style="list-style-type: none"> ▪ Enteral Nutrients Equipment and Supplies (PE04) ▪ Ostomy Supplies (PD06) ▪ Support Surfaces: pressure reducing beds/mattresses/overlays/pads (DM20) ▪ Surgical Dressings (S01) ▪ Urological Supplies (PD09) ▪ Walkers (M05) ▪ Wheelchair Seating/Cushions (M10) |
|---|---|

Payment Method

Credit Card Payment		Check Payment	Check Number
<input type="checkbox"/> Visa <input type="checkbox"/> Mastercard <input type="checkbox"/> Discover <input type="checkbox"/> American Express	<input type="checkbox"/> Check (enclosed)		
Credit Card Number	Security Code	Expiration Date	
Billing Address			
City	State	Zip Code	
Name as it appears on card		Cardholder Signature	

The issuer of the card identified on this form is authorized to pay the amount shown as Payment Amount upon proper presentation. I agree to pay such Payment Amount (together with any other charges due thereon) subject to and in accordance with the Agreement governing the use of such card. Make Check or Money Order payable to BOC. If your check is returned for any reason, you must submit a bank draft, money order, or credit card payment with an additional fee of \$35.00 to cover the returned check processing fee. Applicants applying outside of the contiguous United States will be subject to an applicable surcharge for additional travel expenses. BOC does not offer refunds or accept post-dated checks.

You may email or fax this application and documentation to:

fa@bocusa.org
410.581.6228

Or, mail completed application and documentation to:

Board of Certification/Accreditation
Attention: Accreditation Department
10461 Mill Run Circle, Suite 1250
Owings Mills, Maryland 21117