DRAFT

Please check one. Directions for completing this form are on Page 2.

☐ New Application
☐ Change Request
☐ Voluntary Termination

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0929

Section 1011 PROVIDER ENROLLMENT APPLICATION

1. Applicant's Legal Business Name as Reported to the IRS and Individual Physician Name when applicant is Physician in Box 9.	2. Doing Business AS (DBA) Name *(if applicable)*
3. Physical Address	4. Name, telephone number, and address of person to be contacted on matters involving the application.
5. County	6. E-mail address of person to be contacted on matters involving the application.
7. State of Service (Note: A separate application must be submitted for each State of Service)	8. Current Medicare Fiscal Intermediary or Carrier

9. Type of Applicant (check one)

☐ Hospital
☐ Physician
☐ Physician Group (**must** complete attachments 1 and 2)
☐ Ambulance

10. Applicant's Medicare Identification Number, NPI and SSN

Hospital _____ (Medicare #/CCN and NPI)
Physician _____ (NPI and UPIN or PTAN)
Physician SSN _____
Physician Group _____ (NPI and UPIN or PTAN)
Ambulance _____ (NPI and UPIN or PTAN)

11. Hospital Election (hospital only)

☐ Payment for hospital and physician services

*(Note: Hospitals electing to receive payment for both hospital and physician services **must** complete Attachment 1.)*

☐ Payment for hospital and a portion of on-call payments made by the hospital for physician services.

(Note: If a hospital elects this option, physicians will separately bill for section 1011 services.

12. ☐ Physician Privileges

*(Note: If a physician has privileges at multiple hospitals, the physician **must** complete Attachment 2)*

Hospital Name _____ Medicare Number _____ NPI Number _____

☐ Physician Group Privileges

*(Note: If enrolling a group, the group **must** complete Attachments 1 and 2)*

13. Applicant's Federal Tax Identification Number	14. Applicant's Routing Transit Number, Deposit Account Number Routing Transit # _____ ☐ Checking Account # _____ ☐ Savings

ALL PROVIDERS

In order to receive payment under section 1011 of the Medicare Modernization Act of 2003, the provider submitting this enrollment application agrees to collection requirements approved under the Paperwork Reduction Act. This agreement, upon submission by the provider of services and acceptance by the Secretary of Health and Human Services, shall be binding on the provider of services and the Secretary.

The hospital, physician, ambulance provider, or any other person or entity receiving section 1011 payments (hereinafter "payee") acknowledges that those payments may be retroactively adjusted at the end of each fiscal year in accordance with subsection (c)(2) of section 1011. If CMS determines that payments must be retroactively adjusted, the payee agrees that it will promptly remit the full amount of the reduction to CMS in accordance with instructions provided with the notice of retroactive adjustment. Payee acknowledges that there will be no appeal or review of the determination of retroactive adjustment. Any payment owed to CMS must be remitted promptly, but in no event later than 30 days after notice.

HOSPITALS ONLY

I agree to provide patient eligibility information to physicians and ambulance providers within 120 days of the date of service. I agree to notify the physicians within my hospital about my payment election (see item 10 above.) I further agree to reimburse physicians in a prompt manner after receiving section 1011 reimbursement and agree not to charge an administrative or other fee with respect to transferring reimbursement to a physician.

ATTENTION: READ THE FOLLOWING PROVISION OF FEDERAL LAW CAREFULLY BEFORE SIGNING.

Whoever, 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 statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000, imprisoned not more than 5 years, or both (18 U.S.C. section 1001).

To the best of my knowledge and belief, all data in this application are true and correct, and the governing body of the applicant has duly authorized the document.

15. Write Name and Title of Authorized Official	16. Telephone Number *(including area code)*
17. Signature of Authorized Official	18. Date

Form CMS-10115 (07/05) EF 07/2005

APPLICATION DEFINITIONS and INSTRUCTIONS
Section 1011 Provider Enrollment Application Form CMS-10115

The purpose of collecting the information on the section 1011 Enrollment Application is to determine or verify the eligibility of individuals or organizations enrolling in the section 1011 program as providers. This information will also be used to ensure that payments are made to eligible providers as described in section 1011(e)(4) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. All information on this form is required for new applications to be processed. Applications not properly or fully completed are denied and returned as incomplete.

Application Definitions

CMS Form 10115
This application allows eligible providers to apply for payment of some or all of their unreimbursed costs of providing services required by Section 1867 of the Social Security Act and related hospital inpatient, outpatient, and ambulance services furnished to undocumented aliens, aliens paroled into the United States at a U.S. port of entry for the purpose of receiving such services, and Mexican citizens permitted temporary entry to the U.S. with a laser visa.

Application Submission
To enroll in this program, a provider must **MAIL** an original **APPLICATION** with an original signature to the following address. An original or copy of the Medicare 855i or your Medicare confirmation letter must be included. Applicable attachments must be included with the application as well as an Electric Funds Transfer (EFT) Agreement, (FORM CMS-588) and an Electronic Remittance Advice (ERA) Request Application. Applications missing any information, attachments or EFT Agreement and ERA application will be denied and returned to the provider.

TrailBlazer Health Enterprises, LLC
P.O. Box 660529
Dallas, TX 75266-0529

Change Requests
Once a section 1011 Provider Identification Number (PIN) has been issued, changes may be made to the information on file. The information that is changing should be completed on the Application as well as boxes 1, 2, 10, 13, 15, 17 and 18. An original signature of the Authorized Official is required. The change request will be denied if the required information is not completed.

Voluntary Termination
Should a provider choose to no longer participate in the section 1011 program, they may terminate their PIN. Sections 1, 2, 10, 13, 15, 17 and 18 must be completed on the application. An original signature of the Authorized Official is required. The termination will not be processed if the required information is not completed.

Application Instructions

Box 1
List the legal business name that is reported to the Internal Revenue Service (IRS) for tax reporting purposes and also list the physician's name when applicant is a physician as checked in Box 9.

Box 2
Indicate the Doing Business Name if different than **Box 1.**

Box 3
Record the physical address of the facility, ambulance company or physician office.

Box 4
Provide the name and address of the enrollment contact person.

Box 5
Submit the county of the physical address in **Box 3**.

Box 6
Note an e-mail address of the contact person listed in **Box 4.**

Box 7
Provide the state where services will be performed. A separate application is required for each State of Service.

Box 8
List your current Medicare Intermediary or Carrier (if applicable).

Box 9
Check the correct box indicating the type of provider you are according to the below defined terms.
Hospital - This term is defined at section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e)).
Physician - This term is defined at section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)).

Box 10
Medicare Identification Number is a generic term for any number that uniquely identifies the provider. Hospitals must provide their Medicare Number or CMS Certification Number (CCN) and NPI number; physicians must provide either their UPIN or Provider Transaction Access Number (PTAN), NPI number and SSN; ambulance providers must provide their UPIN or PTAN and their NPI number.

Box 11
HOSPITALS ONLY: Hospitals must select to receive payment for both hospital and physician services or just for hospital services and a portion of on-call payments. Should a hospital elect to receive payment for physician services, Attachment 1 must be completed and the hospital agrees to bill section 1011 for for all physicians employed by or contracted with that hospital and not solely for employed physicians. A hospital electing this option must bill for any and all physician services performed in that hospital, without regard to the legal arrangement with the physician. Hospitals may not submit payment requests for certain physicians while allowing others to bill separately.

Box 12
PHYSICIANS ONLY: Physicians should elect to enroll separately or with a group. Physicians enrolling separately should indicate the hospital name, and NPI for which that physician has privileges. If the physician has privileges at multiple hospitals then Attachment 2 *must* be completed. Groups enrolling their physicians *must* complete Attachments 1 *and* 2 and obtain individual signatures of the physicians in which they are enrolling.

Box 13
List the Tax Identification Number which is the number issued by the Internal Revenue Service (IRS) that is used by the provider to report tax information to the IRS.

Box 14
Furnish the applicable routing and account numbers for banking information and specify whether it is a checking or savings account. Information recorded in this box should also match banking information in the EFT Agreement. The information concerning your financial institution should be available through your organization's treasurer or financial institution. A contact person and telephone number are important for verification purposes. Your financial institution can assist you in providing the correct banking information, including the bank's routing number.

Boxes 15 - 17: Provide the name and title of the Authorized Official with an original signature and a phone number. An Authorized Official is an appointed official to whom the provider has granted legal authority to enroll it in section 1011, to make changes and/or updates to the provider's financial information, and to commit the provider to fully abide by the laws and program instructions of section 1011. The authorized official must be the provider's general partner, chairman of the board, chief financial officer, chief executive officer, chief operating officer, president, direct owner of five percent of more of the provider or must hold a position of similar status and authority within the provider's organization such as Director, Administrator, County Commissioner, Chancellor, Chief, Vice President or AVP. **The physician's signature is required on the physician application as the authorized official for individual physician.**

SECTION 1011 PROVIDER ENROLLMENT APPLICATION

ATTACHMENT 1

This attachment is required for hospitals electing to receive section 1011 payment for hospital and physician services ***and*** physician groups electing to receive payment for group members (physicians) and must list the names and provider numbers of physicians with hospital privileges. All information is required and a physician signature is required for group applications only.

PHYSICIAN NAME	NPI Number	UPIN or PTAN	PHYSICIAN SIGNATURE (GROUP ENROLLMENT ONLY)

SECTION 1011 PROVIDER ENROLLMENT APPLICATION

ATTACHMENT 2

This attachment is required for physicians with privileges at more than one hospital or Physician Group applications.

Physicians with hospital privileges at more than one hospital must list the names, Medicare numbers (CCN) and NPI numbers of the hospitals where they have privileges.

Physician Groups must list the names, Medicare numbers and NPI numbers (CCN) of the hospitals where the group physicians have privileges.

Hospital Name	Medicare Number (CCN)	NPI Number