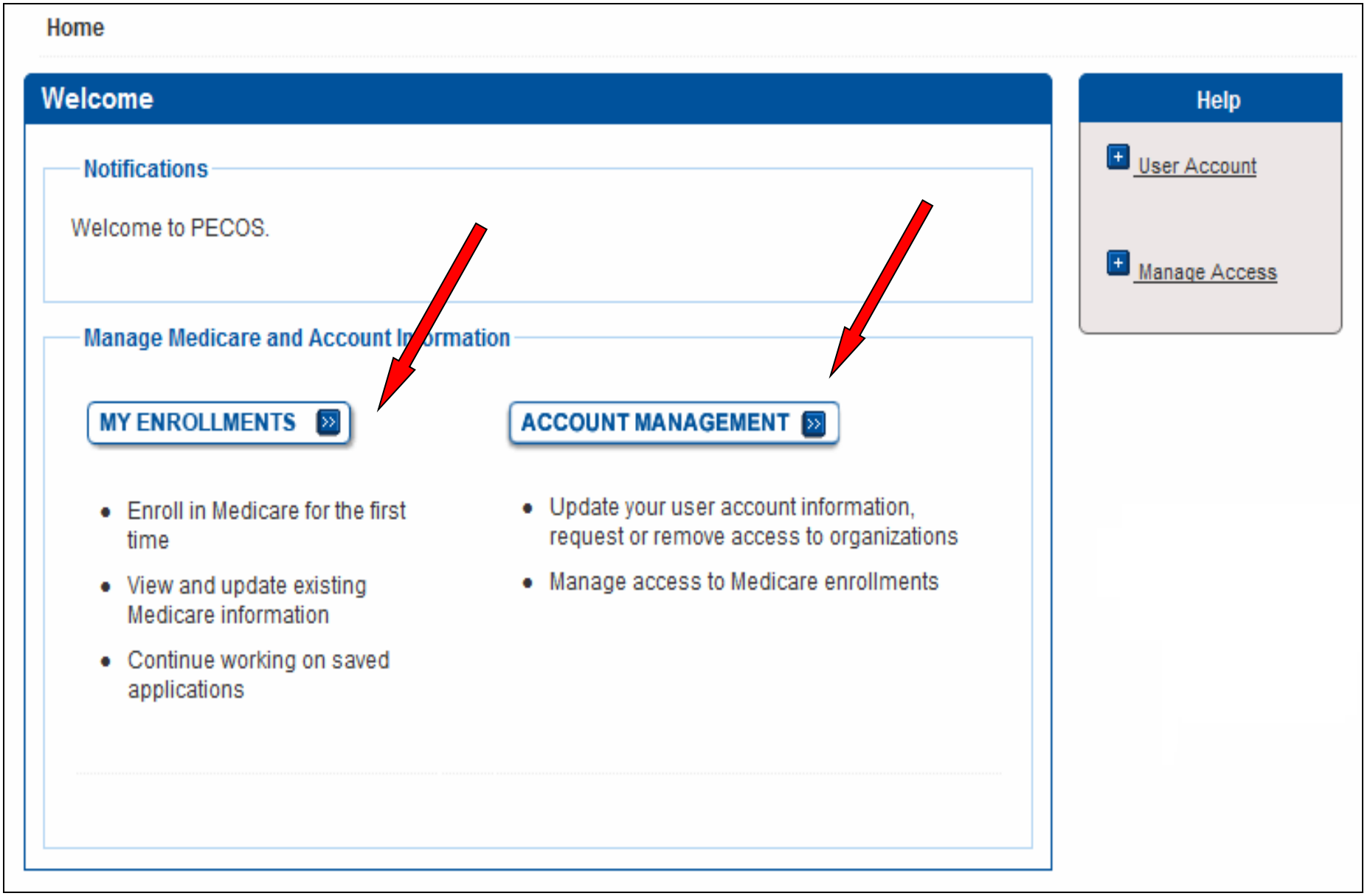
Internet-based Provider Enrollment, Chain and Ownership System (PECOS)

Enrollment Example


Home
Welcome
Notifications
Welcome to PECOS.
Manage Medicare and Account Information
MY ENROLLMENTS
ACCOUNT MANAGEMENT
Enroll in Medicare for the first time
View and update existing Medicare information
Continue working on saved applications
Update your user account information, request or remove access to organizations
Manage access to Medicare enrollments
Help
User Account
Manage Access

Home > My Enrollments

My Enrollments

New Application

To enroll in the Medicare program for the first time or to create a new enrollment, please click the "New Application" button below.

NEW APPLICATION

Existing Associates

There are no Associates currently present for the details provided.

Help

- Medicare Part A Services
- Medicare Part B Services
- Legal Business Name
- National Provider Identifier (NPI)

Application Questionnaire

(*) Red asterisk indicates a required field.

Applicant Description

Please select the description that best matches the provider.*

- ○ **Sole Owner of a PA, PC or LLC**
  The applicant provides practitioner services through an incorporated business of which he/she is the only owner (the practitioner and business are legally distinct).

- ○ **X Self-Employed**
  The applicant provides healthcare services from a facility that he/she owns/leases/rents (the practitioner and business are legally the same).

- ○ **Group Member Only**
  The applicant reassigns to a group practice/clinic or individual

- ○ **Group Member and is Self-Employed**
  The applicant is self-employed and provides healthcare services as an employee of another provider.

- ○ **Disregarded Entity**
  The applicant provides healthcare services through a business which he/she is the only owner that chooses to be disregarded as separate from the business (The practitioner and business are considered legally the same).

PREVIOUS PAGE NEXT PAGE

CANCEL

Help

- Sole Owner
- Professional Corporation (PC)
- Professional Association (PA)
- Limited Liability Company (LLC)
- Disregarded Entity

Home > My Enrollments > Application Questionnaire

Application Questionnaire

(*) Red asterisk indicates a required field.

Applicant Identification Information

First Name*

JOHN

Last Name*

DOE

Social Security Number (SSN)*

123-45-6789

123-45-6789

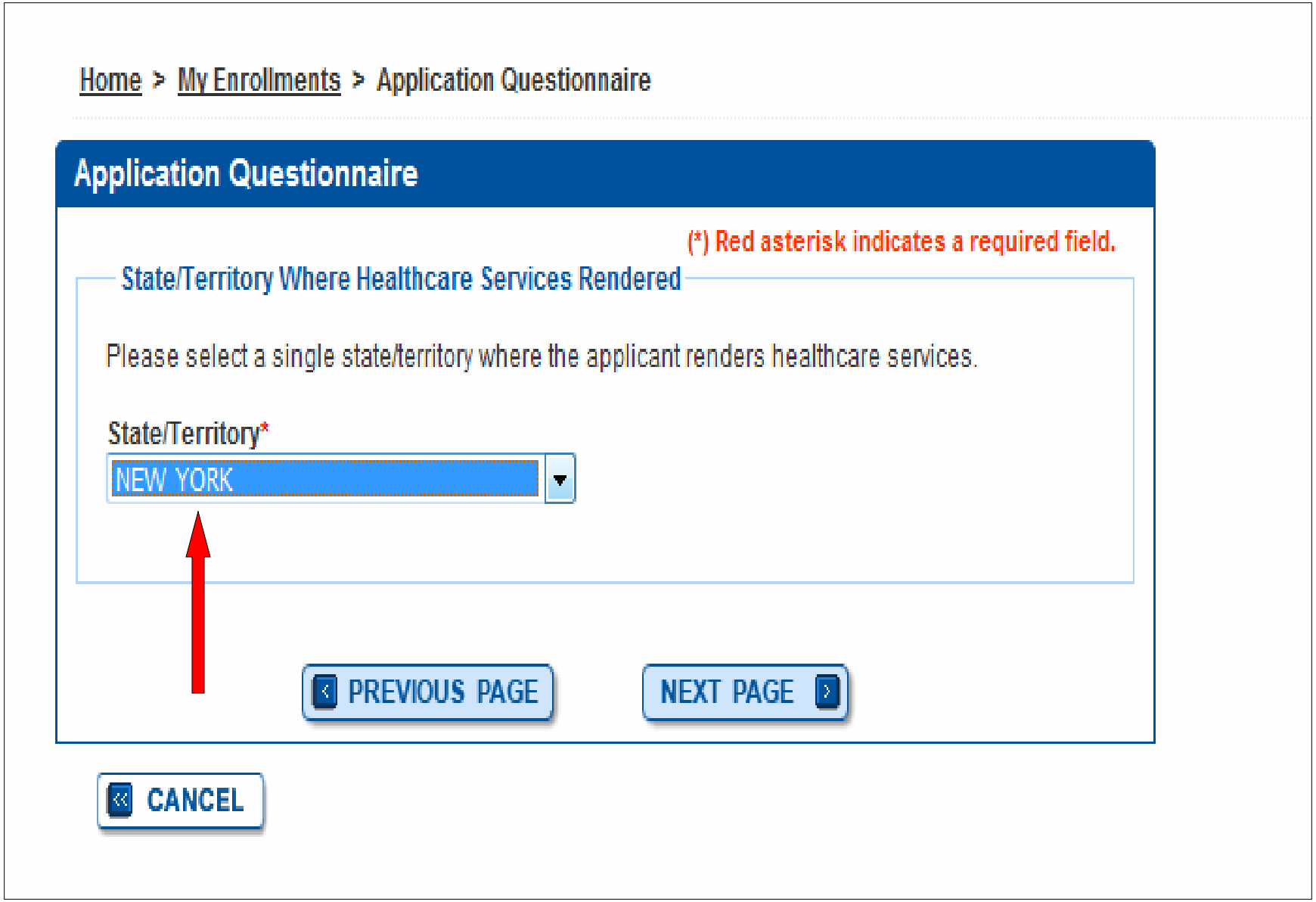
Date of Birth*

mm/dd/yyyy

01/18/1974

PREVIOUS PAGE

NEXT PAGE


Home > My Enrollments > Application Questionnaire
Application Questionnaire
(*) Red asterisk indicates a required field.
State/Territory Where Healthcare Services Rendered
Please select a single state/territory where the applicant renders healthcare services.
State/Territory*
NEW YORK
PREVIOUS PAGE
NEXT PAGE
CANCEL

Home > My Enrollments > Application Questionnaire

Application Questionnaire

(*) Red asterisk indicates a required field.

Primary Medicare Services Rendered

Please select the primary Medicare Services rendered by the applicant.*

Note: A separate application is required for each primary healthcare service rendered.

Part B Physician Specialties*

INTERNAL MEDICINE

Part B Non-physician Specialties*

Select Non-Physician Specialty

Part B Supplier Services*

Select Supplier Type

Part A Provider Services*

Select Provider Type

Undefined Type Specification*

Home > My Enrollments > Application Questionnaire

Application Questionnaire

(*) Red asterisk indicates a required field.

Reassignment of Benefits

Is the applicant employed by a business or individual that will receive the practitioner's Medicare claims payments?*

- ( ) Yes
- (X) No

PREVIOUS PAGE NEXT PAGE

Confirm Reason for Application

Medicare Part B Enrollment

Based on your responses, the following reason for application was identified.

- **A Medicare Part B practitioner is enrolling in the Medicare program for the first time using their social security number (SSN). No reassignment of benefits exists with this application.**

The application is for:

Name	Social Security Number (SSN)	Practitioner Specialty	State
JOHN DOE	123-45-6789	INTERNAL MEDICINE	NEW YORK

Clicking on the 'Start Application' button will create a Medicare application using the above information.

At the conclusion of this process:

- The application is submitted to the appropriate Medicare fee-for-service contractor(s) for processing
- The practitioner must sign a statement certifying the submitted information
- The certification statement, additional required signatures, and required attachments must be mailed to the identified fee-for-service contractor(s)

Help

- Reassignment
- Practitioner Specialty
- Fee-for-Service Contractor
- Certification Statement

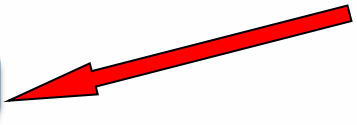
Home > My Enrollments > Initial Enrollment > Personal Information

Personal Information

Topic Summary

This topic requests personal and identification information about the applicant. (more information about Personal Information)

ADD INFORMATION



Personal Information

No Personal Information has been listed. Please click "Add Information" above.

RETURN TO TOPICS

NEXT TOPIC

Help

Applicant

Home > My Enrollments > Initial Enrollment > Personal Information > ADD

Personal Information

(*) Red asterisk indicates a required field.

Other Name for the Applicant

Does the applicant have any other name to supply?(e.g. former or maiden name, professional name, etc.)*

- ( ) Yes
- (X) No

Type of Other Name *
Select Type

Other Type of Name

Other First Name *

Other Middle Name

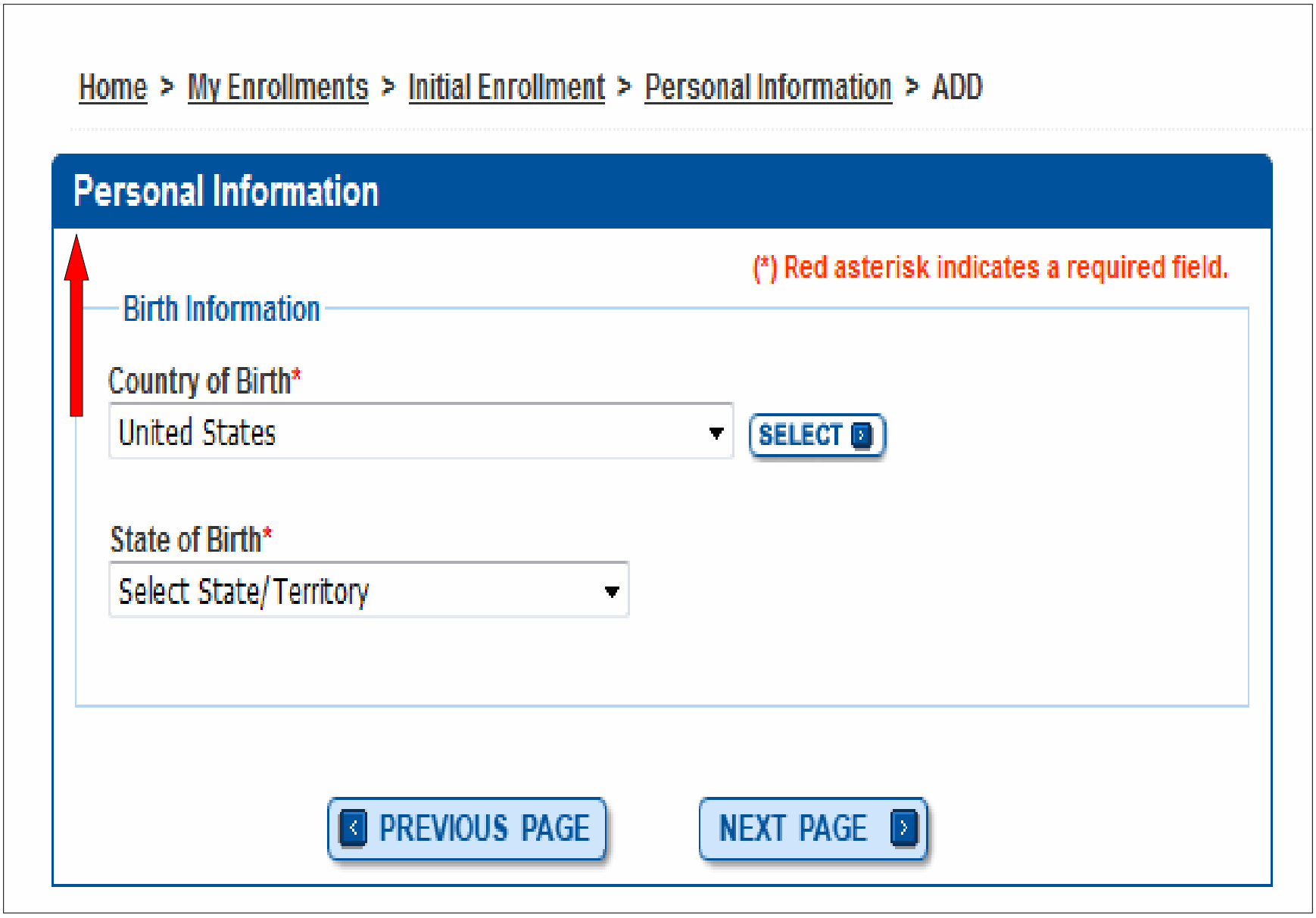
Other Last Name *

Other Name Suffix
Select Suffix

Other Credentials (M.D., D.O., etc.)

Help

Other Name (Individual)


Home > My Enrollments > Initial Enrollment > Personal Information > ADD
Personal Information
(*) Red asterisk indicates a required field.
Birth Information
Country of Birth*
United States
SELECT
State of Birth*
Select State/Territory
PREVIOUS PAGE
NEXT PAGE

Home > My Enrollments > Initial Enrollment > Personal Information > ADD

Personal Information

Medical/Professional School Information

(*) Red asterisk indicates a required field.

Medical School or other Professional School *

YOUR MEDICAL SCHOOL NAME

Year of Graduation

yyyy

2002

PREVIOUS PAGE

SAVE

CMS

Home > My Enrollments > Initial Enrollment > Personal Information

Personal Information

Topic Summary

This topic requests personal and identification information about the applicant. (more information about Personal Information)

Personal Information

XXXXXXXXXXXXXXXXXXXXXX

Date of Birth: 01/18/1974
Social Security Number: 123-45-6789
Gender: Male
Drug Enforcement Agency (DEA) Number: XXXXXXXXX
Country of Birth: United States
State of Birth: NY
Medical School or other Professional School:
Year of Graduation: XXXX

EDIT

Help

Applicant

Topic Summary

The practitioner specialty for this enrollment is listed below for your reference. This topic allows you to identify any secondary specialties for the practitioner. (more information about Practitioner Specialty)

Practitioner Specialty Information

Practitioner Specialties

Practitioner Type: Physician

Primary Physician Specialty	Secondary Physician Specialties	
	ADD	
INTERNAL MEDICINE	PULMONARY DISEASE	DELETE
	CRITICAL CARE (INTENSIVISTS)	DELETE

PREVIOUS TOPIC

NEXT TOPIC

Practitioner Specialty

Practitioner Type

Primary Physician Specialty

Secondary Physician Specialities

Home > My Enrollments > Initial Enrollment > License and Certification Information > ADD

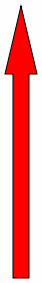
License and Certification Information

(*) Red asterisk indicates a required field.

Type of Information

What type of information would you like to enter? *

- ( ) License Information
- ( ) Certification Information



NEXT PAGE

CANCEL

Residency/Fellowship Status

(*) Red asterisk indicates a required field.

Topic Summary

The topic requests information about the applicant's residency or fellowship status. (more information about Residency/Fellow Status)

Is the applicant currently in an approved training program as either a resident or a fellow?*

- ( ) Yes
- (X) No

ADD INFORMATION

Residency/Fellowship Status Information

No Residency or Fellowship Status has been listed. Please answer the question above.

Help

- Residency
- Fellowship

Home > My Enrollments > Initial Enrollment > PAR Status

PAR Status

Topic Summary

This topic requests information to determine if the applicant agrees to accept assignment for all covered services provided to Medicare patients. (more information about PAR Status)

PAR Status Information

Does the applicant agree to accept assignment for all covered services provided to Medicare patients? *

X Yes

No

PAR Status Information

No PAR Status Information has been listed. Please select the answer to the above question.

Help

PAR Status

Fee-for-Service Contractor

Correspondence Address

Topic Summary

This topic requests information about the correspondence address for the applicant.

(more information about Correspondence Address)

Note: Do not use the contact information of a billing agency, staffing company, or managing organization as the contact information.

Correspondence Address Information

Address: xx xxxxx xxx
xxxxx xxxxx xx 12345-6789
United States
Telephone: (xxx) xxx-xxxx
Fax: (xxx) xxx-xxxx

EDIT

Adverse Legal Actions

(*) Red asterisk indicates a required field.

Topic Summary

The topic requests information about adverse legal actions imposed against the applicant.
(more information about Adverse Legal Actions)

Has an adverse legal action ever been imposed against an applicant under any current or former name or business entity? *

- Yes
- No

Adverse Legal Actions That Must be Reported

Convictions

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.

Help

- Adverse Legal Action
- Revocation
- Federal Non-Procurement Program
- Federal Procurement Program

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.

Exclusions, Revocations or Suspensions

1. 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.
2. Any revocation or suspension of accreditation.
3. 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.
4. Any current Medicare payment suspension under any Medicare billing number.

ADD INFORMATION >>

Adverse Legal Actions Information

No adverse legal actions have been listed. Please answer the question above.

Physical Location and "Special Payments" Address

(*) Red asterisk indicates a required field.

National Provider Identifier (NPI)

Please provide the National Provider Identifier (NPI) that applies to the individual. If a National Provider Identifier (NPI) has been issued for the individual, it must be identified for this application.

National Provider Identifier (NPI) *

0123456789

NEXT PAGE

Help

+ National Provider Identifier (NPI)

Home > My Enrollments > Initial Enrollment > Physical Location and "Special Payments" Address > ADD

Physical Location and "Special Payments" Address

(*) Red asterisk indicates a required field.

Physical Location Address

Effective Date of Information *
mm/dd/yyyy
Date Begin Practicing at Location

Location Name *
John Doe MD

Address Line 1 *
10 Oak St.

Address Line 2

City *
Your Town

State/Territory:* NY

ZIP Code+4 *
55555 4444

PREVIOUS PAGE NEXT PAGE

Address Verification

(*) Red asterisk indicates a required field.

Address Verification

The address you have provided did not verify with the United States Postal Service (USPS) database. We have identified a verified, standardized address that corresponds to the address you provided.

Please select the address that you would like to submit: *

Verified USPS address:

10 Oak St.
Your Town, NY 55555 4444

Address you entered:

10 Oak St.
Your Town, NY 55555 4444

PREVIOUS PAGE NEXT PAGE

Physical Location and "Special Payments" Address

(*) Red asterisk indicates a required field.

Physical Location Contact Information

Telephone *

(555) 555-5555 x Extension

(123) 321-1234

Fax

(555) 555-5555

E-mail Address

PREVIOUS PAGE NEXT PAGE

Home > My Enrollments > Initial Enrollment > Physical Location and "Special Payments" Address > ADD

Physical Location and "Special Payments" Address

(*) Red asterisk indicates a required field.

You must resolve the following error(s) to continue

- The Telephone Number must be in the following format (555) 555-5555. Please re-enter the correct number.
- The Fax Number must be in the following format (555) 555-5555. Please re-enter the correct number.

Physical Location Contact Information

Telephone *
(555) 555-5555 x Extension

(123) 321-1234

Fax
(555) 555-5555

E-mail Address

PREVIOUS PAGE NEXT PAGE

Physical Location and "Special Payments" Address

CLIA Numbers

Please provide any CLIA numbers that apply to this physical location.

CLIA Number

ADD MORE

Note: Use the Add More button to add more than one CLIA number.

PREVIOUS PAGE NEXT PAGE

Help

Clinical Laboratory Improvement Amendments (CLIA) Number

Home > My Enrollments > Initial Enrollment > Physical Location and "Special Payments" Address > ADD

Physical Location and "Special Payments" Address

FDA Numbers

Please provide any FDA/Radiology (Mammography) Certification numbers that apply to this physical location.

FDA/Radiology (Mammography) Certification Number

ADD MORE

Note: Use the Add More button to add more than one FDA/Radiology (Mammography) Certification number.

PREVIOUS PAGE NEXT PAGE

Help

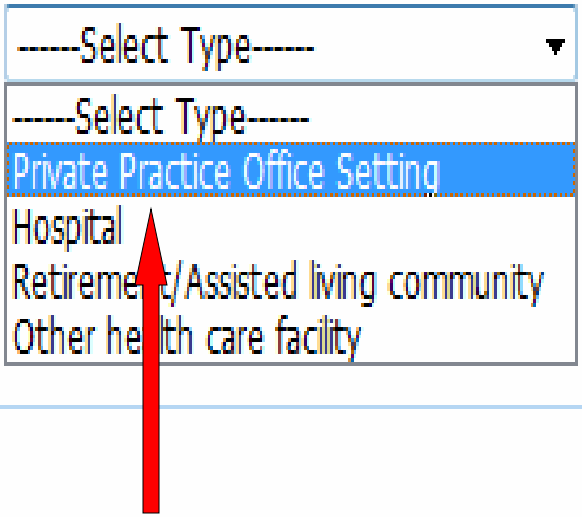
FDA/Radiology (Mammography) Certification Number

Physical Location and "Special Payments" Address

(*) Red asterisk indicates a required field.

Practice Location Type

Is this practice location a:*



PREVIOUS PAGE NEXT PAGE

Home > My Enrollments > Initial Enrollment > Physical Location and "Special Payments" Address > ADD

Physical Location and "Special Payments" Address

(*) Red asterisk indicates a required field.

"Special Payments" Address (Domestic)

Country *

United States SELECT

Payment Location Name:

Effective Date of Information *

mm/dd/yyyy

Date You Begin Receiving Payment at this Location

Address Line 1 *

Address Line 2

City *

State/Territory *

------ Select State/Territory ------

ZIP Code+4 *

PREVIOUS PAGE SAVE

Home > My Enrollments > Initial Enrollment > Physical Location and "Special Payments" Address

Physical Location and "Special Payments" Address

Topic Summary

This topic requests information about the Physical Location and "Special Payments" Address of the applicant's practice location and/or base of operations. (more information about Physical Location and "Special Payments" Address)

ADD INFORMATION

Physical Location and "Special Payments Address" Information

Identification Number(s)

National Provider Identifier(NPI):

EDIT

John Doe

Location Type: Practice Location

Physical Address:

10 Oak St
Your Town, NY 55555 44444

EDIT DELETE

Payment Address:

EDIT DELETE

CLIA and FDA Certification Number(s):

ADD

Help

"Special Payments" Address

CLIA and FDA Certification Number(s):

ADD

NORTHERN WESTCHESTER HOSPITAL

Location Type: Practice Location

Phvsical Address:

Payment Address:

EDIT DELETE EDIT DELETE

CLIA and FDA Certification Number(s):

ADD

Rendering Healthcare Services at the Patient's Home

(*) Red asterisk indicates a required field.

Topic Summary

This topic requests information about the locations where this applicant renders healthcare services in a patient's home. You may either list your locations individually by the cities or zip codes you service or you may identify the state. (more information about Rendering Healthcare Services at the Patient's Home)

Does the applicant render health care services in patient's homes?*

- ( ) Yes
- (X) No

ADD INFORMATION >>

Rendering Healthcare Services at the Patient's Home

No locations have been listed. Please answer the question above.

Individuals with Managing Control

(*) Red asterisk indicates a required field.

Topic Summary

This topic requests information about individuals with ownership interest in and/or managing control of the applicant.
All managing employees for the practice locations listed on this enrollment must be reported.

(more information about Individuals with Managing Control)

Does the applicant have any individuals having managing control (managing employees) to report? *

- ( ) Yes
- (X) No

ADD INFORMATION

Managing Employees Information

You have indicated that the applicant does not need to report an individual having managing control. Please click the "Next Topic" button or change the answer to the question above.

PREVIOUS TOPIC

NEXT TOPIC

Help

- Limited Partnership
- Five Percent (5%) or More Ownership Control
- Partner
- Managing Control

Patient Records Storage Location

(*) Red asterisk indicates a required field.

Topic Summary

This topic requests information about where patient medical records are stored. (more information about Record Storage Location)

Where are the patient's medical records stored (for current and former patients)? *

X At one of the Practice Locations or Base(s) of Operations reported on this enrollment

○ At a different location

ADD INFORMATION

Patient Records Storage Location Information

No patient records storage locations have been listed. Please answer the question above.

PREVIOUS TOPIC

NEXT TOPIC

Help

- Practice Location
- Base of Operations
- Provider
- Independent Diagnostic Testing Facilities (IDTF)
- Mobile Facilities/ Portable Units

Contact Person

Topic Summary

The topic requests information about the person or persons that the Medicare contractor should contact if any questions exist about the application. (more information about Contact Person)

ADD INFORMATION

Contact Person Information

No contact person has been listed. Please click "Add Information" above.

Contact Person

Topic Summary

The topic requests information about the person or persons that the Medicare contractor should contact if any questions exist about the application. (more information about Contact Person)

ADD INFORMATION

Contact Person Information

XXXXXXXXXXXXXXXXXXXX

Address: XXXXXXXXXXXXXXX
XXXXXXXXXXXXX , NY XXXXX-XXXX
Telephone: (XXX) XXX-XXXX
Fax: (XXX) XXX-XXXX
E-mail Address: XXXX@XXX.com

EDIT DELETE

Home > My Enrollments > Initial Enrollment

Topics for this Enrollment

Enrollment ID: XXXXXXXXXXXXXXX PacID: XXXXXXXXXXXXXXXXXXXXXXXXX

Reason for Application

- Practitioner is Enrolling in Medicare for the First Time

Topics

The data required for this enrollment application is grouped into topics. In order to electronically submit this enrollment application, you must complete all of the following topics.

You may view and print this enrollment application at any time during the enrollment process by clicking the View and Print button below.

This application is collecting the following topics:

Completed	Topics
✓	Personal Information more information about Personal Information
✓	Practitioner Specialty more information about Practitioner Specialty
✓	PAR Status Information more information about PAR Status Information
✓	Physical Location and "Special Payments" Address more information about Physical Location and "Special Payments" Address
✓	Rendering Healthcare Services at a Patient's Home more information about Rendering Healthcare Services at a Patient's Home

- ✓ **Practitioner Specialty** more information about Practitioner Specialty
- ✓ **PAR Status Information** more information about PAR Status Information
- ✓ **Physical Location and "Special Payments" Address** more information about Physical Location and "Special Payments" Address
- ✓ **Rendering Healthcare Services at a Patient's Home** more information about Rendering Healthcare Services at a Patient's Home
- ✓ **Resident/Fellow Status** more information about Resident/Fellow Status
- ✓ **Correspondence Address** more information about Correspondence Address
- ✓ **License and Certification Information** more information about License and Certification Information
- ✓ **Adverse Legal Actions** more information about Adverse Legal Actions
- ✓ **Individual Control** more information about Individual Control
- ✓ **Patient Records Storage Location** more information about Patient Records Storage Location
- ✓ **Billing Agency** more information about Billing Agency
- ✓ **Contact Person** more information about Contact Person

Home > My Enrollments > Initial Enrollment > Submission Process

Submission Process

Submission Process Overview

The following steps must be completed to submit this application:

- **Step 1. Error Check:** System checks for data errors or inconsistencies.
- **Step 2. Select Fee-For-Service Contractor:** Additional information is asked to help identify the Medicare Fee-For-Service Contractor who will process this application.
- **Step 3. Select Signatories:** The individuals required to sign this application will be identified.
- **Step 4. Printing and Mailing:** Review and print the forms required for or associated with this application.
- **Step 5. Submit:** Submit the application to electronically route it for processing.
- **Step 6. Print Receipt:** A receipt of the electronic submission is provided.

Click 'Next Page' to begin the Error Check.

NEXT PAGE

CANCEL

Home > My Enrollments > Initial Enrollment > Submission Process

Submission Process: Error Check

No Errors or Warnings Exist

No Errors or Warnings were found for this enrollment application. Please proceed with the submission process.

NEXT PAGE

CANCEL

Home > My Enrollments > Initial Enrollment > Submission Process

Medicare Fee-for-Service Contractor

(*) Red asterisk indicates a required field.

Medicare Fee-For-Service Contractor Selection

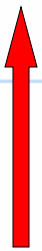
Please select a Fee-For-Service Contractor.

The Fee-For-Service Contractor will answer the applicant's questions, process the enrollment application, and pay the applicant's claims.

Note: It is recommended that the applicant select the Fee-For-Service Contractor of the Chain Home Office.

Fee-For-Service Contractor*

NATIONAL GOVERNMENT SERVICES



PREVIOUS PAGE NEXT PAGE

CANCEL

Help

Fee-for-Service Contractor

Home > My Enrollments > Initial Enrollment > Submission Process

Submission Process

Signatory for Individual Enrollment

The following individual practitioner must provide a signature:

- **John Doe**

PREVIOUS PAGE NEXT PAGE

CANCEL

Submission Process

Printing and Mailing Instructions

Each document listed below may be saved to your computer and/or printed for your personal records by clicking the "View and Print" link next to each document. Only the Certification / Authorization Statement(s) and the required supporting documentation must be printed and mailed to the Medicare contractor listed below. Please do not mail a copy of this application to the Medicare contractor if you are submitting it electronically.

1. **Print Submission Materials:** Print all required supporting documents. Click on the "View and Print" link next to "List of Supporting Documentation" below for a list of supporting documentation relevant to this application.
2. **Mail Items to Fee-For-Service Medicare Contractor:** The identified Medicare contractor is responsible for processing electronically submitted and mailed materials for this enrollment application. In order to complete the processing of your application, mail the Certification / Authorization Statement(s) and all required supporting documentation to the Medicare contractor listed below within 7 days of your electronic submission. Failure to do so may result in a rejection.

   NATIONAL GOVERNMENT SERVICES
   P.O. BOX 4792
   SYRACUSE, NY 13221-4792

Action	Document Name
View and Print	Certification Statement for Individual Practitioners
View and Print	List of Supporting Documentation
View and Print	Copy of this Application (For your records only, please do not mail)
View and Print	CMS-460 Medicare Participating Physician or Supplier Agreement

NATIONAL GOVERNMENT SERVICES
P.O. BOX 4792
SYRACUSE, NY 13221-4792

Action	Document Name
View and Print	Certification Statement for Individual Practitioners
View and Print	List of Supporting Documentation
View and Print	Copy of this Application (For your records only, please do not mail)
View and Print	CMS-460 Medicare Participating Physician or Supplier Agreement

Note:

- For security reasons, Social Security Numbers and the year of birth in Date of Birth fields will not appear on the printed Medicare application. If you plan to mail your printed application to the Medicare contractor instead of submitting it electronically, please review the application and insert the Social Security Numbers and year of birth where they are required but not displayed.
- Documents in PDF format require the Adobe Acrobat Reader®. If you experience problems with PDF documents, please download the latest version of the Reader®.

PREVIOUS PAGE NEXT PAGE

CANCEL

Supporting Documentation for Individual Practitioners

Please mail all applicable supporting documentation to your Medicare fee-for-service contractor. Additional documentation may also be requested by your Medicare fee-for-service contractor to validate information that you have reported in this application.

Optional documentation is recommended to assist in processing this enrollment submission.

Required Supporting Documentation

1. Copy of National Provider Identifier (NPI) notification that you received from the National Plan Provider Enumeration System (NPPES).
2. Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name (e.g., CP 575). (Note: This information is needed if the applicant is enrolling a professional corporation, professional association, or limited liability company with this application, or enrolling as a sole proprietor using an Employer Identification Number.)
3. 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.
4. Completed Form CMS 588—Authorization Agreement of Electronic Funds Transfer. Note if a supplier already receives payments electronically and is not making a change to his/her

Help

- National Provider Identifier (NPI)
- Adverse Legal Action
- Electronic Fund Transfer (EFT)
- Security Consent Form

Optional documentation is recommended to assist in processing this enrollment submission.

Required Supporting Documentation

1. Copy of National Provider Identifier (NPI) notification that you received from the National Plan Provider Enumeration System (NPPES).
2. Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name (e.g., CP 575). (Note: This information is needed if the applicant is enrolling a professional corporation, professional association, or limited liability company with this application, or enrolling as a sole proprietor using an Employer Identification Number.)
3. 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.
4. Completed Form CMS 588—Authorization Agreement of Electronic Funds Transfer. Note if a supplier already receives payments electronically and is not making a change to his/her banking information, the CMS-588 is not required.
5. Copy(s) of all professional school degrees or certificates, professional licenses, and/or evidence of qualifying course work.

Required, if applicable, Supporting Documentation

1. Completed Form CMS 460 - Medicare Participating Physician or Supplier Agreement.

Optional Supporting Documentation

1. Security Consent Form.
2. Any additional documentation or letters of explanation as needed.

PRINT >> CLOSE >>

+ Adverse Legal Action

+ Electronic Fund Transfer (EFT)

+ Security Consent Form

Home > My Enrollments > Initial Enrollment > Submission Process

Submission Process

Submit Electronically

You are now ready to submit this Medicare Application for processing. Please review the summary below to ensure this is the application and reason you wish to submit. Upon submission, the enrollment information is sent to a fee-for-service contractor for processing. Any corrections to this application must be coordinated through the Medicare contractor.

Applicant Name: John Doe

Tracking ID: 111222333444555

Reason(s) for submission:

- A Medicare Part B practitioner is enrolling in the Medicare program for the first time to bill for Part B services. A reassignment of benefits may exist.

PREVIOUS PAGE SUBMIT

Help

Fee-for-Service Contractor

Tracking ID

Submission Receipt

Submission Complete

You have successfully submitted your enrollment!

Remember:

- You must have all certification statements and other documents requiring a signature signed by the individual displayed on each printed form
- You must mail all signed forms and supporting documentation to your Fee-For-Service contractor. An enrollment application cannot be fully processed until all these items have been received
- You should print this page for your records
- You may print additional copies of an enrollment, certification statement, or list of supporting documentation (these documents can be accessed from the My Enrollments page)

Enrollment Tracking Information

Applicant Name:XXXX XXXXXXXX

Tracking ID:XXXXXXXXXXXXXXXXXX

Submitted Date: XX - JUNE - 2009

Submitted By: XXXXXX XXXXXXX

Contact Email(s):
xxxxxx@xxx.com

Enrollment Tracking Information

Applicant Name: XXXXX XXXXXXX

Tracking ID: XXXXXXXXXXXXXXXXX

Submitted Date: XX - JUNE - 2009

Submitted By: XXXXXXX XXXXXX

Contact Email(s):

XXXXXXX@XXXXXX.com

Reason(s) for submission:

- A Medicare Part B practitioner is enrolling in the Medicare program for the first time to bill for Part B services. A reassignment of benefits may exist.

Medicare Contractor(s)

Medicare Contractor(s): The identified contractors are responsible for processing electronically submitted and mailed materials for this enrollment application. If you have more than one contractor, you will need to submit all certification statements and supporting documentation to each contractor.

NATIONAL GOVERNMENT SERVICES
P.O. BOX 4792
SYRACUSE NY 13221-4792

PRINT >> MY ENROLLMENTS >>

Final Step

- Print, sign and date the two-page Certification Statement and mail it along with all requested supporting documentation to the Medicare contractor

Note: Do not mail the CMS-855 paper that can be printed from Internet-based PECOS.

Retain this information for your records.