GoScripts™

Complete Referral and Documentation Software

HME supplier update form

Section One: Update Supplier Location/Branch Information

☐ New ☐ Existing ☐ Remove (Please check one)

***Required for New Location/Branch**

NPI #: _____ Medicaid # (if applicable): _____

Location/Branch Name: _____

Mailing Address: _____

City, State, Zip: _____ Primary Contact: _____

Phone Number: _____ Fax Number: _____

Section Two: New Authorized Users

(Please list any new users (Full Name) who will be authorized to place orders for the above location.)

Name 1: _____ Title: _____ Email: _____

Name 2: _____ Title: _____ Email: _____

Name 3: _____ Title: _____ Email: _____

Section Three: Authorized Users for Removal

(Please list any existing users (Full Name) who are no longer authorized to place orders for the above location.)

Name 1: _____ Title: _____ Email: _____

Name 2: _____ Title: _____ Email: _____

Name 3: _____ Title: _____ Email: _____

Please fax or email this form to GoScripts once completed:

Fax: (678) 243-1822 | Email: goscriptsenrollmentform@brightree.com