Revisions to Form CMS-10114 NATIONAL PROVIDER IDENTIFIER (NPI) APPLICATION/UPDATE FORM

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
1.	All	Bottom of Page	Omit the following after Form CMS-10114	Omit '(02/05)'	Revising the application; therefore, this date will change.
2.	1	Instructions at top	Insert (in bold) after first sentence beginning with 'Please PRINT…'	**Use only blue or black ink.**	Revised for clarification purposes. Applicants tend to use other color ink which is difficult to scan, and pencil is unacceptable.
3.	1	Section 1A2	Delete the following after the word NPI:	Delete the 'No.'	Editorial Change
4.	1	Section 1A2	Add the following check boxes under Change of Information	Add Information Replace Information	Included to specify the type of change requested.
5.	1	Section 1A3	Revise as follows:	3. Deactivation (See Instructions) NPI:_________________________ Reason (Check one of the following) Death Business Dissolved Other, Specify: (See Instructions) _________________________	Clarification is given in the instructions; therefore, this section was revised to instruct the application to '(See instructions)'.
6.	1	Section 1A	Add a check box after #3 Deactivation and add the following information to this section:	4. Reactivation (See Instructions) NPI: _________________________ Reason: ________________________________ ____________________________	This addition is in compliance with the NPI Final Rule. This was inadvertently absent from the original application form.
7.	1	Section 1B	Replace: (Check the Appropriate box) with the following in bold:	(**Check only one box**)	Revised to clarify instruction to the applicant.
8.	1	Section 1B1	Bold and revise as follows:	(**Complete Sections 2A, 3, 4A, and 5 only)**	Revised to clarify instruction to the applicant.
9.	1	Section 1B1	Add the following indented question below #1 and above #2.	Is the individual a sole proprietor? (See Instructions) Yes No	Added for unique identification purposes and to provide clarification regarding enumeration of Sole Proprietors.
10.	1	Section 1B2	Bold and revise as follows:	(**Complete Sections 2B, 3, 4B, and 5 only)**	Revised to clarify instruction to the applicant.

11.	1	Section 1B2	Add the following indented question below #2.	Is the organization a subpart? (See Instructions) Yes No If yes, enter the Legal Business Name (LBN) and Taxpayer Identification Number (TIN) of the "parent" organization health care provider: Parent Organization LBN:_____________________ Parent Organization TIN:______________________	Added for unique identification purposes. This addition will assist in uniquely identifying subparts of an organization health care provider.
12.	1	Section 2A13	Add the word specify to the box marked 'Other'	Other, specify:___________________________	Editorial change.
13.	1	Section 2A19	Add the following to #19 after 'Number'	(ITIN) (See Instructions)	Revised instructions have been included on this collection.
14.	1	Section 2B	Replace title: 'Organizations and Groups' with the following:	Organizations (includes Groups)	Revised for clarification purposes.
15.	1	Section 2B2	Revise as follows:	2. Employer Identification Number (EIN)	Revised to omit 'or SSN' which was incorrectly included on the original application.
16.	2	Section 3B7	Add the following to #7:	(Required)	Revised for clarification purposes. This information is required.
17.	2	Section 3C	Revise as follows:	Issuer Number State (If applicable) Medicare UPIN _________ Medicare OSCAR _________ Medicare PIN _________ Medicare NSC _________ Medicaid _________ _________ (State is required if Medicaid number is furnished.) Other, Specify: _______________ _________ __________ _______________ _________ __________	Revised for clarification purposes and to ensure information is properly furnished.
18.	2	Section 3C	Revise last column	**Issuer** *(For Other Number Type Only)*	Revised for clarification purposes.

			header as follows:		
19.	2	Section 3D1	Bold the following word:	**Primary**	Bolded for clarification purposes.
20.	2	Section 3D2, 3D5, 3D8	Revise 'License Number' as follows:	License Number (See instructions)	Revised instructions have been included.
21.	3	Section 5A	Revise as follows:	If you checked the box, complete only items 8 and 9 in this section (Section 5).	Revised to accurately instruct the applicant on which information of this section should be completed.
22.	3	Section 5A8	Expand the box for #8 E-mail Address to accommodate longer handwritten addresses.		Expanded to capture a longer e-mail address.
23.	3	Bottom of Page	Revise the email address (www.NPPES.cms.hhs.gov) as follows:	https://nppes.cms.hhs.gov	Revised to display the correct URL or web address.
24.	3	Bottom of Page	Revise as follows:	**Or send the completed signed application to:**	Revised to remind the provider to sign the application.
25.	3	Bottom of Page	Bold the following last sentence:	**Do not send the applications to this address.**	Bolded direction to assist the applicant.
26.	5	Instructions at top	Insert after first sentence beginning with 'Please PRINT…'	Use only blue or black ink.	Revised for clarification purposes. Applicants tend to use other color ink which is difficult to scan, and pencil is unacceptable.
27.	5	Instruction Section 1A2	Revise the paragraph as follows:	If changing information, check box #2, write your NPI in the space provided, and provide the add/replace information within the appropriate section. If you are adding information, please check the 'Add Information' box and fill out the appropriate section(s) with the information you are adding. If you are replacing information, please check the 'Replace Information' box and fill out the appropriate section(s) with the replaced information. See the instructions in Section 4, then sign and date the certification statement in Section 4A or 4B. All changes must be reported to the NPI Enumerator within 30 days of the change. It is not necessary to complete sections that are not being changed;	Instructions revised for clarification purposes..

				however, please ensure that your NPI is legible and correct. Complete Section 5 so that we may contact you in the event of problems processing this form.	
28.	5	Instruction Section 1A3	Revise as follows:	3. **Deactivation** If you are deactivating the NPI, check box #3. Record the NPI you want to deactivate, indicate the reason for deactivation, and complete Section 2. Sign and date the certification statement in Section 4A or 4B, as appropriate. See instructions for Section 4. Use additional sheets of paper if necessary.	Instructions revised for clarification purposes.
29.	5	Instruction Section 1A	Add the following:	4. **Reactivation** If you are reactivating the NPI, check box #4. Record the NPI you want to reactivate, provide the reason for reactivation, and complete Section 2. Sign and date the certification statement in Section 4A or 4B, as appropriate. See instructions for Section 4. Use additional sheets of paper if necessary.	Instructions added for this collection.
30.	5	Instruction Section 1B	Revise as follows:	**B. Entity Type** Check only one box (Required for initial applications) Entity Type 1: Individuals who render health care or furnish health care to patients; e.g., physicians, dentists, nurses, chiropractors, pharmacists, physical therapists. Note that incorporated individuals may obtain NPIs for themselves if they are health care providers and may obtain NPIs for their corporations (Entity Type 2 Organizations). A sole proprietor is an Entity Type 1. (A sole proprietorship is a form of business in which one person owns all the assets of the business and is solely liable for all the debts of the business in an individual capacity. Therefore, sole	Instructions revised for clarification purposes.

				proprietorships are not organization health care providers.) Note that sole proprietors may obtain only one NPI. Sole proprietors must report their SSNs (not EINs even if they have EINs). Entity Type 2: Organizations that render health care or furnish health care supplies to patients; e.g., hospitals, home health agencies, ambulance companies, group practices, health maintenance organizations, durable medical equipment suppliers, pharmacies. If the organization is a subpart, check yes and furnish the Legal Business Name (LBN) and Taxpayer Identification Number (TIN) of the "parent" organization health care provider. (A subpart is a component of an organization health care provider. A subpart may be a different location or may furnish a different type of health care than the organization health care provider. For ease of reference, we refer to that organization health care provider as the "parent".)	
31.	5	Instruction Section 2A	Add the following as the last sentence of the note:	A sole proprietor is an individual.	Instruction added for clarification purposes.
32.	5	Instruction Section 2A1-6	Replace the words 'block 19' with the following:	block 18	Revised for correction.
33.	5	Instruction Section 2A18	Add the following bolded sentence as the last sentence:	**If you do not furnish your SSN, you must furnish another proof of identity with this application form: a photocopy of your driver's license, State issued ID, birth certificate, passport, or information requested in item #19.**	Revised to include clarification on acceptable proof of identity.
34.	5	Instruction Section 2A19	Revise the first sentence as followed:	If you do not qualify for an SSN, furnish your IRS Individual Taxpayer Identification Number (ITIN) along with a photocopy of your driver's license, State issued ID, birth certificate or passport.	Revised to include clarification on acceptable proof of identity.
35.	5	Instruction	Bold the following	**You may not use an ITIN if you have an SSN.**	Revised for clarification purposes.

		Section 2A19	sentence and add the following information:	**Do not enter an Employer Identification Number (EIN) in the ITIN field. Note: A photocopy of your driver's license, State issued ID, birth certificate or passport must accompany your ITIN.**	
36.	5	Instruction 2A19	Revise the last bolded sentence as follows:	**If you do not furnish the information requested in block 18 or 19, you must furnish another proof of identity with this application form: a photocopy of your driver's license, State issued ID, birth certificate or passport.**	Revised to include clarification on acceptable proof of identity.
37.	5	Instruction Section 2B1-2	Delete the following words:	or Social Security Number (SSN)	Correction.
38.	6	Instruction Section 3A	Move the word '(Required)' from the end of the paragraph up to the title line as follows:	**A. Mailing Address Information** *(Required)*	Format change.
39.	6	Instruction Section 3A	Delete the last sentence	Delete: 'You may also add an email address.'	Correction.
40.	6	Instruction Section 3B	Move the word '(Required)' from the end of the paragraph up to the title line as follows:	**B. Practice Location Information** *(Required)*	Format change.
41.	6	Instruction Section 3C	Replace the parenthetical phrase '(show State) with the following:	(the name of the State is required if Medicaid Number is furnished)	Revised for clarification purposes.
42.	6	Instructions Section 3C	Delete (Optional) and replace it with '(Situational, Required if known) as follows:	**C. Other Provider Identification Numbers** (Situational, Required if known)	Revised for clarification purposes.
43.	6	Instructions - Section 3C	Add 'or organizations, such as the DEA number' in the second sentence after 'health plans' and before '(give	or organizations, such as the DEA number	Revised for clarification purposes.

			a brief description of issuer)'.		
44.	6	Instruction Section 3C	Add the following sentence after the sentence “If you do not have such numbers…”	Organizations should only furnish other provider identification numbers that belong to the organization; do not list identification numbers that belong to health care providers who are individuals who work for the Organizations. NOTE: Information provided may be disclosed under specific circumstances (See Privacy Statement on Page 4).	Revised for clarification purposes.
45.	6	Instruction Section 3D	Delete the following sentence:	Delete: ‘You may provide a written description instead in the space provided, and we will assign the closest appropriate code.	Revised for clarification purposes.
46.	6	Instructions Section 3D	Add the following sentence to the first paragraph after the first sentence (i.e., between the two sentences of the first paragraph).	You must select a primary taxonomy code in order to facilitate aggregate reporting of providers by classification/specialization.	Added for clarification purposes.
47.	6	Instruction Section 3D	Revise the first sentence in the second paragraph to read as follows:	Furnish the provider’s health care license, registration, or certificate number(s) (if applicable).	Revised for clarification purposes.
48.	6	Instruction Section 3D	Delete the following	Physician Assistant Psychoanalyst Licensed Psychiatric Technician The following organizations are also required to submit a license number. Provide your license number(s) and State(s) where issued: Home Health Agency Hospital Unit Hospital Clinical Medical Laboratory Managed Care Organization Nursing Facility Pharmacy Federally Qualified Health Center	Deleted for correction. This information was incorrect.
49.	6	Instruction Section 3D	Revise the sentence before the note that begins ‘You may use the same license…’ as	You may use the same license, registration, or certification number for multiple taxonomies; e.g., if you are a physician with several different specialties.	Revised for clarification purposes.

			follows:		
50.	6	Instruction Section 4	Add the following sentence after the first sentence beginning with ‘By his/her signature, the authorized official binds…’	This section is intended for organizations; not health care providers who are individuals.	Added for clarification purposes.
51.	6	Instructions Section 5	Delete (Optional) and replace it with ‘(Required) as follows:	**SECTION 5 – CONTACT PERSON** (If the contact person is the same person identified in 2A or 4B, complete items 8 & 9 in this section.) (Required)	Revised for correction and clarification. The collection of this information is required. This change is in accordance to the NPI Final Rule.
52.	6	Section 5	Revise the following sentence beginning with ‘Please note that if a contact person is not provided, all….’ as follows:	Please note that if a contact person is not provided, all questions about this application will be directed to the health care provider named in Section 2 or the authorized official named in Section 4, as appropriate.	Revised for clarification purposes.
53.	6	Instructions - Section 5	Add the following as the second sentence before 'Please note...': 'The contact person can be the health care provider. The contact person will receive the NPI notification once the health care provider has been assigned an NPI.'	The contact person can be the health care provider. The contact person will receive the NPI notification once the health care provider has been assigned an NPI.	Added for clarification purposes.