Medicare Part B

2009 IHS Partnership

Provider Enrollment

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Today's Objectives

- Provider Enrollment Overview
- How to complete the 855I
- Internet-based PECOS
- Enrollment tips

Provider Outreach and Education

- **Our Goal**
- Help providers realize it is much more cost effective for their practices to file claims correctly the first time, every time.
- Working together, we can make a difference!

Provider Enrollment

- Physicians and non-physician practitioners must enroll and maintain their Medicare enrollment in the program to be eligible to receive Medicare payments for covered services furnished to Medicare beneficiaries.

Provider Enrollment (Cont.)

- The provider/supplier enrollment process is a critical function.
- Physicians and non-physician practitioners can apply for enrollment in the Medicare program or make a change in their enrollment information using either:
  - The Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or
  - The paper enrollment application process.

Provider Enrollment (Cont.)

- **Provider Enrollment, Chain and Ownership System (PECOS)**
- PECOS is a national database that supports the provider enrollment function. CMS launched this new enrollment system in 2003 for Medicare contractors.

Provider Enrollment (Cont.)

- **Enrollment Applications**
  - CMS-855B (Clinics/Group Practices and Certain Other Suppliers).
  - CMS-855I (Physicians and Non-Physician Practitioners).
  - CMS-855R (Reassignment of Medicare Benefits).

Provider Enrollment (Cont.)

- Prescreening ensures providers have submitted all required supporting documentation and a complete enrollment application.
- If an application is received that contains at least one missing required data element, or the provider fails to submit all required supporting documentation:
  - TrailBlazer will send a letter to the provider (where appropriate, the letter can be sent by e-mail or fax) that documents and requests the missing information.
  - TrailBlazer is not required to make any additional requests for the missing data elements or documentation after the initial letter.

Provider Enrollment (Cont.)

The provider must furnish all the missing information within 30 calendar days of the request. If the provider fails to do so, the application is rejected. The provider will be notified by letter with the reasons for rejection and how to reapply. If the provider wishes to reapply, they will be required to begin a new process.

Diane Free Amanda Ball Liz Hawthorne

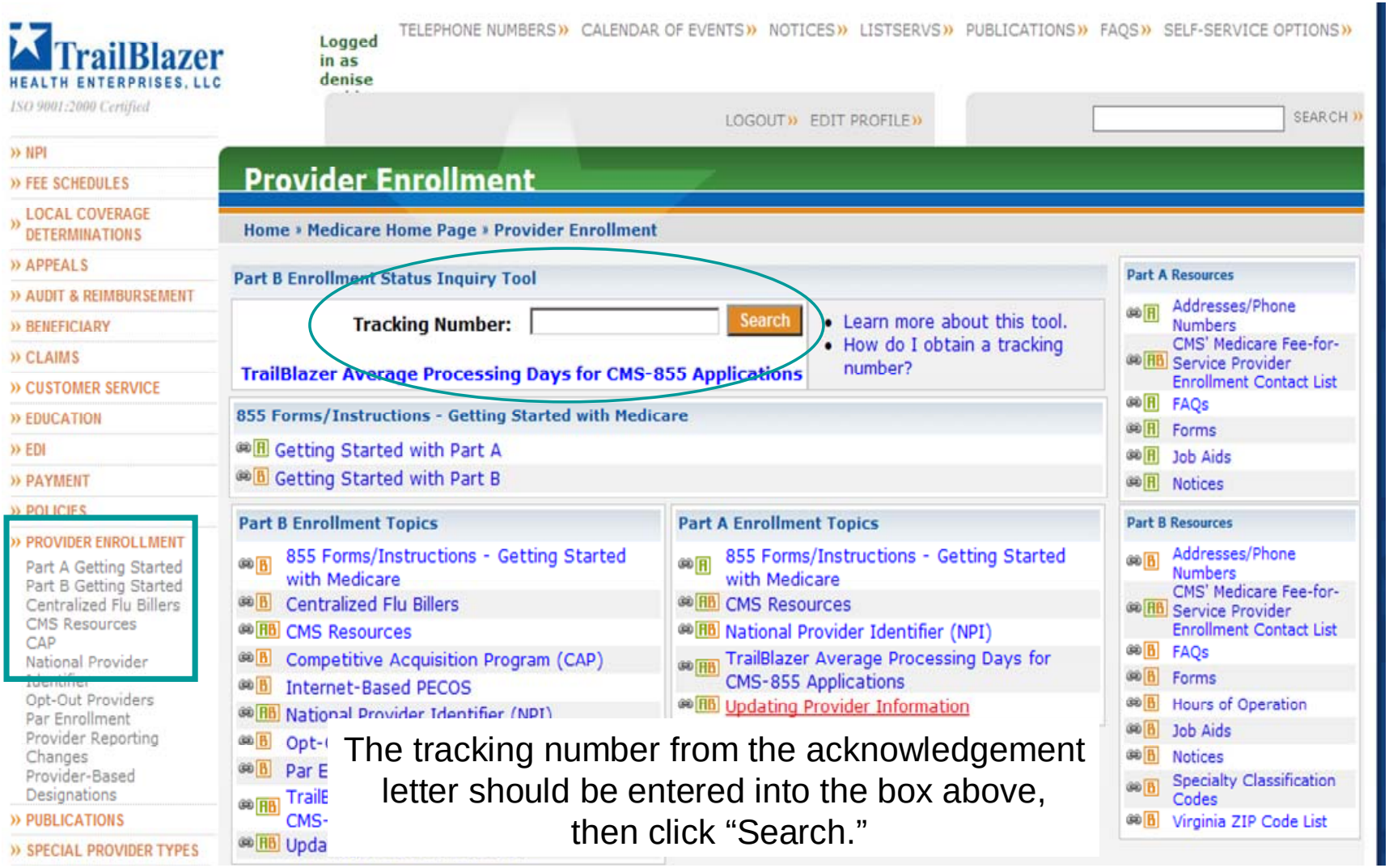
Provider Enrollment (Cont.)

- Once it is determined that the application will not be returned, it goes through different phases of verification, validation and final processing.
- If additional information is needed during these phases, the provider could receive an **e-mail, fax or letter** requesting information. This **e-mail, fax or letter** will be directed to the person listed as the contact person in Section 13 of the CMS-855 form.

Provider Enrollment (Cont.)

- Once the enrollment process has begun, the provider will receive an acknowledgment letter.
- The acknowledgment letter will have a tracking number to allow the provider to track the various phases of the application via the TrailBlazer Provider Enrollment page.
- Providers are encouraged to periodically monitor the progress of the pending application and act accordingly if there are any requests for additional information during the processing phases.

Provider Enrollment (Cont.)



The tracking number from the acknowledgement letter should be entered into the box above, then click “Search.”

Provider Enrollment Status Inquiry

PEStatus-Results

Listed below is the current status of your enrollment.

Provider Enrollment Status Results

Provider:	
Status:	Finalized – Enrollment or change of information approved. Notification sent to provider.
Details:	The initial enrollment, reassignment or change of information has been approved, and the Medicare enrollment confirmation letter was mailed to the correspondence address listed on the CMS-855.

History:

Date	Description
3/3/2009	The initial enrollment, reassignment or change of information has been approved, and the Medicare enrollment confirmation letter was mailed to the correspondence address listed on the CMS-855.
2/27/2009	The enrollment is in the final processing stages and should be completed upon final verification of cross over to the Medicare System.
2/27/2009	The enrollment is in the final processing stages. Application is pending entry into the Provider Enrollment Chain Ownership System (PECOS) and the Medicare System.
2/11/2009	The provider is being contacted by phone or letter for one of the following: 1. NPI error because of date of birth discrepancy. 2. NPI error because of EIN mismatch, or 3. Provider must make a name change with the Social Security Administration.
2/9/2009	This application is being screened for quality control.
2/5/2009	The enrollment is in the final processing stages. Application is pending entry into the Provider Enrollment Chain Ownership System (PECOS) and the Medicare System.
2/5/2009	The application has been screened. Requested information and/or supporting documentation has been received and is now being verified and validated. Applications requesting more information are processed within 60 days of receipt of the requested information.
1/20/2009	The enrollment application has missing data or supporting documentation which requires the submission of this information. The request was faxed, emailed or mailed to the contact person listed on the CMS 855. Verification and validation of the application data will begin once the requested information has been received. The verification process may take up to 60 days after receipt of the information.
1/20/2009	The enrollment application has been screened. Any requested information and supporting documentation has been received and is now being verified and validated. Applications not requiring more information are processed within 60 days of the initial receipt date. Applications requiring more information are processed within 60 days of receipt of the requested information.

CMS-855I Enrollment Application

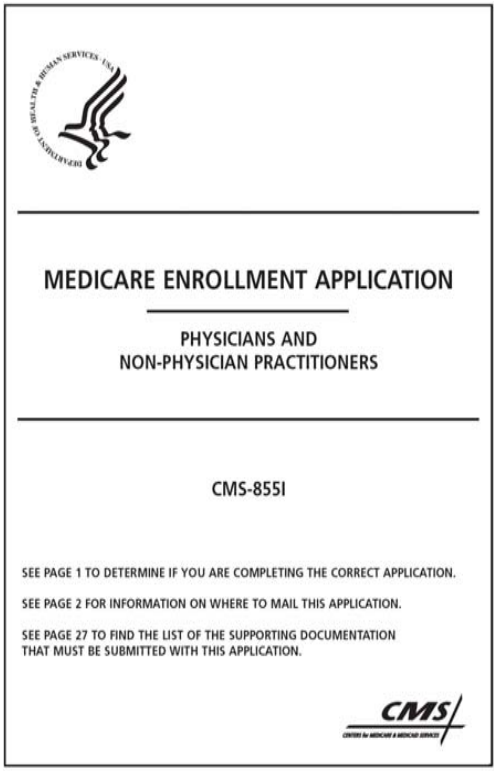
- The CMS-855I form is for:
  - All physicians
  - Non-physician practitioners, including:
    - Anesthesiology assistant
    - Audiologist
    - Certified nurse midwife
    - Certified registered nurse anesthetist
    - Clinical nurse specialist
    - Clinical social worker
    - Mass immunization roster biller
    - Nurse practitioner
    - Occupational therapist in private practice
    - Physical therapist in private practice
    - Physician assistant
    - Psychologist, clinical
    - Psychologist billing independently
    - Registered dietitian or nutrition professional

Obtaining the CMS-855I Application

- The most current version of the CMS-855I application should be used. The application will be used as a guide throughout this job aid. Please take a moment to print the application.

- The most current version of this form can be obtained from the following CMS Web site at: http://www.cms.hhs.gov/cmsforms/downloads/cms855i.pdf

- The CMS-855I is also available on the TrailBlazer Health Enterprises Web Site at: http://www.trailblazerhealth.com/Provider%20Enrollment/PartBGettingStarted.aspx



MEDICARE ENROLLMENT APPLICATION

PHYSICIANS AND
NON-PHYSICIAN PRACTITIONERS

CMS-855I

SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION.

SEE PAGE 2 FOR INFORMATION ON WHERE TO MAIL THIS APPLICATION.

SEE PAGE 27 TO FIND THE LIST OF THE SUPPORTING DOCUMENTATION
THAT MUST BE SUBMITTED WITH THIS APPLICATION.

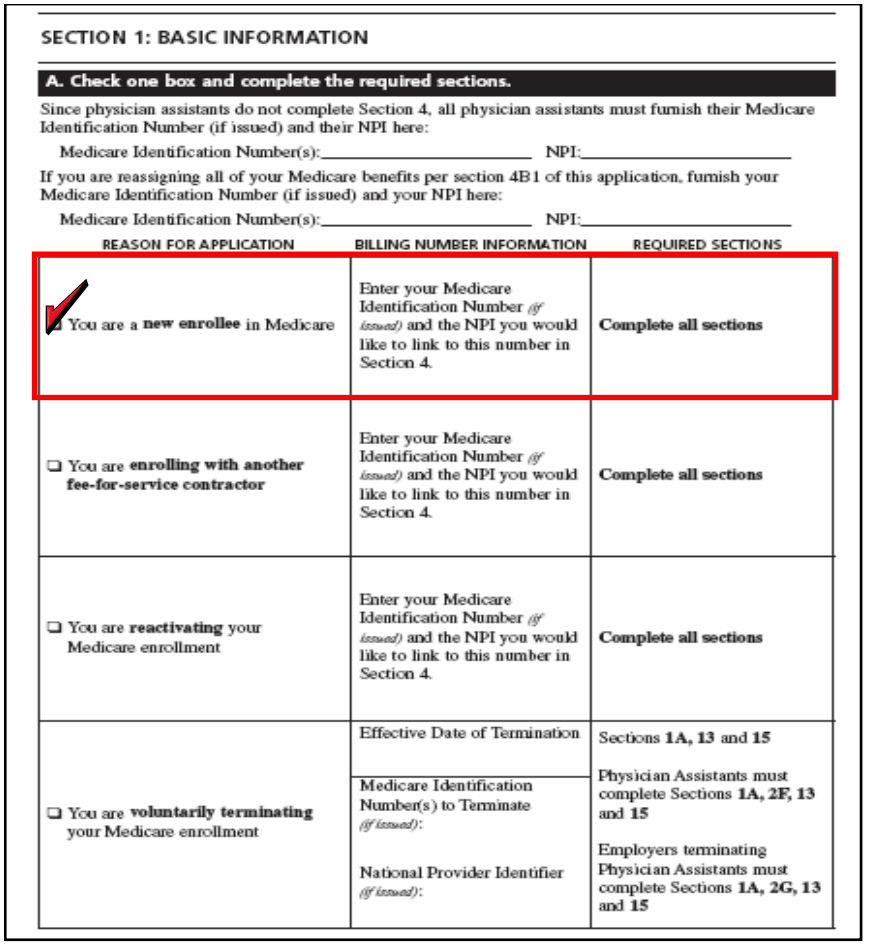
CMS

Instructions for Completing and Submitting the 855I Application

- Type or print all information so it is legible. Do not use pencil.
- Report additional information within a section by copying and completing that section for each individual entry.
- Attach all required supporting documentation.
- Keep a copy of the completed Medicare enrollment package for the office records.
- Send completed applications with original signatures and all required documentation to the designated Medicare fee-for-service contractor.
- If the new provider is already established in PECOS, only an 855R will be required. Contact Enrollment to verify before only sending the 855R, otherwise it will be returned with a request for both forms.

Section 1: Basic Information

- Complete in **blue** or **black ink.** **Do not use pencil.**
- **Section 1.A.**
- This section captures information about why the application is being completed.
- If you are a physician assistant, furnish your National Provider Identifier (NPI) on the first line.
- If you are reassigning all of your benefits to a group organization, furnish your NPI on the second line.
- Find the section that applies to new enrollees.
- Only one reason per application should be checked.



SECTION 1: BASIC INFORMATION

A. Check one box and complete the required sections.

Since physician assistants do not complete Section 4, all physician assistants must furnish their Medicare Identification Number (if issued) and their NPI here:

Medicare Identification Number(s):_____ NPI:_____

If you are reassigning all of your Medicare benefits per section 4B1 of this application, furnish your Medicare Identification Number (if issued) and your NPI here:

Medicare Identification Number(s):_____ NPI:_____

REASON FOR APPLICATION	BILLING NUMBER INFORMATION	REQUIRED SECTIONS
☑ You are a **new enrollee** in Medicare	Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4.	**Complete all sections**
❑ You are **enrolling with another fee-for-service contractor**	Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4.	**Complete all sections**
❑ You are **reactivating** your Medicare enrollment	Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4.	**Complete all sections**
❑ You are **voluntarily terminating** your Medicare enrollment	Effective Date of Termination Medicare Identification Number(s) to Terminate *(if issued)*: National Provider Identifier *(if issued)*:	Sections **1A, 13** and **15** Physician Assistants must complete Sections **1A, 2F, 13** and **15** Employers terminating Physician Assistants must complete Sections **1A, 2G, 13** and **15**

Section 1: Basic Information (Cont.)

- **Section 1.B**

- New enrollees will not complete this section.

SECTION 1: BASIC INFORMATION (Continued)

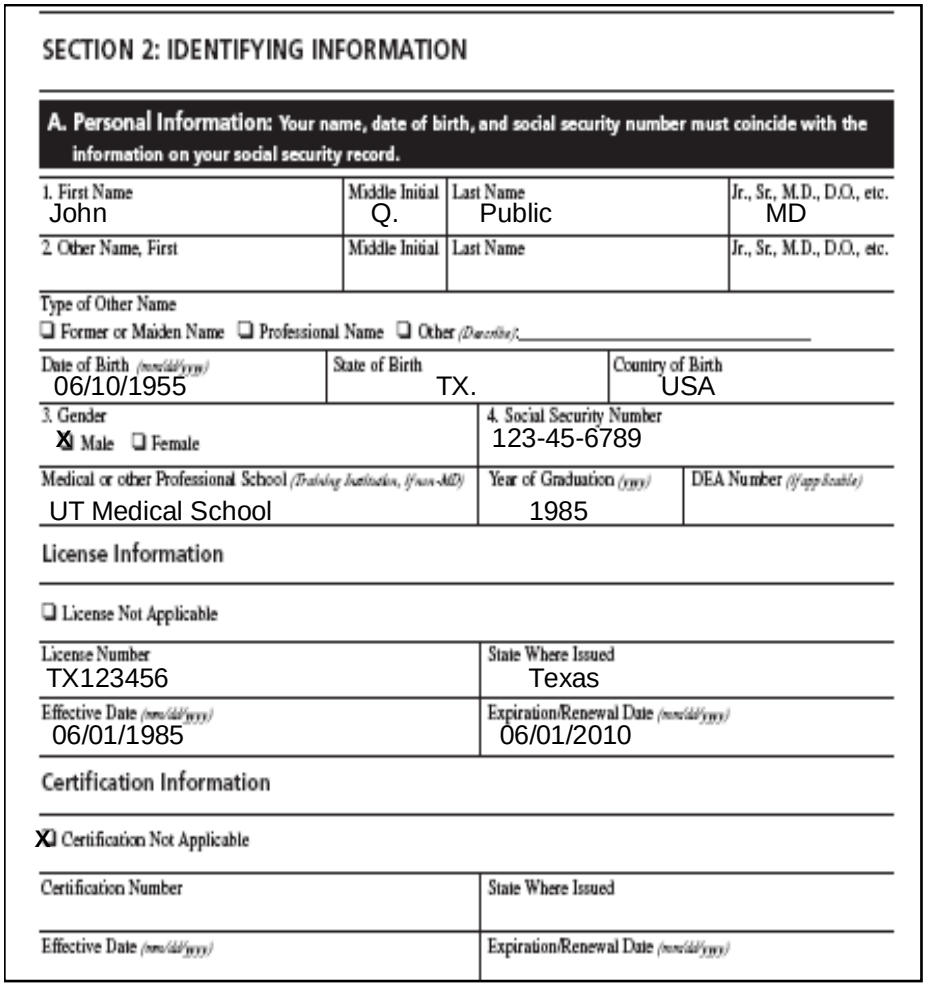
❑ You are **changing** your Medicare information	Medicare Identification Number *(if issued)*: NPI:	Go to Section **1B**
❑ You are **revalidating** your Medicare enrollment	Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4.	**Complete all sections**

B. Check all that apply and complete the required sections.

	REQUIRED SECTIONS
❑ Identifying Information	**1, 2** (complete only those sections that are changing), **3, 13** and **15**
❑ Adverse Legal Actions / Convictions	**1, 2A, 3, 13** and **15**
❑ Practice Location Information, Payment Address and Medical Record Storage Information	**1, 2A, 3, 4** (complete only those sections that are changing), **13** and **15**
❑ Individuals Having Managing Control	**1, 2A, 3, 6, 13,** and **15**
❑ Billing Agency Information	**1, 2A, 3, *8*** (complete only those sections that are changing), **13** and **15**

Section 2: Identifying Information

- **Section 2.A**
- This section is personal information and should be completed in its entirety.
- List the name as it appears with the Social Security Agency (SSA). If the provider has recently had a name change, the name must be updated with the SSA before Medicare can enroll or update the provider's record. The Social Security Number (SSN) must be included in this section.
- Include copies of all licenses and/or certifications.



SECTION 2: IDENTIFYING INFORMATION

A. Personal Information: Your name, date of birth, and social security number must coincide with the information on your social security record.

1. First Name	Middle Initial	Last Name	Jr., Sr., M.D., D.O., etc.
John	Q.	Public	MD
2. Other Name, First	Middle Initial	Last Name	Jr., Sr., M.D., D.O., etc.

Type of Other Name
❑ Former or Maiden Name ❑ Professional Name ❑ Other (Describe):

Date of Birth (mm/dd/yyyy)	State of Birth	Country of Birth
06/10/1955	TX.	USA

3. Gender	4. Social Security Number
X Male ❑ Female	123-45-6789

Medical or other Professional School (Training Institution, if non-MD)	Year of Graduation (yyyy)	DEA Number (If applicable)
UT Medical School	1985	

License Information

❑ License Not Applicable

License Number	State Where Issued
TX123456	Texas
Effective Date (mm/dd/yyyy)	Expiration/Renewal Date (mm/dd/yyyy)
06/01/1985	06/01/2010

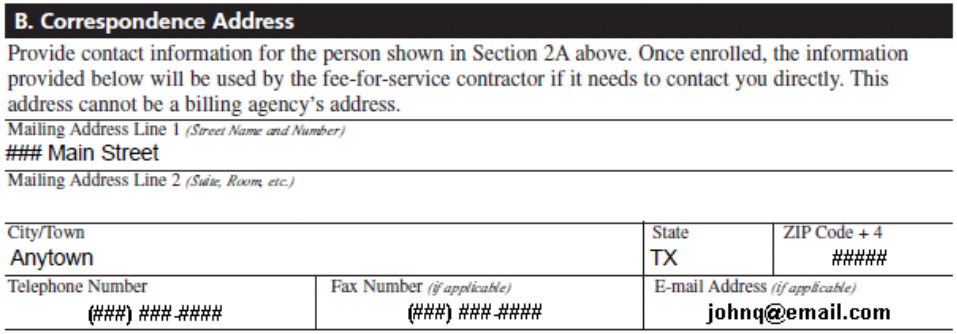
Certification Information

X Certification Not Applicable

Certification Number	State Where Issued
Effective Date (mm/dd/yyyy)	Expiration/Renewal Date (mm/dd/yyyy)

Section 2: Identifying Information (Cont.)

- **Section 2.B**
- The correspondence address is where the applicant in 2.A can be contacted.
- The address cannot be a billing agency's address or the provider's representative.



B. Correspondence Address

Provide contact information for the person shown in Section 2A above. Once enrolled, the information provided below will be used by the fee-for-service contractor if it needs to contact you directly. This address cannot be a billing agency's address.

Mailing Address Line 1 *(Street Name and Number)*
Main Street

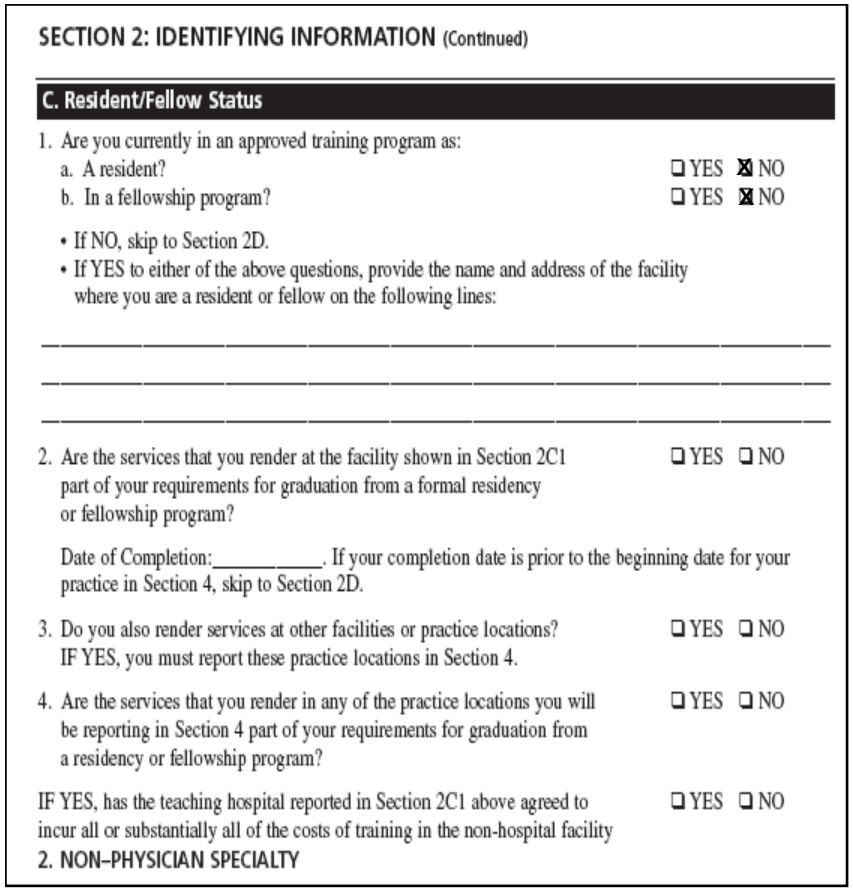
Mailing Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4
Anytown	TX	#####

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*
(###) ###-####	(###) ###-####	johnq@email.com

Section 2: Identifying Information (Cont.)

- **Section 2.C**
- **Physicians are required to complete this section.**
- If the provider is not a resident or in a fellowship program, check "No" in Questions 1.a and 1.b and skip to Section 2.D.
- If either Question 1.a or 1.b are answered "Yes," Questions 2, 3 and 4 must be completed.
- The date of completion in Question 2 must be furnished.



SECTION 2: IDENTIFYING INFORMATION (Continued)

C. Resident/Fellow Status

1. Are you currently in an approved training program as:
   a. A resident? ❑ YES ☒ NO
   b. In a fellowship program? ❑ YES ☒ NO
   - If NO, skip to Section 2D.
   - If YES to either of the above questions, provide the name and address of the facility where you are a resident or fellow on the following lines:

_____

_____

_____

2. Are the services that you render at the facility shown in Section 2C1 part of your requirements for graduation from a formal residency or fellowship program? ❑ YES ❑ NO

   Date of Completion:_____. If your completion date is prior to the beginning date for your practice in Section 4, skip to Section 2D.

3. Do you also render services at other facilities or practice locations? IF YES, you must report these practice locations in Section 4. ❑ YES ❑ NO

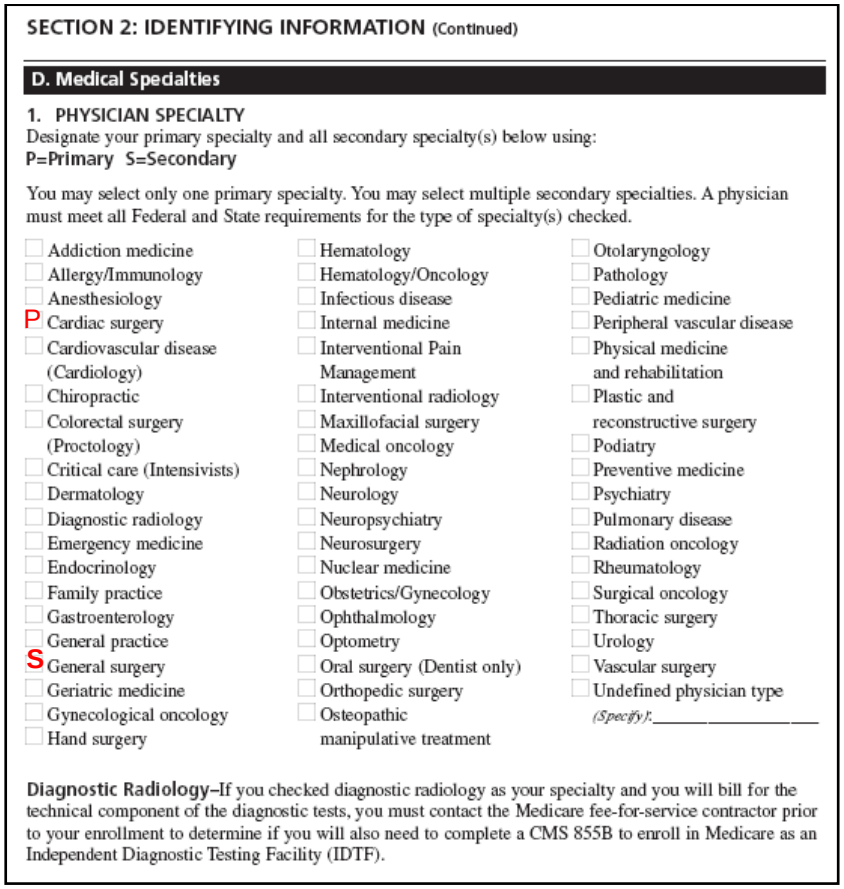
4. Are the services that you render in any of the practice locations you will be reporting in Section 4 part of your requirements for graduation from a residency or fellowship program? ❑ YES ❑ NO

IF YES, has the teaching hospital reported in Section 2C1 above agreed to incur all or substantially all of the costs of training in the non-hospital facility ❑ YES ❑ NO

2. NON–PHYSICIAN SPECIALTY

Section 2: Identifying Information (Cont.)

- **Section 2.D.1**
- Designate the **p**rimary and all **s**econdary specialties.
- Enter a **"P"** for primary in the box next to the specialty. If there is a secondary specialty, enter an **"S"** in the box next to the secondary specialty.
- List only one primary, but multiple secondary specialties if applicable.



SECTION 2: IDENTIFYING INFORMATION (Continued)

D. Medical Specialties

1. PHYSICIAN SPECIALTY

Designate your primary specialty and all secondary specialty(s) below using:
P=Primary S=Secondary

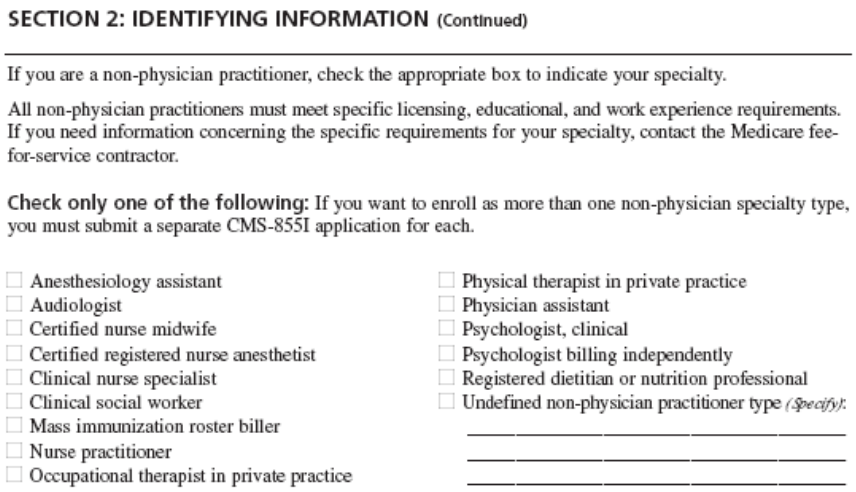
You may select only one primary specialty. You may select multiple secondary specialties. A physician must meet all Federal and State requirements for the type of specialty(s) checked.

Addiction medicine	Hematology	Otolaryngology
Allergy/Immunology	Hematology/Oncology	Pathology
Anesthesiology	Infectious disease	Pediatric medicine
P Cardiac surgery	Internal medicine	Peripheral vascular disease
Cardiovascular disease (Cardiology)	Interventional Pain Management	Physical medicine and rehabilitation
Chiropractic	Interventional radiology	Plastic and reconstructive surgery
Colorectal surgery (Proctology)	Maxillofacial surgery	Podiatry
Critical care (Intensivists)	Medical oncology	Preventive medicine
Dermatology	Nephrology	Psychiatry
Diagnostic radiology	Neurology	Pulmonary disease
Emergency medicine	Neuropsychiatry	Radiation oncology
Endocrinology	Neurosurgery	Rheumatology
Family practice	Nuclear medicine	Surgical oncology
Gastroenterology	Obstetrics/Gynecology	Thoracic surgery
General practice	Ophthalmology	Urology
S General surgery	Optometry	Vascular surgery
Geriatric medicine	Oral surgery (Dentist only)	Undefined physician type
Gynecological oncology	Orthopedic surgery	*(Specify)*:_____
Hand surgery	Osteopathic manipulative treatment	

Diagnostic Radiology–If you checked diagnostic radiology as your specialty and you will bill for the technical component of the diagnostic tests, you must contact the Medicare fee-for-service contractor 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).

Section 2: Identifying Information (Cont.)

- **Section 2.D.2**
- This section is for non-physician practitioners only.
- Please see application instructions for non-physician practitioners.



SECTION 2: IDENTIFYING INFORMATION (Continued)

If you are a non-physician practitioner, check the appropriate box to indicate your specialty.

All non-physician practitioners must meet specific licensing, educational, and work experience requirements. If you need information concerning the specific requirements for your specialty, contact the Medicare fee-for-service contractor.

Check only one of the following: If you want to enroll as more than one non-physician specialty type, you must submit a separate CMS-855I application for each.

- ☐ Anesthesiology assistant
- ☐ Audiologist
- ☐ Certified nurse midwife
- ☐ Certified registered nurse anesthetist
- ☐ Clinical nurse specialist
- ☐ Clinical social worker
- ☐ Mass immunization roster biller
- ☐ Nurse practitioner
- ☐ Occupational therapist in private practice
- ☐ Physical therapist in private practice
- ☐ Physician assistant
- ☐ Psychologist, clinical
- ☐ Psychologist billing independently
- ☐ Registered dietitian or nutrition professional
- ☐ Undefined non-physician practitioner type *(Specify)*:

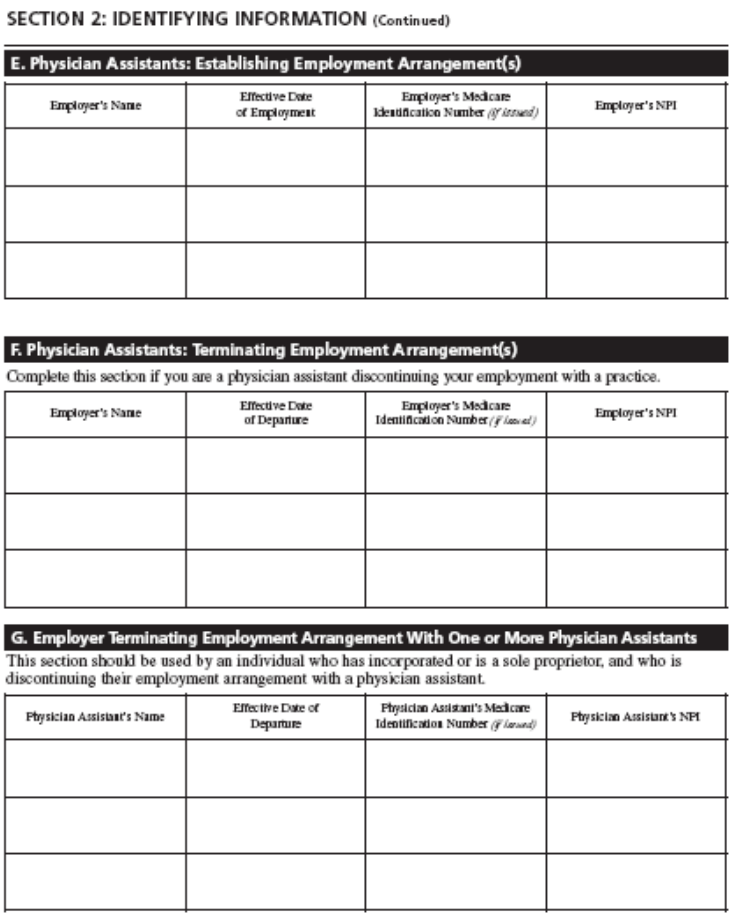
_____

_____

_____

Section 2: Identifying Information (Cont.)

- **Section 2.E–G**
- This section establishes the employment arrangement or terminates employment for a physician assistant.
- Please see application instructions for non-physician practitioner.



SECTION 2: IDENTIFYING INFORMATION (Continued)

E. Physician Assistants: Establishing Employment Arrangement(s)

Employer's Name	Effective Date of Employment	Employer's Medicare Identification Number *(if issued)*	Employer's NPI

F. Physician Assistants: Terminating Employment Arrangement(s)

Complete this section if you are a physician assistant discontinuing your employment with a practice.

Employer's Name	Effective Date of Departure	Employer's Medicare Identification Number *(if issued)*	Employer's NPI

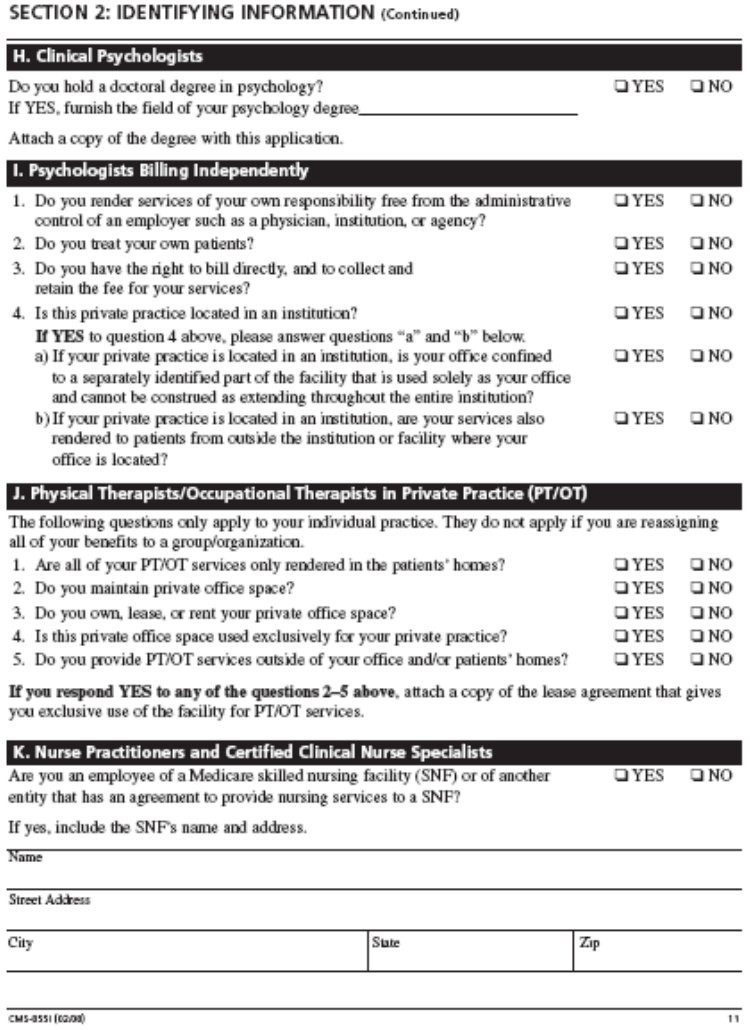
G. Employer Terminating Employment Arrangement With One or More Physician Assistants

This section should be used by an individual who has incorporated or is a sole proprietor, and who is discontinuing their employment arrangement with a physician assistant.

Physician Assistant's Name	Effective Date of Departure	Physician Assistant's Medicare Identification Number *(if issued)*	Physician Assistant's NPI

Sections 2.H–K: Identifying Information

- **Section 2.H–K**
- These sections are completed if applicable to the provider's specific specialty.
- Leave this page blank if not applicable to provider's specific specialty.



SECTION 2: IDENTIFYING INFORMATION (Continued)

H. Clinical Psychologists

Do you hold a doctoral degree in psychology? ❑ YES ❑ NO

If YES, furnish the field of your psychology degree_____

Attach a copy of the degree with this application.

I. Psychologists Billing Independently

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 this 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

J. Physical Therapists/Occupational Therapists in Private Practice (PT/OT)

The following questions only apply to your individual practice. They do not apply if you are reassigning all of your benefits to a group/organization.

1. Are all of your PT/OT 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 PT/OT services outside of your office and/or patients' homes? ❑ YES ❑ NO

If you respond YES to any of the questions 2–5 above, attach a copy of the lease agreement that gives you exclusive use of the facility for PT/OT services.

K. Nurse Practitioners and Certified Clinical Nurse Specialists

Are you an employee of a Medicare skilled nursing facility (SNF) or of another entity that has an agreement to provide nursing services to a SNF? ❑ YES ❑ NO

If yes, include the SNF's name and address.

Name

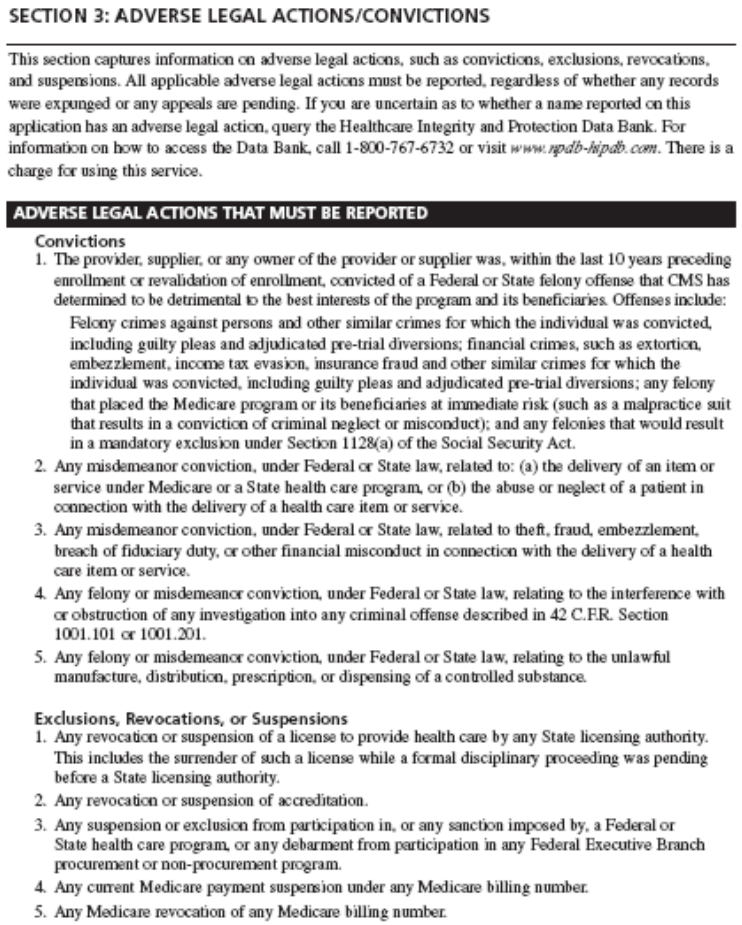
Street Address

City	State	Zip

CMS-855I (02/00) 11

Section 3: Adverse Legal Actions

- **Section 3**
- For all past or present legal convictions, exclusions, revocations and suspensions regardless of whether or not the record has been expunged or an appeal is pending.
- A list of reportable items is provided on page 12.



SECTION 3: ADVERSE LEGAL ACTIONS/CONVICTIONS

This section captures information on adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending. If you are uncertain as to whether a name reported on this application has an adverse legal action, query the Healthcare Integrity and Protection Data Bank. For 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.

ADVERSE LEGAL ACTIONS THAT MUST BE REPORTED

Convictions

1. The provider, supplier, or any owner of the provider or supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, 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. Offenses include:

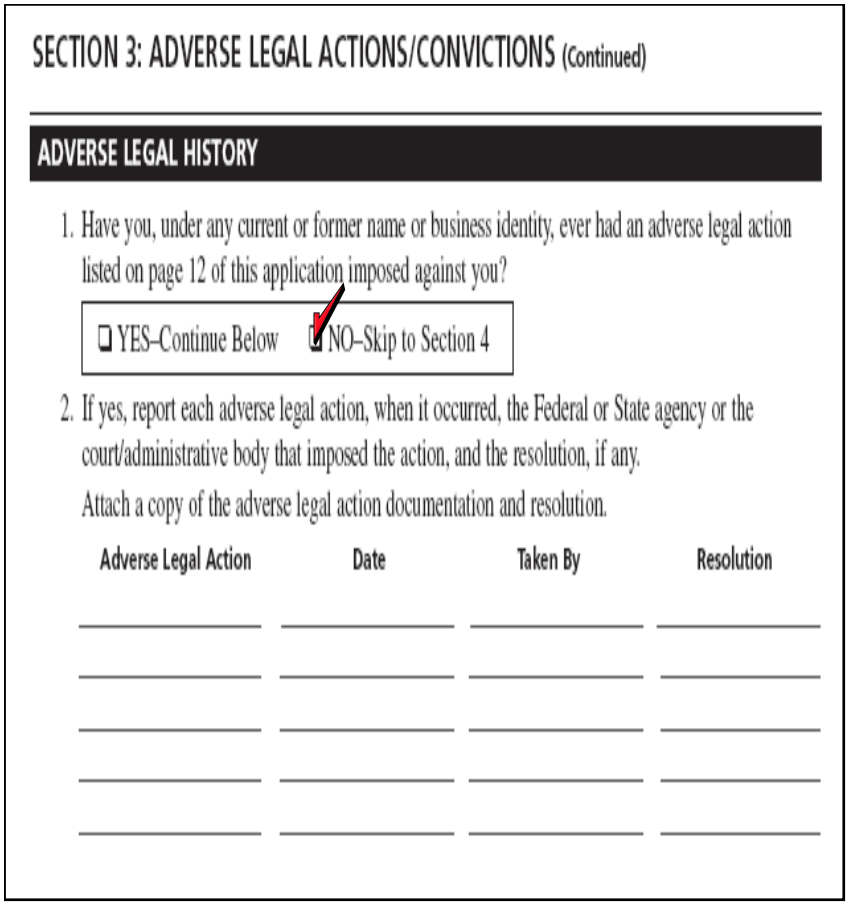
   Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; 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); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
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 felony or 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 felony or 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.
5. Any Medicare revocation of any Medicare billing number.

Section 3: Adverse Legal Actions (Cont.)

- **Section 3**
- Providers must answer Question 1.
- If the answer is “Yes” to Question 1, provider’s must complete question 2.
- Failure to supply this information could result in Medicare provider number(s) not being issued to new providers.



SECTION 3: ADVERSE LEGAL ACTIONS/CONVICTIONS (Continued)

ADVERSE LEGAL HISTORY

1. Have you, under any current or former name or business identity, ever had an adverse legal action listed on page 12 of this application imposed against you?

☐ YES–Continue Below ☑ NO–Skip to Section 4

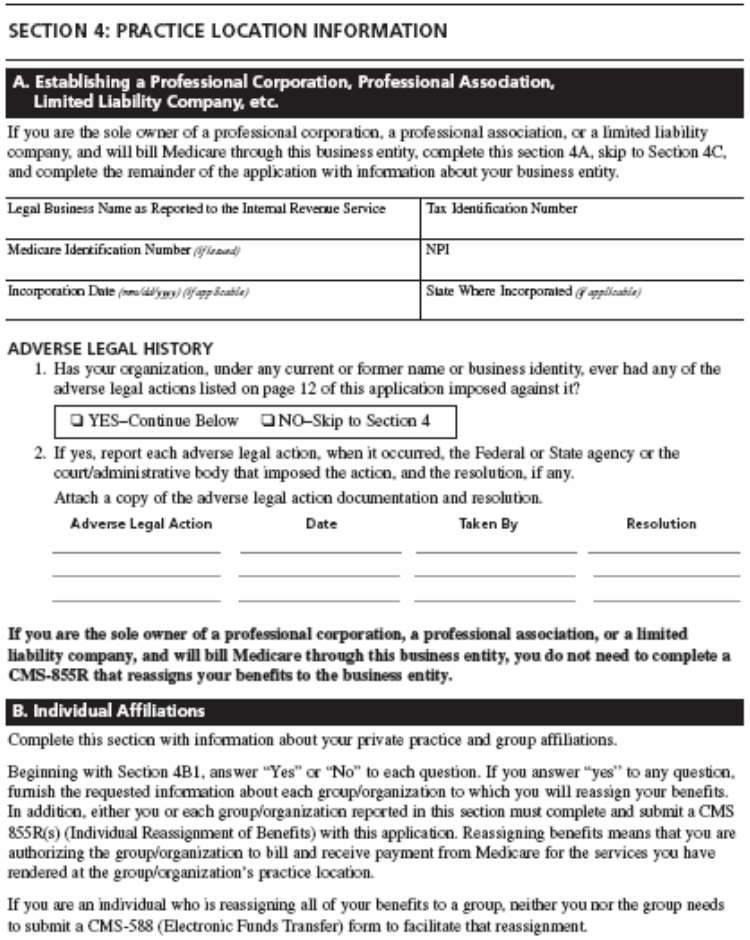
2. If yes, report each adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the adverse legal action documentation and resolution.

Adverse Legal Action	Date	Taken By	Resolution

Section 4: Practice Location Information

- **Section 4.A**
- Providers enrolling in a group do **not** complete this section. **Skip to Section 4.B**



SECTION 4: PRACTICE LOCATION INFORMATION

A. Establishing a Professional Corporation, Professional Association, Limited Liability Company, etc.

If you are the sole owner of a professional corporation, a professional association, or a limited liability company, and will bill Medicare through this business entity, complete this section 4A, skip to Section 4C, and complete the remainder of the application with information about your business entity.

Legal Business Name as Reported to the Internal Revenue Service	Tax Identification Number
Medicare Identification Number *(If issued)*	NPI
Incorporation Date *(mm/dd/yyyy) (If applicable)*	State Where Incorporated *(If applicable)*

ADVERSE LEGAL HISTORY

1. Has your organization, under any current or former name or business identity, ever had any of the adverse legal actions listed on page 12 of this application imposed against it?

   ❑ YES–Continue Below ❑ NO–Skip to Section 4

2. If yes, report each adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

   Attach a copy of the adverse legal action documentation and resolution.

Adverse Legal Action	Date	Taken By	Resolution

If you are the sole owner of a professional corporation, a professional association, or a limited liability company, and will bill Medicare through this business entity, you do not need to complete a CMS-855R that reassigns your benefits to the business entity.

B. Individual Affiliations

Complete this section with information about your private practice and group affiliations.

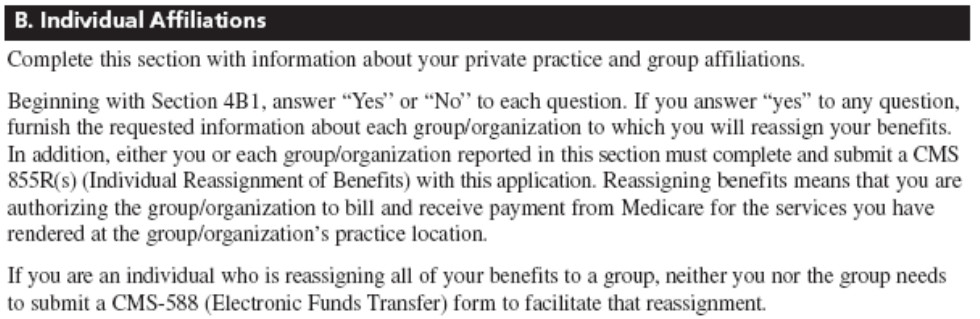
Beginning with Section 4B1, answer "Yes" or "No" to each question. If you answer "yes" to any question, furnish the requested information about each group/organization to which you will reassign your benefits. In addition, either you or each group/organization reported in this section must complete and submit a CMS 855R(s) (Individual Reassignment of Benefits) with this application. Reassigning benefits means that you are authorizing the group/organization to bill and receive payment from Medicare for the services you have rendered at the group/organization's practice location.

If you are an individual who is reassigning all of your benefits to a group, neither you nor the group needs to submit a CMS-588 (Electronic Funds Transfer) form to facilitate that reassignment.

Section 4: Practice Location Information (Cont.)

- **Section 4.B**

- This section identifies the groups/organizations to which the providers will reassign benefits.



B. Individual Affiliations

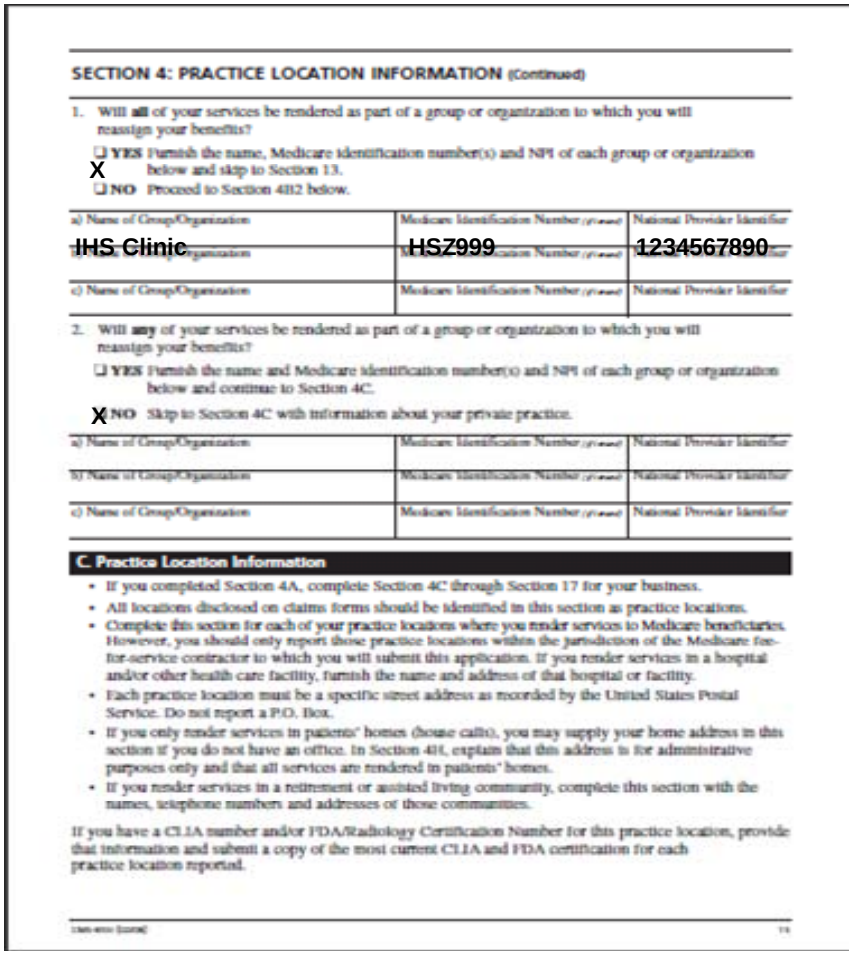
Complete this section with information about your private practice and group affiliations.

Beginning with Section 4B1, answer "Yes" or "No" to each question. If you answer "yes" to any question, furnish the requested information about each group/organization to which you will reassign your benefits. In addition, either you or each group/organization reported in this section must complete and submit a CMS 855R(s) (Individual Reassignment of Benefits) with this application. Reassigning benefits means that you are authorizing the group/organization to bill and receive payment from Medicare for the services you have rendered at the group/organization's practice location.

If you are an individual who is reassigning all of your benefits to a group, neither you nor the group needs to submit a CMS-588 (Electronic Funds Transfer) form to facilitate that reassignment.

Section 4: Practice Location Information (Cont.)

- **Section 4.B – Example**
- If you have a provider working for you that does not work at any other location then:
  - Check “Yes” to Question 4.B.1.
  - Check “No” to Question 4.B.2.
- If you have a provider working for you that also has their own private practice then:
  - Check “No” to Question 4.B.1.
  - Check “Yes” to Question 4.B.2.
- Enter the name of the group/organization, Medicare number and NPI where you will work.
- **Skip to Section 13**.



SECTION 4: PRACTICE LOCATION INFORMATION (Continued)

1. Will **all** of your services be rendered as part of a group or organization to which you will reassign your benefits?

❑ **YES** Furnish the name, Medicare identification number(s) and NPI of each group or organization below and skip to Section 13.
X
❑ **NO** Proceed to Section 4B2 below.

a) Name of Group/Organization	Medicare Identification Number	National Provider Identifier
IHS Clinic	HSZ999	1234567890
b) Name of Group/Organization		
c) Name of Group/Organization		

2. Will **any** of your services be rendered as part of a group or organization to which you will reassign your benefits?

❑ **YES** Furnish the name and Medicare identification number(s) and NPI of each group or organization below and continue to Section 4C.

X **NO** Skip to Section 4C with information about your private practice.

a) Name of Group/Organization	Medicare Identification Number	National Provider Identifier
b) Name of Group/Organization		
c) Name of Group/Organization		

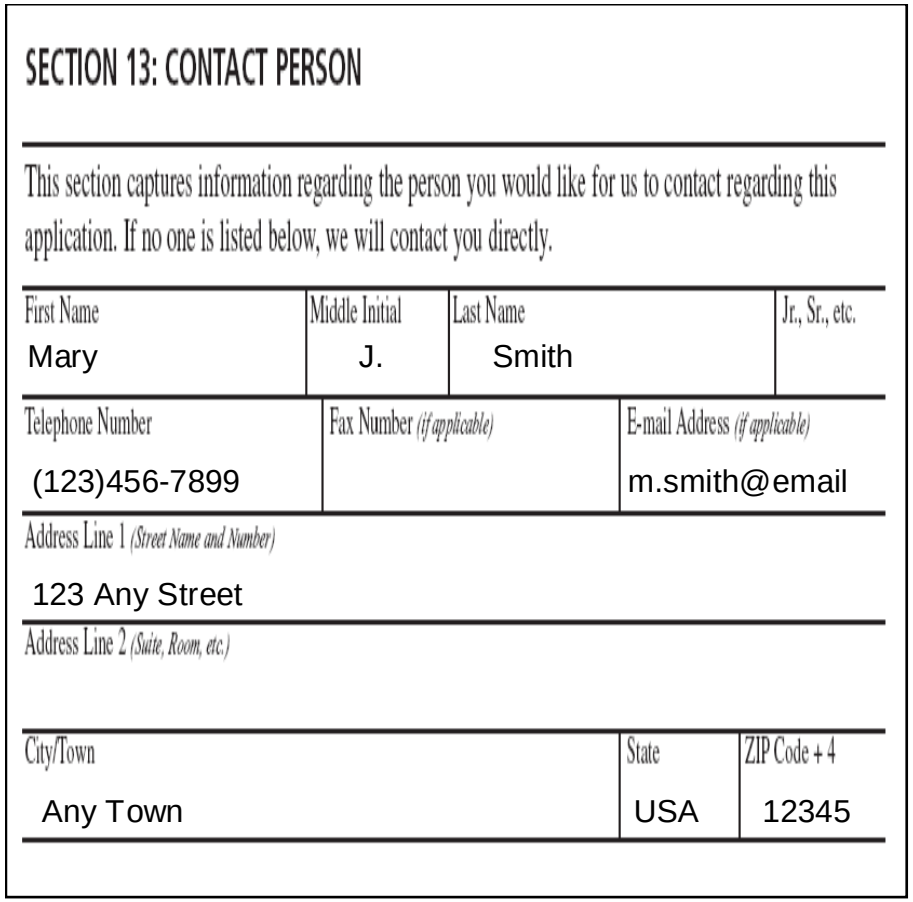
C. Practice Location Information

- If you completed Section 4A, complete Section 4C through Section 17 for your business.
- All locations disclosed on claims forms should be identified in this section as practice locations.
- Complete this section for each of your practice locations where you render services to Medicare beneficiaries. However, you should only report those practice locations within the jurisdiction of the Medicare fee-for-service contractor to which you will submit this application. If you render services in a hospital and/or other health care facility, furnish the name and address of that hospital or facility.
- Each practice location must be a specific street address as recorded by the United States Postal Service. Do not report a P.O. Box.
- If you only render services in patients' homes (house calls), you may supply your home address in this section if you do not have an office. In Section 4H, 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.

If you have a CLIA number and/or FDA/Radiology Certification Number for this practice location, provide that information and submit a copy of the most current CLIA and FDA certification for each practice location reported.

Section 13: Contact Person

- **Section 13**
- The contact person should be someone who can answer questions about the information on the application.
- Medicare will not list the contact person on the Medicare provider's record.
- If no one is listed, Medicare will contact the provider directly.



SECTION 13: CONTACT PERSON

This section captures information regarding the person you would like for us to contact regarding this application. If no one is listed below, we will contact you directly.

First Name	Middle Initial	Last Name	Jr., Sr., etc.
Mary	J.	Smith	

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*
(123)456-7899		m.smith@email

Address Line 1 *(Street Name and Number)*

123 Any Street

Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4
Any Town	USA	12345

Section 14: Penalties for Falsifying Information

- **Section 14**
- This section outlines the penalties for falsifying information and should be read by the provider listed in Section 2.
- This section does not have an area to be completed.

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION

This section explains the penalties for deliberately furnishing false information in this application to gain or maintain enrollment in the Medicare program.

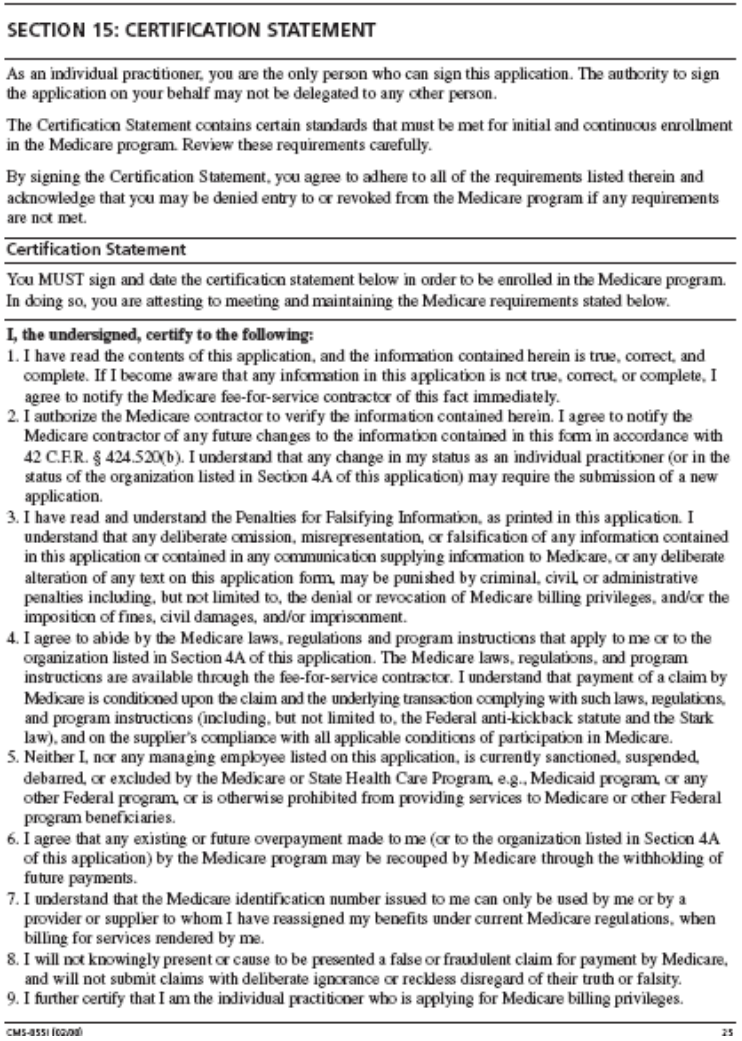
1. 1. 18 U.S.C. § 1001 authorizes criminal penalties against an individual who, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious, 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. 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.

Section 15: Certification Statement

- **Section 15**
- Only the individual practitioner has the authority to sign this application.
- The individual practitioner must read and understand page 25.



SECTION 15: CERTIFICATION STATEMENT

As an individual practitioner, you are the only person who can sign this application. 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.

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. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare fee-for-service 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 in accordance with 42 C.F.R. § 424.520(b). I understand that any change in my status as an individual practitioner (or in the status of the organization listed in Section 4A of this application) 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 or to the organization listed in Section 4A of this application. The Medicare laws, regulations, and program instructions are available through the fee-for-service contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the supplier's compliance with all applicable conditions of participation in Medicare.
5. Neither I, nor any managing employee listed on this application, is currently sanctioned, suspended, debarred, or excluded by the Medicare or State Health Care Program, e.g., 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 (or to the organization listed in Section 4A of this application) by the Medicare program may be recouped by Medicare through the withholding of future payments.
7. I understand that the Medicare identification 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.

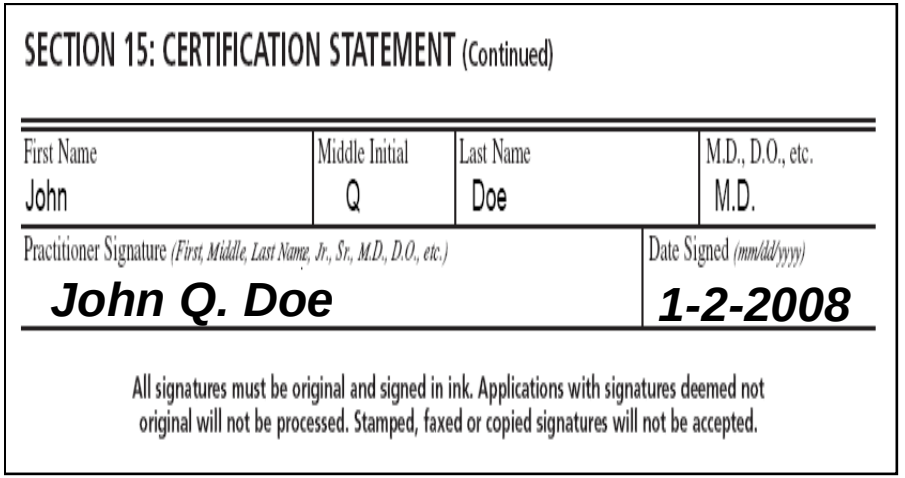
CMS-855I (02/08) 25

Section 15: Certification Statement (Cont.)

- **Section 15**

- All signatures must be original and signed in ink. Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

- To indicate an original signature, the practitioner should sign in **blue** ink.



SECTION 15: CERTIFICATION STATEMENT (Continued)

First Name	Middle Initial	Last Name	M.D., D.O., etc.
John	Q	Doe	M.D.

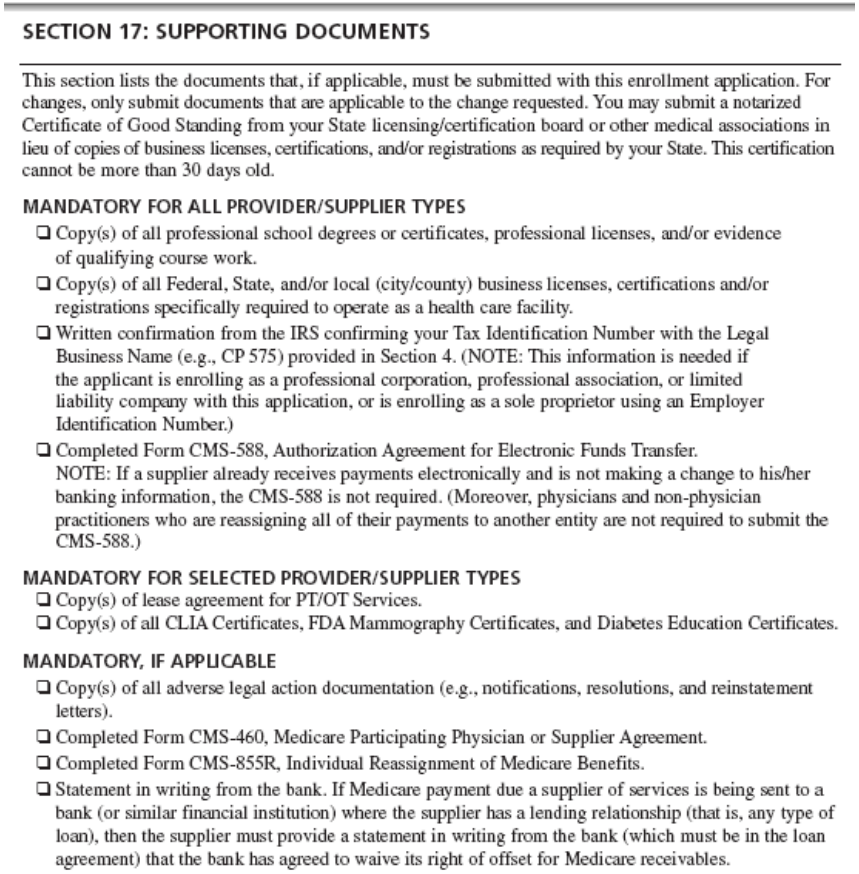
Practitioner Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*
John Q. Doe	***1-2-2008***

All signatures must be original and signed in ink. Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

Section 17: Supporting Documents

- **Section 17**

- This section indicates what is attached to the application. Check the corresponding boxes for all information being attached to the application.



SECTION 17: SUPPORTING DOCUMENTS

This section lists the documents that, if applicable, must be submitted with this enrollment application. For changes, only submit documents that are applicable to the change requested. You may submit a notarized Certificate of Good Standing from your State licensing/certification board or other medical associations in lieu of copies of business licenses, certifications, and/or registrations as required by your State. This certification cannot be more than 30 days old.

MANDATORY FOR ALL PROVIDER/SUPPLIER TYPES

- ❑ Copy(s) of all professional school degrees or certificates, professional licenses, and/or evidence of qualifying course work.
- ❑ 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.
- ❑ Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name (e.g., CP 575) provided in Section 4. (NOTE: This information is needed if the applicant is enrolling as a professional corporation, professional association, or limited liability company with this application, or is enrolling as a sole proprietor using an Employer Identification Number.)
- ❑ Completed Form CMS-588, Authorization Agreement for 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. (Moreover, physicians and non-physician practitioners who are reassigning all of their payments to another entity are not required to submit the CMS-588.)

MANDATORY FOR SELECTED PROVIDER/SUPPLIER TYPES

- ❑ Copy(s) of lease agreement for PT/OT Services.
- ❑ Copy(s) of all CLIA Certificates, FDA Mammography Certificates, and Diabetes Education Certificates.

MANDATORY, IF APPLICABLE

- ❑ Copy(s) of all adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters).
- ❑ Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement.
- ❑ Completed Form CMS-855R, Individual Reassignment of Medicare Benefits.
- ❑ Statement in writing from the bank. If Medicare payment due a supplier of services is being sent to a bank (or similar financial institution) where the supplier has a lending relationship (that is, any type of loan), then the supplier must provide a statement in writing from the bank (which must be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.

Provider Enrollment (Cont.)

- **Mail enrollment forms to:**

  Physical address:

  TrailBlazer Health Enterprises, LLC

  Medicare Part B IHS Provider Enrollment

  Executive Center III

  8330 LBJ Freeway

  Dallas, TX 75243-1756

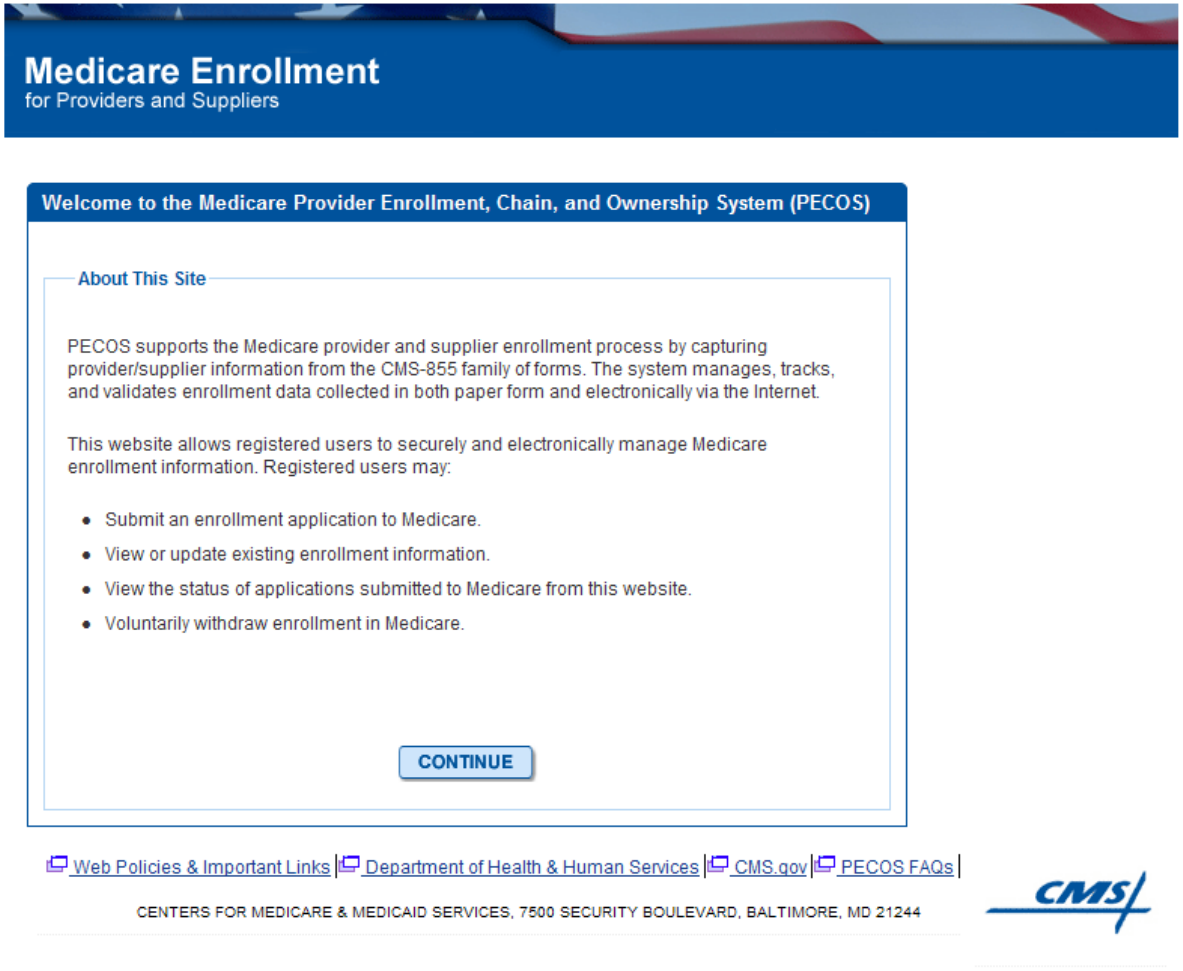
Internet-Based PECOS

Steps Physicians and Non-physician Practitioners must make to complete an enrollment application on-line:

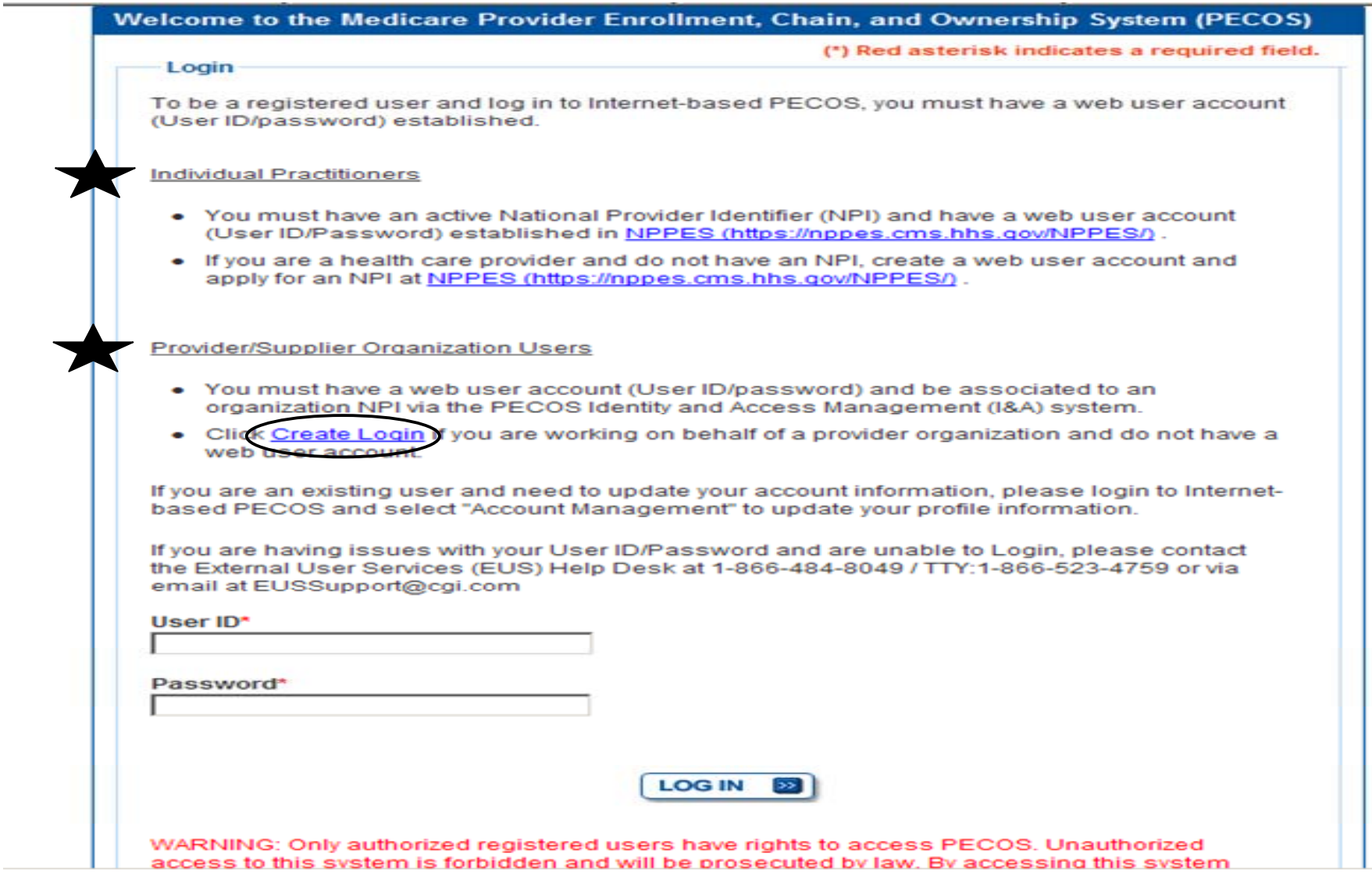
- Have a valid NPI and NPPES user ID and password
- Personal identifying information

Internet-Based PECOS

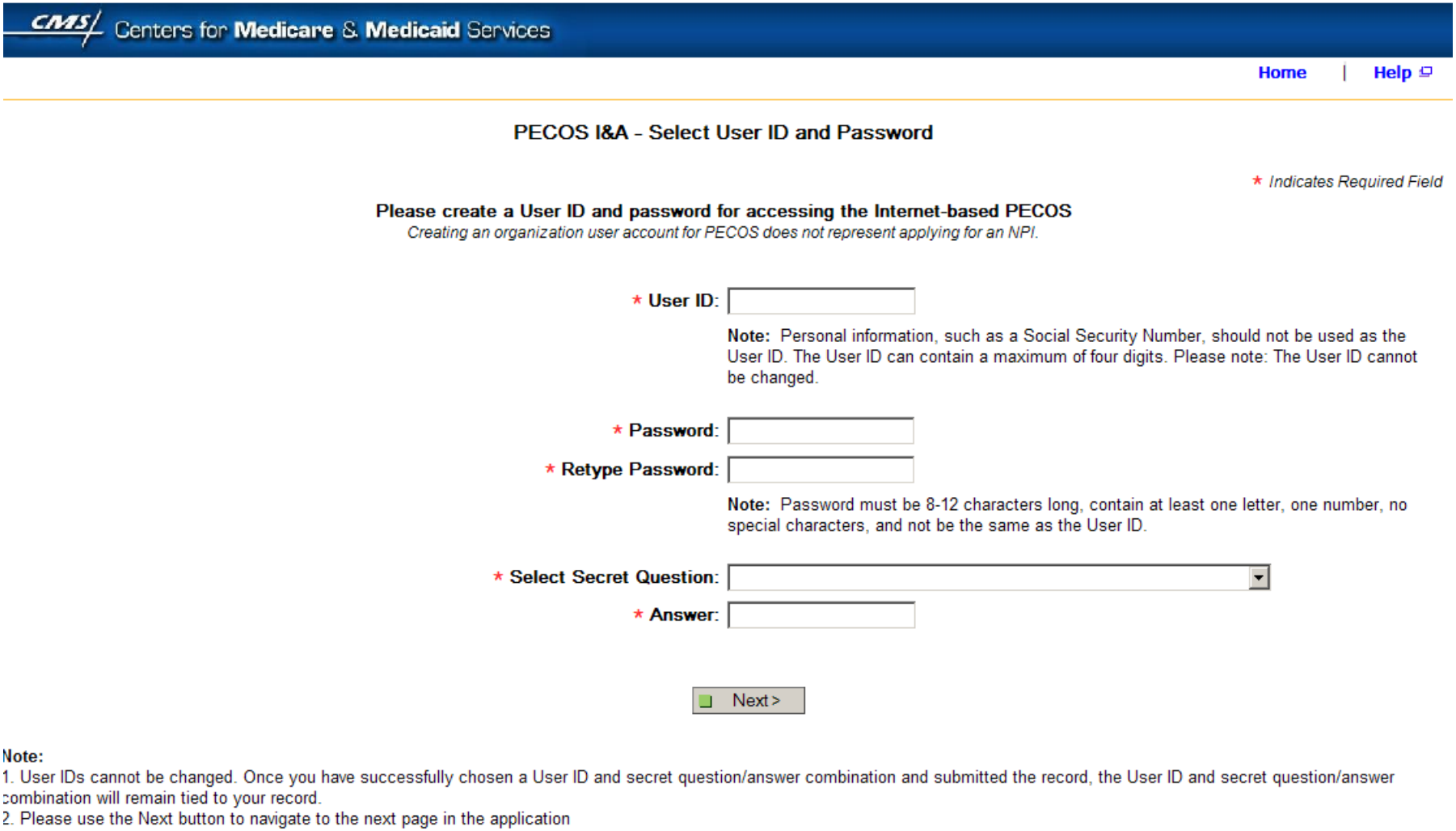
https://pecos.cms.hhs.gov/pecos/login.do



Login


Welcome to the Medicare Provider Enrollment, Chain, and Ownership System (PECOS)
(*) Red asterisk indicates a required field.
Login
To be a registered user and log in to Internet-based PECOS, you must have a web user account (User ID/password) established.
Individual Practitioners
You must have an active National Provider Identifier (NPI) and have a web user account (User ID/Password) established in NPPES (https://nppes.cms.hhs.gov/NPPES/) .
If you are a health care provider and do not have an NPI, create a web user account and apply for an NPI at NPPES (https://nppes.cms.hhs.gov/NPPES/) .
Provider/Supplier Organization Users
You must have a web user account (User ID/password) and be associated to an organization NPI via the PECOS Identity and Access Management (I&A) system.
Click Create Login if you are working on behalf of a provider organization and do not have a web user account.
If you are an existing user and need to update your account information, please login to Internet-based PECOS and select "Account Management" to update your profile information.
If you are having issues with your User ID/Password and are unable to Login, please contact the External User Services (EUS) Help Desk at 1-866-484-8049 / TTY:1-866-523-4759 or via email at EUSSupport@cgi.com
User ID*
Password*
LOG IN
WARNING: Only authorized registered users have rights to access PECOS. Unauthorized access to this system is forbidden and will be prosecuted by law. By accessing this system

Create User ID and Password for Group



Hours of Operation

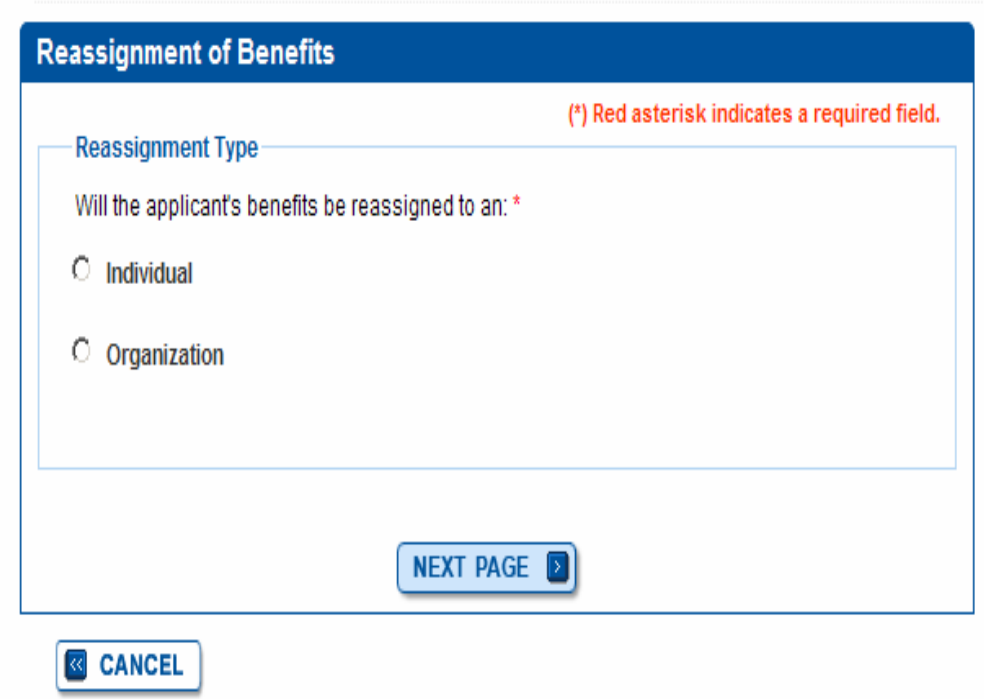
- For Providers:
  - PECOS Web should be available to physicians and non-physicians practitioners Monday through Saturday from:
    - 3:00am to 11:00am (Mountain Time)
    - 4:00am to 12:00pm (Central Standard Time)
    - 5:00am to 1:00am (Eastern Time)

Feedback

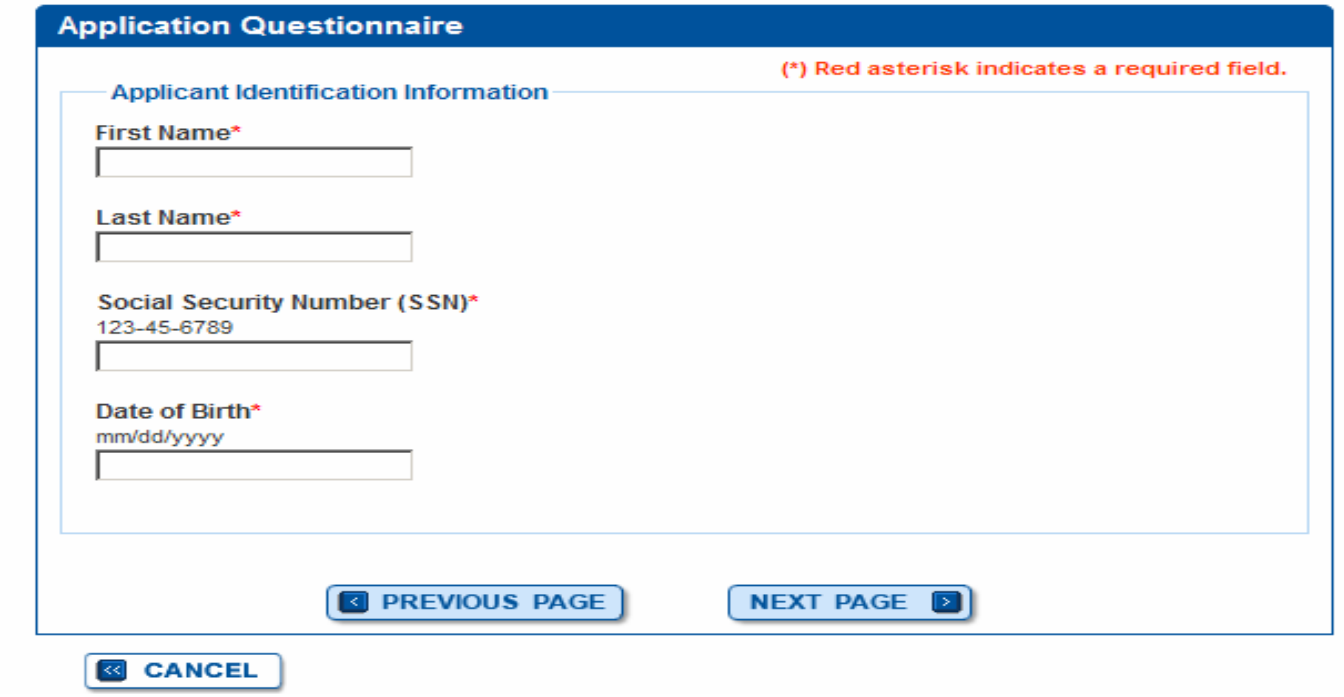
- Provide real-time feedback with messages and application status:
  - **Submitted**: The enrollment application has been submitted to the Medicare contractor.
  - **In-Process**: The enrollment application is in review by the Medicare contractor.
  - **Returned for Corrections**: The enrollment application requires corrective action by the provider.
  - **Approved/Denied**: The enrollment process has been completed and the provider will receive a confirmation letter.
  - **Processed**: The enrollment status is in a finalized status. This means the enrollment could be approved, rejected, withdrawn, etc.

Feedback (Cont.)

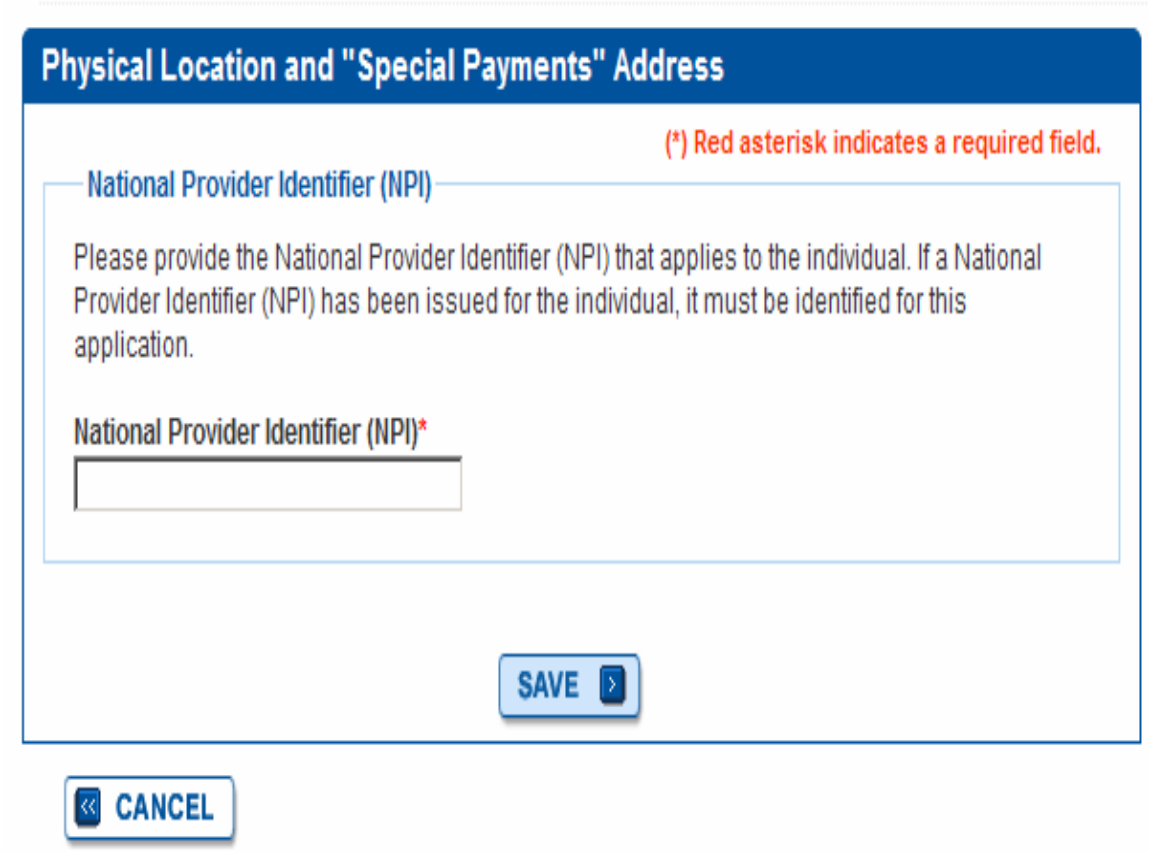
- The provider will be prompted to answer a series of questions from the data he or she enters into PECOS Web



Feedback (Cont.)



Feedback (Cont.)



Feedback (Cont.)

- **Before submission, PECOS will:**
  - Flag mistakes and indicate missing information and will require providers to correct or furnish information before submission.
  - Verify Name, DOB and SSN listed with the SSA.
  - Verify existence of group enrollment in PECOS for reassignment of benefits.
  - Verify address with the USPS system.

NOTE: Once the Internet-based PECOS application is electronically submitted, it is 'locked,' meaning the application cannot be edited by the physician or non-physician practitioner until the Medicare contractor processes or returns the application electronically through PECOS for corrections.

Finalize Application

- The provider must print, sign, date and mail the certification statement and all supporting documents to the Medicare Contractor. CMS is currently allowing providers to submit this information within 30 days. However, this could change in the future.

- **Note:** A Medicare contractor will not process an Internet enrollment application without the signed and dated certification statement. In addition, the effective date of filing an enrollment application is the date the Medicare contractor receives the signed certification statement that is associated with the Internet submission.

System Questions

- TrailBlazer is only responsible for answering policy questions not systems questions.
  - EUS is the contractor for systems questions.
    - 1-866-484-8049

What Can You Do On-Line?

- Establish a new initial enrollment.
  - This occurs when there is no existing record in PECOS.
- Make a change to an existing enrollment application.
  - This occurs when the provider has an established record in PECOS and is needing to make a change.
- Add or change a reassignment of benefits.
  - Adding or changing a reassignment of benefits (CMS-855R).
- Reactivation of enrollment of voluntary withdraw.
  - This occurs when a provider is reactivating a deactivated provider or when a provider voluntarily withdraws from Medicare (i.e. retires).

Confirmation Letter

After the application is approved and finalized, a confirmation letter will be sent to either the contact person or provider.

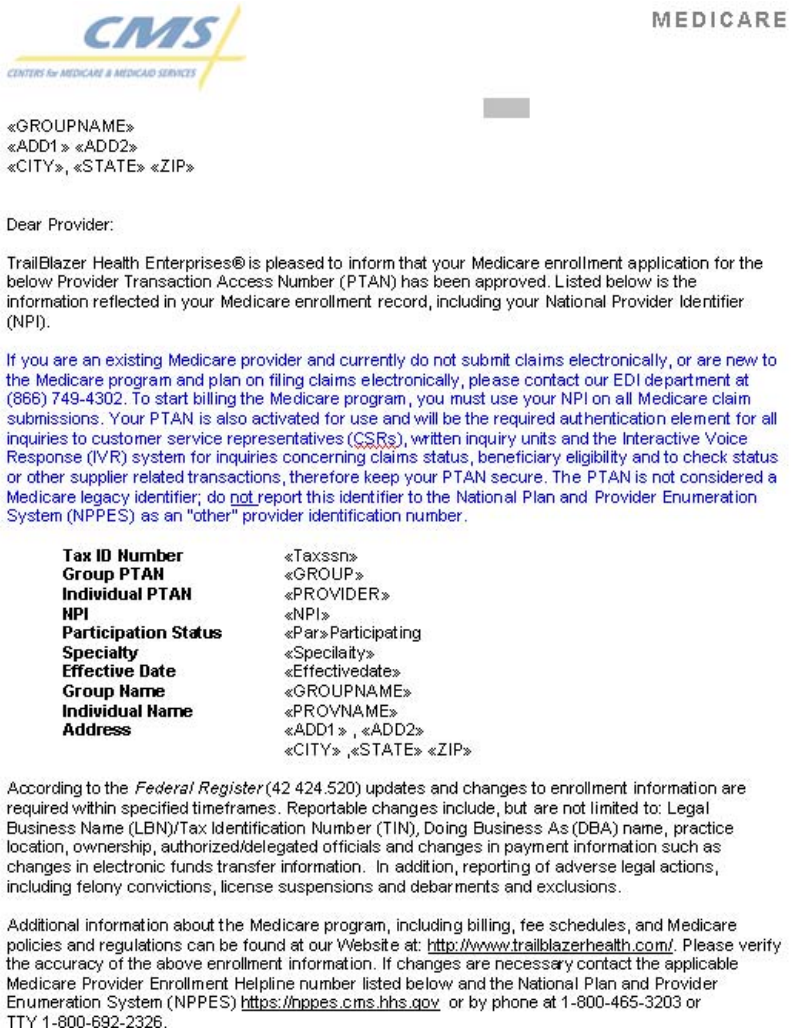
Allow 15-days from completion to receive letter. If letter is not received, fax a request to (903)463-0387. The request must be on the provider's letterhead and include:

- Provider/Group name
- PTAN (if known)
- NPI
- Social Security Number (SSN) or tax ID
- Signature of provider or authorized official
- Contact name and fax or address to send letter

Confirmation Letter (Cont.)

Confirmation letter provides:

- PTAN
- NPI
- Provider name
- Provider specialty
- Effective date



CMS
CENTERS for MEDICARE & MEDICAID SERVICES

MEDICARE

«GROUPNAME»
«ADD1» «ADD2»
«CITY», «STATE» «ZIP»

Dear Provider:

TrailBlazer Health Enterprises® is pleased to inform that your Medicare enrollment application for the below Provider Transaction Access Number (PTAN) has been approved. Listed below is the information reflected in your Medicare enrollment record, including your National Provider Identifier (NPI).

If you are an existing Medicare provider and currently do not submit claims electronically, or are new to the Medicare program and plan on filing claims electronically, please contact our EDI department at (866) 749-4302. To start billing the Medicare program, you must use your NPI on all Medicare claim submissions. Your PTAN is also activated for use and will be the required authentication element for all inquiries to customer service representatives (CSRs), written inquiry units and the Interactive Voice Response (IVR) system for inquiries concerning claims status, beneficiary eligibility and to check status or other supplier related transactions, therefore keep your PTAN secure. The PTAN is not considered a Medicare legacy identifier; do not report this identifier to the National Plan and Provider Enumeration System (NPPES) as an "other" provider identification number.

Tax ID Number	«Taxssn»
Group PTAN	«GROUP»
Individual PTAN	«PROVIDER»
NPI	«NPI»
Participation Status	«Par»Participating
Specialty	«Specilaity»
Effective Date	«Effectivedate»
Group Name	«GROUPNAME»
Individual Name	«PROVNAME»
Address	«ADD1» , «ADD2» «CITY» ,«STATE» «ZIP»

According to the *Federal Register* (42 424.520) updates and changes to enrollment information are required within specified timeframes. Reportable changes include, but are not limited to: Legal Business Name (LBN)/Tax Identification Number (TIN), Doing Business As (DBA) name, practice location, ownership, authorized/delegated officials and changes in payment information such as changes in electronic funds transfer information. In addition, reporting of adverse legal actions, including felony convictions, license suspensions and debarments and exclusions.

Additional information about the Medicare program, including billing, fee schedules, and Medicare policies and regulations can be found at our Website at: http://www.trailblazerhealth.com/. Please verify the accuracy of the above enrollment information. If changes are necessary contact the applicable Medicare Provider Enrollment Helpline number listed below and the National Plan and Provider Enumeration System (NPPES) https://nppes.cms.hhs.gov or by phone at 1-800-465-3203 or TTY 1-800-692-2326.

Enrollment Changes

Change Request (CR) 6310 – Effective date for Medicare billing.

Effective April 1, 2009 the effective date for new providers will be the later of the date of application filing or the date they first began furnishing services at a new location.

Example: On January 15 an agreement was made between Dr. Smith and clinic for him to begin work on February 15. Dr. Smith completes and signs 855 forms on January 15, and clinic sends to enrollment on January 20. Application received by enrollment on January 25. Effective date for Dr. Smith will be established as February 15.

Enrollment Problems and Resolutions

Problem	Resolution
Provider number has been deactivated for infrequent billing.	Infrequent billing deactivations are performed as a fraud prevention measure to prevent unauthorized use of inactive Medicare Provider Identification Numbers (PINs) and Provider Transaction Access Numbers (PTANs). The system-generated deactivations are performed once per month for all PINs with no paid claims activity for four consecutive quarters. To reactivate billing privileges, the provider must submit a complete CMS-855 application.

CMS guidelines state that after four quarters, if a claim has not been processed for a provider the PTAN is to be deactivated.

Enrollment Problems and Resolutions (Cont.)

Problem	Resolution
Incorrect National Provider Identifier (NPI) on file and claims are rejecting as NPI not on crosswalk.	NPI changes made in the National Plan and Provider Enumeration System (NPPES) will automatically update the Medicare NPI crosswalk. The Medicare contractor claims processing and enrollment systems receive daily NPI file updates from the NPPES. When the NPPES NPI data conflicts with the information in the contractor's claims and enrollment system, the provider may experience claim rejects. To resolve some NPI conflicts, the provider will need to submit a CMS-855 enrollment application.

Any updates made to NPPES must also be updated in the Medicare enrollment system.

Enrollment Problems and Resolutions (Cont.)

Problem	Resolution
NPI Corrections	**Group practices and organizations should submit the following CMS-855B sections:** • CMS-855B, Section 2B.1 – Supplier Identification Information. • CMS-855B, Section 4A – Practice Location Information. The provider should complete a separate Section 4A (page 14) for each NPI to legacy PIN to practice address combination. • CMS-855B, Section 15 – Certification Statement. The certification statement must be signed by the owner or the authorized official for the practice. **Sole proprietors and physicians in a solo practice should submit the following CMS-855I sections:** • CMS-855I, Section 4A – Practice Location Information. • CMS-855I, Section 4B (page 16) – Practice Location Information. The provider should complete a separate Section 4B (page 16) for each NPI to legacy PIN to practice address combination. • CMS-855I, Section 15 – Certification Statement. The certification statement must be signed by the owner or the authorized official for the practice. The CMS-855 applications for the correction of NPI problems can be faxed to TrailBlazer℠ Provider Enrollment at (903) 463-0374. The fax cover letter should indicate "NPI Correction" and include a phone number where the submitter can be reached. The approximate processing time for an NPI correction is 21 days from the date of receipt of all of the needed information. The submitter should use his successful fax confirmation as confirmation of TrailBlazer's receipt of the faxed documentation.

Enrollment Problems and Resolutions (Cont.)

Problem	Resolution
Confirmation letter has not been received.	**Individual Physician or Practitioner Confirmation Letter Requests** Fax a letter requesting a copy of the individual physician or practitioner confirmation letter to (903) 463-0387. The request must be on the provider's letterhead and include the provider's name, PTAN and signature. Include the address where the confirmation letter can be mailed or the fax number and contact person. **Group Practice and Organization Confirmation Letter Requests** Fax a letter requesting a copy of the provider's confirmation letter to (903) 463-0387. The request must be on the group or organization's letterhead and include the PTAN and signature of the authorized official for the practice.

Enrollment Problems and Resolutions (Cont.)

Problem	Resolution
Confirmation letter has wrong information on it (such as the specialty).	Contact Provider Enrollment Customer Service at (866) 539-5596 for Colorado, New Mexico, Oklahoma, Texas and Indian Health Service (IHS) or (866) 697-9670 for Virginia to request a corrected confirmation letter.
Application processed incorrectly (Social Security number keyed incorrectly, suite number not included, wrong specialty shown, etc.); TrailBlazer error.	Contact Provider Enrollment Customer Service at (866) 539-5596 for Colorado, New Mexico, Oklahoma, Texas and IHS or (866) 697-9670 for Virginia to notify TrailBlazer of the error.
Enrollment application delay	Incomplete or missing information is the main cause in the delay of an application. Before completing an application, view the job aids and PowerPoint presentations on the Enrollment Web page to assist you in completing your application. http://www.trailblazerhealth.com/Provider%20Enrollment/Default.aspx?DomainID=1

Part B Enrollment Contacts

Diane Free
(903) 463-0375

Amanda Ball
(903) 463-0731

Liz Hawthorne
(903) 463-0735

Diane Free Amanda Ball Liz Hawthorne

Questions?

Thank You for Attending

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