

## 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 NPDES or PECOS username and password to login.

\* User ID

\* Password

[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 IDP](#) before enrolling with Medicare.

## 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 \(e.g. LLC, P.C.\) 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.

### Existing Associates

There are no Associates currently present for the details provided.

### Help

- [Medicare Part A Services](#)
- [Medicare Part B Services](#)
- [Local 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**

- Enroll in Medicare for the first time
- View and update existing Medicare information
- Continue working on saved applications

**ACCOUNT MANAGEMENT**

- 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  
11/01/XXXX

**PREVIOUS PAGE**      **NEXT PAGE**

**CANCEL**

**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**

**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
—	<a href="#">Personal Information</a> <small>more information about Personal Information</small>
✓	<a href="#">Practitioner Specialty</a> <small>more information about Practitioner Specialty</small>
—	<a href="#">Correspondence Address</a> <small>more information about Correspondence Address</small>
—	<a href="#">License and Certification Information</a> <small>more information about License and Certification Information</small>
—	<a href="#">Final Adverse Actions</a> <small>more information about Final Adverse Actions</small>
—	<a href="#">Ordering and Referring Reason</a> <small>more information about Ordering and Referring Reason</small>
—	<a href="#">Contact Person</a> <small>more information about Contact Person</small>
—	<a href="#">Required and/or Supporting Documentation</a> <small>more information about Required and/or Supporting Documentation</small>

### 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](#)

## Other Name for the Applicant

(\*) Red asterisk indicates a required field.

\* 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)

Medicare ID (if issued)

\* Medicare ID type

\* Medicare ID Effective Date

**Personal Information** (\*) Red asterisk indicates a required field.

**Medical/Professional School Information**

\* Medical School or other Professional School

\* Year of Graduation

[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

**Previously Entered Address Information** (\*) Red asterisk indicates a required field.

Select an address or enter a new address in the fields below:  
 Select address

**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:**  
 Forks

\* **Address Line 1**  
 341 N Forks Ave

**Address Line 2**

\* **City**  
 Forks

\* **State/Territory**  
 WASHINGTON

\* **ZIP Code +4**  
 98331 8641

### Address Verification

**Address Verification** (\*) Red asterisk indicates a required field.

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

**Correspondence Contact Information** (\*) Red asterisk indicates a required field.

**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

**Topic Summary** (\*) Red asterisk indicates a required field.

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 FGHC

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

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 x

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:

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 x

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: 109012012000004  
PacID: 400075500008012012000004  
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
<input checked="" type="checkbox"/>	<a href="#">Personal Information</a> more information about Personal Information
<input checked="" type="checkbox"/>	<a href="#">Practitioner Specialty</a> more information about Practitioner Specialty
<input checked="" type="checkbox"/>	<a href="#">Correspondence Address</a> more information about Correspondence Address
<input checked="" type="checkbox"/>	<a href="#">License and Certification Information</a> more information about License and Certification Information
<input checked="" type="checkbox"/>	<a href="#">Final Adverse Actions</a> more information about Final Adverse Actions
<input checked="" type="checkbox"/>	<a href="#">Ordering and Referring Reason</a> more information about Ordering and

### 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**

\* 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  
643-26-5178

\* 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

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.

### 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.

### 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.

The applicant entering this page is required to identify any supporting documentation that 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**