MEDICARE ENROLLMENT APPLICATION

PHYSICIANS AND NON-PHYSICIAN PRACTITIONERS

CMS-855I

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

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

SEE SECTION 13 FOR A LIST OF SUPPORTING DOCUMENTATION TO BE SUBMITTED WITH THIS APPLICATION.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-xxxx

WHO SHOULD COMPLETE AND SUBMIT THIS APPLICATION

All physicians, as well as all non-physician practitioners listed below, must complete this application to enroll in the Medicare program and receive a Medicare billing number.

- Anesthesiology assistant
- Audiologist
- Certified clinical nurse specialist
- Certified nurse midwife
- Certified registered nurse anesthetist
- Clinical social worker
- Mass immunization roster biller
- Nurse practitioner
- Occupational therapist in private practice
- Physical therapist in private practice
- Physician assistant
- Psychologist, clinical
- Psychologist billing independently
- Registered dietitian or nutrition professional
- Speech language pathologist

If your non-physician practitioner type is not listed above, contact your designated Medicare Administrative Contractor (MAC) before you submit this application.

Complete this application if you are an individual practitioner who plans to bill Medicare and you are:

- An individual practitioner who will provide services in a private setting.
- An individual practitioner who will provide services in a group setting.
- An individual practitioner who has formed a professional corporation, professional association, limited liability company, etc., of which you are the sole owner.
- Currently enrolled in Medicare and you received notice to revalidate your enrollment.
- Currently enrolled in Medicare and your current Medicare billing number has been deactivated and you need to reactivate it to resume billing.
- Currently enrolled in Medicare but need to enroll in another MACs jurisdiction (e.g., you have opened a practice location in a geographic territory serviced by another MAC).
- Currently enrolled in Medicare and need to make changes to your enrollment information (e.g., you have added or changed a practice location).
- Voluntarily terminating your Medicare enrollment.

If you provide services in a group/clinic or other health care organization setting, you will also need to complete the CMS-855R (Reassignment of Medicare Benefits), to reassign your benefits to each group/clinic/organization. If you terminate your association with a group/clinic/organization, use the CMS-855R to report that termination.

Physicians and non-physician practitioners can apply for enrollment 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
- Submit the paper CMS-855I application. Be sure you are using the most current version.

For additional information regarding the Medicare enrollment process, including Internet-based PECOS and to get the current version of the CMS-855I, go to **http://www.cms.gov/MedicareProviderSupEnroll**.

BILLING NUMBER AND NATIONAL PROVIDER IDENTIFIER INFORMATION

The Provider Transaction Access Number (PTAN), often referred to as a Medicare Supplier Number or Medicare Billing Number is a generic term for any number other than the National Provider Identifier (NPI) that is used by a practitioner to bill the Medicare program.

The National Provider Identifier (NPI) is the standard unique health identifier for health care providers and suppliers and is assigned by the National Plan and Provider Enumeration System (NPPES). **To enroll in Medicare, you must obtain an NPI and furnish it on this application prior to enrolling in Medicare or when submitting a change to your existing Medicare enrollment information.** Applying for the NPI is a process separate from Medicare enrollment. To obtain an NPI, you may apply online at **https://nppes.cms.hhs.gov**. For more information about NPI enumeration, visit **www.cms.gov/NationalProvIdentStand.**

NOTE: The Name and Social Security Number (SSN) that you furnish in Section 2A must be the same Name and SSN you used to obtain your National Provider Identifier (NPI). Your Name, SSN and National Provider Identifier ***must*** match exactly in both the Medicare Provider Enrollment Chain and Ownership System (PECOS) and the National Plan and Provider Enumeration System (NPPES).

INSTRUCTIONS FOR COMPLETING THIS APPLICATION

- Type or print all information so that it is legible. Do not use pencil. Blue ink preferred.
- When necessary to report additional information, copy and complete the applicable section as needed.
- Attach all required supporting documentation.
- Keep a copy of your completed Medicare enrollment package for your own records.

TIPS TO AVOID DELAYS IN YOUR ENROLLMENT

To avoid delays in the enrollment process, you should:

- Complete all required sections, as shown in Section 1.
- Ensure that the correspondence address shown in Section 9A is the practitioner's address.
- Enter your NPI(s) in the applicable section(s).
- Include the Electronic Funds Transfer (EFT) Authorization Agreement with your enrollment application.
- Sign and Date Section 15.
- Respond timely to development/information requests.

IMPORTANT INFORMATION ABOUT INDIVIDUAL VERSUS ORGANIZATIONS NPIs

Individual Health Care Providers, including Sole Proprietors (Entity Type 1): Individual health care providers are eligible for an Entity Type 1 NPI (Individuals). A sole proprietor/sole proprietorship is an individual, and as such, is eligible for an individual Type 1 NPI. The sole proprietor must apply for this NPI using his or her own Social Security Number (SSN), not an Employer Identification Number (EIN) even if he/she has an EIN.

Organization Health Care Providers (Entity Type 2): Organization health care providers are group health care providers, not individual providers, and are eligible for an Entity Type 2 NPI (Organizations). Organization health care providers may have a single employee or thousands of employees. For example, an incorporated individual may be the only health care provider who is employed by that organization provider (the corporation that he/she formed). Examples of organization providers include hospitals, home health agencies, clinics, nursing homes, ambulance companies, and health care provider corporations formed by individuals.

ADDITIONAL INFORMATION

The MAC 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 within 30 days of the request.

The information you provide on this form 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.

ACRONYMS COMMONLY USED IN THIS APPLICATION

C.F.R: Code of Federal Regulation
EFT: Electronic Funds Transfer
EIN: Employer Identification Number
IHS: Indian Health Service
IRS: Internal Revenue Service
LBN: Legal Business Name
LLC: Limited Liability Corporation
MAC: Medicare Administrative Contractor
NPI: National Provider Identifier
NPPES: National Plan and Provider Enumeration System
PECOS: Provider Enrollment Chain and Ownership System
PTAN: Provider Transaction Access Number also referred to as the Medicare Identification Number
SSN: Social Security Number
TIN: Tax Identification Number
U.S.C.: United States Code

WHERE TO MAIL YOUR APPLICATION

Send the completed application with original signatures and all required documentation to your designated MAC. The MAC that services your State is responsible for processing your enrollment application. To locate the mailing address for your designated MAC, go to **www.cms.gov/MedicareProviderSupEnroll**.

SECTION 1: BASIC INFORMATION

A. REASON FOR SUBMITTING THIS APPLICATION

Check one box and complete the sections of this application as indicated.

☐ You are a **new enrollee** in Medicare	**Complete all applicable sections**
☐ You are **enrolling with another Medicare Administrative Contractor (MAC)**	**Complete all applicable sections**
☐ You are **revalidating** your Medicare enrollment	**Complete all applicable sections**
☐ You are **reactivating** your Medicare enrollment	**Complete all applicable sections**
☐ You are **reporting a change** to your Medicare enrollment information	**Go to Section 1B below**
☐ You are **voluntarily terminating** your Medicare enrollment **NOTE:** This is not the same as "opting out" of the Medicare Program. Effective date of termination *(mm/dd/yyyy)*: _____	**Sections 1A, 2A, 11 (optional), and 15** **Physician Assistants must complete Sections 1A, 1B, 2A, 5B, 11 (optional), and 15** **Employers terminating Physician Assistants must complete Sections 1A, 1B, 2A, 5B, 11 (optional), and 15**

B. WHAT INFORMATION IS CHANGING?

Check all that apply and complete the required sections.

Please note: When reporting ANY change of information, Sections 1, 2A, 3 and 15 MUST always be completed. Otherwise, only complete the information that is changing within the required section or sub-section.

☐ Personal Identifying Information	**1, 2A, 3, 11 (optional)** and **15**
☐ Final Adverse Actions	**1, 2A, 3, 11 (optional)** and **15**
☐ Medical Specialty Information	**1, 2A, 3, 4, 11 (optional)** and **15**
☐ Supplier Specific Information	**1, 2A, 3, 5A–5E as applicable, 11 (optional)** and **15**
☐ Physician Assistant Employment Arrangements	**1, 2A, 3, 5B, 11 (optional)** and **15**
☐ Private Practice Information	**1, 2A, 3, 6, 11 (optional)** and **15**
☐ Private Practice Business Information	**1, 2A, 3, 7, 11 (optional)** and **15**
☐ Managing Employee Information	**1, 2A, 3, 8, 11 (optional)** and **15**
☐ Address Information ☐ Correspondence Mailing Address ☐ Revalidation Request Package Mailing Address ☐ Remittance Notices/Special Payment Mailing Address ☐ Medicare Beneficiary Medical Records Storage Address	**1, 2A, 3, 9 as applicable for the address that is being changed, 11 (optional)** and **18**
☐ Billing Agency Information	**1, 2A, 3, 10, 11 (optional)** and **15**
☐ Any other information not specified above	**1, 2A, 3, 11 (optional)** and **15 and the applicable section or sub-section that is changing**

SECTION 2: PERSONAL IDENTIFYING INFORMATION

BEFORE COMPLETING THIS CMS-855I ENROLLMENT APPLICATION, PLEASE NOTE that with the exception of Section 12 (Group/Clinic Reassignment/Affiliation Information), ALL information furnished in this application must be about the individual identified in Section 2A (Personal Information) and the practice location in Section 6, including how and where the individual identified in Section 2A renders health care services and how that individual operates the private practice in Section 6. This ensures Medicare is able to communicate directly with the individual as well as properly reimburse the individual for services rendered to Medicare beneficiaries.

A. PERSONAL INFORMATION

Your name, date of birth, and social security number must match your social security record.

First Name	Middle Initial	Last Name	Jr., Sr., M.D., etc.
Other Name, First	Middle Initial	Last Name	Jr., Sr., M.D., etc.

Type of Other Name

☐ Former or Maiden Name ☐ Professional Name ☐ Other *(Describe)*:_____

Social Security Number (SSN)	Date of Birth *(mm/dd/yyyy)*	Gender ☐ Male ☐ Female

Medicare Identification Number (PTAN) *(if issued)*	National Provider Identifier (NPI) (Type 1 – Individual)

B. EDUCATIONAL INFORMATION

Medical or other Professional School *(Training Institution, if non-MD)*	Year of Graduation *(yyyy)*

C. RESIDENT/FELLOW STATUS

NOTE: Resident is defined as an intern, resident or fellow who participates in an approved medical residency program.

1. Are you currently in an approved training program as:
   a. A resident or intern? ☐ YES ☐ NO
   b. Or in a fellowship program? ☐ YES ☐ NO
   - If NO to both of the above questions, skip to Section 3.
   - If YES to either of the above questions, provide the name and address of the facility where you are a resident, intern or fellow below.

Name of Hospital or Facility		
Street Address		
City/Town	State	ZIP Code + 4

2. Are the services that you render at the facility shown in Section 2C1b part of your requirements for graduation from a formal residency or fellowship program? ☐ YES ☐ NO
   Date of Completion:_____
   If your completion date is prior to the beginning date for your practice in Section 6, skip to Section 3.
3. Do you also render services at other facilities or practice locations?
   If YES, you must report these practice locations in Section 6 and/or Section 12. ☐ YES ☐ NO
4. Are the services that you render in any of the practice locations you will be reporting in Section 6 or 12 part of your requirements for graduation from a residency or fellowship program? ☐ YES ☐ NO
   IF YES, has the teaching hospital reported in Section 2C1b above agreed to incur all or substantially all of the costs of training in the non-hospital facility. ☐ YES ☐ NO

SECTION 3: FINAL ADVERSE LEGAL ACTIONS

This section captures information regarding 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.

A. CONVICTIONS

1. If you were, within the last 10 years preceding enrollment or revalidation of enrollment, 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 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.

B. 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 past or current Medicare payment suspension under any Medicare billing number.
5. Any Medicare revocation of any Medicare billing number.

C. FINAL ADVERSE LEGAL ACTION HISTORY

If you are reporting a change in this section, check the box and furnish the effective date below.

☐ **Change** **Effective Date** *(mm/dd/yyyy)*: _____

1. Have you, under any current or former name, ever had a final adverse legal action listed above imposed against you?

   ☐ YES–Continue Below ☐ NO–Skip to Section 4

2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/ administrative body that imposed the action, and the resolution, if any.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

Attach a copy of the final legal adverse action documentation(s) and resolution(s).

SECTION 4: MEDICAL SPECIALTY INFORMATION

A. PHYSICIAN SPECIALTY

Designate your primary specialty and all secondary specialty(s) below using: P=Primary S=Secondary

You may select only one primary specialty. You may select multiple secondary specialties. A physician must meet all Federal and State requirements for the type of specialty(s) checked.

- ☐ Addiction Medicine
- ☐ Allergy/Immunology
- ☐ Anesthesiology
- ☐ Cardiac Electrophysiology
- ☐ Cardiac Surgery
- ☐ Cardiovascular Disease (Cardiology)
- ☐ Chiropractic
- ☐ Colorectal Surgery (Proctology)
- ☐ Critical Care (Intensivists)
- ☐ Dermatology
- ☐ Diagnostic Radiology
- ☐ Emergency Medicine
- ☐ Endocrinology
- ☐ Family Practice
- ☐ Gastroenterology
- ☐ General Practice
- ☐ General Surgery
- ☐ Geriatric Medicine
- ☐ Geriatric Psychiatry
- ☐ Gynecological Oncology
- ☐ Hand Surgery
- ☐ Hematology
- ☐ Hematology/Oncology
- ☐ Hospice/Palliative Care
- ☐ Infectious Disease
- ☐ Internal Medicine
- ☐ Interventional Pain Management
- ☐ Interventional Radiology
- ☐ Maxillofacial Surgery
- ☐ Medical Oncology
- ☐ Nephrology
- ☐ Neurology
- ☐ Neuropsychiatry
- ☐ Neurosurgery
- ☐ Nuclear Medicine
- ☐ Obstetrics/Gynecology
- ☐ Ophthalmology
- ☐ Optometry
- ☐ Oral Surgery (Dentist only)
- ☐ Orthopedic Surgery
- ☐ Osteopathic Manipulative Medicine
- ☐ Otolaryngology
- ☐ Pain Management
- ☐ Pathology
- ☐ Pediatric Medicine
- ☐ Peripheral Vascular Disease
- ☐ Physical Medicine and Rehabilitation
- ☐ Plastic and Reconstructive Surgery
- ☐ Podiatry
- ☐ Preventive Medicine
- ☐ Psychiatry
- ☐ Pulmonary Disease
- ☐ Radiation Oncology
- ☐ Rheumatology
- ☐ Sleep Medicine
- ☐ Sports Medicine
- ☐ Surgical Oncology
- ☐ Thoracic Surgery
- ☐ Urology
- ☐ Vascular Surgery
- ☐ Undefined Physician Type

(Specify):_____

B. 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 your designated MAC.

Check only one of the following: If you want to enroll as more than one non-physician specialty type, you must submit a separate CMS-855I application for each.

- ☐ Anesthesiology Assistant
- ☐ Audiologist
- ☐ Certified Nurse Midwife
- ☐ Certified Registered Nurse Anesthetist
- ☐ Certified Clinical Nurse Specialist (See Section 5E)
- ☐ Clinical Social Worker
- ☐ Mass Immunization Roster Biller
- ☐ Nurse Practitioner (See Section 5E)
- ☐ Occupational Therapist In Private Practice (See Section 5D)
- ☐ Physical Therapist In Private Practice (See Section 5D)
- ☐ Physician Assistant (See Section 5B)
- ☐ Psychologist, Clinical (See Section 5C)
- ☐ Psychologist Billing Independently (See Section 5C)
- ☐ Registered Dietitian or Nutrition Professional
- ☐ Speech Language Pathologist
- ☐ Undefined Non-Physician Practitioner Type

(Specify): _____

SECTION 5: SUPPLIER SPECIFIC INFORMATION

Complete the appropriate sub-section below where applicable for your supplier type checked in Section 4 (Medical Specialty Information).

A. LICENSE/CERTIFICATION/REGISTRATION INFORMATION (ALL SUPPLIERS)

1. License Information

☐ License Not Applicable

License Number	Effective Date *(mm/dd/yyyy)*	State Where Issued

2. Certification Information

☐ Certification Not Applicable

Certification Number	Effective Date *(mm/dd/yyyy)*	State Where Issued

3. Drug Enforcement Agency (DEA) Registration Information

☐ Registration Not Applicable

DEA Registration Number	Effective Date *(mm/dd/yyyy)*	State Where Issued

B. PHYSICIAN ASSISTANT INFORMATION

1. Physician Assistants: Establishing Employment Arrangement(s)

Complete this section if you are a physician assistant to establish your current employment arrangement(s).

EMPLOYER'S NAME	EFFECTIVE DATE OF EMPLOYMENT	EMPLOYER'S MEDICARE IDENTIFICATION NUMBER (IF ISSUED)	EMPLOYER'S NPI	EMPLOYER'S EIN

2. Physician Assistants: Terminating Employment Arrangement(s)

Complete this section if you are a physician assistant discontinuing a current employment arrangement(s).

EMPLOYER'S NAME	EFFECTIVE DATE OF EMPLOYMENT	EMPLOYER'S MEDICARE IDENTIFICATION NUMBER (IF ISSUED)	EMPLOYER'S NPI	EMPLOYER'S EIN

3. Employer Terminating Employment Arrangement with One or More Physician Assistants

Complete this section if you are an individual practitioner who has incorporated or is a sole proprietor, and you are discontinuing the employment arrangement of a physician assistant(s).

PHYSICIANS ASSISTANT'S NAME	EFFECTIVE DATE OF DEPARTURE	PHYSICIANS ASSISTANT'S MEDICARE IDENTIFICATION NUMBER A (IF ISSUED)	PHYSICIANS ASSISTANT'S NPI

SECTION 5: SUPPLIER SPECIFIC INFORMATION *(Continued)*

C. PSYCHOLOGIST INFORMATION

1. Clinical Psychologists

Do you hold a doctoral degree in psychology? ☐ YES ☐ NO

If YES, furnish the field of your psychology degree_____

Attach a copy of the degree with this application.

2. Psychologists Billing Independently

a. Do you render services of your own responsibility free from the administrative control of an employer such as a physician, institution, or agency? ☐ YES ☐ NO

b. Do you treat your own patients? ☐ YES ☐ NO

c. Do you have the right to bill directly, and to collect and retain the fee for your services? ☐ YES ☐ NO

d. Is this private practice located in an institution? ☐ YES ☐ NO

If YES to question d above, please answer questions 1 and 2 below.

1. If your private practice is located in an institution, is your office confined to a separately identified part of the facility that is used solely as your office and cannot be construed as extending throughout the entire institution? ☐ YES ☐ NO
2. If your private practice is located in an institution, are your services also rendered to patients from outside the institution or facility where your office is located? ☐ YES ☐ NO

D. PHYSICAL/OCCUPATIONAL THERAPIST INFORMATION

Physical Therapists/Occupational Therapists in Private Practice (PT/OT)

The following questions only apply to your individual practice. They do not apply if you are reassigning all of your benefits to a group/clinic/organization.

1. Are all of your PT/OT services only rendered in the patients' homes? ☐ YES ☐ NO
2. Do you maintain private office space? ☐ YES ☐ NO
3. Do you own, lease, or rent your private office space? ☐ YES ☐ NO
4. Is this private office space used exclusively for your private practice? ☐ YES ☐ NO
5. Do you provide PT/OT services outside of your office and/or patients' homes? ☐ YES ☐ NO

If you responded YES to questions 2, 3 or 4 above, you must have and attach a copy of any written agreement that gives you exclusive use of the facility for PT/OT services.

E. NURSE/NURSE PRACTITIONER INFORMATION

Nurse Practitioners and Certified Clinical Nurse Specialists

Are you an employee of a skilled nursing facility (SNF) or of another entity that has an agreement to provide nursing services to a SNF? ☐ YES ☐ NO

If yes, furnish the SNF's name and address below.

Skilled Nursing Facility Name		
Street Address		
City	State	Zip

SECTION 6: PRIVATE PRACTICE LOCATION INFORMATION

☐ **If you do not have a private practice and render ALL of your health care services in a group or clinic setting and you reassign all your benefits to the group(s)/clinic(s), check this box and complete Section 12 (Group/ Clinic Reassignment/Affiliation Information). You do not need to complete Sections 6 through 10.**

☐ **If you render services in both your own private practice and also in a group/clinic setting where you reassign your benefits, check this box and complete Sections 6 through 11 about your private practice and Section 12 about your group/clinic reassignment/affiliations.**

Complete this section for each of your practice locations where you render services to Medicare beneficiaries. This includes all locations you will disclose on claims forms for reimbursement. If you have and see patients at more than one private practice location or health care facility, copy and complete this section for each location.

All reported practice location addresses must be a specific street address as recorded by the United States Postal Service. Your practice location must be the physical location where you render services to Medicare beneficiaries. Your practice location address cannot be a Post Office (P.O.) Box.

If you render services in a hospital, retirement or assisted living community, and/or other health care facilities, furnish the name, address and telephone number for those facilities.

If you only render services in patients' homes (house calls only), you may supply your home address in this section if you do not have a separate office. In Section 6C explain that this address is for administrative purposes only and that all services are rendered in patients' homes. You must then also complete Section 6B as appropriate.

However, on this enrollment application, only report those practice locations that are within the jurisdiction of the designated Medicare Administrative Contractor to which you will be submitting this application. If you have to report practice locations outside the jurisdiction of the designated MAC who you are submitting this application you must submit a separate CMS 855I Enrollment Application to the MAC who has jurisdiction for those locations.

If you have a CLIA Certification Number and/or FDA Radiology Certification Number for the practice location being reported below, provide that information and submit a copy of the most current CLIA and/or FDA certification for each reported practice location that is currently certified.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ **Change** ☐ **Add** ☐ **Delete** **Effective Date** *(mm/dd/yyyy)*: _____

A. PRACTICE LOCATION INFORMATION

Practice Location Name *("Doing Business As" name if different from Legal Business Name)*

Practice Location Street Address Line 1 *(Street Name and Number – NOT a P.O. Box)*

Practice Location Street Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

Medicare Identification Number for this location – PTAN *(if issued)*	Date you saw your first Medicare patient at this practice location *(mm/dd/yyyy)*

Is your private practice located in a:

☐ Private Office Setting
☐ Ambulatory Surgical Center
☐ Hospital
☐ Indian Health Services Facility (IHS)
☐ Retirement or Assisted Living Community
☐ Skilled Nursing Facility or Other Nursing Facility
☐ Other Health Care Facility
*(Specify):*_____

CLIA Number for this location *(if applicable)*	FDA Radiology (Mammography) Certification Number for this location *(if applicable)*

Accepting New Patient Status Information *(your response is optional and will be annotated with your listing in the Medicare Provider Directory)*

Are you accepting new Medicare patients? ☐ YES ☐ NO

SECTION 6: PRIVATE PRACTICE LOCATION INFORMATION *(Continued)*

B. RENDERING SERVICES IN PATIENTS' HOMES

List the city/town, county, State, and ZIP code for all locations where you render health care services in patients' homes. If you provide health care services in more than one State, complete a separate enrollment application (CMS-855I) for each State where services are rendered.

If you are adding or deleting locations, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ **Add** ☐ **Delete** **Effective Date** *(mm/dd/yyyy)*: _____

1. Initial Reporting and/or Additions
If you are reporting or adding an entire State, check the box below and specify the State.

☐ Entire State of _____

If services are provided in selected cities/towns or counties, provide the locations below. Only list ZIP codes if you are not servicing the entire city/town or county.

CITY/TOWN	COUNTY	STATE	ZIP CODE

2. Deletions
If you are deleting an entire State, check the box below and specify the State.

☐ Entire State of _____

If services are provided in selected cities/towns or counties, provide the locations below. Only list ZIP codes if you are not servicing the entire city/town or county.

CITY/TOWN	COUNTY	STATE	ZIP CODE

C. COMMENTS/SPECIAL CIRCUMSTANCES

Explain any unique circumstances concerning your practice location(s) or the method by which you render health care services (e.g., you only render services in patients' homes, nursing facilities, retirement communities, etc.).

SECTION 7: PRIVATE PRACTICE BUSINESS INFORMATION

If your private practice is established as a professional corporation, a professional association, or a limited liability company, and you are the sole owner, and will bill Medicare through this business entity, complete this section with information about your business entity.

If you are the sole owner of a professional corporation, professional association or limited liability company, and will bill Medicare through this business entity, you do not need to complete a CMS-855R to reassign your benefits as a practitioner to your business entity.

A. PRIVATE PRACTICE BUSINESS INFORMATION

Legal Business Name as Reported to the Internal Revenue Service	Tax Identification Number
Medicare Identification Number (PTAN) *(if issued)*	NPI (Type 2 – Organization) *(if issued)*
Incorporation Date *(mm/dd/yyyy) (if applicable)*	State Where Incorporated *(if applicable)*

B. EMPLOYER IDENTIFICATION NUMBER (EIN) INFORMATION

NOTE: Furnish your EIN if you are a sole proprietor and you want Medicare payments to be reported under your EIN. Unless indicated in this section, payments will be made to your SSN. You cannot use both an SSN and EIN. You can only use one EIN to bill Medicare.

To qualify for this payment arrangement, you:

- Must be a sole proprietor,
- Cannot reassign all of your Medicare payments, and
- Want your payments to be made to your EIN. Furnish IRS documentation showing your EIN.

Employer Identification Number (EIN)

C. BUSINESS STRUCTURE INFORMATION

Identify the type of business structure for your private practice (Check one):

☐ Not Publically Traded Corporation (regardless of whether "for-profit" or "non-profit")

☐ Publically Traded Corporation (regardless of whether "for-profit" or "non-profit")

☐ Sole Proprietor/Sole Proprietorship

☐ Limited Liability Company (LLC)

☐ Partnership ("general" or "limited")

☐ Other (Specify) _____

D. INTERNAL REVENUE SERVICE REGISTRATION INFORMATION

Identify how your business is registered with the IRS. (**NOTE:** If your business is a Federal and/or State government entity indicate "Non-Profit" below.)

☐ Proprietary ☐ Non-Profit ☐ Disregarded Entity

E. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for your legal business reported in Section 7A above. If you are reporting a change in this section, please check the box and list effective date below.

☐ **Change** **Effective Date** *(mm/dd/yyyy)*: _____

1. Has your business, under any current or former name or business identity, ever had a final adverse legal action listed in Section 3 of this application imposed against it?

   ☐ YES–Continue Below ☐ NO–Skip to Section 8

2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/ administrative body that imposed the action, and the resolution, if any.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

Attach a copy of the final legal adverse action documentation(s) and resolution(s).

SECTION 8: MANAGING EMPLOYEE INFORMATION

This section captures information about your managing employees. A managing employee means an individual who furnishes operational or managerial services, or who directly or indirectly conducts the day-to-day operations for your private practice, either as an employee under contract, or through some other arrangement.

All managing employees at any of your practice locations shown in Section 6 must be reported in this section. If there is more than one managing employee, copy and complete this section as needed.

A. MANAGING EMPLOYEE IDENTIFYING INFORMATION

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ **Change** ☐ **Add** ☐ **Delete** **Effective Date** *(mm/dd/yyyy)*: _____

First Name	Middle Initial	Last Name	Jr., Sr., M.D., etc.

Social Security Number *(Required)*	Date of Birth *(mm/dd/yyyy)*
Medicare Identification Number *(if issued)*	NPI *(if issued)*
Effective Date as Managing Employee *(mm/dd/yyyy)*	Termination Date *(if applicable) (mm/dd/yyyy)*

B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for the individual reported in Section 8A above. If you are reporting a change in this section, please check the box and list effective date below.

☐ **Change** **Effective Date** *(mm/dd/yyyy)*: _____

1. Has this individual in Section 8A above, under any current or former name, ever had a final adverse legal action listed in Section 3 of this application imposed against him/her?

   ☐ YES–Continue Below ☐ NO–Skip to Section 9

2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

Attach a copy of the final adverse legal action documentation and resolution.

SECTION 9: IMPORTANT ADDRESS INFORMATION

A. CORRESPONDENCE MAILING ADDRESS

This is the address where correspondence will be sent to you by your designated MAC.

☐ Check here if you want all Correspondence mailed to the address furnished below.

☐ Check here if you want all Correspondence mailed to your Practice Location address in Section 6A and skip this sub-section (9A).

If you are reporting a change in this section, check the box below and furnish the effective date.

☐ **Change** **Effective Date** *(mm/dd/yyyy)*: _____

Business Location Name *(NOT your billing agent, staffing company, or managing organization)*

Attention

Mailing Address Line 1 *(P.O. Box or Street Name and Number)*

Mailing Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number *(if applicable)*	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

B. REVALIDATION REQUEST PACKAGE MAILING ADDRESS

This is the address where your enrollment revalidation request package will be sent.

☐ Check here if your Revalidation Request Package should be mailed to the address furnished below.

☐ Check here if your Revalidation Request Package should be mailed to your Practice Location Address in Section 6A and skip this sub-section (9B).

☐ Check here if your Revalidation Request Package should be mailed to your Correspondence Address in Section 9A and skip this sub-section (9B).

If you are reporting a change in this section, check the box below and furnish the effective date.

☐ **Change** **Effective Date** *(mm/dd/yyyy)*: _____

Business Location Name *(This may be your billing agent, staffing company, or managing organization)*

Attention

Mailing Address Line 1 *(P.O. Box or Street Name and Number)*

Mailing Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number *(if applicable)*	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

SECTION 9: IMPORTANT ADDRESS INFORMATION *(Continued)*

C. REMITTANCE NOTICES/SPECIAL PAYMENTS MAILING ADDRESS

Furnish an address where remittance notices and special payments should be sent for services rendered at the practice location(s) reported in Section 6. Please note that payments will be made in your name or, if a business is reported in Section 7, payments will be made in the name of the business.

Medicare will issue all routine payments via electronic funds transfer (EFT). Since payment will be made by EFT, the "special payments" address below should indicate where all other payment information (e.g., remittance notices and non-routine "special payments") should be sent.

☐ Check here if your Remittance Notice/Special Payments should be mailed to the address furnished below.

☐ Check here if your Remittance Notice/Special Payments should be mailed to your Practice Location Address in Section 6A and skip this sub-section (9C).

☐ Check here if your Remittance Notice/Special Payments should be mailed to your Correspondence Address in Section 9A and skip this sub-section (9C).

NOTE: If you are a new enrollee, you must submit an EFT Authorization Agreement (CMS-588) with this application. If you need to make changes to your current EFT Authorization Agreement (CMS-588), contact your designated MAC.

If you are reporting a change in this section, check the box below and furnish the effective date.

☐ **Change** **Effective Date** *(mm/dd/yyyy)*: _____

"Special Payments" Address Line 1 *(PO Box or Street Name and Number)*

"Special Payments" Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

D. MEDICARE BENEFICIARY MEDICAL RECORDS STORAGE ADDRESS

If your Medicare beneficiaries' medical records are stored at a location other than the location shown in Section 6, complete this section with the name and address of the storage location. This includes the records for both current and former Medicare beneficiaries.

Post office boxes and drop boxes are not acceptable as a physical address where Medicare beneficiaries' records are maintained. The records must be your records, not the records of another practitioner. If all records are stored at the business location reported in Section 6, please indicate below.

☐ Records are stored at the business location reported in Section 6.

☐ Records are stored at the location indicated below.

If you are changing, adding, or deleting information, check the applicable box and furnish the effective date.

☐ **Change** ☐ **Add** ☐ **Delete** **Effective Date** *(mm/dd/yyyy)*: _____

1. Paper Storage

Name of Storage Facility

Storage Facility Address Line 1 *(Street Name and Number)*

Storage Facility Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

2. Electronic Storage

Do you store your patient medical records electronically? ☐ YES ☐ NO

If yes, identify where/how these records are stored below. This can be a website, URL, in-house software program, online service, vendor, etc. This must be a site that can be accessed by the MAC if necessary.

Site where electronic records stored

SECTION 10: BILLING AGENCY INFORMATION

A billing agency is a company or individual that you contract with to prepare and submit your claims. If you use a billing agency you must complete this section. Even if you use a billing agency, you are responsible for the accuracy of the claims submitted on your behalf.

☐ Check here if this section does not apply and skip to Section 11.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ **Change** ☐ **Add** ☐ **Delete** **Effective Date** *(mm/dd/yyyy)*: _____

BILLING AGENCY NAME AND ADDRESS

Legal Business Name as Reported to the Internal Revenue Service or Individual Name as reported to the Social Security Administration

If Individual, Billing Agent Date of Birth *(mm/dd/yyyy)*

Billing Agency Tax Identification Number or Billing Agent Social Security Number *(required)*

Billing Agency "Doing Business As" Name *(if applicable)*

Billing Agency Address Line 1 *(Street Name and Number)*

Billing Agency Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

Billing Agent/Agency Medicare Identification Number(s) *(if issued)*	Billing Agent/Agency NPI *(if issued)*

SECTION 11: CONTACT PERSON INFORMATION

If questions arise during the processing of this application, your designated MAC will contact the individual indicated below. If no one is listed below, your designated MAC will contact you directly.

☐ Contact person listed below.

First Name	Middle Initial	Last Name	Jr., Sr., MD., etc.

Address Line 1 *(Street Name and Number)*

Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

Relationship or Affiliation to You

NOTE: The Contact Person listed in this section will only be authorized to discuss issues concerning this enrollment application. Your designated MAC will not discuss any other enrollment issues about you with the above Contact Person.

SECTION 12: GROUP/CLINIC REASSIGNMENT/AFFILIATION INFORMATION

Complete this section with information about all group/clinic or other health care organizations to whom you will be reassigning any or all of your benefits. All information furnished below must be that of the group/clinic or health care organization and not your own, (i.e., group PTAN and group NPI).

In addition, either you or each group/clinic or health care organization you report in this section must complete and submit a CMS-855R (Individual Reassignment of Benefits) with this application. Reassigning benefits means that you are authorizing the group/clinic or health care organization to bill and receive payment from Medicare for the services you render at the group/clinic's or health care organization's practice location.

In the future, each time you join a new group/clinic or other health care organization or terminate a current affiliation you must submit a new CMS-855R. You do not need to submit an updated CMS-855I. Submission of the CMS-855R will ensure your group/clinic or other health care organization affiliations are properly maintained and current.

You do not need to submit a CMS-588 (Electronic Funds Transfer Authorization Agreement) if you are reassigning **all** of your benefits and will not bill Medicare directly for any of your services.

1. Name of Group/Clinic/Organization	
Medicare ID – PTAN of Group/Clinic/Organization	NPI of Group/Clinic/Organization
Group/Clinic/Organization Contact Person – First Name	Last Name
Contact Person Telephone Number	Contact Person Email Address *(if applicable)*

2. Name of Group/Clinic/Organization	
Medicare ID – PTAN of Group/Clinic/Organization	NPI of Group/Clinic/Organization
Group/Clinic/Organization Contact Person – First Name	Last Name
Contact Person Telephone Number	Contact Person Email Address *(if applicable)*

3. Name of Group/Clinic/Organization	
Medicare ID – PTAN of Group/Clinic/Organization	NPI of Group/Clinic/Organization
Group/Clinic/Organization Contact Person – First Name	Last Name
Contact Person Telephone Number	Contact Person Email Address *(if applicable)*

4. Name of Group/Clinic/Organization	
Medicare ID – PTAN of Group/Clinic/Organization	NPI of Group/Clinic/Organization
Group/Clinic/Organization Contact Person – First Name	Last Name
Contact Person Telephone Number	Contact Person Email Address *(if applicable)*

5. Name of Group/Clinic/Organization	
Medicare ID – PTAN of Group/Clinic/Organization	NPI of Group/Clinic/Organization
Group/Clinic/Organization Contact Person – First Name	Last Name
Contact Person Telephone Number	Contact Person Email Address *(if applicable)*

SECTION 13: SUPPORTING DOCUMENTATION INFORMATION

This section lists the documents that, if applicable, must be submitted with this enrollment application. For changes, only submit documents that are applicable to the change requested. Your designated Medicare Administrative Contractor may request, at any time during the enrollment process, documentation to support or validate information reported on this application. In addition, your designated MAC may also request documents from you other than those identified in this Section as are necessary to ensure correct billing of Medicare.

MANDATORY FOR ALL PRACTITIONER TYPES

☐ Completed Form CMS-588, Electronic Funds Transfer Authorization Agreement.
NOTE: If you already receive payments electronically and are not making a change to your banking information, the CMS-588 is not required. Physicians and non-physician practitioners who are reassigning all of their payments to another entity are not required to submit the CMS-588.

☐ Written confirmation from the IRS (e.g., IRS form CP 575) confirming your Tax Identification Number with the Legal Business Name provided in Section 7.
NOTE: This information is needed if the applicant is enrolling their professional corporation, professional association, or limited liability corporation with this application or enrolling as a sole proprietor using an Employer Identification Number.

MANDATORY, IF APPLICABLE

☐ Copy of IRS Determination Letter, if you are registered with the IRS as non-profit (e.g., IRS 501(c)(3)).

☐ Copy(s) of all final adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters).

☐ Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement.
NOTE: The CMS-460 must be submitted for all initial enrollments or reactivations only if you want to be a participating practitioner in Medicare.

☐ Completed Form CMS-855R, Individual Reassignment of Medicare Benefits.

☐ If Medicare payments due you are being sent to a bank (or similar financial institution) where you have a lending relationship (that is, any type of loan), you must provide a statement in writing **from the bank** (which must be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.

☐ Written confirmation from the IRS confirming your Limited Liability Company (LLC) is automatically classified as a Disregarded Entity (e.g., Form 8832).
NOTE: A Disregarded Entity is an eligible entity that is not treated as a separate entity from its single owner for income tax purposes.

☐ Copy of current CLIA and FDA certification for each practice location reported.

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION ON THIS APPLICATION

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.

   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.
5. 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.
6. 18 U.S.C. 1347 authorizes criminal penalties against individuals who knowing and willfully execute, or attempt, to executive 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.
7. 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.

SECTION 15: CERTIFICATION STATEMENT AND SIGNATURE

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. Review these requirements carefully.

By signing this 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.

A. CERTIFICATION STATEMENT

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.

Under the penalty of perjury, I, the undersigned, certify to the following:

1. 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 my designated Medicare Administrative Contractor of this fact in accordance with the time frames established in 42 CFR § 424.516.
2. I authorize the Medicare Administrative Contractor to verify the information contained herein. I agree to notify the Medicare Administrative Contractor of a change in ownership, practice location and/or Final Adverse Action within 30 days of the reportable event. In addition, I agree to notify the Medicare Administrative Contractor of any other changes to the information in 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. I understand that any change in the business structure of my practice may require the submission of a new application.
3. 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 denial or revocation of Medicare billing privileges, and/or the imposition of fines, civil damages, and/or imprisonment.
4. I agree to abide by the Medicare laws, regulations and program instructions that apply to me or to my business reported in Section 7 of this application. The Medicare laws, regulations, and program instructions are available through the designated Medicare Administrative 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 my compliance with all applicable conditions of participation in Medicare.
5. Neither I, nor any managing employee reported in this application, is currently sanctioned, suspended, debarred, or excluded by Medicare or State Health Care Program, e.g., Medicaid program, or any other Federal program, or is otherwise prohibited from providing services to Medicare or other Federal program beneficiaries.
6. I agree that any existing or future overpayment made to me (or to the business reported in Section 7 of this application) by the Medicare program may be recouped by Medicare through the withholding of future payments.
7. I understand that the Medicare identification number issued to me can only be used by me or by a Medicare enrolled provider or supplier to whom I have reassigned my benefits under current Medicare regulations when billing for services rendered by me.
8. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.
9. I further certify that I am the individual practitioner who is applying for Medicare billing privileges and the signature below is my signature.

B. SIGNATURE AND DATE

First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.

Practitioner Signature *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*	Date Signed *(mm/dd/yyyy)*

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

MEDICARE SUPPLIER ENROLLMENT APPLICATION PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) is authorized to collect the information requested on this form by Sections 1124, 1124A, 1814, 1815, 1833, 1834 and 1866 of the Social Security Act, Sections 501(c) and 3402(t) of the Internal Revenue Code and Section 7701(c) of the United States Code.

The purpose of collecting this information is to determine or verify the eligibility of individuals and organizations to enroll in the Medicare program as providers and 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 or suppliers 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 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 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.