Please return completed form to:
Pfizer Inc
Master Data Team
500 Arcola Rd
E Bldg, 4th Fl
Collegeville, PA 19426-3982
Fax: (484) 563-0060
Email: CIG Admin@pfizer.com

Customer Account Application

Healthcare Practitioner General Account Information

Section I Account Information

_____
Account Name (If group practice or clinic)

_____
Physician Name

_____
Address Suite#

_____ ____ _____
City State Zip Code

_____
Contact Name

_____ _____
Telephone Number Fax Number

E-Mail Address_____

Section II Billing Information (If different from Section I)

_____
Billing Account Name

_____
Billing Address

_____ ____ _____
City State Zip Code

_____
Contact Name

_____ _____
Telephone Number Fax Number

Do you agree to be contacted by: ☐ Fax ☐ Email

Section III Nature of Business

Is this a consulting office? ☐ Yes ☐ No

Do you perform invasive procedures? ☐ Yes ☐ No

Are you part of a group practice or a single practitioner? ☐ Single ☐ Group

Group Practice Name_____

Customer Account Application (continued)

Section IV Licensure and Identifiers

Will you purchase directly from Pfizer? _____ If no, who is your primary wholesaler? _____

Please include all licenses related to this location.

_____

Class (type) of license: (**Photo copy of license required**)

_____

State License Number State Expiration Date (mm/dd/yy)

_____

DEA Number Expiration Date (mm/dd/yy)

IRS Employee Tax ID: _____ (if applicable)

Is this account exempt from sales and use tax? ☐Yes ☐No

_____

State Tax Exemption Number (**Photo copy of State Exemption required**)

Section V Certification

I certify that the above information is true and correct to the best of my knowledge, information and belief, made after diligent inquiry.

Signature Title Date (mm/dd/yy)