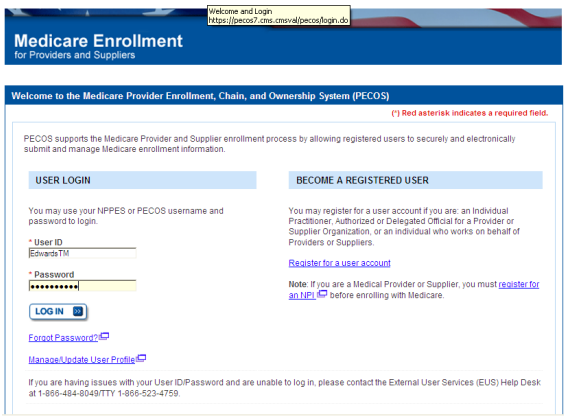
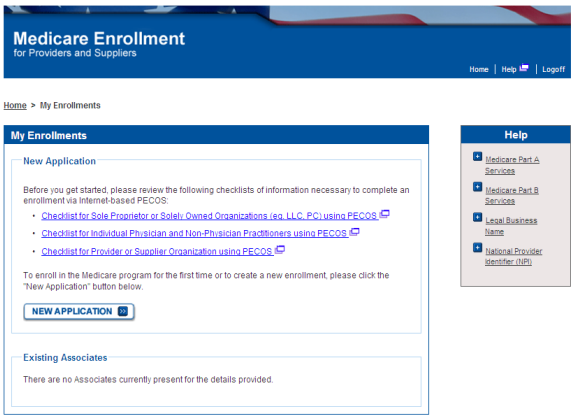
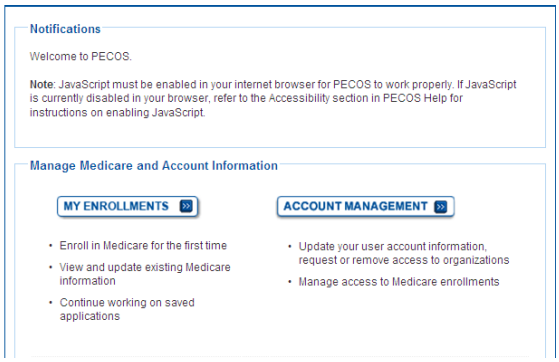
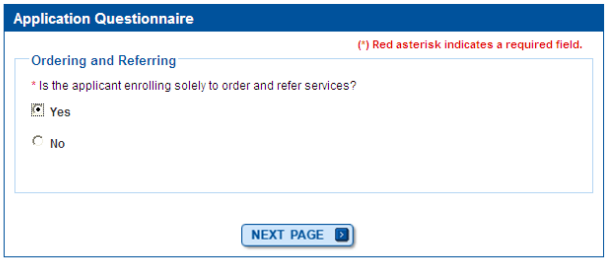

Welcome and Login
https://pecos7.cms.cmsvol/pecos/login.do
Medicare Enrollment
for Providers and Suppliers
Welcome to the Medicare Provider Enrollment, Chain, and Ownership System (PECOS)
(*) Red asterisk indicates a required field.
PECOS supports the Medicare Provider and Supplier enrollment process by allowing registered users to securely and electronically submit and manage Medicare enrollment information.
USER LOGIN
You may use your NPPES or PECOS username and password to login.
* User ID
EdwardsTM
* Password
LOG IN
Forgot Password?
Manage/Update User Profile
If you are having issues with your User ID/Password and are unable to log in, please contact the External User Services (EUS) Help Desk at 1-866-484-8049/TTY 1-866-523-4759.
BECOME A REGISTERED USER
You may register for a user account if you are: an Individual Practitioner, Authorized or Delegated Official for a Provider or Supplier Organization, or an individual who works on behalf of Providers or Suppliers.
Register for a user account
Note: If you are a Medical Provider or Supplier, you must register for an NPI before enrolling with Medicare.

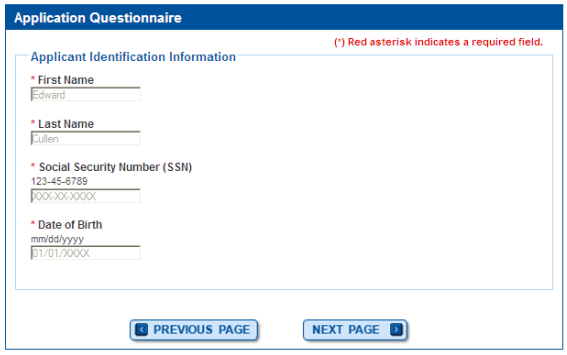

Medicare Enrollment
for Providers and Suppliers
Home | Help | Logoff
Home > My Enrollments
My Enrollments
New Application
Before you get started, please review the following checklists of information necessary to complete an enrollment via Internet-based PECOS:
Checklist for Sole Proprietor or Solely Owned Organizations (eg, LLC, PC) using PECOS
Checklist for Individual Physician and Non-Physician Practitioners using PECOS
Checklist for Provider or Supplier Organization using PECOS
To enroll in the Medicare program for the first time or to create a new enrollment, please click the "New Application" button below.
NEW APPLICATION
Existing Associates
There are no Associates currently present for the details provided.
Help
Medicare Part A Services
Medicare Part B Services
Legal Business Name
National Provider Identifier (NPI)

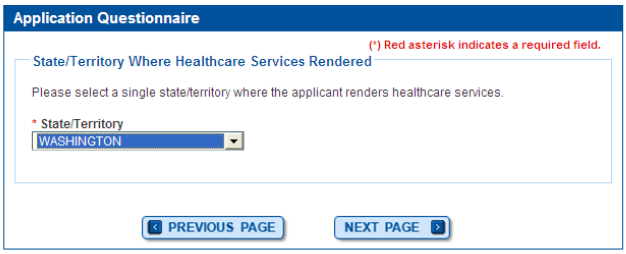

Notifications
Welcome to PECOS.
Note: JavaScript must be enabled in your internet browser for PECOS to work properly. If JavaScript is currently disabled in your browser, refer to the Accessibility section in PECOS Help for instructions on enabling JavaScript.
Manage Medicare and Account Information
MY ENROLLMENTS
ACCOUNT MANAGEMENT
Enroll in Medicare for the first time
View and update existing Medicare information
Continue working on saved applications
Update your user account information, request or remove access to organizations
Manage access to Medicare enrollments


Application Questionnaire
(*) Red asterisk indicates a required field.
Ordering and Referring
* Is the applicant enrolling solely to order and refer services?
Yes
No
NEXT PAGE

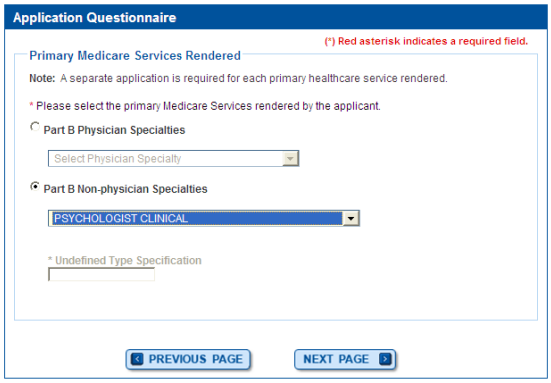

CANCEL


Home | Help | Logoff

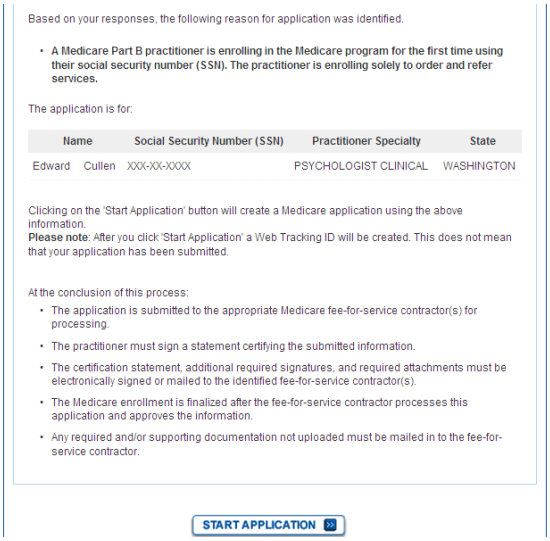

Application Questionnaire
(*) Red asterisk indicates a required field.
Applicant Identification Information
* First Name
Edward
* Last Name
Cullen
* Social Security Number (SSN)
123-45-6789
XXX-XX-XXXX
* Date of Birth
mm/dd/yyyy
01/01/XXXX
PREVIOUS PAGE
NEXT PAGE


Application Questionnaire
(*) Red asterisk indicates a required field.
State/Territory Where Healthcare Services Rendered
Please select a single state/territory where the applicant renders healthcare services.
* State/Territory
WASHINGTON
PREVIOUS PAGE
NEXT PAGE

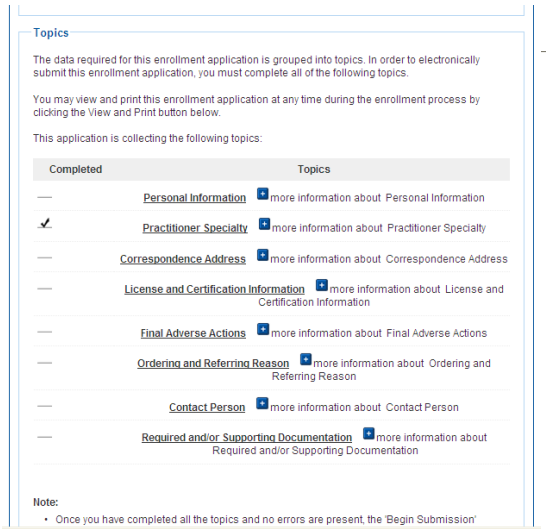

CANCEL

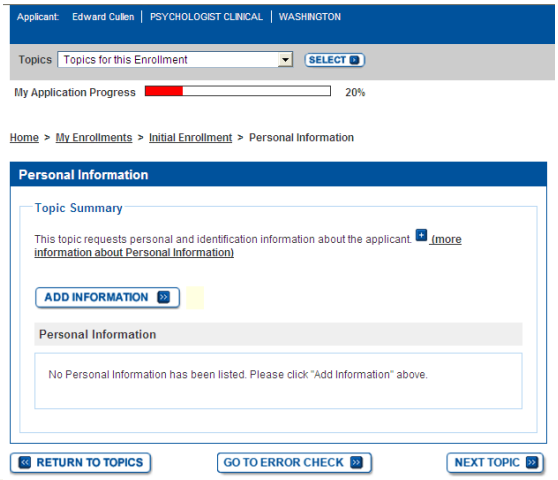

Application Questionnaire
(*) Red asterisk indicates a required field.
Primary Medicare Services Rendered
Note: A separate application is required for each primary healthcare service rendered.
* Please select the primary Medicare Services rendered by the applicant.
Part B Physician Specialties
Select Physician Specialty
Part B Non-physician Specialties
PSYCHOLOGIST CLINICAL
* Undefined Type Specification
PREVIOUS PAGE
NEXT PAGE

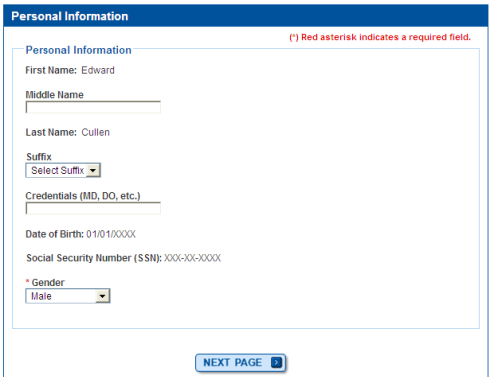

CANCEL

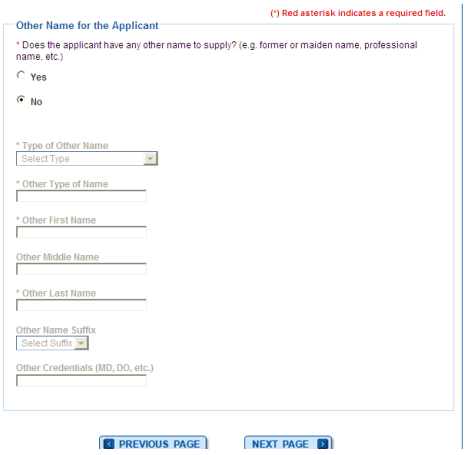

Based on your responses, the following reason for application was identified.
A Medicare Part B practitioner is enrolling in the Medicare program for the first time using their social security number (SSN). The practitioner is enrolling solely to order and refer services.
The application is for:
Name
Social Security Number (SSN)
Practitioner Specialty
State
Edward Cullen XXX-XX-XXXX PSYCHOLOGIST CLINICAL WASHINGTON
Clicking on the 'Start Application' button will create a Medicare application using the above information.
Please note: After you click 'Start Application' a Web Tracking ID will be created. This does not mean that your application has been submitted.
At the conclusion of this process:
The application is submitted to the appropriate Medicare fee-for-service contractor(s) for processing.
The practitioner must sign a statement certifying the submitted information.
The certification statement, additional required signatures, and required attachments must be electronically signed or mailed to the identified fee-for-service contractor(s).
The Medicare enrollment is finalized after the fee-for-service contractor processes this application and approves the information.
Any required and/or supporting documentation not uploaded must be mailed in to the fee-for-service contractor.

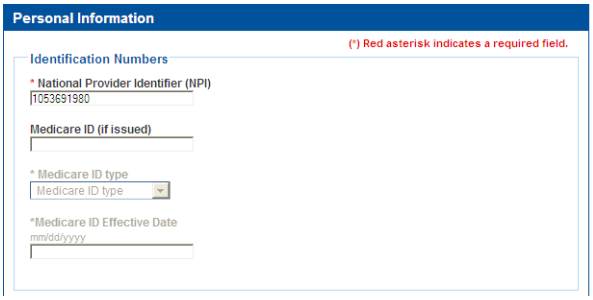
START APPLICATION

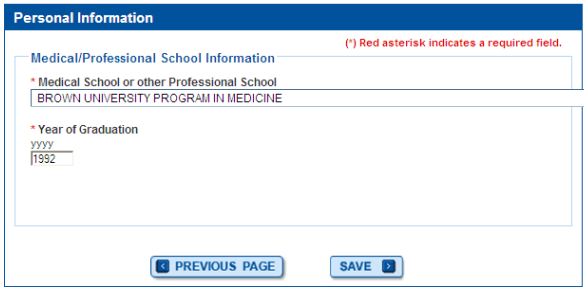

Topics
The data required for this enrollment application is grouped into topics. In order to electronically submit this enrollment application, you must complete all of the following topics.
You may view and print this enrollment application at any time during the enrollment process by clicking the View and Print button below.
This application is collecting the following topics:
Completed
Topics
Personal Information
more information about Personal Information
Practitioner Specialty
more information about Practitioner Specialty
Correspondence Address
more information about Correspondence Address
License and Certification Information
more information about License and Certification Information
Final Adverse Actions
more information about Final Adverse Actions
Ordering and Referring Reason
more information about Ordering and Referring Reason
Contact Person
more information about Contact Person
Required and/or Supporting Documentation
more information about Required and/or Supporting Documentation
Note:
Once you have completed all the topics and no errors are present, the 'Begin Submission'

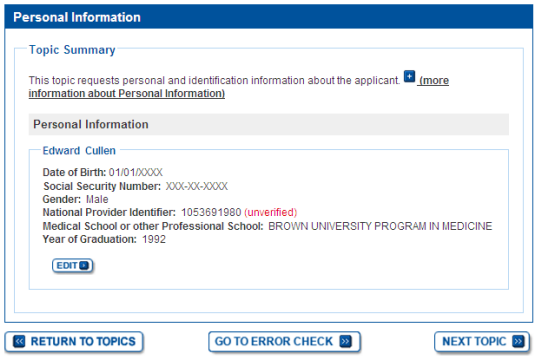

Applicant: Edward Cullen | PSYCHOLOGIST CLINICAL | WASHINGTON
Topics
Topics for this Enrollment
SELECT
My Application Progress
20%
Home > My Enrollments > Initial Enrollment > Personal Information
Personal Information
Topic Summary
This topic requests personal and identification information about the applicant. (more information about Personal Information)
ADD INFORMATION
Personal Information
No Personal Information has been listed. Please click "Add Information" above.
RETURN TO TOPICS
GO TO ERROR CHECK
NEXT TOPIC

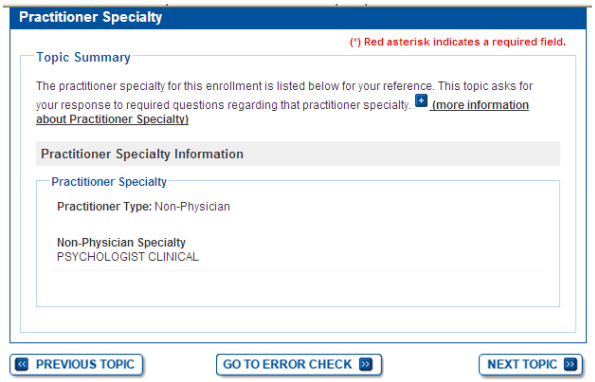

Personal Information
(*) Red asterisk indicates a required field.
Personal Information
First Name: Edward
Middle Name
Last Name: Cullen
Suffix
Select Suffix
Credentials (MD, DO, etc.)
Date of Birth: 01/01/XXXX
Social Security Number (SSN): XXX-XX-XXXX
* Gender
Male
NEXT PAGE

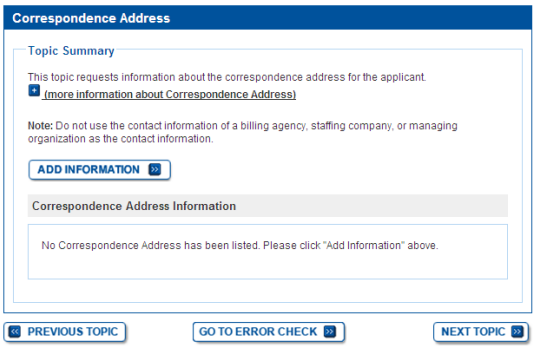

(*) Red asterisk indicates a required field.
Other Name for the Applicant
* Does the applicant have any other name to supply? (e.g. former or maiden name, professional name, etc.)
Yes
No
* Type of Other Name
Select Type
* Other Type of Name
* Other First Name
Other Middle Name
* Other Last Name
Other Name Suffix
Select Suffix
Other Credentials (MD, DO, etc.)
PREVIOUS PAGE
NEXT PAGE

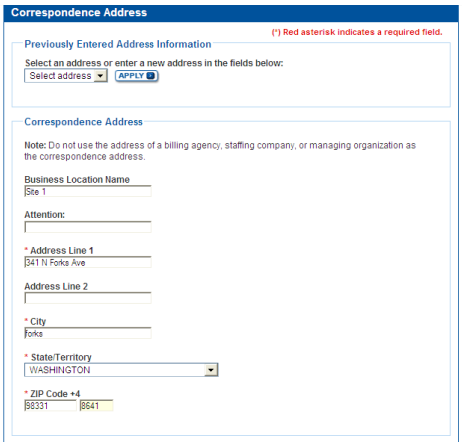

Personal Information
(*) Red asterisk indicates a required field.
Identification Numbers
* National Provider Identifier (NPI)
1053691980
Medicare ID (if issued)
* Medicare ID type
Medicare ID type
*Medicare ID Effective Date
mm/dd/yyyy


Personal Information
(*) Red asterisk indicates a required field.
Medical/Professional School Information
* Medical School or other Professional School
BROWN UNIVERSITY PROGRAM IN MEDICINE
* Year of Graduation
yyyy
1992
PREVIOUS PAGE
SAVE

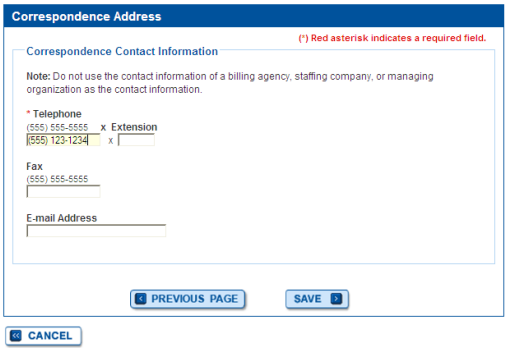

Personal Information
Topic Summary
This topic requests personal and identification information about the applicant. (more information about Personal Information)
Personal Information
Edward Cullen
Date of Birth: 01/01/XXXX
Social Security Number: XXX-XX-XXXX
Gender: Male
National Provider Identifier: 1053691980 (unverified)
Medical School or other Professional School: BROWN UNIVERSITY PROGRAM IN MEDICINE
Year of Graduation: 1992
EDIT
RETURN TO TOPICS
GO TO ERROR CHECK
NEXT TOPIC

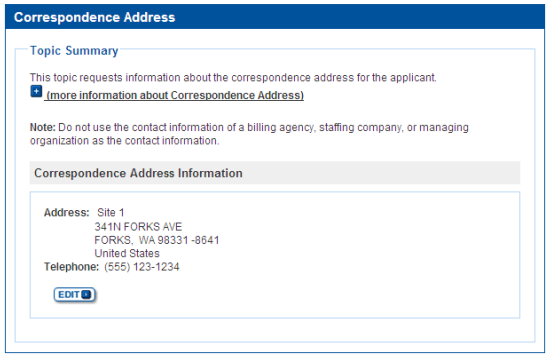

Practitioner Specialty
(*) Red asterisk indicates a required field.
Topic Summary
The practitioner specialty for this enrollment is listed below for your reference. This topic asks for your response to required questions regarding that practitioner specialty. (more information about Practitioner Specialty)
Practitioner Specialty Information
Practitioner Specialty
Practitioner Type: Non-Physician
Non-Physician Specialty
PSYCHOLOGIST CLINICAL
PREVIOUS TOPIC
GO TO ERROR CHECK
NEXT TOPIC

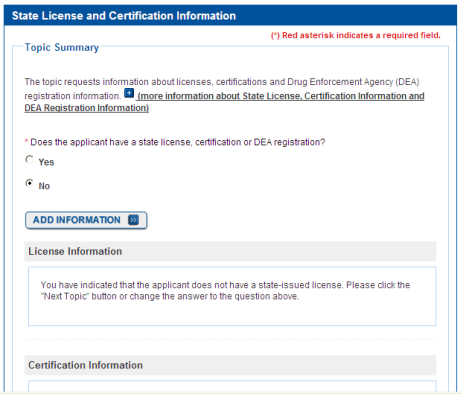

Correspondence Address
Topic Summary
This topic requests information about the correspondence address for the applicant.
(more information about Correspondence Address)
Note: Do not use the contact information of a billing agency, staffing company, or managing organization as the contact information.
ADD INFORMATION
Correspondence Address Information
No Correspondence Address has been listed. Please click "Add Information" above.
PREVIOUS TOPIC
GO TO ERROR CHECK
NEXT TOPIC

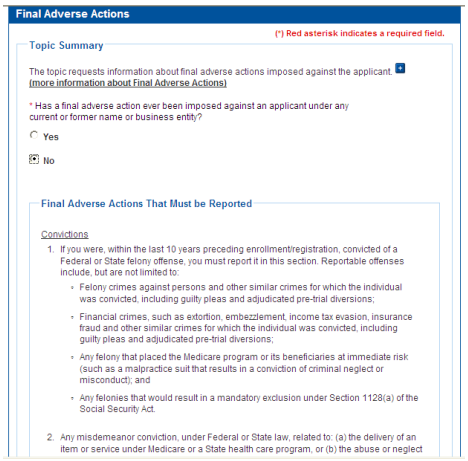

Correspondence Address
(*) Red asterisk indicates a required field.
Previously Entered Address Information
Select an address or enter a new address in the fields below:
Select address
APPLY
Correspondence Address
Note: Do not use the address of a billing agency, staffing company, or managing organization as the correspondence address.
Business Location Name
Site 1
Attention:
* Address Line 1
341 N Forks Ave
Address Line 2
* City
forks
* State/Territory
WASHINGTON
* ZIP Code +4
98331
8641

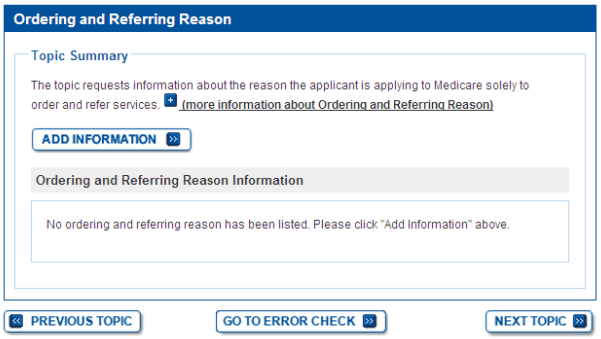

Address Verification
(*) Red asterisk indicates a required field.
Address Verification
The address you have provided did not verify with the United States Postal Service (USPS) database. We have identified a verified, standardized address that corresponds to the address you provided.
* Please select the address that you would like to submit:
Verified USPS address:
341N FORKS AVE
FORKS, WA 98331 -8641
Address you entered:
341 N Forks Ave
forks, WA 98331 -8641
PREVIOUS PAGE
NEXT PAGE

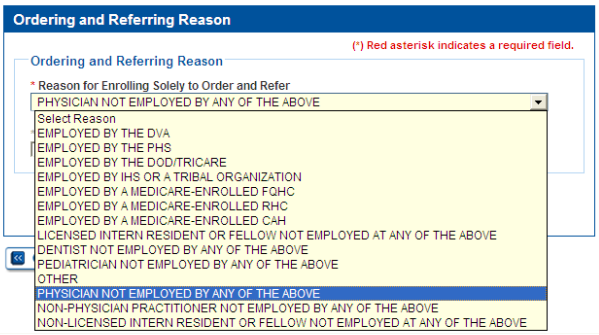

Correspondence Address
(*) Red asterisk indicates a required field.
Correspondence Contact Information
Note: Do not use the contact information of a billing agency, staffing company, or managing organization as the contact information.
* Telephone
(555) 555-5555 x Extension
(555) 123-1234 x
Fax
(555) 555-5555
E-mail Address
PREVIOUS PAGE
SAVE
CANCEL

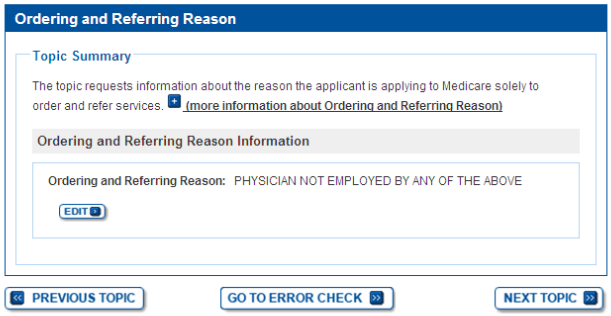

Correspondence Address
Topic Summary
This topic requests information about the correspondence address for the applicant.
(more information about Correspondence Address)
Note: Do not use the contact information of a billing agency, staffing company, or managing organization as the contact information.
Correspondence Address Information
Address: Site 1
341N FORKS AVE
FORKS, WA 98331 -8641
United States
Telephone: (555) 123-1234
EDIT
PREVIOUS TOPIC
GO TO ERROR CHECK
NEXT TOPIC

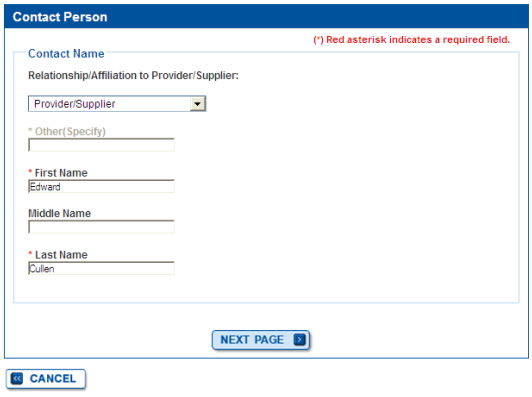

State License and Certification Information
(*) Red asterisk indicates a required field.
Topic Summary
The topic requests information about licenses, certifications and Drug Enforcement Agency (DEA) registration information.
(more information about State License, Certification Information and DEA Registration Information)
* Does the applicant have a state license, certification or DEA registration?
Yes
No
ADD INFORMATION
License Information
You have indicated that the applicant does not have a state-issued license. Please click the "Next Topic" button or change the answer to the question above.
Certification Information

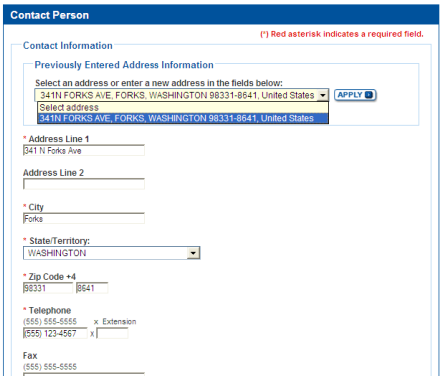

Final Adverse Actions
(*) Red asterisk indicates a required field.
Topic Summary
The topic requests information about final adverse actions imposed against the applicant.
(more information about Final Adverse Actions)
* Has a final adverse action ever been imposed against an applicant under any current or former name or business entity?
Yes
No
Final Adverse Actions That Must be Reported
Convictions
1. If you were, within the last 10 years preceding enrollment/registration, convicted of a Federal or State felony offense, you must report it in this section. Reportable offenses include, but are not limited to:
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

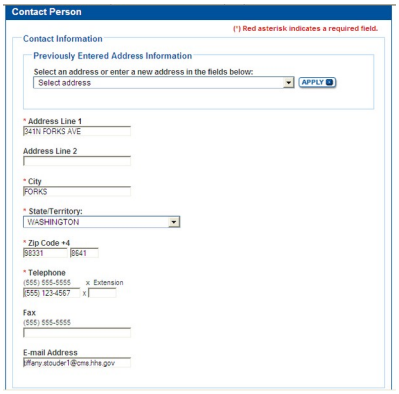

Ordering and Referring Reason
Topic Summary
The topic requests information about the reason the applicant is applying to Medicare solely to order and refer services.
(more information about Ordering and Referring Reason)
ADD INFORMATION
Ordering and Referring Reason Information
No ordering and referring reason has been listed. Please click "Add Information" above.
PREVIOUS TOPIC
GO TO ERROR CHECK
NEXT TOPIC


Ordering and Referring Reason
(*) Red asterisk indicates a required field.
Ordering and Referring Reason
* Reason for Enrolling Solely to Order and Refer
PHYSICIAN NOT EMPLOYED BY ANY OF THE ABOVE
Select Reason
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
LICENSED INTERN 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
PHYSICIAN NOT EMPLOYED BY ANY OF THE ABOVE
NON-PHYSICIAN PRACTITIONER NOT EMPLOYED BY ANY OF THE ABOVE
NON-LICENSED INTERN RESIDENT OR FELLOW NOT EMPLOYED AT ANY OF THE ABOVE

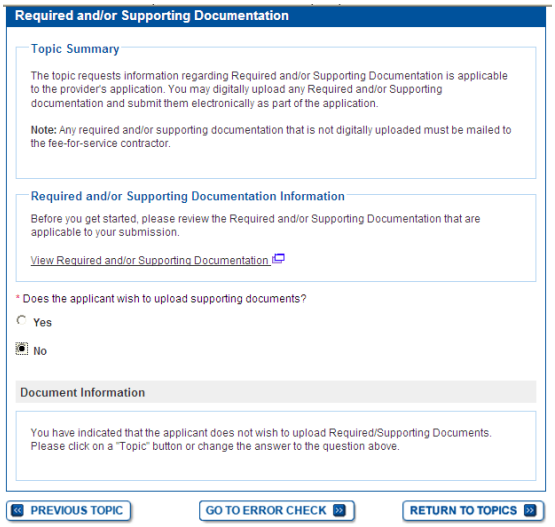

Ordering and Referring Reason
Topic Summary
The topic requests information about the reason the applicant is applying to Medicare solely to order and refer services.
(more information about Ordering and Referring Reason)
Ordering and Referring Reason Information
Ordering and Referring Reason: PHYSICIAN NOT EMPLOYED BY ANY OF THE ABOVE
EDIT
PREVIOUS TOPIC
GO TO ERROR CHECK
NEXT TOPIC

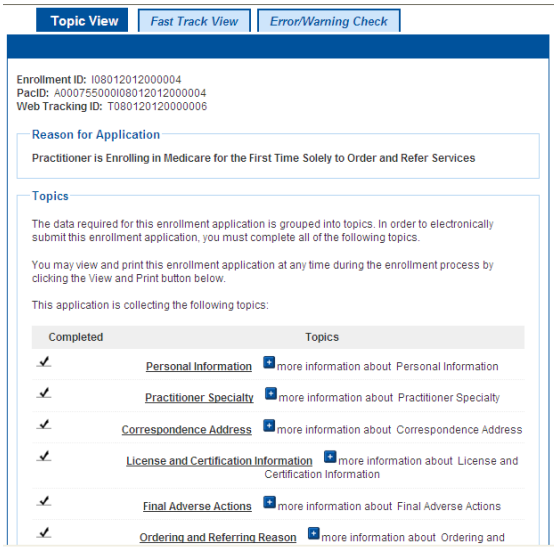

Contact Person
(*) Red asterisk indicates a required field.
Contact Name
Relationship/Affiliation to Provider/Supplier:
Provider/Supplier
* Other(Specify)
* First Name
Edward
Middle Name
* Last Name
Cullen
NEXT PAGE
CANCEL

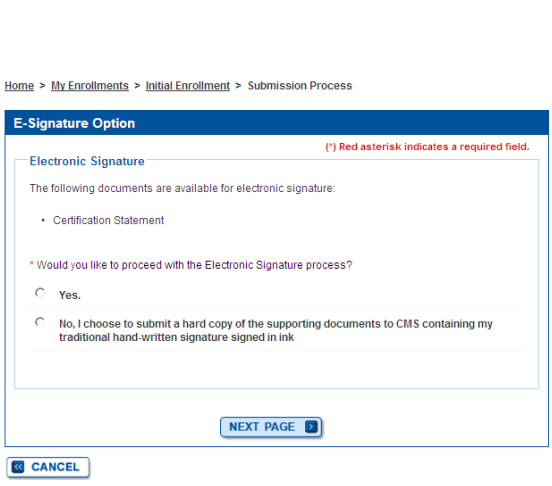

Contact Person
(*) Red asterisk indicates a required field.
Contact Information
Previously Entered Address Information
Select an address or enter a new address in the fields below:
341N FORKS AVE, FORKS, WASHINGTON 98331-8641, United States
APPLY
Select address
341N FORKS AVE, FORKS, WASHINGTON 98331-8641, United States
* Address Line 1
341 N Forks Ave
Address Line 2
* City
Forks
* State/Territory:
WASHINGTON
* Zip Code +4
98331
8641
* Telephone
(555) 555-5555
x Extension
(555) 123-4567
Fax
(555) 555-5555

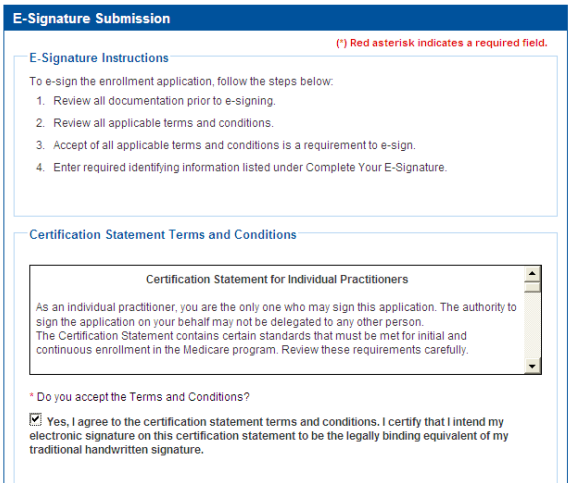

Contact Person
(*) Red asterisk indicates a required field.
Contact Information
Previously Entered Address Information
Select an address or enter a new address in the fields below:
Select address
APPLY
* Address Line 1
341N FORKS AVE
Address Line 2
* City
FORKS
* State/Territory:
WASHINGTON
* Zip Code +4
98331
8641
* Telephone
(555) 555-5555
x Extension
(555) 123-4567
Fax
(555) 555-5555
E-mail Address
tiffany.stouder1@cms.hhs.gov

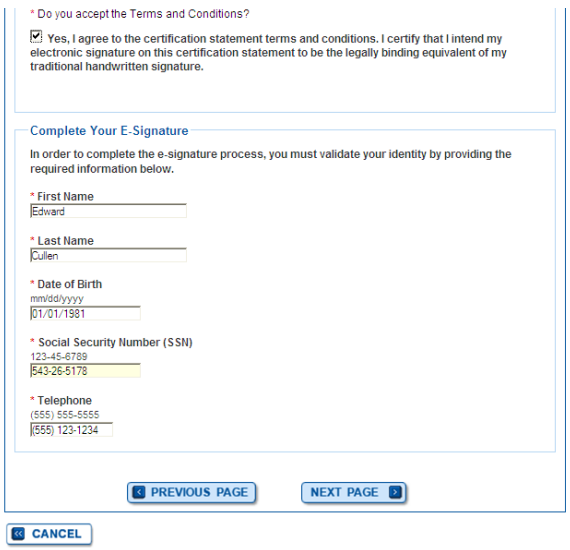

Contact Person
Topic Summary
The topic requests information about the person or persons that the Medicare contractor should contact if any questions exist about the application.
(more information about Contact Person)
ADD INFORMATION
Contact Person Information
Edward Cullen
Relationship/Affiliation to Provider/Supplier: Provider/Supplier
Address: 341N FORKS AVE
FORKS, WA 98331-8641
Telephone: (555) 123-4567
E-mail Address: tiffany.stouder1@cms.hhs.gov
EDIT
DELETE
PREVIOUS TOPIC
GO TO ERROR CHECK
NEXT TOPIC

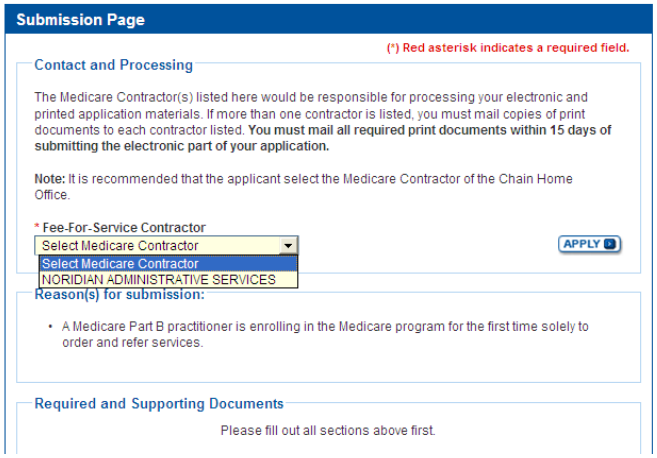

Required and/or Supporting Documentation
Topic Summary
The topic requests information regarding Required and/or Supporting Documentation is applicable to the provider's application. You may digitally upload any Required and/or Supporting documentation and submit them electronically as part of the application.
Note: Any required and/or supporting documentation that is not digitally uploaded must be mailed to the fee-for-service contractor.
Required and/or Supporting Documentation Information
Before you get started, please review the Required and/or Supporting Documentation that are applicable to your submission.
View Required and/or Supporting Documentation
* Does the applicant wish to upload supporting documents?
Yes
No
Document Information
You have indicated that the applicant does not wish to upload Required/Supporting Documents. Please click on a "Topic" button or change the answer to the question above.
PREVIOUS TOPIC
GO TO ERROR CHECK
RETURN TO TOPICS

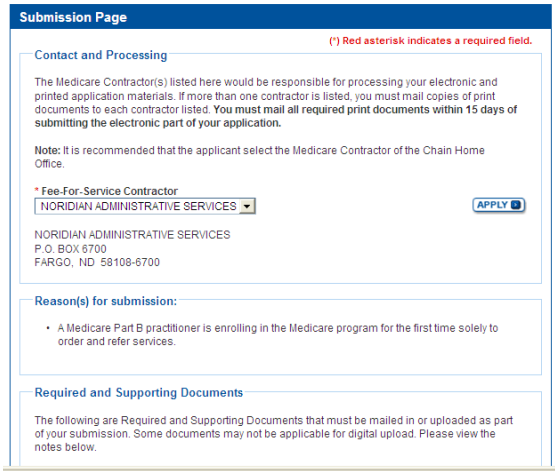

Topic View
Fast Track View
Error/Warning Check
Enrollment ID: I08012012000004
PacID: A00075500008012012000004
Web Tracking ID: T080120120000006
Reason for Application
Practitioner is Enrolling in Medicare for the First Time Solely to Order and Refer Services
Topics
The data required for this enrollment application is grouped into topics. In order to electronically submit this enrollment application, you must complete all of the following topics.
You may view and print this enrollment application at any time during the enrollment process by clicking the View and Print button below.
This application is collecting the following topics:
Completed
Topics
Personal Information
more information about Personal Information
Practitioner Specialty
more information about Practitioner Specialty
Correspondence Address
more information about Correspondence Address
License and Certification Information
more information about License and Certification Information
Final Adverse Actions
more information about Final Adverse Actions
Ordering and Referring Reason
more information about Ordering and


Home > My Enrollments > Initial Enrollment > Submission Process
E-Signature Option
(*) Red asterisk indicates a required field.
Electronic Signature
The following documents are available for electronic signature:
• Certification Statement
* Would you like to proceed with the Electronic Signature process?
Yes.
No, I choose to submit a hard copy of the supporting documents to CMS containing my traditional hand-written signature signed in ink
NEXT PAGE
CANCEL


E-Signature Submission
(*) Red asterisk indicates a required field.
E-Signature Instructions
To e-sign the enrollment application, follow the steps below:
1. Review all documentation prior to e-signing.
2. Review all applicable terms and conditions.
3. Accept of all applicable terms and conditions is a requirement to e-sign.
4. Enter required identifying information listed under Complete Your E-Signature.
Certification Statement Terms and Conditions
Certification Statement for Individual Practitioners
As an individual practitioner, you are the only one who may 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. Review these requirements carefully.
* Do you accept the Terms and Conditions?
Yes, I agree to the certification statement terms and conditions. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my traditional handwritten signature.


* Do you accept the Terms and Conditions?
Yes, I agree to the certification statement terms and conditions. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my traditional handwritten signature.
Complete Your E-Signature
In order to complete the e-signature process, you must validate your identity by providing the required information below.
* First Name
Edward
* Last Name
Cullen
* Date of Birth
mm/dd/yyyy
01/01/1981
* Social Security Number (SSN)
123-45-6789
543-26-5178
* Telephone
(555) 555-5555
(555) 123-1234
PREVIOUS PAGE
NEXT PAGE
CANCEL


Submission Page
(*) Red asterisk indicates a required field.
Contact and Processing
The Medicare Contractor(s) listed here would be responsible for processing your electronic and printed application materials. If more than one contractor is listed, you must mail copies of print documents to each contractor listed. You must mail all required print documents within 15 days of submitting the electronic part of your application.
Note: It is recommended that the applicant select the Medicare Contractor of the Chain Home Office.
* Fee-For-Service Contractor
Select Medicare Contractor
Select Medicare Contractor
NORIDIAN ADMINISTRATIVE SERVICES
APPLY
Reason(s) for submission:
• A Medicare Part B practitioner is enrolling in the Medicare program for the first time solely to order and refer services.
Required and Supporting Documents
Please fill out all sections above first.


Submission Page
(*) Red asterisk indicates a required field.
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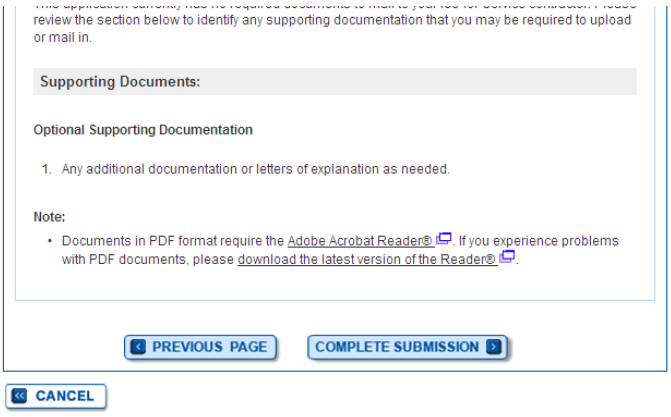
Note: It is recommended that the applicant select the Medicare Contractor of the Chain Home Office.
* Fee-For-Service Contractor
NORIDIAN ADMINISTRATIVE SERVICES
APPLY
NORIDIAN ADMINISTRATIVE SERVICES
P.O. BOX 6700
FARGO, ND 58108-6700
Reason(s) for submission:
• A Medicare Part B practitioner is enrolling in the Medicare program for the first time solely to order and refer services.
Required and Supporting Documents
The following are Required and Supporting Documents that must be mailed in or uploaded as part of your submission. Some documents may not be applicable for digital upload. Please view the notes below.


review the section below to identify any supporting documentation that you may be required to upload or mail in.
Supporting Documents:
Optional Supporting Documentation
1. Any additional documentation or letters of explanation as needed.
Note:
• Documents in PDF format require the Adobe Acrobat Reader®. If you experience problems with PDF documents, please download the latest version of the Reader®.
PREVIOUS PAGE
COMPLETE SUBMISSION
CANCEL