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# MEDICARE ENROLLMENT APPLICATION

FOR ELIGIBLE ORDERING AND REFERRING  
PHYSICIANS AND NON-PHYSICIAN PRACTITIONERS

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**CMS-8550**

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

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



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## WHO SHOULD COMPLETE THIS APPLICATION

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Physicians and non-physician practitioners can apply for enrollment for the sole purpose of ordering and referring items and/or services to beneficiaries 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 (e.g., CMS 855O).

For additional information regarding the Medicare enrollment process, including Internet-based PECOS, go to <http://www.cms.gov/MedicareProviderSupEnroll>.

Most physicians and non-physician practitioners enroll in the Medicare program to be reimbursed for the covered services they furnish to Medicare beneficiaries. However, with the implementation of Section 6405 of the Affordable Care Act, CMS permits certain physicians and non-physician practitioners to enroll in the Medicare program for the sole purpose of ordering or referring items or services for Medicare beneficiaries. These physicians and non-physician practitioners do not and will not send claims to a Medicare contractor for the services they furnish. The physicians and non-physician practitioners who may wish to enroll in Medicare solely for the purpose of ordering and referring include, but are not limited to, those who are:

- employed by the Department of Veterans Affairs (DVA)
- employed by the Public Health Service (PHS)
- employed by the Department of Defense (DOD) Tricare
- employed by IHS or tribal organizations
- employed by Federally Qualified Health Centers (FQHC), Rural Health clinics (RHC) or Critical Access Hospitals (CAH)
- licensed residents and physicians in a fellowship
- dentists, including oral surgeons
- pediatricians

CMS is **not** requiring these physicians and non-physician practitioners to send the CMS 460, “Medicare Participating Physician or Supplier Agreement,” or the CMS 588, “Electronic Funds Transfer (EFT) Authorization Agreement.”

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## BILLING NUMBER INFORMATION

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The NPI is the standard unique health identifier for health care providers and is assigned by the National Plan and Provider Enumeration System (NPPES). **As an enrolling Medicare supplier, you must obtain an NPI prior to enrolling in Medicare.** Applying for the NPI is a process separate from Medicare enrollment. To obtain an NPI, you may apply online at <https://NPPES.cms.gov>. For more information about NPI enumeration, visit [www.cms.gov/NationalProvIdentStand](http://www.cms.gov/NationalProvIdentStand).

The Medicare Identification Number, often referred to as a Provider Transaction Access Number (PTAN) or Medicare legacy number, is a generic term for an identifier that Medicare assigns to its enrolled providers and suppliers.

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## INSTRUCTIONS FOR COMPLETING AND SUBMITTING THIS APPLICATION

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- Type or print all information so that it is legible. Do not use pencil.
- Keep a copy of your completed Medicare enrollment application and any supporting data for your own records.
- Send the completed application with original signatures to your designated Medicare fee-for-service contractor.
- Sign and date the application in Section 6 (blue ink recommended).

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## AVOID DELAYS IN YOUR ENROLLMENT

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To avoid delays in the enrollment process, you should:

- Complete all required sections.
- Ensure that the correspondence address shown in Section 2 is your address.
- Enter your NPI in the applicable section.
- Enter all applicable dates.
- Send the completed application to your designated fee-for-service contractor.

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## ADDITIONAL INFORMATION

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For additional information regarding the Medicare enrollment process, visit [www.cms.gov/MedicareProviderSupEnroll](http://www.cms.gov/MedicareProviderSupEnroll).

The fee-for-service contractor may request, at any time during the enrollment process, documentation to support and validate information reported on the application. You are responsible for providing this documentation in a timely manner.

The information you provide on this form will not be shared. It is protected under 5 U.S.C. Section 552(b) (4) and/or (b)(6), respectively. For more information, see the last page of this application to read the Privacy Act Statement.

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## MAIL YOUR APPLICATION

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The Medicare fee-for-service contractor (also referred to as a carrier or a Medicare administrative contractor) that services your State is responsible for processing your enrollment application. To locate the mailing address for your fee-for-service contractor, go to [www.cms.gov/MedicareProviderSupEnroll](http://www.cms.gov/MedicareProviderSupEnroll).

## SECTION 1: BASIC INFORMATION

Check one box and complete the required sections.

REASON FOR APPLICATION	NPI	REQUIRED SECTIONS
<input type="checkbox"/> You are enrolling for the sole purpose of ordering/referring	Enter your NPI:	Complete all sections
<input type="checkbox"/> You are enrolled solely to order and refer and are updating your information	Enter your NPI:	Complete all sections

## 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.
2. Other First Name	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 ( <i>mm/dd/yyyy</i> )	State of Birth	Country of Birth
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3. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	4. Social Security Number
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Medical or other Professional School ( <i>Training Institution, if non-MD</i> )	Year of Graduation ( <i>yyyy</i> )	DEA Number ( <i>if applicable</i> )
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### License Information

License Not Applicable

License Number	State Where Issued
Effective Date ( <i>mm/dd/yyyy</i> )	Expiration/Renewal Date ( <i>mm/dd/yyyy</i> )

### 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 Medicare contractor if it needs to contact you directly. This address cannot be a billing agency's address. This address cannot be a billing address or P.O. Box.

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

Mailing Address Line 2 (*Apt. #*)

City/Town	State	ZIP Code + 4
Telephone Number	Fax Number ( <i>if applicable</i> )	
E-mail Address ( <i>if applicable</i> )		

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**SECTION 2: IDENTIFYING INFORMATION (Continued)**

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**C. FACTOR REQUIRING YOU TO ENROLL SOLELY TO ORDER OR REFER**

You are enrolling in Medicare solely to order or refer because you are (check one):

- Employed by the DVA
- Employed by the PHS
- Employed by the DoD/Tricare
- Employed by IHS or a Tribal Organization
- Employed by a Medicare-enrolled FQHC
- Employed by a Medicare-enrolled RHC
- Employed by a Medicare-enrolled CAH
- Physician not employed by any of the above
- Non-physician practitioner not employed by any of the above
- Licensed resident or fellow not employed at any of the above
- Dentist not employed by any of the above
- Pediatrician not employed by any of the above
- Other (*Specify*):

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**SECTION 2: IDENTIFYING INFORMATION (Continued)**

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**D. MEDICAL SPECIALTIES****1. Physician Specialty**

If you are a physician, designate your primary specialty. A physician must meet all Federal and State requirements for the type of specialty(s) checked.

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

**2. Non-Physician Specialty**

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:**

- |  |  |
|--|--|
| <input type="checkbox"/> Certified nurse midwife   | <input type="checkbox"/> Psychologist billing independently                  |
| <input type="checkbox"/> Clinical nurse specialist | <input type="checkbox"/> Unlisted non-physician practitioner type (Specify): |
| <input type="checkbox"/> Clinical social worker    | _____  |
| <input type="checkbox"/> Nurse practitioner        | _____  |
| <input type="checkbox"/> Physician assistant       | _____  |
| <input type="checkbox"/> Clinical psychologist     |  |

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## **SECTION 3: FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS**

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This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

### **Convictions**

1. The physician or non-physician practitioner was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has 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 Identification Number.
5. Any Medicare revocation of any Medicare Identification Number.

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**SECTION 3: FINAL ADVERSE ACTIONS/CONVICTIONS** *(Continued)*

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**FINAL ADVERSE HISTORY**

1. Have you, under any current or former name or business identity, ever had a final adverse action listed on page 6 of this application imposed against you?

<input type="checkbox"/> YES—Continue Below	<input type="checkbox"/> NO—Skip to Section 4
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2. If yes, report each final adverse 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 final adverse action documentation and resolution.

FINAL ADVERSE ACTION	DATE	TAKEN BY	RESOLUTION



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**SECTION 4: CONTACT PERSON**

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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 at the Correspondence Address in Section 2B.

First Name	Middle Initial	Last Name	Jr., Sr., etc.
Telephone Number		Fax Number <i>(if applicable)</i>	
E-mail Address <i>(if applicable)</i>			
Address Line 1 <i>(Street Name and Number)</i>			
Address Line 2 <i>(Suite, Room, etc.)</i>			
City/Town	State		ZIP Code + 4

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## SECTION 5: PENALTIES FOR FALSIFYING INFORMATION

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

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.
5. 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.
6. 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.

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**SECTION 5: PENALTIES FOR FALSIFYING INFORMATION (Continued)**

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7. 18 U.S.C. 1347 authorizes criminal penalties against individuals who knowing and willfully execute, or attempt, to execute a scheme or artifice to defraud any health care benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by or under the control of any, health care benefit program in connection with the delivery of or payment for health care benefits, items, or services. Individuals shall be fined or imprisoned up to 10 years or both. If the violation results in serious bodily injury, an individual will be fined or imprisoned up to 20 years, or both. If the violation results in death, the individual shall be fined or imprisoned for any term of years or for life, or both.
8. The government may assert common law claims such as “common law fraud,” “money paid by mistake,” and “unjust enrichment.”

Remedies include compensatory and punitive damages, restitution, and recovery of the amount of the unjust profit.

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## SECTION 6: CERTIFICATION STATEMENT

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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 solely to order and refer items and services for Medicare beneficiaries. 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.

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### Certification Statement

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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 understand that in the future if I wish to be reimbursed by Medicare for services performed, I must first submit the appropriate paper CMS-855 application or use Internet-based PECOS to submit an enrollment application to the Medicare program.**
2. 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.
3. I authorize the Medicare contractor to **verify** the information contained herein. I agree to notify the Medicare contractor of a change in Section 2 information and/or Section 3 within 30 days of the reportable event. In addition, I agree to notify the Medicare contractor of any other changes to the information to this form within 90 days of the effective date of change. I understand that any change to my status as an individual practitioner may require the submission of a new application.
4. 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 imposition of fines, civil damages, and/or imprisonment.
5. I agree to abide by Medicare's laws, regulations and program instructions. The Medicare laws, regulations, and program instructions are available through the Medicare 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.
6. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare.
7. I further certify that I am the individual practitioner who is applying for the sole purpose of ordering and referring items or services to Medicare beneficiaries.

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**SECTION 6: CERTIFICATION STATEMENT (Continued)**

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First Name	Middle Initial	Last Name	M.D., D.O., etc.
Practitioner Signature ( <i>First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.</i> )			Date Signed ( <i>mm/dd/yyyy</i> )

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

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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 xxxx-xxxx. The time required to complete this information collection is estimated to 4 hours 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, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

**DO NOT MAIL APPLICATIONS TO THIS ADDRESS.** Mailing your application to this address will significantly delay application processing.

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## MEDICARE SUPPLIER ENROLLMENT APPLICATION PRIVACY ACT STATEMENT

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The Centers for Medicare & Medicaid Services (CMS) is authorized to collect the information requested on this form by sections 1124(a)(1), 1124A(a)(3), 1128, 1814, 1815, 1833(e), and 1842(r) of the Social Security Act [42 U.S.C. §§ 1320a-3(a)(1), 1320a-7, 1395f, 1395g, 1395(l)(e), and 1395u(r)] and section 31001(1) of the Debt Collection Improvement Act [31 U.S.C. § 7701(c)].

The purpose of collecting this information is to determine or verify the eligibility of individuals and organizations to enroll in the Medicare program as suppliers of goods and services to Medicare beneficiaries and to assist in the administration of the Medicare program. This information will also be used to ensure that no payments will be made to providers who are excluded from participation in the Medicare program. All information on this form is required, with the exception of those sections marked as “optional” on the form. Without this information, the ability to make payments will be delayed or denied.

The information collected will be entered into the Provider Enrollment, Chain and Ownership System (PECOS). The information in this application will be disclosed according to the routine uses described below.

Information from these systems may be disclosed under specific circumstances to:

1. CMS contractors to carry out Medicare functions, collating or analyzing data, or to detect fraud or abuse;
2. A congressional office from the record of an individual health care provider in response to an inquiry from the congressional office at the written request of that individual health care practitioner;
3. The Railroad Retirement Board to administer provisions of the Railroad Retirement or Social Security Acts;
4. Peer Review Organizations in connection with the review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XVIII of the Social Security Act;
5. To the Department of Justice or an adjudicative body when the agency, an agency employee, or the United States Government is a party to litigation and the use of the information is compatible with the purpose for which the agency collected the information;
6. To the Department of Justice for investigating and prosecuting violations of the Social Security Act, to which criminal penalties are attached;
7. To the American Medical Association (AMA), for the purpose of attempting to identify medical doctors when the National Plan and Provider Enumeration System is unable to establish identity after matching contractor submitted data to the data extract provided by the AMA;
8. An individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, or to the restoration or maintenance of health;
9. Other Federal agencies that administer a Federal health care benefit program to enumerate/enroll providers of medical services or to detect fraud or abuse;
10. State Licensing Boards for review of unethical practices or non-professional conduct;
11. States for the purpose of administration of health care programs; and/or
12. Insurance companies, self insurers, health maintenance organizations, multiple employer trusts, and other health care groups providing health care claims processing, when a link to Medicare or Medicaid claims is established, and data are used solely to process supplier’s health care claims.

The supplier should be aware that the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503) amended the Privacy Act, 5 U.S.C. § 552a, to permit the government to verify information through computer matching.

### **Protection of Proprietary Information**

Privileged or confidential commercial or financial information collected in this form is protected from public disclosure by Federal law 5 U.S.C. § 552(b)(4) and Executive Order 12600.

### **Protection of Confidential Commercial and/or Sensitive Personal Information**

If any information within this application (or attachments thereto) constitutes a trade secret or privileged or confidential information (as such terms are interpreted under the Freedom of Information Act and applicable case law), or is of a highly sensitive personal nature such that disclosure would constitute a clearly unwarranted invasion of the personal privacy of one or more persons, then such information will be protected from release by CMS under 5 U.S.C. §§ 552(b)(4) and/or (b)(6), respectively.