

# **State of Oklahoma**

## **Department of Rehabilitation Services**

### **Durable Medical Equipment Contract**

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## APPENDIX:

DURABLE MEDICAL EQUIPMENT VENDOR CREDENTIALING INFORMATION  
DURABLE MEDICAL EQUIPMENT VENDOR APPLICATION REQUIREMENTS  
CONTRACT SIGNATURE PAGE

# **Department of Rehabilitation Services**

## **Durable Medical Equipment Contract**

It is hereby agreed between the Department of Rehabilitation Services and the Durable Medical Equipment vendor named on the signature page, that the Durable Medical Equipment vendor shall be a Provider in the Department of Rehabilitation Services' network of providers.

This contract is entered into for the purpose of defining the conditions for reimbursement by the Department of Rehabilitation Services to the Provider. It in no way is meant to impact on the Provider's decision as to what is considered appropriate Durable Medical Equipment services.

### **I. RECITALS**

- 1.1 The Department of Rehabilitation Services (DRS), is a statutory body created by 74 O.S. §166.1, as amended, to administer and manage a certain program of medical care for persons eligible for public assistance.
- 1.2 The Provider is a Durable Medical Equipment vendor that is duly licensed by the State of Practice and satisfies additional criteria as established by DRS.
- 1.3 The intent of this Contract is to provide access to enhanced quality Durable Medical Equipment at an affordable, competitive cost to DRS and its beneficiaries.
- 1.4 Failure to abide by any of the following provisions may result in non-renewal of the Contract or may be cause for termination.

### **II. DEFINITIONS**

- 2.1 "Allowable Fee" means the maximum charge payable to a Durable Medical Equipment vendor for a specific product in accordance with the provisions in Article VI of this Contract. The Provider shall charge the usual and customary fee unless the fee schedule limits otherwise.
- 2.2 "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C.1395dd(e)(1)(A)).
- 2.3 "Durable Medical Equipment" (DME) means those services provided by a Network Durable Medical Equipment vendor that are pre-authorized by DRS.
- 2.4 "Medical" means belonging to the study and practice of medicine for the prevention, alleviation or management of a physical or mental defect, illness, or condition.
- 2.5 "Medically Necessary" means services or supplies that, under the provisions of this Contract, are determined to be:
  - a) appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition, and
  - b) provided for the diagnosis and treatment of the medical condition, and

- c) within standards of acceptable, prudent medical practice within the community, and
  - d) not primarily for the convenience of the beneficiary, the beneficiary's Provider or another Provider, and
  - e) any condition which, if left untreated, could deteriorate into a life threatening situation, and
  - f) the most appropriate supply or level of service that can safely be provided. For hospital stays, this means that the acute care as an inpatient is necessary due to the kind of services the Beneficiary is receiving or the severity of the Beneficiary's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.
- 2.6 "Beneficiaries" means all persons eligible for benefits provided by DRS as determined by established criterion.
- 2.7 "Network Provider" means a Durable Medical Equipment vendor who has entered into this Contract with the DRS to accept scheduled reimbursement for pre-authorized Durable Medical Equipment services provided to beneficiaries.
- 2.8 "Prior Authorization" means a function performed by DRS to assess the health care services available to the beneficiary and authorize appropriate services prior to services being rendered.
- 2.9 "Third Party Payor" means an insurance company or other entity making payment directly to the Provider on behalf of the DRS.

### **III. RELATIONSHIP BETWEEN DRS AND THE DURABLE MEDICAL EQUIPMENT VENDOR**

- 3.1 DRS has negotiated and entered into this Contract with the Provider on behalf of the individuals who are Beneficiaries of DRS. The Provider is an independent contractor who has entered into this Contract to become a Network Provider and is not, nor is intended to be, the employee, agent or other legal representative of DRS in the performance of the provisions of this Contract. Nothing in this Contract shall be construed or be deemed to create a relationship contrary to that of independent contractor for the purposes of this Contract.
- 3.2 Nothing in this Contract is intended to be construed, or be deemed to create any rights or remedies in any third party, including but not limited to, a beneficiary or a Network Provider other than the Provider named in this contract.

### **IV. DURABLE MEDICAL EQUIPMENT VENDOR SERVICES AND RESPONSIBILITIES**

- 4.1 The Provider agrees to provide quality Durable Medical Equipment services in a cost efficient manner.
- 4.2 For the purpose of reimbursement, the vendor shall provide Durable Medical Equipment services to beneficiaries that are medically necessary and pre-authorized under the established benefits of DRS.
- 4.3 The Provider agrees to submit billing data and records of treatment in the manner and form prescribed by DRS. The individual's medical case records will be available during regular working hours to authorized representatives of DRS. The Provider agrees to retain one copy of the billing data and records of treatment and all other records upon which a claim is based, in its file for a period of 6 years.
- 4.4 It is understood that any person seeking medical services has the right to make application for payment on his behalf by DRS for compensable services provided by the Provider. The Provider

and/or Provider's office staff agrees to assist the patient in making application for such care and services.

- 4.5 The Provider shall participate in the Prior Authorization procedures as established by DRS.
- 4.6 The Provider shall accurately complete the Network Provider application that is attached to and made part of this Contract. The Provider shall notify the DRS' Network Manager of any change in the information contained in the application within 15 days of such change, including resolved litigation listed as "pending" on the original application.
- 4.7 The Provider shall submit to a patient record audit upon 48 hours advance notice.
- 4.8 Authorized representatives of DRS shall have the right to make physical inspections of the Provider's office and to examine such records as they relate to financial statements submitted under this Contract or to payments claimed by the Provider under this Contract; and to conduct audits of the financial records of the Provider at any time, as provided by the Code of Federal Regulations, Title 34 § 74.53.
- 4.9 The Provider agrees that all information provided is true, accurate and complete. The Provider understands that payment and satisfaction of all claims will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may subject Provider to prosecution under applicable Federal and State laws. The Provider further agrees that work, services or materials shown by any invoice or claim have been completed or supplied in accordance with the plans, specifications, order or requests furnished. The Provider further agrees that no payment has been made, given or donated or agreed to pay, give or donate, either directly or indirectly to any elected official, officer or employee of the State of Oklahoma of money or any other thing of value to obtain payment.
- 4.10 The Provider agrees to disclose to DRS, prior to approval or renewal of this Contract, the name of any person who has an ownership or controls an interest in, or is an agent or managing employee of the Provider who has been convicted of a criminal offense related to such person's involvement in any program under Titles V, XVIII, XIX, or XX of the Social Security Act since inception of these programs.
- 4.11 The Provider shall disclose ownership and control interests at the time of entering into this Contract on the required Federal reporting form and at other times that DRS or the Secretary of Education, may require and in a form designated by DRS.
- 4.12 The Provider agrees to submit, within 35 days of the date on a request by DRS full and complete information about:
  - a) The ownership of any subcontractor with whom the Provider has had business transactions totaling more than \$25,000 during the twelve month period ending on the date of the request;
  - b) Any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and subcontractor, during the 5 years period ending on the date of the request.
- 4.13 The Provider agrees and understands that payment cannot be made by DRS to vendors providing care and/or services under Federally-assisted programs unless care and/or service is provided without discrimination on the grounds of race, color, national origin, disability or unless program enabling legislation permits on the basis of age. This assures DRS is in compliance with Title 34, Code of

Federal Regulations, § 76.500. These laws and regulations prohibit excluding from participation in, denying the benefits of, or subjecting to discrimination, under any program or activity receiving Federal Financial Assistance, any person on the grounds of race, color, national origin, any qualified person on the basis of disability or without distinctions made on the basis of age except as legislatively permitted or required. Written complaints of non-compliance with either law should be made to the Director of Rehabilitation Services, 3535 NW 58<sup>th</sup> St., Ste. 500, Oklahoma City, Oklahoma 73112, or the Secretary of Education, Washington, D.C., or both.

## **V. DRS SERVICES AND RESPONSIBILITIES**

- 5.1 DRS agrees to pay the Provider compensation pursuant to the provisions of Article VI.
- 5.2 DRS agrees to grant the Provider the status of "Network Provider" and to identify the Provider as a Network Provider on informational materials disseminated to beneficiaries.
- 5.3 DRS agrees to continue listing the Provider as a Network Provider until this Contract terminates.
- 5.4 DRS agrees to provide the vendor access to a list of all Network Providers.
- 5.5 DRS agrees to provide appropriate documentation to beneficiaries for the verification of prior authorization procedures and to establish the provision of appropriate health care.
- 5.6 DRS agrees to adhere to confidentiality of patient's records and to only release pertinent clinical information in accordance with State and Federal guidelines.
- 5.7 DRS shall give a forty-eight (48) hours' notice prior to an audit.
- 5.8 DRS shall establish and maintain prior authorization procedures.

## **VI. COMPENSATION AND BILLING**

- 6.1 The Provider shall seek payment only from DRS for the provision of Durable Medical Equipment services except as provided in paragraph 6.3. The payment from DRS shall be limited to the amounts referred to in paragraph 6.2.
- 6.2 DRS agrees to pay the Provider's billed charge for each procedure or the fee set by DRS for that procedure, whichever is less. DRS shall have the right to categorize what shall constitute a procedure. DRS and the beneficiary's financial liability shall be limited to the procedures' allowable as determined by DRS, paid by applying appropriate coding methodology, whether the Provider has billed appropriately or not.
- 6.3 The Provider agrees to accept the payment from DRS as full and complete a payment for services for recipients of public assistance. If the patient is a recipient of Medical Assistance, Rehabilitation Services only, payment from the Department shall represent payment in full except the Provider may collect an amount not to exceed that shown on DRS form, DRS-C-100, Medical Services Authorization.
- 6.4 The Provider shall refund within 30 days of discovery to DRS any overpayments made by DRS.

- 6.5 The Provider shall bill DRS on forms acceptable to DRS within 1 year of providing the medical services. The Provider shall use the current HCPCS codes and ICD codes, when applicable. The Provider shall furnish, upon request at no cost, all information, including medical records, reasonably required by DRS to verify and substantiate the provision of medical services and the charges for such services if the beneficiary and the Provider are seeking reimbursement through DRS.
- 6.6 DRS shall reimburse the Provider within 30 days of receipt of billings that are accurate, complete and otherwise in accordance with Article VI of this Contract. DRS will not be responsible for delay of reimbursement due to circumstances beyond DRS' control.
- 6.7 The Provider agrees to release all Provider liens for which payment has been made for Title XIX by DRS and notify DRS. However, this provision does not affect the Provider's entitlement to file a lien or liens for non-pre-authorized services.
- 6.8 DRS shall have the right at all reasonable times and to the extent permitted by law to inspect and duplicate all medical and billing records relating to medical services rendered to beneficiaries at no cost to DRS or the beneficiary.

## **VII. UTILIZATION MANAGEMENT**

- 7.1 The Provider shall adhere to and cooperate with DRS's established Prior Authorization procedures. These procedures do not guarantee a beneficiary's eligibility or that benefits are payable, but assure the Provider that the medical services to be provided are pre-authorized under the plan.
- 7.2 The Durable Medical Equipment Vendor shall request prior authorization from DRS or its designee for all Durable Medical Equipment products.
- 7.3 Prior Authorization procedures are intended to enable DRS to ensure that services are provided at the appropriate level of care. In no event is it intended that the procedures interfere with the Provider's decision regarding the patient's care.

## **VIII. LIABILITY AND INSURANCE**

- 8.1 Neither party to this Contract, DRS nor the Provider, nor any agent, employee or other representative of a party, shall be liable to third parties for any negligent act by commission or omission of the other party in performance of this Contract and the terms and provisions herein.
- 8.2 The Provider, at vendor's sole expense, shall maintain a minimum of \$1,000,000 per occurrence of insurance coverage for professional liability.

## **IX. DISPUTE RESOLUTION**

- 9.1 DRS and the Provider agree that their authorized representatives will meet in a timely manner and negotiate in good faith to resolve any problems or disputes that may arise in performance of the terms and provisions of this Contract. Nothing in this Article shall interfere with either party's rights under Article X.

## **X. TERM AND TERMINATION**

- 10.1 The term of this Contract shall be for one year commencing on the prescribed date, or the effective date on the signature page, whichever is later, and shall remain in effect until terminated by either party subject to 10.2.

- 10.2 Either party may terminate this Contract with or without cause, upon giving 30 day notice pursuant to 11.2.
- 10.3 Nothing in this Contract shall be construed to limit either party's remedies at law or in equity in the event of a material breach of this Contract.
- 10.4 This Contract shall terminate with respect to a Provider upon failure to maintain Provider's professional liability insurance in accordance with this Contract.
- 10.5 Following the effective date of termination, this Contract shall be of no further force or effect, except that each party shall remain liable for any obligations or liabilities arising from activities carried on by it hereunder prior to the effective date of termination of this Contract.
- 10.6 Following termination of this Contract, DRS shall continue to have access to the Provider records of equipment provided to beneficiaries for 6 years from the date of provision of the services to which the records refer as set forth in Paragraph 6.8.

## **XI. GENERAL PROVISIONS**

- 11.1 This Contract or any of the rights, duties, or obligations of the parties hereunder, shall not be assigned by either party without the express written consent and approval of the other party.
- 11.2 Any notice required to be given pursuant to the terms and provisions of this Contract shall be in writing, postage prepaid, and shall be sent by certified mail, return receipt requested, to DRS at the mailing address below or the Provider at the mailing address listed on the Application. The notice shall be effective on the date indicated on the return receipt.

Department of Rehabilitation Services  
ATTN: Network Management  
P.O. Box 57630  
Oklahoma City, OK 73157-7630

The Network Newsletter serves as the primary method by which providers receive all other notifications mandated by the terms of the provider contracts. These notices from EGID may be sent via electronic newsletters distributed electronically to each Network Provider's correspondence email address. Printed newsletters are sent via the postal service to the mailing address on record for providers without internet access or those who have undeliverable email addresses.

- 11.3 Notwithstanding the provisions of Paragraph 11.1 of this Contract, DRS may appoint an administrator to administer any of the terms of the Network Contract referenced herein, and any and all duties or acts required of DRS under this Contract and to receive any notices required by this Contract.
- 11.4 This Contract, together with its exhibits, contains the entire agreement between DRS and the Provider relating to the rights granted and the obligations assumed by the parties concerning the provision of medical services to beneficiaries. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this Contract not expressly set forth in this Contract are of no force or effect.



- 11.5 This Contract, or any part, section or exhibit of, or attached to it, may be amended at any time during the term of the Contract by mutual written consent of duly authorized representatives of DRS and the Provider.
- 11.6 This Contract is subject to all applicable Federal laws, Oklahoma State Statutes and Rules and Regulations. Any provision of this Contract that is not in conformity with existing or future legislation shall be considered amended to comply with such legislation. Any interpretations or disputes with respect to contract provisions shall be resolved in accordance with Federal laws and State of Oklahoma statutes.
- 11.7 The terms and provisions of this Contract shall be deemed to be severable one from the other, and the determination at law or in a court of equity that one term or provision is unenforceable, shall have no effect on the remaining terms and provisions of this entire Contract, or any one of them, in accordance with the intent and purpose of the parties hereto.
- 11.8 In accordance with Presidential Executive Order 12549, all providers certify that neither they nor their principals are presently debarred or suspended or otherwise ineligible for participation in federal assistance programs.
- 11.9 All Providers certify that neither they nor their principals are presently debarred or suspended or otherwise ineligible according to the Excluded Parties List System (EPLS)/Office of Inspector General (OIG) excluded provider lists.

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**Department of Rehabilitation Services**  
**Network Durable Medical Equipment Vendor Credentialing Information**  
**Contract /Applications**

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The Department of Rehabilitation (DRS) requires all three addresses on the respective pages of the application.

1. **Service Address** – This address is used for the location where health care services are performed and/or the physical location of the provider. The service address will be used for the on-line provider directory which is used by members and providers to identify and locate all Department of Rehabilitation Services Network Providers.
  
2. **Mailing Address** – Mailing contact information, if listed, will be utilized for all legal, contractual notices as defined in section 11.2 or 12.2 of the facility contracts. An email address must be included for this contact in order to access the online fee schedules. All notices will be sent electronically.
  
3. **Billing Address** – This address is used for submitting all claims to Department of Rehabilitation Services for processing and appears in box 33 of the CMS-1500 claim form or box 2 on the UB-04. If box 2 is not used by the facility, the billing address appears in Box 1 of the UB-04. Claims will be paid exclusively to the billing address.

Each address must have a corresponding phone number, email address, fax number and contact person.

Insurance Certificate/Face Sheet must have name of the applicant listed as the insured. The insurance limits must be at the levels required in the contract and must indicate clearly the coverage type(s) stated in the contract. Product liability coverage in lieu of professional/medical liability is acceptable for DME only.

W-9 forms must be signed and list only the Tax ID number for each location listed on the application which will be used on claim forms

**Please return entire application packet with the new information**

**Department of Rehabilitation Services**  
**Durable Medical Equipment**  
**Vendor Application Requirements**

Please complete the attached Application and submit with the required attachments listed below.

Complete all sections of the application. If an area of inquiry is not applicable to the facility, please indicate. If you need additional space to provide complete answers, attach additional sheets of paper and clearly indicate the item to which each sheet applies.

*Retain the Contract for your records.*

**REQUIRED ATTACHMENTS**

Please attach a copy of each of the following documents to your completed Application:

- Current state(s) license(s)**
- Face Sheet of current general and medical liability insurance policy**  
Insurance Certificate/Face Sheet must have the name or the Facility listed as the insured. The insurance limits must be at the levels in the Contract and must indicate clearly that it is general and medical liability coverage.
- W-9 form for each Federal Tax Identification Number**  
W-9 forms must be signed and list only the Federal Tax Identification Number listed on the Application which will be used on claim forms submitted to Department of Rehabilitation Services.
- Contract Signature Page**
- Copy of Medicare Certification Letter**
- Copy of TJC, AAHC, or CARF Accreditation (if applicable)**

**Incomplete applications will be returned**

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## Department of Rehabilitation Services Network Facility Application

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The completed Network Facility Application should be returned to the Department of Rehabilitation Services at the Office of Management and Enterprise Services Employees Group Insurance Division in its entirety, accompanied by the applicable attachments. You may mail, fax or email the completed application to:

Department of Rehabilitation Services  
ATTN: Network Management  
P.O. Box 57630  
Oklahoma City, Oklahoma 73157-7630  
Phone: 1-405-717-8790 or 1-844-804-2642  
Fax: 1-405-717-8977  
[EGID.NetworkManagement@omes.ok.gov](mailto:EGID.NetworkManagement@omes.ok.gov)

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### General Information

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Legal Name of Owner: \_\_\_\_\_

Trade Name/DBA: \_\_\_\_\_

Medicare Facility Classification: \_\_\_\_\_ Medicare Number: \_\_\_\_\_

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### License Information

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State: \_\_\_\_\_

License Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

A copy of facility license is required for each state of practice.

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### Accreditation

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Is this Facility accredited by The Joint Commission:             Yes             No

Joint Commission Program ID Number: \_\_\_\_\_

Date of most current accreditation: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Is this Facility accredited by the AAAHC?                     Yes             No

Date of most current accreditation: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Is this Facility accredited by CARF?                             Yes             No

Date of most current accreditation: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

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## Insurance Information

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Copy of Insurance Certificate/Face sheet is required.

Please provide the following information about the Facility's current general and medical liability insurance coverage.

Name of Carrier: \_\_\_\_\_

Limits of General and Medical Liability Per Occurrence: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

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## Important Facility Contacts

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CEO/Administrator: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

CFO: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Credentialing Contact: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

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## Address Information

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Federal Tax ID Number: \_\_\_\_\_ National Provider Identification: \_\_\_\_\_

**Attach a completed W9 form for each Federal Tax ID number**

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### **Physical Address – physical location of the facility**

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THIS ADDRESS AND PHONE NUMBER WILL APPEAR ON THE WEBSITE PROVIDER DIRECTORY

Physical Address: \_\_\_\_\_

City

State

ZIP

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Email Address: \_\_\_\_\_

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**Mailing Address- for correspondence/credentialing**

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Mailing Address: \_\_\_\_\_

City

State

ZIP

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Email Address: \_\_\_\_\_

Mailing contact information, if listed, will be utilized for all legal, contractual notices as defined in section 11.2 or 12.2 of the facility contracts. An email address must be included for this contact in order to access the online fee schedules. All notices will be sent electronically.

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**Billing/Remit Address – for claims payments and remittance statements**

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ALL BILLING INFORMATION MUST MATCH THE INFORMATION REFLECTED ON SUBMITTED CLAIMS

Name Submitted on Claims: \_\_\_\_\_

Billing Office Name (if applicable): \_\_\_\_\_

Billing Address: \_\_\_\_\_

City

State

ZIP

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Email Address: \_\_\_\_\_

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**Additional Location**

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Federal Tax ID Number: \_\_\_\_\_ National Provider Identification: \_\_\_\_\_

**Attach a completed W9 form for each Federal Tax ID number**

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**Physical Address – physical location of the facility**

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THIS ADDRESS AND PHONE NUMBER WILL APPEAR ON THE WEBSITE PROVIDER DIRECTORY

Physical Address: \_\_\_\_\_

City

State

ZIP

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Email Address: \_\_\_\_\_

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**Mailing Address- for correspondence/credentialing**

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Mailing Address: \_\_\_\_\_

City

State

ZIP

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Email Address: \_\_\_\_\_

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**Billing/Remit Address – for claims payments and remittance statements**

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ALL BILLING INFORMATION MUST MATCH THE INFORMATION REFLECTED ON SUBMITTED CLAIMS

Name Submitted on Claims: \_\_\_\_\_

Billing Office Name (if applicable): \_\_\_\_\_

Billing Address: \_\_\_\_\_

City

State

ZIP

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Please use copies of these pages to report any additional locations**

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**Additional Information**

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Please indicate if your company can provide any of the following:

- Breast pumps and supplies
- Positive airway pressure devices and supplies
- Wigs and supplies
- Hearing Aids
- Ostomy Supplies

**Department of Rehabilitation Services**  
**Durable Medical Equipment**  
**Contract Signature Page**

When signed by both parties below, this constitutes agreement and acceptance of all terms and conditions contained in the Durable Medical Equipment Contract to be effective the date denoted on the copy of the executed Signature Page returned to the Provider. The original of this signed document will remain on file in the office of the Department of Rehabilitation, and a copy will be returned to the Provider. By signing, both parties agree that this document shall become a part of the Contract.

**FOR THE FACILITY:**

\_\_\_\_\_  
Legal Name of Owner (Typed or Printed)

\_\_\_\_\_  
Trade Name/DBA (Typed or Printed)

\_\_\_\_\_  
Federal Tax ID Number

Address of the Facility:  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Authorized Officer or Representative (Typed or Printed)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature Date

**FOR DRS:**

\_\_\_\_\_  
Executive Director  
Department of Rehabilitation Services  
3535 NW 58th St., Ste. 500  
Oklahoma City, OK 73112

**Please return completed application, signature page and required attachments to:**

**Department of Rehabilitation Services**  
**Attn: Network Management**  
**P.O. Box 57630**  
**Oklahoma City, OK 73157-7630**  
**Email: EGID.DRSNetworkManagement@omes.ok.gov**  
**Phone: 405-717-8921 or toll-free 888-835-6919**  
**Fax: 405-717-8977**