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Part III

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 420, et al.

Medicare Program; Requirements for Establishing and Maintaining Medicare Billing Privileges; Proposed Rule

Proposed Rules

Federal Register
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This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 420, 424, 489, and 498

[CMS–6002–P]

RIN 0938–AH73

Medicare Program; Requirements for Establishing and Maintaining Medicare Billing Privileges

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would require that all providers and suppliers (other than physicians who have elected to ''opt-out'' of the Medicare program) complete an enrollment form and submit specified information to us, and periodically update and certify to the accuracy of the enrollment information, to receive and maintain billing privileges in the Medicare program. The information must clearly identify the provider or supplier and its place of business, provide documentation that it is qualified to perform the services for which it is billing, ensure that it is not currently excluded from the Medicare program, and meets any other applicable Medicare requirements. If we determine the information submitted is incomplete, invalid, or insufficient to meet Medicare requirements, we would have the discretion to reject, deny, deactivate, or revoke billing privileges.

This proposed rule would implement provisions in the Medicare statute that require the Secretary to ensure that all Medicare providers and suppliers are qualified to provide the appropriate health care services. These statutory provisions include requirements meant to protect beneficiaries and the Medicare trust fund by preventing unqualified, fraudulent, or excluded providers and suppliers from providing services to Medicare beneficiaries or billing the Medicare program or its beneficiaries.

DATES: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on June 24, 2003.

ADDRESSES: In commenting, please refer to file code CMS–6002–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. Mail written comments (one original and two copies) to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–6002–P, P.O. Box 8013, Baltimore, MD 21244–8013.

Please allow sufficient time for us to receive mailed comments on time in the event of delivery delays.

If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) to one of the following addresses:

Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5–14–03, 7500 Security Boulevard, Baltimore, MD 21244–8013.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available if you wish to retain proof of filing by stamping in and retaining an extra copy of the comments being filed).

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and could be considered late.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Michael C. Collett, (410) 786–6121.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone (410) 786–7197.

Copies: To order copies of the **Federal Register** containing this document, send your request to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250–7954. Specify the date of the issue requested and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512–1800 (or toll-free at 1–888–293–6498) or by faxing to (202) 512–2250. The cost for each copy is $10. As an alternative, you can view and photocopy the **Federal Register** document at most libraries designated as Federal Depository Libraries and at many other public and academic libraries throughout the country that receive the **Federal Register**.

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I. Background

A. General

The Medicare program, Title XVIII of the Social Security Act (the Act), is currently the principal payer for health care for 39.2 million enrolled beneficiaries. Under section 1802 of the Act, a beneficiary may obtain health services from any institution, agency, or person qualified to participate in the Medicare program. Qualifications to participate are specified in statute and in regulations. See, for example, sections 1814, 1815, 1819, 1833, 1834, 1842, 1861, 1866, and 1891 of the Act; and 42 CFR Chapter IV, Subchapter E, which concerns standards and certification requirements.

Providers and suppliers furnishing services must comply with the Medicare requirements stipulated in the Act and in our regulations. These requirements are meant to ensure compliance with applicable statutes, as well as to promote the furnishing of high quality care. We and/or State Survey and Certification Agencies inspect facilities when required, for compliance with regulatory and operational requirements before we allow them to participate in the Medicare program. Thereafter, either

as part of a scheduled re-certification survey, or as a result of a complaint or other information received that would directly affect the provider's or supplier's business relationship with the Medicare program or indicate non-compliance of this regulation, we will review and re-verify the continued adherence to our requirements. The initial certification and subsequent re-certification ensure that Medicare requirements are met and continue to be met, and promote the appropriate spending of the Medicare trust fund by helping to ensure that unqualified providers and suppliers are not granted billing privileges with the Medicare program.

Historically, a provider or supplier wishing to receive payment from Medicare or its beneficiaries would contact a fiscal intermediary (FI), State Survey Agency, or carrier. In compliance with sections 1816 or 1842 of the Act, as stipulated in 42 CFR Part 421, we contract with FIs and carriers to administer payment for services and to carry out other administrative responsibilities that the law imposes. Our Regional Offices, State Survey Agencies, carriers and FIs use statutes, regulations, and operating instructions as guidance when assigning appropriate identification numbers and determining whether to grant billing privileges in the Medicare program to providers and suppliers.

As Medicare program expenditures have grown, increasing attention has been focused on strategies to curb improper Medicare payments by implementing business processes and standards that safeguard the Medicare program and its beneficiaries, while ensuring that well qualified individuals and health care organization serve beneficiaries as promptly as possible.

B. Specific Authority to Collect Enrollment Information

1. Various sections of the Act and the Code of Federal Regulations require providers and suppliers to furnish information concerning the amounts due and the identification of individuals or entities who furnish medical services to beneficiaries before payment can be made.

Sections 1102 and 1871 of the Act allow general authority for the Secretary to prescribe regulations for the efficient administration of the Medicare program. Under the above authority, this proposed regulation will require the collection of information from providers and suppliers for the purpose of enrolling in the Medicare program and granting privileges to bill the program for health care services rendered to Medicare beneficiaries.

Sections 1814(a), 1815(a), and 1833(e) of the Act require the submission of information necessary to determine the amounts due to a provider or other person.

Section 1842(r) of the Act requires us to establish a system for furnishing a unique identifier for each physician who furnishes services for which payment may be made. To do so, we need to collect information unique to that physician.

Section 1862(e)(1) of the Act states that no payment may be made when an item or service was at the medical direction of an individual or entity that has been excluded in accordance with sections 1128, 1128A, 1156, or 1842(j)(2) of the Act.

Section 1834(j) of the Act states that no payment may be made for items furnished by a supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) unless that supplier obtains, and renews at such intervals as we may require, a billing number.

The Balanced Budget Act of 1997 (BBA) (Public Law 105–33), section 4313, amended sections 1124(a)(1) and 1124A of the Act to require disclosure of both the Employer Identification Number (EIN) and Social Security Number (SSN) of each provider or supplier, each person with ownership or control interest in the provider or supplier, any subcontractor in which the provider or supplier directly or indirectly has a five percent or more ownership interest, and any managing employees. The Secretary of Health and Human Services (the Secretary) signed and sent to the Congress a ''Report to Congress on Steps Taken to Assure Confidentiality of Social Security Account Numbers as Required by the Balanced Budget Act'' on January 26, 1999, with mandatory collection of SSNs and EINs effective on or about April 26, 1999.

2. Section 31001(i)(1) of the Debt Collection Improvement Act of 1996 (DCIA) (Public Law 104–134) amended 31 U.S.C. section 7701 by adding paragraph (c) to require that any person or entity doing business with the Federal Government must provide their Tax Identification Number (TIN).

3. We are authorized to collect information on the Form CMS 855 (Office of Management and Budget (OMB) approval number 0938–0685) to ensure that correct payments are made to providers and suppliers under the Medicare program as established by Title XVIII of the Act.

II. Current Enrollment Initiatives

For a number of years, concern about easy entry into the Medicare program by unqualified or even fraudulent providers or suppliers has led us to step up our efforts on a number of fronts to establish more stringent controls on provider and supplier entry into the Medicare system. For example, in 1993 we established the National Supplier Clearinghouse (NSC), our contractor for enrolling suppliers of DMEPOS in Medicare. We instituted new procedures to use validation software to certify the existence of the listed business address for suppliers of DMEPOS. The NSC also checked the DMEPOS supplier telephone numbers against a national directory. This initial effort resulted in the revocation of about 1,500 supplier billing numbers and an estimated savings of $7 million per month to the Medicare trust fund.

In fiscal year 1998, we required site visits for all new DMEPOS suppliers. The DMEPOS visits resulted in:

- 156 denials of new applicants, out of 159 visits; and
- 656 revocations of existing suppliers, out of 2,091 visits.

In fiscal years 1998 and 1999, our carriers and FIs submitted proposals to conduct site visits for those provider or supplier types that they believed would yield the greatest benefit in their regions. After reviewing the submitted proposals, we funded 320 site visits to various enrolling and currently enrolled Independent Diagnostic Testing Facilities (IDTFs), skilled nursing facilities (SNFs), home health agencies (HHAs), rural health clinics, comprehensive outpatient rehabilitation facilities, physician groups, clinical psychologists, and ambulance companies. The project provided useful information for making appropriate determinations for the eligibility to bill Medicare. In the course of these reviews—

- 219 provider numbers were authorized or maintained;
- 30 provider numbers were deactivated;
- 37 provider applications were denied; and
- 34 providers were referred to contractor fraud units.

These site visits proved valuable to some providers by helping them to enroll in the Medicare program properly. The site visits were also helpful to us in ensuring that we only conduct business with legitimate providers. We believe that site visits are an important component of successful provider enrollment. As past experience has demonstrated, in many cases site

visits are the only method we have to ensure that providers and suppliers actually exist and meet the requirements to participate in the Medicare program, particularly in the absence of State licensure or regulation. Left unchecked, Medicare program resources and the health of Medicare beneficiaries may be vulnerable.

III. Provisions of the Proposed Rule

This proposed rule would build on our collective experience and set forth our standard enrollment requirements in new subpart P in Part 424 of this chapter. We are proposing that all providers and suppliers, other than the ''opt-out'' physicians and ''opt-out'' practitioners described below, must submit an enrollment application with specific information to enroll in the Medicare program, obtain a Medicare billing number, and receive Medicare billing privileges. The provisions of this proposed rule would supplement, but not replace or nullify, existing regulations concerning the establishment of provider or supplier agreements, the issuance of provider or supplier billing numbers, and payment for Medicare covered services or supplies to eligible providers or suppliers.

Specifically, we are proposing to require that providers and suppliers prove their qualifications and identity and submit specified information to us before they are granted billing privileges in the Medicare program. If the provider or supplier fails to meet the requirements or submit the required information, we would not enroll it in the Medicare program or, if it is currently in the program, we would revoke its billing privileges. We believe the documentation and associated verification methods we use to determine whether to grant a provider or supplier billing privileges are necessary to ensure compliance with Medicare requirements and to prevent abuse of the Medicare program and the inappropriate use of Medicare funds. We also believe that such requirements will not hinder qualified individuals and organizations from enrolling or maintaining enrollment in the Medicare program.

A. Scope and Definitions

We are proposing to establish our standard enrollment requirements in Part 424, new subpart P. In proposed § 424.500 (Scope) we are stating that these requirements apply to all providers and suppliers except those physicians and other eligible practitioners who have elected to ''opt-out'' of Medicare as described in Part 405, subpart D of our regulations.

In proposed § 400.502 (Definitions) we are establishing the definitions for several key terms used throughout subpart P. The terms ''provider'' and ''supplier'' are not defined in this subpart because their definitions have already been established throughout 42 CFR. The term ''provider'' is defined in both § 488.1 and § 400.202. Together these sections define a provider as including a hospital, a critical access hospital, a skilled nursing facility, a nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice, that has in effect an agreement to participate in Medicare; or a provider of outpatient physical therapy or speech pathology services; or a community mental health center. The term ''supplier,'' as defined in § 400.202, is a physician or other practitioner, or an entity other than a provider (as defined in §§ 400.202 and 488.1) that furnishes health care services under Medicare. Section 488.1 also defines ''supplier'' to mean independent laboratory; portable X-ray services; physical therapist in independent practice; ESRD facility; rural health clinic; Federally qualified health center; or chiropractor. The term ''supplier'' also includes ''indirect suppliers,'' as indicated in 45 CFR 61.3.

We define ''managing employee'' to be ''a general manager, business manager, administrator, director, or other individual that exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of, the institution, organization, or agency, either under contract or through some other arrangement, regardless of whether the individual is a W–2 employee.''

Section 1124A of the Act and 42 CFR 420.204 authorize the Secretary to collect information about ''managing employees.'' Section 1124A incorporates by reference the following definition of ''managing employee,'' contained in 1126(b) of the Act: ''An individual, including a general manager, business manager, administrator, and director, who exercises operational or managerial control over the entity, or who directly or indirectly conducts the day-to-day operations of the entity.'' We have found that a number of providers and suppliers are managed by individuals that have control over the day-to-day operations of the entity and are not ''employees.'' Some of these individuals have been known to bill Medicare fraudulently, and are on the Office of Inspector General (OIG) ''List of Excluded Individuals and Entities and/or the General Services Administration'' (GSA) ''List of Parties Excluded from Federal Procurement and Nonprocurement Programs''. These lists are commonly referred to as the ''OIG Sanction List'' for those parties excluded by the QIG from participation in any Federal health care programs (as defined in section 1128B(f) of the Act), and the ''GSA Debarment List'' for those parties debarred, suspended or otherwise excluded by other Federal agencies from participation in Federal procurement and non-procurement programs and activities, in accordance with the Federal Acquisition and Streamlining Act of 1994, and with the HHS Common Rule at 455 CFR Part 76.

Extending the term ''managing employee'' to include individuals performing managerial duties who are not technically employees would be consistent with the legislative intent to require information on those individuals that have effective control over a provider's or supplier's day-to-day operations.

B. Basic Enrollment Requirement

Proposed § 424.505 requires a provider or supplier to have a valid Medicare billing number for the date a service was rendered in order to receive payment for covered Medicare services from either Medicare (in the case of assigned claims) or the Medicare beneficiary (in the case of unassigned claims).

Under longstanding policy and operating procedures, any claim submitted without an active billing number is incomplete and cannot be processed for payment. Providers and suppliers who are not enrolled in the Medicare program must adhere to the mandatory claims submission rules found at § 424.32(a)(1) (Basic requirements for all claims) and section 1848(g)(1)(B) of the Act. In addition, a claim submitted without a valid Medicare billing number would not be considered a valid claim and would be rejected. If the mandatory claims submission requirements are not met the provider or supplier could have sanctions imposed as outlined in section 1848(g)(4) of the Act for failure to file a claim as required.

C. Requirements for Obtaining a Billing Number and Medicare Billing Privileges

To obtain a Medicare billing number and be eligible to receive payment for Medicare covered services, providers and suppliers must enroll in the Medicare program and meet other applicable Federal requirements. The Medicare program, through its contractors, requires specific identifying

information from a provider or supplier before payment is authorized. Our issuance of an identification number to a provider or supplier does not automatically convey the privilege to bill Medicare. There must be a corresponding approval of the provider or supplier as meeting all Federal requirements to bill Medicare for the number to be an approved and active Medicare billing number.

In new § 424.510 (Form CMS 855), we propose that a provider or supplier must submit to us the appropriate completed form CMS 855—Provider/Supplier Enrollment Application based on the type of provider or supplier enrolling. As part of our continuing efforts to improve the enrollment process, the series of CMS 855 enrollment forms with proposed revisions are being submitted with this proposed rule, to be published in the **Federal Register** concurrently for review and public comment. Some of the proposed revisions are the removal of certain data collections from all forms in the series such as information on clearinghouses used in claims submission, practice locations from the CMS 855R, and a shortened attachment for ambulance companies in the CMS 855B. We have also simplified the sections for reporting owners and managers and added instructional clarifications. The forms are identified as follows:

- Form CMS 855A—For providers billing fiscal intermediaries.
- Form CMS 855B—For supplier organizations billing carriers.
- Form CMS 855I—For individual health care practitioners billing carriers.
- Form CMS 855R—For individual health care practitioners to reassign benefits to an organization.
- Form CMS 855S—For DMEPOS Suppliers billing the NSC.

The CMS 855 applications will be used to gather information on providers and suppliers for the purpose of authorizing billing numbers and establishing eligibility to furnish services to Medicare beneficiaries. The information submitted will also uniquely identify the providers and suppliers for the purpose of enumeration and payment. OMB has approved the CMS 855 for these purposes (OMB approval number 0938–0685).

At proposed § 424.510(a)(1) we are requiring that a provider or supplier submit the following on its CMS 855: Complete and accurate responses to all information requested within each section as applicable to the provider or supplier type.

- Any documentation currently required by CMS under this or other statutory or regulatory authority to uniquely identify the provider or supplier (for example, a social security number (SSN) or a tax identification number (TIN)).
- Any documentation currently required by CMS under this or other statutory or regulatory authority to establish the provider or supplier's eligibility to furnish services to beneficiaries in the Medicare program (for example, a medical license or business license).

Under the authorities mentioned earlier in this preamble all providers, suppliers, and other health care related individuals and entities who will receive Medicare reimbursements, either directly or indirectly as a result of enrolling in the Medicare program, must furnish their SSN and/or TIN as a condition of maintaining an active enrollment status and billing privileges. We also maintain the right to require persons with ownership or control interests (as that term is defined in section 1124(a)(3) of the Act) in such providers and suppliers, and of all managing employees (as that term is defined in section 1126(b) of the Act and at 42 CFR 420.201) of such providers and suppliers to also furnish their SSN and/or TIN as a condition of enrollment.

We are proposing that providers and suppliers must certify that all the information furnished on the CMS 855 is accurate, complete, truthful, and verifiable. Any concealment or misrepresentation of material information in these applications constitutes a violation of this regulation and may result in the rejection, denial, or revocation of the provider or supplier's enrollment and billing privileges. In addition, such concealment or misrepresentation will be referred to the Office of Inspector General for investigation and appropriate criminal, civil or administrative action.

In § 424.510(a)(2), we propose that the CMS 855 must be signed by an individual who has the authority to bind the provider or supplier both legally and financially to the requirements set forth in subpart P. This person must be the individual practitioner or have an ownership or control interest in the provider or supplier, as that term is defined in section 1124(a)(3) of the Act, such as, be the provider's or supplier's general partner, chairman of the board, chief financial officer, chief executive officer, president, or hold a position of similar status and authority within the provider or supplier organization. The signature would attest that the information submitted is accurate, complete, and truthful, and the provider or supplier is aware of, and will abide by, Medicare rules and regulations.

To ensure that the individual signing the form can bind the enrollee from a financial and legal standpoint, we would require the following persons to sign the enrollment form:

- In the case of an individual practitioner, the applying practitioner.
- In the case of a sole proprietorship, the applying sole proprietor.
- In the case of a corporation, partnership, group, limited liability company (LLC), or other organization, an authorized official, as defined in § 424.502. When an authorized official signs the application, the signed application is considered binding upon the corporation partnership, organization, group, or LLC (hereafter referred to in this section as an organization), as applicable. This requirement establishes accountability for the accuracy of the information on the CMS 855 and ensures that the provider or supplier is committed to taking the necessary steps to comply with these requirements. In addition to the signature requirements, we are establishing a delegation of authority. As required above, the original and all subsequent revalidation CMS 855s submitted by an organization to enroll or maintain enrollment in the Medicare program must have certification statements signed by the current authorized official on file with Medicare. Any subsequent updates or changes made outside the enrollment or revalidation process may be signed by a delegated official of the enrolled organization.

The delegated official must be a W–2 managing employee of the provider or supplier who is enrolling in, or currently enrolled in, the Medicare program, or be an individual with ownership or control interest in the provider or supplier.

The delegation of signature authority will not apply for individual practitioners and sole proprietors. All CMS 855s submitted by individual practitioners or sole proprietors must be signed by the enrolling/enrolled individual.

As proposed in § 424.510(a)(2)(ii), the delegation of authority must be assigned by the authorized official currently on file with us or the authorized official who has signed the CMS 855 currently being submitted to us. All delegations of authority must be submitted via the CMS 855 and must include the title of each person delegated authority to update or change the organization's enrollment information. The assignment

must be signed by both the authorized official currently on file with Medicare and the person(s) being delegated as an official of the organization. The signature of the delegated official will bind the organization both legally and financially, as if the signature was that of the authorized official. Once the delegation of authority is established, the signatures of the authorized official or the assigned delegated official(s) will be the only acceptable signature(s) on correspondence to report updates or changes to the enrollment information.

As proposed in § 424.510(b), we would verify initial compliance with Medicare statutes and regulations before providers and suppliers are granted billing privileges, as well as on a continuing basis. The verifications would be based on information submitted by providers and suppliers on the CMS 855.

We are proposing in § 424.510(c) that providers and suppliers, including those that are deemed to meet Medicare health and safety requirements by virtue of their accreditation by a national accrediting body, must attest via signature on the CMS 855 that they have met all the requirements set forth in this regulation before they are granted billing privileges. Those providers for which certification is required must meet the provisions of 42 CFR Part 488 concerning mandatory State survey and certification requirements. Providers also must have completed a provider agreement in accordance with 42 CFR Part 489, which specifies the requirements for provider agreements. In addition, in paragraphs (d) and (e) in proposed § 424.510, we are requiring that providers and suppliers must be operational as defined in § 424.502 and must meet additional requirements that apply to both enrolling and currently enrolled providers and suppliers before receiving a Medicare billing number and becoming eligible for Medicare payments.

In recognition of the effectiveness of site visits, we are proposing, at § 424.510(f), a plan for integrating site visits as part of our enrollment validation process and general program oversight activities. We are reserving the right to perform on-site inspections of the provider or supplier when we deem necessary to ensure compliance with Medicare enrollment requirements. For certain providers and suppliers this practice has always been the case (for example, Hospitals, Skilled Nursing Facilities (SNFs), and Home Health Agencies (HHAs)), but we are extending this to all providers and suppliers when deemed necessary based on questionable enrollment information. Site visits for enrollment purposes will not affect those site visits performed for establishing conditions of participation. Our proposed site visits and on-site inspections to ensure compliance with Medicare enrollment requirements are unrelated to the compliance-related site visits already being conducted by the OIG. After a provider or supplier enters into a corporate integrity agreement with the OIG, usually as the result of a Federal False Claims Act settlement, the OIG may conduct a site visit as part of its work in monitoring the provider or supplier's compliance with the terms of the corporate integrity agreement. Upon the provider or supplier's successful completion of the enrollment process, including State survey and certification, accreditation, and approval of the CMS 855, we will grant Medicare billing privileges and issue a billing number if one has not already been issued. The effective date for reimbursement of Medicare covered services will continue to be determined based on current Medicare regulations and policy based on the type of provider or supplier submitting claims. Currently, the effective dates for reimbursement can be found at § 489.13 for providers and suppliers requiring State survey or certification or accreditation, §§ 424.5 and 424.44 for non-surveyed or certified/accredited suppliers, and § 424.57 and section 1834(j)(1)(A) of the Act for DMEPOS suppliers. For those providers and suppliers seeking accreditation from a CMS approved accreditation organization, the effective date for reimbursement will be the later of the date accreditation was received or the final approval of the CMS 855. Based on the regulations cited above, CMS will not issue Medicare billing numbers or grant Medicare billing privileges retroactive to the date that the provider or supplier received final approval of their enrollment application (CMS 855). We are proposing to use this process because we believe there is a relationship between fulfilling the requirements stipulated in the Medicare program statutes and related laws, the integrity of the provider and supplier, the quality of care furnished to Medicare beneficiaries, and the confidence of the public in the Medicare program.

In the future there will be universal provider and supplier numbers, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), for uniquely identifying a provider or supplier and for purposes of billing all health plans, including Medicare and Medicaid. When this universal number is in place, it will still be necessary for providers and suppliers to apply for enrollment as a Medicare provider or supplier and be granted Medicare billing privileges.

D. Requirements for Reporting Changes and Updates To, and the Periodic Revalidation of, Medicare Enrollment Information

We propose that, under new § 424.515, a provider or supplier must update its enrollment information, and re-certify as to its accuracy when any changes are made. We will also periodically require revalidation of the enrollment information by all providers and suppliers when enrollment information has aged over three years. The revalidation process will ensure that we have complete and current information on all Medicare providers and suppliers and ensure continued compliance with Medicare requirements. In addition, this process further ensures that Medicare beneficiaries are receiving services furnished only by legitimate providers and suppliers, and strengthens our ability to protect the Medicare trust fund.

The accuracy of the data describing the individuals or organizations with whom we do business is essential to efficient and effective operation of the Medicare program. For this reason, we are proposing at § 424.520(b), that individuals and organizations are responsible for updating their CMS 855 information to reflect any changes in a timely manner. We define timely as meaning within 90 days, with the exception of a change in ownership or control of the provider or supplier which must be reported within 30 days. Failure to do so may result in deactivation or even revocation of their billing privileges.

We will determine, upon receipt of any changes, if continued enrollment in the Medicare program is proper. We expect that in the vast majority of cases, updates or changes will not affect the status of the provider or supplier. Where it does, we will follow the revocation procedures outlined later in this rule.

When no such changes or updates have been reported or submitted for a period of time, we believe that it is prudent to take steps to confirm the continued validity of the information that was previously submitted. We believe that this revalidation of enrollment information should be accomplished in a way that minimizes the reporting burden to the provider or supplier, but also mitigates the risk to the program of maintaining incomplete or inaccurate information that materially affects the relationship of the program to the provider or supplier. For

this reason, we are proposing that we would initiate a revalidation process for any individual or organization that has not submitted a change or update within the last three years. Routine revalidation may or may not be accompanied by site visits.

We reserve the right to perform non-routine revalidation and request the provider or supplier to re-certify as to the accuracy of the enrollment information when warranted to assess and confirm the validity of the enrollment information. Non-routine revalidation may be triggered as a result of information indicating local problems, national initiatives, fraud investigations, complaints from beneficiaries, or other reasons that cause us to question the integrity of the provider or supplier in its relationship with the Medicare program. Like routine revalidation, non-routine revalidation may or may not be accompanied by site visits.

We are proposing that the revalidation of enrollment information occur no more than once every 3 years. We reserve the right to adjust this schedule if we determine that revalidation should occur on a more frequent basis due to complaints or evidence we receive indicating non-compliance with the Medicare statute or regulations by specific provider or supplier types. The schedule may also be on a less frequent basis if we determine that the integrity of and compliance with the Medicare statute and regulations by specific provider or supplier types indicates that less frequent validation is justified. If such a change were to occur, we will notify all affected providers and suppliers in writing at least 90-days in advance of implementing the change. We will continue to revalidate enrollment information for Ambulance Service Suppliers in accordance with regulations set forth at § 410.41(c)(2) (Requirements for ambulance suppliers), and DME suppliers will continue to renew enrollment in accordance with regulations set forth at § 424.57(e) (Special payment rules for items furnished by DMEPOS suppliers and issuance of DMEPOS supplier billing numbers). We specifically invite further comments on the initially proposed revalidation time frame.

We propose at new § 424.515(a) that during the revalidation or update process all providers and suppliers must attest by way of a signed certification statement that the requirements set forth in this regulation continue to be met. This requirement will not only ensure continued accuracy of the CMS 855 information, but will also ensure that the provider or supplier is committed to taking the necessary steps to maintain compliance with these requirements. However, it should be noted that periodic validation of a provider or supplier's Medicare enrollment information is separate from the survey requirements for the provider or supplier as contained in 42 CFR chapter IV, subchapter E (standards and certification).

We would require the information submitted for revalidation or update to include any new or changed documentation as required by CMS under this or other statutory or regulatory authority that identifies the provider or supplier, and any documentation as required by CMS under this or other statutory or regulatory authority required to verify the provider or supplier's continued eligibility to furnish services to beneficiaries in the Medicare program. We would also require a signature on the completed CMS 855 that meets the requirements proposed in § 424.510(a)(3).

We are also requiring at proposed § 424.515(b) that a provider or supplier must submit a CMS 855 with complete information for revalidation within 60 calendar days of our revalidation notification. For those providers and suppliers who initially enrolled in the Medicare program via the CMS 855, we would furnish a copy of the information currently on file for their review, request that they make any changes, and certify via their signature that the information is accurate, complete, and truthful. We estimate that completion of the form will require on average 8 hours. Therefore, we believe 60 days is a reasonable time frame for providers and suppliers to comply.

As part of the revalidation process, we would verify the accuracy of the reported information on the applicable CMS 855. Because survey and certification are independent program requirements distinct from the revalidation of enrollment information requirements set forth in this subpart, we are stating in proposed § 424.515(c) that new surveys or certifications are not required for the revalidation process. However, providers must continue to meet the provisions of 42 CFR Part 488 concerning mandatory State survey and certification requirements. When applicable, providers must also have completed a provider agreement in accordance with 42 CFR Part 489, which specifies the requirements for provider agreements. We would also reserve the right, at proposed § 424.575(d), to perform on-site inspections, to further ensure compliance with Medicare requirements.

We understand that the resubmission and update of enrollment information will place an obligation on providers and suppliers. We are considering a variety of ways to minimize the burden of this important information collection and verification provision (including the use of Internet technology).

To reduce the burden when reporting updates or changes in the future, we will require that all providers and suppliers currently in the Medicare program complete, in its entirety, the CMS 855 at least once if they have not done so in the past. This will ensure that we have the most current and accurate information, and will allow us to make full use of electronic data submissions via the Internet. By having a complete enrollment record, we will be able to produce and transmit or mail the CMS 855, pre-complete with previously reported information, to the provider or supplier for their review and signature certification as to the continued accuracy of the information and require them to update any information that is no longer current.

E. Additional Provider and Supplier Requirements for Enrolling and Maintaining Active Enrollment Status in the Medicare Program

In new § 424.520, we are specifying the additional requirements that providers and suppliers must meet to enroll or maintain enrollment in the Medicare program. The provider or supplier must certify that it meets, and continues to meet, the following requirements:

- Compliance with Title XVIII of the Act (Medicare Statutory Provisions) and applicable regulations.
- Compliance with all applicable Federal and State licensure and regulatory requirements that apply to the specific provider or supplier type that relate to providing health care services.
- Not employing or contracting with individuals or entities excluded from participation in Federal Health care programs for the provision of items and services reimbursable under these programs in violation of section 1128A(a)(6) of the Act.

The OIG program exclusion regulations were amended effective August 25, 1995, in accordance with the Federal Acquisition Streamlining Act of 1994 (FASA), and with the HHS Common Rule at 45 CFR part 76, to explain the scope and effect of an OIG exclusion. In accordance with the FASA, government-wide reciprocal effect will be given by all Federal

agencies to an administrative sanction imposed by any Federal agency. Specifically, the law provides that: ''No agency shall allow a party to participate in any procurement and non-procurement activity if any [other] agency has debarred, suspended, or otherwise excluded, that party from participation in a procurement or non-procurement activity.'' (FASA, section 2455). Therefore, consistent with FASA, its implementing regulation, and OIG regulations (42 CFR 1001.1901(b)), we would deny or revoke enrollment (revocation effective on the date of the exclusion) if the provider or supplier is subject to an OIG exclusion, or is debarred, suspended or otherwise excluded by any other Federal health care program or agency.

F. Rejection of a Provider or Supplier's CMS 855 for Medicare Enrollment

In new § 424.525, we propose that if a provider or supplier enrolling in the Medicare program for the first time fails to furnish complete information on the CMS 855, or fails to furnish missing information or any necessary supporting documentation as required by CMS under this or other statutory or regulatory authority within 60 calendar days of our request to furnish the information, we would reject the provider or supplier's CMS 855 application. Rejection will not occur if the provider or supplier is actively communicating with CMS to resolve any issues regardless of any timeframes.

Upon notification of a rejected CMS 855, the provider or supplier must again begin the enrollment process by completing and submitting a new CMS 855 and all applicable documentation. We are specifying in § 424.525(b) that the new form must also update any information that is different from that originally submitted. This will ensure that we have the most recent information about the provider or supplier. The enrollment process would culminate in the granting of billing privileges, or denial or rejection of the application.

G. Denial of Enrollment

We would deny enrollment in the Medicare program to providers or suppliers whom we determine to be ineligible. Providers and suppliers who are denied enrollment would not receive Medicare billing privileges. In § 424.530(a) we are proposing that a provider or supplier applying for enrollment in the Medicare program may be denied enrollment for the following reasons:

- Under § 424.530 (a)(1), enrollment may be denied if the provider or supplier were found not to be in compliance (for example, failure to furnish required documentation, lack of qualified practice location) with the Medicare enrollment requirements applicable to the type of provider or supplier enrolling, unless the reason for non-compliance were corrected or the provider or supplier has submitted a plan of corrective action as outlined in Part 488 and under section 1812(h)(2)(c) of the Act.
- In § 424.530(a)(2) we propose that enrollment may also be denied if: (A) the provider or supplier, or any owner, managing employee, authorized or delegated official; or (B) any supervising physician, medical director, or other health care personnel furnishing Medicare reimbursable services who is required to be reported on the providers' or suppliers' CMS 855—(for example, an ambulance crew member.)
- Is excluded from the Medicare, Medicaid and any other Federal health care programs, as defined in § 1001.2, in accordance with § 1001.1901(a);
- Is debarred, suspended, or otherwise excluded from participating in any other Federal procurement or non-procurement activity in accordance with FASA section 2455; (See HHS Common Rule provisions that discuss the effect of a program exclusion under Title XI of the Act, as well as other Federal agency debarments, suspensions, and exclusions found at 45 CFR 76.100(c) and (d)).

We are required to ensure that no payments are made to any providers or suppliers who are excluded from participation in the Medicare program under authorities found in sections 1128, 1156, 1862, 1867, and 1892 of the Act, or who are debarred, suspended or otherwise excluded as authorized by FASA. This includes any individual, entity, or any provider or supplier that arranges or contracts with (by employment or otherwise) an individual or entity that the provider or supplier knows or should know is excluded from participation in a Federal health care program for the provision of items or services for which payment may be made under such a program (section 1128A(a)(6) of the Act), and any provider or supplier that has been debarred, suspended, or otherwise excluded from participation in any other Executive Branch procurement or non-procurement programs or activity (FASA, section 2455).

Therefore, when an individual or entity is excluded by the OIG under section 1128 of the Act, the exclusion is applicable to participation in all Federal health care programs (including Medicare and Medicaid as defined in section 1128B(f) of the Act). In addition, section 1862(e) of the Act prohibits the Secretary from paying for items and services furnished by excluded individuals. We believe that our general authorities, in combination with the prohibition against paying for items or services furnished by excluded individuals, provides authority for us to deny enrollment unless a provider or supplier terminates its relationship with the relevant individual. The denial would remain effective until that provider, supplier, managing employee, or an authorized or delegated official; or a medical director, supervising physician, or other health care personnel furnishing Medicare reimbursable services, is no longer excluded or sanctioned. Section 424.530(b)(3) also provides that the denial may be within 30 days of the denial notification.

We also propose, in § 424.530(a)(3), that we may deny enrollment in the Medicare program if the provider or supplier, or any owner of the provider or supplier, has been convicted of a Federal or State felony offense that we determine to be detrimental to the best interests of the Medicare program or its beneficiaries. This authority is afforded to us in many of the HIPAA fraud and abuse provisions and section 4302 of the BBA. In making assessments, we are proposing to include any felony convictions from the last 10 years or more. In addition, we will consider the severity of the underlying offense.

Felonies that we determine to be detrimental to the best interests of the Medicare program or its beneficiaries include:

- Within the last 10 years or more preceding enrollment or revalidation of enrollment, crimes against persons, such as rape, murder, kidnapping, assault and battery, robbery, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions. We believe it is reasonable for the Medicare program to question the ability of the individual or entity with such a history to respect the life and property of program beneficiaries.
- Within the last 10 years or more preceding enrollment or revalidation of enrollment, financial crimes, such as extortion, embezzlement, income tax evasion, making false statements, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions. We believe it is reasonable for the Medicare program to question the honesty and integrity of the individual or entity with such a history in providing services and

claiming payment under the Medicare program.

• Within the last 10 years or more preceding enrollment or revalidation of enrollment, any felony that placed the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.

• Any felonies referred to in section 1128 of the Act.

Under section 1128(a) of the Act, the Secretary must exclude individuals or entities convicted of certain crimes, such as program-related crimes, crimes related to patient abuse or neglect, and conviction of a felony related to health care fraud or controlled substances. In addition, the Secretary has authority to exclude individuals and entities for other adverse actions including when an individual or entity is owned or controlled by a sanctioned or convicted individual, in accordance with section 1128(b)(8) of the Act.

In cases where the provider or supplier is not a convicted individual but, rather, has an ownership or management relationship with a convicted or excluded individual, that provider or supplier may also be subject to civil monetary penalties (section 1128A(a)(6) of the Act). In addition, we may deny or revoke billing privileges if such a relationship exists. However, the denial may be reversed if, within 30 days of the denial notification, the provider or supplier terminates its ownership or management relationship with the convicted or excluded individual or organization. We specifically invite further comments on our approach to treating convicted felons, and any impact that may have on access to care for Medicare beneficiaries.

We propose in § 424.530(a)(4) that we may deny enrollment if the provider or supplier has deliberately submitted false or misleading information on their CMS 855 to gain enrollment in the Medicare program. Offenders may be subject to fines or imprisonment, or both, in accordance with current law and regulation.

In § 424.530(a)(5) we propose possible denial of enrollment where there are repeated instances in which, upon onsite review or other reliable evidence, we do not find present those licensed medical professionals required under the Medicare statute or regulations to supervise treatment or provide Medicare covered services for Medicare patients; or we determine that the provider or supplier is not operational to furnish Medicare covered services or supplies.

As outlined in proposed § 424.530(b), if the denied provider or supplier appeals the decision, and the denial is upheld, that provider or supplier may submit a new CMS 855 after we notify it that the original determination has been upheld. If the provider or supplier did not appeal the determination, it may submit a new CMS 855 when the time frame for appeal rights has lapsed. We are proposing this latter requirement to prevent administrative difficulties that might result in processing two enrollment forms if a new one is submitted during the time period when the provider or supplier may appeal an initial denial.

Medicare enrollment denials will impact the provider or supplier on a national scale. In proposed § 424.530(c), we state that when a provider or supplier is denied enrollment in Medicare, we will review all other related Medicare enrollment files that the denied provider or supplier has an association with (for example, as an owner or managing employee) to determine if the denial warrants an adverse action of the associated Medicare provider or supplier.

H. Revocation of Enrollment and Billing Privileges from the Medicare Program

Revocation occurs when an enrolled provider or supplier's billing privileges are terminated. In proposed § 424.535, we outline the causes for revocation and what a provider or supplier would need to do to re-enroll in the Medicare program after revocation. In considering whether to revoke enrollment and billing privileges in the Medicare program, we would consider the severity of the offenses, mitigating circumstances, program and beneficiary risk if enrollment continued, possibility of corrective action plans, beneficiary access to care, and any other pertinent factors.

In general, we propose revocation criteria that are similar to our reasons for denial of initial Medicare program enrollment. In § 424.535(a)(1) we propose that a provider or supplier's enrollment and billing privileges may be revoked if, at any time, it is determined to be out of compliance with the Medicare enrollment requirements outlined in subpart P including failure to report changes to enrollment information timely or failure to adhere to corrective action plans, and has not corrected the problem within 30 days of notice of non-compliance or submitted a plan of corrective action as cited earlier. We are providing that we may request additional documentation from the provider or supplier to determine compliance if adverse information is received or otherwise found concerning the provider or supplier. If requested documentation as required by CMS under this or other statutory or regulatory authority is not submitted within 30 calendar days of our request, we would immediately begin revocation proceedings. If the documentation is received timely, we would review and verify the information to determine if we should proceed with the revocation. Providers requiring State survey and certification would continue to receive payment during the data verification review under current regulations found at Part 488 and under section 1819(h)(2)(c) of the Act. Providers and suppliers not subject to State survey and certification may have its payments suspended during the data review.

We are also proposing that we may revoke a provider or supplier's billing privileges if the provider or supplier establishes:

• Repeated instances in which, upon onsite review or other reliable evidence, we do not find present those licensed medical professionals required under the Medicare statute or regulation to supervise treatment of, or to provide Medicare covered service for, Medicare patients. Additional proposed reasons that may result in the revocation of billing privileges in § 424.535(a) include the following:

• In accordance with section 1862(e)(1) and (2) of the Act, the provider or supplier, any owner, managing employee, authorized or delegated official, supervising physician or other health care personnel who must be reported on the CMS 855 (for example, ambulance crew member), of the provider or supplier, becomes excluded from the Medicare, Medicaid or any other Federal health care programs, as defined in § 1001.2, in accordance with section 1128 or 1156 of the Act, or is debarred, suspended or otherwise by any Federal health care program or agency.

• The provider or supplier, or any owner of the provider or supplier, is convicted of a Federal or State felony offense that we determine to be detrimental to the best interests of the program as outlined in ''Denial of Enrollment'' above.

• The provider or supplier certified as ''true'' deliberately submitted false or misleading information on the CMS 855 in order to enroll or maintain enrollment in the Medicare program. (Offenders may be subject to criminal or civil prosecution, in accordance with current laws and regulations).

• Upon onsite review, we determine that the provider or supplier is no longer operational to furnish Medicare covered services or supplies.

• The provider or supplier fails to furnish complete and accurate information on the CMS 855 and any applicable documentation within 60 calendar days of our notice to re-certify its enrollment information.

• The provider or supplier knowingly sells to or allows another individual or entity to use its billing number.

In addition to the revocation of the provider's or supplier's billing privileges, we propose at § 424.535(b) that any provider agreement in effect at the time of revocation will also be terminated effective with the date of revocation. We do not feel it would be prudent for CMS to maintain an active provider agreement for a provider or supplier whose business relationship with Medicare was adverse enough as to cause the revocation of their billing privileges. Section 1866(b)(2)(A) of the Act states that the Secretary may terminate a provider agreement after the Secretary ''has determined that the provider fails to comply substantially with the provisions of Title XVIII.'' We will amend §§ 489.53 and 498.3 to reflect this proposal.

In new § 424.535(c) we propose that upon notification of the revocation of its billing number, if the provider or supplier seeks to re-establish enrollment and billing privileges in the Medicare program (either after the appeals process is exhausted or in place of the appeals process), then the provider or supplier must complete and submit a new CMS 855 as a new provider or supplier and applicable documentation. Providers must be re-surveyed or re-certified by the State survey agency as a new provider and must establish a new provider agreement with our Regional Office.

If the billing privileges are revoked due to the adverse activity of an individual or organization other than the provider or supplier, the revocation may be reversed if the provider or supplier terminates their business relationship with the individual or organization that was responsible for the revocation within 30 days.

As with a denial of Medicare enrollment, revocations would impact the provider or supplier on a national scale. As proposed in § 424.535(d), if a provider or supplier's billing privileges are revoked, we would review all other related Medicare enrollment files that the revoked provider or supplier has an association with (for example, as an owner or managing employee) to determine if the revocation warrants an adverse action of the associated Medicare provider or supplier.

I. Deactivation of Medicare Billing Privileges

When a provider or supplier's billing number is deactivated, billing privileges have been temporarily suspended, but can be restored upon the submission of updated or re-certified information. In new § 424.540, we propose to deactivate a provider or supplier's Medicare billing number if no Medicare claims are submitted for 2 consecutive calendar quarters (6 months) unless current policy or regulations specify otherwise for specific provider or supplier types. Our current policy requires deactivation of billing numbers after 4 consecutive calendar quarters (12 months) of no claim submissions. We are including this reduction to the current requirement because we are aware of a number of program integrity issues related to inactive Medicare billing numbers. We wish to prevent, for example, questionable businesses from deliberately obtaining multiple numbers so that they could keep one ''in reserve'' in the event their practices result in suspension of claims payment under their active number. We also wish to prevent fraudulent entities from obtaining information about discontinued providers or suppliers, for example, using the Medicare billing number of a deceased physician. While we are proposing to use 6 months of no billing as a criteria for deactivation, we are seeking comments on the feasibility and reasonableness of this time frame. We are interested in receiving comments on whether this time frame should apply to all categories of providers and suppliers, or whether there should be a special process for categories of providers and suppliers that would have reason to bill Medicare infrequently.

We are also proposing to deactivate a billing number if we discover changes to the information provided on the provider or supplier's CMS 855 that were not reported within 90 days of the change. This includes, but is not limited to, changes to billing services, a change in the practice location, or a change of any managing employee. A change in ownership or control must be reported within 30 calendar days.

Deactivation of Medicare billing privileges is considered a temporary action to protect the provider or supplier from misuse of their billing number and to also protect the Medicare trust fund from unnecessary overpayments. The temporary deactivation of a billing number will not have any effect on a provider or supplier's participation agreement or conditions of participation.

In proposed § 424.540(b), we state that a provider or supplier whose billing number has been deactivated for any reason other than non-submission of a claim for 6 months and who wants to reactivate its Medicare billing number must complete and submit a new CMS 855. Those providers and suppliers whose billing number has been deactivated after non-submission of a claim must re-certify that the enrollment information current on file with Medicare is correct before the claim will be paid. In addition, the provider or supplier must meet all current Medicare requirements in place at the time of the re-activation. The provider or supplier must also be prepared to submit a valid claim or risk subsequent deactivate of their billing number. Once notified, we will give all reactivations of Medicare billing numbers priority handling to ensure expedient payment of claims. Reactivation of a Medicare billing number would not require re-survey or certification by State agency, or the establishment of a new provider agreement.

J. Provider and Supplier Appeal

In new § 424.545, we propose that a provider or supplier that has been denied enrollment in the Medicare program, or whose enrollment has been revoked, may appeal our decision in accordance with our regulations at Part 405, Subpart H, for suppliers or Part 498, Subpart A, for providers. CMS is currently drafting a single regulatory appeals process for all providers and suppliers denied or revoked from participation in the Medicare program. In keeping with current policy, we also propose that no payments will be made during the appeals process. If the provider or supplier is successful in overturning a denial or revocation, unpaid claims for services furnished during the overturned period may be resubmitted.

In addition, we propose in new § 424.545(b) that a provider or supplier whose billing privilege has been deactivated may file a rebuttal using procedures found at § 405.74.

K. Prohibitions on the Sale or Transfer of Billing Privileges

We propose in new § 424.550 that a provider or supplier would be prohibited from selling its Medicare billing number to any individual or entity, or allowing another individual or entity to use its Medicare billing number. Similarly, we would prohibit a provider or supplier from transferring its Medicare billing privileges to any individual or entity, except during a change in ownership, as stated below. A

provider or supplier does not have independent authority to sell or transfer any billing number issued or the billing privileges granted with the billing number assigned.

We propose this policy because only we and our agents have the authority to issue Medicare billing numbers and grant Medicare billing privileges. These numbers are issued only after the information about the provider or supplier collected on the CMS 855 is verified. Because it is used to uniquely identify a provider or supplier, the Medicare billing number we issue is solely for use by the specific provider or supplier to whom it was issued.

In the case of a provider or supplier undergoing a change of ownership as described in part 489 subpart A, we would require at § 424.550(b) that a CMS 855 be completed and submitted by both the current owner and the new owner before the completion of the ownership change. Failure of the current owner to submit the CMS 855 prior to the change of ownership may result in sanctions and/or penalties, after the date of ownership change, in accordance with §§ 424.520, 424.540, and 489.53. Failure of the new owner to submit the CMS 855 prior to the change of ownership may result in the deactivation of the Medicare billing number until the CMS 855 has been submitted.

We may deactivate a Medicare billing number at any time before final transference of the provider agreement to the new owner. This may occur as a result of the submission of a CMS 855 with material omissions, or preliminary information received or determined by us that makes us question whether the new owner will ultimately be granted a final transference of the provider agreement. This allows us the right to ensure that billing privileges are given only to a new owner for which we have adequate information to, at a minimum, determine that the new owner should have billing privileges prior to the complete validation of their CMS 855 and the transfer of the provider agreement.

We understand that not all enrollment information is available before the change of ownership. We will work with the new owner(s) to ensure a seamless transition, but it is the provider's or supplier's responsibility to report this and any other changes to us to prevent us from imposing any adverse action against it.

For those providers and supplier not covered by Part 489, any change in the ownership or control of the provider or supplier must be reported on the CMS 855 within 90 days of the change as noted in § 424.540(a)(2). Generally, a change of ownership that also changes the tax identification number will require a new CMS 855 from the new owner.

L. Payment Liability

In new § 424.555, we propose that any expenses for services furnished to a Medicare beneficiary by those categories of suppliers covered by section 1834 of the Act (that is, suppliers of DMEPOS) are the responsibility of that supplier if the supplier has been denied Medicare billing privileges. We further propose that no payment may be made for covered services furnished to a Medicare beneficiary by a provider or supplier whose billing privileges have been deactivated or revoked. The Medicare beneficiary will have no financial responsibility for this type of expense, and the provider or supplier must refund on a timely basis any amounts collected from the beneficiary for those covered services.

We are proposing these provisions because a provider or supplier who fails to provide valid enrollment information, or who is not a valid provider or supplier type under the Medicare program, cannot be verified as a legitimate provider or supplier for purposes of this rule. Claims or bills submitted for covered Medicare services must have an active Medicare billing number. Claims or bills submitted by a provider or supplier who is not properly enrolled, and does not have an active Medicare billing number, would be considered incomplete and would be returned. The provider or supplier would then be in violation of the mandatory claims submission requirements and could be fined for each occurrence. An incomplete claim returned for this reason would not be afforded appeal rights for the provider or supplier. However, as described earlier, a provider or supplier may appeal a denial or revocation of enrollment in accordance with regulations elsewhere in this subpart.

Sections 1802(b), 1834(j), 1866, and 1870 of the Act, provide Medicare beneficiaries with certain protections against liabilities imposed by providers and suppliers. In section 1834(j)(4), for example, the statute protects the beneficiary against demands for payment for covered Medicare services by certain categories of suppliers that have not been granted Medicare billing privileges. Section 1866 of the Act prohibits providers that have entered into agreements described in that section from charging the beneficiary for covered items or services that are not paid by Medicare because the provider has failed to comply with certain requirements. Furthermore, section 1802(b) of the Act, which sets forth a variety of criteria under which physicians and practitioners may enter into private contracts with Medicare beneficiaries, provides for additional beneficiary protection. Section 1870 provides that, except under certain circumstances, any payment to a provider of services with respect to items or services furnished shall be considered a payment to the individual, but that the individual will not be liable for overpayment to the provider where the individual is without fault.

In addition, section 1128A(a)(6) of the Act provides for criminal penalties for providers and suppliers having knowledge of events affecting the right to benefit or payment, and concealing or failing to disclose such an event with an intent to fraudulently secure benefit or payment when it is not authorized.

IV. Data Requested on the CMS 855 and Its Iterations

Because we are intending to use the CMS 855 series of forms as the principal information collection instrument, we are providing the following information about the data requested on the CMS 855 forms. In addition to the legal authority already cited in this preamble, the following additional provisions of the statute grant us the authority to collect the information required to complete the CMS 855:

- Section 1814(a) of the Act states that payment for services furnished to an individual may only be made to providers eligible under section 1866 and only if a written request is filed in such a form and manner as the Secretary may prescribe.
- Sections 1815(a) and 1833(e) of the Act authorize the Secretary to withhold Medicare payments until the provider or supplier furnishes such information as may be necessary to determine amounts due.
- Section 1866(a)(1) of the Act establishes provider agreement requirements; including a requirement not to charge the beneficiary (except as provided in section 1866(a)(2)) for items or services for which the beneficiary would have been entitled to have payment had the provider complied with procedural requirements.

A. Information Collection on the CMS 855

Since its inception in April 1996, the CMS 855 has been revised three times, in May 1997, January 1998, and in November 2001. A new proposed revision of the CMS 855 series is being submitted with this proposed rule for

additional public comment. Each revision has been based on comments received from our contractors, the health care industry, and new requirements imposed through legislation. All revisions are submitted to OMB and published in the **Federal Register** for public comment before approval and implementation.

The primary function of the CMS 855 is to gather information from a provider or supplier that tells us who it is, whether it meets certain qualifications to be a health care provider or supplier, where it practices or renders its services, the identity of the owners of the enrolling entity, and information necessary to establish the correct claims payment. The goal of evaluating and revising the CMS 855 is to simplify and clarify the information collection without jeopardizing our need to collect specific information. Listed below are the various sections of the CMS 855 and the information that each section collects. Not all sections apply to all provider and supplier types. For specific information collection requirements by provider or supplier type, review the applicable CMS 855 as mentioned earlier in this preamble.

1. Provider or Supplier Application

To ensure efficient processing of the CMS 855, this section requires the provider or supplier to give the reason for submission of the CMS 855 and to state whether it is currently known (enrolled) in Medicare and for any current Medicare identifiers (billing numbers or Medicare contractor name(s)).

2. General Identification Information

This section collects personal and business information to uniquely identify the provider or supplier with such information as type or specialty, name, business name, address, date of birth, SSN, EIN, correspondence address, and other similar information. This information is needed to uniquely identify the provider or supplier. Moreover, as detailed above, section 1124(a)(1) of the Act requires disclosure of both EINs and SSNs. See also section 31001(I) of the DCIA.

3. Adverse Legal Action(s) and Overpayment(s)

The information obtained in this section enables us to determine if an individual or entity should have its Medicare billing number denied or revoked. Table A in this section cites specific adverse legal actions which have a direct bearing on the individual's or entity's professional competence, professional performance, or financial integrity that the provider or supplier must report to Medicare. These actions may serve as a basis for the Secretary, as set forth in section 1128 of the Act, to exclude an individual or entity from participation in Medicare and all other Federal health care programs.

4. Current Practice Location(s)

This section collects information to verify that the practice location where services are proposed to be or are being furnished by the enrolling provider or supplier meets Medicare requirements.

5. Ownership Interest and/or Managing Control Information (Organizations)

6. Ownership Interest and/or Managing Control Information (Individuals)

7. Chain Home Office Information

The information collected in the above three sections (5 through 7) is needed to ensure that all individuals and entities deriving financial benefit from the Medicare program are identified as required in sections 1124 and 1124A(a) of the Act, and in § 420.204. Those sections state that as a condition for approval or renewal of a contract or agreement, and for an entity to receive payment under Title XVIII, complete information as to the identity of each person and/or organization with an ownership or controlling interest of 5 percent or more and each managing employee as defined in section 1126(b) of the Act and § 420.201, must be disclosed.

8. Billing Agency

This section is needed to capture identifying information, such as legal business name and address, and to obtain information about the contract between the provider or supplier and the billing agency that submits bills or claims for Medicare payments on behalf of a Medicare provider or supplier. In addition, we need this information to verify that the biller has been authorized by the provider or supplier to submit bills or claims on the provider or supplier's behalf. We need to be able to monitor agreements made between billing and collection agents and providers and suppliers to ensure compliance with Medicare requirements found at 1842(b)(6) of the Act and §§ 424.73 and 424.80.

9. For Future Use

10. Staffing Company

This section is needed to capture identifying information, such as legal business name and address, and to obtain information about the contract between the provider or supplier and the staffing company that submits bills or claims for Medicare payments on behalf of a Medicare provider or supplier. In addition, we need this information to verify that the biller has been authorized by the provider or supplier to submit bills or claims on the provider or supplier's behalf. We need to be able to monitor agreements made between staffing companies and providers and suppliers to ensure compliance with Medicare requirements found at section 1842(b)(6) of the Act and §§ 424.73 and 424.80.

11. Surety Bond Information

This section will be used on an ''as needed'' basis and would furnish us with information regarding certain providers and suppliers that are required to obtain a surety bond under section 4312 of the BBA (codified at sections 1834(a)(16), 1861(o)(7), 1861(p)(4)(A)(v) and 1861(cc)(2)(I)) of the Act. The BBA further grants the Secretary the authority, at his or her discretion, to impose the requirements on other Medicare providers or suppliers (other than physicians or other practitioners as defined in section 1842(b)(18)(C) of the Act). See also section 1834(a)(16) of the Act.

12. Capitalization Requirements for Home Health Agencies (HHAs)

This section collects information required by § 489.28, which requires all HHAs enrolling in Medicare for the first time to submit proof of sufficient operating funds.

13. Contact Person(s)

This information will allow a Medicare contractor to establish a direct point of contact to resolve issues pertaining to the completion and validation of the information furnished in the CMS 855.

14. Penalties for Falsifying Information on this Enrollment Application

This section is informational only. It cites various statutory references in the United States Code and the Social Security Act concerning actual knowledge, deliberate ignorance or reckless disregard of the truth or falsity of the information contained therein on an application to receive payment.

15. Certification Statement

The certification statement is being revised. Statement 3 on the CMS 855A, CMS 855B, and CMS 855S forms and statement 4 on the CMS 855I form have been changed to provide a better understanding of Medicare policy. An additional statement is also being added to the CMS 855A and CMS 855B forms for providers and suppliers that receive

accreditation from an outside organization authorizing the release of the survey to us or our agents. By adding this language to the certification statement, the current CMS 1514 form will be eliminated for Medicare purposes.

16. Delegated Official (Optional)

The signature(s) obtained in sections 15 and 16 would attest that the provider or supplier has submitted accurate, complete, and truthful information as required by sections 1814(a) and 1833(e) of the Act, and that the person the provider or supplier has authorized to sign for the provider or supplier attests on behalf of the provider or supplier to having read and understood the information furnished and collected in the CMS 855, and that the information is accurate, complete, and truthful. By signing the certification statement, the provider or supplier, or the authorized or delegated official signing on behalf of the provider or supplier, is attesting, among other things, that the provider or supplier is aware of and will abide by all applicable Medicare laws and regulations.

17. Attachments

This section is a checklist of possible documents that should be submitted with the enrollment application. These documents are used as evidence or proof of the validity of the information furnished through the CMS 855.

B. Information Pertaining to Specific Provider and Supplier Types

1. Attachment 1 to Form CMS 855B—Ambulance Service Suppliers

We must collect specific information on ambulance service suppliers to verify their eligibility to receive payment for Medicare covered services. Section 410.41 (Requirements for ambulance suppliers) sets forth the requirements for ambulance service suppliers. An ambulance must be specially designed to respond to medical emergencies or provide acute medical care to transport the sick and injured and comply with all State and local laws governing an emergency transportation vehicle. We require that, at a minimum, an ambulance contain a stretcher, linens, emergency medical supplies, oxygen equipment, and other lifesaving emergency medical equipment as required by State or local laws, and be equipped with emergency warning lights, sirens, and two-way telecommunications.

Note: This attachment replaced the HCFA R–88 (OMB Approval Number 0938–0460).

2. Attachment 2 to Form CMS 855B—Independent Diagnostic Testing Facilities (IDTFs)

IDTFs must submit specific information to us to justify their eligibility to receive payment for Medicare covered services. The information collected in this attachment allows us to assess compliance with 42 CFR § 410.33 (Independent diagnostic testing facility). In addition, 42 CFR § 440.30 (Other laboratory and x-ray services) defines laboratory and X-ray services. These services may be provided in an office or similar facility other than a hospital outpatient facility or clinic, and must be furnished by a laboratory that meets the requirements of Part 493 of chapter IV, 42 CFR.

C. Supplemental Applications

1. Supplemental Application CMS 855S (DMEPOS Supplier Application)

The information collected in this iteration of the CMS 855 allows us to assess compliance with § 424.57 (Special payment rules for items furnished by DMEPOS suppliers and issuance of DMEPOS supplier billing numbers), which outlines specific standards that must be met for the enrollment and renewal of enrollment for DMEPOS suppliers. This collection was previously approved by OMB via the HCFA 192 (OMB Approval Number 0938–0594). The CMS 855S has replaced the HCFA 192.

Note: A DMEPOS supplier is not required to submit a CMS 855B form in addition to a CMS 855S.

2. Supplemental Application CMS 855R (Individual Reassignment of Benefits Application)

The CMS 855R will be used to link individual Medicare suppliers with Medicare entities to whom the individual reassigns his or her benefits and is used in conjunction with the CMS 855I or the CMS 855B during initial enrollment into the Medicare program, or whenever an individual supplier wishes to, or is required to, reassign its benefits. The CMS 855R contains only the information needed to identify and link individual suppliers reassigning their benefits to the individuals and entities to whom their benefits are being reassigned.

V. Sanctions and Penalties

The CMS 855 states that the following penalties may be imposed:

- 18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes or uses any false, fictitious, or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to 5 years. Offenders that are organizations are subject to fines of up to $500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender.
- Section 1128B(a)(1) of the Act authorizes criminal penalties against an individual who ''knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program.'' The offender is subject to fines of up to $25,000 or imprisonment for up to 5 years, or both.
- The Civil False Claims Act, 31 U.S.C. 3729, imposes a civil penalty of $5,000 to $10,000 per violation, plus three times the amount of damages sustained by the Government and imposes civil liability, in part, on any person who—
- Knowingly presents, or causes to be presented, to an officer or an employee of the United States Government a false or fraudulent claim for payment or approval;
- Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or
- Conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.
- Section 1128A(a)(1) of the Act imposes administrative sanctions on a person for the submission to a Federal health care program of false or otherwise improper claims.

These administrative sanctions include a civil monetary penalty of up to $10,000 for each item or service falsely or fraudulently claimed an assessment of up to triple the amount claimed, and exclusion from participation in all Federal health care programs.

The government may assert common law claims such as ''common law fraud,'' ''money paid by mistake,'' and ''unjust enrichment.'' Remedies include compensatory and punitive damages, restitution, and recovery of the amount of the unjust profit.

In addition, the following two sanctions will be added to the CMS 855 form:

• 18 U.S.C. 1035 authorizes criminal penalties against individuals in any matter involving a health care benefit program who knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact; or makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items, or services. The individual shall be fined or imprisoned up to 5 years or both.

• 18 U.S.C. 1347 authorizes criminal penalties against individuals who knowing and willfully execute, or attempt, to execute a scheme or artifice to defraud any health care benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by or under the control of, any health care benefit program in connection with the delivery of or payment for health care benefits, items, or services. Individuals shall be fined or imprisoned up to 10 years or both. If the violation results in serious bodily injury, an individual shall be fined or imprisoned up to 20 years, or both. If the violation results in death, the individual shall be fined or imprisoned for any term of years or for life, or both.

VI. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), agencies are required to provide a 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to OMB for review and approval. To evaluate fairly whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comments on the following issues:

• Whether the information collection is necessary and useful to carry out the proper functions of the agency;

• The accuracy of the agency's estimate of the information collection burden;

• The quality, utility, and clarity of the information to be collected; and

• Recommendations to minimize the information collection burden.

Therefore, we are soliciting public comment on each of these issues for the information collection requirement discussed below.

The following sections of this document contain information collection requirements:

Section 424.510 Requirements for Obtaining a Billing Number and Medicare Billing Privileges

To enroll in the Medicare program and obtain and activate a Medicare provider or supplier billing number, § 424.510(a) requires a provider or supplier to complete and submit a CMS 855 to us, demonstrating that the provider or supplier meets all of the requirements set forth in this section. The burden associated with these requirements are currently captured in the CMS 855 (OMB Approval Number 0938–0685) and shown below in Table 1.

TABLE 1.—CURRENT ESTIMATED HOURS FOR COMPLETION OF CMS 855 FORMS FOR INITIAL ENROLLMENT

CMS form number	Estimated number of respondents	Estimated time for completion per respondent	Total number of hours for completion	Total cost in dollars (million)
855A	5,000	8 Hours	40,000	$3
855B	10,000	8 Hours	80,000	$6
855I	50,000	5 Hours	250,000	$3
855R	100,000	15 Minutes	25,000	$.3
855S	9,000	8 Hours	72,000	$5.4
Total Estimated Hourly and Financial Burden			467,000	$17.7

The estimated number of respondents is based on current Medicare contractor workload reports. The cost in dollars is based on hourly salaries for applicable staff to complete the applications.

Section 424.510(f) states that we reserve the right to perform on-site inspections of a provider or supplier to verify and ensure validity of the information submitted to us or our agents and to determine compliance with Medicare requirements. We intend to conduct on-site visits of all new suppliers of DMEPOS before they can enroll in the Medicare program. The burden associated with these requirements are currently captured and approved in form HCFA–R–263 (OMB Approval Number 0938–0749).

We also intend to conduct approximately 490 on-site visits to Community Mental Health Centers. The burden associated with these requirements are currently captured and approved in form HCFA–R–273 OMB Approval Number 0938–0770). We also intend to conduct approximately 2800 visits to IDTFs on an annual basis. We will seek OMB approval for these visits. The burden associated with this requirement is the time and effort necessary for a facility to provide documentation to verify information provided on their CMS 855 and to demonstrate that they meet other necessary Medicare requirements and regulations.

TABLE 2.—ESTIMATED ANNUAL REPORTING BURDEN

CFR sections	Annual number of responses	Frequency	Average burden per response (hours)	Annual burden (hours)	Annual cost
424.510(f)	2800	1	4	11,200	$0

Since these site visits are unannounced and performed to ensure proper physical location, equipment, and personnel to meet Medicare requirements, we do not expect the

provider or supplier to incur any financial burden.

We may also conduct on-site visits of providers or suppliers based on any information that leads us or our agents to believe that an administrative action, investigation or audit is warranted. Information collected under these situations is exempt from the PRA, as stipulated under 5 CFR 1320.4.

Section 424.515 Requirements for Reporting Changes and Updates to, and the Periodic Revalidation of, Medicare Enrollment Information

A provider or supplier must re-certify for revalidation its enrollment information no more than once every 3 years. Section 424.515(b) states that within 60 calendar days of our notice to re-certify their enrollment information for revalidation, a provider or supplier must submit any new or revised CMS 855 information and documentation necessary to demonstrate that they meet the requirements set forth in this section.

TABLE 3.—ESTIMATED ANNUAL REPORTING BURDEN

CFR sections	Annual number of responses	Frequency	Average burden per response (minutes)	Annual burden (hours)	Annual cost (million)
424.515(b)	387,000	(**)	95	612,750	$15

** Frequency is no more than once every 3 years. (1.16 million providers and suppliers/3 years × 95 minutes/60 minutes.)

The burden hours shown above are for the most restrictive reporting. As indicated elsewhere in this preamble, we are exploring various options and are soliciting comments on ways of minimizing the burden on providers and suppliers during the process of revalidating their enrollment information.

The estimated cost is based on $40 per application per provider to review and return.

Section 424.520 Additional Provider and Supplier Requirements for Enrolling and Maintaining Active Enrollment Status in the Medicare Program

Following enrollment and periodic recertification of enrollment information, a provider or supplier must report to us any changes to the information furnished on the CMS 855 or supporting documentation within 90 calendar days of the change.

TABLE 4.—ESTIMATED ANNUAL REPORTING BURDEN

CFR section	Annual number of responses	Frequency	Average burden per response (hours)	Annual burden (hours)	Annual cost (millions)
424.20	40,000	1	1	40,000	$1.6

Section 424.525 Rejection of a Provider or Supplier's CMS 855 for Medicare Enrollment

We will reject a provider or supplier's CMS 855 if the provider or supplier does not furnish missing or necessary information and documentation to us within 60 calendar days of a request. We believe that the burden associated with this requirement is captured in § 424.515, as we will merely be seeking the information initially requested in the CMS 855.

Section 424.525(b) states that upon notification of a rejected CMS 855, the provider or supplier must once again begin the enrollment process by completing and submitting a new CMS 855 and all applicable documentation if it wishes to obtain a Medicare billing number.

TABLE 5.—ESTIMATED ANNUAL REPORTING BURDEN

CFR sections	Annual number of responses	Frequency	Average burden per response (minutes)	Annual burden (hours)	Annual cost
424.525(b)	11,250	1	95	17,812	$563,000

The annual dollar cost is based on $50 per respondent to update and resubmit a previously submitted enrollment application.

Section 424.535 Revocation of Enrollment and Billing Privileges From the Medicare Program

Section 424.535(b) states that upon notification of the revocation of its billing number and billing privileges, if the provider or supplier seeks to re-establish enrollment in the Medicare program it must re-enroll in the Medicare program through the completion and submission of a new CMS 855 and applicable documentation.

TABLE 6.—ESTIMATED ANNUAL REPORTING BURDEN

CFR sections	Annual number of responses	Frequency	Average burden per response (hours)	Annual burden (hours)	Annual cost (millions)
424.535(b)	2000	1	8	16,000	$1.2

The annual dollar cost is based on $600 per respondent to re-enroll in the Medicare program.

Providers must also be re-surveyed or re-certified by the State Survey Agency and must establish a new provider agreement with our Regional Office. The burden associated with the survey and certification requirement is exempt from the PRA, as provided in section 4204(c) of Pub. L. 100–203 COBRA 87, as amended by Pub. L. 100–360 (Medicare Catastrophic Coverage Act of 1988). The burden associated with the requirement to establish a new provider agreement (Form HCFA–460) is currently approved under OMB Approval Number 0938–0373.

Section 424.540 Deactivation of Medicare Billing Privileges

Section 424.540(a)(1) states that if no Medicare claims are submitted for two consecutive calendar quarters (6 months) we would deactivate a provider or supplier's Medicare billing number. The provider or supplier must complete and submit a CMS 855 for validation to reactivate its Medicare billing number and billing privileges.

TABLE 7.—ESTIMATED ANNUAL REPORTING BURDEN

CFR sections	Annual No. of responses	Frequency	Average burden per response (minutes)	Annual burden hours	Annual cost
424.540 (a)(1)	1200	1	95	1,900	$48,000

The annual cost is based on $40 per respondent to review and re-certify via signature their previously submitted enrollment application/information.

Table 8 below shows the total estimated hourly and financial burden for all requirements outlined and proposed in this rule.

TABLE 8.—ESTIMATED HOURLY AND FINANCIAL BURDEN FOR ALL REQUIREMENTS

CFR section	Annual No. of responses	Annual burden hours	Annual cost (million)
424.500	618,250	1.2 million	$36.6

We have submitted a copy of this proposed rule to OMB for its review of the information collection requirements in §§ 424.510, 424.515, 424.520, 424.525, 424.535, and 424.540 and related forms in the addendum. These requirements are not effective until they have been approved by OMB.

If you have any comments on any of these information collection and record keeping requirements, please mail the original and 3 copies directly to the following:

Centers for Medicare and Medicaid Services, Office of Information Services, Information Technology Investment Management Group, Division of CMS Enterprise Standards, Room C2–26–17, 7500 Security Boulevard, Baltimore, MD 21244–1850, Attn.: John Burke CMS–6002–P.

And,

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington. DC 20503, Attn: Brenda Aguilar, CMS Desk Officer.

VII. Regulatory Impact Analysis

We have examined the impacts of this proposed rule under Executive Order (E.O.) 12866, the Unfunded Mandate Reform Act of 1995, and the Regulatory Flexibility Act. E.O. 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits. In addition, a Regulatory Impact Analysis must be prepared for major rules with economically significant effects ($100 million or more in any one year). This proposed rule would establish in regulations specific provider and supplier initial enrollment procedures and the periodic revalidation of eligibility. It is not expected to have an impact that would meet the threshold criteria to be considered economically significant.

The Unfunded Mandate Reform Act of 1995, in section 202, requires that agencies prepare an assessment of anticipated costs and benefits before proposing any rule that may result in an annual expenditure by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million adjusted for inflation. The rule has no consequential adverse impact on State, local, or tribal governments. This rule may reduce some State burdens since they will no longer certify providers that are not qualified to participate in the Medicare program. The impact on the private sector is well below the threshold.

Consistent with the Regulatory Flexibility Act, we prepare a Regulatory Flexibility Analysis (RFA) unless we certify that a rule would not have a

significant economic impact on a substantial number of small entities. The RFA is to include a justification of why action is being taken, the kinds and number of small entities that the proposed rule will affect, and an explanation of any considered meaningful options that achieve the objectives and would lessen any significant adverse economic impact on the small entities. For purposes of the RFA, entities with annual revenues of $5 million to $25 million depending on the type of health care provider and non-profit organizations are considered to be small entities. Because of the scope of this rule, all small entities that participate in the Medicare program are considered providers and suppliers and will be affected, but we do not expect that effect to be of a significant nature. As we show in section B of this impact analysis, the annual burden on providers and suppliers for completing the CMS 855 forms would not rise to the level of a significant burden.

The following analysis, together with the rest of this preamble, explains the rationale, purpose, and alternatives considered in the proposed rule. This is an administrative initiative that may result in Medicare program savings but at this time those savings are inestimable. We believe the probable costs providers or suppliers would incur as a result of this rule to be negligible.

A. Rationale, Purpose, and Alternatives Considered

As noted elsewhere in this preamble, we are responsible for protecting the Medicare trust fund by ensuring that unqualified, fraudulent, or excluded providers and suppliers do not bill the Medicare program. Past experience with a number of program integrity efforts have identified that granting billing privileges to entities that do not exercise sound business practices can result in uncollectable overpayments. The ease of obtaining a billing number in the past has paved the way for unscrupulous businesses to defraud the government deliberately by billing for services never furnished or furnished at inflated prices.

The provisions of this proposed rule supplement, but do not replace or nullify, existing regulations concerning the establishment of provider or supplier agreements, the issuance of provider or supplier billing numbers, and payment for Medicare covered services or supplies to eligible providers and suppliers. Basically, this rule consolidates current regulations found throughout the Code of Federal Regulations and more clearly defines what Medicare expects from providers and suppliers rendering services to the Medicare beneficiaries. Moreover, we have revised the ''Provider Supplier Enrollment Application (CMS 855)'' which will greatly decrease the current burden to the provider or supplier when applying for billing privileges. We expect this rule to ensure that the Medicare program has adequate information on those who seek to bill the program for services. Furthermore, it assures us that information will be periodically updated and reviewed. We believe that establishing the foundation for a sound business relationship with providers and suppliers will minimize billing problems and otherwise protect the Medicare trust fund. Similarly, we believe it is necessary for us to impose the requirements of this regulation on existing providers and suppliers and to establish safeguards that enable us to deny enrollment of unqualified providers and suppliers, and to revoke the billing privileges of egregious offenders whose actions place the Medicare trust fund at risk.

The primary goal of this rule, through standard enrollment requirements and periodic revalidation of the enrollment information, is to allow us to collect and maintain (keep current) a unique and equal data set on all current and future providers and suppliers that are or will bill the Medicare program for services rendered to our beneficiaries. By achieving this goal, we will be better positioned to combat and reduce the number of fraudulent and abusive providers and suppliers in the Medicare program, thereby protecting the trust fund and the Medicare beneficiaries. This rule will also allow us to develop, implement, and enforce national provider and supplier enrollment procedures to be administered uniformly by all Medicare contractors. Over time, we strongly believe that any current burden imposed on the providers and suppliers will be greatly diminished through the use of computer storage and web based internet technology.

Studies performed by our contractors, the GAO and OIG have shown numerous instances of fictitious applicants being granted Medicare billing numbers. This proposed rule would integrate the request for enrollment with sufficient data to substantiate an appropriate level of performance on the part of a new or continuing business. In prior studies, the OIG has found applicants who had submitted applications with nonexistent addresses. In some instances suppliers had no inventory of goods to be sold, lacked business licenses, had no financial investment, or lacked any experience in the business venture.

The GAO report concluded: ''Weaknesses in CMS' current provider enrollment process have made Medicare vulnerable to dishonest providers. To protect the integrity of Medicare, CMS and its contractors must have effective practices for reviewing applicants to verify that they are eligible for enrollment in the program, as well as the authority to deny or revoke enrollment to those that are not.'' This report also concluded that, '': Periodic revalidation of provider enrollment data should be a valuable means of ensuring that CMS has current, useful data on active providers and that providers no longer eligible to participate in Medicare are dropped from the program.'' Therefore, based on the above recommendation and our own successes with our 3-year re-enrollment policy currently in effect for DME suppliers, we are seeking to expand this requirement to all providers and suppliers billing the Medicare program.

We have already stepped up our efforts to seek more uniformity in the enrollment process. However, our experience clearly shows that the best means for preventing payment errors and, in worst cases, abuse by providers and suppliers, is to discourage and prevent their entry into the Medicare program through this rule and the authority to deny enrollment or revoke their billing number.

We realize that some entities will perceive our proposed requirements as a barrier to their access to serving Medicare beneficiaries. We do not believe that bona fide businesses will experience any difficulty in obtaining or maintaining a Medicare billing number. We also do not believe that the impact of these proposed requirements would fall any more heavily on underserved areas than on major metropolitan areas. We estimate that furnishing the requested information would require no more than 8 hours of a provider or supplier's time. Most businesses should have the information readily available.

B. Rural Hospital Impact Statement

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. As noted above, there is a minimum amount of time needed to gather data and provide the information requested on the CMS 855

when initially enrolling or when resubmitting enrollment information to obtain and maintain a Medicare billing number. We are not preparing a rural impact statement since we have determined, and certify, that we do not expect this rule to impose any additional burden or otherwise significantly impact the operations of a substantial number of small rural hospitals. By default, due to their smaller size, the burden to small rural hospitals would actually be less than the average provider.

There are currently about 1.2 million providers (hospitals, home health agencies, rural health clinics, skilled nursing facilities, etc.) and suppliers (physicians, nurses, ambulance companies, clinical laboratories, durable medical equipment suppliers, etc.) enrolled in the Medicare program. In addition, about 74,000 new providers and suppliers apply to enroll in Medicare each year. Listed below is the current estimated annual burden on the affected public in both hours and dollars.

1. Estimated Costs for Completion of CMS 855 Forms for Initial Enrollment

Assumptions:

a. The monetary cost to the respondents is calculated as follows based on the following assumptions:

- The CMS 855I and CMS 855R will be completed by clerical staff (secretary), and
- The CMS 855A, CMS 855B, and CMS 855S will be completed by professional staff (attorney or accountant).

b. Estimated Cost per Form

The monetary cost to the respondent to complete and submit the necessary CMS 855 form is:

- $600 for the CMS 855A, CMS 855B, and CMS 855S
- $60 for the CMS 855I, and
- $3 for the CMS 855R

c. Estimated Hourly Wage for Staff Completing Forms. The cost per respondent per form has been determined using the following wages:

- $12.00 per hour (clerical wage)
- $75.00 per hour (professional wage)

CURRENT ESTIMATED HOURS FOR COMPLETION OF CMS 855 FORMS FOR INITIAL NEW ENROLLMENTS

CMS form number	Estimated number of respondents	Estimated time for completion per respondent	Total number of hours for completion	Total costs in dollars (million)
855A	5,000	8 Hours	40,000	$3
855B	10,000	8 Hours	80,000	$6
855I	50,000	5 Hours	250,000	$3
855R	100,000	15 Minutes	25,000	$.3
855S	9,000	8 Hours	72,000	$5.4
Total Estimated Hourly and Financial Burden			467,000	$17.7

The estimated number of respondents is based on current Medicare contractor workload reports.

2. Completing Forms to Report Changes to Enrollment Information

The hourly burden and monetary cost estimate for this activity for all forms is:

- 100,000 respondents X 1 hour each = 100,000 hours

Average cost per respondent = $420
Total cost for all respondents = $42 million

3. Completing Forms to Re-Certify Enrollment Information (3 yr cycle)

The hourly burden and monetary cost estimate for this activity for all forms is:

- 330,000 respondents X 2 hours each = 660,000 hours Average cost per respondent = $40

Total cost for all respondents = $13.2 million

Based on the above, the estimated current total annual hour burden for all classes of providers (hospitals, home health agencies, rural health clinics, skilled nursing facilities, etc.) and suppliers (physicians, nurses, ambulance companies, clinical laboratories, durable medical equipment suppliers, etc.) is 1,227,000 hours.

Based on the above, the estimated current annual monetary burden for all classes of providers (hospitals, home health agencies, rural health clinics, skilled nursing facilities, etc.) and suppliers (physicians, nurses, ambulance companies, clinical laboratories durable medical equipment suppliers, etc.) is $32.9 million. The 1997 revenue receipts for all classes of providers and suppliers is $913.7 billion. The cost of obtaining and maintaining billing privileges in the Medicare program on average is less than 1 percent of the total revenue.

Although it is possible that a few entities may be significantly affected by these proposed rules, we do not expect that a substantial number of affected entities will experience a significant increase in the reporting burden; therefore, the Secretary certifies that this rule is not expected to impose any additional burden or otherwise significantly impact a substantial number of small entities. We also invite comments on our impact analysis and regulatory flexibility analysis.

C. Alternatives Considered

Since this proposed rule is a codification of our current policies on provider and supplier enrollment, with the exception of imposing a cyclical revalidation process, we did not seek alternatives to this process. However, the current process was reviewed and, when possible, proposed or made that would reduce the current burden, such as the time frame for reporting changes.

Although we do not expect this rule to have a significant economic impact, we are revising the requirements for reporting changes to the provider or supplier's enrollment information to reduce the current burden. Currently, provides and suppliers must report any changes to their enrollment information within 30-days. We are proposing to change this requirement to 90-days (or quarterly). We considered retaining the current requirement but determined the 30-day timeframe as too stringent in light of the rapid changes seen in today's health care industry. This change is expected to reduce the administrative burden for the providers, suppliers, our contractors, and us.

In accordance with the provisions of Executive Order 12866, this rule was reviewed by OMB.

VIII. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, if we proceed with a subsequent document, we will

respond to the major comments in the preamble to that document.

List of Subjects

42 CFR Part 420

Fraud, Health facilities, Health professions, Medicare.

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 498

Administrative practice and procedure, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in this preamble, 42 CFR chapter IV is proposed to be amended as set forth below:

PART 420—PROGRAM INTEGRITY: MEDICARE

1. The authority citation for part 420 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. In § 420.201, the definition for managing employee is revised to read as follows:

* * * * *

Managing employee means a general manager, business manager, administer, director, or other individual that exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the institution, organization, or agency, either under contract or through some other arrangement, whether or not the individual is a W–2 employee.

* * * * *

PART 424—CONDITIONS FOR MEDICARE PAYMENT

1. The authority citation for part 424 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. In § 424.1, the introductory text to paragraph (a)(1) is republished, and the following statutory reference is added to paragraph (a)(1) in numerical order to read as follows:

§ 424.1 Basis and scope.

(a) *Statutory basis.* (1) This part is based on the indicated provisions of the following sections of the Act:

* * * * *

1833(e)—Requirement to furnish information to determine payment.

* * * * *

3. Subparts N and O are added and reserved.

4. Subpart P is added to read as follows:

Subpart P—Requirements for Establishing and Maintaining Medicare Billing Privileges

Sec.

Subpart P—Requirements for Establishing and Maintaining Medicare Billing Privileges

§ 424.500 Scope.

The provisions of this subpart contain the requirements for enrollment, periodic resubmission and certification of enrollment information for revalidation, and timely reporting of updates and changes to enrollment information. These requirements apply to all providers and suppliers except for physicians and practitioners who have entered into a private contract with a beneficiary as described in part 405, subpart D of this chapter. Providers and suppliers must meet and maintain these enrollment requirements to bill either the Medicare program or its beneficiaries.

Note to § 424.500: Throughout subpart P, references to ''supplier'' or ''suppliers'' do not include those physicians or practitioners who have elected to ''opt-out'' of Medicare as described in part 405, subpart D of this chapter.

§ 424.502 Definitions.

As used in this subpart, unless the context indicates otherwise—

Approve/Approval means the enrolling provider or supplier has been determined to be eligible under Medicare rules and regulations to receive a Medicare billing number and Medicare billing privileges.

Authorized official means an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the laws, regulations, and program instruction of the Medicare program.

Deactivate means that the provider or supplier's billing privileges have been temporarily stopped, but can be restored upon the submission of updated information.

Delegated official means an individual who has been delegated by the ''Authorized official'', the authority to report changes and updates to the enrollment record. The delegated official must be an individual with ownership or control interest in, or be a W–2 managing employee of the provider or supplier.

Deny/Denial means the enrolling provider or supplier has been determined to be ineligible to receive Medicare billing privileges for Medicare covered services provided to Medicare beneficiaries. Providers and suppliers who have been denied Medicare enrollment cannot bill for Medicare covered services.

Enroll/Enrollment means the process that Medicare uses to—

(1) Identify a provider or supplier;

(2) Validate its eligibility to provide services to Medicare beneficiaries;

(3) Identify and confirm the provider or supplier's practice location(s) and owner(s); and

(4) Grant the provider or supplier Medicare billing privileges.

Managing employee means a general manager, business manager, administrator, director, or other individual that exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the provider or supplier, either under contract or through some other arrangement, whether or not the individual is a W–2 employee of the provider or supplier.

Operational means the provider or supplier has a qualified physical practice location, is open to the public for the purpose of providing health care related services, is prepared to submit valid Medicare claims, *and* is properly staffed, equipped, and stocked (as applicable, based on the type of facility or organization, provider or supplier specialty, or the services or supplies being rendered), to furnish these services.

Owner means any individual or entity that has any partnership interest in, or that has 5 percent or more direct or indirect ownership of the provider or supplier as defined in section 1124A(a) of the Act.

Reject/Rejected means that the provider or supplier's enrollment application has not been processed due to incomplete information or that additional information or corrected information was not received from the provider or supplier within 60 days after it was requested.

Revoke/Revocation means that the provider or supplier's billing privileges have been terminated.

§ 424.505 Basic enrollment requirement.

To receive payment for covered Medicare services from either Medicare (in the case of assigned claims) or a Medicare beneficiary (in the case of unassigned claims), a provider or supplier must have a valid Medicare billing number and been granted billing privileges for the date the service or supplies were furnished.

§ 424.510 Requirements for obtaining a billing number and Medicare billing privileges.

Providers and suppliers must submit enrollment information via the applicable form CMS 855 for verification by the Medicare program to obtain a Medicare billing number and be granted billing privileges. Upon the provider or supplier's successful completion of the enrollment process, including State survey and certification, accreditation, and approval of the CMS 855, The Centers for Medicare & Medicaid Services (CMS) issues a billing number and grants billing privileges that enable the provider or supplier to bill the Medicare program or the Medicare beneficiaries for Medicare covered services. Currently, the effective dates for reimbursement can be found at § 489.13 of this chapter for providers and suppliers requiring State survey or certification or accreditation, § 424.5 and § 424.44 for non-surveyed or certified/accredited suppliers, and § 424.57 and section 1834(j)(1)(A) of the Act for DMEPOS suppliers. For those providers and suppliers seeking accreditation from a CMS approved accreditation organization, the effective date for reimbursement will be the later of the date accreditation was received or the final approval of the CMS 855. CMS will not issue Medicare billing numbers or grant Medicare billing privileges retroactive to the date that the provider or supplier received final approval of their enrollment application (CMS 855). To obtain a billing number and be granted billing privileges, the following enrollment requirements must be met:

(a) *Form CMS 855.* A provider or supplier must submit to CMS the applicable completed CMS 855—Medicare Health Care Provider/Supplier Enrollment Application. The completed form will provide information for the purpose of establishing eligibility to receive payment for covered services furnished to Medicare beneficiaries. The information obtained uniquely identifies the provider and supplier for the purpose of enumeration, and provides information to CMS necessary for CMS to verify that the provider or supplier is not, and should not be, excluded from participation in the Medicare program, and that it renders services covered by the Medicare program.

(1) *Content.* The submitted CMS 855 must include the following:

(i) Complete, accurate, and truthful responses to all information requested within each section as applicable to the provider or supplier type.

(ii) Any documentation required by CMS under this or other statutory or regulatory authority to uniquely identify the provider or supplier. This documentation may include, but is not limited to, proof of the legal business name, practice location, social security number (SSN), tax identification number (TIN), and owners of the business.

(iii) Any documentation required by CMS under this or other statutory or regulatory authority to establish the provider or supplier's eligibility to furnish services to beneficiaries in the Medicare program, including copies of pertinent licenses.

(2) *Signature(s).* The certification statement found on the CMS 855 must be signed by an individual who has the authority to bind the provider or supplier, both legally and financially, to the requirements set forth in this chapter. This person must also have an ownership or control interest in the provider or supplier, as that term is defined in section 1124(a)(3) of the Act, such as, be the general partner, chairman of the board, chief financial officer, chief executive officer, president, or hold a position of similar status and authority within the provider or supplier organization. The signature attests that the information submitted is accurate and that the provider or supplier is aware of, and will abide by, all applicable Medicare laws, regulations, and program instructions.

(i) *Requirements.* The signature requirements set forth below outline who must sign the CMS 855 for an enrolling provider or supplier:

(A) In the case of an individual practitioner, the applying practitioner.

(B) In the case of a sole proprietorship, the applying sole proprietor.

(C) In the case of a corporation, partnership, group, limited liability company, or other organization (hereafter referred to collectively in this section as an organization), an authorized official, as defined in § 424.502. When an authorized official signs the certification statement on behalf of an organization, the signed statement is considered legally binding upon the organization.

(ii) *Delegation of Authority.* The original CMS 855 submitted for an organization's initial enrollment and all subsequent CMS 855s submitted for periodic revalidation of the organization's enrollment data (as required to maintain enrollment in the Medicare program) must be signed by an authorized official. Any updates or changes reported outside of the initial enrollment or periodic revalidation process may be signed by a delegated official(s) of the organization. The delegated official's signature binds the organization both legally and financially, as if the signature was that of the authorized official. Before the delegation of authority is established, the only acceptable signature on the CMS 855 to report updates or changes to the enrollment information will be that of the authorized official currently on file with Medicare. Once the delegation of authority is established, the only acceptable signatures on correspondence to report updates or changes to the enrollment information will be those of the authorized official and the person(s) to whom this authority has been delegated in accordance with the procedures detailed herein. Individual practitioners and sole proprietors can not delegate signature authority when submitting a CMS 855 for any reason. All CMS 855s submitted by individual practitioners and sole proprietors must be signed by the enrolling/enrolled individual. Each delegation of authority to a delegated official must—

(A) Be assigned by the authorized official currently on file with CMS;

(B) Be submitted to CMS via the CMS 855;

(C) Include the title of each person delegated authority to update or change the organization's enrollment information;

(D) Include the SSN of the delegated individual where that individual has an ownership or control interest in the organization or is a W–2 managing employee as defined in section 1126(b) of the Act; and

(E) Be signed by the authorized official and the delegated official(s) of the organization.

(*1*) *Verification of information.* The information submitted by the provider or supplier on the applicable CMS 855 must be such that CMS can validate it for accuracy as of the time of submission.

(*2*) *Completion of any applicable State surveys, certifications, and provider agreements.* The providers or suppliers who are mandated under the provision in Part 488 of this chapter to be surveyed or certified by the State Survey and Certification Agency, and to also enter into and sign a provider agreement as outlined in part 489 of this chapter, must also meet those requirements as part of the process to obtain Medicare billing privileges.

(*3*) *Ability to furnish Medicare covered services or supplies.* The provider or supplier must be operational to furnish Medicare covered services and/or supplies before being granted Medicare billing privileges.

(*4*) *Additional requirements.* Providers and suppliers must meet the provisions of § 424.520 regarding additional compliance and reporting requirements.

(*5*) *On-site inspections.* CMS reserves the right, when we deem necessary, to perform on-site inspections of a provider or supplier to verify that the enrollment information submitted to CMS or its agents is accurate and to determine compliance with Medicare enrollment requirements. Site visits for enrollment purposes will not affect those site visits performed for establishing conditions of participation.

(b) [Reserved]

§ 424.515 Requirements for reporting changes and updates to, and the periodic revalidation of, Medicare enrollment information.

To maintain Medicare billing privileges a provider or supplier must resubmit and re-certify as to the accuracy via an authorized signature, its enrollment information for validation no more than once every 3 years. Initially, all providers and suppliers currently in or initially enrolling in the Medicare program will be required to complete the applicable CMS 855 at least once. The provider or supplier will enter the three-year revalidation cycle once a completed CMS 855 has been submitted and validated. (Ambulance service providers will continue to resubmit enrollment information in accordance with § 410.41(c)(2) and DME suppliers will continue to renew enrollment in accordance with § 424.57(e) of this chapter). The requirements for the resubmission, recertification and reverification of enrollment information include the following:

(a) *Submission of form CMS 855 and supporting documentation.* The provider or supplier must meet the submission, content, signature, verification, operational, inspection, and other requirements outlined in § 424.510.

(b) *Processing time.* A provider or supplier must submit to us the applicable CMS 855 with complete and accurate information and applicable supporting documentation within 60 calendar days of our notification to resubmit and certify to the accuracy of its enrollment information.

(c) *Completion of any applicable State surveys, certifications and provider agreements.* A new survey and certification and a new provider agreement are not required for the purpose of resubmission and certification for revalidation of enrollment information. Providers and suppliers must continue to meet the requirements of parts 488 and 489 of this subchapter, if applicable.

(d) *On-site inspections.* CMS reserves the right to perform on-site inspections of a provider or supplier to verify that the information submitted to CMS or its agents is accurate and to determine compliance with Medicare enrollment requirements. Site visits for enrollment purposes will not affect those site visits performed for establishing conditions of participation.

(e) *Adjustments to 3-year re-validation cycle and non-routine re-validations.* (1) Revalidation of enrollment information will occur no more than once every 3 years. CMS reserves the right to adjust this schedule if it is determined that revalidation should occur on a more frequent basis due to complaints or evidence received indicating non-compliance with the Medicare statute or regulations by specific provider or supplier types. The schedule may also be on a less frequent basis if it is determined that the integrity of and compliance with the Medicare statute and regulations by specific provider or supplier types indicate that less frequent validation is justified. CMS will continue to revalidate enrollment information for Ambulance Service Suppliers in accordance with regulations set forth at § 410.41(c)(2) of this chapter (Requirements for ambulance suppliers), and DME suppliers will continue to renew enrollment in accordance with regulations set forth at § 424.57(e) (Special payment rules for items furnished by DMEPOS suppliers and issuance of DMEPOS supplier billing numbers).

(2) CMS also reserves the right to perform non-routine revalidation and request the provider or supplier to re-certify as to the accuracy of the enrollment information when warranted to assess and confirm the validity of the enrollment information. Non-routine revalidation may be triggered as a result of random checks, information indicating local problems, national initiatives, complaints, or other reasons that cause CMS to question the integrity of the provider or supplier in its relationship with the Medicare program. Like routine revalidation, non-routine revalidation may or may not be accompanied by site visits.

§ 424.520 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare program.

(a) *Certifying compliance.* CMS enrolls and maintains an active enrollment status for a provider or supplier when that provider or supplier certifies that it meets, and continues to meet, and CMS verifies that it meets, and continues to meet, all of the following requirements:

(1) Compliance with Title XVIII of the Social Security Act and applicable Medicare regulations.

(2) Compliance with Federal and State licensure, certification and regulatory requirements, as required, based on the type of services or supplies the provider or supplier type will furnish and bill Medicare.

(3) Not employing or contracting with individuals or entities—

(i) Excluded from participation in any Federal health care programs, for the provision of items and services covered under the programs, in violation of section 1128A(a)(6) of the Act; or

(ii) Debarred by the General Services Administration (GSA) from any other Executive Branch procurement or non-procurement programs or activities, in accordance with the Federal Acquisition and Streamlining Act of 1994, and with

the HHS Common Rule at 45 CFR part 76.

(b) *Reporting requirements.* Following enrollment, a provider or supplier must report to CMS any changes to the information furnished on the CMS 855 or supporting documentation within 90 calendar days of the change, with the exception of changes in ownership or control of the provider or supplier which must be reported within 30 calendar days. Failure to do so may result in the deactivation or revocation of the provider or supplier's Medicare billing number.

§ 424.525 Rejection of a provider or supplier's CMS 855 for Medicare Enrollment

(a) *Reasons for rejection.* CMS rejects a provider or supplier's CMS 855 for the following reasons:

(1) The provider or supplier fails to furnish complete information within 60 calendar days of CMS's request for the information as required.

(2) The provider or supplier fails to furnish supporting documentation within 60 calendar days of CMS's request for the documentation as required.

(b) *Extension of 60-day period.* CMS will not reject any provider or supplier enrollment application if the provider or supplier is actively communicating with CMS to resolve any issues regardless of the length of time it takes to resolve those issues.

(c) *Resubmission after rejection.* To enroll in Medicare and obtain a Medicare billing number and billing privileges after notification of a rejected CMS 855, the provider or supplier must complete and submit a new CMS 855 and all applicable documentation for CMS review and approval.

§ 424.530 Denial of enrollment.

(a) *Reasons for denial.* CMS may deny a provider or supplier's enrollment in the Medicare program for the following reasons:

(1) *Compliance.* The provider or supplier at any time is found not to be in compliance with the Medicare enrollment requirements described in the CMS 855 enrollment form applicable to the type of provider or supplier enrolling, and has not submitted a plan of corrective action as outlined in part 488 of this chapter and under section 1819(h)(2)(c) of the Act.

(2) *Provider or supplier conduct.* The provider or supplier, or any owner, managing employee, or an authorized or delegated official; or any medical director, supervising physician, or other health care personnel furnishing Medicare reimbursable services who is required to be reported on the CMS 855, in accordance with section 1862(e)(1) of the Act,—

(i) Is excluded from the Medicare, Medicaid and any other Federal health care programs, as defined in § 1001.2 of this title, in accordance with section 1128 or 1156 of the Act; or

(ii) Is debarred, suspended, or otherwise excluded from participating in any other Federal procurement or non-procurement activity in accordance with FASA section 2455; or

(3) *Felonies.* The provider, supplier, or any owner of the provider or supplier, has been convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. The conviction must have occurred within the last 10 years or more and CMS will consider the severity of the underlying offense.

(i) Offenses include—

(A) Felony crimes against persons (such as rape, murder, or assault) and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions.

(B) Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions.

(C) Any felony that placed the Medicare program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct).

(D) Any felonies outlined in section 1128 of the Act.

(ii) Denials based on felony convictions are for a period to be determined by the Secretary, but not less than 10 years from the date of conviction if the individual has been convicted on one previous occasion for one or more offenses.

(4) *False or misleading information.* The provider or supplier has submitted false or misleading information on the CMS 855 to gain enrollment in the Medicare program. (Offenders may be referred to the Office of Inspector General for investigation and possible criminal, civil, or administrative sanctions).

(5) *Onsite review.* Upon onsite review or other reliable evidence—

(i) There are repeated instances in which we do not find present or available those medical professionals required under the Medicare statute and regulations to supervise treatment of, or provide Medicare covered services for, Medicare patients; or

(ii) We determine that the provider or supplier is not operational to furnish Medicare covered services.

(b) *Resubmission after denial.* A provider or supplier that is denied enrollment in the Medicare program must not submit a new CMS 855 until the following has occurred:

(1) If the denial was not appealed, the provider or supplier may reapply after its appeal rights have lapsed.

(2) If the denial was appealed, the provider or supplier may reapply after CMS notification that the original determination has been upheld.

(c) *Reversal of denial.* If the denial was due to adverse activity (sanction, exclusion, debt, felony) of an owner, managing employee, or an authorized or delegated official; or of a medical director, supervising physician, or other health care personnel of the provider or supplier furnishing Medicare reimbursable services, the denial may be reversed if the provider or supplier terminates and submits proof that it has terminated its business relationship with that individual or organization within 30 days of the denial notification.

(d) *Additional review.* When a provider or supplier is denied enrollment in Medicare, CMS automatically reviews all other related Medicare enrollment files that the denied provider or supplier has an association with (for example, as an owner or managing employee) to determine if the denial warrants an adverse action of the associated Medicare provider or supplier.

§ 424.535 Revocation of enrollment and billing privileges in the Medicare program.

(a) *Reasons for revocation.* We may revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement for the following reasons:

(1) Non-compliance. The provider or supplier, at any time is determined not to be in compliance with the enrollment requirements described in the CMS 855 enrollment form applicable to its provider or supplier type and has not submitted a plan of corrective action as outlined in part 488 of this chapter and under section 1819(h)(2)(C) of the Act. All providers and suppliers will be granted an opportunity to correct the deficient compliance requirement prior to a final determination to revoke billing privileges.

(i) CMS may request additional documentation from the provider or supplier to determine compliance if adverse information is received or otherwise found concerning the provider or supplier.

(ii) Requested additional documentation must be submitted within 60 calendar days of request.

(2) *Provider or supplier conduct.* The provider or supplier, or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier is—

(i) Excluded from the Medicare, Medicaid, and any other Federal health care program, as defined in § 1001.2 of this title, in accordance with section 1128 or 1156 of the Act; or

(ii) Is debarred, suspended, or otherwise excluded from participating in any other Federal procurement or nonprocurement program or activity in accordance with the Federal Acquisition Streamlining Act implementing regulations and the Department of Health and Human Services nonprocurement common rule at 45 CFR part 76.

(3) *Felonies.* The provider, supplier, or any owner of the provider or supplier, has been convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. The conviction must have occurred within the last 10 years or more and CMS will consider the severity of the underlying offense.

(i) Offenses include—

(A) Felony crimes against persons (such as rape, murder, or assault) and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions.

(B) Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions.

(C) Any felony that placed the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.

(D) Any felonies outlined in section 1128 of the Act.

(ii) Denials based on felony convictions are for a period to be determined by the Secretary, but not less than 10 years from the date of conviction if the individual has been convicted on one previous occasion for one or more offenses.

(4) *False or misleading information.* The provider or supplier certified as ''true'' false or misleading information on the CMS 855 to be enrolled or maintain enrollment in the Medicare program. (Offenders may be subject to either fines or imprisonment, or both, in accordance with current law and regulations.)

(5) *Onsite review.* CMS determines, upon onsite review, that the provider or supplier is no longer operational to furnish Medicare covered services or supplies, or we do not find present or available those professionals required under Medicare statute or regulation to supervise treatment of, or to provide Medicare covered services for, Medicare patients.

(6) *Inadequate re-verification information.* The provider or supplier fails to furnish complete and accurate information and any applicable documentation within 60 calendar days of the provider or supplier's notification from CMS to resubmit and certify to the accuracy of its enrollment information.

(7) *Misuse of billing number.* The provider or supplier knowingly sells to or allows another individual or entity to use its billing number. This does not include those providers or suppliers who enter into a valid reassignment of benefits as outlined in § 424.80.

(b) *Effect of revocation on provider agreements.* When a provider's or supplier's billing privilege has been revoked, any provider agreement in effect at the time of revocation will be terminated effective with the date of revocation.

(c) *Re-enrollment after revocation.* If a provider or supplier seeks to re-establish enrollment in the Medicare program after notification that its billing number and billing privileges have been revoked (either after the appeals process is exhausted or in place of the appeals process) the following conditions apply:

(1) The provider or supplier must re-enroll in the Medicare program through the completion and submission of a new applicable CMS 855 and applicable documentation, as a new provider or supplier, for validation by CMS.

(2) Providers must be re-surveyed and/or re-certified by the State Survey Agency as a new provider and must establish a new provider agreement with CMS's Regional Office.

(d) *Reversal of revocation.* If the revocation was due to adverse activity (sanction, exclusion, debt, or felony) against an owner, managing employee, or an authorized or delegated official; or a medical director, supervising physician, or other personnel of the provider or supplier furnishing Medicare reimbursable services, the revocation may be reversed if the provider or supplier terminates and submits proof that it has terminated its business relationship with that individual within 30 days of the revocation notification.

(e) *Additional review.* When a provider or supplier is revoked from the Medicare program, CMS automatically reviews all other related Medicare enrollment files that the revoked provider or supplier has an association with (for example, as an owner or managing employee) to determine if the revocation warrants an adverse action of the associated Medicare provider or supplier.

§ 424.540 Deactivation of Medicare billing privileges.

(a) *Reasons for deactivation.* CMS deactivates a provider or supplier's Medicare billing privileges for the following reasons:

(1) The provider or supplier does not submit any Medicare claims for two consecutive calendar quarters (6 months), unless current policy or regulations specify otherwise for your provider or supplier type.

(2) The provider or supplier does not report a change to the information supplied on its CMS 855 within 90 calendar days of when the change occurred. Changes that must be reported include, but are not limited to, a change in practice location, a change of any managing employee, and a change in billing services. A change in ownership or control must be reported within 30 calendar days as stated in §§ 424.520(b) and 424.550(b).

(b) *Reactivation of billing privileges.* The provider or supplier must either complete and submit a new CMS 855 to reactivate its Medicare billing number and billing privileges or, at a minimum, re-certify that the enrollment information currently on file with Medicare is correct. The provider or supplier must meet all current Medicare requirements in place at the time of reactivation, and be prepared to submit a valid Medicare claim. Reactivation of a Medicare billing number does not require a new survey and certification of the provider or supplier by the State Survey Agency or the establishment of a new provider agreement.

(c) *Effect of deactivation.* Deactivation of Medicare billing privileges is considered a temporary action to protect the provider or supplier from misuse of Medicare billing numbers and to protect the Medicare trust fund from unnecessary overpayments. The temporary deactivation of a Medicare billing number will not have any effect on a provider or supplier's participation agreement or any conditions of participation.

§ 424.545 Provider and supplier appeal rights.

(a) A provider or supplier that has been denied enrollment in the Medicare program or whose Medicare enrollment has been revoked may appeal CMS's decision in accordance with part 405, subpart H, for suppliers, or part 498, subpart A for providers, of this chapter, which set forth the appeals process for providers and suppliers. When revocation of billing privileges also results in the termination of a corresponding provider agreement, the provider may appeal CMS's decision in accordance with part 489 with the final decision of the appeal applying to both the billing privileges and the provider agreement. No payment will be made during the appeals process. If the provider or supplier is successful in overturning a denial or revocation unpaid claims for services furnished during the overturned period may be resubmitted.

(b) A provider or supplier whose billing privileges have been deactivated may file a rebuttal in accordance with § 405.374 of this chapter.

§ 424.550 Prohibitions on the sale or transfer of billing privileges.

(a) *General rule.* A provider or supplier is prohibited from selling its Medicare billing number or privileges to any individual or entity, or allowing another individual or entity to use its Medicare billing number.

(b) *Change of ownership.* In the case of a provider undergoing a change of ownership in accordance with part 489, subpart A of this chapter, the current owner and the prospective new owner must complete and submit a CMS 855 before completion of the change of ownership. If the current owner fails to complete and submit a CMS 855 to report the change, they may be sanctioned or penalized, even after the date of ownership change, in accordance with §§ 424.520, 424.540, and 489.53 of this chapter. If the prospective new owner fails to submit a new CMS 855 containing information concerning the new owner within 30 days of the change of ownership, CMS may deactivate the Medicare billing number. If an incomplete CMS 855 is submitted, CMS may also deactivate the Medicare billing number based upon material omissions on the submitted CMS 855, or based on preliminary information received or determined by CMS that makes CMS question whether the new owner will be ultimately granted a final transference of the provider agreement.

(c) *Providers and suppliers not covered by part 489 of this chapter.* For those providers and suppliers not covered by part 489, any change in the ownership or control of the provider or supplier must be reported on their CMS 855 within 30 days of the change as noted in § 424.540(a)(2). Generally, a change of ownership which also changes the tax identification number will require the completion and submission of a new CMS 855 from the new owner.

§ 424.555 Payment liability.

(a) No payment may be made for services furnished to a Medicare beneficiary by suppliers of durable medical equipment, prosthetics, orthotics, and other supplies unless the supplier obtains (and renews, as set forth in section 1834(j) of the Act) Medicare billing privileges.

(b) No payment may be made for covered services furnished to a Medicare beneficiary by a provider or supplier if the billing privileges of the provider or supplier have been deactivated, denied, or revoked. The Medicare beneficiary has no financial responsibility for such expenses, and the provider or supplier must refund on a timely basis to the Medicare beneficiary any amounts collected from the Medicare beneficiary for these covered services.

(c) If any provider or supplier furnishes a service for which payment may not be made by reason of paragraph (b) of this section, any expense incurred for such service shall be the responsibility of the provider or supplier. The provider or supplier may also be criminally liable for pursuing payments that may not be made by reason of paragraph (b) of this section, in accordance with section 1128A(a)(6) of the Act.

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

7. The authority citation for part 489 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

8. In § 489.53, paragraph (a)(15) is added to read as follows:

§ 489.53 Termination by CMS.

(a) * * *

(15) It had its enrollment in the Medicare program revoked pursuant to § 424.535 of this chapter.

* * * * *

PART 498—APPEALS PROCEDURES FOR DETERMINATIONS THAT AFFECT PARTICIPATION IN THE MEDICARE PROGRAM AND FOR DETERMINATIONS THAT AFFECT THE PARTICIPATION OF ICFS/MR AND CERTAIN NFS IN THE MEDICARE PROGRAM

9. The authority citation for part 498 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

10. In § 498.3, paragraph (b)(16) is added to read as follows:

§ 498.3 Scope and applicability.

* * * * *

(b) * * *

(16) Whether a provider or supplier has had its Medicare enrollment revoked pursuant to § 424.535 of this chapter.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.774, Medicare—Supplementary Medical Insurance Program.)

Dated: October 19, 2001.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: January 10, 2003.

Tommy G. Thompson,

Secretary.

BILLING CODE 4120–01–P

MEDICARE

FEDERAL HEALTH CARE
PROVIDER/SUPPLIER ENROLLMENT APPLICATION

Application for Health Care Providers that will Bill Medicare Fiscal Intermediaries

CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS 855A (01/2003)

OMB Approval No. 0938-0685

Keep a copy of this completed package for your own records

Upon completion, return this application and all necessary documentation to:

OMB Approval No. 0938-0685

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare Provider/Supplier Enrollment Application

Privacy Act Statement

The Centers for Medicare and Medicaid Services (CMS) is authorized to collect the information requested on this form by sections 1124(a)(1), 1124A(a)(3), 1128, 1814, 1815, 1833(e), and 1842(r) of the Social Security Act [42 U.S.C. §§ 1320a-3(a)(1), 1320a-7, 1395f, 1395g, 1395(l)(e), and 1395u(r)] and section 31001(1) of the Debt Collection Improvement Act [31 U.S.C. § 7701(c)].

The purpose of collecting this information is to determine or verify the eligibility of individuals and organizations to enroll in the Medicare program as providers/suppliers of goods and services to Medicare beneficiaries and to assist in the administration of the Medicare program. This information will also be used to ensure that no payments will be made to providers or suppliers who are excluded from participation in the Medicare program. All information on this form is required, with the exception of those sections marked as "optional" on the form. Without this information, the ability to make payments will be delayed or denied.

The information collected will be entered into the Provider Enrollment, Chain and Ownership System (PECOS), and either system number 09-70-0525 titled Unique Physician/Practitioner Identification Number (UPIN) System (published in Vol. 61 of the Federal Register at page 20,528 (May 7, 1996)), or the National Provider Identifier (NPI) System, Office of Management and Budget (OMB) approval 0938-0684 (R-187). The information in this application will be disclosed according to the routine uses described below.

Information from these systems may be disclosed under specific circumstances to:

1) CMS contractors to carry out Medicare functions, collating or analyzing data, or to detect fraud or abuse;
2) A congressional office from the record of an individual health care provider/supplier in response to an inquiry from the congressional office at the written request of that individual health care practitioner;
3) The Railroad Retirement Board to administer provisions of the Railroad Retirement or Social Security Acts;
4) Peer Review Organizations in connection with the review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XVIII of the Social Security Act;
5) To the Department of Justice or an adjudicative body when the agency, an agency employee, or the United States Government is a party to litigation and the use of the information is compatible with the purpose for which the agency collected the information;
6) To the Department of Justice for investigating and prosecuting violations of the Social Security Act, to which criminal penalties are attached;
7) To the American Medical Association (AMA), for the purpose of attempting to identify medical doctors when the Unique Physician Identification Number Registry is unable to establish identity after matching contractor submitted data to the data extract provided by the AMA;
8) An individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, or to the restoration or maintenance of health;
9) Other Federal agencies that administer a Federal health care benefit program to enumerate/enroll providers/suppliers of medical services/supplies or to detect fraud or abuse;
10) State Licensing Boards for review of unethical practices or non-professional conduct;
11) States for the purpose of administration of health care programs; and/or
12) Insurance companies, self insurers, health maintenance organizations, multiple employer trusts, and other health care groups providing health care claims processing, when a link to Medicare or Medicaid claims is established, and data are used solely to process provider's/supplier's health care claims.

The enrolling provider or supplier should be aware that the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503) amended the Privacy Act, 5 U.S.C. § 552a, to permit the government to verify information through computer matching.

Protection of Proprietary Information

Privileged or confidential commercial or financial information collected in this form is protected from public disclosure by Federal law 5 U.S.C. § 552(b)(4) and Executive Order 12600.

Protection of Confidential Commercial and/or Sensitive Personal Information

If any information within this application (or attachments thereto) constitutes a trade secret or privileged or confidential information (as such terms are interpreted under the Freedom of Information Act and applicable case law), or is of a highly sensitive personal nature such that disclosure would constitute a clearly unwarranted invasion of the personal privacy of one or more persons, then such information will be protected from release by CMS under 5 U.S.C. §§ 552(b)(4) and/or (b)(6), respectively.

OMB Approval No. 0938-0685

INSTRUCTIONS FOR HEALTH CARE PROVIDERS THAT WILL BILL MEDICARE FISCAL INTERMEDIARIES

Please **PRINT** or **TYPE** all information so it is legible. Do not use pencil. Failure to provide all requested information might cause the application to be returned and may delay the enrollment process. See inside front cover for mailing instructions. Electronic copies of all CMS Medicare enrollment forms can be found at the Medicare website at http://www.cms.hhs.gov. These electronic forms may be downloaded to your computer, completed on screen, printed, signed, and mailed to the appropriate Medicare contractor.

Whenever additional information needs to be reported within a section, copy and complete that section for each additional entry. We strongly suggest maintaining a photocopy of the provider's completed application and supporting documents for future reference.

This application is to be completed by all health care provider organizations that provide medical services to Medicare beneficiaries and who bill fiscal intermediaries. For purposes of this application and Medicare enrollment, all such organizations will be referred to as "providers." A list of the provider types that should complete this application can be found in Section 2A. Failure to promptly submit a completed form CMS 855A to the fiscal intermediary will result in delays in obtaining enrollment and billing privileges.

To have Medicare payments sent electronically to a provider's bank account, the provider should complete the form "Medicare Authorization Agreement for Electronic Funds Transfers" (Form HCFA-588). This form should have been received in the initial enrollment package. If not, it can be obtained from the Medicare fiscal intermediary.

APPLICATION SUBMISSION AND PROCESSING

This application should be submitted directly to your intermediary of preference. See the CMS website http://www.cms.hhs.gov for a listing of fiscal intermediaries. Providers that are part of a chain, or that share fiscal data with other enrolled providers, may choose the same fiscal intermediary, even if they are not located in the area normally serviced by that fiscal intermediary. Home Health Agencies (HHA) and Hospices should submit this application to their regional home health intermediary (RHHI). However, if the HHA is provider based, it should submit this application to its parent provider's fiscal intermediary. The provider's fiscal intermediary of preference does not automatically guarantee that it will be assigned to that fiscal intermediary. Providers, who are currently enrolled in the Medicare program and are requesting to change their fiscal intermediary, must submit their request to the Medicare Regional Office prior to submission of this application. However, this is not applicable when the fiscal intermediary changes as the result of a CHOW, acquisition/merger, or a consolidation and the fiscal intermediary of preference is the fiscal intermediary currently being used by the provider who is acquiring the changing provider. The fiscal intermediary will answer any questions you have concerning completion of the CMS 855A.

The provider must immediately contact the local State Agency that handles the provider type being enrolled. The State Agency will provide you with any State-specific forms required for your provider type. They will also do preliminary planning for any required State Surveys or notice of accreditation in lieu of a survey (when this is permitted).

If the provider does not currently have a Medicare identification number, the CMS regional office will assign one upon the successful completion of enrollment. Issuance of a Medicare identification number usually requires a written agreement (usually a provider agreement) with CMS. If the fiscal intermediary should contact the provider for additional information, the provider must furnish the information immediately to ensure the timely processing of this application.

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DEFINITIONS OF MEDICARE ENROLLMENT TERMINOLOGY

To help you understand certain terms used throughout the application, we have included the following definitions.

Authorized Official-An appointed official to whom the provider has granted the legal authority to enroll it in the Medicare program, to make changes and/or updates to the provider's status in the Medicare program (e.g., new practice locations, change of address, etc.) and to commit the provider to fully abide by the laws, regulations, and program instructions of Medicare. The authorized official must be the provider's general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of 5% or more of the provider (see Section 5 for the definition of a "direct owner"), or must hold a position of similar status and authority within the provider's organization.
Billing Agency-A company that the enrolling provider contracts with to furnish claims processing functions for the provider.
Carrier-The Part B Medicare claims processing contractor.
Delegated Official-Any individual who has been delegated, by the provider's "Authorized Official," the authority to report changes and updates to the provider's enrollment record. A delegated official **must** be a managing employee (W-2) of the provider or have a 5% ownership interest, or any partnership interest, in the provider.
Fiscal Intermediary-The Part A Medicare claims processing contractor.
Legal Business Name-The organization name reported to the Internal Revenue Service (IRS) for tax reporting purposes.
Medicare Identification Number-This is a generic term for any number that uniquely identifies the enrolling provider. Examples of Medicare identification numbers are Unique Physician/Practitioner Identification Number (UPIN), Online Survey Certification and Reporting number (OSCAR), National Provider Identifier (NPI), and National Supplier Clearinghouse (number) (NSC).
Mobile Facility/Portable Unit-These terms apply when a service that requires medical equipment is provided in a vehicle, or the equipment for the service is transported to multiple locations within a geographic area. The most common types of mobile facilities/portable units are mobile IDTFs, portable X-ray, portable mammography, and mobile clinics. Physical therapists and other medical practitioners (e.g., physicians, nurse practitioners, physician assistants) who perform services at multiple locations (i.e., house calls, assisted living facilities) are not considered to be mobile facilities/portable units.
Provider-A provider is a hospital, critical access hospital, skilled nursing facility, nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice, that has in effect an agreement to participate in Medicare; or a rural health clinic (RHC), Federally qualified health center (FQHC), rehabilitation agency, or public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech pathology services; or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services. A provider is not synonymous with the corporation or other legal entity that owns or operates the provider. The "provider" is the CMS recognized provider type listed above. Therefore, an owning or operating entity may own or operate many providers.
Provider Identification Number (PIN)-This number is assigned to providers, suppliers, groups and organizations in Medicare Part B. This number will identify who provided the service to the beneficiary on the Medicare claim form.
Supplier-A physician or other practitioner, or an organization other than a provider that furnishes health care services under Medicare Part B. The term supplier also includes independent laboratories, portable x-ray services, physical therapists in private practice, end stage renal disease (ESRD) facilities, and chiropractors.
Tax Identification Number (TIN)-This is a number issued by the Internal Revenue Service (IRS) that the provider uses to report tax information to the IRS.
Unique Physician/Practitioner Identification Number (UPIN)-This number is assigned to physicians, non-physician practitioners, and suppliers to identify the referring or ordering physician on Medicare claims.

To reduce the burden of furnishing some types of supporting documentation, we have designated specific types of documentation to be furnished on an "as needed" basis. However, the fiscal intermediary may request documentation at any time during the enrollment process to support or validate information that is reported in this application. Some examples of documents that may be requested for validation are billing agreements, W-2 forms, pay stubs, articles of incorporation, and partnership agreements.

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SECTION 1: GENERAL APPLICATION INFORMATION

This section is to identify the reason for submittal of this application. It will also indicate whether the provider currently has a business relationship with Medicare.

A. Reason for Submittal of this Application - This section identifies the reason this application is being submitted.

1. Check one of the following:

Initial Enrollment:

- If the provider is enrolling in the Medicare program for the first time under this tax identification number.
- For a change of ownership of an enrolled provider when the new owner will not be accepting assignment of the current provider agreement.

Revalidation:

- If the provider has been requested to revalidate its enrollment information currently on file with Medicare. Periodically (about once every three years), Medicare will require the provider to confirm and update **all** of its enrollment information. Check this box and complete this entire application unless instructed otherwise by the Medicare fiscal intermediary. A copy of the original application with all changes clearly indicated with a current signature and date may be submitted.

Change of Information:

- If the provider is adding, deleting, or changing information under this tax identification number. Check the appropriate section where the change will be made. When providing the changed information, furnish the provider's Medicare identification number in Section 1 and provide the new/changed information within the appropriate section. Sign and date the certification statement. **All changes must be reported to the fiscal intermediary within 90 days of the effective date of the change.** If the provider organization's tax identification number has changed, a new complete CMS 855A enrollment application must be submitted as it is assumed that this provider has changed ownership. If this is not the case, please provide evidence that a change of ownership has not occurred.

NOTE: If the provider is adding a new practice location that requires a **separate** State Survey or Accreditation and a **separate** Medicare Agreement, then a **separate** CMS 855A enrollment application must be submitted for the new provider practice location. For more information concerning the addition of practice locations, contact the State Agency or CMS regional office. If a new practice location is determined **not** to be a new provider, the updated information can be submitted as a practice location change in Section 4.

Voluntary Termination of Provider Billing Number:

- If the provider will no longer be submitting claims to the Medicare program using this billing number. Voluntary termination ensures that the provider's billing number will not be fraudulently used in the event of the provider ceasing its operations. Furnish the date the provider will stop billing for Medicare covered services. In addition to completing this section, furnish the provider's Medicare identification number in Section 1 under "Change of Information" and sign the certification statement (Section 15 or 16).
- If a provider is reporting a "CHOW" and the new owner will not be accepting assignment of the assets and Medicare liabilities of the old owner. The effective date should be the date when the old owner will no longer permit use of its billing number.

NOTE: "Voluntary Termination" **cannot** be used to circumvent any corrective action plan or any pending/ongoing investigation.

Change of Ownership (CHOW):

- See note below and instructions for Section 1B to determine if a valid CHOW applies and needs to be reported.

Acquisitions and/or Mergers (including the CHOW):

- See note below and the instructions for Section 1C to determine if a valid acquisition/merger (and related CHOW) applies and needs to be reported.

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Consolidations (including the CHOW):

- See note below and the instructions for Section 1D to determine if a valid consolidation applies and needs to be reported.

NOTE: All sub-units of a provider with separate provider agreements that will remain in operation after a CHOW, acquisition/merger, or consolidation require completion and submission of a separate CMS 855A. All related CMS 855As should be submitted together, when administratively practical, for the providers involved. If a sub-unit will no longer be in operation upon the completion of the CHOW, acquisition/merger, or consolidation, a CMS 855A must be submitted for the sub-unit requesting a voluntary termination of its billing number.

2. Tax Identification Number (TIN) – Furnish the provider organization's taxpayer identification number (e.g., the number the provider uses to report tax information to the IRS) and attach documentation (e.g., a copy of the CP-575 form) from the IRS showing that the name matches that reported in this application. If the provider does not have an IRS CP-575, IRS Form 941, or IRS 501(c)(3) determination letter, any legal document from the IRS that shows the provider's name and TIN will be acceptable proof. Other IRS documents that may be submitted include an IRS Form 990 or a quarterly tax payment coupon. The name and TIN number on the IRS document should match those shown on this application. Upon request, the IRS will provide a Form 147C showing the provider's name and TIN.

NOTE: An IRS CP 575 or other documentation must be submitted for each TIN reported on this application.

If the provider cannot obtain the required IRS document, explain why in a separate attachment and provide evidence that links its legal business name with the reported TIN. If the name and TIN do not match on the submitted documents, explain why and refer to the documents which confirm the identification of the provider or owner as applicable (e.g., if the provider recently changed its name and the IRS has not sent it an updated document). The provider may then submit the old IRS document with the old name, as well as a copy of documentation filed with the IRS and State concerning the name change.

3. Medicare Identification Number (MIN) - Indicate whether the provider is currently enrolled in the Medicare program. If the provider is currently enrolled in Medicare (i.e., with another fiscal intermediary) provide the name of the intermediary in this space. The provider must also furnish its Medicare identification number in the space provided. This number is issued by Medicare to identify the provider. It is also the number used on claims forms and may be referred to as a Medicare provider number, provider identification number, national provider identifier (NPI), or Online Survey Certification and Reporting (OSCAR) number. Report all currently active numbers.

NOTE: If enrolling as a provider in the Medicare program for the first time, an OSCAR number will be issued to the provider as part of the enrollment process.

4. Fiscal Intermediary Preference

   a) For new providers enrolling in Medicare for the 1st time, check the box given and furnish the name of the provider's fiscal intermediary preference in Section 1A4c, if known. Otherwise, leave blank.

   b) For providers who are currently enrolled in the Medicare program and are requesting to change their fiscal intermediary as the result of a CHOW, acquisition/merger, or a consolidation. The request to change fiscal intermediaries must be submitted to the Medicare Regional Office prior to submission of this application.

   NOTE: Currently enrolled providers who only seek to change their fiscal intermediary are not required to complete this application. Instead, they should request the change directly to their CMS regional office.

   c) For "a" or "b" above, furnish the name of the provider's fiscal intermediary preference. When submitting this application for any reason other than those given in Sections 1A4a or 1A4b above, currently enrolled providers should show their current fiscal intermediary here and skip the above check boxes.

5. Indicate if this provider would like to submit claims electronically. If the provider would like to submit claims electronically once enrolled in the Medicare program, the provider will need to complete an Electronic Data Interchange (EDI) agreement with the fiscal intermediary. Checking this box will alert the intermediary to contact their claims processing department. The claims processing department will contact the provider to process an EDI agreement once its enrollment has been completed, approved, and a Medicare billing number issued to the provider. These agreements cannot be established until the enrollment process has been completed and a Medicare billing number has been issued.

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MEDICARE FEDERAL HEALTH CARE PROVIDER/SUPPLIER ENROLLMENT APPLICATION

Application for Health Care Providers that will Bill Medicare Fiscal Intermediaries

General Instructions

The Medicare Federal Health Care Provider/Supplier Enrollment Application has been designed by the Centers for Medicare and Medicaid Services (CMS) to assist in the administration of the Medicare program and to ensure that the Medicare program is in compliance with all regulatory requirements. The information collected in this application will be used to ensure that payments made from the Medicare trust fund are only paid to qualified health care providers, and that the amounts of the payments are correct. This information will also identify whether the provider is qualified to render health care services and/or furnish supplies to Medicare beneficiaries. To accomplish this, Medicare must know basic identifying and qualifying information about the health care provider that is seeking billing privileges in the Medicare program.

Medicare needs to know: (1) the type of health care provider enrolling, (2) what qualifies this provider as a health care related provider of services and/or supplies, (3) where this provider intends to render these services and/or furnish supplies, and (4) those persons or entities with an ownership interest, or managerial control, as defined in this application, over the provider.

This application **MUST** be completed in its entirety, unless the appropriate box is checked to indicate the section does not apply or when reporting a change to previously submitted information. If a section does not apply to this provider, check (√) the appropriate box in that section and skip to the next section.

1. General Application Information

A. Reason for Submittal of this Application

This section is to be completed with general information as to why this application is being submitted and whether this provider currently has a business relationship with another Federal health care program.
To ensure timely processing of this application, Numbers 1, 2 and 3 below MUST ALWAYS be completed.

1. Check one: ☐ Initial Enrollment ☐ Revalidation

☐ Change of Information (Check appropriate Section(s) Being Changed)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 10
☐ 11 ☐ 12 ☐ 13 ☐ 15 ☐ 16

☐ Voluntary Termination of Billing Number - Effective Date (MM/DD/YYYY):_____
Billing Number to be Terminated:_____

☐ Change of Ownership (CHOW) - See Instructions and Complete Section 1B

☐ Acquisition/Merger (including the CHOW) - See Instructions and Complete Section 1C

☐ Consolidation (including the CHOW) - See Instructions and Complete Section 1D

2. Tax Identification Number:_____

3. Is this provider currently enrolled in the Medicare program? ☐ YES ☐ NO
IF YES, furnish the following information about the current fiscal intermediary (FI):

Current FI Name:_____Current Medicare Identification Number or NPI:_____

4. Fiscal Intermediary Preference:

a) Check here ☐ if this provider is enrolling in the Medicare program for the first time. If known, furnish the name of the provider's fiscal intermediary preference in Section 1A4c below.

b) Check here ☐ if this provider is currently enrolled in the Medicare program and is requesting a change of its fiscal intermediary as a result of a CHOW, acquisition/merger, or a consolidation, and furnish the name of the new preferred fiscal intermediary in Section 1A4c below.

c) Name of Preferred Fiscal Intermediary:_____

5. Check here ☐ if this provider would like to submit claims electronically and is enrolling in Medicare for the first time.

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B. Change of Ownership Information (CHOW Only)

This section is to be completed with information that identifies the name and Medicare identification number of the currently enrolled provider (Transferor) prior to the change of ownership. This section must be completed by **both** the current owner(s) (to protect them from any future liabilities) and the new owner (to establish payment under its tax identification number) on separate CMS 855A applications. Two copies of the sales or other asset transfer agreement, in its current form, must be submitted with this application, and a copy of the final agreement must be submitted by the new owner once the sale is executed.

NOTE: If you are an individual currently enrolled as a provider and you undergo a change of ownership as a result of your incorporation, you must submit two copies of your "articles of incorporation" in lieu of a "Sales Agreement."

- The "**current**" owner (Transferor) is defined as the "old" or "selling" owner.
- The "**new**" owner is defined as the "purchasing" owner.

Any provider undergoing a "Change of Ownership" (CHOW) in accordance with the principles discussed in 42 CFR 489.18 must check the "Change of Ownership (CHOW)" box in Section 1A1. For all other ownership changes check the "Change of Information" box in Section 1A. To determine if a CHOW applies to this provider, review the principles in 42 CFR 489.18 for guidance. If further assistance is needed, contact the fiscal intermediary.

For current/selling owner(s)
A currently enrolled provider that will transfer its ownership interest to new owners in accordance with the principles discussed in 42 CFR § 489.18 should complete this section. This current owner only needs to complete the following sections of this application when reporting a CHOW: Check the Change of Ownership (CHOW) box in Section 1A1, then complete Section 1A2, 1A3, 1B, 2, 13, and sign and date the Certification Statement in Section 15.

1. Furnish the legal business name used by the current owner.
2. Furnish the "doing business as" name used by the current owner.
3. Furnish the Medicare identification number, the projected date that the current owner will no longer have ownership, and the name of the current owner's fiscal intermediary.
4. Indicate if the new owner will be accepting assignment of the current "Provider Agreement." This question does not apply to ESRD clinics.

For new/purchasing owner(s)
A prospective new owner who is participating in a Change of Ownership (CHOW) in accordance with the principles discussed in 42 CFR § 489.18 must complete this entire application. The prospective new owner should check the Change of Ownership (CHOW) box in Section 1A1. If the prospective new owner will not accept assignment of all terms and conditions of the "Provider Agreement" (including the provision concerning the responsibility for Medicare liabilities of the current owner), then the prospective new owner cannot have the current "Provider Agreement" transferred to them. The organization will then be considered a new provider to the Medicare program and must obtain approval through the normal enrollment process by submitting a CMS 855A (Initial Enrollment) prior to obtaining the right to bill Medicare.

1. Furnish the legal business name used by the current owner.
2. Furnish the "doing business as" name used by the current owner.
3. Furnish the Medicare identification number, the projected date that the current owner will no longer have ownership, and the name of the current owner's fiscal intermediary.
4. Indicate if the new owner will be accepting assignment of the current "Provider Agreement." This question does not apply to ESRD clinics.

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C. Acquisitions/Merger (including the CHOW)

Furnish the effective date of the acquisition/merger in the space provided. Two copies of the sales or other asset transfer agreement, in its current form, must be submitted with this application, and a copy of the final agreement must be submitted once the sale is executed.

This section must be completed when an acquisition results in one or more provider (OSCAR) numbers being voluntarily deactivated from the Medicare program. In general, a provider's number is deactivated if the acquisition results in **only one remaining t**ax identification number (TIN), State survey or accreditation, and Medicare agreement. If the acquisition only results in an existing provider having new owners but it will keep its current provider number, then the instructions in Section 1B above for a Change of Ownership (CHOW only) should be used.

This section should be completed on **separate** CMS 855As by **both:**

- The provider that is acquiring another provider, and
- The provider that is being acquired by another provider.

1. Provider Being Acquired - All providers being acquired should be reported in this section.

   a) Furnish the legal business name and TIN of the provider organization being acquired.

   b) Furnish the name of the fiscal intermediary and the Medicare identification number of the provider being acquired.

   c) Report all sub-units of the provider being acquired that currently have an active Medicare identification number but have not entered into separate provider agreements, and furnish the sub-unit's Medicare identification number. Do not report sub-units of the provider being acquired that have separate provider agreements. If these sub-units are also being acquired in this transaction, a separate CMS 855A must be submitted for each.

2. Acquiring Provider - This section is to be completed by both the acquired provider and the acquiring provider with information about the acquiring provider.

   a) Furnish the legal business name and the TIN of the provider that is acquiring other providers.

   b) Furnish the name of the fiscal intermediary and Medicare identification number of the acquiring provider.

NOTE: The acquiring provider should also complete Section 4 (Practice Location) to report the location of the provider it acquired as a new or additional practice location from which it will furnish services.

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1. General Application Information (Continued)

B. Change of Ownership Information (CHOW Only)

This section is to be completed with information that identifies the name and Medicare identification number of the currently enrolled provider (Transferor) prior to the change of ownership. This section must be completed by both the current owner(s) (to protect them from any future liabilities) and the new owner (to establish payment under its tax identification number). **Submit two copies of the sales or other asset transfer agreement with this application.**

1. Legal Business Name of Transferor as Reported to the IRS		
2. "Doing Business As" Name of Transferor (if applicable)		
3. Medicare Identification Number of Transferor	Projected Effective Date of Transfer (MM/DD/YYYY)	Name of Fiscal Intermediary of Transferor
4. Will the new owner be accepting assignment of the current "Provider Agreement?"	☐ YES ☐ NO	

C. Acquisitions/Merger (including the CHOW) Effective Date of Acquisition:_____

This section is to be completed when:
1) A currently enrolled provider is acquiring another currently enrolled provider(s), or
2) A currently enrolled provider is being acquired by another currently enrolled provider.
All providers involved in the acquisition must complete this section. For each provider, furnish the following information: legal business name, tax identification number, current fiscal intermediary, and Medicare identification number. For the provider being acquired, furnish the name of the sub-units of that provider and provide each sub-unit's Medicare identification number. Also indicate whether that sub-unit will remain active. If more than one provider is being acquired, copy and complete this section as needed.
NOTE: Submit two copies of the sales or other asset transfer agreement(s) with this application.

1. Provider Being Acquired

This section is to be completed with information about the currently enrolled provider that is being acquired and will no longer retain its current Medicare provider number as a result of this acquisition.

a) Legal Business Name of the "Provider Being Acquired" as Reported to the IRS	Tax Identification Number
b) Current Fiscal Intermediary	Medicare Identification Number

c) Furnish the name and Medicare identification number of all sub-units of the above provider that have separate Medicare identification numbers but have not entered into separate provider agreements, such as PPS excluded swing bed units of a hospital.

Name/Department:	Medicare Identification Number:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

2. Acquiring Provider

This section is to be completed with information about the organization acquiring the provider identified in Section 1C1.

a) Legal Business Name of the "Acquiring Provider" as Reported to the IRS	Tax Identification Number
b) Current Fiscal Intermediary	Medicare Identification Number

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D. Consolidations (including the CHOW)

Furnish the effective date of the consolidation in the space provided. Two copies of the sales or other asset transfer agreement, in its current form, must be submitted with this application, and a copy of the final agreement must be submitted once the sale is executed.

This section should be completed when a consolidation of providers will result in issuance of a **new** provider number. This usually results from the creation of a **new** provider organization, which has been issued a **new** TIN from the IRS. All applicable sections of this application should be completed for the **new** provider organization (this is similar to being an initial enrollment).

Consolidations that result in **two** or more provider (OSCAR) numbers being deactivated from the Medicare program should be reported in this section. In general, a provider number is deactivated when a TIN is removed from the IRS tax rolls. If a transaction results in an existing provider having new owners but keeping its current provider number, then the instructions in Section 1B above for a Change of Ownership (CHOW) should be used. If a transaction results in an existing provider having new owners that will be using the provider number of the acquiring provider, then the instructions in Section 1C (Acquisitions/Merger) should be used.

1. 1st Consolidating Provider

Complete this section about the 1st currently enrolled provider that, as a result of this consolidation, will no longer retain its current Medicare provider number.

a) Furnish the legal business name and TIN of the 1st provider involved in this consolidation.

b) Furnish the name of this provider's fiscal intermediary and its Medicare identification number.

c) Report all sub-units of the provider being consolidated that currently have an active Medicare identification number but have not entered into separate provider agreements, and furnish the sub-unit's Medicare identification number. Do not report sub-units of the provider being consolidated that have separate provider agreements. If these sub-units are also being consolidated in this transaction, a separate CMS 855A must be submitted for each.

2. 2nd Consolidating Provider

Complete this section about the 2nd currently enrolled provider that, as a result of this consolidation, will also no longer retain its current Medicare provider number.

a) Furnish the legal business name and TIN of the 2nd provider involved in this consolidation.

b) Furnish the name of this provider's fiscal intermediary and its Medicare identification number.

c) Report all sub-units of the provider being consolidated that currently have an active Medicare identification number but have not entered into separate provider agreements, and furnish the sub-unit's Medicare identification number. Do not report sub-units of the provider being consolidated that have separate provider agreements. If these sub-units are also being consolidated in this transaction, a separate CMS 855A must be submitted for each.

3. Newly Created Provider Identification Information

Complete this section with information about the newly created provider.

a) Furnish the legal business name and TIN of the newly created provider organization that resulted from this consolidation.

b) Furnish the new provider organization's fiscal intermediary preference.

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1. General Application Information (Continued)

D. Consolidations (including the CHOW) **Effective Date of Consolidation:**_____

All currently enrolled providers that are consolidating with other currently enrolled providers must complete this section with information about all the providers involved. This section is only to be completed when the consolidation of two or more providers results in an entirely new provider and the issuance of a new Medicare provider number. For each provider, furnish the following information: legal business name, tax identification number, current fiscal intermediary, Medicare identification number, and all sub-units of each provider. For each sub-unit, furnish the Medicare identification number and indicate which sub-units will remain active. In addition, complete Section 1D3 with identifying information about the newly created provider. If there are more than two consolidating providers, copy and complete this section as needed.

1. 1st Consolidating Provider

This section is to be completed with information about the 1st currently enrolled provider that, as a result of this consolidation, will no longer retain its current Medicare provider number.

a) Legal Business Name of the Provider Organization as Reported to the IRS	Tax Identification Number
b) Current Fiscal Intermediary	Medicare Identification Number

c) Furnish the name and Medicare identification number of all sub-units of the above provider that have separate Medicare identification numbers but have not entered into separate provider agreements, such as PPS excluded swing bed units of a hospital.

Name/Department:	Medicare Identification Number:
_____	_____
_____	_____
_____	_____
_____	_____

2. 2nd Consolidating Provider

This section is to be completed with information about the 2nd currently enrolled provider that, as a result of this consolidation, will also no longer retain its current Medicare provider number.

a) Legal Business Name of the Provider Organization as Reported to the IRS	Tax Identification Number
b) Current Fiscal Intermediary	Medicare Identification Number

c) Furnish the name and Medicare identification number of all sub-units of the above provider that have separate Medicare identification numbers but have not entered into separate provider agreements, such as PPS excluded swing bed units of a hospital.

Name/Department:	Medicare Identification Number:
_____	_____
_____	_____
_____	_____
_____	_____

3. Newly Created Provider Identification Information

Complete this section with identifying information about the newly created provider resulting from this consolidation.

a) Legal Business Name of the new Provider as Reported to the IRS	Tax Identification Number
b) Fiscal Intermediary Preference	

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SECTION 2: PROVIDER IDENTIFICATION

A. Type of Provider

1. Type of provider - Check the appropriate box to identify the type of provider for which this application is being submitted. Only **one** provider type may be checked per application. If the provider functions as two or more provider types, a separate CMS 855A must be submitted for each type. If the provider changes the type of services it provides (becomes a different provider type), a new CMS 855A must be completed and submitted (except for hospitals changing the type of hospital services provided – see #2 below).

NOTE: The only Medicare-eligible provider types are those listed. If this provider believes it meets Medicare eligibility requirements to participate in the Medicare program and its provider type is not listed, check the "Other" box and specify the type of service this provider will furnish to Medicare beneficiaries. Before checking "Other," be certain that this provider is an organizational provider type that would submit claims to a Medicare Fiscal Intermediary. Some medical organizations may own or control supplier types that are only eligible to submit claims to a Medicare carrier. These suppliers must complete the CMS 855B and submit it to their local carrier.

2. If "Hospital" was checked in Section 2A1, check all applicable types of services this hospital furnishes. If the hospital is reporting a change in the types of services it provides, check the change box and check **all** current types of provided services.
3. If "Hospital" was checked in Section 2A1:

Check the appropriate box to indicate if the hospital wants one Medicare Part B services billing number, multiple Part B services billing numbers for each department (e.g., cardiology, pathology, radiology), or if this section is not applicable. If a combination of both separate billing numbers for some departments and combined billing numbers for groups of other departments are requested, furnish all details in Section 2G. If multiple numbers are being requested, each department to be issued a Part B Medicare billing number must be reported here.

NOTE: Hospitals must complete and submit the form CMS 855B to the local Medicare carrier to obtain a Part B Medicare billing number.

4. If this hospital has a compliance plan which states that the hospital checks all managing employees against the exclusion/debarment lists of both the HHS Office of the Inspector General (OIG) and the General Services Administration (GSA), check "Yes" in the box provided. Otherwise, check "No." At any time, CMS or its Medicare contractor may request a copy of the compliance plan.

The licenses, certifications and registrations which must be submitted with this application are those required by Medicare or the State to function as the provider type for which this provider is enrolling. Local licenses/permits that are not of a medical nature are not required but any business license required to operate as a health care facility **must** be submitted. Required documents that can only be obtained after a State Survey are not required as part of the application submission but **must** be furnished within 30 days of the provider receiving them.

B. Provider Identification Information - Check the box "Change" only if reporting a change to existing information. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

1. Furnish the legal business name for this provider as reported to the IRS for tax purposes. This may be the same name as that of the owner of this provider.
2. Provide any "doing business as" name this provider uses. The "doing business as" name is the name the provider is generally known by to the public.
3. Check the appropriate box to indicate the organizational structure of this provider. Check "Corporation" if the provider is such, regardless of whether the provider is "for-profit" or "non-profit." "Partnership" should be checked for all "General" or "Limited" partnerships. All other providers should check "Other," and specify the type of organizational structure (e.g., limited liability company).
4. Furnish this provider's "Medicare Year-End Cost Report Date." This date will determine when cost reports and audits are due for this provider. This date may be the same as the provider's "fiscal year-end date.

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2. Provider Identification

This section is to be completed with information specifically related to the provider submitting this application. Furnish the following information about the provider: (1) provider type, (2) provider name, (3) the mailing address and telephone number where Medicare can contact the provider directly, (4) whether the provider has been accredited or Federally approved, and (5) whether the provider has any "prospective payment system" (PPS) exclusions.

A. Type of Provider

Check the appropriate boxes below. The provider must meet all Medicare requirements for the type of provider checked. Submit copies of all required licenses, certifications, and registrations with this application.

1. Type of Provider (Check one):

- ☐ Religious Non-Medical Health Care Institution (RNHCI)
- ☐ Community Mental Health Center
- ☐ Comprehensive Outpatient Rehabilitation Facility
- ☐ End-Stage Renal Disease Facility (ESRD)
- ☐ Federally Qualified Health Center (FQHC)
- ☐ Histocompatibility Laboratory
- ☐ Home Health Agency
- ☐ Home Health Agency (Sub-unit)
- ☐ Hospice
- ☐ Hospital (If checked, complete Sections 2A2 and 2A3)
- ☐ Indian Health Services Facility
- ☐ Multiple Hospital Component in a Medical Complex
- ☐ Organ Procurement Organization (OPO)
- ☐ Outpatient Physical Therapy/Occupational Therapy/ Speech Pathology Services
- ☐ Psychiatric Unit (of Hospital)
- ☐ Rehabilitation Agency (unit of a Hospital)
- ☐ Rural Health Clinic
- ☐ Skilled Nursing Facility
- ☐ Other (Specify):_____

2. If this provider is a hospital, check all applicable sub-groups listed below:

☐ Hospital ☐ Change Effective Date:_____

- ☐ Hospital—General
- ☐ Hospital—Alcohol/Drug
- ☐ Hospital—Acute Care
- ☐ Hospital—Children's (excluded from PPS)
- ☐ Hospital—Critical Access
- ☐ Hospital—Critical Access (Swing-Bed unit)
- ☐ Hospital—Long-Term (excluded from PPS)
- ☐ Hospital—Long-Term (Swing-Bed unit)
- ☐ Hospital—Psychiatric (excluded from PPS)
- ☐ Hospital—Short-Term (General and Specialty)
- ☐ Hospital—Short-Term (Swing-Bed unit)
- ☐ Hospital—Rehabilitation (excluded from PPS)
- ☐ Hospital—Rehabilitation (Swing-Bed unit)

☐ Other (Specify):

_____

3. Hospital Departments billing for Practitioner Services:
If this provider is a hospital, check the appropriate box below. See instructions before completing this section.

☐ Not Applicable

☐ Single billing number for all departments ☐ Separate billing number for each department listed below

_____ _____ _____

_____ _____ _____

_____ _____ _____

4. Does this hospital have a compliance plan stating that all managing employees are checked against the OIG exclusion and GSA debarment lists? ☐ YES ☐ NO

B. Provider Identification Information ☐ Change Effective Date:_____

Furnish the provider's legal business name (as reported to the IRS), "doing business as" name (name provider generally known by to the public), and the various operating dates and places of formal business registration and/or incorporation. If incorporated, the provider may be required to submit a copy of its "Articles of Incorporation" for validation purposes.

1. Legal Business Name as Reported to the IRS

2. "Doing Business As" (DBA) Name (if applicable)

3. Identify the type of organizational structure for this provider (Check one):
☐ Corporation ☐ Partnership ☐ Other (Specify):_____

4. Medicare Year-End Cost Report Date (MM/DD)

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C. Correspondence Address - Check the box "Change" only if reporting a change to existing information. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

- **Furnish a name, address, and telephone number where Medicare or the Medicare fiscal intermediary can directly get in touch with the enrolling provider.**

This section will assist us in contacting the provider with any questions we have concerning its business relationship with the Medicare program. The provider must furnish a name, address, and telephone number where Medicare or the fiscal intermediary can directly contact it to resolve any personal or business issues that arise as a result of its enrollment in the Medicare program. This data will also be used to furnish the provider with important changes or other information concerning the Medicare program that may directly affect the provider and/or its Medicare payments. This address **cannot** be that of the billing agency, management service organization, or staffing company. If we suspect that the provider's billing number is being misused, or if we have a legal question, we will contact the provider directly. This is to protect the provider as well as the Medicare program.

D. Accreditation - Check the box "Change" only if reporting a change to existing information. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

1. Indicate whether this provider is accredited by any accrediting organization that Medicare has approved for acceptance in lieu of a State Survey.
2. If "Yes," furnish the date accreditation was received, and
3. Furnish the name of the Medicare-approved accrediting body or organization.

E. Federal Approval (FQHCs and OPOs only) – This section must be completed by all Federally Qualified Health Centers and Organ Procurement Organizations. To be eligible to enroll in the Medicare program, FQHCs and OPOs must receive federal approval to operate as a health care provider.

Check the box "Change" only if reporting a change to existing information. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

1. Indicate if this FQHC or OPO has received federal approval. If "Yes,"
2. Furnish the date of approval and submit a copy of the approval certificate with this application.

F. Prospective Payment System Exclusions - Check the box "Change" only if reporting a change to existing information. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

1. Indicate if this provider has any "Prospective Payment System Exclusions." This section is primarily for hospitals that have psychiatric units or rehabilitation agencies (units).
2. If "Yes," indicate the type of unit to be excluded by checking one or both boxes provided.

G. Comments – This section is to be used as an opportunity to explain any unique billing number requests or to clarify any other information furnished in this section (Section 2 - Provider Identification).

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2. Provider Identification (Continued)

C. Correspondence Address ☐ **Change** **Effective Date:**_____

This must be an address and telephone number where Medicare can contact the provider directly.

Mailing Address (Organization or Individual Name)		
Mailing Address Line 1 (Street Name and Number)		
Mailing Address Line 2 (Suite, Room, etc.)		
City	State	ZIP Code + 4
Telephone Number ( ) (Ext.) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

Note: Sections 2D through 2F below require a "Yes," "No," or "Pending" response. If a specific question does not apply to this provider, check "No" and continue with the next question. If the response is "Yes" or "Pending," furnish the additional information requested in that section and continue with the next question.

D. Accreditation ☐ **Change** **Effective Date:**_____

1. Is this provider accredited? ☐ YES ☐ NO ☐ PENDING
   IF YES, complete the following:
2. Date of Accreditation (MM/DD/YYYY):_____
3. Name of Accrediting Body:_____

E. Federal Approval (FQHCs and OPOs only) ☐ **Change** **Effective Date:**_____

1. Is this provider Federally approved? ☐ YES ☐ NO ☐ PENDING
   IF YES, complete the following:
2. Date of Approval (MM/DD/YYYY):_____

F. Prospective Payment System Exclusions ☐ **Change** **Effective Date:**_____

1. Does this provider have any "Prospective Payment System" (PPS) excluded units? ☐ YES ☐ NO
   IF YES, check the type(s) of excluded unit(s) below:
2. Type of unit(s) to be excluded: ☐ Psychiatric Unit ☐ Rehabilitation Agency (unit)

G. Comments

Use this section to explain any unique billing number requests or to clarify any other information furnished in this Section.

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SECTION 3: ADVERSE LEGAL ACTIONS AND OVERPAYMENTS

A. Adverse Legal History - This section is to be completed with information concerning any adverse legal actions that have been imposed or levied against this provider, as identified in Section 2B. See Table A on the application form for a list of adverse actions that must be reported.

If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. The provider must state whether, under any current or former name or business identity, it has ever had any of the adverse legal actions listed in Table A of the application form imposed against it.

2. If the answer to this question is "Yes," supply all requested information. Attach copies of official documentation related to the adverse legal action. Such documentation includes adverse legal action notifications (e.g., notification of disciplinary action; criminal court documentation that verifies the conviction of a crime) and documents that evidence how the adverse legal action was finally resolved (e.g., reinstatement notices, etc.).

If the provider is uncertain as to whether it falls within one of the adverse legal action categories or whether a name reported on this application has an adverse legal action, query the Healthcare Integrity and Protection Data Bank. If information is needed on how to access the data bank, call 1-800-767-6732 or visit www.npdb-hipdb.com. There is a charge for using this service.

Table A--This is the list of adverse legal actions that must be reported. All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

B. Overpayment Information - Current laws found in the Federal Streamlining Act and the Debt Collection Improvement Act require all Federal agencies to determine whether an individual or business entity that enters into a business relationship with that agency has any outstanding debts, including overpayments under different identifiers. Failure to furnish information about overpayments will put the provider in violation of these Acts and subject it to possible denial of its Medicare enrollment.

1. The provider, as identified in Section 2B, must report all outstanding Medicare overpayments that it is liable for, including those paid to the provider, or on its behalf, under a different name. For purposes of this section, the term "outstanding Medicare overpayment" is defined as a debt that meets **all** of the conditions listed below:

   a) The overpayment arose out of the provider's current or previous enrollment in Medicare. This includes any overpayment incurred by the provider under a different name or business identity, or in another Medicare contractor jurisdiction;

   b) CMS (or its contractors) has determined that the provider is liable for the overpayment; and

   c) The overpayment is not or has not been included as part of a repayment plan approved by CMS (or its contractors), nor is the overpayment amount being repaid through the withholding of Medicare payments to the provider.

Any overpayment not meeting all of these conditions should not be reported.

2. Furnish the name or business identity under which the overpayment occurred and the account number under which the overpayment exists.

NOTE: Overpayments that occur after the provider's enrollment has been approved do not need to be reported unless the provider is enrolling with a different Medicare contractor.

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3. Adverse Legal Actions and Overpayments

This section is to be completed with information concerning any adverse legal actions and/or overpayments that have been imposed or levied against this provider (see Table A below for list of adverse actions that must be reported).

A. Adverse Legal History ☐ **Change** **Effective Date:**_____

1. Has this provider, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A below imposed against it? ☐ YES ☐ NO
2. **IF YES**, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:

Table A

1) Any felony conviction under Federal or State law, regardless of whether it was health care related.

2) Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.

3) Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.

4) Any misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.

5) Any misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

6) Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.

7) Any revocation or suspension of accreditation.

8) Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.

9) Any current Medicare payment suspension under any Medicare billing number.

Note: All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

B. Overpayment Information

1. Does this provider, under any current or former name or business identity, have any outstanding Medicare overpayments? ☐ YES ☐ NO
2. **IF YES**, furnish the name and account number under which the overpayment(s) exists.

Name under which the overpayment occurred:	Account number under which the overpayment exists:

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SECTION 4: CURRENT PRACTICE LOCATION(S)

A. Practice Location Information - Check the appropriate box to indicate whether the provider is adding a new practice location, deleting a practice location, or changing information about an existing practice location. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise, complete this section as follows:

If a reported addition or change does not require a separate OSCAR number and/or corresponding separate provider agreement (e.g., a branch or provider-based clinic), check the appropriate box and complete this section. If adding a location that requires a completely separate OSCAR number and/or corresponding separate provider agreement, a new application must be submitted for the new location as a new provider.

Home Health Agencies (HHAs) should complete this section with their administrative address and skip to Section 4E.

Community Mental Health Centers (CMHCs) must report all alternative sites where core services are provided (proposed alternative sites for initial enrollment and actual alternative sites for those CMHCs already participating in Medicare). In accordance with provisions of the Public Health Service Act, a CMHC is required to provide mental health services principally to individuals who reside in a defined geographic area (service area). Therefore, CMHCs must service a distinct and definable community. Those CMHCs operating or proposing to operate outside this specific community must have a separate provider agreement/number, submit a separate enrollment application, and individually meet the requirements to participate. CMS will determine if the alternative site is permissible or whether the site must have a separate agreement/number. CMS will consider the actual demonstrated transportation pattern of CMHC clients within the community to ensure that all core services and partial hospitalization are available from each location within the community. A CMHC patient must be able to access and receive services he/she needs at the parent CMHC site or the alternative site within the distinct and definable community served by the parent.

NOTE: Hospitals must report all practice locations where the hospital provides services. Do not report separately enrolled provider/supplier types such as SNFs, HHAs, RHCs, physician practices, clinics, etc. Practice location addresses fall into one of two categories as listed below. When furnishing the practice locations, the hospital should report the addresses in the order shown below.

- **1st** - All location addresses where the hospital performs inpatient services.
- **2nd** – All other location addresses where the hospital performs any other non-inpatient service.

NOTE: If an organization owns other providers or suppliers that are required to obtain separate provider numbers (i.e., OSCAR numbers or UPINs) do not report them as practice locations. Each of these other providers or suppliers must enroll via a separate CMS 855A or CMS 855B as appropriate.

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Practice Location Information (continued)

1. Furnish the name the provider uses at this practice location and the date the provider started rendering services at this location.
2. Furnish a complete street address, telephone number, fax number, and e-mail address (if applicable) for the provider's practice/business location.

The address must be a specific street address as recorded by the United States Postal Service. Do not report a P.O. Box. If the provider renders services in a hospital and/or other health care facility for which it bills Medicare directly for the services furnished at that facility, furnish the name and address of that hospital or facility. Do not furnish the provider's billing agency information anywhere in this section. The fax number and e-mail addresses are optional.

3. This question is to be completed by providers that indicated that they are a hospital in Section 2A1. Indicate if the practice location shown in Section 4A is an address where inpatient services are furnished.
4. Indicate whether the provider owns/leases the practice location.
5. Report any CLIA number(s) and/or FDA/Radiology (Mammography) Certification Number(s) that have been issued to this provider for this practice location for which the provider will be billing for these types of services. Submit copies of all current valid certificates with this application.
6. This question is to be completed by providers that indicated that they are a home health agency in Section 2A1. HHA's must report all branch office locations as separate practice locations. If the branch office has been issued a Medicare identification number, furnish it in the space provided.

B. Mobile Facility and/or Portable Units

To properly pay claims, Medicare must be able to distinguish when services are provided in a mobile facility or with portable units. If the provider has a mobile facility or portable unit, provide this information in this section. A "mobile facility" is generally a mobile home, trailer, or other large vehicle that has been converted, equipped, and licensed to render health care services. These vehicles usually travel to local shopping centers or community centers to see and treat patients **inside** the vehicle. A "portable unit" is when the provider transports medical equipment to a fixed location (e.g., physician's office, nursing home) to render service to the patient.

- State whether or not this provider furnishes services in or from a mobile facility or portable unit. If "Yes," use Sections 4C through 4E to furnish information about the mobile/portable services.

C. Base of Operations Address - Check the appropriate box to indicate whether the provider is using this section to add a new mobile/portable practice location, delete a mobile/portable practice location, or change information about an existing mobile/portable practice location. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

- If the base of operations address is the same as the practice location reported above in Section 4A1, check the box and skip to Section 4D.

1. Provide the base of operations name and the date the provider started practicing from this location.
2. Provide the address from where personnel are dispatched, where mobile/portable equipment is stored and, when applicable, where vehicles are parked when not in use. Provide the telephone number, fax number and e-mail address (if applicable) for this base of operations location.

D. Vehicle Information - Check the appropriate box to indicate whether the provider is using this section to add a vehicle, delete a vehicle, or change information about a vehicle. Provide the effective date of the change, and sign and date the certification statement. Otherwise:

1.-3. Furnish the type of vehicle and the vehicle identification number. A copy of all health care related permit(s), license(s), and registration(s) must be submitted for each vehicle reported.

This section is to provide us with information about the mobile unit when the services are rendered **in or from** the vehicle. Do not furnish information about the vehicle(s) that are used only to transport medical equipment (e.g., when the equipment is transported in a van but is used in a fixed setting, such as a doctor's office) or ambulance vehicles.

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4. Current Practice Location(s)

This section is to be completed with information about the physical location(s) where this provider currently renders health care services. If this provider operates a mobile facility or portable units, furnish the address of the "Base of Operations," as well as vehicle information and the geographic area serviced by these facilities or units. In addition, cite where this provider wants its payments sent, and where the provider maintains patients' records. If there is more than one practice location, copy and complete this section for each.

A. Practice Location Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Practice Location Name			Date Started at this Location (MM/DD/YYYY)
2. Practice Location Address Line 1 (Street Name and Number)			
Practice Location Address Line 2 Suite, Room, etc.)			
City	County/Parish	State	ZIP Code + 4
Telephone Number ( )	(Ext.) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

3. **Hospitals Only:** Is the practice location above an inpatient services practice location? ☐ YES ☐ NO

4. Does this provider: own this practice location? ☐ YES ☐ NO
lease this practice location? ☐ YES ☐ NO

5. CLIA Number for this location (if applicable)	FDA/Radiology (Mammography) Certification Number(s) for this location (if applicable)

6. **HHA's Only:** Is the above practice location a branch office in acordance with 42 CFR 484.2? ☐ YES ☐ NO
Medicare Identification Number for this Branch Office:_____

B. Mobile Facility and/or Portable Units ☐ **Change** **Effective Date:**_____

Does this organization furnish health care services from a mobile facility or portable unit? ☐ YES ☐ NO
IF YES, use Sections 4C through 4E to furnish information about the mobile/portable services.
IF NO, proceed to Section 4E (Geographic Location).

C. Base of Operations Address ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

The base of operations is the location from where personnel are dispatched, where mobile/portable equipment is stored and, when applicable, where vehicles are parked when not in use. See instructions for further examples.
Check here ☐ and skip to Section 4D if the "Base of Operations" address is the same as the "Practice Location."

1. Base of Operations Name			Date Started at this Location (MM/DD/YYYY)
2. Street Address Line 1 (Street Name and Number)			
Street Address Line 2 (Suite, Room, etc.)			
City	County/Parish	State	ZIP Code + 4
Telephone Number ( )	(Ext.) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

D. Vehicle Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

If the mobile health care services are rendered in a vehicle, such as a mobile home or trailer, furnish the following vehicle information. See the instructions for a full explanation of the types of vehicles that need to be reported. If more than three vehicles are used, copy and complete this section as needed.

1. Type of Vehicle (van, mobile home, trailer, etc.)	Vehicle Identification Number
2. Type of Vehicle (van, mobile home, trailer, etc.)	Vehicle Identification Number
3. Type of Vehicle (van, mobile home, trailer, etc.)	Vehicle Identification Number

Note: For each vehicle, a copy of all health care related permits/licenses/registrations MUST be submitted.

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E. Geographic Location where the Base of Operations and/or Vehicle Renders Services - This section is to be completed by all **Home Health Agencies, Hospice Organizations**, and **Mobile** and/or **Portable** facilities with information identifying the geographic area(s) where health care services are rendered.

Check the appropriate box when the provider is using this section to add a geographic location or delete a geographic location. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

1. Initial Reporting and/or Additions

- The provider should furnish the county/parish, city, State and ZIP Code for all locations at which it will render services to Medicare beneficiaries in or from its mobile facility or portable unit. For those mobile facilities or portable units that travel across State lines, and when those States are serviced by different Medicare contractors (fiscal intermediaries), then the provider must complete a separate CMS 855A enrollment application for each Medicare contractor jurisdiction.

2. Deletions

- If deleting a location where mobile or portable services were provided, indicate the county/parish, city, State, and ZIP Code of the location being deleted.

F. Medicare Payment "Pay To" Address - The provider must indicate where it wants its Medicare payments to be sent. Check the box "Change" only if reporting a change to existing information. Provide the date of that change, and sign and date the certification statement. Otherwise:

- Provide the P.O. Box or street address, city, State and ZIP Code for the address where payments are to be sent.

The ability to establish more than one "pay to" address will be addressed by the provider's fiscal intermediary. Some Medicare fiscal intermediaries do not allow multiple payment addresses. Payment will be made in the provider's "legal business name" as shown in Section 2B1.

- The "Pay To" address is not the same address used for Electronic Funds Transfers. If the provider would like payments to be deposited in its bank account electronically, place a check in the box given and complete the form "Medicare Authorization Agreement for Electronic Funds Transfers (Form HCFA-588).

- If payment will be made by electronic funds transfer, the "Pay To" address should indicate where the provider wants other financial or payment information sent.

G. Location of Patients' Medical Records - Check the appropriate box if using this section to add a new location where patients' records are kept, delete a location, or change information about an existing location. Provide the effective date of that change, complete the appropriate information, and sign and date the certification statement. Otherwise:

1. If all of the provider's patients' medical records are stored at the practice location shown in Section 4A or the base of operations shown in Section 4C, check the box provided and skip this section.

2. If any of the provider's patients' medical records are stored at a location other the practice location shown in Section 4A or the base of operations shown in Section 4C, this section must be completed with a complete address of the storage location.

Post Office Boxes and drop boxes are not acceptable as physical addresses where patients' medical records are maintained. For IDTFs and mobile facilities/portable units, the patients' medical records must be under the provider's control. The records must be the provider's records, not the records of another provider/supplier.

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4. Practice Location (Continued)

E. Geographic Location ☐ **Add** ☐ **Delete** **Effective Date:**_____

This section is to be completed by all **Home Health Agencies, Hospice Organizations**, and **Mobile** and/or **Portable** facilities with information identifying the geographic area(s) where health care services are rendered.

Furnish the county/parish, city, State and ZIP Code for all locations where mobile and/or portable services are rendered.

Note: If this provider renders mobile health care services in more than one State, and those States are served by different Medicare contractors, then a separate CMS 855A enrollment application must be completed for each Medicare contractor jurisdiction.

1. Initial Reporting and/or Additions:

County/Parish:	City:	State:	ZIP Code(s):

2. Deletions:

County/Parish:	City:	State:	ZIP Code(s):

F. Medicare Payment "Pay To" Address ☐ **Change** **Effective Date:**_____

Check here ☐ and complete and submit Form HCFA-588 with this application if the provider would like its payments electronically transferred to its bank account.

Furnish the address where payments should be sent for services rendered at the practice location in Section 4A or 4C.

"Pay To" Address (Organization or Individual Name)

"Pay To" Address Line 1 (Street Name and Number)

"Pay To" Address Line 2 (Suite, Room, etc.)

City	State	ZIP Code + 4

G. Location of Patients' Medical Records ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Check here ☐ if **all** patients' medical records are stored at the location shown in Section 4A or 4C, and skip this section.
2. If **any** of the patients' medical records are stored in a location other than the location shown in Section 4A or 4C, complete this section with the name and address of the storage location.

Name of Storage Facility/Location

Storage Facility Address Line 1 (Street Name and Number)

Storage Facility Address Line 2 (Suite, Room, etc.)

City	State	ZIP Code + 4

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SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS)

This section is to be completed with information about any organization that has 5% or more (direct or indirect) ownership of, any partnership interest in, and/or managing control of the provider identified in Section 2B. See examples below of organizations that should be reported in this section. If individuals, and not organizations, own or manage the provider, do not complete this section. These individuals must be reported in Section 6. If there is more than one organization, copy and complete this section for each.

A. Check Box - Check the box if there are no organizations to be reported in this section. If this box is checked, proceed to Section 6.

B. Organization with Ownership Interest and/or Managing Control - Identification Information - If adding, deleting, or changing information on an existing owner, partner, or managing organization, check the appropriate box, indicate the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. If not reporting a change, complete this section for the following:

All organizations that have any of the following **must** be reported in Section 5B:

- 5% or more ownership of the provider,
- Managing control of the provider, or
- A partnership interest in the provider, regardless of the percentage of ownership the partner has.

Owning/Managing organizations are generally one of the following types:

- Corporations (including non-profit corporations)
- Partnerships and Limited Partnerships (as indicated above)
- Charitable and/or Religious organizations
- Governmental and/or Tribal organizations

NOTE: All partners within a partnership must be reported in Section 6 of this application. This applies to both "General" and "Limited" partnerships. For instance, if a limited partnership has several limited partners and each of them only has a 1% interest in the provider, each limited partner must be reported in this application, even though each owns less than 5%. The 5% threshold primarily applies to corporations and other organizations that are not partnerships. The 5% threshold primarily applies to corporations or other organizations that are not partnerships.

***IMPORTANT* – Only report organizations in this section. Individuals must be reported in Section 6.**

1. Check all boxes that apply to indicate the relationship between the provider and the owning or managing organization.

2. Provide the legal business name of the owning or managing organization.

3. If applicable, provide the owning or managing organization's "doing business as" name.

4. Provide the owning or managing organization's business street address.

5. Provide the owning or managing organization's tax identification number and, if one (or more) has been issued, its Medicare identification number(s).

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The following contains an explanation of the terms "direct ownership," "indirect ownership," and "managing control," as well as instructions concerning organizations that must be reported in this application.

EXAMPLES OF 5% OR MORE "DIRECT" OWNERSHIP

All organizations that own 5% or more of the provider must be reported in this application.

Many providers may be owned by only one organization. For instance, suppose the provider is a skilled nursing facility is wholly (100%) owned by Company A. In this case, Company A is considered to be a direct owner of the skilled nursing facility, in that it actually owns the assets of the business. As such, the provider would have to report Company A in this section.

There are occasionally more complex ownership situations. Many organizations that directly own a provider are themselves wholly or partly owned by other organizations (or even individuals). This is often the result of the use of holding companies and parent/subsidiary relationships. Such organizations and individuals are considered to be "indirect" owners of the provider. Using our first situation above, if Company B owned 100% of Company A, Company B is considered to be an indirect owner of the provider. In other words, a direct owner has an actual ownership interest in the provider (e.g., owns stock in the business, etc.), whereas an indirect owner has an ownership interest in an organization that owns the provider. For purposes of this application, direct and indirect owners must be reported if they own at least 5% of the provider. To calculate whether these indirect owners meet the 5% ownership level, review the formula outlined in Example 1 in this section.

For purposes of this application, ownership also includes "financial control." Financial control exists when:

(1) An organization or individual is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the provider or any of the property or assets of the provider, **and**

(2) The interest is equal to or exceeds 5% of the total property and assets of the provider.

To calculate whether an organization or individual has financial control over the provider, use the formula outlined in Example 2 of the instructions for this section.

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EXAMPLES OF "INDIRECT" LEVELS OF OWNERSHIP FOR ENROLLMENT PURPOSES

Example 1 (Ownership)

LEVEL 3	***Individual X*** 5%	***Individual Y*** 30%
LEVEL 2	***Company C*** 60%	***Company B*** 40%
LEVEL 1	***Company A*** 100%	

- Company A owns 100% of the Enrolling Provider
- Company B owns 40% of Company A
- Company C owns 60% of Company A
- Individual X owns 5% of Company C
- Individual Y owns 30% of Company B

In this example, Company A (Level 1) is the direct owner of the Enrolling Provider. Companies B and C as well as Individuals X and Y are indirect owners of the Enrolling Provider. To calculate ownership shares using the above-cited example, utilize the following steps:

LEVEL 1

The diagram above indicates that Company A owns 100% of the Enrolling Provider. Company A must therefore be reported in Section 5.

LEVEL 2

To calculate the percentage of ownership held by Company C of the Enrolling Provider, multiply:

The percentage of ownership the LEVEL 1 owner has in the Enrolling Provider
MULTIPLIED BY
The percentage of ownership the LEVEL 2 owner has in that LEVEL 1 owner

It is known that Company A, the LEVEL 1 (or direct) owner, owns 100% of the Enrolling Provider. The diagram also indicates that Company C, a LEVEL 2 owner, owns 60% of Company A. As such, multiply 100% (or 1.0) by 60% (.60). The result is .60. Therefore, Company C indirectly owns 60% of the Enrolling Provider, and must be reported in Section 5.

Repeat the same procedure for Company B, the other LEVEL 2 owner. Because Company B owns 40% of Company A, multiply this figure by 100% (again, the ownership stake Company A has in the Enrolling Provider). Therefore, 1.0 multiplied by .40 equals .40, so Company B owns 40% of the Enrolling Provider, and must be reported in Section 5.

This process is continued until all LEVEL 2 owners have been accounted for.

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LEVEL 3

To calculate the percentage of ownership that Individual X has in the Enrolling Provider, multiply:

The percentage of ownership the LEVEL 2 owner has in the Enrolling Provider
MULTIPLIED BY
The percentage of ownership the LEVEL 3 owner has in that LEVEL 2 owner

It has already been established that Company C owns 60% of the Enrolling Provider. According to the example above, Individual X (Level 3) owns 5% of Company C. Therefore, multiply 60% (.60) by 5% (.05), resulting in .03. This means that Individual X owns 3% of the Enrolling Provider and does not need to be reported in this application.

Repeat this process for Company B, which owns 40% of the Enrolling Provider. The diagram states that Individual Y (Level 3) owns 30% of Company B. We thus multiply 40% (.40) by 30% (.30). The result is .12, or 12%. Because Individual Y owns 12% of the Enrolling Provider, Individual Y must be reported in this application (in Section 6 - Individuals).

This process is continued until all owners in LEVEL 3 have been accounted for. Should there be entities at LEVEL 4 and above that have at least a 5% ownership interest in the Enrolling Provider, the Enrolling Provider may submit an organizational chart identifying these entities and/or individuals. The chart should contain the names, business addresses and TINs of these entities, and/or the names and social security numbers of these individuals.

Example 2 (Financial Control)

The percentage of financial control can be calculated by using the following formula:

Dollar amount of the mortgage, deed of trust, or other obligation secured by the Enrolling Provider or any of the property or assets of the Enrolling Provider
DIVIDED BY
Dollar amount of the total property and assets of the Enrolling Provider

Example: Two years ago, a provider obtained a $20 million loan from Entity X to add a third floor to its facility. Various assets of the provider secure the mortgage. The total value of the provider's property and assets is $100 million.

Using the formula described above, divide $20 million (the dollar amount of the secured mortgage) by $100 million (the total property and assets of the Enrolling Provider). This results in .20, or 20%. Because Entity X's interest represents at least 5% of the total property and assets of the Enrolling Provider, financial control exists and Entity X must be reported in this section.

MANAGING CONTROL (ORGANIZATIONS)

Any organization that exercises operational or managerial control over the provider, or conducts the day-to-day operations of the provider, is a managing organization and must be reported. The organization need not have an ownership interest in the provider in order to qualify as a managing organization. This could be a management services organization under contract with the provider to furnish management services for this business location.

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SPECIAL TYPES OF ORGANIZATIONS

Governmental/Tribal Organizations: If a Federal, State, county, city or other level of government, or an Indian tribe, will be legally and financially responsible for Medicare payments received (including any potential overpayments), the name of that government or Indian tribe should be reported as an owner. The provider must submit a letter on the letterhead of the responsible government (e.g., government agency) or tribal organization, which attests that the government or tribal organization will be legally and financially responsible in the event that there is any outstanding debt owed to CMS. This letter must be signed by an "authorized official" of the government or tribal organization who has the authority to legally and financially bind the government or tribal organization to the laws, regulations, and program instructions of Medicare. See Section 15 for further information on and a definition of "authorized officials."

Charitable and Religious Organizations: Many non-profit organizations are charitable or religious in nature, and are operated and/or managed by a Board of Trustees or other governing body. The actual name of the Board of Trustees or other governing body should be reported in this section.

C. Adverse Legal History - This section is to be completed with information concerning any adverse legal actions that have been imposed or levied against the organization(s) reported in this section. See Table A in Section 3 of the application form for a list of adverse actions that must be reported.

If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. The provider must state whether the organization reported in Section 5B, under any current or former name or business identity, has ever had any of the adverse legal actions listed in Section 3 (Table A) of this form imposed against it.

2. If the answer to this question is "Yes," supply all requested information. Attach copies of official documentation related to the adverse legal action. Such documentation includes adverse legal action notifications (e.g., notification of disciplinary action; criminal court documentation that verifies the conviction of a crime) and documents that evidence how the adverse legal action was finally resolved (e.g., reinstatement notices, etc.).

If the provider is uncertain as to whether the owning or managing organization falls within one of the adverse legal action categories, the provider should query the Healthcare Integrity and Protection Data Bank. If the provider needs information on how to access the data bank, call 1-800-767-6732 or visit www.npdb-hipdb.com.

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5. Ownership Interest and/or Managing Control Information (Organizations)

This section is to be completed with information about all organizations that have 5% or more (direct or indirect) ownership interest of, any partnership interest in, and/or managing control of, the provider identified in Section 2B, as well as any information on adverse legal actions that have been imposed against that organization. See instructions for examples of organizations that should be reported here. If there is more than one organization, copy and complete this section for each.

A. Check here ☐ if this section does not apply and skip to Section 6.

B. Organization with Ownership Interest and/or Managing Control - Identification Information

☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Check all that apply:	☐ 5% or more Ownership Interest ☐ Managing Control	☐ Partner
2. Legal Business Name		
3. "Doing Business As" Name (if applicable)		
4. Business Address Line 1 (Street Name and Number)		
Business Address Line 2 (Suite, Room, etc.)		
City	State	ZIP Code + 4
5. Tax Identification Number	Medicare Identification Number(s) (if applicable)	

C. Adverse Legal History ☐ **Change** **Effective Date:**_____

This section is to be completed for the organization reported in Section 5B above.

1. Has the organization in Section 5B above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against it? ☐ YES ☐ NO

2. **IF YES**, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS)

This section is to be completed with information about any individual who has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the provider identified in Section 2B. In addition, all officers, directors, and managing employees of the provider must be reported in this section. If there is more than one individual, copy and complete this section for each. **The provider MUST have at least ONE owner and/or managing employee.** If this is a "one person" operation, then report yourself in this section as **both** a 5% or greater owner and a managing employee or director/officer.

NOTE: Hospitals Only: Hospitals that have checked "Yes" to having a compliance plan in accordance with Medicare requirements in Section 2.A.3.b. are not required to report their managing employees in this application. However, this section **must** be completed for the Authorized Official reported in Section 15 and all Delegated Officials reported in Section 16.

A. Individual with Ownership Interest and/or Managing Control - Identification Information - If adding, deleting, or changing information on an existing 5% or greater owner, partner, officer, director, or managing employee, check the appropriate box, indicate the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. If not reporting a change, complete this section for the following:

The following individuals **must** be reported in Section 6A: (see below for definitions of these terms)

- All persons who have a 5% or greater ownership interest in the provider;
- If (and only if) the provider is a corporation (whether for-profit or non-profit), all officers and directors of the provider;
- All managing employees of the provider, and
- All individuals with a partnership interest in the provider, regardless of the percentage of ownership the partner has.

NOTE: All partners within a partnership must be reported in this application. This applies to both "General" and "Limited" partnerships. For instance, if a limited partnership has several limited partners and each of them only has a 1% interest in the provider, each limited partner must be reported in this application, even though each owns less than 5%. The 5% threshold primarily applies to corporations and other organizations that are not partnerships.

For purposes of this application, the terms "officer," "director," and "managing employee" are defined as follows:

- The term **"Officer"** is defined as any person whose position is listed as being that of an officer in the provider's **"Articles of Incorporation"** or **"Corporate Bylaws," OR** anyone who is appointed by the board of directors as an officer in accordance with the provider's corporate bylaws.
- The term **"Director"** is defined as a member of the provider's **"Board of Directors."** It does not necessarily include a person who may have the word "Director" in his/her job title (e.g., Departmental Director, Director of Operations). See note below.

NOTE: A person who has the word "Director" in his/her job title may be a "managing employee," as defined below. Moreover, where a provider has a governing body that does not use the term "Board of Directors," the members of that governing body will still be considered "Directors." Thus, if the provider has a governing body titled "Board of Trustees" (as opposed to "Board of Directors"), the individual trustees are considered "Directors" for Medicare enrollment purposes.

- The term **"Managing Employee"** is defined as any individual, including a general manager, business manager, or administrator, who exercises operational or managerial control over the provider, or who conducts the day-to-day operations of the provider. For Medicare enrollment purposes, "managing employee" also includes individuals who are not actual employees of the provider but, either under contract or through some other arrangement, manage the day-to-day operations of the provider.

NOTE: If a governmental or tribal organization will be legally and financially responsible for Medicare payments received (per the instructions for Governmental/Tribal Organizations in Section 5), the provider is only required to report its managing employees in Section 6. Owners, partners, officers, and directors do not need to be reported.

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Refer to the instructions and examples in Section 5 for further clarification of what is meant by the terms "direct owner" and "indirect owner." If further assistance is needed in completing this section, contact the fiscal intermediary.

IMPORTANT **– Only Individuals should be reported in Section 6. Organizations must be reported in Section 5.**

1. Furnish the individual's name, title, date of birth, social security number, and Medicare identification number (if applicable).

NOTE: Section 1124A of the Social Security Act requires that the provider furnish Medicare with the individual's social security number.

2. Indicate the individual's relationship with the enrolling provider identified in Section 2B. If this individual has a title other than those listed in this section, check the "Other" box and specify the title used by this individual.

Example: A provider is 100% owned by Company C, which itself is 100% owned by Individual D. Assume that Company C is reported in Section 5B as an owner of the provider. Assume further that Individual D, as an indirect owner of the provider, is reported in Section 6A1. Based on this example, the provider would check the "5% or Greater Indirect Owner" box in Section 6A2.

B. Adverse Legal History - This section is to be completed with information concerning any adverse legal actions that have been imposed or levied against individuals reported in Section 6A. See Table A in Section 3 of this application for a list of adverse actions that must be reported.

If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. The provider must state whether the individual reported in Section 6A, under any current or former name or business identity, has ever had any of the adverse legal actions listed in Section 3 (Table A) of this form imposed against him or her.

2. If the answer to this question is "Yes," supply all requested information. Attach copy(s) of official documentation related to the adverse legal action. Such documentation includes adverse legal action notifications (e.g., notification of disciplinary action; criminal court documentation that verifies the conviction of a crime) and documents that evidence how the adverse legal action was finally resolved (e.g., reinstatement notices, etc.).

If the provider is uncertain as to whether this individual falls within one of the adverse legal action categories, the provider should query the Healthcare Integrity and Protection Data Bank. If the provider needs information on how to access the data bank, call 1-800-767-6732 or visit www.npdb-hipdb.com.

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6. Ownership Interest and/or Managing Control Information (Individuals)

This section is to be completed with information about any individual that has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the provider identified in Section 2B. All officers, directors, and managing employees of the provider must also be reported in this section. In addition, any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each individual.

A. Individual with Ownership Interest and/or Managing Control - Identification Information

☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.

Title	Date of Birth (MM/DD/YYYY)

Social Security Number	Medicare Identification Number (if applicable)

2. What is the above individual's relationship with the supplier in Section 2B? (Check all that apply.)

☐ 5% or Greater Direct Owner
☐ 5% or Greater Indirect Owner
☐ Other (Specify):_____
☐ Managing Employee
☐ Director/Officer
☐ Partner

B. Adverse Legal History ☐ **Change** **Effective Date:**_____

This section is to be completed for the individual reported in Section 6A above.

1. Has the individual in Section 6A above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against him or her? ☐ YES ☐ NO

2. IF YES, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:

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SECTION 7: CHAIN HOME OFFICE INFORMATION

All providers that are currently part of a chain organization or who are joining a chain organization must complete this section with information about the chain home office. This information will be used to ensure proper reimbursement when the provider year-end cost report is filed with the Medicare fiscal intermediary. It is important to furnish the information in this section to avoid overpayments and/or other administrative actions or penalties.

Chain organizations are generally defined as multiple providers owned, leased, or through any other devise, controlled by a single organization. The controlling organization is known as the chain "home office." Typically, the chain "home office":

- Maintains uniform procedures in each facility for handling admissions, utilization review, preparation and processing admission notices and bills, and
- Maintains and centrally controls individual provider cost reports and fiscal records. In addition, a major portion of the Medicare audit for each provider in the chain can be performed centrally at the chain "home office."

A few of the most common provider types that would typically be in a chain organization are Comprehensive Outpatient Rehabilitation Facilities (CORFs), Skilled Nursing Facilities (SNFs), and Home Health Agencies (HHAs).

A. Check Box - If this section does not apply to this provider, check the box provided and skip to Section 8.

B. Type of Action this Provider is Reporting - Check the appropriate box to indicate the type of action this provider is reporting about its relationship to the chain organization.

Check the:

- 1st box if this provider is enrolling in Medicare for the 1st time, or is undergoing a change of ownership. If this box is checked, complete this entire section.
- 2nd box if the provider is no longer associated with the chain organization previously reported. Furnish the effective date of this action, and identify the old chain home office in Section 7D.
- 3rd box if the provider has changed from one chain to another. Furnish the effective date of this action, and complete Section 7D with information about the NEW chain home office.
- 4th box if only the name of the chain home office is changing and all other information remains the same. Furnish the effective date of this action, and furnish the new chain home office name in Section 7D1.

C. Chain Home Office Administrator Information - If this section is being completed to report a change to the information previously reported about the chain home office administrator, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

- Furnish the name of the chain home office administrator, and his/her title, social security number, and date of birth.

D. Chain Home Office Information - If this section is being completed to report a change to the information previously reported about the chain home office, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. Furnish the legal business name of the chain home office as reported to the IRS.
2. Furnish the street address, telephone number, fax number, and e-mail address of the home office corporate headquarters. Do not give a P.O. Box or Drop Box address.
3. Furnish the home office tax identification number and the home office "cost report" year-end date.
4. Furnish the name of the home office fiscal intermediary and the home office chain number. If this is a new chain organization, furnish the name of the fiscal intermediary of choice for the home office and write "pending" in the space for chain number.

E. Type of Business Structure of the Chain Home Office - If this section is being completed to report a change to the information previously reported about the chain home office's business structure, check "Change," provide the effective date of the change, check the appropriate box in this section, and sign and date the certification statement. Otherwise:

- Check one of the choices given that best describes the home office business structure.

F. Provider's Affiliation to the Chain Home Office - If this section is being completed to report a change to the information previously reported about the provider's affiliation to the chain home office, check "Change," provide the effective date of the change, check the appropriate box, and sign and date the certification statement. Otherwise:

- Check the appropriate box to indicate how this provider is affiliated with the home office.

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7. Chain Home Office Information

This section is to be completed with information about the "Home Office" for those providers that are members of, or are joining, a chain organization.

A. Check here ☐ if this section does not apply and skip to Section 8.

B. Type of Action this Provider is Reporting

Check one:

☐ Provider in chain for first time (Initial Enrollment or Change of Ownership)

☐ Provider dropped out of current chain Effective date:_____

☐ Provider in a different chain since last report Effective date:_____

☐ Provider in same chain under new chain name Effective date:_____

C. Chain Home Office Administrator Information ☐ **Change** **Effective Date:**_____

Name of Home Office Administrator or CEO First	Middle	Last	Jr., Sr., etc.
Title of Home Office Administrator	Social Security Number	Date of Birth (MM/DD/YYYY)	

D. Chain Home Office Information ☐ **Change** **Effective Date:**_____

1. Name of Home Office as Reported to the IRS

2. Home Office Business Street Address Line 1 (Street Name and Number)

Home Office Business Street Address Line 2 (Suite, Room, etc.)

City	State	ZIP Code + 4
Telephone Number ( ) (Ext.) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

3. Home Office Tax Identification Number	Home Office Cost Report Year-End Date (MM/DD)
4. Home Office Intermediary	Home Office Chain Number

E. Type of Business Structure of the Chain Home Office ☐ **Change** **Effective Date:**_____

Check one:

Voluntary:

☐ Non-Profit – Religious Organization

☐ Non-Profit – Other (Specify):_____

Proprietary:

☐ Individual

☐ Corporation

☐ Partnership

☐ Other (Specify):_____

Government:

☐ Federal

☐ State

☐ City

☐ County

☐ City-County

☐ Hospital District

☐ Other (Specify below):

_____

F. Provider's Affiliation to the Chain Home Office ☐ **Change** **Effective Date:**_____

Check one:

☐ Joint Venture/Partnership ☐ Managed/Related ☐ Leased

☐ Operated/Related ☐ Wholly Owned ☐ Other (Specify):_____

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SECTION 8: BILLING AGENCY

The purpose of collecting this information is to develop effective monitoring of agents/agencies that prepare and/or submit claims to bill the Medicare program on behalf of the provider. A billing agency is a company or individual that the provider hires or contracts with to furnish claims processing functions for its business locations. Any entity that meets this description must be reported in this section.

A. Check Box - If this provider does not use a billing agency, check the box and skip to Section 10.

B. Billing Agency Name and Address - If reporting a change to information about a previously reported billing agency, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. Furnish the name and tax identification number of the billing agency.

2. Furnish the "doing business as" name of the billing agency.

3. Furnish the complete address and telephone number of the billing agency.

C. Billing Agreement/Contract Information - If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement.

The provider that is enrolling is responsible for responding to the questions listed.

These questions are designed to show that the provider fully understands and comprehends its billing agreement and that it intends to adhere to all Medicare laws, regulations, and program instructions. At any time, the fiscal intermediary or CMS may request copies of all agreements/contracts associated with this billing agency.

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8. Billing Agency

This section is to be completed with information about all billing agencies this provider uses or contracts with that submit claims to Medicare on the provider's behalf. If more than one billing agency is used, copy and complete this section for each. The provider may be required to submit a copy of its current signed billing agreement/contract if Medicare cannot verify the information in this section.

A. Check here ☐ if this section does not apply and skip to Section 10.

B. Billing Agency Name and Address ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Legal Business Name as Reported to the IRS	Tax Identification Number
2. "Doing Business As" Name (if applicable)	
3. Business Street Address Line 1	
Business Street Address Line 2	

City	State	ZIP Code + 4
Telephone Number (Ext.) ( ) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

C. Billing Agreement/Contract Information ☐ **Change** **Effective Date:**_____

Answer the following questions about the provider's agreement/contract with the above billing agency.

1. Does the provider have unrestricted access to its Medicare remittance notices? ☐ YES ☐ NO
2. Does the provider's Medicare payment go directly to the provider? ☐ YES ☐ NO
   IF NO, proceed to Question 3.
   IF YES, skip Questions 3, 4 and 5.
3. Does the provider's Medicare payment go directly to a bank? ☐ YES ☐ NO
   IF NO, proceed to Question 4.
   IF YES, answer the following questions and skip Questions 4 and 5.
   a) Is the bank account only in the name of the provider? ☐ YES ☐ NO
   b) Does the provider have unrestricted access to the bank account and statements? ☐ YES ☐ NO
   c) Does the bank only answer to the provider regarding what the provider wants from the bank (e.g., sweep account instructions, bank statements, closing account, etc.)? ☐ YES ☐ NO
4. Does the provider's Medicare payment go directly to the billing agent? ☐ YES ☐ NO
   IF NO, proceed to Question 5.
   IF YES, answer the following question and skip Question 4.
   a) Does the billing agent cash the provider's check? ☐ YES ☐ NO
      IF NO, proceed to Question b.
      IF YES, are <u>all</u> of the following conditions included in the billing agreement? ☐ YES ☐ NO
      1) The agent receives payment under an agency agreement with the provider. ☐ YES ☐ NO
      2) The agent's compensation is not related in any way to the dollar amounts billed or collected. ☐ YES ☐ NO
      3) The agent's compensation is not dependent upon the actual collection of payment. ☐ YES ☐ NO
      4) The agent acts under payment disposition instructions that the provider may modify or revoke at any time. ☐ YES ☐ NO
      5) In receiving payment, the agent acts only on behalf of the provider (except insofar as the agent uses part of that payment as compensation for the agent's billing and collection services). ☐ YES ☐ NO
   b) Does the billing agent either give the Medicare payment directly to this provider or deposit the payment into this provider's bank account? ☐ YES ☐ NO
5. Who receives the provider's Medicare payment?_____

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SECTION 9: FUTURE USE

This section is being reserved for possible future use.

SECTION 10: STAFFING COMPANY

The purpose of collecting this data is to develop effective internal controls to promote adherence to applicable Federal and State laws.

A staffing company is an organization that contracts with health care professionals to furnish health care at medical facilities (such as hospital emergency rooms) where it is also under contract (or some similar agreement) to furnish such. A staffing company cannot bill Medicare in the staffing company's name for medical services or supplies furnished under this arrangement. If the provider has an agreement/contract with a staffing company to furnish services to Medicare beneficiaries, complete this section. At any time, the fiscal intermediary may request a copy of the agreement/contract signed by the provider and the staffing company.

NOTE: If the provider uses a staffing company but the individual physicians or non-physician practitioners reassign their benefits directly to the provider this section does not need to be completed. If the staffing company acts as the billing agent for the physicians or non-physician practitioners it should be reported in Section 8.

A. Check Box - If the provider does not use a staffing company, check the box provided and skip to Section 11.

B. 1st Staffing Company Name and Address - Indicate if this provider is making a change concerning its relationship with a staffing company by checking the appropriate box "add," "delete," or "change." Provide the new information and the effective date of the change, and sign and date the certification statement. Otherwise:

1. Furnish the legal business name and tax identification number of the staffing company.

2. If applicable, furnish the staffing company's "doing business as" (DBA) name. If the reported staffing company uses more than one DBA name with this provider, report all that apply for Medicare claims.

3. Furnish the complete mailing address, telephone number, fax number and e-mail address for the staffing company.

C. 1st Staffing Company Contract/Agreement Information - The enrolling provider must respond to the questions listed to verify that it fully understands and comprehends its contract and that it plans to adhere to all Medicare laws, regulations, and program instructions. At any time, the fiscal intermediary or carrier can request a copy of the agreement/contract signed by the provider and the staffing company.

D-E. 2nd Staffing Company - Sections D and E are to be used to report information on a 2nd staffing company that the provider may be working for (or under contract with) to provide medical services. See instructions for Sections B and C above.

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9. Future Use — This Section Not Applicable

10. Staffing Company

This section is to be completed with information about all staffing companies that this provider uses, either under written contract or by an unwritten agreement. If this provider uses more than one staffing company, copy and complete this section for each. The provider may be required to submit a copy of its current signed staffing company agreement/contract.

A. Check here ☐ if this section does not apply and skip to Section 11.

B. 1st Staffing Company Name and Address ☐ Add ☐ Delete ☐ Change Effective Date:_____

1. Legal Business Name as Reported to the IRS	Tax Identification Number
2. "Doing Business As" Name (if applicable)	
3. Business Street Address Line 1	
Business Street Address Line 2	

City	State	ZIP Code + 4
Telephone Number (Ext.) ( ) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

C. 1st Staffing Company Contract/Agreement Information

Answer the following questions about the staffing company and the provider's contract/agreement with them.

1. Does the staffing company shown in Section 10B above **and** the billing agency identified in Section 8B have a common owner(s)? ☐ YES ☐ NO
2. If applicable, are there any provisions in the staffing company contract/agreement that supersede or contradict the enrolling provider's billing agreement? ☐ Not applicable ☐ YES ☐ NO
3. What department(s) of this provider does this company staff?_____ _____

D. 2nd Staffing Company Name and Address ☐ Add ☐ Delete ☐ Change Effective Date:_____

1. Legal Business Name as Reported to the IRS	Tax Identification Number
2. "Doing Business As" Name (if applicable)	
3. Business Street Address Line 1	
Business Street Address Line 2	

City	State	ZIP Code + 4
Telephone Number (Ext.) ( ) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

E. 2nd Staffing Company Contract/Agreement Information

Answer the following questions about the staffing company and the provider's contract/agreement with them.

1. Does the staffing company shown in Section 10D above **and** the billing agency identified in Section 8B have a common owner(s)? ☐ YES ☐ NO
2. If applicable, are there any provisions in the staffing company contract/agreement that supersede or contradict the enrolling provider's billing agreement? ☐ Not applicable ☐ YES ☐ NO
3. What department(s) of this provider does this company staff?_____ _____

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SECTION 11: SURETY BOND INFORMATION

This section is to be completed by those provider types mandated by law to obtain a surety bond in order to enroll in and bill the Medicare program. Furnish all requested information about the provider's insurance agent, surety company, and the surety bond. To determine which provider types currently require a surety bond, check the CMS web-site, or contact the local State Agency or provider group association. Provider types that may be required to obtain a surety bond are home health agencies, comprehensive outpatient rehabilitation facilities, and rehabilitation agencies.

The surety bond must be an annual bond, continuous bond, or a government security in lieu of a bond (i.e., a Treasury note, United States bond, or other Federal public debt obligation). Annual surety bond renewals must be reported to the fiscal intermediary on a timely basis to ensure continuance of claim payments. A certified true or notarized copy of the original surety bond must be submitted with this application. Failure to submit the surety bond will prevent the processing of this application. If an insurance agent or an insurance broker issues the bond, the provider must supply a certified copy of the agent's Power of Attorney with this application.

A. Check Box – Check the box if this provider is not required to obtain a surety bond for Medicare enrollment and skip to Section 12.

B. Check Box - Check the box if this provider qualifies for an exemption as a government entity and skip to Section 12

If this provider believes it is government-operated and entitled to an exemption to the surety bond requirement, the provider must furnish a letter signed by a government official of the Federal, State, local or Tribal Government (on official government letterhead), asserting that the government agency/tribe will back the debts owed by this provider in full faith and credit of the government/tribe. This letter can be the same letter that is referred to in Section 5 of these instructions. Otherwise, a surety bond **must** be obtained prior to participating in the Medicare program.

C. Name and Address of Surety Bond Company - If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. Furnish the legal business name and tax identification number of the surety bond company liable for this bond.
2. Furnish the complete business address, telephone number and e-mail address of the surety bond company.

D. Name and Address of Insurance Agency/Broker - If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. Provide the legal business name of the agency that issued the bond.
2. Provide the name of the individual agent who issued the bond for the bond agency.
3. Furnish the complete business address, telephone number and e-mail address of the agency.

E. Surety Bond Information - If the supplier has a Government Security check "Not Applicable" and skip to Section F below. If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise, complete this section with specific information about the bond as follows:

1. State the dollar amount of the bond and the bond number.
2. Furnish the effective date of the bond. If reporting a new bond or new surety bond company, furnish the expiration date of the current bond.
3. Indicate if the bond is renewed annually or if it is continuous.
4. Indicate if this is a "Dual Obligee Bond." A dual obligee bond is issued when a provider bills both the Medicare and Medicaid programs.

F. Government Security - If the supplier has a Surety Bond check "Not Applicable," skip this section and complete Section E above. If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise, complete this section with specific information about the government security as follows:

1. State the amount of the bond, the effective date, and the Federal Reserve Account number.
2. Check the appropriate box indicating the type and duration for which the government security will be effective.

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11. Surety Bond Information

This section is to be completed by providers mandated by law to obtain a surety bond in order to enroll in and bill the Medicare program. See instructions to determine whether this provider is required to obtain a surety bond. Furnish all requested information about the provider's insurance agent, surety company, and the surety bond.

A. Check here ☐ if this section does not apply and skip to Section 12.

B. Check here ☐ if this provider qualifies for a waiver of the bond requirement based on its operation as a government entity. See instructions for specific documentation requirements and skip to Section 12.

C. Name and Address of Surety Bond Company ☐ **Change**		**Effective Date:**_____
1. Legal Business Name of Surety Bond Company as Reported to the IRS		Tax Identification Number
2. Business Address Line 1 (Street Name and Number)		
Business Address Line 2 (Suite, Room, etc.)		
City	State	ZIP Code + 4
Telephone Number (Ext.) ( ) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

D. Name and Address of Insurance Agency/Broker		
☐ **Add** ☐ **Delete** ☐ **Change**		**Effective Date:**_____
1. Legal Business Name of Agency/Broker as Reported to the IRS		
2. Name of Individual Agent		
3. Business Address Line 1 (Street Name and Number)		
Business Address Line 2 (Suite, Room, etc.)		
City	State	ZIP Code + 4
Telephone Number (Ext.) ( ) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

E. Surety Bond Information ☐ **Not Applicable** ☐ **Change**		**Effective Date:**_____
1. Amount of Surety Bond $		Surety Bond Number
2. Effective Date of Surety Bond (MM/DD/YYYY)		If reporting a new bond, give cancellation date of the current bond (MM/DD/YYYY)
3. Is the surety bond:	☐ Annual? (or)	☐ Continuous?
4. Check here ☐ if this is a Medicare/Medicaid "Dual Obligee Surety Bond."		

F. Government Security ☐ **Not Applicable** ☐ **Change**		**Effective Date:**_____
If a government security has been purchased, furnish the following information.		
1. Amount $	Effective Date (MM/DD/YYYY)	Federal Reserve Bank Account Number

2. Check the appropriate box below:

a) Is the Treasury Bill: ☐ Not Applicable ☐ 3 months? ☐ 6 months? ☐ 1 year?

b) Is the Treasury Note: ☐ Not Applicable ☐ 2 years? ☐ 5 years? ☐ 10 years?

c) Is the government security a 30-year Treasury Bond? ☐ YES ☐ NO ☐ Not Applicable

Note: If the government security is less than one year in duration, the provider must submit proof of the renewable government security at least 14 days prior to the expiration date.

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SECTION 12: CAPITALIZATION REQUIREMENTS FOR HOME HEALTH AGENCIES (HHAs)

All HHAs and HHA sub-units enrolling in the Medicare program must complete this section. HHAs and HHA sub-units initially enrolling in Medicare, Medicaid, or both programs on or after January 1, 1998 are required to provide documentation supporting that they have sufficient initial reserve operating funds (capitalization) to operate for the first three months of operation in the Medicare and/or Medicaid program(s). The capitalization requirement applies to all HHAs and HHA sub-units that are enrolling in the Medicare program, including HHAs or HHA sub-units currently participating in the Medicare program that, as a result of a change of ownership, will be issued a new provider number. The capitalization requirement does not apply to a branch of an HHA. Regulations found at 42 CFR 489.28 require that an intermediary determine the required amount of reserve operating funds needed for the enrolling HHA or HHA sub-unit by comparing the enrolling HHA or HHA sub-unit to at least three other new HHAs that it serves which are comparable to the enrolling HHA or HHA sub-unit. Factors to be considered are geographic location, number of visits, type of HHA or HHA sub-unit and business structure of the HHA or HHA sub-unit. The fiscal intermediary then verifies that the enrolling HHA or HHA sub-unit has the required funds. To assist the fiscal intermediary in determining the amount of funds necessary, the enrolling HHA or HHA sub-unit should complete this section. For additional information on capitalization requirements, see Volume 63, Number 2 of the Federal Register published on January 5, 1998, beginning at page 292.

A. Check Box - Check the box provided if this section does not apply and skip to Section 13.

B. Type of Home Health Agency - Check the appropriate box to indicate if this HHA is operated as a non-profit agency, or a proprietary (for-profit) agency.

C. Projected Number of Visits by this Home Health Agency - Furnish the number of visits this HHA projects it will make during the first (next) three months of operations and the first (next) 12 months of operations. If this is an established HHA that is currently providing services, furnish the projected number of visits for the next three and twelve months, beginning with next month.

D. Financial Documentation - Although not required with this application, in order to expedite the enrollment process the HHA may attach a copy of its most current savings, checking or other financial statement(s) that verifies the initial reserve operating funds.

1. These documents should be submitted with:

   a) An attestation from an officer of the bank or other financial institution stating that the funds are in the account(s) and are immediately available for the HHA's use, and

   b) Certification from the HHA regarding any borrowed funds.

2. Indicate whether or not the HHA will be submitting the required documentation (financial statements and attestations) with this application.

NOTE: If the HHA chooses not to submit the above documents with this application, the HHA will be requested to do so prior to being issued a Medicare billing number.

E. Additional Information

Use this space to explain or justify any unique financial situations of this HHA that may be helpful in determining the HHA's compliance with the capitalization requirements.

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12. Capitalization Requirements for Home Health Agencies (HHAs)

This section is to be completed by Home Health Agencies with information about capitalization. As of January 1, 1998 all HHAs are required to provide documentation verifying that they have sufficient initial reserve operating funds (capitalization) to operate for the first three months of operation in the Medicare program. See instructions for further details on capitalization requirements.

A. Check here ☐ if this section does not apply and skip to Section 13.

B. Type of Home Health Agency

Check one: ☐ Non-profit Agency ☐ Proprietary Agency

C. Projected Number of Visits by this Home Health Agency

How many visits does this HHA project it will make in the first: three months of operation?_____
twelve months of operation?_____

D. Financial Documentation

1. Although not required to be submitted concurrently with this application, in order to expedite the enrollment process the HHA may attach a copy of its most current savings, checking or other financial statement(s) that verifies the initial reserve operating funds, accompanied by:
   a) An attestation from an officer of the bank or other financial institution stating that the funds are in the account(s) and are immediately available for the HHA's use, and
   b) Certification from the HHA attesting that at least 50% of the reserve operating funds are non-borrowed funds.

2. Will the HHA be submitting the above documentation with this application? ☐ YES ☐ NO

NOTE: The Fiscal Intermediary may require a subsequent attestation that the funds are still available. If the Fiscal Intermediary determines that the HHA requires funds in addition to those indicated on the originally submitted account statement(s), it will require verification of the additional amount as well as a new attestation statement.

E. Additional Information

Provide any additional information, either in the space below or through documentation, necessary to assist the fiscal intermediary or State agency in properly comparing this HHA with other comparable HHAs.

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SECTION 13: CONTACT PERSON(S)

To assist in the timely processing of the provider's application, provide the full name, e-mail address, telephone number, and mailing address of an individual who can be reached to answer questions regarding the information furnished in this application (preferably the individual who completed this application). The provider is not required to furnish a contact person in this section. It should be noted that if a contact person is not provided, all questions about this application will be directed to the authorized official named in Section 15B.

A. Check Box - If this section does not apply, check the box and skip to Section 14.

B. Contact Person Information – If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

- Provide the name, e-mail address, telephone number, and mailing address of an individual who can answer questions about the information furnished in this application.

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION ON THIS ENROLLMENT APPLICATION

The provider should review this section to understand those penalties that can be applied against it for deliberately furnishing false information to enroll or maintain enrollment in the Medicare program.

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13. Contact Person(s)

Furnish the name(s) and telephone number(s) of a person(s) who can answer questions about the information furnished in this application (preferably the individual who completed this application). If a contact person is not reported in this section, all questions will be directed to the authorized official named in Section 15B.

A. Check here ☐ if this section does not apply and skip to Section 14.

B. Contact Name and Telephone Number ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:_____**

Name: First	Last	
Address Line 1 (Street Name and Number)		
Address Line 2 (Suite, Room, etc.)		
City	State	ZIP Code + 4
E-mail Address (if applicable)	Telephone Number ( )	(Ext.) ( )

14. Penalties for Falsifying Information on this Enrollment Application

This section explains the penalties for deliberately furnishing false information in this application to gain or maintain enrollment in the Medicare program.

1. 18 U.S.C. § 1001 authorizes criminal penalties against an individual who, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry.

Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000 (18 U.S.C. § 3571). Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against any individual who, "knowingly and willfully," makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program.

The offender is subject to fines of up to $25,000 and/or imprisonment for up to five years.

3. The Civil False Claims Act, 31 U.S.C. § 3729, imposes civil liability, in part, on any person who:

a.) knowingly presents, or causes to be presented, to an officer or any employee of the United States Government a false or fraudulent claim for payment or approval;

b.) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or

c.) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

The Act imposes a civil penalty of $5,000 to $10,000 per violation, plus three times the amount of damages sustained by the Government.

4. Section 1128A(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency...a claim...that the Secretary determines is for a medical or other item or service that the person knows or should know:

a.) was not provided as claimed; and/or

b.) the claim is false or fraudulent.

This provision authorizes a civil monetary penalty of up to $10,000 for each item or service, an assessment of up to three times the amount claimed, and exclusion from participation in the Medicare program and State health care programs.

5. The government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment."

Remedies include compensatory and punitive damages, restitution, and recovery of the amount of the unjust profit.

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SECTION 15: CERTIFICATION STATEMENT

This section is used to officially notify the provider of additional requirements that must be met and maintained in order for the provider to be enrolled in the Medicare program. This section also requires the signature and date signed of an authorized official who can legally and financially bind the provider to the laws, regulations, and program instructions of the Medicare program. Section 16 permits the authorized official to delegate signature authority to certain individual(s) (delegated officials) for the purpose of reporting changes to the provider's enrollment record after the provider has been enrolled. The provider may have no more than one currently active authorized official at any given time. See 15B below to determine who within the provider organization qualifies as an authorized official.

A. Additional Requirements for Medicare Enrollment – These are the additional requirements that must be met and maintained by the provider to enroll in and bill the Medicare program. Carefully read these requirements. By signing, the provider will be attesting to having read these requirements and that the provider understands them.

B. 1st Authorized Official Signature - If adding a new, or deleting an existing authorized official, check the appropriate box and indicate the effective date of that change.

NOTE: The authorized official must also be reported in Section 6.

- The authorized official must sign and date this application.

By his/her signature, the authorized official binds the provider to all of the requirements listed in the Certification Statement and acknowledges that the provider may be denied entry to or revoked from the Medicare program if any requirements are not met. **All signatures must be original.** Faxed, photocopied, or stamped signatures will not be accepted.

C. 2nd Authorized Official Signature - This section provided to report a second (optional) authorized official for this provider. See instructions above for Section 15B.

An authorized official is an appointed official to whom the provider has granted the legal authority to enroll it in the Medicare program, to make changes and/or updates to the provider's status in the Medicare program (e.g., new practice locations, change of address, etc.), and to commit the provider to fully abide by the laws, regulations, and program instructions of Medicare. The authorized official must be the provider's general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of 5% or more of the provider (see Section 5 for definition of a "direct owner"), or must hold a position of similar status and authority within the provider's organization.

Only the authorized official has the authority to sign (1) the initial CMS 855A enrollment application on behalf of the provider and (2) the CMS 855A enrollment application that must be submitted as part of the periodic revalidation process. The delegated official has no such authority.

By signing this form for initial enrollment in the Medicare program or for revalidation purposes, the authorized official agrees to immediately notify the fiscal intermediary if any information in the application is not true, correct, or complete. In addition, the authorized official, by his/her signature, agrees to notify the fiscal intermediary of any future changes to the information contained in this form, after the provider is enrolled in Medicare, within 90 days of the effective date of the change.

Governmental/Tribal Organizations

As stated in the instructions for Governmental/Tribal Organizations in Section 5, the authorized official signing the CMS 855A in Section 15 must be the same person submitting the letter attesting that the governmental or tribal organization will be legally and financially responsible for any outstanding debts owed to CMS. For instance, the head of a County Department of Health and Human Services would ordinarily qualify as an authorized official of the governmental entity.

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SPECIAL REPORTING REQUIREMENTS

To change authorized officials, the provider must:

- Check the "Delete" box in Section 15B,
- Provide the effective date of the deletion, and
- Have the authorized official being deleted provide his/her printed name, signature, and date of signature.

NOTE: If the current authorized official's signature is unattainable (e.g., person has left the company), the Medicare contractor may request documentation verifying that the person is no longer the authorized official.

To then add a new authorized official, the provider must:

- Copy the page containing the Certification Statement,
- Check the "Add" box in Section 15B and provide the effective date of the addition,
- Have the new authorized official provide the information requested in 15B, and
- Have the new authorized official provide his/her signature and date of signature.

By signing his or her name, the new authorized official assumes from the prior authorized official all of the powers (e.g., the power to delegate authority to a delegated official, etc.) previously held by the latter, and also agrees to adhere to all Medicare requirements, including those outlined in Sections 15A and 15B of the Certification Statement. However, a change of the authorized official has no bearing on the authority of existing delegated officials to make changes and/or updates to the provider's status in the Medicare program.

If the provider is reporting a change of information about the current authorized official (e.g., change in job title), this section should be completed as follows:

- Check the box to indicate a change and furnish the effective date,
- Provide the new information, and
- Have the authorized official sign and date this section.

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15. Certification Statement

This section is used to officially notify the provider of additional requirements that must be met and maintained in order for the provider to be enrolled in the Medicare program. This section also requires the signature and date signed of an "Authorized Official" who can legally and financially bind the provider to the laws, regulations, and program instructions of the Medicare program. Section 16 permits the "Authorized Official" to delegate signature authority to other individual(s) (Delegated Officials) employed by the provider for the purpose of reporting future changes to the provider's enrollment record. See instructions to determine who within the provider qualifies as an Authorized Official and a Delegated Official.

A. Additional Requirements for Medicare Enrollment

By his/her signature(s), the authorized official named below and the delegated official(s) named in Section 16 agree to adhere to the following requirements stated in this Certification Statement:

1.) I agree to notify the Medicare contractor of any future changes to the information contained in this form within 90 days of the effective date of the change. I understand that any change in the business structure of this provider may require the submission of a new application.
2.) I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare billing number(s), and/or the imposition of fines, civil damages, and/or imprisonment.
3.) I agree to abide by the Medicare laws, regulations, and program instructions that apply to this provider. The Medicare laws, regulations, and program instructions are available through the Medicare contractor.
4.) Neither this provider, nor any 5% or greater owner, partner, officer, director, managing employee, authorized official, or delegated official thereof is currently sanctioned, suspended, debarred, or excluded by the Medicare or Medicaid program, or any other Federal program, or is otherwise prohibited from providing services to Medicare or other Federal program beneficiaries.
5.) I agree that any existing or future overpayment made to the provider by the Medicare program may be recouped by Medicare through the withholding of future payments.
6.) I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.
7.) I authorize the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Osteopathic Association (AOA), or any other national accrediting body whose standards are recognized by the Secretary as meeting the Medicare program participation requirements, to release to any authorized representative, employee, or agent of the Centers for Medicare & Medicaid Services (CMS), a copy of my most recent accreditation survey, together with any information related to the survey that CMS may require (including corrective action plans).

B. 1st Authorized Official Signature ☐ **Add** ☐ **Delete** **Effective Date:**_____

I have read the contents of this application. My signature legally and financially binds this provider to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete to the best of my knowledge, and I authorize the Medicare program contractor to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare program contractor of this fact immediately.

Authorized Official Name **Print** First	Middle	Last	Jr., Sr., etc.
Authorized Official **Signature** (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)		Title/Position	Date (MM/DD/YYYY) Signed

C. 2nd Authorized Official Signature ☐ **Add** ☐ **Delete** **Effective Date:**_____

I have read the contents of this application. My signature legally and financially binds this provider to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete to the best of my knowledge, and I authorize the Medicare program contractor to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare program contractor of this fact immediately.

Authorized Official Name **Print** First	Middle	Last	Jr., Sr., etc.
Authorized Official **Signature** (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)		Title/Position	Date (MM/DD/YYYY) Signed

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SECTION 16: DELEGATED OFFICIAL (OPTIONAL)

A delegated official must be a W-2 managing employee of the provider, or an individual with a 5% or greater direct ownership interest in, or any partnership interest in, the enrolling provider. Delegated officials are persons who are delegated the legal authority by the authorized official reported in Section 15B to make changes and/or updates to the provider's status in the Medicare program. This individual must also be able to commit the provider to fully abide by the laws, regulations, and program instructions of Medicare. For purposes of this section only, if the individual being assigned as a delegated official is a managing employee, that individual **must** be an actual W-2 employee of the enrolling provider. The Medicare contractor may request evidence indicating that the delegated official is an actual employee of the provider. Independent contractors are not considered "employed" by the provider. A provider can have no more than three delegated officials at any given time.

The signature of the authorized official in Section 16B2 constitutes a legal delegation of authority to any and all delegated official(s) assigned in Section 16.

A. Check Box - If the provider chooses not to assign any delegated officials in this application, check the box in this section. There is no requirement that the provider have a delegated official. However, if no delegated officials are assigned, the authorized official will be the only person who can make changes and/or updates to the provider's status in the Medicare program. All delegated officials must meet the following requirements:

- The delegated official must sign and date this application.
- The delegated official must furnish his/her title/position, and
- The delegated official must check the box furnished if they are a W-2 employee.

NOTE: Section 6 **MUST** be completed for **all** delegated officials. This requirement also includes delegated officials of a hospital that indicated it has a compliance plan and did not report any managing individuals in Section 6.

B. Delegated Official Signature

If the provider chooses to add delegated officials or to delete existing ones, this section should be completed as follows:

- Check the appropriate box indicating if the delegated official is being added or deleted and furnish the effective date,
- The authorized official must provide his or her signature and date of signature in Sections 15B and 16B2,
- The delegated official(s) to be added must provide the information and their signature in Section 16B, and
- The delegated official(s) to be deleted does not have to sign or date the application.

NOTE: All signatures must be original. Faxed, photocopied, or stamped signatures will not be accepted.

If the provider is reporting a change of information about an existing delegated official (e.g., change in job title), this section should be completed as follows:

- Check the box marked "Change" and furnish the effective date,
- Provide the new information, and
- The authorized official must sign and date Sections 15B and 16B2.

Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the provider's Medicare status. Even when delegated officials are reported in this application, an authorized official retains the authority to make any such changes and/or updates by providing his or her printed name, signature, and date of signature as required in Section 15B.

In addition, the delegated official, by his/her signature, agrees to notify the Medicare contractor of any changes to the information contained in this application within 90 days of the effective date of the change.

B. 2nd Delegated Official Signature - This section provided to report a second (optional) delegated official for this provider. See instructions above for Section 15B.

C. 3rd Delegated Official Signature - This section provided to report a third (optional) delegated official for this provider. See instructions above for Section 15B.

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SECTION 17: ATTACHMENTS

This section contains a list of documents that, if applicable, must be submitted with this enrollment application. Failure to provide the required documents will delay the enrollment process.

- Check the appropriate boxes indicating which documents are being submitted with this application.

NOTE: The licenses, certifications and registrations which must be submitted with this application are those required by Medicare and the State to function as the provider type for which this provider is enrolling (e.g., CLIA and FDA mammography certificates, hazardous waste disposal license, etc.). Local licenses/permits that are not of a medical nature are not required but any business license required to operate as a health care facility **must** be included with this application. Required documents that can only be obtained after a State Survey are not required as part of the application submission but **must** be furnished within 30 days of the provider receiving them. The Medicare contractor will furnish specific licensing requirements for your provider type upon request.

In lieu of copies of the above-requested documents, the enrolling provider may submit a notarized Certificate of Good Standing from the provider's State licensing/certification board or other medical associations. This certification cannot be more than 30 days old.

If the enrolling provider has had a previously revoked or suspended license, certification, or registration reinstated, attach a copy of the reinstatement notice with this application.

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16. Delegated Official (Optional)

The signature of the authorized official below constitutes a legal delegation of authority to the official(s) named in this section to make changes and/or updates to this provider's enrollment information. The signature(s) of the delegated official(s) shall have the same force and effect as that of the authorized official, and shall legally and financially bind the provider to all the laws, regulations, and program instructions of the Medicare program. By his or her signature, the delegated official certifies that he or she has read the Certification Statement in Section 15 and agrees to adhere to all of the stated requirements. The delegated official also certifies that he/she meets the definition of a delegated official. When making changes and/or updates to the provider's enrollment information maintained by the Medicare program, the delegated official certifies that the information provided is true, correct, and complete to the best of his/her knowledge. If assigning more than one delegated official (maximum of three), copy and complete this section as needed.

A. Check here ☐ if this provider will not be assigning any delegated official(s) and skip to Section 17.

B. 1st Delegated Official Signature ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Delegated Official Name **Print** First	Middle	Last	Jr., Sr., etc.
Delegated Official **Signature** (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed
Title/Position	☐Check here only if Delegated Official is a W-2 employee		
2. **Signature** of Authorized Official Assigning this Delegation (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed

C. 2nd Delegated Official Signature ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Delegated Official Name **Print** First	Middle	Last	Jr., Sr., etc.
Delegated Official **Signature** (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed
Title/Position	☐Check here only if Delegated Official is a W-2 employee		
2. **Signature** of Authorized Official Assigning this Delegation (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed

D. 3rd Delegated Official Signature ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Delegated Official Name **Print** First	Middle	Last	Jr., Sr., etc.
Delegated Official **Signature** (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed
Title/Position	☐Check here only if Delegated Official is a W-2 employee		
2. **Signature** of Authorized Official Assigning this Delegation (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed

17. Attachments

This section is a list of documents that, if applicable, should be submitted with this completed enrollment application.

Place a check next to each document (as applicable or required) from the list below that is being included with this completed application.

☐Copy(s) of all CLIA Certificates, FDA Mammography Certificates, and Diabetes Education Certificates
☐Copy(s) of all State Pharmacy licenses
☐Copy(s) of all adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters)
☐Copy(s) of all surety bonds and/or Agent's Power of Attorney
☐Copy(s) of all sales agreements (CHOWS, Acquisitions/Mergers, and Consolidations only) (2 copies)
☐Copy(s) of all documents that demonstrate meeting capitalization requirements (HHAs only)
☐Completed Form HCFA-588-Authorization Agreement for Electronic Funds Transfer
☐IRS documents confirming the tax identification number and legal business name (e.g., CP 575)
☐Any additional documentation or letters of explanation as needed

MEDICARE

FEDERAL HEALTH CARE
PROVIDER/SUPPLIER ENROLLMENT APPLICATION

Application for Health Care Suppliers that will Bill Medicare Carriers

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB Approval No. 0938-0685

Keep a copy of this completed package for your own records

Upon completion, return this application and all necessary documentation to:

OMB Approval No. 0938-0685

Medicare Provider/Supplier Enrollment Application

Privacy Act Statement

The Centers for Medicare and Medicaid Services (CMS) is authorized to collect the information requested on this form by sections 1124(a)(1), 1124A(a)(3), 1128, 1814, 1815, 1833(e), and 1842(r) of the Social Security Act [42 U.S.C. §§ 1320a-3(a)(1), 1320a-7, 1395f, 1395g, 1395(l)(e), and 1395u(r)] and section 31001(1) of the Debt Collection Improvement Act [31 U.S.C. § 7701(c)].

The purpose of collecting this information is to determine or verify the eligibility of individuals and organizations to enroll in the Medicare program as providers/suppliers of goods and services to Medicare beneficiaries and to assist in the administration of the Medicare program. This information will also be used to ensure that no payments will be made to providers or suppliers who are excluded from participation in the Medicare program. All information on this form is required, with the exception of those sections marked as "optional" on the form. Without this information, the ability to make payments will be delayed or denied.

The information collected will be entered into the Provider Enrollment, Chain and Ownership System (PECOS), and either system number 09-70-0525 titled Unique Physician/Practitioner Identification Number (UPIN) System (published in Vol. 61 of the Federal Register at page 20,528 (May 7, 1996)), or the National Provider Identifier (NPI) System, Office of Management and Budget (OMB) approval 0938-0684 (R-187). The information in this application will be disclosed according to the routine uses described below.

Information from these systems may be disclosed under specific circumstances to:

1) CMS contractors to carry out Medicare functions, collating or analyzing data, or to detect fraud or abuse;
2) A congressional office from the record of an individual health care provider/supplier in response to an inquiry from the congressional office at the written request of that individual health care practitioner;
3) The Railroad Retirement Board to administer provisions of the Railroad Retirement or Social Security Acts;
4) Peer Review Organizations in connection with the review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XVIII of the Social Security Act;
5) To the Department of Justice or an adjudicative body when the agency, an agency employee, or the United States Government is a party to litigation and the use of the information is compatible with the purpose for which the agency collected the information;
6) To the Department of Justice for investigating and prosecuting violations of the Social Security Act, to which criminal penalties are attached;
7) To the American Medical Association (AMA), for the purpose of attempting to identify medical doctors when the Unique Physician Identification Number Registry is unable to establish identity after matching contractor submitted data to the data extract provided by the AMA;
8) An individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, or to the restoration or maintenance of health;
9) Other Federal agencies that administer a Federal health care benefit program to enumerate/enroll providers/suppliers of medical services/supplies or to detect fraud or abuse;
10) State Licensing Boards for review of unethical practices or non-professional conduct;
11) States for the purpose of administration of health care programs; and/or
12) Insurance companies, self insurers, health maintenance organizations, multiple employer trusts, and other health care groups providing health care claims processing, when a link to Medicare or Medicaid claims is established, and data are used solely to process provider's/supplier's health care claims.

The enrolling provider or supplier should be aware that the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503) amended the Privacy Act, 5 U.S.C. § 552a, to permit the government to verify information through computer matching.

Protection of Proprietary Information

Privileged or confidential commercial or financial information collected in this form is protected from public disclosure by Federal law 5 U.S.C. § 552(b)(4) and Executive Order 12600.

Protection of Confidential Commercial and/or Sensitive Personal Information

If any information within this application (or attachments thereto) constitutes a trade secret or privileged or confidential information (as such terms are interpreted under the Freedom of Information Act and applicable case law), or is of a highly sensitive personal nature such that disclosure would constitute a clearly unwarranted invasion of the personal privacy of one or more persons, then such information will be protected from release by CMS under 5 U.S.C. §§ 552(b)(4) and/or (b)(6), respectively.

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INSTRUCTIONS FOR HEALTH CARE SUPPLIERS THAT WILL BILL MEDICARE CARRIERS

Please **PRINT** or **TYPE** all information so it is legible. Do not use pencil. Failure to provide all requested information may cause the application to be returned and may delay the enrollment process. Certain sections of the application have been omitted because they do not apply to suppliers. See inside front cover for mailing instructions. Electronic copies of all CMS Medicare enrollment forms can be found at the Medicare website at http://www.cms.hhs.gov. These electronic forms may be downloaded to your computer, completed on screen, printed, signed, and mailed to the appropriate Medicare contractor.

Whenever additional information needs to be reported within a section, copy and complete that section for each additional entry. We strongly suggest maintaining a photocopy of this completed application and supporting documents for future reference.

This application is to be completed by all suppliers that will bill Medicare carriers for medical services provided to Medicare beneficiaries. Failure to promptly submit a completed form CMS 855B to the carrier will result in delays in obtaining enrollment and billing privileges.

This form is also used to enroll physician(s), non-physician practitioner(s) and other health care providers/suppliers who form a practice together and bill Medicare as a single supplier. This includes incorporated individuals, partnerships, groups, organizations and corporations, hereafter referred to as "organizations." An individual whose business is incorporated, has received a tax identification number for the business, and receives Medicare payment in the name of the business would qualify as an organization. Partnership agreements may be requested by the carrier on an "as needed" basis to determine if the partnership meets State requirements. If a supplier has individual practitioners, each member of the supplier must receive his or her own Unique Physician Identification Number (UPIN) and enroll as an individual (using the Application for Individual Health Care Practitioners, CMS 855I). Once the individual practitioner is enrolled, he/she can enroll as a member of an organization. When joining an organization every member of the organization must complete a copy of the CMS 855R (Individual Reassignment of Benefits).

In addition to completing this enrollment application, the supplier may wish to submit additional forms in the following situations:

- To accept assignment of the Medicare Part B payment for all services the supplier renders, the organization should complete the form "Medicare Participating Physician or Supplier Agreement" (Form HCFA-460).
- To have Medicare payments sent electronically to a supplier's bank account, the supplier should complete the form "Medicare Authorization Agreement for Electronic Funds Transfers" (Form HCFA-588).

If the supplier plans to do any of the above, submit the appropriate form(s)/agreement(s) with this application. The forms should have been received with this initial enrollment package. If not, they can be obtained from the Medicare carrier or the forms can be found at the Medicare website at http://www.cms.hhs.gov.

To reduce the burden of furnishing certain types of supporting documentation, we have designated specific types of documentation to be furnished on an "as needed" basis. However, the carrier may request documentation at any time during the enrollment process to support or validate information that is reported in this application. Some examples of documents that may be requested for validation purposes are billing agreements, IRS W-2 forms, pay stubs, articles of incorporation, and partnership agreements.

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DEFINITIONS OF MEDICARE ENROLLMENT TERMINOLOGY

To help you understand certain terms used throughout the application, we have included the following definitions.

Authorized Official-An appointed official to whom the supplier has granted the legal authority to enroll it in the Medicare program, to make changes and/or updates to the supplier's status in the Medicare program (e.g., new practice locations, change of address, etc.) and to commit the supplier to fully abide by the laws, regulations, and program instructions of Medicare. The authorized official must be the supplier's general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of 5% or more of the supplier (see Section 5 for the definition of a ("direct owner"), or must hold a position of similar status and authority within the supplier organization.

Billing Agency-A company that the enrolling supplier contracts with to furnish claims processing functions for the supplier.

Carrier-The Part B Medicare claims processing contractor.

Delegated Official-Any individual who has been delegated, by the supplier's "Authorized Official," the authority to report changes and updates to the supplier's enrollment record. A delegated official **must** be a managing employee (W-2) of the supplier or have a 5% ownership interest, or any partnership interest, in the supplier.

Fiscal Intermediary-The Part A Medicare claims processing contractor.

Legal Business Name-The name reported to the Internal Revenue Service (IRS) for tax reporting purposes.

Medicare Identification Number-This is a generic term for any number that uniquely identifies the enrolling supplier. Examples of Medicare identification numbers are Unique Physician/Practitioner Identification Number (UPIN), National Provider Identifier (NPI), Online Survey Certification and Reporting number (OSCAR), National Supplier Clearinghouse (number) (NSC), and Provider Identification number (PIN).

Mobile Facility/Portable Unit-These terms apply when a service that requires medical equipment is provided in a vehicle, or the equipment for the service is transported to multiple locations within a geographic area. The most common types of mobile facilities/portable units are mobile IDTFs, portable X-ray, portable mammography, and mobile clinics. Physical therapists and other medical practitioners (e.g., physicians, nurse practitioners, physician assistants) who perform services at multiple locations (i.e., house calls, assisted living facilities) are not considered to be mobile facilities/portable units.

Provider-A provider is a hospital, critical access hospital, skilled nursing facility, nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice, that has in effect an agreement to participate in Medicare; or a rural health clinic (RHC), Federally qualified health center (FQHC), rehabilitation agency, or public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech pathology services; or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services. A provider is not synonymous with the corporation or other legal entity that owns or operates the provider. The "provider" is the CMS recognized provider type listed above. Therefore, an owning or operating entity may own or operate many providers.

Provider Identification Number (PIN)-This number is assigned to providers, suppliers, groups and organizations in Medicare Part B. This number will identify who provided the service to the beneficiary on the Medicare claim form.

Supplier-A physician or other practitioner, or an organization other than a provider that furnishes health care services under Medicare Part B. The term supplier also includes independent laboratories, portable x-ray services, physical therapists in private practice, end stage renal disease (ESRD) facilities, and chiropractors. For enrollment purposes, suppliers that submit claims for durable medical equipment, prosthetics, orthotics, or supplies (DMEPOS) must complete the CMS 855S. This application (CMS 855B) is not for DMEPOS suppliers.

Tax Identification Number (TIN)-This is a number issued by the Internal Revenue Service (IRS) that the supplier uses to report tax information to the IRS.

Unique Physician/Practitioner Identification Number (UPIN)-This number is assigned to physicians, non-physician practitioners, and suppliers to identify the referring or ordering physician on Medicare claims.

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SECTION 1: GENERAL APPLICATION INFORMATION

This section is to identify the reason for submittal of this application. It will also indicate whether the supplier currently has a business relationship with Medicare.

A. Reason for Submittal of this Application - This section identifies the reason this application is being submitted.

1. Check one of the following:

Initial Enrollment:

- If the supplier is enrolling in the Medicare program for the first time with this Medicare carrier under this tax identification number.
- If the supplier is already enrolled with a carrier but needs to enroll in another carrier's jurisdiction.
- If the supplier is enrolled with this carrier but has a new tax identification number.
- When a **hospital** is enrolling with a carrier to bill for Part B services.

NOTE: The supplier must be able to submit a valid claim within six months of enrolling or risk deactivation of its billing number once it has enrolled.

Reactivation:

- If the supplier's Medicare billing number was deactivated. To reactivate billing privileges, the supplier may be required to either submit an updated CMS 855B or certify to the accuracy of its enrollment information currently on file with CMS. In addition, prior to being reactivated, the supplier must be able to submit a valid claim. It must also meet all current requirements for its supplier type, regardless of whether it was previously enrolled in the program.

Revalidation:

- If the supplier has been requested to revalidate its enrollment information currently on file with Medicare. Periodically (about once every three years), Medicare will require the supplier to confirm and update **all** of its enrollment information. Check this box and complete this entire application unless instructed otherwise by the Medicare carrier. A copy of the original application with all changes clearly indicated with a current signature and date may be submitted.

Change of Information:

- If the supplier is adding, deleting, or changing information under this tax identification number. Check the appropriate section where the change will be made. When providing the changed information, furnish the supplier's Medicare identification number in Section 1 and provide the new/changed information within the appropriate section. Sign and date the certification statement. **All changes must be reported to the carrier within 90 days of the effective date of the change.**

- **Tax Identification Number Change:** If the supplier is reporting a change to it's tax identification number, a complete new CMS 855B enrollment application must be submitted as it is assumed that a change of ownership has occurred. If this is not the case, please provide evidence that a change of ownership has not occurred when reporting this change.

- If the supplier is adding or deleting a member who currently is reassigning his/her benefits to the supplier, it only needs to complete a CMS 855R to make such a change. The member may also delete his/her reassignment of benefits by completing and submitting the CMS 855R.

Voluntary Termination of Billing Number:

- If the supplier will no longer be submitting claims to the Medicare program using this billing number. Voluntary termination ensures that the supplier's billing number will not be fraudulently used in the event of the supplier ceasing its operations. Furnish the date the supplier will stop billing for Medicare covered services. In addition to completing this section, furnish the supplier's Medicare identification number in Section 1 under "Change of Information," and sign and date the certification statement (Section 15).

NOTE: "Voluntary Termination" **cannot** be used to circumvent any corrective action plan or any pending/ongoing investigation.

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Change of Ownership (Hospitals, Portable X-Ray Facilities, and Ambulatory Surgical Centers) - Only

- When a hospital undergoes a change of ownership (CHOW), in addition to the required submission of a CMS 855A, the hospital must also submit a new CMS 855B for the new ownership.
- When a portable x-ray facility or ambulatory surgical center undergoes a change of ownership that results in the issuance of a new tax identification number (TIN), the new owners must submit a completed CMS 855B and attach a copy of the sales agreement.

2. Tax Identification Number (TIN) - Provide the supplier's taxpayer identification number (e.g., the number the supplier uses to report tax information to the IRS) and attach documentation (e.g., a copy of the IRS CP-575) from the IRS showing that the name matches that reported in this application. If the supplier does not have an IRS CP-575, any legal document from the IRS that shows the supplier's name and TIN will be acceptable proof. Upon request, the IRS will provide a Form 147C showing the supplier's name and TIN.

NOTE: An IRS CP 575 or other documentation must be submitted for each TIN reported on this application.

If the supplier cannot obtain the required IRS document, explain why in a separate attachment and provide evidence that links its legal business name with the reported TIN. If the name and TIN do not match on the submitted documents, explain why and refer to the documents that confirm the identification of the supplier or owner as applicable (e.g., if the supplier recently changed its name and the IRS has not sent it an updated document). The supplier may then submit the old IRS document with the old name, as well as a copy of documentation filed with the IRS and State concerning the name change.

3. Indicate whether the supplier is currently enrolled in the Medicare program. If the supplier is currently enrolled in Medicare (i.e., within another carrier's jurisdiction) provide the name of the carrier in this space. The supplier must also provide its Medicare identification number in the space provided. This number is issued by Medicare to identify the supplier. It is also the number used on claims forms and may be referred to as a Medicare provider number, provider identification number, or National Supplier Clearinghouse number. Report all currently active numbers.

4. Indicate if this supplier would like to submit claims electronically. If the supplier would like to submit claims electronically once enrolled in the Medicare program, the supplier will need to complete an Electronic Data Interchange (EDI) agreement with the local Medicare carrier. Checking this box will alert the carrier to contact their claims processing department. The claims processing department will contact the supplier to process an EDI agreement once its enrollment has been completed, approved, and a Medicare billing number issued to the supplier. These agreements cannot be established until the enrollment process has been completed and a Medicare billing number has been issued.

NOTE: Rural Health Clinics – If this supplier is a rural health clinic enrolling for a Part-B carrier billing number, check "Yes" in the box provided and furnish the rural health clinics' fiscal intermediary name and OSCAR number in the spaces provided.

If the supplier does not currently have a Medicare identification number, it will be assigned one upon the successful completion of enrollment. Your local carrier will assign a separate supplier identification number. The carrier will explain what number(s) has been issued and how it is to be used. If the carrier should contact the supplier for additional information, the supplier must provide the information immediately to ensure the timely processing of this application.

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MEDICARE FEDERAL HEALTH CARE PROVIDER/SUPPLIER ENROLLMENT APPLICATION

Application for Health Care Suppliers that will Bill Medicare Carriers

General Instructions

The Medicare Federal Health Care Provider/Supplier Enrollment Application has been designed by the Centers for Medicare and Medicaid Services (CMS) to assist in the administration of the Medicare program and to ensure that the Medicare program is in compliance with all regulatory requirements. The information collected in this application will be used to ensure that payments made from the Medicare trust fund are only paid to qualified health care suppliers, and that the amounts of the payments are correct. This information will also identify whether the supplier is qualified to render health care services to Medicare beneficiaries. To accomplish this, Medicare must know basic identifying and qualifying information about the supplier that is seeking billing privileges in the Medicare program. If enrolling in the Medicare program as a supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) do not complete this application. DMEPOS suppliers should contact the National Supplier Clearinghouse (NSC) at 866-238-9652 to obtain a CMS 855S for Medicare enrollment.

Medicare needs to know: (1) the type of health care supplier enrolling, (2) what qualifies this supplier to furnish health care related services, (3) where and how this supplier intends to render these services, and (4) those persons or entities with an ownership interest, or managerial control, as defined in this application, over the supplier.

This application **MUST** be completed in its entirety, unless the appropriate box is checked to indicate the section does not apply or when reporting a change to previously submitted information. If a section does not apply to this supplier, check (√) the appropriate box in that section and skip to the next section. Sections 7, 9, 11, and 12 have been deliberately omitted from this application because they are not applicable to the enrollment of suppliers that bill Medicare carriers.

1. General Application Information

This section is to be completed with general information as to why this application is being submitted and whether this supplier currently has a business relationship with Medicare or any another Federal health care program.
To ensure timely processing of this application, Numbers 1, 2 and 3 below MUST ALWAYS be completed.

A. Reason for Submittal of this Application

1. Check one:

☐ Initial Enrollment ☐ Reactivation ☐ Revalidation

☐ Change of Information (Check appropriate Section(s) below and furnish this supplier's Medicare Identification Number here):_____

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 8 ☐ 10 ☐ 13 ☐ 15 ☐ 16
Attachment 1 - ☐ 1 ☐ 2 ☐ 3 Attachment 2 - ☐ 1 ☐ 2 ☐ 3 ☐ 4

☐ Voluntary Termination of Billing Number—Effective Date (MM/DD/YYYY):_____
Medicare Billing Number to be Terminated:_____

☐ Change of Ownership (Hospitals, Portable X-Ray Facilities, and Ambulatory Surgical Centers) - **Only**

2. Tax Identification Number:_____

3. Is this supplier currently enrolled in the Medicare program? ☐ YES ☐ NO
IF YES, furnish the following information about the current carrier:

Current Carrier Name:_____ Current Medicare Identification Number or NPI:_____

4. Check here ☐ if this supplier would like to submit claims electronically and is enrolling in Medicare for the first time.

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SECTION 2: SUPPLIER IDENTIFICATION

A. Type of Supplier - Check the box "Change" only if reporting a change to existing information. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

1. Type of Supplier - Check the appropriate box to identify the type of services the supplier will provide. Only **one** supplier type may be checked per application. If the supplier functions as two or more supplier types, a separate CMS 855B must be submitted for each type. If the supplier changes the type of service it provides (becomes a different supplier type), a new CMS 855B must be completed and submitted.

Rural Health Clinics and Federally Qualified Health Centers - Rural health clinics and Federally Qualified Health Centers currently enrolled with a fiscal intermediary for Part A Medicare services, and are now enrolling with a carrier for Part B Medicare services, should check "Multi-Specialty Clinic."

If this supplier is either an **Ambulatory Surgical Center or a Portable X-Ray Facility**, it must be surveyed by the appropriate State agency prior to enrolling in the Medicare program. Therefore, immediately contact the State Agency that handles these supplier types. The State agency will provide you with any State-specific forms that are required. It will also do preliminary planning for any required State surveys.

For suppliers that are **"Medical Faculty Practice Plans,"** all Medicare requirements must be met prior to enrollment. Other documentation may be required by the Medicare carrier to verify requirements of a medical faculty practice plan (e.g., IRS approval of 501(c)(3) non-profit status, documentation that physicians are employees of the university, etc.).

Diagnostic Radiology Group Practices/Clinics: If this supplier organization performs radiological diagnostic tests, see page 55 of these instructions for important additional enrollment information and check with the local Medicare carrier to determine if enrollment as an Independent Diagnostic Testing Facility (IDTF) is required. In general, physicians who perform examinations of the patient in addition to performing the diagnostic radiological tests, portable x-ray suppliers, and FDA approved diagnostic mammography suppliers do not usually require IDTF enrollment.

Clinic/Group Practices: If this clinic/group will be billing for diagnostic tests, other than clinical laboratory or pathology tests, see page 51 of these instructions to determine if this supplier must also enroll as an Independent Diagnostic Testing Facility (IDTF).

2. Indicate whether the supplier will be receiving reassigned benefits from individual practitioners. This will alert the carrier that it will be receiving CMS 855R(s) to be associated with the supplier's application.
3. PT/OT Groups Only - If the supplier is enrolling as an occupational or physical therapy group, it must answer the questions listed to determine its eligibility to bill Medicare.

B. Supplier Identification Information - Check the box "Change" only if reporting a change to existing information. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

1. Furnish the legal business name for this supplier as reported to the IRS for tax purposes.
2. Provide any "doing business as" name this supplier uses. The "doing business as" name is the name the supplier is generally known by to the public.
3. Check the appropriate box to indicate the organizational structure of this supplier. Check "Corporation" if the supplier is such, regardless of whether the supplier is "for-profit" or "non-profit." "Partnership" should be checked for all "General" and "Limited" partnerships. All other suppliers should check "Other," and specify the type of organizational structure (e.g., limited liability company). The carrier may request a copy of the supplier's "articles of incorporation" if needed to validate certain information.

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2. Supplier Identification

This section is to be completed with information specifically related to the supplier submitting this application. Furnish the following information about the supplier: (1) supplier type, (2) supplier name, and (3) the mailing address and telephone number where Medicare can contact the supplier directly.

A. Type of Supplier ☐ **Change** **Effective Date:**_____

The supplier must meet all Medicare requirements for the type of supplier checked below. If this supplier is a single specialty clinic/group practice, the specialty must be reported. Submit copies of all required licenses, certifications, and registrations with this application.

1. Type of Supplier (Check one):

☐ Ambulance Service Supplier
☐ Ambulatory Surgical Center
☐ Diagnostic Radiology Group Practice/Clinic
☐ Hospital or other provider type which is also enrolled with a fiscal intermediary (complete 2E on page 11)
☐ Independent Clinical Laboratory (CLIA)
☐ Independent Diagnostic Testing Facility (IDTF)
☐ Mammography Screening Center
☐ Managed Care Plan (non-Medicare + Choice)
☐ Mass Immunization Roster Biller Only
☐ Medicare +Choice Organization
☐ Medical Faculty Practice Plan:
See instructions for specific documentation requirements
☐ Multi-Specialty Clinic or Group Practice
☐ Occupational Therapy Group (complete 2A2 below)
☐ Other Medical Care Group
☐ Physical Therapy Group (complete 2A2 below)
☐ Portable X-ray Facility
☐ Public Health/Welfare Agency
☐ Radiation Therapy Center
☐ Slide Preparation Facility
☐ Voluntary Health/Charitable Agency
☐ *Single-Specialty Clinic/Group Practice:
*Specify group/clinic specialty below:
_____
☐ Other (Specify):_____

2. Will this supplier be receiving reassigned benefits from individual practitioners? ☐ YES ☐ NO
IF YES, submit a CMS 855R for each individual practitioner who will be reassigning benefits to this supplier.

3. **PT/OT Groups ONLY** - All occupational and physical therapy groups must answer the following questions:
a) Are all of the group's PT/OT services only rendered in patients' homes? ☐ YES ☐ NO
b) Does this group maintain private office space? ☐ YES ☐ NO
c) Does this group own, lease, or rent its private office space? ☐ YES ☐ NO
d) Is this private office space used exclusively for the group's private practice? ☐ YES ☐ NO
e) Does this group furnish PT/OT services outside of its office and/or patients' homes? ☐ YES ☐ NO
IF YES, provide a copy of the lease agreement that gives the group exclusive use of the facility for PT/OT services.

B. Supplier Identification Information ☐ **Change** **Effective Date:**_____

Furnish the supplier's legal business name (as reported to the IRS), "doing business as" name (name supplier generally known by to the public), and organizational structure.

1. Legal Business Name as Reported to the IRS

2. "Doing Business As" (DBA) Name (if applicable)

3. Identify the type of organizational structure for this supplier (Check one):
☐ Corporation ☐ Partnership ☐ Other (Specify):_____

C. Correspondence Address ☐ **Change** **Effective Date:**_____

This must be an address and telephone number where Medicare can contact this supplier directly.

Mailing Address (Organization or Individual Name)

Mailing Address Line 1 (Street Name and Number)

Mailing Address Line 2 (Suite, Room, etc.)

City	State	ZIP Code + 4

Telephone Number (Ext.)	Fax Number (if applicable)	E-mail Address (if applicable)
( ) ( )	( )	

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C. Correspondence Address - Check the box "Change" only if reporting a change to existing information. Provide the new information and the effective date of that change, and sign and date the certification statement. Otherwise:

- **Furnish an address and telephone number where Medicare or the Medicare carrier can directly get in touch with the enrolling supplier.**

NOTE: This section will assist us in contacting the supplier with any questions we have concerning its business relationship with the Medicare program. The supplier must provide an address and telephone number where Medicare or the carrier can directly contact it to resolve any personal or business issues that arise as a result of its enrollment in the Medicare program. This data will also be used to provide the supplier with important changes or other information concerning the Medicare program that may directly affect the supplier and/or its Medicare payment. This address **cannot** be that of the billing agency, management service organization, or staffing company. If we suspect that the supplier's billing number is being misused, or if we have a legal question, we will contact the supplier directly. This is to protect the supplier as well as the Medicare program.

D. Accreditation (Ambulatory Surgical Centers (ASCs) ONLY) - Check the box "Change" only if reporting a change to existing information. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

1. Indicate whether this ASC is accredited by any accrediting organization that Medicare has approved for acceptance in lieu of a State Survey. If "Yes:"

2. Furnish the date accreditation was received, and

3. Furnish the name of the Medicare-approved accrediting body or organization.

E. Hospitals and Other Providers Enrolled with a Fiscal Intermediary (Only) - This section is **only** to be completed by hospitals and certain other provider organizations that are currently enrolled or enrolling with a fiscal intermediary. Generally, this applies to hospitals that need departmental billing numbers to bill for Part B practitioner services. Hospitals requiring a Part B billing number to sell pathology services should also complete this section. If the hospital requires more then one departmental Part B billing number list each department needing a number. If the provider is other than a hospital, or is also enrolled or enrolling with a fiscal intermediary, and believes it needs or will need a Part B billing number, contact the local carrier to determine if this form should be submitted. Otherwise:

- Furnish the department name(s) and/or type(s) of service this provider will render that require a Part B Medicare supplier billing number from the local Medicare carrier.

NOTE: Provider-Based Clinic – A hospital that is enrolling a clinic that is not provider-based should not complete this section. They should check "Multi-Specialty Clinic or Group Practice" in Section 2A1 on page 9 and complete this entire application for the clinic.

F. Suppliers Employing Physician Assistants (Only) – This section is to be completed by all supplier groups/clinics who need to delete physician assistants (PAs) from the practice when they are no longer employed by the practice.

- Check the delete box and provide the effective date of the deletion and the name and Medicare identification number of the PA.

NOTE: Supplier groups/clinics should not use or submit the CMS 855R form to report physician assistants. The CMS 855R is only used to reassign benefits that would otherwise be paid directly to a practitioner.

G. Comments – This section is to be used as an opportunity to explain any unique or unusual circumstances concerning the supplier's practice location(s), the method by which the supplier renders health care services, or any special billing number requirements.

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2. Supplier Identification (Continued)

D. Accreditation (Ambulatory Surgical Centers (ASCs) ONLY) ☐ **Change** **Effective Date:**_____

1. Is this supplier accredited? ☐ YES ☐ NO ☐ PENDING
   IF YES, complete the following:
2. Date of Accreditation (MM/DD/YYYY):_____
3. Name of Accrediting Body:_____

E. Hospitals and Other Providers Enrolled with a Fiscal Intermediary (ONLY))

This section is **only** to be completed by hospitals and other providers currently enrolled or enrolling with a Medicare fiscal intermediary for Part A services and **only** if this provider needs to obtain a Part B supplier billing number from the local Medical carrier to bill for practitioner services. **See instructions before completing this section.**

List department or service requiring a Part B Medicare carrier billing number below:

_____ _____ _____

_____ _____ _____

_____ _____ _____

F. Suppliers Employing Physician Assistants (Only)

This section is to be completed by any supplier group/clinic when deleting employed physician assistants from the practice.

Delete	Date	Physician Assistant Name	Medicare Identification Number
☐	_____	_____	_____
☐	_____	_____	_____
☐	_____	_____	_____
☐	_____	_____	_____
☐	_____	_____	_____
☐	_____	_____	_____
☐	_____	_____	_____

G. Comments

Explain any unique or unusual circumstances concerning the supplier's practice location(s), the method by which the supplier renders health care services, or any special billing number requirements.

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SECTION 3: ADVERSE LEGAL ACTIONS AND OVERPAYMENTS

A. Adverse Legal History - This section is to be completed with information concerning any adverse legal actions that have been imposed or levied against this supplier, as identified in Section 2B. See Table A on the application form for a list of adverse actions that must be reported.

If reporting a change to existing information check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. The supplier must state whether, under any current or former name or business identity, it has ever had any of the adverse legal actions listed in Table A of the application form imposed against it.

2. If the answer to this question is "Yes," supply all requested information. Attach copies of official documentation related to the adverse legal action. Such documentation includes adverse legal action notifications (e.g., notification of disciplinary action; criminal court documentation that verifies the conviction of a crime) and documents that evidence how the adverse legal action was finally resolved (e.g., reinstatement notices, etc.).

If the supplier is uncertain as to whether it falls within one of the adverse legal action categories or whether a name reported on this application has an adverse legal action, query the Healthcare Integrity and Protection Data Bank. If information is needed on how to access the data bank, call 1-800-767-6732 or visit www.npdb-hipdb.com. There is a charge for using this service.

Table A--This is the list of adverse legal actions that must be reported. All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

B. Overpayment Information - Current laws found in the Federal Streamlining Act and the Debt Collection Improvement Act require all Federal agencies to determine whether an individual or business entity that enters into a business relationship with that agency has any outstanding debts, including overpayments under different identifiers. Failure to furnish information about overpayments will put the supplier in violation of these Acts and subject it to possible denial of its Medicare enrollment.

1. The supplier, as identified in Section 2B, must report all outstanding Medicare overpayments that it is liable for, including those paid to the supplier, or on its behalf, under a different name. For purposes of this section, the term "outstanding Medicare overpayment" is defined as a debt that meets **all** of the conditions listed below:

   a) The overpayment arose out of the supplier's current or previous enrollment in Medicare. This includes any overpayment incurred by the supplier under a different name or business identity, or in another Medicare contractor jurisdiction;

   b) CMS (or its contractors) has determined that the supplier is liable for the overpayment; and

   c) The overpayment is not or has not been included as part of a repayment plan approved by CMS (or its contractors), nor is the overpayment amount being repaid through the withholding of Medicare payments to the supplier.

Any overpayment not meeting all of these conditions should not be reported.

2. Furnish the name or business identity under which the overpayment occurred and the account number under which the overpayment exists.

NOTE: Overpayments that occur after the supplier's enrollment has been approved do not have to be reported unless the supplier is enrolling with a different Medicare contractor.

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3. Adverse Legal Actions and Overpayments

This section is to be completed with information concerning any adverse legal actions and/or overpayments that have been imposed or levied against this supplier (see Table A below for list of adverse actions that must be reported).

A. Adverse Legal History ☐ **Change** **Effective Date:**_____

1. Has this supplier, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A below imposed against it? ☐ YES ☐ NO
2. **IF YES**, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Table A

1) Any felony conviction under Federal or State law, regardless of whether it was health care related.

2) Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.

3) Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.

4) Any misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.

5) Any misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

6) Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.

7) Any revocation or suspension of accreditation.

8) Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.

9) Any current Medicare payment suspension under any Medicare billing number.

Note: All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

B. Overpayment Information

1. Does this supplier, under any current or former name or business identity, have any outstanding Medicare overpayments? ☐ YES ☐ NO
2. **IF YES**, furnish the name and account number under which the overpayment(s) exists.

Name under which the overpayment occurred:	Account number under which the overpayment exists:
_____	_____
_____	_____

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SECTION 4: CURRENT PRACTICE LOCATION(S)

A. Practice Location Information - Check the appropriate box if the supplier is using this section to add a new practice location, delete a practice location, or change information about an existing practice location. Provide the new information, the effective date of that change, and sign and date the certification statement. Otherwise:

1. Furnish the name of the business at this practice location and furnish the date the supplier started rendering services at this location.

NOTE: Only report those practice locations within the Medicare carrier's jurisdiction where the supplier will be submitting this application. If the supplier has practice locations in more than one Medicare carrier's jurisdiction, a separate CMS 855B must be completed for those practice locations and submitted to the Medicare carrier that has jurisdiction over those locations.

2. Provide a complete street address, telephone number, fax number, and e-mail address (if applicable) for the supplier's practice/business location.

NOTE: The address must be a specific street address as recorded by the United States Postal Service. Do not furnish a P.O. Box. If the supplier renders services in a hospital and/or other health care facility for which it bills Medicare directly for the services rendered at that facility, furnish the name and address of the hospital or facility. Do not provide the billing agency's information anywhere in this section. The fax and e-mail addresses are optional.

NOTE: **Managed Care Plan** – Managed care organizations (including Medicare + Choice Organizations), that have contracts with Medicare are only required to provide county/parish, State, and Zip Code.

3. Indicate whether the supplier owns or leases the practice location.

4. Indicate whether this address is that of a hospital, retirement/assisted living community, group practice office/clinic, or other health care facility. Please specify the location if it does not fall within one of these categories.

5. Report any CLIA number(s) and/or FDA/Radiology (Mammography) Certification Number(s) that have been issued to this practice location and which this supplier will be billing for these types of services.

A copy of the most current CLIA and FDA certifications for each of the practice locations reported must be submitted with this application. Do not report certificate information that was not issued under this tax identification number.

The supplier may receive more than one supplier identification number depending upon which "physician fee locality" the practice is located. The local Medicare carrier will determine whether more than one Medicare billing number will be issued.

B. Mobile Facility and/or Portable Units

To properly pay claims, Medicare must be able to determine when services are provided in a mobile facility or with portable units. If the supplier has a mobile facility or portable unit, provide this information in this section. A "mobile facility" is generally a mobile home, trailer, or other large vehicle that has been converted, equipped, and licensed to render health care services. These vehicles usually travel to local shopping centers or community centers to see and treat patients **inside** the vehicle. A "portable unit" is when the supplier transports medical equipment to a fixed location (e.g., physician's office, nursing home) to render services to the patient.

- State whether or not the supplier furnishes services in or from a mobile facility or portable unit. If "Yes," use Sections 4C through 4E to furnish information about the mobile/portable services.

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C. Base of Operations Address - Check the appropriate box to indicate whether the supplier is using this section to add a new mobile/portable practice location, delete a mobile/portable practice location, or change information about an existing mobile/portable practice location. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

- If the base of operations address is the same as the practice location reported above in Section 4A, check the box and skip to Section 4D.

1. Provide the base of operations name and the date the supplier started practicing from this location.

2. Provide the address from where personnel are dispatched, where mobile/portable equipment is stored and, when applicable, where vehicles are parked when not in use. Provide the telephone number, fax number and e-mail address (if applicable) for this base of operations location.

NOTE: If this supplier does not have a physical location where equipment and/or vehicles are stored or from where personnel report on a regular basis, complete this section with information about the location of the dispatcher/scheduler and fully explain the method of operation in Section 2G. This situation may occur if the supplier operates mobile units that travel continuously from one location directly to another.

D. Vehicle Information - Check the appropriate box to indicate whether the supplier is using this section to add a vehicle, delete a vehicle, or change information about a vehicle. Provide the effective date of the change, and sign and date the certification statement. Otherwise:

1.-3. Furnish the type of vehicle and the vehicle identification number. A copy of all health care related permit(s), license(s), and registration(s) must be submitted for each vehicle reported.

This section is to provide us with information about the mobile unit when the services are rendered **in or from** the vehicle. Do not furnish information about the vehicle(s) that are used only to transport medical equipment (e.g., when the equipment is transported in a van but is used in a fixed setting, such as a doctor's office) or ambulance vehicles.

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4. Current Practice Location(s)

This section is to be completed with information about the physical location(s) where this supplier currently renders health care services. If this supplier operates a mobile facility or portable units, furnish the address for the "Base of Operations," as well as vehicle information and the geographic area served by these facilities or units. In addition, cite where this supplier wants its payments sent, and where the supplier maintains patients' medical records. If there is more than one practice location, copy and complete this section for each.

A. Practice Location Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Practice Location (Name)			Date Started at this Location (MM/DD/YYYY)
2. Practice Location Address Line 1 (Street Name and Number)			
Practice Location Address Line 2 (Suite, Room, etc.)			
City	County/Parish	State	ZIP Code + 4
Telephone Number ( )	(Ext.) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

3. Does this provider: own this practice location? ☐ YES ☐ NO
lease this practice location? ☐ YES ☐ NO

4. Is this practice location a:
hospital? ☐ YES ☐ NO
retirement/assisted living community? ☐ YES ☐ NO
group practice office/clinic ☐ YES ☐ NO
other health care facility? (Specify):_____ ☐ YES ☐ NO

5. CLIA Number for this location (if applicable)	FDA/Radiology (Mammography) Certification Number(s) for this location (if applicable)

B. Mobile Facility and/or Portable Units ☐ **Change** **Effective Date:**_____

Does this supplier furnish health care services from a mobile facility or portable unit? ☐ YES ☐ NO
IF YES, use Sections 4C through 4E to furnish information about the mobile/portable services.
IF NO, proceed to Section 4F (Medicare Payment "Pay To" Address).

C. Base of Operations Address ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

The base of operations is the location from where personnel are dispatched, where mobile/portable equipment is stored and, when applicable, where vehicles are parked when not in use. See instructions for further examples.
Check here ☐ and skip to Section 4D if the "Base of Operations" address is the same as the "Practice Location."

1. Base of Operations (Name)			Date Started at this Location (MM/DD/YYYY)
2. Street Address Line 1 (Street Name and Number)			
Street Address Line 2 (Suite, Room, etc.)			
City	County/Parish	State	ZIP Code + 4
Telephone Number ( )	(Ext.) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

D. Vehicle Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

If the mobile health care services are rendered inside a vehicle, such as a mobile home or trailer, furnish the following vehicle information. See the instructions for a full explanation of the types of vehicles that need to be reported. If more than three vehicles are used, copy and complete this section as needed.

1. Type of Vehicle (van, mobile home, trailer, etc.)	Vehicle Identification Number
2. Type of Vehicle (van, mobile home, trailer, etc.)	Vehicle Identification Number
3. Type of Vehicle (van, mobile home, trailer, etc.)	Vehicle Identification Number

Note: For each vehicle, a copy of all health care related permits/licenses/registrations MUST be submitted.

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E. Geographic Location where the Base of Operations and/or Vehicle Renders Services - Check the appropriate box when the supplier is using this section to add or delete a geographic location. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

1. Initial Reporting and/or Additions

- The supplier should furnish the county/parish, city, State and ZIP Code for all locations at which it will render services to Medicare beneficiaries in or from its mobile facility or portable unit. For those mobile facilities or portable units that travel across State lines, and when those States are served by different Medicare contractors (carriers), the supplier must complete a separate CMS 855B enrollment application for each Medicare contractor jurisdiction.

2. Deletions

- If deleting a location where mobile or portable services were provided, indicate the county/parish, city, State, and ZIP Code of the location being deleted.

F. Medicare Payment "Pay To" Address - The supplier must indicate where it wants its Medicare payments to be sent. Check the box "Change" only if reporting a change to existing information. Provide the date of that change, and sign and date the certification statement. Otherwise:

- Provide the P.O. Box or street address, city, State and ZIP Code for the address where payments are to be sent.

The ability to establish more then one "Pay To" address will be addressed by the local Medicare carrier. Some Medicare carriers do not allow multiple payment addresses. Payment will be made in the supplier's "legal business name" as shown in Section 2B1.

- The "Pay To" address is not the same address used for Electronic Funds Transfers. If the supplier would like payments to be deposited in its bank account electronically, place a check in the box given and complete the form "Medicare Authorization Agreement for Electronic Funds Transfers (Form HCFA-588).

- If payment will be made by electronic funds transfer, the "Pay To" address should indicate where the supplier wants all other payment information to be sent (e.g., remittance notices, special payments, etc.).

G. Location of Patients' Medical Records - Check the appropriate box if using this section to add a new location where patients' medical records are kept, delete a location, or change information about an existing location. Provide the effective date of that change, complete the appropriate information, and sign and date the certification statement. Otherwise:

1. If all of the supplier's patients' medical records are stored at the practice location shown in Section 4A or the base of operations shown in Section 4C, check the box provided and skip this section.

2. If any of the supplier's patients' medical records are stored at a location other the practice location shown in Section 4A or the base of operations shown in Section 4C, this section must be completed with a complete address of the storage location.

Post Office Boxes and drop boxes are not acceptable as physical addresses where patients' records are maintained. For IDTFs and mobile facilities/portable units, the patients' medical records must under the supplier's control. The records must be the supplier's records, not the records of another provider/supplier.

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4. Practice Location (Continued)

E. Geographic Location where the Base of Operations and/or Vehicle Renders Services

☐ **Add** ☐ **Delete** **Effective Date:**_____

Furnish the county/parish, city, State and ZIP Code for all locations where mobile and/or portable services are rendered.

Note: If this supplier renders mobile health care services in more than one State, and those States are served by different Medicare contractors, a separate CMS 855B enrollment application must be completed for each Medicare contractor jurisdiction.

1. Initial Reporting and/or Additions:

County/Parish:	City:	State:	ZIP Code(s):

2. Deletions:

County/Parish:	City:	State:	ZIP Code(s):

F. Medicare Payment "Pay To" Address ☐ **Change** **Effective Date:**_____

Check here ☐ and complete and submit Form HCFA-588 with this application if the supplier would like its payments electronically transferred to its bank account.

Furnish the address where payment should be sent for services rendered at the practice location(s) in Section 4A or 4C.

"Pay To" Address Line 1 (Street Name and Number)

"Pay To" Address Line 2 (Suite, Room, etc.)

City	State	ZIP Code + 4

G. Location of Patients' Medical Records ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Check here ☐ if **all** patients' medical records are stored at the location shown in Section 4A or 4C, and skip this section.
2. If **any** of the patients' medical records are stored at a location other than the location shown in Section 4A or 4C, complete this section with the name and address of the storage location.

Name of Storage Facility/Location

Storage Facility Address Line 1 (Street Name and Number)

Storage Facility Address Line 2 (Suite, Room, etc.)

City	State	ZIP Code + 4

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SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS)

This section is to be completed with information about any organization that has 5% or more (direct or indirect) ownership of, any partnership interest in, and/or managing control of the supplier identified in Section 2B. See examples below of organizations that should be reported in this section. If individuals, and not organizations, own or manage the supplier, do not complete this section. These individuals must be reported in Section 6. If there is more than one organization, copy and complete this section for each.

A. Check Box - Check the box if there are no organizations to be reported in this section. If this box is checked, proceed to Section 6.

B. Organization with Ownership Interest and/or Managing Control - Identification Information - If adding, deleting, or changing information on an existing owner, partner, or managing organization, check the appropriate box, indicate the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. If not reporting a change, complete this section for the following:

All organizations that have any of the following **must** be reported in Section 5B:

- 5% or more ownership of the supplier,
- Managing control of the supplier, or
- A partnership interest in the supplier, regardless of the percentage of ownership the partner has.

Owning/Managing organizations are generally one of the following types:

- Corporations (including non-profit corporations)
- Partnerships and Limited Partnerships (as indicated above)
- Charitable and/or Religious organizations
- Governmental and/or Tribal organizations

NOTE: All partners within a partnership must be reported in Section 6 of this application. This applies to both "General" and "Limited" partnerships. For instance, if a limited partnership has several limited partners and each of them only has a 1% interest in the supplier, each limited partner must be reported in this application, even though each owns less than 5%. The 5% threshold primarily applies to corporations or other organizations that are not partnerships.

***IMPORTANT* – Only report organizations in this section. Individuals must be reported in Section 6.**

1. Check all boxes that apply to indicate the relationship between the supplier and the owning or managing organization.

2. Provide the legal business name of the owning or managing organization.

3. If applicable, provide the owning or managing organization's "doing business as" name.

4. Provide the owning or managing organization's complete business street address.

5. Provide the owning or managing organization's tax identification number and, if one (or more) has been issued, its Medicare identification number(s).

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The following contains an explanation of the terms "direct ownership," "indirect ownership," and "managing control," as well as instructions concerning organizations that must be reported in this application.

EXAMPLES OF 5% OR MORE "DIRECT" OWNERSHIP

All organizations that own 5% or more of the supplier must be reported in this application.

Many suppliers may be owned by only one organization. For instance, suppose the supplier is an ambulance company that is wholly (100%) owned by Company A. In this case, Company A is considered to be a direct owner of the ambulance company, in that it actually owns the assets of the business. As such, the supplier would have to report Company A in this section.

There are occasionally more complex ownership situations. Many organizations that directly own a supplier are themselves wholly or partly owned by other organizations (or even individuals). This is often the result of the use of holding companies and parent/subsidiary relationships. Such organizations and individuals are considered to be "indirect" owners of the supplier. Using our situation above, if Company B owned 100% of Company A, Company B is considered to be an indirect owner of the supplier. In other words, a direct owner has an actual ownership interest in the supplier (e.g., owns stock in the business, etc.), whereas an indirect owner has an ownership interest in an organization that owns the supplier. For purposes of this application, direct and indirect owners must be reported if they own at least 5% of the supplier. To calculate whether these indirect owners meet the 5% ownership level, review the formula outlined in Example 1 in this section.

For purposes of this application, ownership also includes "financial control." Financial control exists when:

(1) An organization or individual is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the supplier or any of the property or assets of the supplier, **and**

(2) The interest is equal to or exceeds 5% of the total property and assets of the supplier.

To calculate whether an organization or individual has financial control over the supplier, use the formula outlined in Example 2 of the instructions for this section.

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EXAMPLES OF "INDIRECT" LEVELS OF OWNERSHIP FOR ENROLLMENT PURPOSES

Example 1 (Ownership)

LEVEL 3	***Individual X*** 5%	***Individual Y*** 30%
LEVEL 2	***Company C*** 60%	***Company B*** 40%
LEVEL 1	***Company A*** 100%	

- Company A owns 100% of the Enrolling Supplier
- Company B owns 40% of Company A
- Company C owns 60% of Company A
- Individual X owns 5% of Company C
- Individual Y owns 30% of Company B

In this example, Company A (Level 1) is the direct owner of the Enrolling Supplier. Companies B and C as well as Individuals X and Y are indirect owners of the Enrolling Supplier. To calculate ownership shares using the above-cited example, utilize the following steps:

LEVEL 1

The diagram above indicates that Company A owns 100% of the Enrolling Supplier. Company A must therefore be reported in Section 5.

LEVEL 2

To calculate the percentage of ownership held by Company C of the Enrolling Supplier, multiply:

The percentage of ownership the LEVEL 1 owner has in the Enrolling Supplier
MULTIPLIED BY
The percentage of ownership the LEVEL 2 owner has in that LEVEL 1 owner

It is known that Company A, the LEVEL 1 (or direct) owner, owns 100% of the Enrolling Supplier. The diagram also indicates that Company C, a LEVEL 2 owner, owns 60% of Company A. As such, multiply 100% (or 1.0) by 60% (.60). The result is .60. Therefore, Company C indirectly owns 60% of the Enrolling Supplier, and must be reported in Section 5.

Repeat the same procedure for Company B, the other LEVEL 2 owner. Because Company B owns 40% of Company A, multiply this figure by 100% (again, the ownership stake Company A has in the Enrolling Supplier). Therefore, 1.0 multiplied by .40 equals .40, so Company B owns 40% of the Enrolling Supplier, and must be reported in Section 5.

This process is continued until all LEVEL 2 owners have been accounted for.

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LEVEL 3

To calculate the percentage of ownership that Individual X has in the Enrolling Supplier, multiply:

The percentage of ownership the LEVEL 2 owner has in the Enrolling Supplier
MULTIPLIED BY
The percentage of ownership the LEVEL 3 owner has in that LEVEL 2 owner

It has already been established that Company C owns 60% of the Enrolling Supplier. According to the example above, Individual X (Level 3) owns 5% of Company C. Therefore, multiply 60% (.60) by 5% (.05), resulting in .03. This means that Individual X owns 3% of the Enrolling Supplier and does not need to be reported in this application.

Repeat this process for Company B, which owns 40% of the Enrolling Supplier. The diagram states that Individual Y (Level 3) owns 30% of Company B. We thus multiply 40% (.40) by 30% (.30). The result is .12, or 12%. Because Individual Y owns 12% of the Enrolling Supplier, Individual Y must be reported on this application (in Section 6 - Individuals).

This process is continued until all owners in LEVEL 3 have been accounted for. Should there be entities at LEVEL 4 and above that have at least a 5% ownership interest in the Enrolling Supplier, the Enrolling Supplier may submit an organizational chart identifying these entities and/or individuals. The chart should contain the names, business addresses and TINs of these entities, and/or the names and social security numbers of these individuals.

Example 2 (Financial Control)

The percentage of financial control can be calculated by using the following formula:

Dollar amount of the mortgage, deed of trust, or other obligation secured by the Enrolling Supplier or any of the property or assets of the Enrolling Supplier
DIVIDED BY
Dollar amount of the total property and assets of the Enrolling Supplier

Example: Two years ago, a supplier obtained a $20 million loan from Entity X to add a third floor to its facility. Various assets of the supplier secure the mortgage. The total value of the supplier's property and assets is $100 million.

Using the formula described above, divide $20 million (the dollar amount of the secured mortgage) by $100 million (the total property and assets of the Enrolling Supplier). This results in .20, or 20%. Because Entity X's interest represents at least 5% of the total property and assets of the Enrolling Supplier, financial control exists and Entity X must be reported in this section.

MANAGING CONTROL (ORGANIZATIONS)

Any organization that exercises operational or managerial control over the supplier, or conducts the day-to-day operations of the supplier, is a managing organization and must be reported. The organization need not have an ownership interest in the supplier in order to qualify as a managing organization. This could be a management services organization under contract with the supplier to furnish management services for this business location.

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SPECIAL TYPES OF ORGANIZATIONS

Governmental/Tribal Organizations: If a Federal, State, county, city or other level of government, or an Indian tribe, will be legally and financially responsible for Medicare payments received (including any potential overpayments), the name of that government or Indian tribe should be reported as an owner. The supplier must submit a letter on the letterhead of the responsible government (e.g., government agency) or tribal organization, which attests that the government or tribal organization will be legally and financially responsible in the event that there is any outstanding debt owed to CMS. This letter must be signed by an "authorized official" of the government or tribal organization who has the authority to legally and financially bind the government or tribal organization to the laws, regulations, and program instructions of Medicare. See Section 14 for further information on and a definition of "authorized officials."

Charitable and Religious Organizations: Many non-profit organizations are charitable or religious in nature, and are operated and/or managed by a Board of Trustees or other governing body. The actual name of the Board of Trustees or other governing body should be reported in this section.

C. Adverse Legal History - This section is to be completed with information concerning any adverse legal actions that have been imposed or levied against the organization(s) reported in this section. See Table A in Section 3 of the application form for a list of adverse actions that must be reported.

If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. The supplier must state whether the organization reported in Section 5B, under any current or former name or business identity, has ever had any of the adverse legal actions listed in Section 3 (Table A) of this form imposed against it.

2. If the answer to this question is "Yes," supply all requested information. Attach copies of official documentation related to the adverse legal action. Such documentation includes adverse legal action notifications (e.g., notification of disciplinary action; criminal court documentation that verifies the conviction of a crime) and documents that evidence how the adverse legal action was finally resolved (e.g., reinstatement notices, etc.).

If the supplier is uncertain as to whether the owning or managing organization falls within one of the adverse legal action categories, the supplier should query the Healthcare Integrity and Protection Data Bank. If the supplier needs information on how to access the data bank, call 1-800-767-6732 or visit www.npdb-hipdb.com.

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5. Ownership Interest and/or Managing Control Information (Organizations)

This section is to be completed with information about all organizations that have 5% or more (direct or indirect) ownership interest of, any partnership interest in, and/or managing control of, the supplier identified in Section 2B, as well as any information on adverse legal actions that have been imposed against that organization. See instructions for examples of organizations that should be reported here. If there is more than one organization, copy and complete this section for each.

A. Check here ☐ if this section does not apply and skip to Section 6.

B. Organization with Ownership Interest and/or Managing Control—Identification Information

☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Check all that apply:	☐ 5% or more Ownership Interest ☐ Managing Control	☐ Partner
2. Legal Business Name		
3. "Doing Business As" Name (if applicable)		
4. Business Address Line 1 (Street Name and Number)		
Business Address Line 2 (Suite, Room, etc.)		
City	State	ZIP Code + 4
5. Tax Identification Number	Medicare Identification Number(s) (if applicable)	

C. Adverse Legal History ☐ **Change** ☐ **Effective Date:**_____

This section is to be completed for the organization reported in Section 5B above.

1. Has the organization in Section 5B above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against it? ☐ YES ☐ NO

2. IF YES, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS)

This section is to be completed with information about any individual who has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the supplier identified in Section 2B. In addition, all officers, directors, and managing employees of the supplier must be reported in this section. If there is more than one individual, copy and complete this section for each. **The supplier MUST have at least ONE owner and/or managing employee.** If this is a "one person" operation, then report yourself in this section as **both** a 5% or greater owner and a managing employee or director/officer.

A. Individual with Ownership Interest and/or Managing Control - Identification Information - If adding, deleting, or changing information on an existing 5% or greater owner, partner, officer, director, or managing employee, check the appropriate box, indicate the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. If not reporting a change, complete this section for the following:

The following individuals **must** be reported in Section 6A: (see below for definitions of these terms)

- All persons who have a 5% or greater ownership interest in the supplier;
- If (and only if) the supplier is a corporation (whether for-profit or non-profit), all officers and directors of the supplier;
- All managing employees of the supplier, and
- All individuals with a partnership interest in the supplier, regardless of the percentage of ownership the partner has.

NOTE: All partners within a partnership must be reported in this application. This applies to both "General" and "Limited" partnerships. For instance, if a limited partnership has several limited partners and each of them only has a 1% interest in the supplier, each limited partner must be reported in this application, even though each owns less than 5%. The 5% threshold primarily applies to corporations and other organizations that are not partnerships.

For purposes of this application, the terms "officer," "director," and "managing employee" are defined as follows:

- The term **"Officer"** is defined as any person whose position is listed as being that of an officer in the supplier's **"Articles of Incorporation"** or **"Corporate Bylaws," OR** anyone who is appointed by the board of directors as an officer in accordance with the supplier's corporate bylaws.
- The term **"Director"** is defined as a member of the supplier's **"Board of Directors."** It does not necessarily include a person who may have the word "Director" in his/her job title (e.g., Departmental Director, Director of Operations). See note below.

NOTE: A person who has the word "Director" in his/her job title may be a "managing employee," as defined below. Moreover, where a supplier has a governing body that does not use the term "Board of Directors," the members of that governing body will still be considered "Directors." Thus, if the supplier has a governing body titled "Board of Trustees" (as opposed to "Board of Directors"), the individual trustees are considered "Directors" for Medicare enrollment purposes.

- The term **"Managing Employee"** is defined as any individual, including a general manager, business manager, administrator, or medical director who exercises operational or managerial control over the supplier, or who conducts the day-to-day operations of the supplier. For Medicare enrollment purposes, "managing employee" also includes individuals who are not actual employees of the supplier but, either under contract or through some other arrangement, manage the day-to-day operations of the supplier.

NOTE: If a governmental or tribal organization will be legally and financially responsible for Medicare payments received (per the instructions for Governmental/Tribal Organizations in Section 5), the supplier is only required to report its managing employees in Section 6. Owners, partners, officers, and directors do not need to be reported.

Refer to the instructions and examples in Section 5 for further clarification of what is meant by the terms "direct owner" and "indirect owner." If further assistance is needed in completing this section, contact the Medicare carrier.

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***IMPORTANT* – Only Individuals should be reported in Section 6. Organizations must be reported in Section 5.**

1. Furnish the individual's full name, title, date of birth, social security number, and Medicare identification number or NPI (if applicable).

NOTE: Section 1124A of the Social Security Act requires that the supplier furnish Medicare with the individual's social security number.

2. Indicate the individual's relationship with the enrolling supplier identified in Section 2B. If this individual has a title other than that listed in this section, check the "Other" box and specify the title used by this individual.

Example: A supplier is 100% owned by Company C, which itself is 100% owned by Individual D. Assume that Company C is reported in Section 5B as an owner of the supplier. Assume further that Individual D, as an indirect owner of the supplier, is reported in Section 6A1. Based on this example, the supplier would check the "5% or Greater Indirect Owner" box in Section 6A2.

B. Adverse Legal History - This section is to be completed with information concerning any adverse legal actions that have been imposed or levied against individuals reported in Section 6A. See Table A in Section 3 of this application for a list of adverse actions that must be reported.

If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. The supplier must state whether the individual reported in Section 6A, under any current or former name or business identity, has ever had any of the adverse legal actions listed in Section 3 (Table A) of this form imposed against him or her.

2. If the answer to this question is "Yes," supply all requested information. Attach copy(s) of official documentation related to the adverse legal action. Such documentation includes adverse legal action notifications (e.g., notification of disciplinary action; criminal court documentation that verifies the conviction of a crime) and documents that evidence how the adverse legal action was finally resolved (e.g., reinstatement notices, etc.).

If the supplier is uncertain as to whether this individual falls within one of the adverse legal action categories, the supplier should query the Healthcare Integrity and Protection Data Bank. If the supplier needs information on how to access the data bank, call 1-800-767-6732 or visit www.npdb-hipdb.com.

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6. Ownership Interest and/or Managing Control Information (Individuals)

This section is to be completed with information about any individual who has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the supplier identified in Section 2B. All officers, directors, and managing employees of the supplier must also be reported in this section. In addition, any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each individual.

A. Individual with Ownership Interest and/or Managing Control—Identification Information

☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.

Title	Date of Birth (MM/DD/YYYY)
Social Security Number	Medicare Identification Number (if applicable)

2. What is the above individual's relationship with the supplier in Section 2B? (Check all that apply.)

☐ 5% or Greater Direct Owner
☐ 5% or Greater Indirect Owner
☐ Other (Specify):_____
☐ Managing Employee
☐ Director/Officer
☐ Partner

B. Adverse Legal History ☐ **Change** ☐ **Effective Date:**_____

This section is to be completed for the individual reported in Section 6A above.

1. Has the individual in Section 6A above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against him or her? ☐ YES ☐ NO

2. IF YES, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:

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SECTION 7: CHAIN HOME OFFICE INFORMATION

This section has been intentionally omitted.

SECTION 8: BILLING AGENCY

The purpose of collecting this information is to develop effective monitoring of agents/agencies that prepare and/or submit claims to bill the Medicare program on behalf of the supplier. A billing agency is a company or individual that the supplier hires or contracts with to furnish claims processing functions for its business locations. Any entity that meets this description must be reported in this section.

A. Check Box - If this supplier does not use a billing agency, check the box and skip to Section 10.

B. Billing Agency Name and Address - If reporting a change to information about a previously reported billing agency, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. Furnish the name and tax identification number of the billing agency.

2. Furnish the "doing business as" name of the billing agency.

3. Furnish the complete address and telephone number of the billing agency.

C. Billing Agreement/Contract Information - If reporting a change to existing information about a previously reported billing agreement/contract, check "Change," provide the effective date of the change, complete this entire questionnaire, and sign and date the certification statement. Otherwise:

The supplier that is enrolling is responsible for responding to the questions listed.

These questions are designed to show that the supplier fully understands and comprehends its billing agreement and that it intends to adhere to all Medicare laws, regulations, and program instructions. At any time, the Medicare contractor or CMS may request copies of all agreements/contracts associated with this billing agency.

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7. Chain Home Office Information — This Section Not Applicable

8. Billing Agency

This section is to be completed with information about all billing agencies this supplier uses or contracts with that submit claims to Medicare on behalf of the supplier. If more than one billing agency is used, copy and complete this section for each. The supplier may be required to submit a copy of its current signed billing agreement/contract if Medicare cannot verify the information furnished in this section.

A. Check here ☐ if this section does not apply and skip to Section 10.

B. Billing Agency Name and Address ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Legal Business Name as Reported to the IRS		Tax Identification Number
2. "Doing Business As" Name (if applicable)		
3. Business Street Address Line 1 (Street Name and Number)		
Business Street Address Line 2 (Suite, Room, etc.)		
City	State	ZIP Code + 4
Telephone Number (Ext.) ( ) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

C. Billing Agreement/Contract Information ☐ **Change** **Effective Date:**_____

Answer the following questions about the supplier's agreement/contract with the above billing agency.

1. Does the supplier have unrestricted access to its Medicare remittance notices? ☐ YES ☐ NO
2. Does the supplier's Medicare payment go directly to the supplier? ☐ YES ☐ NO
   IF NO, proceed to Question 3.
   IF YES, skip Questions 3, 4 and 5.
3. Does the supplier's Medicare payment go directly to a bank? ☐ YES ☐ NO
   IF NO, proceed to Question 4.
   IF YES, answer the following questions and skip Questions 4 and 5.
   a) Is the bank account only in the name of the supplier? ☐ YES ☐ NO
   b) Does the supplier have unrestricted access to the bank account and statements? ☐ YES ☐ NO
   c) Does the bank only answer to the supplier regarding what the supplier wants from the bank (e.g., sweep account instructions, bank statements, closing account, etc.)? ☐ YES ☐ NO
4. Does the supplier's Medicare payment go directly to the billing agent? ☐ YES ☐ NO
   IF NO, proceed to Question 5.
   IF YES, answer the following question and skip Question 5.
   a) Does the billing agent cash the supplier's check? ☐ YES ☐ NO
      IF NO, proceed to Question b.
      IF YES, are <u>all</u> of the following conditions included in the billing agreement? ☐ YES ☐ NO
      1) The agent receives payment under an agency agreement with the supplier. ☐ YES ☐ NO
      2) The agent's compensation is not related in any way to the dollar amounts billed or collected. ☐ YES ☐ NO
      3) The agent's compensation is not dependent upon the actual collection of payment. ☐ YES ☐ NO
      4) The agent acts under payment disposition instructions that the supplier may modify or revoke at any time. ☐ YES ☐ NO
      5) In receiving payment, the agent acts only on behalf of the supplier (except insofar as the agent uses part of that payment as compensation for the agent's billing and collection services). ☐ YES ☐ NO
   b) Does the billing agent either give the Medicare payment directly to this supplier or deposit the payment into this supplier's bank account? ☐ YES ☐ NO
5. Who receives the supplier's Medicare payment?_____

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SECTION 9: FOR FUTURE USE

This section has been intentionally omitted.

SECTION 10: STAFFING COMPANY

The purpose of collecting this data is to develop effective internal controls to promote adherence to applicable Federal and State laws.

A staffing company is an organization that contracts with health care professionals to furnish health care at medical facilities (such as hospital emergency rooms) where it is also under contract (or some similar agreement) to furnish such services. A staffing company cannot bill Medicare in the staffing company's name for medical services or supplies furnished under this arrangement. If the supplier has an agreement/contract with a staffing company to furnish services to Medicare beneficiaries, complete this section. At any time, the carrier may request a copy of the agreement/contract signed by the supplier and the staffing company.

A. Check Box - If the supplier does not work for (or is not under contract with) a staffing company, check the box provided and skip to Section 13. If the supplier has been hired by (or is under contract with) a staffing company, complete the appropriate fields of this section with information about the staffing company.

B. 1st Staffing Company Name and Address - Indicate if this supplier is making a change concerning its relationship with a staffing company by checking the appropriate box "add," "delete," or "change." Provide the new information and the effective date of the change, and sign and date the certification statement. Otherwise:

1. Furnish the legal business name and tax identification number of the staffing company.

2. If applicable, furnish the staffing company's "doing business as" (DBA) name. If the reported staffing company uses more than one DBA name with this supplier, report all that apply for Medicare claims.

3. Furnish the complete mailing address, telephone number, fax number and e-mail address for the staffing company.

C. 1st Staffing Company Contract/Agreement Information - The enrolling supplier must respond to the questions listed to verify that it fully understands and comprehends its contract and that it plans to adhere to all Medicare laws, regulations, and program instructions. At any time, the carrier can request a copy of the agreement/contract signed by the supplier and the staffing company.

D-E. 2nd Staffing Company - Sections D and E are to be used to report information on a 2nd staffing company that the supplier may be working for (or under contract with) to provide medical services. See instructions for Sections B and C above.

SECTION 11: SURETY BOND INFORMATION

This section has been intentionally omitted.

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9. For Future Use — This Section Not Applicable

10. Staffing Company

This section is to be completed with information about all staffing companies that use this supplier, either under written contract or by some other arrangement, to staff any other health care facilities. If this supplier is used by more than two staffing companies, copy and complete this section as needed. The supplier may be required to submit a copy of its current signed staffing company agreement/contract(s).

A. Check here ☐ if this entire section does not apply and skip to Section 13.

B. 1st Staffing Company using this Supplier - Name and Address

☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Legal Business Name as Reported to the IRS		Tax Identification Number
2. "Doing Business As" Name (if applicable)		
3. Business Street Address Line 1 (Street Name and Number)		
Business Street Address Line 2 (Suite, Room, etc.)		
City	State	ZIP Code + 4
Telephone Number (Ext.) ( ) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

C. 1st Staffing Company using this Supplier - Contract/Agreement Information

Answer the following questions about the staffing company and the supplier's contract/agreement with them.

1. Does the staffing company shown in Section 9B above **and** the billing agency identified in Section 8B have a common owner(s)? ☐ YES ☐ NO
2. If applicable, are there any provisions in the staffing contract/agreement that supersede or contradict the enrolling supplier's billing agreement? ☐ Not applicable ☐ YES ☐ NO

D. 2nd Staffing Company using this Supplier - Name and Address

☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Legal Business Name as Reported to the IRS		Tax Identification Number
2. "Doing Business As" Name (if applicable)		
3. Business Street Address Line 1 (Street Name and Number)		
Business Street Address Line 2 (Suite, Room, etc.)		
City	State	ZIP Code + 4
Telephone Number (Ext.) ( ) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

E. 2nd Staffing Company using this Supplier - Contract/Agreement Information

Answer the following questions about the staffing company's contract/agreement with this supplier.

1. Does the staffing company shown in Section 9D above **and** the billing agency identified in Section 8B have a common owner(s)? ☐ YES ☐ NO
2. If applicable, are there any provisions in the staffing contract/agreement that supersede or contradict the enrolling supplier's billing agreement? ☐ Not applicable ☐ YES ☐ NO

11. Surety Bond Information — This Section Not Applicable

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SECTION 12: CAPITALIZATION REQUIREMENTS FOR HOME HEALTH AGENCIES

This section has been intentionally omitted.

SECTION 13: CONTACT PERSON INFORMATION (OPTIONAL)

To assist in the timely processing of the supplier's application, provide the full name, e-mail address, telephone number, and mailing address of an individual who can be reached to answer questions regarding the information furnished in this application (preferably the individual who completed this application). The supplier is not required to furnish a contact person in this section. It should be noted that if a contact person is not provided, all questions about this application will be directed to the authorized official named in Section 15B.

A. Check Box - If this section does not apply, check the box and skip to Section 14.

B. Contact Person Information – If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

- Provide the name, e-mail address, telephone number, and mailing address of an individual who can answer questions about the information furnished in this application.

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION ON THIS ENROLLMENT APPLICATION

The supplier should review this section to understand those penalties that can be applied against it for deliberately furnishing false information to enroll or maintain enrollment in the Medicare program.

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12. Capitalization Requirements for Home Health Agencies This Section Not Applicable

13. Contact Person Information (Optional)

Furnish the name, telephone number and address of a person who can answer questions about the information furnished in this application (preferably the individual who completed this application). If a contact person is not furnished in this section, all questions will be directed to the authorized official named in Section 15B.

A. Check here ☐ if this section does not apply and skip to Section 14.

B. Contact Person Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

Name: First	Last	
Address Line 1 (Street Name and Number)		
Address Line 2 (Suite, Room, etc.)		
City	State	ZIP Code + 4
E-mail Address (if applicable)	Telephone Number ( )	(Ext.) ( )

14. Penalties for Falsifying Information on this Enrollment Application

This section explains the penalties for deliberately furnishing false information in this application to gain or maintain enrollment in the Medicare program.

1. 18 U.S.C. § 1001 authorizes criminal penalties against an individual who, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry.

Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000 (18 U.S.C. § 3571). Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against any individual who, "knowingly and willfully," makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program.

The offender is subject to fines of up to $25,000 and/or imprisonment for up to five years.

3. The Civil False Claims Act, 31 U.S.C. § 3729, imposes civil liability, in part, on any person who:
   a.) knowingly presents, or causes to be presented, to an officer or any employee of the United States Government a false or fraudulent claim for payment or approval;
   b.) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or
   c.) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

The Act imposes a civil penalty of $5,000 to $10,000 per violation, plus three times the amount of damages sustained by the Government.

4. Section 1128A(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency...a claim...that the Secretary determines is for a medical or other item or service that the person knows or should know:
   a.) was not provided as claimed; and/or
   b.) the claim is false or fraudulent.

This provision authorizes a civil monetary penalty of up to $10,000 for each item or service, an assessment of up to three times the amount claimed, and exclusion from participation in the Medicare program and State health care programs.

5. The government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment."

Remedies include compensatory and punitive damages, restitution, and recovery of the amount of the unjust profit.

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SECTION 15: CERTIFICATION STATEMENT

This section is used to officially notify the supplier of additional requirements that must be met and maintained in order for the supplier to be enrolled in the Medicare program. This section also requires the signature and date signed of an authorized official who can legally and financially bind the supplier to the laws, regulations, and program instructions of the Medicare program. Section 16 permits the authorized official to delegate signature authority to certain individual(s) (delegated officials) for the purpose of reporting changes to the supplier's enrollment record after the supplier has been enrolled. The supplier may have no more than one currently active authorized official at any given time. See below to determine who within the supplier organization qualifies as an authorized official.

A. Additional Requirements for Medicare Enrollment – These are the additional requirements that must be met by the supplier to enroll in and maintained by the supplier to bill the Medicare program. Carefully read these requirements. By signing, the supplier will be attesting to having read these requirements and that the supplier understands them.

B. Authorized Official Signature - If adding a new, or deleting an existing authorized official, check the appropriate box and indicate the effective date of that change. Otherwise:

- The authorized official must sign and date this application.

NOTE: The authorized official must also be reported in Section 6.

By his/her signature, the authorized official binds the supplier to all of the requirements listed in the Certification Statement and acknowledges that the supplier may be denied entry to or revoked from the Medicare program if any requirements are not met. **All signatures must be original.** Faxed, photocopied, or stamped signatures will not be accepted.

C. 2nd Authorized Official Signature - This section provided to report a second (optional) authorized official for this supplier. See instructions above for Section 15B.

An authorized official is an appointed official to whom the supplier has granted the legal authority to enroll it in the Medicare program, to make changes and/or updates to the supplier's status in the Medicare program (e.g., new practice locations, change of address, etc.), and to commit the supplier to fully abide by the laws, regulations, and program instructions of Medicare. The authorized official must be the supplier's general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of 5% or more of the supplier (see Section 5 for definition of a "direct owner"), or must hold a position of similar status and authority within the supplier's organization.

Only the authorized official has the authority to sign (1) the initial CMS 855B enrollment application on behalf of the supplier and (2) the CMS 855B enrollment application that must be submitted as part of the periodic revalidation process. The delegated official has no such authority.

By signing this form for initial enrollment in the Medicare program or for revalidation purposes, the authorized official agrees to immediately notify the Medicare program contractor if any information in the application is not true, correct, or complete. In addition, the authorized official, by his/her signature, agrees to notify the Medicare contractor of any future changes to the information contained in this form, after the supplier is enrolled in Medicare, within 90 days of the effective date of the change.

Governmental/Tribal Organizations

As stated in the instructions for Governmental/Tribal Organizations in Section 5, the authorized official signing the CMS 855B in Section 15 must be the same person submitting the letter attesting that the governmental or tribal organization will be legally and financially responsible for any outstanding debts owed to CMS. For instance, the head of a County Department of Health and Human Services would ordinarily qualify as an authorized official of the governmental entity.

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SPECIAL REPORTING REQUIREMENTS

To change authorized officials, the supplier must:

- Check the "Delete" box in Section 15B,
- Provide the effective date of the deletion, and
- Have the authorized official being deleted provide his/her printed name, signature, and date of signature.

NOTE: If the current authorized official's signature is unattainable (e.g., person has left the company), the Medicare contractor may request documentation verifying that the person is no longer the authorized official.

To then add a new authorized official, the supplier must:

- Copy the page containing the Certification Statement,
- Check the "Add" box in Section 15B and provide the effective date of the addition,
- Have the new authorized official provide the information requested in 15B, and
- Have the new authorized official provide his/her signature and date of signature.

By signing his or her name, the new authorized official assumes from the prior authorized official all of the powers (e.g., the power to delegate authority to a delegated official, etc.) previously held by the latter, and also agrees to adhere to all Medicare requirements, including those outlined in Sections 15A and 15B of the Certification Statement. However, a change of the authorized official has no bearing on the authority of existing delegated officials to make changes and/or updates to the supplier's status in the Medicare program.

If the supplier is reporting a change of information about the current authorized official (e.g., change in job title), this section should be completed as follows:

- Check the box to indicate a change and furnish the effective date,
- Provide the new information, and
- Have the authorized official sign and date this section.

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15. Certification Statement

This section is used to officially notify the supplier of additional requirements that must be met and maintained in order for the supplier to be enrolled in the Medicare program. This section also requires the signature and date signed of an "Authorized Official" who can legally and financially bind the supplier to the laws, regulations, and program instructions of the Medicare program. Section 16 permits the "Authorized Official" to delegate signature authority to other individual(s) (Delegated Officials) employed by the supplier for the purpose of reporting future changes to the supplier's enrollment record. See instructions to determine who qualifies as an Authorized Official and a Delegated Official for the supplier.

A. Additional Requirements for Medicare Enrollment

By his/her signature(s), the authorized official named below and the delegated official(s) named in Section 16 agree to adhere to the following requirements stated in this Certification Statement:

1.) I agree to notify the Medicare contractor of any future changes to the information contained in this form within 90 days of the effective date of the change. I understand that any change in the business structure of this supplier may require the submission of a new application.

2.) I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare billing number(s), and/or the imposition of fines, civil damages, and/or imprisonment.

3.) I agree to abide by the Medicare laws, regulations and program instructions that apply to this supplier. The Medicare laws, regulations, and program instructions are available through the Medicare contractor.

4.) Neither this supplier, nor any 5% or greater owner, partner, officer, director, managing employee, authorized official, or delegated official thereof is currently sanctioned, suspended, debarred, or excluded by the Medicare or Medicaid program, or any other Federal program, or is otherwise prohibited from supplying services to Medicare or other Federal program beneficiaries.

5.) I agree that any existing or future overpayment made to the supplier by the Medicare program may be recouped by Medicare through the withholding of future payments.

6.) I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

7.) I authorize the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Osteopathic Association (AOA), or any other national accrediting body whose standards are recognized by the Secretary as meeting the Medicare program participation requirements, to release to any authorized representative, employee, or agent of the Centers for Medicare & Medicaid Services (CMS), a copy of my most recent accreditation survey, together with any information related to the survey that CMS may require (including corrective action plans).

B. 1st Authorized Official Signature ☐ **Add** ☐ **Delete** **Effective Date:**_____

I have read the contents of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete to the best of my knowledge, and I authorize the Medicare program contractor to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare program contractor of this fact immediately.

Authorized Official Name **Print** First	Middle	Last	Jr., Sr., etc.
Authorized Official **Signature** (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)		Title/Position	Date (MM/DD/YYYY) Signed

C. 2nd Authorized Official Signature ☐ **Add** ☐ **Delete** **Effective Date:**_____

I have read the contents of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete to the best of my knowledge, and I authorize the Medicare program contractor to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare program contractor of this fact immediately.

Authorized Official Name **Print** First	Middle	Last	Jr., Sr., etc.
Authorized Official **Signature** (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)		Title/Position	Date (MM/DD/YYYY) Signed

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SECTION 16: DELEGATED OFFICIAL (OPTIONAL)

A delegated official must be a W-2 managing employee of the supplier, or an individual with a 5% or greater direct ownership interest in, or any partnership interest in, the enrolling supplier. Delegated officials are persons who are delegated the legal authority by the authorized official reported in Section 15B to make changes and/or updates to the supplier's status in the Medicare program. This individual must also be able to commit the supplier to fully abide by the laws, regulations, and program instructions of Medicare. For purposes of this section only, if the individual being assigned as a delegated official is a managing employee, that individual **must** be an actual W-2 employee of the enrolling supplier. The Medicare contractor may request evidence indicating that the delegated official is an actual employee of the supplier. Independent contractors are not considered "employed" by the supplier. A supplier can have no more than three delegated officials at any given time.

The signature of the authorized official in Section 16B2 constitutes a legal delegation of authority to any and all delegated official(s) assigned in Section 16.

A. Check Box - If the supplier chooses not to assign any delegated officials in this application, check the box in this section. There is no requirement that the supplier have a delegated official. However, if no delegated officials are assigned, the authorized official will be the only person who can make changes and/or updates to the supplier's status in the Medicare program. All delegated officials must meet the following requirements:

- The delegated official must sign and date this application,
- The delegated official must furnish his/her title/position, and
- The delegated official must check the box furnished if they are a W-2 employee.

NOTE: The delegated official must also be reported in Section 6.

B. Delegated Official Signature

If the supplier chooses to add delegated officials or to delete existing ones, this section should be completed as follows:

- Check the appropriate box indicating if the delegated official is being added or deleted and furnish the effective date,
- The authorized official must provide his or her signature and date of signature in Sections 15B and 16B2,
- The delegated official(s) to be added must provide the information and their signature in Section 16B, and
- The delegated official(s) to be deleted does not have to sign or date the application.

NOTE: All signatures must be original. Faxed, photocopied, or stamped signatures will not be accepted.

If the supplier is reporting a change of information about an existing delegated official (e.g., change in job title, etc.), this section should be completed as follows:

- Check the box marked "Change" and furnish the effective date,
- Provide the new information, and
- The authorized official must sign and date Sections 15B and 16B2.

Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the supplier's Medicare status. Even when delegated officials are reported in this application, an authorized official retains the authority to make any such changes and/or updates by providing his or her printed name, signature, and date of signature as required in Section 15B.

In addition, the delegated official, by his/her signature, agrees to notify the Medicare contractor of any changes to the information contained in this application within 90 days of the effective date of the change.

B. 2nd Delegated Official Signature - This section provided to report a second (optional) delegated official for this provider. See instructions above for Section 15B.

C. 3rd Delegated Official Signature - This section provided to report a third (optional) delegated official for this provider. See instructions above for Section 15B.

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SECTION 17: ATTACHMENTS

This section contains a list of documents that, if applicable, should be submitted with this enrollment application. Failure to provide the required documents will delay the enrollment process.

- Check the appropriate boxes indicating which documents are being submitted with this application.

NOTE: Any licenses that are needed to operate this business (both business and professional) in the State where the enrolling supplier business is located **must** be included with this application.

All enrolling suppliers are required to furnish information on all Federal, State and local (city/county) professional and business licenses, certifications and/or registrations as required in the supplier's State to operate as a health care facility (e.g., CLIA and FDA mammography certificates, hazardous waste disposal license, etc.). The Medicare contractor will supply specific licensing requirements for this supplier type upon request.

In lieu of copies of the above-requested documents, the enrolling supplier may submit a notarized Certificate of Good Standing from the supplier's State licensing/certification board or other medical associations. This certification cannot be more than 30 days old.

If the enrolling supplier has had a previously revoked or suspended license, certification or registration reinstated, attach a copy of the reinstatement notice with this application.

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16. Delegated Official (Optional)

The signature of the authorized official below constitutes a legal delegation of authority to the official(s) named in this section to make changes and/or updates to this supplier's enrollment information. The signature(s) of the delegated official(s) shall have the same force and effect as that of the authorized official, and shall legally and financially bind the supplier to the laws, regulations, and program instructions of the Medicare program. By his or her signature, the delegated official certifies that he or she has read the Certification Statement in Section 15 and agrees to adhere to all of the stated requirements. The delegated official also certifies that he/she meets the definition of a delegated official. When making changes and/or updates to the supplier's enrollment information maintained by the Medicare program, the delegated official certifies that the information provided is true, correct, and complete to the best of his/her knowledge.

A. Check here ☐ if this supplier will not be assigning any delegated official(s) and skip to Section 17.

B. 1st Delegated Official Signature ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Delegated Official Name **Print** First	Middle	Last	Jr., Sr., etc.
Delegated Official **Signature** (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed
Title/Position	☐Check here only if Delegated Official is a W-2 employee		
2. **Signature** of Authorized Official Assigning this Delegation (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed

C. 2nd Delegated Official Signature ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

3. Delegated Official Name **Print** First	Middle	Last	Jr., Sr., etc.
Delegated Official **Signature** (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed
Title/Position	☐Check here only if Delegated Official is a W-2 employee		
4. **Signature** of Authorized Official Assigning this Delegation (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed

D. 3rd Delegated Official Signature ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

5. Delegated Official Name **Print** First	Middle	Last	Jr., Sr., etc.
Delegated Official **Signature** (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed
Title/Position	☐Check here only if Delegated Official is a W-2 employee		
6. **Signature** of Authorized Official Assigning this Delegation (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed

17. Attachments

This section is a list of documents that, if applicable, should be submitted with this completed enrollment application.

Place a check next to each document (as applicable or required) from the list below that is being included with this completed application.

- ☐Copy(s) of all Federal, State, and/or local (city/county) professional licenses, certifications and/or registrations specifically required to operate as a health care facility
- ☐Copy(s) of all Federal, State, and/or local (city/county) business licenses, certifications and/or registrations specifically required to operate as a health care facility
- ☐Copy(s) of all professional school degrees or certificates, or evidence of qualifying course work
- ☐Copy(s) of all documentation verifying IDTF Supervisory Physician(s) proficiency
- ☐Copy(s) of all CLIA Certificates, FDA Mammography Certificates, and Diabetes Education Certificates
- ☐Copy(s) of all adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters)
- ☐Completed Form HCFA-588 - Authorization Agreement for Electronic Funds Transfer
- ☐Completed Form(s) CMS 855R - Individual Reassignment of Benefits
- ☐IRS documents confirming the tax identification number and legal business name (e.g., CP 575)

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Attachment 1 — AMBULANCE SERVICE SUPPLIERS

All ambulance service suppliers enrolling in the Medicare program must complete this attachment. For further information concerning Medicare requirements for ambulance service suppliers, review 42 CFR 410.40, 410.41, and 414.605.

SECTION 1: STATE LICENSE INFORMATION

This section is to be completed with information about the geographic area in which this company furnishes ambulance services. When applicable, State license information, as well as a copy of the license itself, must be submitted with this application.

A. Geographic Service Area - Check the appropriate box when the ambulance company is using this section to add or delete a geographic location. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

1. Initial Reporting and/or Additions - For initial enrollment, report all geographic areas where services are provided. Furnish the county/parish, city, State and ZIP Code for all geographic locations.

NOTE: If the ambulance company renders services in more than one State, and those States are serviced by different Medicare contractors (carriers), the supplier must complete a separate CMS 855B enrollment application for each Medicare contractor jurisdiction.

2. Deletions - If deleting a location where ambulance services were provided, indicate the county/parish, city, State, and ZIP Code of the location being deleted.

B. State License Information - Check the appropriate box to indicate whether the ambulance company is using this section to add, delete, or change information about the supplier's State license. Provide the effective date of that change, complete the appropriate information, and sign and date the certification statement. Otherwise:

1. Indicate whether the ambulance company has been licensed in the State where services are rendered.

2. If the enrolling ambulance company is not licensed by the State, explain why in the space provided.

3. If the answer is "Yes," provide all requested licensing information and attach a copy of the license. The effective date and expiration date must be stated on the license. Claims will be paid based on these dates. The enrolling supplier must provide the Medicare contractor with a copy of the license each time it is renewed in order to receive payment after the expiration date of the current license.

C. Paramedic Intercept Services Information - Check the appropriate box to indicate a change from the information currently on file. Provide the effective date of that change, complete the appropriate information, and sign and date the certification statement. Otherwise:

- Answer "Yes" or "No" to the question about paramedic intercept services. This question is necessary for billing purposes to correctly identify any paramedic intercept services relationships.

Paramedic Intercept Services involve an arrangement between a BLS ambulance company and an ALS ambulance company whereby the latter provides the ALS services and the BLS ambulance company provides the transportation component. If such an arrangement exists between the enrolling ambulance company and another ambulance company, the enrolling ambulance company must attach a copy of the signed contract(s). For more information, see 42 CFR 410.40.

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ATTACHMENT 1

Ambulance Service Suppliers

This attachment is to be completed by all ambulance service suppliers enrolling in the Medicare program.

1. State License Information

This section is to be completed with information about the geographic area in which this company furnishes ambulance services. When applicable, State license information must be provided. In addition, a copy of the current State license must be submitted with this application.

A. Geographic Service Area ☐ **Add** ☐ **Delete** **Effective Date:**_____

Furnish the county/parish, city, State and ZIP Code for all locations where this ambulance company renders service.

Note: If this ambulance company renders services in more than one State, and those States are serviced by different Medicare contractors, a separate CMS 855B enrollment application must be completed for each Medicare contractor jurisdiction.

1. Initial Reporting and/or Additions:

County/Parish:	City:	State:	ZIP Code(s):

2. Deletions:

County/Parish:	City:	State:	ZIP Code(s):

B. State License Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Is this ambulance company licensed in the State where services are rendered and billed for? ☐ YES ☐ NO

2. **IF NO**, explain why:_____

7. **IF YES**, furnish the license information for the State where this ambulance service supplier will be rendering services and billing Medicare. Attach a copy of the current State license.

License Number	Issuing State (if applicable)	Issuing County/Parish (if applicable)

Effective Date (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)

C. Paramedic Intercept Services Information ☐ **Change** **Effective Date:**_____

Does this ambulance company currently participate in a paramedic intercept services arrangement? ☐ YES ☐ NO

IF YES, submit a copy of the signed contractual agreement(s).

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SECTION 2: DESCRIPTION OF VEHICLE

A. 1st Vehicle Information - Check the appropriate box to indicate whether the ambulance company is using this section to add or delete a vehicle currently on file. Provide the effective date of that change, complete the appropriate information, and sign and date the certification statement. Otherwise:

1. The supplier must identify the type (e.g., automobile, aircraft, boat), year, make, model, and vehicle identification number of each vehicle.

2. Indicate what medical equipment each vehicle possesses. The vehicle(s) must be specifically designed to respond to medical emergencies or to provide acute medical care to transport the sick and injured. It must have customary patient care equipment including, but not limited to, a stretcher, clean linens, emergency medical supplies and oxygen equipment, and it must have all other safety and lifesaving equipment as required by State and local authorities.

3. If the ambulance will supply Advance Life Support (ALS) services, please provide documentation of certification from the authorized licensing and regulation agency for the area of operation.

Vehicles must be regularly inspected and re-certified according to applicable State and local licensing laws. Evidence of re-certification must be submitted to the Medicare contractor upon request.

IMPORTANT INSTRUCTIONS FOR AIR AMBULANCE

To qualify as an air ambulance supplier, the following is required:

1. A written statement, signed by the President, Chief Executive Officer or Chief Operating Officer of the airport from where the aircraft is hangered that gives the name and address of the facility, and

2. Proof that the enrolling ambulance company, or the company leasing the air ambulance vehicle to the enrolling ambulance company, possesses a valid charter flight license (FAA 135 Certificate) for the aircraft being used as an air ambulance. If the enrolling ambulance company owns the aircraft, the owner's name on the FAA 135 Certificate must be the same as the enrolling ambulance company's name (or the ambulance company owner as reported in Sections 5 or 6) in this application. If the enrolling ambulance company leases the aircraft from another company, a copy of the lease agreement must accompany this enrollment application.

B. 2nd Vehicle Information – This section is provided to report a second vehicle. See instructions above for Section 2A.

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2. Description of Vehicle

This section is to be completed with information about the vehicles used by this ambulance company, the equipment they carry, and the services they provide. If there are more than two vehicles, copy and complete this section as needed.
A copy of each vehicle's registration MUST be submitted. For air ambulance suppliers, attach a copy of FAA 135.

A. 1st Vehicle Information ☐ Add ☐ Delete ☐ Change **Effective Date:**_____

1. Type (automobile, aircraft, boat, etc.)		Vehicle Identification Number
Make	Model	Year (YYYY)

2. Does this vehicle have the following:

first aid supplies?	☐ YES ☐ NO	other safety/life-saving equipment?	☐ YES ☐ NO
oxygen equipment?	☐ YES ☐ NO	two-way telecommunications radio?	☐ YES ☐ NO
emergency warning lights?	☐ YES ☐ NO	mobile communication/wireless telephone?	☐ YES ☐ NO
sirens?	☐ YES ☐ NO	stretcher?	☐ YES ☐ NO
		clean linens?	☐ YES ☐ NO

Report other medical equipment this vehicle carries:

_____ _____ _____

3. Does this vehicle provide:

advanced life support (Level 1)?	☐ YES ☐ NO	specialty care transport?	☐ YES ☐ NO
advanced life support (Level 2)?	☐ YES ☐ NO	land ambulance?	☐ YES ☐ NO
basic life support?	☐ YES ☐ NO	air ambulance – fixed wing?	☐ YES ☐ NO
emergency runs?	☐ YES ☐ NO	air ambulance – rotary wing?	☐ YES ☐ NO
non-emergency runs?	☐ YES ☐ NO	marine ambulance?	☐ YES ☐ NO

How many crewmembers accompany this vehicle on runs?_____

B. 2nd Vehicle Information ☐ Add ☐ Delete ☐ Change **Effective Date:**_____

1. Type (automobile, aircraft, boat, etc.)		Vehicle Identification Number
Make	Model	Year (YYYY)

2. Does this vehicle have the following:

first aid supplies?	☐ YES ☐ NO	other safety/life-saving equipment?	☐ YES ☐ NO
oxygen equipment?	☐ YES ☐ NO	two-way telecommunications radio?	☐ YES ☐ NO
emergency warning lights?	☐ YES ☐ NO	mobile communication/wireless telephone?	☐ YES ☐ NO
sirens?	☐ YES ☐ NO	stretcher?	☐ YES ☐ NO
		clean linens?	☐ YES ☐ NO

Report other medical equipment this vehicle carries:

_____ _____ _____

3. Does this vehicle provide:

advanced life support (Level 1)?	☐ YES ☐ NO	specialty care transport?	☐ YES ☐ NO
advanced life support (Level 2)?	☐ YES ☐ NO	land ambulance?	☐ YES ☐ NO
basic life support?	☐ YES ☐ NO	air ambulance – fixed wing?	☐ YES ☐ NO
emergency runs?	☐ YES ☐ NO	air ambulance – rotary wing?	☐ YES ☐ NO
non-emergency runs?	☐ YES ☐ NO	marine ambulance?	☐ YES ☐ NO

How many crewmembers accompany this vehicle on runs?_____

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SECTION 3: QUALIFICATION OF CREW

A. 1st Crewmember Information - Check the appropriate box to indicate whether this ambulance company is using this section to add or delete a crewmember currently on file. Provide the effective date of that change, complete the appropriate information, and sign and date the certification statement. Otherwise:

1. Furnish the name, social security number, and date of birth of each crewmember.

2. Report all training completed by each crewmember.

All certificates verifying that the crewmembers have successfully completed the requisite training must be submitted with this application. Crewmembers must continue to pursue and complete continuing education requirements in accordance with State and local licensing laws. Evidence of re-certification must be submitted to the Medicare contractor upon request.

B. 2nd Crewmember Information - This section is provided to report additional crewmembers. See instructions above for Section 3A.

C. 3rd Crewmember Information - This section is provided to report additional crewmembers. See instructions above for Section 3A.

D. 4th Crewmember Information - This section is provided to report additional crewmembers. See instructions above for Section 3A.

E. 5th Crewmember Information - This section is provided to report additional crewmembers. See instructions above for Section 3A.

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3. Qualification of Crew

This section is to be completed with information about all crewmembers. In addition to the identifying information, all health care related training courses completed by the crewmember must be reported. If there are more than five crewmembers, copy and complete this section as needed.

A. 1st Crewmember Information ☐ Add ☐ Delete ☐ Change **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.
Social Security Number		Date of Birth (MM/DD/YYYY)	

2. List training completed by this crewmember (i.e., First Aid, CPR, ACLS, etc.) and attach copy(s) of training certificate(s).

_____

_____

B. 2nd Crewmember Information ☐ Add ☐ Delete ☐ Change **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.
Social Security Number		Date of Birth (MM/DD/YYYY)	

2. List training completed by this crewmember (i.e., First Aid, CPR, ACLS, etc.) and attach copy(s) of training certificate(s).

_____

_____

C. 3rd Crewmember Information ☐ Add ☐ Delete ☐ Change **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.
Social Security Number		Date of Birth (MM/DD/YYYY)	

2. List training completed by this crewmember (i.e., First Aid, CPR, ACLS, etc.) and attach copy(s) of training certificate(s).

_____

_____

D. 4th Crewmember Information ☐ Add ☐ Delete ☐ Change **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.
Social Security Number		Date of Birth (MM/DD/YYYY)	

2. List training completed by this crewmember (i.e., First Aid, CPR, ACLS, etc.) and attach copy(s) of training certificate(s).

_____

_____

E. 5th Crewmember Information ☐ Add ☐ Delete ☐ Change **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.
Social Security Number		Date of Birth (MM/DD/YYYY)	

2. List training completed by this crewmember (i.e., First Aid, CPR, ACLS, etc.) and attach copy(s) of training certificate(s).

_____

_____

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Attachment 2 — INDEPENDENT DIAGNOSTIC TESTING FACILITIES (IDTFs)

All suppliers that perform diagnostic tests, other than clinical laboratory or pathology tests, and are required to enroll as an IDTF must complete this attachment. CMS requires the information in this attachment to determine whether the enrolling supplier meets all IDTF standards. Not all suppliers that perform diagnostic tests are required to enroll as an IDTF. Generally, an entity can bill for the technical component of the diagnostic tests without an IDTF enrollment if it has the following characteristics:

- A physician practice that is owned, directly or indirectly, by one or more physicians or by a hospital;
- A facility that primarily bills for physician services (e.g., evaluation and management (E&M codes)) and not for diagnostic tests;
- A facility that furnishes diagnostic tests primarily to patients whose medical conditions are being treated or managed on an ongoing basis by one or more physicians in the practice;
- The diagnostic tests are performed and interpreted at the same location where the practice physicians also treat patients for their medical conditions.

However, if a substantial portion of the facility's business involves the performance of diagnostic tests, the diagnostic testing services may be a sufficiently separate business to require enrollment as an IDTF. In that case, the physician or physician group practice can continue to be enrolled as a physician or physician group practice but are also required to enroll as an IDTF. The physician or group practice can bill for professional fees and the diagnostic tests they perform on their patients using their billing number. Therefore, the practice must bill as an IDTF for diagnostic tests furnished to Medicare beneficiaries who are not regular patients of the physician or group practice.

Applicants who are unsure if they require IDTF enrollment should contact their Medicare carrier for a determination.

Diagnostic Radiology – Many diagnostic tests are radiological procedures that require the professional services of a radiologist. We recognize that a radiologist's practice is generally different from those of other physicians because radiologists usually do not bill E&M codes or treat a patient's medical condition on an ongoing basis. A radiologist or group practice of radiologists is not necessarily required to enroll as an IDTF. A radiologist or group of radiologists are not required to enroll as an IDTF if all of the following conditions are met:

- The practice is owned by radiologists, a hospital, or both;
- The owning radiologist(s) and any employed or contracted radiologist(s) regularly perform physician services (e.g., test interpretations) at the location where the diagnostic tests are performed;
- The billing patterns of the enrolled facility indicate that the facility is not primarily a testing facility and that it was organized to provide the professional services of radiologists (e.g., (1) the enrolled facility should not be billing for a significant number of purchased interpretations, (2) the facility should rarely only bill for the technical component of a diagnostic test, (3) the facility should bill for a substantial percentage of all interpretations of the diagnostic tests performed by the practice), and
- A substantial majority of the radiological interpretations are performed at the practice location where the diagnostic tests are performed.

If enrolling as a diagnostic radiology group practice or clinic, and will be billing for the technical component (tc) of diagnostic radiological tests without enrolling as an IDTF, the facility should be prepared to prove that it meets the exceptions shown above.

A mobile IDTF that provides X-ray services is not classified as a portable X-ray supplier. Therefore, they cannot bill for transportation and setup. If they desire to bill for these services, they must also enroll as a portable X-ray supplier and bill in accordance with the portable X-ray supplier billing rules.

Before completing this attachment, all providers/suppliers considering enrolling as an IDTF should carefully review 42 CFR 410.33, titled "Independent Diagnostic Testing Facility." This reference is available on the Internet through the National Archives and Records Administration web site, or at many libraries or legal reference services.

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Ambulatory Surgical Centers (ASCs) - An ASC cannot bill for separate diagnostic tests they perform during the ASC's scheduled hours of operation (see 42 CFR 416.2). When a provider or supplier that owns an ASC performs diagnostic tests in the same physical facility as the ASC, but during a time period when the ASC is not in operation, it must submit claims for those diagnostic tests and bill Medicare as an IDTF. Therefore, in this situation, a separate enrollment application is required by the provider or supplier to bill Medicare as an IDTF.

SECTION 1: SERVICE PERFORMANCE

CPT - 4 and HCPCS Codes - For initial enrollment, check the "Add" box and report all CPT-4 and HCPCS codes this IDTF will bill Medicare for. Otherwise:

- Indicate whether you are adding or deleting a code and provide the effective date of the addition or deletion. Provided that this is the only change the IDTF is reporting, complete the appropriate section and sign and date the certification statement. Otherwise:
  - Furnish the CPT – 4 or HCPCS code for which this IDTF intends to bill Medicare,
  - The name and type of equipment used to perform the reported procedure, and
  - The model number of the reported equipment.

The IDTF should report all Current Procedural Technology, Version 4 (CPT-4) codes, HCFA Common Procedural Coding System Codes (HCPCS), and types of equipment (including the model number), for which it will perform tests, supervise, interpret, and/or bill. All codes reported must be for diagnostic tests that an IDTF is allowed to perform. Specifically, diagnostic tests that are clearly surgical in nature, which must be performed in a hospital or ambulatory surgical center, should not be reported.

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ATTACHMENT 2

Independent Diagnostic Testing Facility (IDTF)

This attachment is to be completed by all Independent Diagnostic Testing Facilities enrolling in the Medicare program. See instructions to determine if this supplier needs to complete this Attachment to enroll in Medicare as an IDTF.

1. Service Performance

This section is to be completed with information about the types of tests performed by this IDTF, and the equipment used by this IDTF.

CPT - 4 and HCPCS Codes ☐ **Add** ☐ **Delete** **Effective Date:**_____

Furnish all Current Procedural Terminology, Version 4 (CPT-4) codes or HCFA Common Procedure Coding System codes (HCPCS) for which this IDTF intends to bill Medicare. In addition, report all equipment this IDTF will be using and the model number of each piece of equipment.

	CPT - 4 or HCPCS Code	Equipment	Model Number
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

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SECTION 2: INTERPRETING PHYSICIAN INFORMATION

This section is to be completed with identifying information on all physicians who interpret the test performed by the enrolling IDTF and for which the IDTF will bill Medicare.

A. Check Box - Check the box indicating that this section does not apply if the IDTF will not bill Medicare for interpretations of diagnostic tests performed by the IDTF and skip to Section 3. Otherwise:

B. 1st Interpreting Physician Information - Check the appropriate box to indicate whether completing this section to add, delete, or change information about a previously reported physician. Provide the effective date, complete the appropriate information, and sign and date the certification statement. Otherwise:

- Furnish the full name, social security number, date of birth, and Medicare identification number for each physician.

NOTE: All interpreting physicians must be currently enrolled in the Medicare Program.

NOTE: All interpreting physicians must complete and submit an Individual Reassignment of Benefits (CMS 855R) if:

- The interpreting physician is an employee of the IDTF,
- A contractor is working in a practice location that the IDTF owns or leases.

C. 2nd Interpreting Physician Information - This section is provided to report additional physicians. See instructions above for Section 2B.

D. 3rd Interpreting Physician Information - This section is provided to report additional physicians. See instructions above for Section 2B.

E. 4th Interpreting Physician Information - This section is provided to report additional physicians. See instructions above for Section 2B.

F. 5th Interpreting Physician Information - This section is provided to report additional physicians. See instructions above for Section 2B.

G. 6th Interpreting Physician Information - This section is provided to report additional physicians. See instructions above for Section 2B.

H. 7th Interpreting Physician Information - This section is provided to report additional physicians. See instructions above for Section 2B.

I. 8th Interpreting Physician Information - This section is provided to report additional physicians. See instructions above for Section 2B.

All interpreting physicians whose services will be billed for by the IDTF (commonly known as billing "globally") must be reported.

The IDTF must also report all independent contractor physicians (for which it will bill) who perform professional interpretations off the premises of the IDTF's practice location. For these interpretations to be billable by the IDTF, they must meet the conditions shown in MCM 3060.5 concerning purchased interpretations. A CMS 855R is not required for the interpreting physician in these situations.

When a mobile unit of the IDTF performs a technical component of a diagnostic test and the interpretive physician is the same physician who ordered the test, the IDTF **cannot** bill for the interpretation. Therefore, these interpreting physicians should not be reported since the interpretive physician must submit his/her own claims for these tests.

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2. Interpreting Physician Information

This section is to be completed with identifying information about all physicians whose interpretations will be billed by this IDTF. If there are more than eight physicians, copy and complete this section as needed.

A. Check here ☐ if this section does not apply and skip to Section 3 of this Attachment.

B. 1st Interpreting Physician Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

Name First	Middle	Last	Jr., Sr., etc.
Social Security Number	Date of Birth (MM/DD/YYYY)	Medicare Identification Number	

C. 2nd Interpreting Physician Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

Name First	Middle	Last	Jr., Sr., etc.
Social Security Number	Date of Birth (MM/DD/YYYY)	Medicare Identification Number	

D. 3rd Interpreting Physician Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

Name First	Middle	Last	Jr., Sr., etc.
Social Security Number	Date of Birth (MM/DD/YYYY)	Medicare Identification Number	

E. 4th Interpreting Physician Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

Name First	Middle	Last	Jr., Sr., etc.
Social Security Number	Date of Birth (MM/DD/YYYY)	Medicare Identification Number	

F. 5th Interpreting Physician Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

Name First	Middle	Last	Jr., Sr., etc.
Social Security Number	Date of Birth (MM/DD/YYYY)	Medicare Identification Number	

G. 6th Interpreting Physician Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

Name First	Middle	Last	Jr., Sr., etc.
Social Security Number	Date of Birth (MM/DD/YYYY)	Medicare Identification Number	

H. 7th Interpreting Physician Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

Name First	Middle	Last	Jr., Sr., etc.
Social Security Number	Date of Birth (MM/DD/YYYY)	Medicare Identification Number	

I. 8th Interpreting Physician Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

Name First	Middle	Last	Jr., Sr., etc.
Social Security Number	Date of Birth (MM/DD/YYYY)	Medicare Identification Number	

Note: All interpeting physicians must be currently enrolled in the Medicare Program.

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SECTION 3: PERSONNEL (TECHNICIANS) WHO PERFORM TESTS

This section is to be completed with identifying and qualification information about all personnel who perform the tests furnished by the IDTF. These persons are often referred to as technicians.

A. 1st Personnel (Technician) Information - Check the appropriate box to indicate whether this section is being completed to add, delete, or change information about a previously reported technician. Provide the effective date, complete the appropriate information, and sign and date the certification statement. Otherwise:

1. Furnish the full name, social security number, and date of birth for each technician.

2. If the technician is State licensed or certified, the applicable license and/or certification must be reported.

NOTE: Not all states have licensing requirements for all diagnostic tests. If a reported technician does not have either a State license or certification, or certification from a national credentialling body, he/she cannot perform the IDTF diagnostic tests and should not be reported. Notarized or certified true copies of the State license or certificate should be attached. The only exception to this is when a Medicare payable diagnostic test is not subject to State license or certification requirements, and no generally accepted national credentialling body exists. When this situation occurs, the technician performing the test must be reported. The IDTF should submit as an attachment any educational/credentialling and/or experience that the person has, and must fully justify why the individual should be considered qualified to perform the test(s) reported.

3. If a national credentialling body has certified the technician, furnish the name of the credentialling organization and the type of credentials issued to the technician. Notarized or certified true copies from the national credentialling body must be attached.

4. If the technician is also employed by, or working for, a hospital as well as an IDTF, this must be reported in this section. Furnish the name of the hospital where the technician is working or employed.

B. 2nd Personnel (Technician) Information - This section is provided to report additional technicians. See instructions above for Section 3A.

C. 3rd Personnel (Technician) Information - This section is provided to report additional technicians. See instructions above for Section 3A.

D. 4th Personnel (Technician) Information - This section is provided to report additional technicians. See instructions above for Section 3A.

E. 5th Personnel (Technician) Information - This section is provided to report additional technicians. See instructions above for Section 3A.

F. 6th Personnel (Technician) Information - This section is provided to report additional technicians. See instructions above for Section 3A.

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3. Personnel (Technicians) who Perform Tests

This section is to be completed with information about all non-physician personnel who perform tests for this IDTF. If there are more than six technicians, copy and complete this section as needed.

A. 1st Personnel (Technician) Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.
Social Security Number		Date of Birth (MM/DD/YYYY)	

2. Is this technician State licensed or State certified? ☐ YES ☐ NO

License/Certification Number (if applicable)	License/Certification Issue Date (if applicable) (MM/DD/YYYY)
State of Issuance (if applicable)	Type of License/Certification (if applicable)

3. Is this technician certified by a national credentialling organization? ☐ YES ☐ NO

Name of credentialling organization (if applicable)	Type of Credentials (if applicable)

4. Is this technician employed by a hospital? ☐ YES ☐ NO
IF YES, furnish the name of the hospital here:_____

B. 2nd Personnel (Technician) Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.
Social Security Number		Date of Birth (MM/DD/YYYY)	

2. Is this technician State licensed or State certified? ☐ YES ☐ NO

License/Certification Number (if applicable)	License/Certification Issue Date (if applicable) (MM/DD/YYYY)
State of Issuance (if applicable)	Type of License/Certification (if applicable)

3. Is this technician certified by a national credentialling organization? ☐ YES ☐ NO

Name of credentialling organization (if applicable)	Type of Credentials (if applicable)

4. Is this technician employed by a hospital? ☐ YES ☐ NO
IF YES, furnish the name of the hospital here:_____

C. 3rd Personnel (Technician) Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.
Social Security Number		Date of Birth (MM/DD/YYYY)	

2. Is this technician State licensed or State certified? ☐ YES ☐ NO

License/Certification Number (if applicable)	License/Certification Issue Date (if applicable) (MM/DD/YYYY)
State of Issuance (if applicable)	Type of License/Certification (if applicable)

3. Is this technician certified by a national credentialling organization? ☐ YES ☐ NO

Name of credentialling organization (if applicable)	Type of Credentials (if applicable)

4. Is this technician employed by a hospital? ☐ YES ☐ NO
IF YES, furnish the name of the hospital here:_____

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3. Personnel (Technicians) who Perform Tests (Continued)

D. 4th Personnel (Technician) Information ☐ Add ☐ Delete ☐ Change **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.
Social Security Number		Date of Birth (MM/DD/YYYY)	

2. Is this technician State licensed or State certified? ☐ YES ☐ NO

License/Certification Number (if applicable)	License/Certification Issue Date (if applicable) (MM/DD/YYYY)
State of Issuance (if applicable)	Type of License/Certification (if applicable)

3. Is this technician certified by a national credentialling organization? ☐ YES ☐ NO

Name of credentialling organization (if applicable)	Type of Credentials (if applicable)

4. Is this technician employed by a hospital? ☐ YES ☐ NO
IF YES, furnish the name of the hospital here:_____

E. 5th Personnel (Technician) Information ☐ Add ☐ Delete ☐ Change **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.
Social Security Number		Date of Birth (MM/DD/YYYY)	

2. Is this technician State licensed or State certified? ☐ YES ☐ NO

License/Certification Number (if applicable)	License/Certification Issue Date (if applicable) (MM/DD/YYYY)
State of Issuance (if applicable)	Type of License/Certification (if applicable)

3. Is this technician certified by a national credentialling organization? ☐ YES ☐ NO

Name of credentialling organization (if applicable)	Type of Credentials (if applicable)

4. Is this technician employed by a hospital? ☐ YES ☐ NO
IF YES, furnish the name of the hospital here:_____

F. 6th Personnel (Technician) Information ☐ Add ☐ Delete ☐ Change **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.
Social Security Number		Date of Birth (MM/DD/YYYY)	

2. Is this technician State licensed or State certified? ☐ YES ☐ NO

License/Certification Number (if applicable)	License/Certification Issue Date (if applicable) (MM/DD/YYYY)
State of Issuance (if applicable)	Type of License/Certification (if applicable)

3. Is this technician certified by a national credentialling organization? ☐ YES ☐ NO

Name of credentialling organization (if applicable)	Type of Credentials (if applicable)

4. Is this technician employed by a hospital? ☐ YES ☐ NO
IF YES, furnish the name of the hospital here:_____

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SECTION 4: SUPERVISING PHYSICIAN(S)

This section is to be completed with identifying information about the physician(s) who supervise the operation of the IDTF and who furnish the personal, direct, or general supervision per 42 CFR 410.32(b)(3). The supervising physician must also attest to his/her supervising responsibilities for the enrolling IDTF.

A. Supervising Physician Information - Check the appropriate box to indicate whether this section is being completed to add, delete, or change information about an existing supervising physician. Provide the effective date of the change, complete the appropriate information, and sign and date the certification statement. Otherwise:

1. Provide the full name, social security number, date of birth, Medicare identification number, telephone and fax numbers, and e-mail address for each supervisory physician.

2. General Supervision

- Check the appropriate boxes in this section to indicate the responsibilities assumed by the physician(s) reported in Section 4A1 furnishing General Supervision.

For each physician performing General Supervision, at least one of the three functions listed here must be checked. However, to meet the General Supervision requirement the enrolling IDTF must have at least one supervisory physician for **each** of the three functions. An example is where two physicians are responsible for function 1, a third physician is responsible for function 2, and a fourth physician is responsible for function 3. All four supervisory physicians must complete and sign the supervisory physician section of this application. They should **only** check the function(s) they actually perform.

3. Indicate the type of supervision provided by this physician for the tests performed by this IDTF.

Information concerning the type of supervision (personal, direct, or general) required for performance of specific IDTF tests can be obtained from the Medicare carrier. All IDTFs must report at least one supervisory physician, and at least one supervising physician must perform the supervision requirements stated in 42 CFR 410.32(b)(3). All supervisory physician(s) must be currently enrolled with Medicare. However, they can be enrolled with a Medicare contractor other than the one to which this application is being submitted. The physician's Medicare identification number must be reported.

The type of supervision being performed by each physician who signs the attestation in Section 4B should be indicated in Section 4A3. Definitions of the types of supervision are as follows:

Personal Supervision means a physician must be in attendance in the room during the performance of the procedure.

Direct Supervision in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and provide direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.

General Supervision means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. The qualifications and training of the non-physician personnel who actually perform the diagnostic procedure and the proper operation, maintenance, and calibration of the necessary equipment and supplies are the continuing responsibility of the physician. See the notes in this section of the application for guidance concerning: "Personal," "Direct," and "General" supervision.

B. Attestation Statement for Supervising Physicians – This section must be signed and dated by all Supervising Physician(s) rendering supervisory services for this IDTF.

1) Complete the name of the enrolling IDTF.

2) Report all CPT and HCPCS codes the IDTF performs that this supervising physician **will not** be supervising.

3) Furnish the dated signature of the supervising physician.

NOTE: All signatures must be original. Faxed, photocopied, or stamped signatures will not be accepted.

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4. Supervising Physician(s)

This section is to be completed with information about all supervising physicians. If there is more than one supervising physician, copy and complete this section for each.

A. Supervising Physician Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.
Social Security Number	Date of Birth (MM/DD/YYYY)	Medicare Identification Number (if applicable)	
Telephone Number (Ext.) ( ) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)	

2. General Supervision

For overall IDTF operation in accordance with 42 CFR 410.33(b), check all that apply for the Supervising Physician reported in Section 4A1 above:

- ☐ Assumes responsibility for the overall direction and control of the quality of testing performed.
- ☐ Assumes responsibility for assuring that the non-physician personnel who actually perform the diagnostic procedures are properly trained and meet required qualifications.
- ☐ Assumes responsibility for the proper maintenance and calibration of the equipment and supplies necessary to perform the diagnostic procedures.

3. Type of Supervision Provided

Check the applicable box below indicating the type of supervising provided by the physician reported in Section 4A1 above for the tests performed by the IDTF in accordance with 42 CFR 410.32 (b)(3) (Definitions).

(Check applicable box) ☐ Personal Supervision ☐ Direct Supervision ☐ General Supervision

Note: Personal / Direct: If this Supervising Physician performs Personal or Direct Supervision, he/she must be currently enrolled in Medicare with the Medicare carrier to which this application is being submitted.

Note: General: If this Supervising Physician performs General Supervision, he/she must be licensed in all States where he/she will be performing the General Supervision. If this Supervising Physician is not enrolled with the Medicare carrier to which this application is being submitted, he/she must submit a copy of his/her current State license for the state in which this application is being submitted.

B. Attestation Statement for Supervising Physicians

1) ***I hereby acknowledge that I have agreed to provide (IDTF Name)_____ with the Supervisory Physician services checked above for all CPT-4 and HCPCS codes reported in Section 1B of this Attachment*** (See number 2 below if all reported CPT-4 and HCPCS codes do not apply). ***I also hereby certify that I have the required proficiency in the performance and interpretation of each type of diagnostic procedure, as reported by CPT-4 or HCPCS code in Section 1B of this Attachment (except for those CPT-4 or HCPCS codes identified in number 2 below). I have read and understand the Penalties for Falsifying Information on this Enrollment Application, as stated in Section 14 of this application. I am aware that falsifying information may result in fines and/or imprisonment. If I cease providing the stated Supervisory Physician services, I shall immediately notify the Medicare program.***

2) ***I am not acting as a Supervising Physician for the following CPT-4 and/or HCPCS codes reported in Section 1B of this Attachment.***

CPT-4 or HCPCS Code	CPT-4 or HCPCS Code	CPT-4 or HCPCS Code
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3) **Signature** of Supervising Physician:	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)	Date (MM/DD/YYYY) Signed

MEDICARE

FEDERAL HEALTH CARE
PROVIDER/SUPPLIER ENROLLMENT APPLICATION

Application for Individual Health Care Practitioners

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB Approval No. 0938-0685

Keep a copy of this completed package for your records

Upon completion, return this application and all necessary documentation to:

OMB Approval No. 0938-0685

Medicare Provider/Supplier Enrollment Application

Privacy Act Statement

The Centers for Medicare and Medicaid Services (CMS) is authorized to collect the information requested on this form by sections 1124(a)(1), 1124A(a)(3), 1128, 1814, 1815, 1833(e), and 1842(r) of the Social Security Act [42 U.S.C. §§ 1320a-3(a)(1), 1320a-7, 1395f, 1395g, 1395(l)(e), and 1395u(r)] and section 31001(1) of the Debt Collection Improvement Act [31 U.S.C. § 7701(c)].

The purpose of collecting this information is to determine or verify the eligibility of individuals and organizations to enroll in the Medicare program as providers/suppliers of goods and services to Medicare beneficiaries and to assist in the administration of the Medicare program. This information will also be used to ensure that no payments will be made to providers or suppliers who are excluded from participation in the Medicare program. All information on this form is required, with the exception of those sections marked as "optional" on the form. Without this information, the ability to make payments will be delayed or denied.

The information collected will be entered into the Provider Enrollment, Chain and Ownership System (PECOS), and either system number 09-70-0525 titled Unique Physician/Practitioner Identification Number (UPIN) System (published in Vol. 61 of the Federal Register at page 20,528 (May 7, 1996)), or the National Provider Identifier (NPI) System, Office of Management and Budget (OMB) approval 0938-0684 (R-187). The information in this application will be disclosed according to the routine uses described below.

Information from these systems may be disclosed under specific circumstances to:

1) CMS contractors to carry out Medicare functions, collating or analyzing data, or to detect fraud or abuse;
2) A congressional office from the record of an individual health care provider in response to an inquiry from the congressional office at the written request of that individual health care practitioner;
3) The Railroad Retirement Board to administer provisions of the Railroad Retirement or Social Security Acts;
4) Peer Review Organizations in connection with the review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XVIII of the Social Security Act;
5) To the Department of Justice or an adjudicative body when the agency, an agency employee, or the United States Government is a party to litigation and the use of the information is compatible with the purpose for which the agency collected the information;
6) To the Department of Justice for investigating and prosecuting violations of the Social Security Act, to which criminal penalties are attached;
7) To the American Medical Association (AMA), for the purpose of attempting to identify medical doctors when the Unique Physician Identification Number Registry is unable to establish identity after matching contractor submitted data to the data extract provided by the AMA;
8) An individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, or to the restoration or maintenance of health;
9) Other Federal agencies that administer a Federal health care benefit program to enumerate/enroll providers of medical services or to detect fraud or abuse;
10) State Licensing Boards for review of unethical practices or non-professional conduct;
11) States for the purpose of administration of health care programs; and/or
12) Insurance companies, self insurers, health maintenance organizations, multiple employer trusts, and other health care groups providing health care claims processing, when a link to Medicare or Medicaid claims is established, and data are used solely to process provider's/supplier's health care claims.

The enrolling provider or supplier should be aware that the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503) amended the Privacy Act, 5 U.S.C. § 552a, to permit the government to verify information through computer matching.

Protection of Proprietary Information

Privileged or confidential commercial or financial information collected in this form is protected from public disclosure by Federal law 5 U.S.C. § 552(b)(4) and Executive Order 12600.

Protection of Confidential Commercial and/or Sensitive Personal Information

If any information within this application (or attachments thereto) constitutes a trade secret or privileged or confidential information (as such terms are interpreted under the Freedom of Information Act and applicable case law), or is of a highly sensitive personal nature such that disclosure would constitute a clearly unwarranted invasion of the personal privacy of one or more persons, then such information will be protected from release by CMS under 5 U.S.C. §§ 552(b)(4) and/or (b)(6), respectively.

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INDIVIDUAL HEALTH CARE PRACTITIONER INSTRUCTIONS

Please be sure to **PRINT** or **TYPE** all information so it is legible. Do not use pencil. Failure to provide all requested information might cause your application to be returned and may delay your enrollment. Certain sections of the application have been omitted because they do not apply to individual practitioners. See inside front cover for mailing instructions. Electronic copies of all CMS Medicare enrollment forms can be found at the Medicare website at http://www.cms.hhs.gov. These electronic forms may be downloaded to your computer, completed on screen, printed, signed, and mailed to the appropriate Medicare contractor.

Whenever you need to report additional information within a section, copy and complete that section for each additional entry. We strongly suggest that you keep a photocopy of your completed application and all supporting documents for future reference.

All physicians and non-physician practitioners who render medical services to Medicare beneficiaries and submit claims for the services rendered must complete this application. This form (CMS 855I for Individual Health Care Practitioners) is to report your personal information. If you plan to provide services as part of an organization to which you will reassign your benefits, you must also complete and submit a CMS 855R (Application for the Reassignment of Medicare Benefits) with this application. For each organization you join, you must complete and submit a separate CMS 855R to officially reassign your benefits to that organization. If you are terminating your association with an organization, use the CMS 855R to indicate that change. If you plan to render all of your services in a group setting, you will complete up to Section 4 of this application and then skip to Sections 13 through 17.

In addition to completing this enrollment application (CMS 855I), you may wish to complete and submit additional forms in the following situations:

- To accept assignment of the Medicare Part B payment for your services, complete the form "Medicare Participating Physician or Supplier Agreement" (Form HCFA-460).
- To have Medicare payments sent electronically to your bank account, complete the form "Medicare Authorization Agreement for Electronic Funds Transfers" (Form HCFA-588).

If you plan to do any of the above, submit the appropriate form(s)/agreement(s) with your application. The forms should have been received with this initial enrollment package. If you did not receive them, you can obtain the forms from the Medicare carrier or the forms can be found at http://www.cms.hhs.gov.

DEFINITIONS OF MEDICARE ENROLLMENT TERMINOLOGY

To help understand certain terms used throughout the application, we have included the following definitions:

Billing Agency-A company that you contract with to furnish claims processing functions for your practice.
Carrier-The Part B Medicare claims processing contractor.
Legal Business Name-The name you use when reporting to the Internal Revenue Service (IRS) for tax purposes.
Medicare Identification Number-This is a generic term for any number that uniquely identifies the enrolling practitioner. Examples of Medicare identification numbers are Unique Physician/Practitioner Identification Number (UPIN), National Provider Identifier (NPI), National Supplier Clearinghouse (NSC) number and Provider Identification number (PIN).
Provider Identification Number (PIN)-This number is assigned to providers, suppliers, groups and organizations in Medicare Part B. This number will identify who provided the service to the beneficiary on the Medicare claim form.
Tax Identification Number (TIN)-This is the number issued by the Internal Revenue Service (IRS) that the individual practitioner uses to report tax information to the IRS.
Unique Physician/Practitioner Identification Number (UPIN)-This number is assigned to physicians and non-physician practitioners to identify the referring or ordering physician on Medicare claims.

To reduce the burden of furnishing some types of supporting documentation, we have designated specific types of documentation to be furnished on an "as needed" basis. However, the carrier may request documentation at any time during the enrollment process, to support or validate information that is reported in this application. Some examples of documents that may be requested for validation are billing agreements, IRS W-2 forms, pay stubs, and staffing company contracts.

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SECTION 1: GENERAL INFORMATION

This section is to identify the reason for submittal of this application. It will also indicate whether you currently have a business relationship with Medicare.

A. Reason for Submittal of this Application - This section identifies the reason this application is being submitted.

1. Check one of the following:

Initial Enrollment:

- If you are enrolling in the Medicare program for the first time with this Medicare carrier under this tax identification number.
- If you are already enrolled with a carrier but need to enroll in another carrier's jurisdiction.

NOTE: You must be able to submit a valid claim within six months of enrolling or risk deactivation of your billing number once you have enrolled.

Reactivation:

- If your Medicare billing number was deactivated because of non-billing. Billing privileges may be deactivated when no claims are submitted in a six-month period. To reactivate billing privileges, you will be required to either submit an updated CMS 855I, or certify to the accuracy of your enrollment information currently on file with CMS. In addition, prior to being reactivated, you must be able to submit a valid claim. You must also meet all current requirements for your supplier type, regardless of whether you were previously enrolled in the program unless otherwise stated in regulation.

Revalidation:

- If you have been requested to revalidate your enrollment information currently on file with Medicare. Periodically (about once every three years), Medicare will require you to confirm and update **all** of your enrollment information. Check this box and complete this entire application unless instructed otherwise by the Medicare carrier. You may submit a copy of your original application with all changes clearly indicated and a current signature and date.

Change of Information:

- If you are adding, deleting, or changing information under this tax identification number. Check the appropriate section where the change is being reported. When providing the changed information, provide your Medicare identification number in Section 1, and provide the new/changed information in the applicable section. If you would like to provide a contact person to discuss these changes, please do so in Section 13. You must sign and date the certification statement in Section 15. **All changes must be reported to the carrier within 90 days of the effective date of the change.** Anytime you add a practice location that is located in a different state than where you are currently enrolled, you must provide a copy of your State license with that change.

NOTE: When submitting this application to report a change of information, only complete those sections necessary to report the change.

Voluntary Deactivation of Billing Number:

- If you know you will no longer be submitting claims to the Medicare program using this billing number. Voluntary deactivation ensures that your billing number will not be fraudulently used in the event of your retirement, leaving a group practice, etc. Provide the date you stopped practicing or the date on which you will stop billing for Medicare covered services and the billing number to be deactivated. In addition, please complete Section 1 to identify yourself, and sign and date the certification statement in Section 15.

NOTE: "Voluntary Deactivation" **cannot** be used to circumvent any corrective action plan or any pending/ongoing investigation.

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2. Social Security Number - For identification purposes, you must furnish your social security number. Section 1124A of the Social Security Act requires that you disclose your social security number to receive payment.

3. If you are currently enrolled in another carrier's jurisdiction, report the name of the carrier and your Medicare identification number or NPI in the spaces provided. For individual practitioners who are enrolled, this number will be your UPIN, PIN, NPI, and/or your National Supplier Clearinghouse (NSC) billing number. Report all currently active numbers.

4. Indicate if you would like to submit claims electronically. If you would like to submit claims electronically once you are enrolled in the Medicare program, you will need to complete an Electronic Data Interchange (EDI) agreement with your local Medicare carrier. Checking this box will alert the carrier to contact their claims processing department. The claims processing department will contact you to process an EDI agreement once your enrollment has been completed, approved, and a Medicare billing number issued to you. These EDI agreements cannot be established until the enrollment process has been completed and a Medicare billing number has been issued to you.

NOTE: If you do not have a Medicare identification number, you will be assigned one upon the successful completion of your enrollment. A separate Provider Identification Number (PIN) may be assigned to you by the local carrier. The carrier will explain what number(s) has been issued and how it is to be used. Normally, your application should be processed (from the receipt date at the carrier) within 60 days from the date you submitted it provided you have furnished all the requested information. If the carrier should contact you for additional information, you must provide it immediately to ensure the timely processing of your application.

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MEDICARE FEDERAL HEALTH CARE PRACTITIONER ENROLLMENT APPLICATION

Application for Individual Health Care Practitioners

General Instructions

The Medicare Federal Health Care Practitioner Enrollment Application has been designed by the Centers for Medicare and Medicaid Services (CMS) to assist in the administration of the Medicare program and to ensure that the Medicare program is in compliance with all regulatory requirements. The information collected in this application will be used to ensure that payments made from the Medicare trust fund are only paid to qualified health care practitioners and that the amounts of the payments are correct. This information will also identify whether you are qualified to render health care services and/or supplies to Medicare beneficiaries. To accomplish this, Medicare must know basic identifying and qualifying information about you in order for you to be granted billing privileges in the Medicare program.

When completing this application to enroll and bill the Medicare program as an individual practitioner, you need to tell Medicare (1) who you are, (2) what qualifies you to render health care related services and/or supplies to Medicare beneficiaries, (3) where or how you intend to render these services and/or supplies, and (4) any individuals or organizations that manage your practice.

This application **MUST** be completed in its entirety, unless otherwise stated in these instructions. If a section does not apply to you, check (√) the appropriate box in that section. Sections 7, 11, 12, and 16, have been deliberately omitted from this application because they are not applicable to the enrollment of individual health care practitioners.

1. General Information

This section is to be completed with general information as to why you are submitting this application and whether you currently have a business relationship with Medicare.
To ensure timely processing of this application, Numbers 1, 2, and 3 below MUST ALWAYS be completed.

A. Reason for Submittal of this Application

1. Check one: ☐ Initial Enrollment ☐ Reactivation ☐ Revalidation

☐ Change of Information - Check appropriate Section(s) below and furnish your Medicare Identification Number here:_____

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 8 ☐ 10 ☐ 13

☐ Voluntary Deactivation of Billing Number—Effective Date (MM/DD/YYYY):_____

Medicare Identification Number to be Deactivated:_____

2. Social Security Number:_____

3. Are you currently enrolled in the Medicare program? ☐ YES ☐ NO
IF YES, furnish the following information about your current carrier:

Current Carrier Name:_____ Current Medicare Identification Number or NPI:_____

4. Check here ☐ if you would like to submit claims electronically and are enrolling in Medicare for the first time.

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SECTION 2: PRACTITIONER IDENTIFICATION

A. Personal Information – The information furnished in this section will allow us to uniquely identify you in the Medicare program. Check the box "Change" only if you are reporting a change to existing information in this section. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

1. Provide your full name.
2. If you previously used another name(s), including a maiden name, supply that under "Other Name."
3. Provide your date, State, and country of birth.
4. Indicate your gender.
5. Furnish the name of the medical school or other health care training institution you attended for the Medical Specialty you will check in Section 2E1 or Section 2E2 and your year of graduation or certification.

B. Correspondence Address - This section will assist us in contacting you with any questions we have concerning your business relationship with the Medicare program.

Check the box "Change" only if you are reporting a change to existing information in this section. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

- **You must provide an address and telephone number where we can contact you directly to resolve any issues that may arise as a result of your enrollment in the Medicare program.** It also may be necessary to send you important changes/information concerning the Medicare program that directly impacts you and/or your Medicare payments. Therefore, this address cannot be that of your billing agency, management service organization, or staffing company. You may furnish your home address and telephone number if you choose.

C. Residency Status - Your responses to the questions in this section will assist us in determining your eligibility to bill Medicare for the services you render to Medicare patients.

Check the box "Change" only if you are reporting a change to existing information in this section. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

1. Check to identify if you are currently a resident, intern, or fellow at a health care facility.
   - If "Yes," provide the name of the facility where you serve as a resident/intern/fellow.
   - If "No," skip to Section 2D (Business Information).
2. State whether the services you render in the facility shown in Question 1 are part of your requirements for graduation from a formal residency program.
3. Indicate if you also render services at other facilities or practice locations.
   - If "Yes," you **must** report these other practice locations in Section 4 (Current Practice Location(s)).
4. Indicate if any services that you render, at any practice location you report in Section 4, are required for graduation from a formal residency program.
   - If "Yes," indicate if the teaching hospital has agreed to incur all or substantially all costs of the training in the other facility or practice location.

D. Business Information (if applicable) - Complete this section if you operate your practice as a business under a name different from your individual name. For instance, you must complete this section if your business is setup as a corporation. This information is needed to correctly report to the IRS all Medicare payments you receive and the tax identification number under which these payments are made.

Check the box "Change" only if you are reporting a change to existing information in this section. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

1. If this section does not apply to you, check the box provided and skip to Section 2E (Medical Specialty(s)).
2. Provide the legal business name you use when reporting tax information to the IRS. Supply your tax identification number as issued by the IRS and a copy of the IRS CP 575 or other documentation that confirms the reported TIN.

NOTE: If your business **is a corporation,** you will need to complete three applications. The 1st application (CMS 855I) is required to establish you as an individual practitioner with the Medicare program. The 2nd application (CMS 855B) is required to enroll your business. Once you complete the applications identifying yourself and your business, you must also complete a CMS 855R to reassign benefits payable to you as an individual practitioner to your business, which will be submitting claims for the services you have rendered. In addition, any other practitioners who render services for your business, who will be reassigning their benefits to the business, must also complete a CMS 855R.

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2. Practitioner Identification

This section is to be completed with information about yourself; where Medicare can contact you directly; whether you are rendering services in a health care facility as a resident or an intern; and whether you have established your practice as a separate business entity. You must also designate your medical specialty.

A. Personal Information ☐ **Change** **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
2. Other Name First (including Maiden)	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.

3. Date of Birth (MM/DD/YYYY)	State of Birth	Country of Birth

4. Gender ☐ Male ☐ Female

5. Medical School/Training Institution	Year of Graduation (YYYY)

B. Correspondence Address ☐ **Change** **Effective Date:**_____

You must furnish an address and telephone number where Medicare can contact you directly.

Mailing Address Line 1 (Street Name and Number)

Mailing Address Line 2 (Suite, Room, etc.)

City	State	ZIP Code + 4

Telephone Number (Ext.) ( ) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

C. Residency Status ☐ **Change** **Effective Date:**_____

1. Are you currently: a resident? ☐ YES ☐ NO
an intern? ☐ YES ☐ NO
in a fellowship program? ☐ YES ☐ NO

IF YES to any of the above questions, provide the name of the facility where you are a resident, intern, or fellow on the line below:

_____

IF NO, skip to Section 2D (Business Information) below.

2. Are the services that you render at the facility shown in Question 1 part of your requirements for graduation from a formal residency program? ☐ YES ☐ NO

3. Do you also render services at other facilities or practice locations? ☐ YES ☐ NO

IF YES, you must report these practice locations in Section 4 (Practice Location).

4. Are the services that you render in any of the practice locations you will be reporting in Section 4 (Practice Location) part of your requirements for graduation from a formal residency program? ☐ YES ☐ NO

IF YES, has the teaching hospital reported in Question 1 above agreed to incur all or substantially all of the costs of training in the non-hospital facility or location? ☐ YES ☐ NO

D. Business Information (if applicable) ☐ **Change** **Effective Date:**_____

1. Check here ☐ if this section does not apply to you and skip to Section 2E. Otherwise, furnish the following information if you operate your practice as a business under a name other than your own name.

2. Legal Business Name as Reported to the IRS	Tax Identification Number

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E. Medical Specialty

1. **Physician Specialty** - Check the box "Change" only if you are reporting a change to existing information in this section. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

a) If you are a physician, please enter the appropriate letter (P = primary, S = secondary) to indicate your specialty(s). You may only enter one (1) primary specialty and unlimited secondary specialties. If you do not see your specialty listed, check "Undefined physician type" and report your specialty in the space provided.

b) Submit a copy of your State physician license and furnish the license number, issue date and renewal date in the space provided.

NOTE: Diagnostic Radiology – If you checked diagnostic radiology as your specialty, and you will bill for the technical component (tc) of the diagnostic tests, you must contact the Medicare carrier prior to your enrollment to determine if you will also need to complete a CMS 855B to enroll in Medicare as an Independent Diagnostic Testing Facility (IDTF).

NOTE: Physicians who Bill for Diagnostic Tests (other than clinical laboratory or pathology tests) – As a physician, you may bill for these diagnostic tests as long as you do not provide a substantial portion of the diagnostic tests to patients who **are not** your patients. Patients are considered your own patients if:

- They have a prior relationship with you and are receiving medical treatment from you for a specific medical condition, or
- You are also billing for patient evaluation and management codes (E & M).

A separate (additional) enrollment as an IDTF may be required if, as stated above, substantial portions of your diagnostic tests (other than clinical laboratory or pathology) are provided to patients who are not your patients. Enrollment as an IDTF will not affect your enrollment as a physician. If you only furnish diagnostic tests, claims must be submitted as an IDTF. To enroll as an IDTF, you must complete and submit a CMS 855B.

2. **Non-Physician Specialty** - Check the box "Change" only if you are reporting a change to existing information in this section. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

a) If you are a non-physician practitioner, check the appropriate space to indicate your specialty. You may only check one non-physician specialty. If you want to enroll with more then one non-physician specialty you must submit a separate application for each. If you do not see your specialty listed, check "Undefined non-physician type" and report your specialty in the space provided.

b) All non-physician practitioners must meet specific licensing, educational (including any degrees and/or certificates), and work experience requirements. If you need information concerning the specific requirements for your specialty, contact the Medicare carrier. Submit copies of all necessary documentation to prove your eligibility to enroll in Medicare and furnish any license (or other) number, issue date and renewal date in the space provided.

F. Physician Assistants (PA) Only - Indicate if you are adding or deleting an employer. Provide the new information and the effective date of the addition or deletion. Provided that this is the only change in your information, you need to sign and date the certification statement. Otherwise:

- In order to determine who will be billing for your services, report all employers' names and Medicare billing numbers. This information will allow Medicare to appropriately associate you with each of your employers. All employers must be currently enrolled in the Medicare program.

NOTE: Physician Assistants – When completing this application, PAs should only complete Sections 1, 2, 3, 10, 13, 15 and 17. Also, PAs should not use or submit the CMS 855R form to report employers. The CMS 855R is only used to reassign benefits that would otherwise be paid directly to the practitioner.

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2. Practitioner Identification (Continued)

E. Medical Specialty(s)

1. Physician Specialty ☐ **Change** **Effective Date:**_____

a) Designate your primary speciality and all secondary specialty(s) below using: **P=Primary** **S=Secondary**

_____Addiction medicine	_____Hematology/Oncology	_____Otolaryngology
_____Allergy/Immunology	_____Infectious disease	_____Pathology
_____Anesthesiology	_____Internal medicine	_____Pediatric medicine
_____Cardiac surgery	_____Interventional Pain Management	_____Peripheral vascular disease
_____Cardiovascular disease (Cardiology)	_____Interventional radiology	_____Physical medicine and rehabilitation
_____Chiropractic	_____Maxillofacial surgery	_____Plastic and reconstructive surgery
_____Colorectal surgery (Proctology)	_____Medical oncology	_____Podiatry
_____Critical care (Intensivists)	_____Nephrology	_____Preventive medicine
_____Dermatology	_____Neurology	_____Psychiatry
_____Diagnostic radiology**(see note)	_____Neuropsychiatry	_____Pulmonary disease
_____Emergency medicine	_____Neurosurgery	_____Radiation oncology
_____Endocrinology	_____Nuclear medicine	_____Rheumatology
_____Family practice	_____Obstetrics/Gynecology	_____Surgical oncology
_____Gastroenterology	_____Ophthalmology	_____Thoracic surgery
_____General practice	_____Optometry	_____Urology
_____General surgery	_____Oral surgery (Dentist only)	_____Vascular surgery
_____Geriatric medicine	_____Orthopedic surgery	
_____Gynecological/Oncology	_____Osteopathic manipulative treatment	_____Undefined physician type (Specify): _____
_____Hand surgery		
_____Hematology		

b) **Submit a copy of your State Physician License** and furnish the following information:

License Number	Issue/Effective Date (MM/DD/YYYY)	Expiration/Renewal Date (MM/DD/YYYY)

2. Non–Physician Specialty ☐ **Change** **Effective Date:**_____

a) See instructions for specific non-physician requirements that must be met to enroll in the Medicare program and check the appropriate specialty below.

Check only one:

_____Anesthesiology Assistant	_____Nurse practitioner
_____Audiologist	_____Occupational therapist in private practice (see Sec. I)
_____Certified nurse midwife	_____Physical therapist in private practice (see Sec. I)
_____Certified registered nurse anesthetist	_____Physician assistant (see Sections F)
_____Clinical nurse specialist	_____Psychologist, Clinical (see Section G)
_____Clinical social worker	_____Psychologist billing independently (see Section H)
_____Mass immunization roster biller	_____Registered Dietitian or Nutrition Professional
	_____Undefined non-physician type (Specify): _____

b) Submit documentation (e.g., copies of licenses, degrees) that confirms you have met the requirements for your specialty and furnish the following information:

License (or other) Number	Issue/Effective Date (MM/DD/YYYY)	Expiration/Renewal Date (MM/DD/YYYY)

F. Physician Assistants (PA) Only ☐ **Add** ☐ **Delete** **Effective Date:**_____

This section must be completed by all physician assistants to ensure correct claims coding when billing for your services. Since physician assistants cannot bill the Medicare program directly, they must report the Medicare billing number for all employers that bill Medicare for their services. All employers must be enrolled in the Medicare program.

Employer's Name	Medicare Identification Number
_____	_____
_____	_____
_____	_____

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G. Clinical Psychologists - Questionnaire

Questions 1-4: All clinical psychologists must respond to these questions by checking "Yes" or "No" to determine your eligibility to bill Medicare.

H. Psychologists Billing Independently - Questionnaire

A psychologist billing independently is defined as:

- One who renders services free of the administrative and professional control of an employer such as a physician, institution, or agency, and
- Who maintains office space at his/her own expense and furnishes services only in that space or the patient's home, and
- Has the right to collect fees for the services rendered, and
- The patients treated are the psychologist's own patients.

Questions 1-4: All psychologists must respond to these questions by checking "Yes" or "No" to determine if you are eligible to bill Medicare as a psychologist who is independently billing.

I. Occupational/Physical Therapist in Private Practice (OT/PT) Only - Questionnaire

An occupational therapist/physical therapist in private practice is defined as one who maintains a private office even if services are always furnished in patients' homes. If services are furnished in private practice office space, that space must be owned, leased, or rented by the OT/PT practice and used for the exclusive purpose of operating the OT's /PT's practice.

Questions 1-5: All OTs/PTs must respond to these questions by checking "Yes" or "No." This information will determine your eligibility to bill Medicare.

J. Suppliers Employing Physician Assistants (Only) – This section is to be completed by all suppliers who want to delete physician assistants (PAs) within the practice.

Check if deleting the PA and provide the effective date of the deletion and the name and Medicare identification number of the PA.

NOTE: The supplier should not use or submit the CMS 855R form to report physician assistants. The CMS 855R is only used to reassign benefits that would otherwise be paid directly to a practitioner.

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2. Practitioner Identification (Continued)

G. Clinical Psychologists - Questionnaire

This section must be completed by all clinical psychologists in order to determine if you are eligible to bill Medicare. Please answer all questions in this section.

1. Do you hold a doctoral degree in psychology? ☐ YES ☐ NO
   IF YES, furnish the field of your psychology degree:_____
2. Do you inform each Medicare patient of the desirability of conferring with the patient's attending or primary care physician to consider potential medical conditions contributing to the patient's condition? ☐ YES ☐ NO
3. Contingent upon the patient's consent, do you consult with the patient's designated attending or primary care physician in accordance with accepted professional ethical norms, taking into consideration patient confidentiality? ☐ YES ☐ NO
4. If the patient assents to the consultation, do you attempt to consult with the patient's physician within a reasonable time after receiving consent? ☐ YES ☐ NO

H. Psychologists Billing Independently - Questionnaire

This section must be completed by all psychologists billing independently in order to determine if you are eligible to bill Medicare as a psychologist "billing independently." Please answer all questions in this section.

1. Do you render services of your own responsibility free from the administrative control of an employer such as a physician, institution, or agency? ☐ YES ☐ NO
2. Do you treat your own patients? ☐ YES ☐ NO
3. Do you have the right to bill directly, and to collect and retain the fee for your services? ☐ YES ☐ NO
4. Is your private practice located in an institution? ☐ YES ☐ NO
   IF YES to question 4 above, please answer questions "a" and "b" below.

a) If your private practice is located in an institution, is your office confined to a separately identified part of the facility that is used solely as your office and cannot be construed as extending throughout the entire institution? ☐ YES ☐ NO

b) If your private practice is located in an institution, are your services also rendered to patients from outside the institution or facility where your office is located? ☐ YES ☐ NO

I. Occupational/Physical Therapist in Private Practice (OT/PT) - Questionnaire

This section must be completed by all occupational and physical therapists in order to determine if you are eligible to bill Medicare for services rendered in your private practice. Please answer all questions in this section.

1. Are all of your OT/PT services only rendered in the patients' homes? ☐ YES ☐ NO
2. Do you maintain private office space? ☐ YES ☐ NO
3. Do you own, lease, or rent your private office space? ☐ YES ☐ NO
4. Is this private office space used exclusively for your private practice? ☐ YES ☐ NO
5. Do you provide OT/PT services outside of your office and/or patients' homes? ☐ YES ☐ NO
   IF YES, provide a copy of the lease agreement that gives you exclusive use of the facility for OT/PT services.

J. Suppliers Employing Physician Assistants (Only)

This section is to be completed when deleting PAs from the supplier's practice.

Delete	Date	Physician Assistant Name	Medicare Identification Number
☐	_____	_____	_____
☐	_____	_____	_____
☐	_____	_____	_____
☐	_____	_____	_____
☐	_____	_____	_____
☐	_____	_____	_____
☐	_____	_____	_____

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SECTION 3: ADVERSE LEGAL ACTIONS AND OVERPAYMENTS

A. Adverse Legal History - This section is to be completed with information concerning any adverse legal actions that have been imposed or levied against you. See Table A on the application form for a list of adverse actions that must be reported.

If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. You must state whether, under any current or former name or business identity, you have ever had any of the adverse legal actions listed in Table A of the application form imposed against you.

2. If the answer to this question is "Yes," supply all requested information. Attach copies of official documentation related to the adverse legal action. Such documentation includes adverse legal action notifications (e.g., notification of disciplinary action; criminal court documentation that verifies the conviction of a crime) and documents that evidence how the adverse legal action was finally resolved (e.g., reinstatement notices, etc.).

If you are uncertain as to whether you fall within one of the adverse legal action categories or whether a name reported on this application has an adverse legal action, query the Healthcare Integrity and Protection Data Bank. If you need information on how to access the data bank, call 1-800-767-6732 or visit www.npdb-hipdb.com. There is a charge for using this service.

Table A - This is the list of adverse legal actions that must be reported. All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

B. Overpayment Information - Current laws found in the Federal Streamlining Act and the Debt Collection Improvement Act require all Federal agencies to determine whether an individual or business entity that enters into a business relationship with that agency has any outstanding debts, including overpayments under different identifiers. Failure to furnish information about overpayments will put you in violation of these Acts and subject you to possible denial of your Medicare enrollment.

1. You must report all outstanding Medicare overpayments that you are liable for, including those paid to you, or on your behalf, under a different name. For purposes of this section, the term "outstanding Medicare overpayment" is defined as a debt that meets **all** of the conditions listed below:

   a) The overpayment arose out of your current or previous enrollment in Medicare. This includes any overpayment incurred by you under a different name or business identity, or in another Medicare contractor jurisdiction;

   b) CMS (or its contractors) has determined that you are liable for the overpayment; and

   c) The overpayment is not or has not been included as part of a repayment plan approved by CMS (or its contractors), nor is the overpayment amount being repaid through the withholding of Medicare payments to you.

Any overpayment not meeting all of these conditions should not be reported.

2. Furnish the name or business identity under which the overpayment occurred and the account number under which the overpayment exists.

NOTE: Overpayments that occur after your enrollment has been approved do not need to be reported unless you are enrolling with a different Medicare contractor.

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3. Adverse Legal Actions and Overpayments

This section is to be completed with information concerning any adverse legal actions and/or overpayments that have been imposed or levied against you (see Table A below for list of adverse actions that must be reported).

A. Adverse Legal History ☐ **Change** **Effective Date:**_____

1. Have you, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A below imposed against you? ☐ YES ☐ NO
2. **IF YES**, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Table A

1) Any felony conviction under Federal or State law, regardless of whether it was health care related.

2) Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.

3) Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.

4) Any misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.

5) Any misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

6) Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.

7) Any revocation or suspension of accreditation.

8) Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.

9) Any current Medicare payment suspension under any Medicare billing number.

Note: All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

B. Overpayment Information

1. Do you, under any current or former name or business identity, have any outstanding Medicare overpayments? ☐ YES ☐ NO
2. **IF YES**, furnish the name and account number under which the overpayment(s) exists.

Name under which the overpayment occurred:	Account number under which the overpayment exists:
_____	_____
_____	_____

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SECTION 4: CURRENT PRACTICE LOCATION(S)

This section is to be completed with information about your private practice and group affiliations. If you want to make a change to existing information about your group affiliations, you must use the CMS 855R to report those changes.

A. Group Practice Information

1. Indicate whether **ALL** of your services will be rendered as part of a group or other organization. If "Yes," this means that you do not have a private practice where you treat Medicare patients. This also means that a group(s) or organization(s) will be billing Medicare for the services you render and that you have given the group or organization the authority to bill for you. To reassign your benefits, you must complete and submit a CMS 855R for each group to which your benefits will be reassigned.

   a-c) Provide the legal name and Medicare billing number for up to three groups. If the group's application is pending, indicate "pending" on your application in the space provided for the group's Medicare number. If you belong to more than three groups, copy and complete this section as needed. After completing this section, skip to Sections 13 through 17.

2. Indicate whether **SOME** of your services will be rendered in a group setting. If not, check the box "No," and continue with Section 4B below. If "Yes," this means that in addition to your private practice you will render some services as part of a group practice, and that you have given the authority to the group to bill for these services.

   a-c) Provide the legal name and Medicare billing number for up to three groups. If the group's application is pending, indicate "pending" on your application in the space provided for the group's Medicare number. If you belong to more than three groups, copy and complete this section as needed. After completing this section, continue completing this application at Section 4B with information about your private practice.

B. Practice Location Information - Complete this section for each of your own private practice locations where you render services to Medicare beneficiaries. **The information provided in this section will pertain to your private practice only.** Check the box to indicate if you are adding a new practice location under an existing tax identification number, deleting a practice location, or changing information about an existing practice location. Provided that this is the only change in your information, provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. Provide the name of your practice location. If you use a "doing business as" name, provide that name in this section. Furnish the date you started rendering services at this location.
2. Furnish the complete street address for your practice location.

This address must be a specific street address as recorded by the United States Postal Service. Do not report a P.O. Box. Only report those practice locations within the Medicare carrier jurisdiction where you will be submitting this application, including reporting additions, deletions or other changes to these practice locations. If you render services in a hospital and/or other health care facility that bills Medicare directly for the services you render at that facility, furnish the name and address of that hospital or facility. In addition, provide the telephone number of this practice location. Do not provide a billing agency's telephone number. The fax number and e-mail address are optional.

If you only render services in patients' homes (house calls), you may supply your home address if you do not have an office. In Section 4E, explain that this address is for administrative purposes only and that all services are rendered in patients' homes.

If you render services in a retirement or assisted living community, complete this section with the names, telephone numbers and addresses of those communities.

3. Indicate whether you own/lease the practice location.
4. Indicate whether this address is that of a private practice office setting, hospital, retirement/assisted living community or other health care facility. Please specify if it does not fall within one of these categories.
5. If you have a CLIA number(s) and/or FDA/Radiology (Mammography) Certification Number(s) for this practice location, provide that information in this section. Submit a copy of the most current CLIA and FDA certification for each of the practice locations reported.

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4. Current Practice Location(s)

This section is to be completed with information about where you currently render medical services to Medicare patients. You must complete this entire section beginning with Section 4A1 and carefully follow all instructions in each part. If you need additional space to report additional groups/organizations or if you have more than one private practice location, copy and complete this section as needed for each.

A. Group Practice Information

Beginning with Section 4A1, answer "**Yes**" or "**No**" to each question. When applicable, furnish the group/organization name and Medicare number for each group/organization to which you will reassign your benefits. In addition to identifying the group/organization to which you will reassign your benefits in this section, either you or each group/organization reported in this section must also complete and submit a CMS 855R (Individual Reassignment of Benefits) with this application. Reassigning benefits means that you are authorizing the group/organization to bill Medicare for the services you have rendered at the group/organization's practice location.

1. Will **all** of your services be rendered as part of a group(s) or organization(s) to which you will reassign your benefits? ☐ YES ☐ NO
IF YES, furnish the name and Medicare identification number of each group or organization below and skip to Sections 13 through 17.
IF NO, proceed to Question 2 below.

a) Name of Group/Organization	Group/Organization Medicare Number
b) Name of Group/Organization	Group/Organization Medicare Number
c) Name of Group/Organization	Group/Organization Medicare Number

2. Will **any** of your services be rendered as part of a group(s) or organization(s) to which you will reassign your benefits? ☐ YES ☐ NO
IF YES, furnish the name and Medicare identification number of each group or organization below and continue completing the rest of this application at Section 4B.
IF NO, continue with Section 4B below with information about your private practice.

a) Name of Group/Organization	Group/Organization Medicare Number
b) Name of Group/Organization	Group/Organization Medicare Number
c) Name of Group/Organization	Group/Organization Medicare Number

B. Practice Location Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Practice Location Name			Date You Started Rendering Services at this Location (MM/DD/YYYY)
2. Practice Location Street Address Line 1 (Street Name and Number)			
Practice Location Street Address Line 2 (Suite, Room, etc.)			
City	County/Parish	State	ZIP Code + 4
Telephone Number ( )	(Ext.) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

3. Do you own/lease this practice location? ☐YES ☐ NO

4. Is this practice location a:
private practice office setting? ☐YES ☐ NO
hospital? ☐YES ☐ NO
retirement/assisted living community? ☐YES ☐ NO
other health care facility? (Specify):_____ ☐YES ☐ NO

5. CLIA Number for this location (if applicable)	FDA/Radiology (Mammography) Certification Number for this location (if applicable)

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C. Medicare Payment "Pay To" Address Information - Check the box "Change" only if you are reporting a change to existing information in this section. Provided that this is the only change in your information, furnish the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

If you are enrolling for the first time, state where you want your Medicare payments to be sent. The ability to establish more than one "Pay To" address will be addressed by the local Medicare carrier. Therefore, if you want to establish multiple "Pay To" addresses you need to contact the carrier. Some Medicare carriers do not allow multiple payment addresses.

- Provide the P.O. Box or street address, city, State and ZIP Code for your payment address.

If you would like your payments to be deposited to your bank account electronically, place a check in the box given and complete the "Medicare Authorization Agreement for Electronic Funds Transfers" (Form HCFA-588).

- If payment will be paid by electronic funds transfer (EFT), the "Pay To" address should indicate where you want all other payment information (e.g., remittance notices, special payments, etc.) sent.

NOTE: Payment can only be made in your name as shown in Section 2A1 or your legal business name as shown in Section 2D2.

D. Location of Patients' Medical Records - Check the box "Change" only if you are reporting a change to existing information in this section. Provided that this is the only change in your information, provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. If all of your patients' medical records are located at the practice location in Section 4B, check the box provided and skip this section.

2. If any of your patients' medical records are stored in a location other than the practice location in Section 4B, complete this section with the complete address of all storage locations.

Post Office boxes and drop boxes are not acceptable as physical addresses where patients' medical records are maintained.

E. Comments – This section is to be used as an opportunity to explain any unusual circumstances concerning your practice location, "Pay To" address, the location of your patients' medical records, or how they are maintained and/or stored.

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4. Current Practice Location (Continued)

C. Medicare Payment "Pay To" Address Information ☐ **Change** **Effective Date:**_____

Furnish the address where payments should be sent for services rendered at the practice location in Section 4B.

"Pay To" Address (Organization or Individual Name)		
"Pay To" Address Line 1 (Street Name and Number)		
"Pay To" Address Line 2 (Suite, Room, etc.)		
City	State	ZIP Code + 4

Check here ☐ and submit a completed Form HCFA-588 with this application if you would like to have your payments electronically transferred to your bank account.

D. Location of Patients' Medical Records ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Check here ☐ if **all** of your patients' medical records are stored in the practice location(s) shown in Section 4B, and skip this section.
2. If **any** of your patients' medical records are stored in a location other than the practice location(s) shown in Section 4B, complete this section for each additional storage location.

Name of Storage Facility/Location		
Street Address Line 1		
Street Address Line 2		
City	State	ZIP Code + 4

E. Comments

Explain any unique or unusual circumstances concerning your practice location(s) or the method by which you render health care services (e.g., you only render services in patients' homes (house calls only)).

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SECTION 5: MANAGING CONTROL INFORMATION (ORGANIZATIONS)

This section is to be completed with information about any organization that manages your practice. See explanation below of organizations that should be reported in this section. If individuals, and not organizations, manage your practice, do not complete this section. These individuals must be reported in Section 6. If there is more than one organization, copy and complete this section as needed.

A managing organization is defined as any organization that exercises operational or managerial control over the practitioner's practice/business, or conducts the day-to-day operations of the practitioner's practice/business. This could be a management services organization, either under contract or through some other arrangement with the practitioner to furnish management services for any of his/her practice/business location(s).

In most situations when you use a management services organization, the organization would be reported in this section and the individual person from the organization who works in your office, or handles the management or administrative duties from outside your office, would be reported in Section 6.

A. Check Box - Check the box if there are no organizations to be reported in this section and proceed to Section 6.

B. Organization with Managing Control - Identification Information – Indicate if you are adding or deleting a managing organization, or changing information about an existing managing organization. Provide the new information and the effective date of the change. Provided that this is the only change in your information, you need to sign and date the certification statement. Otherwise:

1. Provide the legal business name of the managing/controlling organization.
2. Provide the managing/controlling organization's "doing business as" name (if applicable).
3. Provide the managing/controlling organization's full business street address.
4. Provide the managing/controlling organization's tax identification number and, if one has been issued, its Medicare identification number.

IMPORTANT **– Only organizations should be reported in Section 5. Individuals must be reported in Section 6.**

SECTION 6: MANAGING EMPLOYEE INFORMATION (INDIVIDUALS)

This section is to be completed with information about all managing individuals (employed or otherwise) working at any of your practice locations, to ensure they meet all the conditions of participation in the Medicare program.

A managing employee is defined as any individual (other than yourself), including a general manager, business manager, office manager or administrator, who exercises operational or managerial control over your practice/business, or who conducts the day-to-day operations of your practice/business. For Medicare enrollment purposes, a managing employee also includes any individual who manages your day-to-day operations, either under contract or through some other arrangement, but who is not your actual employee.

All managing employees at any of your practice locations shown in Section 4B must be reported in this section. However, this does not include individuals employed by hospitals, health care facilities or other organizations shown in Section 4B, or managing employees of any group or organization to which you reassign your benefits. For instance, the CEO of a hospital where one of your practice locations is situated should not be reported. If you have more than three managing employees, copy and complete this section as needed.

A. Check Box - Check the box if there are no managing employees to be reported in this section and proceed to Section 7.

B. Identifying Information - Indicate whether you are adding or deleting a managing employee, or changing information about an existing managing employee. Provide the new information and the effective date of the change. Provided that this is the only change in your information, you need to sign and date the certification statement. Otherwise:

1. Provide the full name of the managing employee.
2. Provide the managing employee's title and date of birth.
3. Provide the managing employee's social security number and Medicare identification number or NPI (if applicable).

C-D. 2nd and 3rd Managing Employee - Identifying Information - Section 6C and 6D are additional sections to provide information about a second and third managing employee. Follow the instructions in Sections 6B.

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5. Managing Control Information (Organizations)

This section is to be completed with information about all organizations that manage the day-to-day operations of the enrolling practitioner's practice. See instructions for an explanation of organizations that should be reported here. If there is more than one management organization, copy and complete this section as needed.

A. Check here ☐ if this section does not apply and skip to Section 6.

B. Organization with Managing Control—Identification Information

☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Legal Business Name as Reported to the IRS		
2. "Doing Business As" Name (if applicable)		
3. Business Address Line 1 (Street Name and Number)		
Business Address Line 2 (Suite, Room, etc.)		
City	State	ZIP Code + 4
4. Tax Identification Number	Medicare Identification Number(s) or NPI(s) (if applicable)	

6. Managing Employee Information (Individuals)

This section is to be completed with personal identification information about all managing employees. See instructions for the definition of managing employee to determine who should be reported here. If there are more than three managing employees, copy and complete this section as needed.

A. Check here ☐ if this section does not apply and skip to Section 8.

B. 1st Managing Employee - Identifying Information

☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.	
2. Title	Date of Birth (MM/DD/YYYY)			
3. Social Security Number	Medicare Identification Number or NPI (if applicable)			

C. 2nd Managing Employee - Identifying Information

☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.	
2. Title	Date of Birth (MM/DD/YYYY)			
3. Social Security Number	Medicare Identification Number or NPI (if applicable)			

D. 3rd Managing Employee - Identifying Information

☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.	
2. Title	Date of Birth (MM/DD/YYYY)			
3. Social Security Number	Medicare Identification Number or NPI (if applicable)			

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SECTION 7: CHAIN HOME OFFICE INFORMATION

This section has been intentionally omitted.

SECTION 8: BILLING AGENCY

The purpose of collecting this information is to develop effective monitoring of agents/agencies that prepare and/or submit claims to bill the Medicare program. A billing agency is a company or individual you hired or contracted with to furnish claims processing functions for your practice. Any entity that meets this description must be reported in this section.

A. Check Box - If you do not have a billing agency, check the box and skip to Section 10.

B. Billing Agency Name and Address - Indicate if you are adding or deleting a billing agent and/or making a change concerning your existing relationship with your billing agency. Provide the new information and the effective date of the change. Provided that this is the only change you are making, you will need to sign and date the certification statement. Otherwise, if you use a billing agency:

1. Provide the billing agency's legal business name and tax identification number.

2. If the billing agency has a "doing business as" name, provide that information in this space.

3. Provide the street address, telephone number, fax number and e-mail address of the billing agency.

C. Billing Agreement/Contract Information - If reporting a change to existing information about a previously reported billing agreement/contract, check "Change," provide the effective date of the change, complete this entire questionnaire, and sign and date the certification statement. Otherwise:

You are responsible for answering the questions listed.

These questions are designed to show that you fully understand and comprehend your billing agreement and that you intend to adhere to all Medicare laws, regulations, and program instructions. If you do not understand a question or you need help in interpreting your agreement, contact the Medicare carrier. At any time, the carrier may request copies of all agreements/contracts associated with this billing agency.

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7. Chain Home Office Information — This Section Not Applicable

8. Billing Agency

This section is to be completed if you use or contract with a billing agency to submit claims to Medicare on your behalf. If you use more than one billing agency, copy and complete this section for each. You may be required to submit a copy of your current signed billing agreement/contract if Medicare cannot verify the information furnished in this section.

A. Check here ☐ if this section does not apply and skip to Section 10.

B. Billing Agency Name and Address ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Legal Business Name as Reported to the IRS	Tax Identification Number
2. "Doing Business As" Name (if applicable)	
3. Business Street Address Line 1	
Business Street Address Line 2	

City	State	ZIP Code + 4
Telephone Number (Ext.) ( ) ( )	Fax Number (optional) ( )	E-mail Address (optional)

C. Billing Agreement/Contract Information ☐ **Change** **Effective Date:**_____

Answer the following questions about your agreement/contract with the above billing agency.

1. Do you have unrestricted access to your Medicare remittance notices? ☐ YES ☐ NO

2. Does your Medicare payment go directly to you? ☐ YES ☐ NO
IF NO, proceed to Question 3.
IF YES, skip Questions 3, 4 and 5.

3. Does your Medicare payment go directly to a bank? ☐ YES ☐ NO
IF NO, proceed to Question 4.
IF YES, answer the following questions and skip Questions 4 and 5.
a) Is the bank account in your name only? ☐ YES ☐ NO
b) Do you have unrestricted access to the bank account and statements? ☐ YES ☐ NO
c) Does the bank only answer to you regarding what you wants from the bank (e.g., sweep account instructions, bank statements, closing account, etc.)? ☐ YES ☐ NO

4. Does your Medicare payment go directly to your billing agent? ☐ YES ☐ NO
IF NO, proceed to Question 5.
IF YES, answer the following question and skip Question 5.
a) Does the billing agent cash your check? ☐ YES ☐ NO
IF NO, proceed to Question b.
IF YES, are <u>all</u> of the following conditions included in the billing agreement?
1) The agent receives payment under an agency agreement with you. ☐ YES ☐ NO
2) The agent's compensation is not related in any way to the dollar amounts billed or collected. ☐ YES ☐ NO
3) The agent's compensation is not dependent upon the actual collection of payment. ☐ YES ☐ NO
4) The agent acts under payment disposition instructions that you may modify or revoke at any time. ☐ YES ☐ NO
5) In receiving payment, the agent acts only on your behalf (except insofar as the agent uses part of that payment as compensation for the agent's billing and collection services). ☐ YES ☐ NO
b) Does the billing agent either give the Medicare payment directly to you or deposit the payment into your bank account? ☐ YES ☐ NO

5. Who receives your Medicare payment?_____

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SECTION 9: FOR FUTURE USE

This section is being reserved for possible future use.

SECTION 10: STAFFING COMPANY

A staffing company is an organization that contracts with health care professionals to furnish health care at medical facilities (such as hospital emergency rooms) where it is also under contract (or some similar agreement) to furnish such services. A staffing company cannot bill Medicare in the staffing company's name for medical services or supplies furnished under this arrangement. If you have an agreement/contract with a staffing company to furnish services to Medicare beneficiaries, complete this section. At any time, the carrier can request a copy of the agreement/contract signed by you and the staffing company.

A. Check Box - If you do not work for (or do not contract with) a staffing company, check this box and skip to Section 13.

B. Staffing Company Name and Address - Indicate if you are "adding," "deleting," or "making a change," concerning your relationship with an existing staffing company by checking the appropriate box. Provide the new information and the effective date of the change, and sign and date the certification statement. Otherwise:

1. Furnish the legal business name and tax identification number of the staffing company.

2. If applicable, furnish the staffing company's "doing business as" (DBA) name. If the reported staffing company uses more than one DBA name with you, report all that apply for Medicare claims.

3. Furnish the complete mailing address, telephone number, fax number and e-mail address for the staffing company.

C. Staffing Company Contract/Agreement Information

Respond to the questions asked in this section to indicate that you fully understand and comprehend your contract with the staffing company and that you plan to adhere to all Medicare laws, regulations, and program instructions. At any time, the carrier can request a copy of the agreement/contract signed by you and the staffing company.

SECTION 11: SURETY BOND INFORMATION

This section has been intentionally omitted.

SECTION 12: CAPITALIZATION REQUIREMENTS FOR HOME HEALTH AGENCIES

This section has been intentionally omitted.

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9. For Future Use — This Section Not Applicable

10. Staffing Company

This section is to be completed if you are under contract to render medical services with a company that staffs health care organizations (e.g., hospital emergency rooms) with medical professionals to treat patients. If you are under contract with more than one staffing company, copy and complete this section for each. You may be required to submit a copy of your current signed staffing company agreement/contract.

A. Check here ☐ if this section does not apply and skip to Section 13.

B. Staffing Company Name and Address ☐ Add ☐ Delete ☐ Change Effective Date:_____

1. Legal Business Name as Reported to the IRS	Tax Identification Number	
2. "Doing Business As" Name (if applicable)		
3. Business Street Address Line 1 (Street Name and Number)		
Business Street Address Line 2 (Suite, Room, etc.)		
City	State	ZIP Code + 4
Telephone Number (Ext.) ( ) ( )	Fax Number (optional) ( )	E-mail Address (optional)

C. Staffing Company Contract/Agreement Information

Answer the following questions about the staffing company and your contract/agreement with it.

1. If you have a contract/agreement with both a billing agency and a staffing company, does the staffing company shown in Section 9B **and** the billing agency identified in Section 8B have a common owner(s)? ☐ Not applicable ☐ YES ☐ NO

2. If you have a contract/agreement with both a billing agency and a staffing company (even if the billing agency and staffing company are the same), are there any provisions in your staffing company contract/agreement that supersede or contradict your billing agreement? ☐ Not applicable ☐ YES ☐ NO

11. Surety Bond Information — This Section Not Applicable

12. Capitalization Requirements for Home Health Agencies — This Section Not Applicable

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SECTION 13: CONTACT PERSON INFORMATION - OPTIONAL

To assist in the timely processing of your application, you may want to provide the full name, e-mail address, telephone number, and mailing address of an individual who can be reached to answer questions regarding the information furnished in this application (preferably the individual who completed this application if other than yourself). You are not required to furnish a contact person in this section. It should be noted that if a contact person is not provided, all questions about this application will be directed to you.

A. Check Box - If you do not have a contact person, check this box and skip to Section 14.

B. Contact Person Information - Indicate if you are completing this section to add or delete a contact person currently on file. State the effective date of the change. If you are changing existing information, check the applicable box and provide the effective date of the change, and sign and date the certification statement. Otherwise:

- Furnish the full name, mailing address, e-mail address, and telephone number of an individual who can answer questions about the information furnished in this application.

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION ON THIS ENROLLMENT APPLICATION

This section explains the penalties for deliberately furnishing false information to acquire or maintain enrollment in the Medicare program. You should review this section to ensure that you understand those penalties that can be applied against you for deliberately furnishing false information in this Medicare enrollment application.

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13. Contact Person Information (Optional)

This section is to be completed with the name and telephone number of a person, other than yourself, who can answer questions about the information furnished in this application (preferably the individual who completed this application). You do not need to furnish any name if you want all questions directed to you.

A. Check here ☐ if this section does not apply and skip to Section 14.

B. Contact Person Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

Name First	Last	
Address Line 1 (Street Name and Number)		
Address Line 2 (Suite, Room, etc.)		
City	State	ZIP Code + 4
E-mail Address (if applicable)	Telephone Number ( )	(Ext.) ( )

14. Penalties for Falsifying Information on this Enrollment Application

This section explains the penalties for deliberately furnishing false information in the application to gain or maintain enrollment in the Medicare program.

1. 18 U.S.C. § 1001 authorizes criminal penalties against an individual who, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry.

Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000 (18 U.S.C. § 3571). Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against any individual who, "knowingly and willfully," makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program.

The offender is subject to fines of up to $25,000 and/or imprisonment for up to five years.

3. The Civil False Claims Act, 31 U.S.C. § 3729, imposes civil liability, in part, on any person who:
   a.) knowingly presents, or causes to be presented, to an officer or any employee of the United States Government a false or fraudulent claim for payment or approval;
   b.) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or
   c.) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

The Act imposes a civil penalty of $5,000 to $10,000 per violation, plus three times the amount of damages sustained by the Government.

4. Section 1128A(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency...a claim...that the Secretary determines is for a medical or other item or service that the person knows or should know:
   a.) was not provided as claimed; and/or
   b.) the claim is false or fraudulent.

This provision authorizes a civil monetary penalty of up to $10,000 for each item or service, an assessment of up to three times the amount claimed, and exclusion from participation in the Medicare program and State health care programs.

5. The government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment."

Remedies include compensatory and punitive damages, restitution, and recovery of the amount of the unjust profit.

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SECTION 15: CERTIFICATION STATEMENT

As an individual practitioner, you are the only person who can sign this application. This applies not only to initial enrollment and revalidation, but also to any changes and/or updates (e.g., new practice locations, change in specialties, address changes, etc.) to your status in the Medicare program. The authority to sign the application on your behalf may not be delegated to any other person.

The Certification Statement contains certain standards that must be met for initial and continuous enrollment in the Medicare program. Review these requirements carefully.

By signing the Certification Statement, you agree to adhere to all of the requirements listed therein and acknowledge that you may be denied entry to or revoked from the Medicare program if any requirements are not met. **Your signature must be an original.** Faxed, photocopied, or stamped signatures will not be accepted.

SECTION 16: DELEGATED OFFICIAL

This section has been intentionally omitted.

SECTION 17: ATTACHMENTS

This section contains a list of documents that, if applicable, must be submitted with this enrollment application. Failure to provide the required documents will delay the enrollment process.

- Check the appropriate boxes indicating which documents are being submitted with this application.

NOTE: Any licenses (both business and professional) that are required by the State where your practice is located **must** be included with this application.

All enrolling practitioners are required to furnish information on all Federal, State and local (city/county) professional and business licenses, certifications and/or registrations as required by the practitioner's State to operate as a health care supplier (e.g., CLIA and FDA mammography certificates, hazardous waste disposal license, etc.). The Medicare contractor will supply specific licensing requirements for your supplier type upon request.

In lieu of copies of the above requested documents, you may submit a notarized Certificate of Good Standing from the State licensing/certification board or other medical associations. This certification cannot be more than 30 days old.

If you have had a previously revoked or suspended license, certification, or registration reinstated, attach a copy of the reinstatement notice with this application.

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15. Certification Statement

You **MUST** sign and date the certification statement below in order to be enrolled in the Medicare program. In doing so, you are attesting to meeting and maintaining the Medicare requirements stated below.

I, the undersigned, certify to the following:

1.) I have read the contents of this application, and the information contained herein is true, correct, and complete to the best of my knowledge. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare program contractor of this fact immediately.

2.) I authorize the Medicare contractor to verify the information contained herein. I agree to notify the Medicare contractor of any future changes to the information contained in this form within 90 days of the effective date of the change. I understand that any change in my status as an individual practitioner may require the submission of a new application.

3.) I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare billing privileges, and/or the imposition of fines, civil damages, and/or imprisonment.

4.) I agree to abide by the Medicare laws, regulations and program instructions that apply to me. The Medicare laws, regulations, and program instructions are available through the Medicare contractor.

5.) Neither I, nor any managing employee, is currently sanctioned, suspended, debarred, or excluded by the Medicare or Medicaid program, or any other Federal program, or is otherwise prohibited from providing services to Medicare or other Federal program beneficiaries.

6.) I agree that any existing or future overpayment made to me by the Medicare program may be recouped by Medicare through the withholding of future payments.

7.) I understand that the Medicare billing number issued to me can only be used by me or by a provider or supplier to whom I have reassigned my benefits under current Medicare regulations, when billing for services rendered by me.

8.) I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

9.) I further certify that I am the individual practitioner who is applying for Medicare billing privileges.

Practitioner Name **Print** First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Practitioner **Signature** (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed	

16. Delegated Official — This Section Not Applicable

17. Attachments

This section is a list of documents that, when applicable, should be submitted with this completed enrollment application.

Place a check next to each document (as applicable or required) that you are including with this completed application.

- ☐ Copy(s) of all Federal, State, and/or local (city/county) professional licenses, certifications and/or registrations specifically required to operate as a health care facility
- ☐ Copy(s) of all Federal, State, and/or local (city/county) business licenses, certifications and/or registrations specifically required to operate as a health care facility
- ☐ Copy(s) of all certificates or evidence of qualifying course work
- ☐ Copy(s) of all CLIA Certificates, FDA Mammography Certificates, and Diabetes Education Certificates
- ☐ Copy(s) of all adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters)
- ☐ Completed Form HCFA-460 – Medicare Participating Physician or Supplier Agreement
- ☐ Completed Form HCFA-588 - Authorization Agreement for Electronic Funds Transfer
- ☐ Completed Form CMS 855R – Individual Reassignment of Benefits
- ☐ IRS documentation confirming the Tax Identification Number with the Legal Business Name (e.g., CP 575)
- ☐ Any additional documentation or letters of explanation as needed

MEDICARE

FEDERAL HEALTH CARE
REASSIGNMENT OF BENEFITS APPLICATION

Application for Individual Health Care Practitioners to Reassign Medicare Benefits

CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS 855R (01/2003)

OMB Approval No. 0938-0685

Keep a copy of this completed package for your own records.

Upon completion, return this application and all necessary documentation to:

OMB Approval No. 0938-0685

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare Provider/Supplier Enrollment Application

Privacy Act Statement

The Centers for Medicare and Medicaid Services (CMS) is authorized to collect the information requested on this form by sections 1124(a)(1), 1124A(a)(3), 1128, 1814, 1815, 1833(e), and 1842(r) of the Social Security Act [42 U.S.C. §§ 1320a-3(a)(1), 1320a-7, 1395f, 1395g, 1395(l)(e), and 1395u(r)] and section 31001(1) of the Debt Collection Improvement Act [31 U.S.C. § 7701(c)].

The purpose of collecting this information is to determine or verify the eligibility of individuals and organizations to enroll in the Medicare program as providers/suppliers of goods and services to Medicare beneficiaries and to assist in the administration of the Medicare program. This information will also be used to ensure that no payments will be made to providers or suppliers who are excluded from participation in the Medicare program. All information on this form is required, with the exception of those sections marked as "optional" on the form. Without this information, the ability to make payments will be delayed or denied.

The information collected will be entered into the Provider Enrollment, Chain and Ownership System (PECOS), and either system number 09-70-0525 titled Unique Physician/Practitioner Identification Number (UPIN) System (published in Vol. 61 of the Federal Register at page 20,528 (May 7, 1996)), or the National Provider Identifier (NPI) System, Office of Management and Budget (OMB) approval 0938-0684 (R-187). The information in this application will be disclosed according to the routine uses described below.

Information from these systems may be disclosed under specific circumstances to:

1) CMS contractors to carry out Medicare functions, collating or analyzing data, or to detect fraud or abuse;
2) A congressional office from the record of an individual health care provider in response to an inquiry from the congressional office at the written request of that individual health care practitioner;
3) The Railroad Retirement Board to administer provisions of the Railroad Retirement or Social Security Acts;
4) Peer Review Organizations in connection with the review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XVIII of the Social Security Act;
5) To the Department of Justice or an adjudicative body when the agency, an agency employee, or the United States Government is a party to litigation and the use of the information is compatible with the purpose for which the agency collected the information;
6) To the Department of Justice for investigating and prosecuting violations of the Social Security Act, to which criminal penalties are attached;
7) To the American Medical Association (AMA), for the purpose of attempting to identify medical doctors when the Unique Physician Identification Number Registry is unable to establish identity after matching contractor submitted data to the data extract provided by the AMA;
8) An individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, or to the restoration or maintenance of health;
9) Other Federal agencies that administer a Federal health care benefit program to enumerate/enroll providers of medical services or to detect fraud or abuse;
10) State Licensing Boards for review of unethical practices or non-professional conduct;
11) States for the purpose of administration of health care programs; and/or
12) Insurance companies, self insurers, health maintenance organizations, multiple employer trusts, and other health care groups providing health care claims processing, when a link to Medicare or Medicaid claims is established, and data are used solely to process provider's/supplier's health care claims.

The enrolling provider or supplier should be aware that the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503) amended the Privacy Act, 5 U.S.C. § 552a, to permit the government to verify information through computer matching.

Protection of Proprietary Information

Privileged or confidential commercial or financial information collected in this form is protected from public disclosure by Federal law 5 U.S.C. § 552(b)(4) and Executive Order 12600.

Protection of Confidential Commercial and/or Sensitive Personal Information

If any information within this application (or attachments thereto) constitutes a trade secret or privileged or confidential information (as such terms are interpreted under the Freedom of Information Act and applicable case law), or is of a highly sensitive personal nature such that disclosure would constitute a clearly unwarranted invasion of the personal privacy of one or more persons, then such information will be protected from release by CMS under 5 U.S.C. §§ 552(b)(4) and/or (b)(6), respectively.

OMB Approval No. 0938-0685

INDIVIDUAL REASSIGNMENT OF MEDICARE BENEFITS INSTRUCTIONS

Please **PRINT** or **TYPE** all information so it is legible. Do not use pencil. Failure to provide all requested information may cause this form to be returned and delay the processing of your reassignment. This application is to be completed for any **individual practitioner** who will be reassigning his or her benefits to an eligible provider or supplier. See inside front cover for return mailing instructions. Electronic copies of all CMS Medicare enrollment forms can be found at the Medicare web-site at http://www.cms.hhs.gov. These electronic forms may be downloaded to your computer, completed on screen, printed, signed, and mailed to the appropriate Medicare contractor.

SECTION 1: GENERAL INFORMATION

Check the applicable box indicating the reason for the submittal of this application.

Add a New Reassignment – Check this box and furnish the effective date when an individual practitioner who is enrolling or is currently enrolled in the Medicare program will be reassigning his/her benefits to this provider/supplier for the 1st time. The provider/supplier **must** be enrolled or currently enrolling in Medicare before a reassignment can be effectuated. When adding a reassignment, complete Sections 1, 2, 3, 5, 6 and 7.

Terminate a Current Reassignment – Check this box and furnish the effective date when an individual practitioner who has reassigned his/her benefits to this provider/supplier is terminating that reassignment. No reassigned claims will be paid to the provider/supplier for services rendered by the practitioner identified in Section 3 after the effective date of deletion.

- When the group/clinic is terminating the reassignment, the group/clinic must complete Sections 1, 2, 3, 6, and 7.
- When the individual practitioner is terminating the reassignment, he/she must complete Sections 1, 2, 3, 4, and 7.

Change Income Reporting Status – Check this box and furnish the effective date when reporting a change in the type of income tax withholding (e.g., if a practitioner changes his/her work status from "Employee" to "Independent Contractor") reported to the IRS for the individual practitioner who has reassigned his/her benefits to this provider/supplier. When changing the practitioner's income reporting status, complete Sections 1, 2, 3, 6 and 7.

Attesting to Current Reassignment – Check this box if you have been requested to declare all those groups or other entities you are affiliated with in which you have current valid reassignment of benefits established. All individuals that have 5 or more active reassignments with 5 or more groups/entities are required to confirm this information periodically. You will need to complete a separate CMS 855R for each group/entity to whom you reassign your benefits. When attesting to current reassignments complete Sections 1, 2, 3, 5, and 7.

NOTE: All changes must be reported to the carrier within 90 days of the effective date of the change.

SECTION 2: PROVIDER/SUPPLIER IDENTIFICATION

This section is to be completed with information about the provider/supplier to which the individual practitioner's benefits will be reassigned or have already been reassigned.

NOTE: Prior to the reassignment of benefits to this provider/supplier, both the individual practitioner **AND** the provider/supplier must be enrolled (or concurrently enrolling) in the Medicare program. If the individual practitioner's or the provider/supplier's initial enrollment application is being submitted concurrently with this reassignment application, write **"pending"** in the Medicare identification number block.

Furnish the provider/supplier's name and tax identification number as reported to the IRS, and the provider/supplier's group specialty and Medicare identification number or National Provider Identifier (NPI).

NOTE: The provider/supplier's name as reported to the IRS must be the same as reported on the provider/supplier's CMS 855B when it enrolled.

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SECTION 3: INDIVIDUAL PRACTITIONER IDENTIFICATION

This section is to be completed for each individual practitioner who is reassigning (or terminating reassignment) of his or her Medicare benefits to the provider/supplier shown in Section 2 of this form.

- Furnish the individual's full given name, social security number, Medicare identification number or National Provider Identifier (NPI), and specialty.

- Indicate what income reporting form the individual receives from the provider/supplier based on his/her employment with the provider/supplier.

NOTE: Prior to the reassignment of benefits to this provider/supplier, both the individual practitioner **AND** the provider/supplier must be enrolled (or concurrently enrolling) in the Medicare program. If the individual practitioner's or the provider/supplier's initial enrollment application is being submitted concurrently with this reassignment application, write **"pending"** in the Medicare identification number block.

Payroll Agent - If the provider/supplier utilizes an IRS approved Payroll Agent to pay the salaries of W-2 employees reassigning their benefits, the provider/supplier must submit copies of the completed IRS Form 2678 (Employer Appointment of Agent), and the letter (IRS Form 1997C) authorizing the appointment of a payroll agent signed by the IRS Service Center Director. These IRS forms will be used as documentation to establish the employer-employee relationship required under § 3060.1 of the Medicare Carriers Manual.

If the individual practitioner receives a form other than those listed in this section, check "Other" and identify the form.

In situations where a provider/supplier contracts with an organization (e.g., a physician group practice) for physician/practitioner services and there is no direct payment to the physician/practitioner from the provider/supplier, the "Other" block for income reporting should be used and the description should indicate **indirect contractual arrangement (ICA)**.

NOTE: To reduce the burden of furnishing some types of supporting documentation, we have designated specific types of documentation to be furnished on an "as needed" basis. However, the carrier may request, at any time, documentation to support or validate information that is reported in this application. Some examples of documents that may be requested for validation are IRS W-2s, pay stubs, or employment contracts.

OMB Approval No. 0938-0685

MEDICARE FEDERAL HEALTH CARE BENEFIT REASSIGNMENT APPLICATION

Application for the Reassignment of Medicare Benefits

General Instructions

The Medicare Federal Health Care Benefit Reassignment Application has been designed by the Centers for Medicare and Medicaid Services (CMS) to assist in the administration of the Medicare program and to ensure that the Medicare program is in compliance with all regulatory requirements. The information collected in this application will be used to ensure that payments made from the Medicare trust fund are only paid to qualified health care providers or suppliers with whom an individual practitioner has a valid reassignment of benefits on file with Medicare, and that the amount of the payments are correct. To accomplish this, Medicare must know basic identifying information about the individual practitioner and the provider/supplier who the individual practitioner is authorizing to receive payment on his or her behalf for services rendered to Medicare beneficiaries.

When completing this application, Medicare must know the name, social security number, and Medicare identification number of the individual practitioner reassigning his or her benefits and the name, tax identification number, and Medicare identification number of the provider/supplier receiving the individual practitioner's reassigned benefits.

This application must be completed any time an individual practitioner reassigns his or her benefits to an eligible provider/supplier. Both the individual practitioner and the eligible provider/supplier must be currently enrolled (or concurrently enrolling) in the Medicare program. Generally, this application will be completed by the provider/supplier, signed by the individual practitioner, and submitted by the provider/supplier. When deleting a current reassignment, either the provider/supplier **or** the individual practitioner may submit this application with the appropriate sections completed.

1. General Information

This section is to be completed with information as to why this reassignment of benefits application is being submitted.

Reason for Submittal of this Application

Check one:

- ☐ Add a New Reassignment – Effective Date:_____
- ☐ Terminate a Current Reassignment – Effective Date:_____
- ☐ Change Income Reporting Status - Effective Date (MM/DD/YYYY):_____
- ☐ Attesting to Current Reassignment

2. Provider/Supplier Identification

This section is to be completed with identifying information about the provider/supplier to which the individual practitioner is reassigning his or her benefits.

Legal Business Name of Provider/Supplier as Reported to IRS	Group Specialty
Tax Identification Number	Medicare Identification Number or NPI

3. Individual Practitioner Identification

This section is to be completed with identifying information about the individual practitioner who will be reassigning (or terminating the reassignment of) his or her benefits to the provider/supplier shown in Section 2 above.

Name First	Middle	Last	Jr., Sr., etc.
Social Security Number	Medicare Identification Number or NPI	Practitioner Specialty	

What income reporting form does the individual practitioner receive from the supplier at the end of the calendar year based on his or her relationship with the provider/supplier shown in Section 2?

Check all that apply: ☐ **W-2** ☐ **1099** ☐ **1065-K1** **Other:**_____

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SECTION 4: STATEMENT OF TERMINATION

This section is to be completed only if you are terminating your reassignment of benefits to the provider/supplier.

- Furnish the provider/supplier's name as reported to the IRS (the name must be the same as reported in Section 2).
- Complete, sign, and date the "Statement of Termination."

NOTE: All signatures must be original. Faxed, photocopied, or stamped signatures are not acceptable.

By his or her signature, the individual practitioner terminates the authority of the provider/supplier to claim or receive any fees or charges for the practitioner's services, and attests to the accuracy of the information provided on this form.

SECTION 5: REASSIGNMENT OF BENEFITS STATEMENT

The individual practitioner who will be reassigning benefits to the eligible provider/supplier must complete, sign, and date this Reassignment of Benefits Statement. Failure to do so will delay the processing of this application, thus limiting CMS's ability to make payments.

- Type or print the individual practitioner's full name.
- The individual practitioner must sign and date this section.

NOTE: All signatures must be original. Faxed, photocopied, or stamped signatures are not acceptable.

SECTION 6: ATTESTATION STATEMENT

Either the authorized official or a delegated official who has been identified on the provider/supplier's CMS 855B application must sign and date this Attestation Statement. By his or her signature, the authorized or delegated official attests to the accuracy of the information provided and certifies that the provider/supplier applying to receive or terminate payments is in fact eligible to receive or terminate reassigned benefits.

NOTE: All signatures must be original. Faxed, photocopied, or stamped signatures are not acceptable.

For further information on the requirements regarding the reassignment of benefits, contact the Medicare carrier.

SECTION 7: CONTACT PERSON

Provide the full name and telephone number of an individual who can be reached to answer questions regarding the information furnished in this application.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0685. The time required to complete this information collection is estimated at 60 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

OMB Approval No. 0938-0685

4. Statement of Termination

This section is to be completed by the individual practitioner to terminate a previously authorized reassignment of benefits.

By my signature, I hereby terminate the authority of _____ to claim or receive any fees or charges for my services. (Name of Individual or Provider/Supplier as Reported to the IRS)

I certify that I have examined the above information and that it is true, accurate and complete to the best of my knowledge. I understand that any deliberate misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws.

Individual Practitioner Name **Print** First	Middle	Last	Jr., Sr., etc.

Individual Practitioner Signature (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)	Date (MM/DD/YYYY) Signed

5. Reassignment of Benefits Statement

This section **MUST** be signed and dated by the individual practitioner shown in Section 3 to authorize the reassignment of his or her benefits to the provider/supplier shown in Section 2.

Medicare law prohibits payment for services provided by an individual practitioner to be paid to another individual or provider/supplier unless the individual practitioner who provided the services specifically authorizes another individual or provider/supplier (employer, facility, or health care delivery system) to receive said payments in accordance with 42 CFR 424.73 and 42 CFR 424.80. By signing this Reassignment of Benefits Statement, you are authorizing the individual or provider/supplier identified in Section 2 to receive Medicare payments on your behalf.

Your employment or contract with this individual or provider/supplier must be in compliance with CMS regulations. All individual practitioners who allow another individual or provider/supplier (employer, facility, or health care delivery system) to receive payment for their services must sign the Reassignment of Benefits Statement.

Individual Practitioner Name **Print** First	Middle	Last	Jr., Sr., etc.

Individual Practitioner **Signature** (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)	Date (MM/DD/YYYY) Signed

6. Attestation Statement

This section requires the signature of an authorized or delegated official of the provider/supplier shown in Section 2. The authorized or delegated official must currently be on file with Medicare for this application to be processed.

I certify that I have examined the above information and that it is true, accurate and complete to the best of my knowledge. I understand that any deliberate misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws. For new reassignments, I also certify that the provider/supplier requesting to receive payments is legally eligible to receive reassigned benefits per CMS regulations.

Authorized/Delegated Official Name **Print** First	Middle	Last	Jr., Sr., etc.

Authorized/Delegated Official **Signature** (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)	Date (MM/DD/YYYY) Signed

7. Contact Person

This section is to be completed with the name, telephone number and address of a person who can answer questions about the information furnished in this application.

Name First	Last	Telephone Number (Ext.) ( ) ( )

Address Line 1 (Street Name and Number)		
City	State	ZIP Code + 4

MEDICARE

FEDERAL HEALTH CARE
PROVIDER/SUPPLIER ENROLLMENT APPLICATION

Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB Approval No. 0938-0685

Keep a copy of this complete package for your own records

Upon completion, return this application and all necessary documentation to:

National Supplier Clearinghouse
Post Office Box 100142
Columbia, South Carolina 29202-3142

Telephone Number 1 (866) 238-9652

OMB Approval No. 0938-0685

Medicare Provider/Supplier Enrollment Application

Privacy Act Statement

The Centers for Medicare and Medicaid Services (CMS) is authorized to collect the information requested on this form by sections 1124(a)(1), 1124A(a)(3), 1128, 1814, 1815, 1833(e), and 1842(r) of the Social Security Act [42 U.S.C. §§ 1320a-3(a)(1), 1320a-7, 1395f, 1395g, 1395l(e), and 1395u(r)] and section 31001(1) of the Debt Collection Improvement Act [31 U.S.C. § 7701(c)].

The purpose of collecting this information is to determine or verify the eligibility of individuals and organizations to enroll in the Medicare program as providers/suppliers of goods and services to Medicare beneficiaries and to assist in the administration of the Medicare program. This information will also be used to ensure that no payments will be made to providers or suppliers who are excluded from participation in the Medicare program. All information on this form is required, with the exception of those sections marked as "optional" on the form. Without this information, the ability to make payments will be delayed or denied.

The information collected will be entered into the Provider Enrollment, Chain and Ownership System (PECOS), and either system number 09-70-0525 titled Unique Physician/Practitioner Identification Number (UPIN) System (published in Vol. 61 of the Federal Register at page 20,528 (May 7, 1996), or the National Provider Identifier (NPI) System (OMB) approval 0938-0684 (R-187). The information in this application will be disclosed according to the routine uses described below.

Information from these systems may be disclosed under specific circumstances to:

1) CMS contractors to carry out Medicare functions, collating or analyzing data, or to detect fraud or abuse;
2) A congressional office from the record of an individual health care provider/supplier in response to an inquiry from the congressional office at the written request of that individual health care practitioner;
3) The Railroad Retirement Board to administer provisions of the Railroad Retirement or Social Security Acts;
4) Peer Review Organizations in connection with the review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XVIII of the Social Security Act;
5) To the Department of Justice or an adjudicative body when the agency, an agency employee, or the United States Government is a party to litigation and the use of the information is compatible with the purpose for which the agency collected the information;
6) To the Department of Justice for investigating and prosecuting violations of the Social Security Act, to which criminal penalties are attached;
7) To the American Medical Association (AMA), for the purpose of attempting to identify medical doctors when the Unique Physician Identification Number Registry is unable to establish identity after matching contractor submitted data to the data extract provided by the AMA;
8) An individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, or to the restoration or maintenance of health;
9) Other Federal agencies that administer a Federal health care benefit program to enumerate/enroll providers/suppliers of medical services/supplies or to detect fraud or abuse;
10) State Licensing Boards for review of unethical practices or non-professional conduct;
11) States for the purpose of administration of health care programs; and/or
12) Insurance companies, self insurers, health maintenance organizations, multiple employer trusts, and other health care groups providing health care claims processing, when a link to Medicare or Medicaid claims is established, and data are used solely to process provider's/supplier's health care claims.

The provider or supplier should be aware that the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503) amended the Privacy Act, 5 U.S.C. § 552a, to permit the government to verify information through computer matching.

Protection of Proprietary Information

Privileged or confidential commercial or financial information collected in this form is protected from public disclosure by Federal law 5 U.S.C. § 552(b)(4) and Executive Order 12600.

Protection of Confidential Commercial and/or Sensitive Personal Information

If any information within this application (or attachments thereto) constitutes a trade secret or privileged or confidential information (as such terms are interpreted under the Freedom of Information Act and applicable case law), or is of a highly sensitive personal nature such that disclosure would constitute a clearly unwarranted invasion of the personal privacy of one or more persons, then such information will be protected from release by CMS under 5 U.S.C. §§ 552(b)(4) and/or (b)(6), respectively.

OMB Approval No. 0938-0685

INSTRUCTIONS FOR APPLICATION FOR DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS) SUPPLIERS

Please be sure to **PRINT** or **TYPE** all information so it is legible. Do not use pencil. Failure to provide all requested information might cause the application to be returned and may delay the enrollment process. Certain sections of the application have been omitted because they do not apply to DMEPOS suppliers. See inside front cover for mailing instructions. Electronic copies of all CMS Medicare enrollment forms can be found at the Medicare website at http://www.cms.hhs.gov. These electronic forms may be downloaded to your computer, completed on screen, printed, signed, and mailed to the appropriate Medicare contractor.

Whenever additional information needs to be reported within a section, copy and complete that section for each additional entry. We strongly suggest that the DMEPOS supplier keep a photocopy of its completed application and supporting documents for future reference.

This application is to be completed by DMEPOS suppliers that will bill Medicare carriers for Durable Medical Equipment, Prosthetics, Orthotics, or Supplies provided to Medicare beneficiaries. Failure to promptly submit a completed form CMS 855S to the National Supplier Clearinghouse will result in delays in obtaining enrollment and billing privileges.

DEFINITIONS OF MEDICARE ENROLLMENT TERMINOLOGY

To help you understand certain terms used throughout the application, we have included the following definitions:

Authorized Official-An appointed official to whom the supplier has granted the legal authority to enroll the supplier in the Medicare program, to make changes and/or updates to the supplier's status in the Medicare program (e.g., new practice locations, change of address, etc.) and to commit the supplier to fully abide by the laws, regulations, and program instructions of Medicare. The authorized official must be the supplier's general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of 5% or more of the supplier (see Section 5 for the definition of a "direct owner"), or must hold a position of similar status and authority within the supplier's organization.
Billing Agency-A company that the enrolling supplier contracts with to furnish claims processing functions for the supplier.
Business Location-This is the physical structure from which the enrolling supplier conducts its business operations.
Carrier-The Part B Medicare claims processing contractor.
Delegated Official-Any individual who has been delegated, by the supplier or the supplier's "Authorized Official," the authority to report changes and updates to the supplier's enrollment record. A delegated official **must** be a managing employee (W-2) of the supplier or have a 5% ownership interest, or any partnership interest, in the supplier.
DMEPOS-Durable Medical Equipment, Prosthetics, Orthotics, and Supplies.
DMEPOS Supplier-A business or individual that furnishes Durable Medical Equipment, Prosthetics, Orthotics, or Supplies.
Enrolling Supplier-The enrolling supplier is the actual business location from where DMEPOS items are furnished. All sections of this application must be completed with information related to the "Business Location" reported in Section 4A.
Fiscal Intermediary-The Part A Medicare claims processing contractor.
Legal Business Name-The name reported to the Internal Revenue Service (IRS) for tax reporting purposes.
Medicare Identification Number-This is a generic term for any number that uniquely identifies the enrolling supplier. Examples of Medicare identification numbers are Unique Physician/Practitioner Identification Number (UPIN), National Provider Identifier (NPI), and National Supplier Clearinghouse (number) (NSC).
National Supplier Clearinghouse (NSC)-This is the DMEPOS Medicare enrollment contractor.
Provider-A provider is a hospital, critical access hospital, skilled nursing facility, nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice, that has in effect an agreement to participate in Medicare; or a rural health clinic (RHC), Federally qualified health center (FQHC), rehabilitation agency, or public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech pathology services; or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.
Provider Identification Number (PIN)-This number is assigned to providers, suppliers, groups and organizations in Medicare Part B. This number will identify who provided the service to the beneficiary on the Medicare claim form.
Supplier-A physician or other practitioner, or an organization other than a provider, that furnishes health care services under Medicare Part B. The term supplier also includes independent laboratories, portable x-ray services, physical therapists in private practice, end stage renal disease (ESRD) facilities, and chiropractors. For enrollment purposes, suppliers who submit claims for durable medical equipment, prosthetics, orthotics, or supplies (DMEPOS) must complete the CMS 855S.
Tax Identification Number (TIN)-The number issued by the IRS and used to report tax information to the IRS.

OMB Approval No. 0938-0685

SECTION 1: GENERAL APPLICATION INFORMATION

This section is to identify the reason for submittal of this application. It will also indicate whether the supplier currently has a business relationship with Medicare.

A. Reason for Submittal of this Application - This section identifies the reason this application is being submitted.

1. Select one of the following:

Initial Enrollment of a New DMEPOS Supplier:
- If the supplier is enrolling in the Medicare program for the first time as a DMEPOS supplier.

Re-enrollment:
- If the supplier is currently enrolled in the program and has been asked to verify and update the enrollment information currently on file, and to attest that it is still eligible to receive Medicare payments.

Reactivation:
- If the supplier's Medicare billing number was deactivated.

To reactivate billing privileges, the supplier may be required to either submit an updated CMS 855S or certify to the accuracy of its enrollment information currently on file with CMS. In addition, prior to being reactivated, the supplier must be able to submit a valid claim. The supplier must also meet all current Medicare requirements as a DMEPOS supplier regardless of whether it was previously enrolled in the program.

Enrollment of a New Location for a Currently Enrolled DMEPOS Supplier:
- If the supplier is currently enrolled in the program and is applying to enroll a new business location.

Change of Information:
- If the supplier is adding, deleting, or changing existing information under this tax identification number.

If an existing supplier changes its name/owner/address, etc., the supplier must annotate the change by checking the section(s) where the change is going to be made, completing the appropriate section(s), and signing and dating the certification statement. For example, if an existing supplier is moving to a new location and has previously completed an application, the supplier completes Sections 1, 4, and 14. The supplier does not complete a full application. When reporting a change of information, always complete Section 1 to identify the supplier and provide the new/changed information in the section checked, and sign and date the certification statement (Section 14). **All changes must be reported to the NSC within 30 days of the effective date of the change.**

Voluntary Termination of Billing Number:
- If the supplier will no longer be submitting claims to the Medicare program using this billing number.

Voluntary termination ensures that the supplier's billing number will not be fraudulently used if the supplier ceases its Medicare operations. Provide the date operations ceased or the date the supplier will stop billing for Medicare covered services and the billing number to be terminated. In addition, complete Section 1 to identify the supplier and sign and date the certification statement (Section 14).

NOTE: "Voluntary Termination" **cannot** be used to circumvent any corrective action plan or any pending/ongoing investigation.

NOTE: Suppliers must furnish their current NSC billing number in the space provided if submitting this application for any reason other than the initial enrollment of a new DMEPOS supplier.

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2. This section identifies the State where the supplier's business location (as reported in Section 4A) is located. Please indicate the two-letter state code for the State where the supplier's business is located (for example, "SC" for "South Carolina").

3. Supplier numbers can be used nationally when filing claims; however, the supplier is required to indicate the region where the majority of claims for this location will be submitted. Claims are submitted based on where the Medicare beneficiary resides. For example, if **most** of the supplier's Medicare beneficiaries reside in MD, DC, and VA, the supplier would check "Region B." See list below to determine the appropriate box(es) to check.

   - **Region A** - Delaware, Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont
   - **Region B** - District of Columbia, Illinois, Indiana, Maryland, Michigan, Minnesota, Ohio, West Virginia, Wisconsin, Virginia
   - **Region C** - Alabama, Arkansas, Colorado, Florida, Georgia, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, Virgin Islands
   - **Region D** - Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Northern Mariana, Oregon, South Dakota, Utah, Washington, Wyoming

4. Indicate whether the supplier is currently enrolled in another part of the Medicare program (e.g., as a home health agency). If "Yes," provide the name of the Medicare contractor to which the supplier submits claims and its Medicare identification number in this space. Report all currently active Medicare numbers. This is the number used to identify the supplier and is used on claims forms. This number may be referred to as a Medicare provider number, provider identification number (PIN), National Provider Number (NPI), or National Supplier Clearinghouse number. Report all numbers that have been issued to this supplier. Attach an additional page if necessary.

If the supplier does not currently have a Medicare identification number, it will be assigned one upon the successful completion of its enrollment. The supplier will receive information about what number(s) has been issued and how it is to be used.

NOTE: To reduce the burden of furnishing some types of supporting documentation, we have designated specific types of documentation to be furnished on an "as needed" basis. However, the NSC may request documentation, at any time during the enrollment or re-enrollment process, to support or validate information that is reported in this application. Some examples of documents that may be requested for validation are billing agreements, IRS W-2 forms, pay stubs, articles of incorporation, and partnership agreements.

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MEDICARE FEDERAL HEALTH CARE PROVIDER/SUPPLIER ENROLLMENT APPLICATION

Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers

General Instructions

The Medicare Federal Health Care Provider/Supplier Enrollment Application has been designed by the Centers for Medicare and Medicaid Services (CMS) to assist in the administration of the Medicare program and to ensure that the Medicare program is in compliance with all regulatory requirements. The information collected in this application will be used to ensure that payments made from the Medicare trust fund are paid only to qualified DMEPOS suppliers, and that the amounts of the payments are correct. This information will also identify whether the DMEPOS supplier is qualified to furnish health care items to Medicare beneficiaries. To accomplish this, Medicare must know basic identifying and qualifying information about the DMEPOS supplier that is seeking billing privileges in the Medicare program.

Medicare needs to know: (1) the type of DMEPOS supplier enrolling, (2) what qualifies this DMEPOS supplier to furnish health care related DMEPOS items, (3) where or how this DMEPOS supplier intends to furnish these items, and (4) those persons or entities with an ownership interest or managerial control, as defined in this application, over the DMEPOS supplier.

This application **MUST** be completed in its entirety, unless the appropriate box is checked to indicate the section does not apply or when reporting a change to previously submitted information. If a section does not apply to this DMEPOS supplier, check (√) the appropriate box in that section and skip to the next section. Sections 7, 9, and 11 have been deliberately omitted from this application because they are not applicable to the enrollment of DMEPOS suppliers that bill Medicare carriers.

1. General Application Information

A. Reason for Submittal of this Application

This section is to be completed with general information as to why this application is being submitted and whether this supplier currently has a business relationship with another Federal health care program.
To ensure timely processing of this application, Numbers 1, 2 and 3 below MUST ALWAYS be completed.

1. Check one:
   - ☐ Initial Enrollment of a New DMEPOS Supplier
   - ☐ Re-enrollment Furnish Current Billing Number:_____
   - ☐ Reactivation Furnish Current Billing Number:_____
   - ☐ Enrollment of a New Location for a Currently Enrolled DMEPOS Supplier
     Furnish Current Billing Number:_____
   - ☐ Change of Information (including Ownership) - (Check appropriate Section(s) below).
     ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 8 ☐ 10 ☐ 12 ☐ 14 ☐ 15
     Furnish Current Billing Number:_____
   - ☐ Voluntary Termination of Billing Number - Effective Date (MM/DD/YYYY):_____
     Furnish Current Billing Number to be terminated:_____

2. Please indicate the two-letter state code for the state where the enrolling business location is located for this DMEPOS supplier.
   _____ _____ (Example: S C for South Carolina)

3. To which region(s) will this supplier submit the majority of claims for this location?
   ☐ Region A ☐ Region B ☐ Region C ☐ Region D ☐ All Regions

4. Is this supplier currently enrolled in the Medicare program other than as a DMEPOS supplier? ☐ YES ☐ NO
   IF YES, furnish the following information about the current enrollment:

Medicare Contractor Name:_____ Medicare Identification Number or NPI:_____

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SECTION 2: SUPPLIER IDENTIFICATION

A. Supplier IRS Identification Information - This section is to be completed with information specifically related to the business location of the DMEPOS supplier submitting this application.

If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. Provide the legal business name as reported to the Internal Revenue Service (IRS), and the tax identification number (TIN) issued by the IRS to this supplier business location or the TIN used by this business location for tax reporting purposes.

Attach documentation (e.g., a copy of the IRS CP-575) from the IRS showing that the supplier business name matches the name reported in this application. If the supplier does not have an IRS CP-575, any official correspondence from the IRS that shows the supplier's name and TIN will be acceptable proof. Upon request, the IRS will provide a Form 147C showing the supplier's name and TIN.

NOTE: An IRS CP 575 or other documentation must be submitted for each TIN reported on this application.

If the supplier cannot obtain the required IRS document, explain why in a separate attachment and provide evidence that links its legal business name with the reported TIN. If the name and TIN do not match on the submitted documents, explain why and refer to the documents that confirm the identification of the supplier or owner as applicable (e.g., if the supplier recently changed its name and the IRS has not sent it an updated document). The supplier may then submit the old IRS document with the old name, as well as a copy of documentation filed with the IRS and State concerning the name change.

2. Furnish the address where the IRS Form 1099 is to be mailed for this supplier. If the supplier has changed or is changing its tax identification number, furnish the tax identification number currently or previously used and reported to Medicare.

B. Type of Business for this Supplier – Indicate the type of business operated by the supplier at this location.

1. Check all items that apply to the business location for which this application is being submitted.

2. Indicate the primary type of business conducted at the business location for which this application is being submitted.

NOTE: Copies of all Federal, State and local (city/county) professional and business licenses, certifications and/or registrations required to practice as a DMEPOS supplier in the enrolling supplier's State (e.g., Federal Drug Enforcement Agency (DEA) number for pharmacies, business occupancy license, local business license), must be submitted with this application.

C. Products and Services to be Furnished by this Supplier – Provide the types of DMEPOS products and services supplied to Medicare beneficiaries from this business location.

1. If this supplier is a physician, check the box provided and skip to Section D.

2. Indicate all primary products and services furnished by this supplier from this business location by circling the letter "P" next to the product or service **and** indicate all secondary products and services furnished by this supplier from this business location by circling the letter "S" next to the product or service.

NOTE: If "Parenteral Nutrition" and/or "Drugs/Pharmaceuticals" have been checked, a copy of the supplier's State pharmacy license **must** be submitted with this application.

D. Liability Insurance Information – All DMEPOS suppliers enrolling in Medicare must have liability insurance. Furnish the requested information about the insurance company and submit a copy(s) of the supplier's current liability insurance policy (or evidence of self-insurance) with this application.

E. Incorporation Information – Indicate if the supplier's business is incorporated.

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2. Supplier Identification

This section is to be completed with information specifically related to the business location of the supplier submitting this application. Furnish the following information: the supplier's legal business name and address as reported to the IRS for issuance of IRS Form 1099, the type of business this supplier operates as, the type(s) of products and services this supplier will furnish, and information about the supplier's liability insurance.

A. Supplier IRS Identification Information ☐ **Change** **Effective Date:**_____

Furnish the supplier's legal business name (as reported to the IRS). A copy of the IRS CP-575 or other correspondence issued by the IRS showing the TIN for this business **MUST** be submitted.

1. Legal Business Name as Reported to the IRS		Tax ID Number
2. 1099 Mailing Address Line 1 (Street Name and Number)		Former Tax ID Number (if changed)
1099 Mailing Address Line 2 (Suite, Room, etc.)		
1099 Mailing Address City	1099 Mailing Address State	1099 Mailing Address ZIP Code + 4

B. Type of Business for this Supplier

The supplier must meet all Medicare requirements for a DMEPOS supplier. Submit copies of all required licenses, certifications, and registrations with this application.

1. Type of Supplier (Check all that apply):

☐ Medical Supply Company
☐ Medical Supply Company with Registered Pharmacist
☐ Medical Supply Company with Respiratory Therapist
☐ Medical Supply Company with Orthotics Personnel
☐ Medical Supply Company with Prosthetics Personnel
☐ Orthotics Personnel
☐ Prosthetics Personnel
☐ Medicare + Choice Organization
☐ Managed Care Plan (non-Medicare + Choice)
☐ Optician
☐ Optometrist
☐ Home Health Agency
☐ Skilled Nursing Facility
☐ Intermediate Care Nursing Facility
☐ Nursing Facility (Other)
☐ Pharmacy
☐ Grocery Store
☐ Department Store
☐ Occupational Therapist/Physical Therapist
☐ Physician
☐ Hospital

2. Which of the above is the primary type of business for the business location of the enrolling supplier?

C. Products and Services to be Furnished by this Supplier

1. Check here ☐ if this supplier is a physician and skip to Section D.

2. Indicate all primary **and** secondary products and services furnished by this supplier by circling the letter "P" or the letter "S" next to the appropriate product or service.

P	S	Enteral Nutrition	P	S	Optician	P	S	Oxygen
P	S	Durable Medical Equipment	P	S	Other (Specify):_____	P	S	Parenteral Nutrition
P	S	Prosthetics	P	S	Diabetic Equipment and Supplies	P	S	Drugs/Pharmaceuticals
P	S	Orthotics	P	S	Dialysis Equipment and Supplies	P	S	Diabetic Footwear

D. Liability Insurance Information

Note: All DMEPOS suppliers must submit a copy of their liability insurance policy or evidence of self-insurance with this application.

Name of Insurance Company			
Insurance Policy Number	Date Policy Issued (MM/DD/YYYY)	Expiration Date of Policy (MM/DD/YYYY)	
Insurance Agent's Name: First	Middle	Last	Jr., Sr., etc.
Agent's Telephone Number ( ) (Ext.) ( )	Agent's Fax Number (if applicable) ( )	E-mail Address (if applicable)	

E. Incorporation Information

Is this DMEPOS supplier business incorporated? ☐ YES ☐ NO

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SECTION 3: ADVERSE LEGAL ACTIONS AND OVERPAYMENTS

A. Adverse Legal History - This section is to be completed with information concerning any adverse legal actions that have been imposed or levied against this supplier, as identified in Section 2A. See Table A on the application form for a list of adverse actions that must be reported.

If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. The supplier must state whether, under any current or former name or business identity, it has ever had any of the adverse legal actions listed in Table A of the application form imposed against it.

2. If the answer to this question is "Yes," supply all requested information. Attach copies of official documentation related to the adverse legal action. Such documentation includes adverse legal action notifications (e.g., notification of disciplinary action; criminal court documentation that verifies the conviction of a crime) and documents that evidence how the adverse legal action was finally resolved (e.g., reinstatement notices, etc.).

If the supplier is uncertain as to whether it falls within one of the adverse legal action categories or whether a name reported on this application has an adverse legal action, query the Healthcare Integrity and Protection Data Bank. If the supplier needs information on how to access the data bank, call 1-800-767-6732 or visit www.npdb-hipdb.com. There is a charge for using this service.

Table A--This is the list of adverse legal actions that must be reported. All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

B. Overpayment Information - Current laws found in the Federal Streamlining Act and the Debt Collection Improvement Act require all Federal agencies to determine whether an individual or business entity that enters into a business relationship with that agency has any outstanding debts, including overpayments under different identifiers. Failure to furnish information about overpayments will put the supplier in violation of these Acts and subject it to possible denial of its Medicare enrollment.

1. The supplier, as identified in Section 2A, must report all outstanding Medicare overpayments that it is liable for, including those paid to the supplier, or on its behalf, under a different name. For purposes of this section, the term "outstanding Medicare overpayment" is defined as a debt that meets **all** of the conditions listed below:

   a) The overpayment arose out of the supplier's current or previous enrollment in Medicare. This includes any overpayment incurred by the supplier under a different name or business identity, or in another Medicare contractor jurisdiction;

   b) CMS (or its contractors) has determined that the supplier is liable for the overpayment; and

   c) The overpayment is not or has not been included as part of a repayment plan approved by CMS (or its contractors), nor is the overpayment amount being repaid through the withholding of Medicare payments to the supplier.

Any overpayment not meeting all of these conditions should not be reported.

2. Furnish the full name or business identity under which the overpayment occurred and the account number under which the overpayment exists.

NOTE: Overpayments that occur after the suppliers' enrollment has been approved do not need to be reported unless the supplier is enrolling with a different Medicare contractor.

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3. Adverse Legal Actions and Overpayments

This section is to be completed with information concerning any adverse legal actions and/or overpayments that have been imposed or levied against this supplier (see Table A below for list of adverse actions that must be reported).

A. Adverse Legal History ☐ Change **Effective Date:**_____

1. Has this supplier, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A below imposed against it? ☐ YES ☐ NO
2. **IF YES**, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:

Table A

1) Any felony conviction under Federal or State law, regardless of whether it was health care related.

2) Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.

3) Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.

4) Any misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.

5) Any misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

6) Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.

7) Any revocation or suspension of accreditation.

8) Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.

9) Any current Medicare payment suspension under any Medicare billing number.

Note: All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

B. Overpayment Information

1. Does this supplier, under any current or former name or business identity, have any outstanding Medicare overpayments? ☐ YES ☐ NO
2. **IF YES**, furnish the name and account number under which the overpayment(s) exists.

Name under which the overpayment occurred:	Account number under which the overpayment exists:

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SECTION 4: CURRENT BUSINESS LOCATION ADDRESS INFORMATION

This section is to be completed with information about the business location for which this application is being submitted. The supplier must also furnish a mailing address for receiving correspondence from Medicare, an address where payments are to be sent, and an address where Medicare beneficiaries' records are stored for this location.

A. Business Location Address Information – This must be the actual address where the supplier's business is physically located. It must be the address and telephone number where Medicare beneficiaries can contact the supplier directly.

NOTE: A separate application must be submitted for each physical business location that conducts business with the public and intends to bill Medicare from that location for the items sold to the public. Locations that serve only as warehouses or repair facilities should not be reported.

If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. Furnish the "doing business as" (DBA) name if different from the legal business name reported in Section 2A for this business location. The "doing business as" name is the name the supplier is generally known by to the public.

2. Provide the street address and telephone number of this business location. A post office box or a drop box address is **not** acceptable as a DMEPOS supplier business location. The address must be the actual physical location of the supplier's business. The telephone number must be the number where customers can call to ask questions or register complaints.

3. Check the appropriate box to indicate the organizational structure of this supplier. Check "Corporation" if the supplier is such, regardless of whether the supplier is "for-profit" or "non-profit." "Partnership" should be checked for all "General" or "Limited" partnerships. All other suppliers should check "Other," and specify the type of organizational structure (e.g., limited liability company).

4. Provide the date this business location was established to furnish and bill for DMEPOS supplies. This date will assist in establishing the effective date for claims processing. Also, when applicable, furnish the date this business location stopped furnishing DMEPOS supplies.

B. "Mail To" Address – The supplier must provide an address and telephone number where it can be directly contacted by Medicare or the NSC to resolve any enrollment or billing issues. This address will also be used to send the supplier important information concerning the Medicare program that may directly affect its Medicare payments. Therefore, this address cannot be that of the billing agency, management service organization, or staffing company. This address may be a post office box or a drop box location.

If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement.

If the "Mail To" address is the same as the "Business" address reported in Section 4A, check the box provided in this section and continue with Section 4C. Otherwise:

1. Furnish a "Mail To" name for the supplier in Section 4A.

2. Furnish an address, telephone number, fax number and email address where Medicare can directly contact the supplier.

3. If the DMEPOS supplier has more than one business location and the "Mail To" address is the same "Mail To" address for all of the supplier's business locations, check the box provided.

NOTE: If the "Mail To" address is a P.O. Box or Drop Box, it can not be the same as the "Business" address reported in Section 4A since a P.O. Box or Drop Box address is not acceptable as a DMEPOS supplier business address.

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C. "Pay To" Address – This address is the address the supplier must provide to indicate **where its Medicare payments are to be sent**. This address may be a post office box or drop box location.

Payment will be made in the DMEPOS supplier's "legal business name" as shown in Section 2A1.

If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement.

If the "Pay To" address is the same as the "Business" address reported in Section 4A, check the box provided at the top of this section and continue with Section 4D. Otherwise:

1. Furnish a "Pay To" address where Medicare can send payments.

   - If payment will be paid by electronic funds transfer (EFT), the "Pay To" address should indicate where the DMEPOS supplier wants all other payment information, (e.g., remittance notices, special payments, etc.) sent.

2. If the DMEPOS supplier has more than one business location and the "Pay To" address is the same "Pay To" address for all of the supplier's business locations, check the box provided.

NOTE: If the "Pay To" address is a P.O. Box or Drop Box, it can not be the same as the "Business" address reported in Section 4A since a P.O. Box or Drop Box address is not acceptable as a DMEPOS supplier business address.

D. Location of Medicare Beneficiaries' Medical Records – All Medicare beneficiary medical records must be accessible to Medicare for possible review. This section only needs to be completed if the supplier's Medicare beneficiaries' medical records are stored in a location other than the business location shown in Section 4A. Post office boxes and drop boxes are not acceptable addresses for the storage of Medicare beneficiaries' medical records.

If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

If the "Location of Medicare Beneficiaries' Medical Records" address is the same as the "Business" address reported in Section 4A, check the box provided at the top of this section and continue with Section 5. Otherwise:

1. Furnish the address where the supplier maintains its Medicare Beneficiaries' medical records.

2. If the DMEPOS supplier has more than one business location and the "Storage Location" address is the same "Storage Location" address for all of the supplier's business locations, check the box provided.

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4. Current Business Location Address Information

This section is to be completed with information about the business location for which this application is being submitted. Also furnish a mailing address for receiving correspondence from Medicare, an address where payments are to be sent, and an address where Medicare beneficiaries' records are stored for this location. A separate application must be submitted for each business location that intends to bill Medicare for the items sold to the public from that location.

A. Business Location Address Information ☐ **Change** **Effective Date:**_____

This must be the physical address and telephone number of the business location and where Medicare beneficiaries can contact the supplier directly. The "Doing Business As" name is the name the supplier is generally known by to the public.

1. "Doing Business As" (DBA) Name (if applicable) for the supplier identified in Section 2A

2. Business Address Line 1 (Street Name and Number)

Business Address Line 2 (Suite, Room, etc.)

Business City	Business State	Business ZIP Code + 4
Telephone Number (Ext.) ( ) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

3. Identify the type of organizational structure for this supplier (Check one):
☐ Corporation ☐ Partnership ☐ Other (Specify):_____

4. Date this Business Started at this Location (MM/DD/YYYY)	Date this Business Terminated at this Location (if applicable) (MM/DD/YYYY)

B. "Mail To" Address ☐ **Same as Section 4A** ☐ **Change** **Effective Date:**_____

This must be an address and telephone number where Medicare can contact the supplier directly.

1. "Mail To" Name for the supplier identified in Section 4A above

2. "Mail To" Address Line 1 (Street Name and Number or P.O. Box)

"Mail To" Address Line 2 (Suite, Room, etc.)

"Mail To" City	"Mail To" State	"Mail To" ZIP Code + 4
Telephone Number (Ext.) ( ) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

3. Check here ☐ if this "Mail To" address is to be used as the mail to address for all of the supplier's business locations.

C. "Pay To" Address ☐ **Same as Section 4A** ☐ **Change** **Effective Date:**_____

Furnish the address **where payment should be sent** for supplies furnished from the business address in Section 4A.

1. "Pay To" Address Line 1 (Street Name and Number or P.O. Box)

"Pay To" Address Line 2 (Suite, Room, etc.)

"Pay To" City	"Pay To" State	"Pay To" ZIP Code + 4

2. Check here ☐ if this "Pay To" address is to be used as the pay to address for all of the supplier's business locations.

D. Location of Medicare Beneficiaries' Medical Records ☐ **Change** **Effective Date:**_____

Check here ☐ if **all** Medicare beneficiary medical records are stored at the business location shown in Section 4A. Otherwise, complete this section with the name and address of the storage location.

1. Medicare Beneficiary Medical Record Storage Location Name

Medicare Beneficiary Medical Record Storage Location Address Line 1 (Street Name and Number)

Storage Location Address Line 2 (Suite, Room, etc.)

Storage Location City	Storage State	Storage ZIP Code + 4

2. Check here ☐ if this "Storage Location" address is to be used as the storage address for all business locations.

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SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS)

This section is to be completed with information about any organization that has 5% or more (direct or indirect) ownership of, any partnership interest in, and/or managing control of the DMEPOS supplier identified in Section 4A. See examples below of organizations that should be reported in this section. If there is more than one organization, copy and complete this section for each.

If individuals, and not organizations, own or manage the DMEPOS supplier, do not complete this section. These individuals must be reported in Section 6.

A. Check Box - Check the box if there are no organizations to be reported in this section. If this box is checked, proceed to Section 6.

B. Organization with Ownership Interest and/or Managing Control - Identification Information - If adding, deleting, or changing information on an existing owner, partner, or managing organization, check the appropriate box, indicate the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. If not reporting a change, complete this section for the following:

All organizations that have any of the following **must** be reported in Section 5B:

- 5% or more ownership of the DMEPOS supplier,
- Managing control of the DMEPOS supplier, or
- A partnership interest in the DMEPOS supplier, regardless of the percentage of ownership the partner has.

Owning/Managing organizations are generally one of the following types:

- Corporations (including non-profit corporations)
- Partnerships and Limited Partnerships (as indicated above)
- Charitable and/or Religious organizations
- Governmental and/or Tribal organizations

NOTE: All individual partners within a partnership must be reported in Section 6 of this application. This applies to both "General" and "Limited" partnerships. For instance, if a limited partnership has several limited partners and each of them only has a 1% interest in the DMEPOS supplier, each limited partner must be reported in this application, even though each owns less than 5%. The 5% threshold primarily applies to corporations and other organizations that are not partnerships.

***IMPORTANT* – Only report organizations in this section. Individuals must be reported in Section 6.**

1. Check all boxes that apply to indicate the relationship between the DMEPOS supplier and the owning or managing organization.

2. Provide the legal business name of the owning or managing organization.

3. If applicable, provide the owning or managing organization's "doing business as" name.

4. Provide the owning or managing organization's complete business street address.

5. Provide the owning or managing organization's tax identification number and, if one (or more) has been issued, its Medicare identification number(s) or NPI(s).

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The following contains an explanation of the terms "direct ownership," "indirect ownership," and "managing control," as well as instructions concerning organizations that must be reported in this application.

EXAMPLES OF 5% OR MORE "DIRECT" OWNERSHIP

All organizations that own 5% or more of the DMEPOS supplier must be reported in this application.

Many DMEPOS suppliers may be owned by only one organization. For instance, suppose the DMEPOS supplier is a pharmacy that is wholly (100%) owned by Company A. In this case, Company A is considered to be a direct owner of the pharmacy, in that it actually owns the assets of the business. As such, the DMEPOS supplier would have to report Company A in this section.

There are occasionally more complex ownership situations. Many organizations that directly own a DMEPOS supplier are themselves wholly or partly owned by other organizations (or even individuals). This is often the result of the use of holding companies and parent/subsidiary relationships. Such organizations and individuals are considered to be "indirect" owners of the DMEPOS supplier. Using our first situation above, if Company B owned 100% of Company A, Company B is considered to be an indirect owner of the DMEPOS supplier. In other words, a direct owner has an actual ownership interest in the DMEPOS supplier (e.g., owns stock in the business, etc.), whereas an indirect owner has an ownership interest in an organization that owns the DMEPOS supplier. For purposes of this application, direct and indirect owners must be reported if they own at least 5% of the DMEPOS supplier. To calculate whether these indirect owners meet the 5% ownership level, review the formula outlined in Example 1 in this section.

For purposes of this application, ownership also includes "financial control." Financial control exists when:

(1) An organization or individual is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the DMEPOS supplier or any of the property or assets of the DMEPOS supplier, **and**

(2) The interest is equal to or exceeds 5% of the total property and assets of the DMEPOS supplier.

To calculate whether an organization or individual has financial control over the DMEPOS supplier, use the formula outlined in Example 2 of the instructions for this section.

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EXAMPLES OF "INDIRECT" LEVELS OF OWNERSHIP FOR ENROLLMENT PURPOSES

Example 1 (Ownership)

LEVEL 3	***Individual X*** 5%	***Individual Y*** 30%
LEVEL 2	***Company C*** 60%	***Company B*** 40%
LEVEL 1	***Company A*** 100%	

- Company A owns 100% of the Enrolling DMEPOS Supplier
- Company B owns 40% of Company A
- Company C owns 60% of Company A
- Individual X owns 5% of Company C
- Individual Y owns 30% of Company B

In this example, Company A (Level 1) is the direct owner of the Enrolling DMEPOS Supplier. Companies B and C as well as Individuals X and Y are indirect owners of the Enrolling DMEPOS Supplier. To calculate ownership shares using the above-cited example, utilize the following steps:

LEVEL 1

The diagram above indicates that Company A owns 100% of the Enrolling DMEPOS Supplier. Company A must therefore be reported in Section 5.

LEVEL 2

To calculate the percentage of ownership held by Company C of the Enrolling DMEPOS Supplier, multiply:

The percentage of ownership the LEVEL 1 owner has in the Enrolling DMEPOS Supplier
MULTIPLIED BY
The percentage of ownership the LEVEL 2 owner has in that LEVEL 1 owner

It is known that Company A, the LEVEL 1 (or direct) owner, owns 100% of the Enrolling DMEPOS Supplier. The diagram also indicates that Company C, a LEVEL 2 owner, owns 60% of Company A. As such, multiply 100% (or 1.0) by 60% (.60). The result is .60. Therefore, Company C indirectly owns 60% of the Enrolling DMEPOS Supplier, and must be reported in Section 5.

Repeat the same procedure for Company B, the other LEVEL 2 owner. Because Company B owns 40% of Company A, multiply this figure by 100% (again, the ownership stake Company A has in the Enrolling DMEPOS Supplier). Therefore, 1.0 multiplied by .40 equals .40, so Company B owns 40% of the Enrolling DMEPOS Supplier, and must be reported in Section 5.

This process is continued until all LEVEL 2 owners have been accounted for.

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LEVEL 3

To calculate the percentage of ownership that Individual X has in the Enrolling DMEPOS Supplier, multiply:

The percentage of ownership the LEVEL 2 owner has in the Enrolling DMEPOS Supplier
MULTIPLIED BY
The percentage of ownership the LEVEL 3 owner has in that LEVEL 2 owner

It has already been established that Company C owns 60% of the Enrolling DMEPOS Supplier. According to the example above, Individual X (Level 3) owns 5% of Company C. Therefore, multiply 60% (.60) by 5% (.05), resulting in .03. This means that Individual X owns 3% of the Enrolling DMEPOS Supplier and does not need to be reported in this application.

Repeat this process for Company B, which owns 40% of the Enrolling DMEPOS Supplier. The diagram states that Individual Y (Level 3) owns 30% of Company B. We thus multiply 40% (.40) by 30% (.30). The result is .12, or 12%. Because Individual Y owns 12% of the Enrolling DMEPOS Supplier, Individual Y must be reported in this application (in Section 6 - Individuals).

This process is continued until all owners in LEVEL 3 have been accounted for. Should there be entities at LEVEL 4 and above that have at least a 5% ownership interest in the Enrolling DMEPOS Supplier, the Enrolling DMEPOS Supplier may submit an organizational chart identifying these entities and/or individuals. The chart should contain the names, business addresses and TINs of these entities, and/or the names and social security numbers of these individuals.

Example 2 (Financial Control)

The percentage of financial control can be calculated by using the following formula:

Dollar amount of the mortgage, deed of trust, or other obligation secured by the Enrolling DMEPOS Supplier or any of the property or assets of the Enrolling DMEPOS Supplier
DIVIDED BY
Dollar amount of the total property and assets of the Enrolling DMEPOS Supplier

Example: Two years ago, a DMEPOS supplier obtained a $20 million loan from Entity X to add a third floor to its facility. Various assets of the DMEPOS supplier secure the mortgage. The total value of the DMEPOS supplier's property and assets is $100 million.

Using the formula described above, divide $20 million (the dollar amount of the secured mortgage) by $100 million (the total property and assets of the Enrolling DMEPOS Supplier). This results in .20, or 20%. Because Entity X's interest represents at least 5% of the total property and assets of the Enrolling DMEPOS Supplier, financial control exists and Entity X must be reported in this section.

MANAGING CONTROL (ORGANIZATIONS)

Any organization that exercises operational or managerial control over the DMEPOS supplier, or conducts the day-to-day operations of the DMEPOS supplier, is a managing organization and must be reported. The organization need not have an ownership interest in the DMEPOS supplier in order to qualify as a managing organization. This could be a management services organization under contract with the DMEPOS supplier to furnish management services for this business location.

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SPECIAL TYPES OF ORGANIZATIONS

Governmental/Tribal Organizations: If a Federal, State, county, city or other level of government, or an Indian tribe, will be legally and financially responsible for Medicare payments received (including any potential overpayments), the name of that government or Indian tribe should be reported as an owner. The DMEPOS supplier must submit a letter on the letterhead of the responsible government (e.g., government agency) or tribal organization, which attests that the government or tribal organization will be legally and financially responsible in the event that there is any outstanding debt owed to CMS. This letter must be signed by an "authorized official" of the government or tribal organization who has the authority to legally and financially bind the government or tribal organization to the laws, regulations, and program instructions of Medicare. See Section 14 for further information on and a definition of "authorized officials."

Charitable and Religious Organizations: Many non-profit organizations are charitable or religious in nature, and are operated and/or managed by a Board of Trustees or other governing body. The actual name of the Board of Trustees or other governing body should be reported in this section.

C. Adverse Legal History - This section is to be completed with information concerning any adverse legal actions that have been imposed or levied against the organization(s) reported in this section. See Table A in Section 3 of the application form for a list of adverse actions that must be reported.

If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. The DMEPOS supplier must state whether the organization reported in Section 5B, under any current or former name or business identity, has ever had any of the adverse legal actions listed in Section 3 (Table A) of this form imposed against it.

2. If the answer to this question is "Yes," supply all requested information. Attach copies of official documentation related to the adverse legal action. Such documentation includes adverse legal action notifications (e.g., notification of disciplinary action; criminal court documentation that verifies the conviction of a crime) and documents that evidence how the adverse legal action was finally resolved (e.g., reinstatement notices, etc.).

If the DMEPOS supplier is uncertain as to whether the owning or managing organization falls within one of the adverse legal action categories, the DMEPOS supplier should query the Healthcare Integrity and Protection Data Bank. If the DMEPOS supplier needs information on how to access the data bank, call 1-800-767-6732 or visit www.npdb-hipdb.com.

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5. Ownership Interest and/or Managing Control Information (Organizations)

This section is to be completed with information about all organizations that have 5% or more (direct or indirect) ownership of, any partnership interest in, and/or managing control of, the supplier identified in Section 4A, as well as any information on adverse legal actions that have been imposed against that organization. See instructions for examples of organizations that should be reported here. If there is more than one organization, copy and complete this section for each.

A. Check here ☐ if this section does not apply and skip to Section 6.

B. Organization with Ownership Interest and/or Managing Control—Identification Information

☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Check all that apply:	☐ 5% or more Ownership Interest ☐ Managing Control	☐ Partner
2. Legal Business Name		
3. "Doing Business As" Name (if applicable)		
4. Business Address Line 1 (Street Name and Number)		
Business Address Line 2 (Suite, Room, etc.)		
City	State	ZIP Code + 4
5. Tax Identification Number	Medicare Identification Number(s) or NPI(s) (if applicable)	

C. Adverse Legal History ☐ **Change** **Effective Date:**_____

This section is to be completed for the organization reported in Section 5B above.

1. Has the organization in Section 5B above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against it? ☐ YES ☐ NO

2. **IF YES**, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:

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SECTION 6. OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS)

This section is to be completed with information about any individual who has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the DMEPOS supplier identified in Section 4A. In addition, all officers, directors, and managing employees of the DMEPOS supplier must be reported in this section. If there is more than one individual, copy and complete this section for each. **The DMEPOS supplier MUST have at least ONE owner and/or managing employee.** If this is a "one person" operation, then report yourself in this section as **both** a 5% or greater owner and a managing employee or director/officer.

A. Individual with Ownership Interest and/or Managing Control - Identification Information - If adding, deleting, or changing information on an existing 5% or greater owner, partner, officer, director, or managing employee, check the appropriate box, indicate the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. If not reporting a change, complete this section for the following:

The following individuals **must** be reported in Section 6A: (see below for definitions of these terms)

- All persons who have a 5% or greater ownership interest in the DMEPOS supplier reported in Section 4A;
- If (and only if) the DMEPOS supplier is a corporation (whether for-profit or non-profit), all officers and directors of the DMEPOS supplier reported in Section 4A;
- All managing employees of the DMEPOS supplier reported in Section 4A, and
- All individuals with a partnership interest in the DMEPOS supplier reported in Section 4A, regardless of the percentage of ownership the partner has.

NOTE: All partners within a partnership must be reported in this application. This applies to both "General" and "Limited" partnerships. For instance, if a limited partnership has several limited partners and each of them only has a 1% interest in the DMEPOS supplier, each limited partner must be reported in this application, even though each owns less than 5%. The 5% threshold primarily applies to corporations and other organizations that are not partnerships.

For purposes of this application, the terms "officer," "director," and "managing employee" are defined as follows:

- The term **"Officer"** is defined as any person whose position is listed as being that of an officer in the DMEPOS supplier's **"Articles of Incorporation"** or **"Corporate Bylaws," OR** anyone who is appointed by the board of directors as an officer in accordance with the DMEPOS supplier's corporate bylaws.
- The term **"Director"** is defined as a member of the DMEPOS supplier's **"Board of Directors."** It does not necessarily include a person who may have the word "Director" in his/her job title (e.g., Departmental Director, Director of Operations). See note below.

NOTE: A person who has the word "Director" in his/her job title may be a "managing employee," as defined below. Moreover, where a DMEPOS supplier has a governing body that does not use the term "Board of Directors," the members of that governing body will still be considered "Directors." Thus, if the DMEPOS supplier has a governing body titled "Board of Trustees" (as opposed to "Board of Directors"), the individual trustees are considered "Directors" for Medicare enrollment purposes.

- The term **"Managing Employee"** is defined as any individual, including a general manager, business manager, or administrator, who exercises operational or managerial control over the DMEPOS supplier, or who conducts the day-to-day operations of the DMEPOS supplier. For Medicare enrollment purposes, "managing employee" also includes individuals who are not actual employees of the DMEPOS supplier but, either under contract or through some other arrangement, manage the day-to-day operations of the DMEPOS supplier.

NOTE: If a governmental or tribal organization will be legally and financially responsible for Medicare payments received (per the instructions for Governmental/Tribal Organizations in Section 5), the provider is only required to report its managing employees in Section 6. Owners, partners, officers, and directors do not need to be reported.

Refer to the instructions and examples in Section 5 for further clarification of what is meant by the terms "direct owner" and "indirect owner." If further assistance is needed in completing this section, contact the National Supplier Clearinghouse.

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IMPORTANT **– Only Individuals should be reported in Section 6. Organizations must be reported in Section 5.**

1. Furnish the individual's full name, title, social security number, date of birth, and Medicare identification number or NPI (if applicable).

NOTE: Section 1124A of the Social Security Act requires that the DMEPOS supplier furnish Medicare with the individual's social security number.

2. Indicate the individual's relationship with the enrolling supplier identified in Section 2A. If this individual has a title other than that listed in this section, check the "Other" box and specify the title used by this individual.

Example: A supplier is 100% owned by Company C, which itself is 100% owned by Individual D. Assume that Company C is reported in Section 5B as an owner of the supplier. Assume further that Individual D, as an indirect owner of the supplier, is reported in Section 6A1. Based on this example, the supplier would check the "5% or Greater Indirect Owner" box in Section 6A2.

B. Adverse Legal History - This section is to be completed with information concerning any adverse legal actions that have been imposed or levied against individuals reported in Section 6A. See Table A in Section 3 of the application form for a list of adverse actions that must be reported.

If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. The DMEPOS supplier must state whether the individual reported in Section 6A, under any current or former name or business identity, has ever had any of the adverse legal actions listed in Section 3 (Table A) of this form imposed against him or her.

2. If the answer to this question is "Yes," supply all requested information. Attach copy(s) of official documentation related to the adverse legal action. Such documentation includes adverse legal action notifications (e.g., notification of disciplinary action; criminal court documentation that verifies the conviction of a crime) and documents that evidence how the adverse legal action was finally resolved (e.g., reinstatement notices, etc.).

If the DMEPOS supplier is uncertain as to whether this individual falls within one of the adverse legal action categories, the DMEPOS supplier should query the Healthcare Integrity and Protection Data Bank. If the supplier needs information on how to access the data bank, call 1-800-767-6732 or visit www.npdb-hipdb.com.

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6. Ownership Interest and/or Managing Control Information (Individuals)

This section is to be completed with information about any individual that has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the supplier identified in Section 4A. All officers, directors, and managing employees of the supplier must also be reported in this section. In addition, any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each individual.

A. Individual with Ownership Interest and/or Managing Control—Identification Information

☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.

Title	Date of Birth (MM/DD/YYYY)
Social Security Number	Medicare Identification Number or NPI (if applicable)

2. What is the above individual's relationship with the supplier in Section 2A? (Check all that apply.)

☐ 5% or Greater Direct Owner
☐ 5% or Greater Indirect Owner
☐ Other (Specify):_____
☐ Managing Employee
☐ Director/Officer
☐ Partner

B. Adverse Legal History ☐ **Change** **Effective Date:**_____

This section is to be completed for the individual reported in Section 6A above.

1. Has the individual in Section 6A above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against him or her? ☐ YES ☐ NO

2. IF YES, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:

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SECTION 7: CHAIN HOME OFFICE INFORMATION

This section has been intentionally omitted.

SECTION 8: BILLING AGENCY

The purpose of collecting this information is to develop effective monitoring of agents/agencies that that prepare and/or submit claims to bill the Medicare program on behalf of the DMEPOS supplier. A billing agency is a company or individual that the DMEPOS supplier hires or contracts with to furnish claims processing functions for its business location. Any entity that meets this description must be reported in this section.

A. Check Box - If this DMEPOS supplier does not use a billing agency, check the box and skip to Section 11.

B. Billing Agency Name and Address - If reporting a change to information about a previously reported billing agency, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. Furnish the name and tax identification number of the billing agency.

2. Furnish the "doing business as" name of the billing agency.

3. Furnish the complete address and telephone number of the billing agency.

C. Billing Agreement/Contract Information - If reporting a change to existing information about a previously reported billing agreement/contract, check "Change," provide the effective date of the change, complete this entire questionnaire, and sign and date the certification statement. Otherwise:

The DMEPOS supplier that is enrolling is responsible for responding to the questions listed.

These questions are designed to show that the DMEPOS supplier fully understands and comprehends its billing agreement and that it intends to adhere to all Medicare laws, regulations, and program instructions. At any time, the NSC or CMS may request copies of all agreements/contracts associated with this billing agency.

SECTION 9: FOR FUTURE USE

This section has been intentionally omitted.

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7. Chain Home Office Information — This Section Not Applicable

8. Billing Agency

This section is to be completed with information about all billing agencies this supplier uses or contracts with that submit claims to Medicare on behalf of the supplier. If more than one billing agency is used, copy and complete this section for each. The supplier may be required to submit a copy of its current signed billing agreement/contract if Medicare cannot verify the information furnished in this section.

A. Check here ☐ if this section does not apply and skip to Section 11.

B. Billing Agency Name and Address ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Legal Business Name as Reported to the IRS	Tax Identification Number
2. "Doing Business As" Name (if applicable)	
3. Business Street Address Line 1 (Street Name and Number)	
Business Street Address Line 2 (Suite, Room, etc.)	
City / State / ZIP Code + 4	
Telephone Number ( ) (Ext.) ( ) / Fax Number (if applicable) ( ) / E-mail Address (if applicable)	

C. Billing Agreement/Contract Information ☐ **Change** **Effective Date:**_____

Answer the following questions about the supplier's agreement/contract with the above billing agency.

1. Does the supplier have unrestricted access to its Medicare remittance notices? ☐ YES ☐ NO
2. Does the supplier's Medicare payment go directly to the supplier? ☐ YES ☐ NO
   IF NO, proceed to Question 3.
   IF YES, skip Questions 3, 4 and 5.
3. Does the supplier's Medicare payment go directly to a bank? ☐ YES ☐ NO
   IF NO, proceed to Question 4.
   IF YES, answer the following questions and skip Questions 4 and 5.
   a) Is the bank account only in the name of the supplier? ☐ YES ☐ NO
   b) Does the supplier have unrestricted access to the bank account and statements? ☐ YES ☐ NO
   c) Does the bank only answer to the supplier regarding what the supplier wants from the bank (e.g., sweep account instructions, bank statements, closing account, etc.)? ☐ YES ☐ NO
4. Does the supplier's Medicare payment go directly to the billing agent? ☐ YES ☐ NO
   IF NO, proceed to Question 5.
   IF YES, answer the following question and skip Question 5.
   a) Does the billing agent cash the supplier's check? ☐ YES ☐ NO
      IF NO, proceed to Question b.
      IF YES, are <u>all</u> of the following conditions included in the billing agreement? ☐ YES ☐ NO
      1) The agent receives payment under an agency agreement with the supplier. ☐ YES ☐ NO
      2) The agent's compensation is not related in any way to the dollar amounts billed or collected. ☐ YES ☐ NO
      3) The agent's compensation is not dependent upon the actual collection of payment. ☐ YES ☐ NO
      4) The agent acts under payment disposition instructions that the supplier may modify or revoke at any time. ☐ YES ☐ NO
      5) In receiving payment, the agent acts only on behalf of the supplier (except insofar as the agent uses part of that payment as compensation for the agent's billing and collection services). ☐ YES ☐ NO
   b) Does the billing agent either give the Medicare payment directly to this supplier or deposit the payment into this supplier's bank account? ☐ YES ☐ NO
5. Who receives the supplier's Medicare payment?_____

9. For Future Use — This Section Not Applicable

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SECTION 10: STAFFING COMPANY - This section has been intentionally omitted.

SECTION 11: SURETY BOND INFORMATION

This section is to be completed by DMEPOS suppliers mandated by law to obtain a surety bond in order to enroll in and bill the Medicare program. Furnish all requested information about the supplier's insurance agent, surety company, and the surety bond. Read the letter sent with this application or call the NSC to determine if this DMEPOS supplier is required to obtain a surety bond. The surety bond must be an annual bond, a continuous bond, or a government security in lieu of a bond, (i.e., a Treasury note, United States bond, or other Federal public debt obligation). Annual surety bond renewals must be reported to the NSC on a timely basis to ensure continuance of claim payments. A certified true or notarized copy of the original surety bond must be submitted with this application. Failure to submit the surety bond will prevent the processing of this application. If an insurance agent or an insurance broker issues the bond, the DMEPOS supplier must also submit a certified copy of the agent's Power of Attorney with this application.

A. Check Box – Check the box if this DMEPOS supplier is not required to obtain a surety bond for Medicare enrollment.

B. Check Box - Check the box if this DMEPOS supplier qualifies for an exemption as a government entity.

If this DMEPOS supplier believes it is a government-operated DMEPOS supplier and is entitled to an exemption to the surety bond requirement, the DMEPOS supplier must furnish a letter signed by a government official of the Federal, State, local or Tribal Government (on official government letterhead), asserting that the government agency/tribe will back the debts owed by this DMEPOS supplier in full faith and credit of the government/tribe with this application. This letter can be the same letter that is referred to in Section 5 of these instructions. Otherwise, a surety bond **must** be obtained prior to participating in the Medicare program.

C. Name and Address of Surety Bond Company - If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. Furnish the legal business name and tax identification number of the surety bond company liable for this bond.
2. Furnish the complete business address, telephone number and e-mail address of the surety bond company.

D. Name and Address of Insurance Agency/Broker - If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. Provide the legal business name of the agency that issued the bond.
2. Provide the name of the individual agent who issued the bond for the bond agency.
3. Furnish the complete business address, telephone number and e-mail address of the agency.

E. Surety Bond Information – If the supplier has a Government Security check "Not Applicable" and skip to Section F below. If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise, complete this section with specific information about the bond as follows:

1. State the dollar amount of the bond and the bond number.
2. Furnish the effective date of the bond. If reporting a new bond or new surety bond company, furnish the expiration date of the current bond.
3. Indicate if the bond is renewed annually or if it is continuous.
4. Indicate if this is a "Dual Obligee Bond." A dual obligee bond is issued when a supplier bills both the Medicare and Medicaid programs.

F. Government Security - If the supplier has a Surety Bond check "Not Applicable," skip this section and complete Section E above. If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise, complete this section with specific information about the government security as follows:

1. State the amount of the bond, the effective date, and the Federal Reserve Account number.
2. Check the appropriate box indicating the type and duration for which the government security will be effective.

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10. Staffing Company — This Section Not Applicable

11. Surety Bond Information

This section is to be completed by all DMEPOS suppliers mandated by regulation (see C.F.R. 424.57) to obtain a surety bond in order to enroll in and bill the Medicare program. Furnish all requested information about the supplier's insurance agent, surety company, and the surety bond.

A. Check here ☐ if this supplier is not required to obtain a surety bond for Medicare enrollment and skip to Section 13. See instructions for surety bond requirements.

B. Check here ☐ if this supplier qualifies for a waiver of the bond requirement based on its operation as a government entity. See instructions for specific documentation requirements and skip to Section 13.

C. Name and Address of Surety Bond Company ☐ **Change**		**Effective Date:**_____
1. Legal Business Name of Surety Bond Company as Reported to the IRS		Tax Identification Number
2. Business Address Line 1 (Street Name and Number)		
Business Address Line 2 (Suite, Room, etc.)		
City	State	ZIP Code + 4
Telephone Number ( ) (Ext.) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

D. Name and Address of Insurance Agency/Broker ☐ **Change**		**Effective Date:**_____
1. Legal Business Name of Agency/Broker as Reported to the IRS		
2. Name of Individual Agent		
3. Business Address Line 1 (Street Name and Number)		
Business Address Line 2 (Suite, Room, etc.)		
City	State	ZIP Code + 4
Telephone Number ( ) (Ext.) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

E. Surety Bond Information ☐ **Not Applicable** ☐ **Change**	**Effective Date:**_____
1. Amount of Surety Bond $	Surety Bond Number
2. Effective Date of Surety Bond (MM/DD/YYYY)	If reporting a new bond, give cancellation date of the current bond (MM/DD/YYYY)
3. Is the surety bond: ☐ Annual? (or) ☐ Continuous?	
4. Check here ☐ if this is a Medicare/Medicaid "Dual Obligee Surety Bond."	

F. Government Security ☐ **Not Applicable** ☐ **Change**		**Effective Date:**_____
If a government security has been purchased, furnish the following information.		
1. Amount $	Effective Date (MM/DD/YYYY)	Federal Reserve Bank Account Number

2. Check the appropriate box below:
   - a) Is the Treasury Bill: ☐ Not Applicable ☐ 3 months? ☐ 6 months? ☐ 1 year?
   - b) Is the Treasury Note: ☐ Not Applicable ☐ 2 years? ☐ 5 years? ☐ 10 years?
   - c) Is the government security a 30-year Treasury Bond? ☐ YES ☐ NO ☐ Not Applicable

Note: If the government security is less than one year in duration, the supplier must submit proof of the renewable government security to the NSC at least 14 days prior to the expiration date.

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SECTION 12: CAPITALIZATION REQUIREMENTS FOR HOME HEALTH AGENCIES

This section has been intentionally omitted.

SECTION 13: CONTACT PERSON INFORMATION (OPTIONAL)

To assist in the timely processing of the DMEPOS supplier's application, provide the full name, SSN, mailing address, e-mail address, and telephone number of an individual who can be reached to answer questions regarding the information furnished in this application (preferably the individual who completed this application). The supplier is not required to furnish a contact person in this section. It should be noted that if a contact person is not provided, all questions about this application will be directed to the authorized official named in Section 15B.

A. Check Box - If this section does not apply, check the box and skip to Section 14.

B. Contact Person Information -- If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

- Provide the full name, e-mail address, telephone number, and mailing address of an individual who can answer questions about the information furnished in this application.

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION ON THIS ENROLLMENT APPLICATION

The DMEPOS supplier should review this section to understand those penalties that can be applied against the supplier for deliberately furnishing false information to enroll or maintain enrollment in the Medicare program.

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12. Capitalization Requirements for Home Health Agencies This Section Not Applicable

13. Contact Person Information (Optional)

Furnish the name(s) and telephone number(s) of a person(s) who can answer questions about the information furnished in this application (preferably the individual who completed this application). If a contact person is not furnished in this section, all questions will be directed to the authorized official named in Section 15B.

A. Check here ☐ If this section does not apply and skip to Section 14.

B. Contact Name and Telephone Number ☐ Add ☐ Delete ☐ Change Effective Date:_____

Name: First	Last	Social Security Number
Address Line 1 (Street Name and Number)		
Address Line 2 (Suite, Room, etc.)		
City	State	ZIP Code + 4
E-mail Address (if applicable)	Telephone Number ( )	(Ext.) ( )

14. Penalties for Falsifying Information on this Enrollment Application

This section explains the penalties for deliberately furnishing false information in this application to gain or maintain enrollment in the Medicare program.

1. 18 U.S.C. § 1001 authorizes criminal penalties against an individual who, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry.

Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000 (18 U.S.C. § 3571). Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against any individual who, "knowingly and willfully," makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program.

The offender is subject to fines of up to $25,000 and/or imprisonment for up to five years.

3. The Civil False Claims Act, 31 U.S.C. § 3729, imposes civil liability, in part, on any person who:
   a) knowingly presents, or causes to be presented, to an officer or any employee of the United States Government a false or fraudulent claim for payment or approval;
   b) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or
   c) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

The Act imposes a civil penalty of $5,000 to $10,000 per violation, plus three times the amount of damages sustained by the Government.

4. Section 1128A(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency...a claim...that the Secretary determines is for a medical or other item or service that the person knows or should know:
   a) was not provided as claimed; and/or
   b) the claim is false or fraudulent.

This provision authorizes a civil monetary penalty of up to $10,000 for each item or service, an assessment of up to three times the amount claimed, and exclusion from participation in the Medicare program and State health care programs.

5. The government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment."

Remedies include compensatory and punitive damages, restitution, and recovery of the amount of the unjust profit.

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SECTION 15: CERTIFICATION STATEMENT

This section is used to officially notify the DMEPOS supplier of additional requirements that must be met and maintained in order for the DMEPOS supplier to be enrolled in the Medicare program. This section also requires the signature and date signed of an authorized official who can legally and financially bind the DMEPOS supplier to the laws, regulations, and program instructions of the Medicare program. Section 16 permits the authorized official to delegate signature authority to certain individual(s) (delegated officials) for the purpose of reporting changes to the DMEPOS supplier's enrollment record after the DMEPOS supplier has been enrolled. The DMEPOS supplier may have no more than two (2) currently active authorized officials at any given time. See 15B below to determine who within the DMEPOS supplier organization qualifies as an authorized official.

A. **Additional Requirements for Medicare Enrollment** – These are the additional requirements that must be met by the DMEPOS supplier to enroll in and maintained by the DMEPOS supplier to bill the Medicare program. Carefully read these requirements. By signing, the DMEPOS supplier will be attesting to having read these requirements and that the DMEPOS supplier understands them.

B. **1st Authorized Official Signature** - If adding a new, or deleting an existing authorized official, check the appropriate box and indicate the effective date of that change.

NOTE: The authorized official must also be reported in Section 6.

- The authorized official must sign and date this application.

By his/her signature, the authorized official binds the DMEPOS supplier to all of the requirements listed in the Certification Statement and acknowledges that the DMEPOS supplier may be denied entry to or revoked from the Medicare program if any requirements are not met. **All signatures must be original.** Faxed, photocopied, or stamped signatures will not be accepted.

C. **2nd Authorized Official Signature** – This section provided to report a second (optional) authorized official for this supplier. See instructions above for Section 15B.

An authorized official is an appointed official to whom the DMEPOS supplier has granted the legal authority to enroll it in the Medicare program, to make changes and/or updates to the DMEPOS supplier's status in the Medicare program (e.g., new practice locations, change of address, etc.), and to commit the DMEPOS supplier to fully abide by the laws, regulations, and program instructions of Medicare. The authorized official must be the DMEPOS supplier him/herself in sole proprietorships or the DMEPOS supplier's general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of 5% or more of the enrolling DMEPOS supplier (see Section 5 for definition of a "direct owner"), or must hold a position of similar status and authority within the DMEPOS supplier's organization.

Only the authorized official has the authority to sign the initial CMS 855S application and the re-enrollment CMS 855S application on behalf of the DMEPOS supplier. The delegated official has no such authority.

By signing this form for initial enrollment in the Medicare program or for re-enrollment purposes, the authorized official agrees to immediately notify the Medicare program contractor if any information in the application is not true, correct, or complete. In addition, the authorized official, by his/her signature, agrees to notify the Medicare contractor of any future changes to the information contained in this form, after the DMEPOS supplier is enrolled in Medicare, within 30 days of the effective date of the change.

Governmental/Tribal Organizations

As stated in the instructions for Governmental/Tribal Organizations in Section 5, the authorized official signing the CMS 855S in Section 15 must be the same person submitting the letter attesting that the governmental or tribal organization will be legally and financially responsible for any outstanding debts owed to CMS. For instance, the head of a County Department of Health and Human Services would ordinarily qualify as an authorized official of the governmental entity.

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SPECIAL REPORTING REQUIREMENTS

To change authorized officials, the DMEPOS supplier must:

- Check the "Delete" box in Section 15B,
- Provide the effective date of the deletion, and
- Have the authorized official being deleted provide his/her printed name, signature, and date of signature.

NOTE: If the current authorized official's signature is unattainable (e.g., person has left the company), the NSC may request documentation verifying that the person is no longer the authorized official.

To then add a new authorized official, the DMEPOS supplier must:

- Copy the page containing the Certification Statement,
- Check the "Add" box in Section 15B and provide the effective date of the addition,
- Have the new authorized official provide the information requested in 15B, and
- Have the new authorized official provide his/her signature and date of signature.

By signing his or her name, the new authorized official assumes from the prior authorized official all of the powers (e.g., the power to delegate authority to a delegated official, etc.) previously held by the latter, and also agrees to adhere to all Medicare requirements, including those outlined in Sections 15A and 15B of the Certification Statement. However, a change of the authorized official has no bearing on the authority of existing delegated officials to make changes and/or updates to the DMEPOS supplier's status in the Medicare program.

If the DMEPOS supplier is reporting a change of information about the current authorized official (e.g., change in job title), this section should be completed as follows:

- Check the box to indicate a change and furnish the effective date,
- Provide the new information, and
- Have the authorized official sign and date this section.

NOTE: DMEPOS supplier's can have **no more than two (2)** authorized officials at any given time.

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15. Certification Statement

This section is used to officially notify the supplier of additional requirements that must be met and maintained in order for the supplier to be enrolled in the Medicare program. This section also requires the signature and date signed of an authorized official who can legally and financially bind the supplier to the laws, regulations, and program instructions of the Medicare program. Section 16 permits the authorized official to delegate signature authority to other individual(s) (delegated officials) employed by the supplier for the purpose of reporting future changes to the supplier's enrollment record. See instructions to determine who qualifies as an authorized official and a delegated official for the supplier.

A. Additional Requirements for Medicare Enrollment

By his/her signature(s), the authorized official named below and the delegated official(s) named in Section 16 agree to adhere to the following requirements stated in this Certification Statement:

1.) I agree to notify the Medicare contractor of any future changes to the information contained in this form within 30 days of the effective date of the change. I understand that any change in the business structure of this supplier may require the submission of a new application.

2.) I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare billing number(s), and/or the imposition of fines, civil damages, and/or imprisonment.

3.) I agree to abide by the Medicare laws, regulations, and program instructions applicable to DMEPOS suppliers. The Medicare laws, regulations, and program instructions are available through the Medicare contractor.

4.) Neither this DMEPOS supplier, nor any 5% or greater owner, partner, officer, director, managing employee, authorized official, or delegated official thereof is currently sanctioned, suspended, debarred, or excluded by the Medicare or Medicaid program, or any other Federal agency or program, or is otherwise prohibited from providing services to Medicare or other Federal program beneficiaries.

5.) I agree that any existing or future overpayment made to the DMEPOS supplier by the Medicare program may be recouped by Medicare through the withholding of future payments.

6.) I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

B. 1st Authorized Official Signature ☐ **Add** ☐ **Delete** **Effective Date:**_____

I have read the contents of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete to the best of my knowledge, and I authorize the Medicare program contractor to verify this information. I also certify that I have read, understand, meet, and will continue to meet all supplier standards as outlined in 42 CFR § 424.57. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare program contractor of this fact immediately.

Authorized Official Name **Print**	First	Middle	Last	Jr., Sr., etc.
Authorized Official **Signature**	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)		Title/Position	Date (MM/DD/YYYY) Signed

C. 2nd Authorized Official Signature ☐ **Add** ☐ **Delete** **Effective Date:**_____

I have read the contents of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete to the best of my knowledge, and I authorize the Medicare program contractor to verify this information. I also certify that I have read, understand, meet, and will continue to meet all supplier standards as outlined in 42 CFR § 424.57. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare program contractor of this fact immediately.

Authorized Official Name **Print**	First	Middle	Last	Jr., Sr., etc.
Authorized Official **Signature**	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)		Title/Position	Date (MM/DD/YYYY) Signed

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SECTION 16: DELEGATED OFFICIAL (OPTIONAL)

A delegated official must be a W-2 managing employee of the DMEPOS supplier, or an individual with a 5% or greater direct ownership interest in, or any partnership interest in, the enrolling DMEPOS supplier. Delegated officials are persons who are delegated the legal authority by the authorized official reported in Section 14B to make changes and/or updates to the DMEPOS supplier's status in the Medicare program. This individual must also be able to commit the DMEPOS supplier to fully abide by the laws, regulations, and program instructions of Medicare. For purposes of this section only, if the individual being assigned as a delegated official is a managing employee, that individual **must** be an actual W-2 employee of the enrolling DMEPOS supplier. The NSC may request evidence indicating that the delegated official is an actual employee of the DMEPOS supplier. Independent contractors are not considered "employed" by the DMEPOS supplier. A DMEPOS supplier can have no more than three delegated officials at any given time.

The signature of the authorized official in Section 16B2 constitutes a legal delegation of authority to any and all delegated official(s) assigned in Section 16.

A. Check Box - If the DMEPOS supplier chooses not to assign any delegated officials in this application, check the box in this section. There is no requirement that the DMEPOS supplier have a delegated official. However, if no delegated officials are assigned, the authorized official will be the only person who can make changes and/or updates to the DMEPOS supplier's status in the Medicare program. All delegated officials must meet the following requirements:

- The delegated official must sign and date this application,
- The delegated official must furnish his/her title/position, and
- The delegated official must check the box furnished if they are a W-2 employee.

NOTE: The delegated official must also be reported in Section 6.

B. 1st Delegated Official Signature

If the DMEPOS supplier chooses to add delegated officials or to delete existing ones, this section should be completed as follows:

- Check the appropriate box indicating if the delegated official is being added or deleted and furnish the effective date,
- The authorized official must provide his or her signature and date of signature in Sections 15B and 16B2,
- The delegated official(s) to be added must provide the information and their signature(s) in Section 16B, and
- The delegated official(s) to be deleted does not have to sign or date the application.

NOTE: All signatures must be original. Faxed, photocopied, or stamped signatures are not acceptable.

If the DMEPOS supplier is reporting a change of information about an existing delegated official (e.g., change in job title, etc.), this section should be completed as follows:

- Check the box marked "Change" and furnish the effective date,
- Provide the new information, and
- The authorized official must sign and date Sections 15B and 16B2.

Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the DMEPOS supplier's Medicare status. Even when delegated officials are reported in this application, an authorized official retains the authority to make any such changes and/or updates by providing his or her printed name, signature, and date of signature as required in Section 15B.

In addition, the delegated official, by his/her signature, agrees to notify the Medicare contractor of any changes to the information contained in this application within 30 days of the effective date of the change.

C. 2nd Delegated Official Signature - This section provided to report a second (optional) delegated official for this supplier. See instructions above for Section 16B.

D. 3rd Delegated Official Signature - This section provided to report a second (optional) delegated official for this supplier. See instructions above for Section 16B.

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SECTION 17: ATTACHMENTS

This section contains a list of documents that, if applicable, must be submitted with this enrollment application. Failure to provide the required documents will delay the enrollment process.

- Check the appropriate boxes indicating which documents are being submitted with this application.

NOTE: Any licenses (both business and professional) that are needed to operate this business in the State where the enrolling DMEPOS supplier business is located as reported in section 4A **must** be included with this application.

All enrolling DMEPOS suppliers are required to furnish information on all Federal, State and local (city/county) professional and business licenses, certifications and/or registrations required to practice as a DMEPOS supplier in DMEPOS supplier's State of business location as reported in section 4A (e.g., Federal Drug Enforcement Agency (DEA) number for pharmacies, business occupancy license, local business license, etc.). The NSC will supply specific licensing requirements for a DMEPOS supplier upon request.

In lieu of copies of the above requested documents, the enrolling DMEPOS supplier may submit a notarized Certificate of Good Standing from the DMEPOS supplier's business location State licensing/certification board or other medical associations. This certification cannot be more than 30 days old.

If the enrolling DMEPOS supplier has had a previously revoked or suspended license, certification, or registration reinstated, attach a copy of the reinstatement notice with this application.

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16. Delegated Official (Optional)

The signature of the authorized official below constitutes a legal delegation of authority to the official(s) named in this section to make changes and/or updates to this supplier's enrollment information. The signature(s) of the delegated official(s) shall have the same force and effect as that of the authorized official, and shall legally and financially bind the supplier to all the laws, regulations, and program instructions of the Medicare program. By his or her signature, the delegated official certifies that he or she has read the Certification Statement in Section 15 and agrees to adhere to all of the stated requirements. The delegated official also certifies that he/she meets the definition of a delegated official. When making changes and/or updates to the supplier's enrollment information maintained by the Medicare program, the delegated official certifies that the information provided is true, correct, and complete.

A. Check here ☐ if this supplier will not be assigning any delegated official(s) and skip to Section 17.

B. 1st Delegated Official Signature ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Delegated Official Name **Print** First	Middle	Last	Jr., Sr., etc.
Delegated Official **Signature** (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed
Title/Position	☐ Check here only if Delegated Official is a W-2 employee		
2. **Signature** of Authorized Official Assigning this Delegation (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed

C. 2nd Delegated Official Signature ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

2. Delegated Official Name **Print** First	Middle	Last	Jr., Sr., etc.
Delegated Official **Signature** (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed
Title/Position	☐ Check here only if Delegated Official is a W-2 employee		
3. **Signature** of Authorized Official Assigning this Delegation (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed

D. 3rd Delegated Official Signature ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

3. Delegated Official Name **Print** First	Middle	Last	Jr., Sr., etc.
Delegated Official **Signature** (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed
Title/Position	☐ Check here only if Delegated Official is a W-2 employee		
4. **Signature** of Authorized Official Assigning this Delegation (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed

17. Attachments

This section is a list of documents that, if applicable, should be submitted with this completed enrollment application.

Place a check next to each document (as applicable or required) from the list below that is being included with this completed application.

- ☐ Copy(s) of all Federal, State, and/or local (city/county) professional licenses, certifications and/or registrations
- ☐ Copy(s) of all Federal, State, and/or local (city/county) business licenses, certifications and/or registrations
- ☐ Copy(s) of all adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters)
- ☐ Copy(s) of all State pharmacy licenses
- ☐ Copy(s) of all surety bonds and/or Agent's Power of Attorney
- ☐ Copy(s) of all liability insurance policies
- ☐ IRS documents confirming the tax identification number and legal business name (e.g., CP 575)
- ☐ Any additional documentation or letters of explanation as needed

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