DME DEALER REGISTRATION

Company Name:_____

Sales Tax ID#_____ Fed, Tax ID # _____

Shipping Address: _____

_____

Billing Address: _____

_____

Phone Number: _____ Fax #: _____

Bills should be: ☐ included in package with product ☐ sent separately.

Contact person for questions about orders: _____

Contact person for questions about bills: _____

Contact person for referrals: _____

Description of your general product line:

Area Served (Cities, counties, etc):

Institutions and Agencies Served:

Are you a Medicaid Provider? _____YES ____NO If yes, in what states?

Are you a Medicare Provider? ____ YES ____NO

If you are a preferred provider for or commonly work with any insurance plans, please tell us which ones:

YOU ARE WELCOME TO COPY ANY OF OUR INFORMATION AS YOU WISH. Let is know if you would like white copies that would be a little easier to reproduce.

Return this form to:

Luminaud inc.

www.luminaud.com e-mail: info@luminaud.com

8688 Tyler Boulevard • Mentor, OH 44060-4348

PHONE HOURS: WEEKDAYS 9:00a to 4:30p EASTERN

Phone **800-255-3408** • 440-255-9082 • Fax 440-255-2250