New Customer Form

Anda MEDS
Physician & Specialty Distribution

Shipping Information

Physician's Name _____ NPI # _____
Business Name _____ Specialty _____
*HIN # _____ *DEA# _____
Shipping Address _____
Suite/Building _____
City _____ State _____ Zip Code _____
Phone # _____ Secondary # _____
Email _____ Fax # _____

Billing Information

Legal Name _____ Tax ID (EIN) # _____
DBA _____
Billing Address _____ Suite/Building _____
City _____ State _____ Zip Code _____
Phone # _____ Secondary # _____
Email _____ Fax # _____

A/P Contact Name _____ Title _____
Phone # _____ Fax # _____ Email _____
Authorized Purchaser _____ Title _____
Phone # _____ Fax # _____ Email _____

Are you a 340B entity? ○ Yes ○ No If yes, please provide 340B ID: _____

Number of affiliated locations _____

Are you part of any other GPO or buying organizations ○ Yes ○ No If yes, please indicate which ones _____

Hours of Operation

M _____ T _____ W _____ TH _____ F _____

Name of person completing form _____ Signature _____
Title _____

Fax signed form to 1-800-989-0700

Sales Representative Name Tamara Forbes

INTERNAL USE ONLY **REMEDY ID #:**

PLEASE ATTACH COPY OF:

1) *STATE MEDICAL OR CLINIC LICENSE*
2) *FEDERAL DEA AND/OR HIN CERTIFICATE*
3) *W-9 FORM*
4) *SALES TAX EXEMPTION CERTIFICATE*

The information and signature provided above will only be used to set up your Anda account.