Account Set-up

FAX 954-598-8521

AndaMEDS
Physician & Specialty Distribution

PHYSICIAN & PRACTICE INFORMATION *(Required)*

Doctor's Name_____

Legal Business Name_____

Tax ID (EIN) #_____

DBA _____

NPI #_____

HIN # _____ DEA # _____

BILLING INFORMATION

Billing Address _____

Suite/Building _____

City _____ State ____ Zip Code _____

SHIPPING INFORMATION

○ SAME AS BILLING ADDRESS

Shipping Address_____

Suite/Building _____

City _____ State ____Zip Code _____

CONTACT INFORMATION

Office Manager's Name _____

Office Phone # _____

Secondary Phone # _____ Fax # _____

Email _____

A/P Contact Name _____

Phone # _____ Fax # _____

Email _____

Authorized Purchaser _____

Phone # _____ Fax # _____

Emai _____

Preferred method of receiving statement ○ Fax ○ Email

HOURS OF OPERATION

M _____ T _____ W _____

TH _____ F _____ S _____

CUSTOMER INSIGHTS *(Optional)*

1. Monthly spend on vaccines _____

2. Do you currently have a contract with any manufacturer? ○ Yes ○ No

If yes, please indicate which ones: _____

_____

_____

_____

3. Do you currently dispense drugs to your patients? ○ Yes ○ No

If no, are you considering dispensing them? ○ Yes ○ No

4. Are you part of a GPO or buying group? ○ Yes ○ No

If yes, please indicate which ones: _____

_____

_____

_____

5. Please list the distributors / manufacturers from which you currently order :

_____

_____

_____

_____

Name of person completing form _____ **Signature** _____ **Date** _____

1 Fill out form

2 Attach copies

- ✓State license
- ✓DEA license and/or HIN certificate
- ✓Sales tax exemption certificate
- ✓W-9 form

3 Fax to 1-800-989-0700

INTERNAL USE ONLY	SALES REP	REMEDY ID #
	ANA DELGADO / TAMARA FORBES	

1-855-772-2879 | www.AndaMEDS.com