**Request For Proposal 25-82984**

**Fee For Service Medicaid Incontinence Supplies**

**Attachment I**

**Pre-Proposal Network Opportunities Form**

**Instructions:** Fill in the blank cells below with the requested information. Forms should be submitted via email to [rfp@idoa.in.gov](mailto:rfp@idoa.in.gov) per the deadline listed in RFP Section 1.24.

The subject line of the email submissions must clearly state the following:

“[**RFP- 25-82984 Attachment I – [*INSERT COMPANY NAME*]**”.

***This is an optional form***.

|  |  |
| --- | --- |
| **Company Name** |  |
| **M/WBE (if applicable)** |  |
| **Company Address** |  |
| **Contact Name and Title** |  |
| **Contact Telephone** |  |
| **Contact Email** |  |