Compu-Max Software Order Form

Compu-Max Software Product Name

Compu-Max software product name: √ only one. If you are ordering more then one system please use a separate form. Software is available from the Compu-Max website.

☐ 2552-10 Hospital	COST REPORT FOR ELECTRONIC FILING OF HOSPITALS
☐ 2540-10 SNF	SNF AND SNF HEALTH CARE COMPLEX COST REPORT
☐ 1728-94 HHA	HOME HEALTH AGENCY COST REPORT
☐ 1984-99 Hospice	HOSPICE COST REPORT
☐ 287-05 Home Office	HOME OFFICE COST STATEMENT
☐ 216-94 OPO	ORGAN PROCUREMENT ORGANIZATION/HISTO LAB COST REPORT
☐ GME	GRADUATE MEDICAL EDUCATION (IRIS)
☐ 2088-92 CORF	OUTPATIENT REHAB PROVIDER COST REPORT
☐ 265-11 Renal Dialysis	INDEPENDENT RENAL DIALYSIS FACILITY COST REPORT
☐ D403 (MA)	MASSACHUSETTS HOSPITAL BASED HEALTH CARE COMPLEXES COST REPORT
☐ OSHPD (CA)	OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT HOSPITAL REPORT
☐ OSHPD LTC (CA)	OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT LTC REPORT
☐ 222-92 FQHC/RHC	INDEPENDENT RURAL HEALTH CLINIC

Payment Information

☐ Enclosed is my check made payable to KPMG LLP.
☐ Attached is a scanned copy of my check made payable to KPMG LLP which will be mailed to KPMG LLP.

Cost Calculation

Software Fee $ _____

State Sales Tax **(If exempt include Sales Tax Exemption Form)** $ _____

Total Amount $ _____

Telephone/E-Mail technical support services included.
KPMG LLP offers a full refund within 30 days if not totally satisfied.

Please send my order to:

Company: _____ Name: _____

Address: _____ Title: _____

Address(2): _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

E-Mail: _____

E-Mail Completed Form (all pages) to:
us-laxadvhccompumax@kpmg.com

Office Use Only: Customer #:_____ SANs #:_____ Date Submitted:_____ Date Approved:_____

KPMG is required by the Sarbanes-Oxley Act of 2002 to obtain audit committee pre-approval for the provision of any non-audit service to an SEC audit client or affiliate. This would also apply in those situations where Compu-Max is used by a consulting firm or a healthcare provider that is an SEC audit client (of affiliate) of the Firm. Although this is a rare occurrence and is normally a formality it does take time to complete our research to determine if a licensee, or a provider served by a consulting firm is an SEC audit client or affiliate. For this reason, please plan ahead and provide us with the following information for the providers (hospitals, skilled nursing facilities, or other healthcare related entities) that you are submitting for this purchase:

Please check either "New", "Renew" or "Delete".
Complete the Provider Name, Fiscal Year End and Medicare Provider Number.
If applicable, type the D403 number for the state of Massachusetts.
If applicable, type the OSHPD-CA number for the state of California.

For each Provider Name type the complete address (street address, city, state and zip code).
If applicable type Ownership or Parent Company name and type complete street address, city, state and zip code.

Incomplete information can delay the processing of the order

Provider Specific Information – Required for all orders

☐ New ☐ Renew ☐ Delete

Provider Name: _____ Fiscal Year Ending (MM/DD/YYYY):_____

Provider Number Medicare: _____ D403-MA or OSHPD-CA Number: _____

Address: _____ City: _____State: _____Zip: _____

Ownership or Parent Company name: _____

Address of Ownership or Parent Company: _____ City: _____State: _____Zip: _____

☐ New ☐ Renew ☐ Delete

Provider Name: _____ Fiscal Year Ending (MM/DD/YYYY):_____

Provider Number Medicare: _____ D403-MA or OSHPD-CA Number: _____

Address: _____ City: _____State: _____Zip: _____

Ownership or Parent Company name: _____

Address of Ownership or Parent Company: _____City: _____State: _____Zip: _____

☐ New ☐ Renew ☐ Delete

Provider Name: _____ Fiscal Year Ending (MM/DD/YYYY):_____

Provider Number Medicare: _____ D403-MA or OSHPD-CA Number: _____

Address: _____ City: _____State: _____Zip: _____

Ownership or Parent Company name: _____

Address of Ownership or Parent Company: _____ City: _____State: _____Zip: _____

Provider Specific Information – Required for all orders

☐ New ☐ Renew ☐ Delete

Provider Name: ______________________ Fiscal Year Ending (MM/DD/YYYY): ______________________

Provider Number Medicare: ______________________ D403-MA or OSHPD-CA Number: ______________________

Address: ______________________ City: ______________ State: __________ Zip: ________

Ownership or Parent Company name: ____

Address of Ownership or Parent Company: ______________________ City: ______________ State: _____ Zip: ________

☐ New ☐ Renew ☐ Delete

Provider Name: ______________________ Fiscal Year Ending (MM/DD/YYYY): ______________________

Provider Number Medicare: ______________________ D403-MA or OSHPD-CA Number: ______________________

Address: ______________________ City: ______________ State: __________ Zip: ________

Ownership or Parent Company name: ____

Address of Ownership or Parent Company: ______________________ City: ______________ State: _____ Zip: ________

☐ New ☐ Renew ☐ Delete

Provider Name: ______________________ Fiscal Year Ending (MM/DD/YYYY): ______________________

Provider Number Medicare: ______________________ D403-MA or OSHPD-CA Number: ______________________

Address: ______________________ City: ______________ State: __________ Zip: ________

Ownership or Parent Company name: ____

Address of Ownership or Parent Company: ______________________ City: ______________ State: _____ Zip: ________

☐ New ☐ Renew ☐ Delete

Provider Name: ______________________ Fiscal Year Ending (MM/DD/YYYY): ______________________

Provider Number Medicare: ______________________ D403-MA or OSHPD-CA Number: ______________________

Address: ______________________ City: ______________ State: __________ Zip: ________

Ownership or Parent Company name: ____

Address of Ownership or Parent Company: ______________________ City: ______________ State: _____ Zip: ________

☐ New ☐ Renew ☐ Delete

Provider Name: ______________________ Fiscal Year Ending (MM/DD/YYYY): ______________________

Provider Number Medicare: ______________________ D403-MA or OSHPD-CA Number: ______________________

Address: ______________________ City: ______________ State: __________ Zip: ________

Ownership or Parent Company name: ____

Address of Ownership or Parent Company: ______________________ City: ______________ State: _____ Zip: ________
