OFFEROR'S QUALIFICATION FORM

Please complete this form as fully and explicitly as possible to facilitate evaluation of your firm. Use additional sheets and substantiating documents when necessary.

A. Exact Legal Name of Contractor: _____

_____
Street Address

_____
City State Zip Code

Contact Person Name: _____ Cell No. _____

Telephone No.: _____ Fax No.: _____

E-mail Address: _____

Subcontractor Name, if applicable: _____

_____
Street Address

_____
City State Zip Code

Contact Person Name: _____ Cell No. _____

Telephone No.: _____ Fax No.: _____

E-mail Address: _____

B. Statement of Experience and Qualifications:

C. References:

Offerer shall list at least three references for whom the offerer has performed pharmacy biling audit within the past 5 years.

1. Name of Firm _____

   Address: _____

   _____

   Contact Person _____

   Telephone _____

   Email _____

2. Name of Firm _____

   Address: _____

   _____

   Contact Person _____

   Telephone _____

   Email _____

3. Name of Firm _____

   Address: _____

   _____

   Contact Person _____

   Telephone _____

   Email _____