Rosenzweig Insurance Agency, Inc.
160 Herricks Rd. Mineola, New York 11501-0070
Tel (516) 352-7495 Fax (516) 358-7940
www.RosenzweigInsurance.com www.PharmacyInsuranceOnline.com

**Please e-mail or fax the completed application to:**
**Pharmacy@RosenzweigInsurance.com**
**Fax: 516-358-7940**
**Attention: Dee or Rambha**

# Medicare Bond Application

## Section I: Bond Applied For

Type of Bond: Surety Bond Effective Date: _____

Obligee: Center for Medicare and Medicaid Services Bond Amount: _____

## Section II: General Information

Applicant Name: _____ Social Security #: _____

Residence Address: _____

Business Name: _____ Percent Ownership of Business: _____

Business Phone: _____ Business Fax: _____

Business Address: _____

Email: _____

Date Business Began Under Present Individual or Firm: _____

Federal Tax ID: _____ NPI #: _____

NSC/PTAN# (if you have one): _____ Do you own your home? ☐ Yes ☐ No

Pharmacy License #: _____ Date of Issue: _____

Type of Business: ☐ Corporation ☐ LLC ☐ Sole Proprietorship ☐ Partnership

Has the company, any predecessor company or any owner ever:

| | | |
|---|---|---|
| Been in a claim with a surety company? | ☐ Yes | ☐ No |
| Within the past 7 years, been involved in any law suits? | ☐ Yes | ☐ No |
| Ever failed in business or filed for bankruptcy? | ☐ Yes | ☐ No |
| Had a tax lien exceeding $1,000? | ☐ Yes | ☐ No |

If yes to any of the above questions, please explain on a separate piece of paper.

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**Attention: Dee or Rambha**

## Section III: Additional Owners and Partners as Required

(If additional owners, please attach information on separate page)

Applicant Name: _____ Social Security #: _____

Residence Address: _____

Do you own your home? ☐ Yes ☐ No Percentage ownership of business: _____

Email: _____

## Section IV: Medicare Information

For how many years have you participated in Medicare? _____

Date of Accreditation: _____ Accreditation Organization: _____

Approximate Amount of Medicare Billings Last Year: $ _____

Approximate Amount of Medicare Billings Two Years Ago: $ _____

Approximate Amount of Medicare Billings Expected Next Year: $ _____

Date of your last audit by Medicare: _____

Any citations or problems reported? ☐ Yes ☐ No

If yes, describe: _____

Has applicant, any predecessor company, any owner or officer ever had a Medicare or Medicaid license revoked, or experienced adverse legal action relative to Medicare or Medicaid?

Yes ☐ No ☐ If yes, describe: _____

Completion of this form constitutes for the bonding company and agency to obtain consumer information and obtain a credit report which will be used to determine bonding eligibility. Bond will not be issued without approval from bonding company and receipt of payment in full. Bond premium is fully earned.

Signature: _____ Title: _____ Date: _____