B|BRAUN

(Revised 5/2026 - all other forms are obsolete and will be accepted until 7/1/2026) Please select the company(s) you are applying credit for:

Accounts Receivable
824 12th Avenue
Bethlehem, PA 18018

☐ B|BRAUN
☐ B BRAUN Interventional Systems SHARING EXPERTISE
☐ AESCULAP
☐ CAPS Central Admixture Pharmacy Services, Inc

Credit Information

Fax: 610-849-1331
Email: CS_CustFileMaint@bbraunusa.com

PLEASE complete all sections of the credit information sheet. Should a section not apply, please indicate "Not Applicable". Failure to complete the form in its entirety will result in the delay of the requested account being established and with credit being denied.

Note: Please understand that all FEIN information will/must be verifiable. If the FEIN is not in our reference databases, it shall be applicant's responsibility to contact the IRS at 1-800-829-0115 and request appropriate documentation to validate the FEIN.

Customer/Facility Name: (Shipping) _____ Legal and DBA

Facility Telephone #: _____ Facility Fax #: _____

Facility Address: _____ Ste: _____

City: _____ State: _____ Zip: _____

FEIN: _____ DUNS #: _____ Email Address for Stmts: _____

Verify with DNB prior to submission

Customer/Facility Name: (Billing) _____

Billing Address: _____ Ste: _____

City: _____ State: _____ Zip: _____

FEIN: _____ DUNS #: _____

Verify with DNB prior to submission

Customer/Facility Name: (Payer) _____

Payer Address: _____ Ste: _____

Must be a physical address, a PO Box is not acceptable

City: _____ State: _____ Zip: _____

FEIN: _____ DUNS #: _____

Verify with DNB prior to submission

Type of Business:

Biomed Repair Facility	Distributor	Home Infusion	Nursing Home	Surgery Center
Canadian Customer	Dr Office	Home Patient	Rehab Hospital	Veterinarian
Clinic	Emergency Ctr	Med/Surg Dealer	Retail	Other: _____
Closed Pharmacy	Hospital	Psych Hospital	Sub Acute Prov.	

Intended use of B. Braun Product(s): ☐ Resell ☐ Use within your company as identified above

Company Web Site Address: _____

Group Purchasing Organization: _____

All accounts require a valid license for set up. Please fill out the fields below with the appropriate governing body license/registration and indicate the type of license/registration listed. Valid types of licenses/registration: Pharmacy, Medical Director/Doctor, Distributor, Wholesaler, Manufacturer, FDA

Please note, if Medical Director/Doctor license is supplied, completion of an additional license verification form will be required.

Name of Licensee(as it appears on license): _____ Issuing State: _____

License Type/number: _____ Expiration Date: _____

Agreement

WE BELIEVE THAT OUR FIRM IS AND WILL CONTINUE TO BE FINANCIALLY ABLE TO MEET ANY AND ALL COMMITMENTS WE HAVE MADE OR MAY MAKE AND WE WILL PAY YOUR INVOICES ACCORDING TO YOUR TERMS. WE UNDERSTAND THAT A SERVICE CHARGE WILL BE ASSESSED ON PAST DUE INVOICES AT THE HIGHEST RATE ALLOWED BY LAW, AND WE AGREE TO PAY SUCH SERVICE CHARGES WHEN BILLED. ALL PAYMENTS WILL BE MADE TO THE ADDRESS OUTLINED BELOW PER THE COMPANY BEING APPLIED TO. WHICH IS THE AGREED SITE OF ANY COLLECTION ACTION THAT MAY BE BROUGHT ON THIS ACCOUNT. IN THE EVENT OF SUCH ACTION WE AGREE TO PAY ALL COSTS AND REASONABLE ATTORNEY FEES. IF WE OBJECT TO ANY INVOICE CHARGE OR THE QUALITY OF ANY PRODUCT DELIVERED TO US BY B. BRAUN MEDICAL WE MUST NOTIFY THEM IN WRITING WITHIN TEN (10) DAYS OF THE DATE OF INVOICE, STATEMENT OF ACCOUNT, OR DELIVERY AT ADDRESS SPECIFIED ABOVE. WE (I) THE UNDERSIGNED, AUTHORIZE B. BRAUN MEDICAL TO VERIFY OUR CREDIT STATUS WITH THE PROVIDED CREDIT TRADE REFERENCES. THE PURCHASE AND SALE OF THE PRODUCTS REFERENCED HEREIN SHALL BE GOVERNED BY B. BRAUN MEDICAL TERMS AND CONDITIONS, WHICH SUPERSEDE THE TERMS AND CONDITIONS OF ANY PURCHASE ORDER OR OTHER DOCUMENTATION USED BY CUSTOMER. WE UNDERSTAND AND AGREE THAT ANY CHANGE IN TERMS MUST BE AUTHORIZED IN ADVANCE BY B. BRAUN MEDICAL FINANCE MANAGEMENT.

Name of Corporation (Payer): _____ Date: _____
(Financially responsible entity)

Signature: _____ Print: _____
Must be a director of the financially responsible entity

Title: _____

Credit Information
(Continued)

Fax: 610-849-1331 Email:
CS_CustFileMaint@bbraunusa.com

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PLEASE NOTE: Should customer claim tax exemption, the Tax Exemption Certificate for any/all Jurisdiction(s) B. Braun Medical product will be delivered to MUST be provided at the time that the Credit Information Form is submitted. Requests/Orders cannot be processed without a copy of your Tax Exemption Certificate.

Customer/Facility Name: _____

Tax Exemption Status: ☐ Exempt ☐ Non-Exempt State(s) Exempt: _____

Tax Exemption Certificate must be attached if claiming exemption status, otherwise, account will not be established.:

Trade Reference(s) *(Excluding Utility Companies):*

Company Name: _____
Phone #: _____
Account #: _____
Contact: _____

Company Name: _____
Phone #: _____
Account #: _____
Contact: _____

Bank Reference(s)

Bank Name: _____
Phone #: _____
Account #: _____
Contact: _____

Your Internal Company Contact Information

Accounts Payable:
Name: _____
Telephone #: _____
Email: _____

Purchasing:
Name: _____
Telephone #: _____
Email: _____

Please complete as applicable
GLN: _____
DEA #: _____

Freight

Freight LTL Vendor(for Aesculap use FedEx Freight LTL): _____
LTL Account number(for Aesculap use FedEx Freight LTL): _____
Parcel Freight Vendor(UPS or FedEx): _____
Parcel Account number(UPS or FedEx): _____

Your organization must clearly define the method in which you shall receive your invoices below:

☐ Email — Email address provided must be generic in nature to a company server such as your AP general email address, not a specific person
Email: _____

☐ EDI — Provide your EDI contact email and telephone number and we will provide same to our EDI team. Additionally provide your EDI partner
Email: _____ Telephone: _____
Please provide email address for direct account statements:
Email: _____

PAYMENT TERMS TO BE GRANTED ARE AT THE SOLE DISCRETION OF THE B BRAUN CREDIT DEPARTMENT

REMIT INFORMATION
PLEASE REMIT PAYMENTS TO:

B. BRAUN MEDICAL INC.
PO BOX 780433
PHILADELPHIA, PA 19178-0433

B. Braun Interventional
PO Box 780412
Philadelphia, PA 19178-0412

Our preferred method of payment is ACH, please contact our Cash Applications Supervisor Lisa Bahnck @ lisa.bahnck@bbraunusa.com if you are interested in setting up your organization for ACH

CAPS
PO Box 780404
Philadelphia, PA 17178-0404

Aesculap, Inc
PO Box 780426
Philadelphia, PA 19178-0426