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	Each Page	Add the draft watermark and remove the form number/date from each page	***Add*** the draft watermark and removing the form number/date from each page	Revising the application; therefore, this date will change.
2.	1	Paragraph above Section 1	Revise as follows:	***Replace:*** Failure to provide complete and accurate information may cause your application to be returned and delay processing. ***With:*** Failure to provide pages 1, 2 and 3 with complete and accurate information may cause your application to be returned and delay processing.	Clarification is given on which pages must be provided in order to avoid the application being returned.
3.	1	Section 1A	Revise as follows:	***Replace:*** A. Reason For Submittal ***With:*** A. Reason For Submittal (Required) (Only provide one Reason for Submittal and/or NPI per form. Use additional forms if necessary.)	Revised to instruct applicants to provide the reason for submittal and to use additional forms if changes to other NPIs are needed.
4.	1	Section 1A1	Revise as follows:	***Replace:*** Initial Application ***With:*** Initial Application * Denotes required field for initial application only.	Revised for clarification purposes.
5.	1	Section 1A2	Revise as follows:	***Replace:*** NPI: _____ ***With:*** NPI: (Required) _____ Only complete the appropriate sections with the information that is changing. If removing information, please indicate within the appropriate field(s) by writing remove.	Revised for clarification purposes.
6.	1	Section 1A3	Revise as follows:	***Replace:*** NPI: _____ Reason (Check one of the following) ***With:*** NPI: (Required) _____ Reason (Check only one box) (Required)	Revised for clarification purposes.
7.	1	Section 1A4	Revise as follows:	***Replace:*** NPI: _____	Revised for clarification

				Reason: _____ ***With:*** NPI: (Required) _____ Reason: (Required) _____	purposes.
8.	1	Section 1B	Revised as follows:	***Replace:*** B. Entity Type (Check only one box) (See Instructions) ***With:*** B. Entity Type (Check only one box) (Required for initial applications only) (See Instructions)	Revised for clarification purposes.
9.	1	Section 2A1	Revise as follows:	***Replace:*** 1. Prefix (e.g., Major, Mrs.) ***With:*** 1. Prefix (e.g., Mr., Mrs.)	Revised for clarification purposes. The previous example was not accurate (as 'Major' is not on the dropdown list of the prefix field
10.	1	Section 2A2	Revise as follows:	***Replace:*** 2. First ***With:*** 2. First*	Revised for clarification purposes on information required for initial applications.
11.	1	Section 2A4	Revise as follows:	***Replace:*** 4. Last ***With:*** 4. Last*	Revised for clarification purposes on information required for initial applications.
12.	1	Section 2A13	Revise as follows:	***Replace:*** ❑ Other, specify _____ ***With:*** ❑ Other	Revised for clarification purposes to remove ',specify_____'. The system does not allow you to input additional information when 'Other' is selected.
13.	1	Section 2A14	Revise as follows:	***Replace:*** 14. Date of Birth (mm/dd/yyyy) ***With:*** 14. Date of Birth* (mm/dd/yyyy)	Revised for clarification purposes on information required for initial applications.
14.	1	Section 2A15	Revise as follows:	***Replace:*** 15. State of Birth (U.S. only) ***With:*** 15. State of Birth* (U.S. only)	Revised for clarification purposes on information required for initial applications.
15.	1	Section 2A16	Revise as follows:	***Replace:*** 16. Country of Birth (if other than U.S.) ***With:*** 16. Country of Birth* (if other than U.S.)	Revised for clarification purposes on information required for initial applications.
16.	1	Section 2A17	Revise as follows:	***Replace:*** 17. Gender ***With:*** 17. Gender*	Revised for clarification purposes on information required for initial applications.
17.	1	Section 2A18	Revise as follows:	***Replace:*** 18. Social Security Number (SSN)	Revised for clarification purposes on information required for initial

				With: 18. Social Security Number (SSN) (See Instructions)	applications.
18.	1	Section 2B	Revise as follows:	***Replace:*** B. Organizations (includes Groups, Corporations and Partnerships) ***With:*** B. Organizations (includes Groups, Corporations and Partnerships) (Do not report an SSN in the EIN field.)	Revised to allow more space for the legal business name of the organization.
19.	1	Section 2B1	Revise as follows: Also, move line to allow more space for the name information.	***Replace:*** 1. Name (Legal Business Name) ***With:*** 1. Name* (Legal Business Name) Also, move line to allow more space for the name information.	Revised for clarification purposes on information required for initial applications. Also, revised to allow more space for the organization's legal business name information.
20.	1	Section 2B2	Revise as follows: Also, move line to allow less space for the EIN information.	***Replace:*** 2. Employer Identification Number (EIN) (Do not report an SSN in this field.) ***With:*** 2. Employer Identification Number* (EIN) Also, move line to allow less space for the EIN information.	Revised for clarification purposes on information required for initial applications. Also, revised to allow less space for the organization's EIN information.
21.	1	Section 2B3	Revise as follows:	***Replace:*** 3. Other Name (Use additional sheets of paper if necessary) ***With:*** 3. Other Name (if applicable)	Revised for clarification purposes on information required for initial applications.
22.	1	Section 2B4	Revise as follows:	***Replace:*** ❑ Other (Describe) _____ ***With:*** ❑ Other	Revised for clarification purposes to remove ' (Describe)_____'. The system does not allow you to input additional information when 'Other' is selected.
23.	2	Section 3A1	Revise as follows: Add the asterisk	***Replace:*** 1. Business Mailing Address Line 1 (Street Number and Name or P.O. Box) ***With:*** 1. Business Mailing Address Line 1* (Street Number and Name or P.O. Box)	Revised for clarification purposes on information required for initial applications.
24.	2	Section 3A3	Revise as follows: Add the asterisk	***Replace:*** 3. Business City ***With:*** 3. Business City*	Revised for clarification purposes on information required for initial applications.
25.	2	Section 3A4	Revise as follows: Add the asterisk	***Replace:*** 4. Business State ***With:*** 4. Business State*	Revised for clarification purposes on information required for initial

					applications.
26.	2	Section 3A5	Revise as follows: Add the asterisk	***Replace:*** 5. Zip+4 or Foreign Postal Code ***With:*** 5. Zip Code or Foreign Postal Code*	Revised for clarification purposes on information required for initial applications.
27.	2	Add new field	Add new field next to Zip code field for the +4 (place on the same line as the zip code field)	***Add:*** 6. +4	Revised for clarification purposes. The zip code is required; however, the +4 is not a required field. This change allows the provider to submit the +4 information separately (if known) or submit changes to that information as needed.
28.	2	Section 3A6	Revise as follows:	***Replace:*** 6. Business Country Name (if outside U.S.) ***With:*** 7. Business Country Name (if outside U.S.)	Revised to renumber the field based on the change above.
29.	2	Section 3A7	Revise as follows:	***Replace:*** 7. Business Telephone Number (Include Area Code & Extension) ***With:*** 8. Business Telephone Number (Include Area Code)	Revised to renumber the field based on the change above.
30.	2	Add new field	Add new field next to Business Telephone Number to capture the extension. (place on the same line between the Business Telephone Number and the Business Fax Number)	***Add:*** 9. Extension	Revised for clarification purposes. The extension of the telephone number is separated out. This will help to reduce confusion when processing the application.
31.	2	Section 3A8	Revise as follows:	***Replace:*** 8. Business Fax Number (Include Area Code) ***With:*** 10. Business Fax Number (Include Area Code)	Revised to renumber the field based on the changes above.
32.	2	Section 3B1	Revise as follows: Add the asterisk	***Replace:*** 1. Business Primary Practice Location Address Line 1 (Street Number and Name - **P.O. Boxes Not Acceptable**)	Revised for clarification purposes on information required for initial applications.

				With: 1. Business Primary Practice Location Address Line 1* (Street Number and Name - **P.O. Boxes Not Acceptable**)	
33.	2	Section 3B3	Revise as follows: Add the asterisk	***Replace:*** 3. Business City ***With:*** 3. Business City*	Revised for clarification purposes on information required for initial applications.
34.	2	Section 3B4	Revise as follows: Add the asterisk	***Replace:*** 4. Business State ***With:*** 4. Business State*	Revised for clarification purposes on information required for initial applications.
35.	2	Section 3B5	Revise as follows: Add the asterisk	***Replace:*** 5. Zip+4 or Foreign Postal Code ***With:*** 5. Zip Code or Foreign Postal Code*	Revised for clarification purposes on information required for initial applications.
36.	2	Add new field	Add new field next to Zip code field for the +4 (place on the same line as the zip code field)	***Add:*** 6. +4	Revised for clarification purposes. The zip code is required; however, the +4 is not a required field. This change allows the provider to submit the +4 information separately (if known) or submit changes to that information as needed.
37.	2	Section 3B6	Revise as follows:	***Replace:*** 6. Business Country Name (if outside U.S.) ***With:*** 7. Business Country Name (if outside U.S.)	Revised to renumber the field based on the change above.
38.	2	Section 3B7	Revise as follows:	***Replace:*** 7. Business Telephone Number (Include Area Code & Extension) ***With:*** 8. Business Telephone Number* (Include Area Code)	Revised to renumber the field based on the change above.
39.	2	Add new field	Add new field next to Business Telephone Number to capture the extension. (place on the same line between the Business Telephone Number and the	***Add:*** 9. Extension	Revised for clarification purposes. The extension of the telephone number is separated out. This will help to reduce confusion when processing the application.

			Business Fax Number)		
40.	2	Section 3B8	Revise as follows:	***Replace:*** 8. Business Fax Number (Include Area Code) ***With:*** 10. Business Fax Number (Include Area Code)	Revised to renumber the field based on the changes above.
41.	2	Section 3C	Revise as follows:	***Replace:*** Do not include SSN, ITIN, or EIN in this section. ***With:*** Do not include SSN, ITIN, EIN, or NPI in this section.	Revised for clarification purposes. NPI information should not be reported in this section.
42.	2	Section 3C	Add language under the Section Header and before the Issuer section:	***Add:*** All Medicare numbers must be specified under one of the following Medicare Types: UPIN, OSCAR/Certification, PIN or NSC.** If you are removing identification numbers, please check the appropriate "Delete" box and provide the 'Identification Number' and 'State where issued' information being deleted.	Added for clarification purposes.
43.	2	Section 3C	Revise as follows:	***Replace:*** Issuer (Number Type Only) — Identification Number — State (if applicable) — Issuer (For Other Medicare UPIN Medicare OSCAR/Certification Medicare PIN Medicare NSC Medicaid (State is required if Medicaid number is furnished) Other, Specify: ***With:*** Issuer (if applicable) — Delete — Identification Number — State where issued Medicare UPIN ☐ Medicare OSCAR/Certification ☐ Medicare PIN ☐ Medicare NSC ☐ Medicaid (State information required) ☐ Other, Specify: _____ ☐	Revised for clarification purposes when processing the application.
44.	2	Section 3D	Revise as follows:	***Replace:*** D. Provider Taxonomy Code (*Provider Type/Specialty. Enter one or more codes*) and License Number information Do not include SSN, ITIN, or EIN in this section. Information on provider taxonomy codes is available at www.wpc-edi.com/taxonomy. Please see instructions if you plan to submit more than one taxonomy code for a Type 2 (organization) entity. 1. Primary Provider Taxonomy Code or describe your specialty or provider type (e.g., chiropractor, pediatric	Revised for clarification purposes.

				hospital) □□□□□□□□□□ 2. License Number (See Instructions) 3. State where issued _____ 4. Primary Provider Taxonomy Code or describe your specialty or provider type (e.g., chiropractor, pediatric hospital) □□□□□□□□□□ 5. License Number (See Instructions) 6. State where issued _____ ***With:*** D. Provider Taxonomy Code (*Provider Type/Specialty*) and License Number information Do not include SSN, ITIN, EIN or NPI in this section. *** Information on provider taxonomy codes is available at www.wpc-edi.com/taxonomy. *** **See instructions for assistance with completing this section**. If you are removing taxonomy codes, please check the appropriate 'Delete' box and provide the taxonomy code/State information being deleted. Provider Taxonomy Code* License Number (If applicable) State where issued (If applicable) 1. Primary Provider Taxonomy code* □□□□□□□□□□ _____ _____ Delete ❑ 2. Provider Taxonomy code* □□□□□□□□□□ _____ _____ ❑ 3. Provider Taxonomy code* □□□□□□□□□□ _____ _____ ❑ 4. Provider Taxonomy code* □□□□□□□□□□ _____ _____	
45.	3	Section 4	Revise as follows:	***Replace:*** SECTION 4 – CERTIFICATION STATEMENT ***With:*** SECTION 4 – CERTIFICATION STATEMENT (See Instructions)	Revised for clarification purposes.
46.	3	Section 4	Add the following note under the last bulleted item:	***Add:*** ******All signatures must be original and signed in ink. Application with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted. ******	Revised for clarification purposes.
47.	3	Section 4A	Revise as Follows:	***Replace:*** A. Individual Practitioner's Signature ***With:*** A. Individual Practitioner's Signature (Required for Type 1 Providers ONLY.)	Revised for clarification purposes.

48.	3	Section 4A1/2	Add an asterisk after signature and date	***Replace:*** 1. Applicant's Signature (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.) 2. Date (mm/dd/yyyy) ***With:*** 1. Applicant's Signature* (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.) 2. Date* (mm/dd/yyyy)	Revised for clarification purposes.
49.	3	Section 4B	Revise as follows:	***Replace:*** B. Authorized Official's Information and Signature for the Organization ***With:*** B. Authorized Official's Information and Signature for the Organization (Required for Type 2 Organizations ONLY.)	Revised for clarification purposes.
50.	3	Section 4b2, 4B4, 4B7, 4B8, 4B9, 4B10	Add an asterisk	Add the asterisk as follows: First* Last* Title/Position* Telephone Number* (Area Code) Authorized Official's Signature* (First, Middle, Last, Jr., Sr., M.D., D.O., etc.) Date* (mm/dd/yyyy)	Revised for clarification purposes.
51.	3	Section 4	Add a separate field for telephone extension and renumber the authorized official's signature and date fields Revise as follows:	***Replace:*** 8. Telephone Number (Area Code & Extension) 9. Authorized Official's Signature (First, Middle, Last, Jr., Sr., M.D., D.O., etc.) 10. Date (mm/dd/yyyy) ***With:*** 8. Telephone Number* (Area Code) 9. Extension 10. Authorized Official's Signature* (First, Middle, Last, Jr., Sr., M.D., D.O., etc.) 11. Date* (mm/dd/yyyy)	Revised for clarification purposes.
52.	3	Section 5A	Revise as follows:	***Replace:*** ❑ Check here if you are the same person	Revised for clarification

				identified in 2A or 4B. If you checked the box, complete only items 8 and 9 in this section (Section 5). ***With:*** Provide the name and telephone number of an individual who can be reached to answer questions regarding the information you furnished in this application. The contact person can be the health care provider. (See Instructions)	purposes.
53.	3	Section 5A2, 5A4, 5A9 and add 5A10	Add an asterisk and add a separate field for the telephone number extension.	***Replace:*** 2. First 4. Last 9. Telephone Number (Area Code & Extension) ***With:*** 2. First* 4. Last* 9. Telephone Number* (Area Code) 10. Extension	Revised for clarification purposes.
54.	5	Instructions – 1st paragraph	Revise as follows	***Replace:*** Failure to provide complete and accurate information may cause your application to be returned and delay processing of your application. ***With:*** Failure to provide pages 1, 2 and 3 with complete and accurate information may cause your application to be returned and delay processing of your application.	Revised for clarification purposes.
55.	5	Instructions - Section 1A2	Revise as follows:	Replace current 'Changes of Information' paragraph with: **2. Change of Information** If changing information, check box #2, write your NPI in the space provided. 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. 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. Please note that some changes, such as a change to a health care provider's date of birth, require a photocopy of the health care provider's U.S. driver's license or birth certificate to be submitted along with the form for verification purposes.	Revised for clarification purposes.

56.	5	Instructions - Section 2A1-6	Remove the following sentence from the paragraph:	Remove: Use additional sheets of paper for multiple credentials if necessary.	Revised for clarification purposes and to
57.	5	Instructions - Section 2A Other name information	Remove the following sentence:	Remove: (Use additional sheets of paper for multiple credentials if necessary.)	Revised for clarification purposes.
58.	5	Instructions - Section 2A7-12	Remove the following sentence:	Remove: Use additional sheets of paper for multiple credentials if necessary.	Revised for clarification purposes.
59.	5	Instructions – Section 2A18	Revise bolded text as follows:	***Replace bolded text beginning with***: **If you do not furnish your SSN, you must furnish 2 proofs of identity…** ***With***: **If you do not furnish your SSN, you must furnish 2 proofs of identity with this application form. Acceptable forms include: balid passport, birth certificate, a photocopy of your U.S. driver's license, State issued identification, or information requested in item 19. Visas and Employer Identification Cards are NOT acceptable.**	Revised for clarification purposes.
60.	5	Instructions 2A19	Revise bolded text as follows	***Replace bolded text beginning with***: **You may not report an ITIN if you have an SSN. Do not enter…** ***With***: **You may not report an ITIN if you have an SSN. Do not enter an Employer Identification Number (EIN) in the ITIN field. Note: Your valid passport, birth certificate, photocopy of the U.S. driver's license or State issued identification must accompany your ITIN. If you do not furnish the information requested in blocks 18 or 19, you must furnish 2 proofs of identity with this application form: valid passport, birth certificate, a valid photocopy of your U.S. driver's license or State issued identification. Visas and Employer Identification Cards are NOT acceptable.**	Revised for clarification purposes.
61.	6	Instructions – Section 2B3	Remove as follows:	***Remove:*** Use additional sheets of paper if necessary.	Revised for clarification purposes.
62.	6	Instructions – Section 3B	Revise as follows	***Replace:*** Provide information on the address of your primary practice location.	Revised for clarification purposes.

				With: Provide information on the address and telephone number of your primary practice location.	
63.					
64.	6	Instructions – 3D (2nd paragraph)	Revise as follows:	***Replace***: The following individual practitioners are required to submit a license number. (If you are one of the following and do not have a license or certification, you must enclose a letter to the Enumerator explaining why not): ***With***: The following individual practitioners are required to submit a license number. (If you are a resident or intern and do not have a license or certificate, you may select the Student in an Organization Health Care Education/Training Program taxonomy code.) (If you are one of the following and do not have a license or certificate, you must enclose a letter to the Enumerator explaining why not):	Revised for clarification purposes.
65.	6	Instructions – Section 3D (3rd paragraph)	Add the following:	***Add the following to the third paragraph that begins with 'You may use the same license…:*** Do not include SSN, ITIN, EIN or NPI in this section. Do not list credentials as a taxonomy description, be specific.	Revised for clarification purposes.
66.	6	Instructions – Section 4 (2nd paragraph)	Remove the following:	Remove: Use additional sheets of paper for multiple credentials if necessary.	Revised for clarification purposes.
67.	6	Instructions – Section 4 /Authorized Official's Information and Signature for the Organization	Add Organization as follows:	Add 'Organization' as follows: By his/her signature, the authorized official binds the organization provider/supplier to all of the requirements listed in the Certification Statement and acknowledges that the organization provider may be denied a National Provider Identifier if any requirements are not met. This section is intended for organization providers; not health care providers who are individuals. All signatures must be original. Stamps, faxed or photocopied signatures are unacceptable. You may include multiple credentials. An authorized official is an appointed official with the legal authority to make changes and/or updates to the organization provider's status (e.g., change of address, etc.) and to commit the organization provider to fully abide by the laws and regulations relating to the National Provider Identifier. The authorized official must be a general partner, chairman of the board, chief financial officer, chief	Revised for clarification purposes.

				executive officer, direct owner of 5 percent or more of the organization provider being enumerated, or must hold a position of similar status and authority within the organization. Only the authorized official(s) has the authority to sign the application on behalf of the organization provider. By signing this application for the National Provider Identifier, the authorized official agrees to immediately notify the NPI Enumerator if any information in the application is not true, correct, or complete. In addition, the authorized official, by his/her signature, agrees to notify the NPI Enumerator of any changes to the information contained in this form within 30 days of the effective date of the change.	
68.	6	Section 5	Revise as follows:	Replace current contact person section with: **SECTION 5 – CONTACT PERSON** *(Required)* 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. The contact person will receive the NPI notification once the health care provider has been assigned an NPI. You may include multiple credentials.	Revised for clarification purposes.
69.					