Form Approved
OMB NO. 0938-0273

MODEL LETTER REQUESTING IDENTIFICATION OF EXTENSION LOCATIONS

Dear (Administrator)

Our records indicate that the facility below is approved in the Medicare program as an outpatient physical therapy/speech pathology provider (OPT/OSP). Providers, in addition to rendering services on their already approved premises at times render services on the premises of other institutions (e.g., skilled nursing facilities) or on a premise owned/leased/rented by the OPT/OSP. If the OPT/OSP bills the Medicare program for these services and renders these services in an area within the institution set aside for rehabilitation care, these premises are considered extension locations of the OPT/OSP. **A patient's home is not considered an extension location.**

Extension locations are considered part of the OPT/OSP and are subject to the same approval policy as is applicable to the OPT/OSP. In addition to meeting applicable sections of the conditions of participation for all outpatient physical therapy/speech pathology providers, these extension locations fall under the OPT/OSP provider agreement and are identified under the OPT/OSP provider number.

Below is a form for the purpose of identifying the extension locations of your OPT/OSP. Please complete this form and return it to the State agency listed below within 30 days. If at any time following completion of this form you plan to delete or add a service or close or add an extension unit, please notify the State agency immediately. If you have any questions or problems, please call the State agency.

STATE AGENCY NAME	STATE AGENCY ADDRESS
FACILITY NAME	SIGNATURE OF AUTHORIZED STATE AGENCY INDIVIDUAL

IDENTIFICATION OF EXTENSION LOCATIONS OF OPT/OSP PROVIDERS

Indicate the name, address and provider number of your approved outpatient physical therapy/speech pathology provider (OPT/OSP) primary site, and complete if applicable, section A, B and C.

NAME	PROVIDER NO.
ADDRESS	TELEPHONE (Area Code)

A. Where services are rendered off the above premises and on the premises of other institutions (including those owned and/or rented by the OPT/OSP), list the name and address of these institutions. If more space is needed, attach an additional sheet of paper.

NAME	ADDRESS
NAME	ADDRESS
NAME	ADDRESS

B. List the number of OPT/OSP services rendered from your primary site.

_____ OPT _____ OSP _____ OOT

List the number of OPT/OSP services rendered from the premises of any extension location(s).

_____ OPT _____ OSP _____ OOT

C. Do your extension locations operate: (check one) _____Full-time _____Part-time

Whoever knowingly and willfully makes or causes to be made a false statement may be prosecuted under applicable Federal or State laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in a denial of a request to participate, or where the entity already participates, a termination of its agreement or contract with the State agency or the Secretary, as appropriate.

SIGNATURE OF AUTHORIZED PERSON	TITLE	DATE

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0273. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.