

PROVIDE IT END-USER HELP DESK AND
SUPPORT
IFB-430-27-01

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 billing 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 _____