

# DIRECT BILL ACCOUNT QUESTIONNAIRE

Below is requested information to begin the process of setting up your new ASD Healthcare account.

**Note:** Replying to this questionnaire does not result in the creation of your account. Once we receive the requested information, an application will be created and sent to you for your review and completion.

Please return the requested information by one of the following methods:

Reply email: Your account setup contact

email: [accountsetup@asdhealthcare.com](mailto:accountsetup@asdhealthcare.com)

fax: 866.385.2368

## Please provide a copy of:

- » The pharmacy or medical license to be linked to your account
- » Your W-9
- » Your tax exemption certificate (if applicable)

## PLEASE COMPLETE THE FOLLOWING

**Shipping** name and address including phone and fax numbers if different than your state pharmacy or medical license

Federal Tax ID number

Do you pay state sales tax?

If no – why not (i.e. retailer, not-for-profit, etc.)?

Group Purchasing Organization

(i.e. Good Neighbor Pharmacy, Vizient, Premier, etc.) if any

**Business** billing name and address and contact person with phone/email

Wholesaler

(AmerisourceBergen, Cardinal, McKesson, etc.) if any

Estimated amount of monthly purchases from ASD Healthcare

Legal (Incorporated) name of ownership

Line of Business /Type of Business