MEDICARE ENROLLMENT APPLICATION

REASSIGNMENT OF MEDICARE BENEFITS

CMS-855R

SEE PAGE 1 FOR INFORMATION ON WHERE TO MAIL THIS APPLICATION.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-xxxx

WHO SHOULD COMPLETE THIS APPLICATION

Complete this application if you are reassigning your right to bill the Medicare program and receive Medicare payments for some or all of the services you render to Medicare beneficiaries, or are terminating a currently established reassignment of benefits. Reassigning your Medicare benefits allows an eligible organization/group to submit claims and receive payment for Medicare Part B services that you have provided. Such an eligible organization/group may be an individual, a clinic/group practice or other organization.

Both the individual practitioner and the eligible organization/group must be currently enrolled (or concurrently enrolling via submission of the CMS-855B for the eligible organization/group and the CMS-855I for the practitioner) in the Medicare program before the reassignment can take effect. Generally, this application is completed by the organization/group, signed by the Authorized/Delegated Official of the organization/group and the individual practitioner, and submitted by the organization/group. When terminating a current reassignment, either the organization/group or the individual practitioner may submit this application with the appropriate sections completed.

NOTE: A separate CMS-855R must be submitted for each reassignment being established or terminated.

The individual or authorized/delegated official, by his/her signature, agrees to notify the Medicare Administrative Contractor (MAC) of any future changes to the reassignment in accordance with 42 C.F.R. 424.516(d)(2).

NOTE: An individual will not need to reassign benefits to a corporation, limited liability company, professional association, etc., of which he/she is the sole owner. See the CMS-855I Application for Physicians and Non-Physician Practitioners for more information.

NOTE: Physicain Assistants: This application should not be used to report employment arrangements. Employment arrangements must be reported in Section 5 of the CMS-855I application.

Physicians and non-physician practitioners can reassign Medicare benefits or terminate a reassignment of Medicare benefits after enrollment in the Medicare program or make a change in their reassignment of Medicare benefit information using either:

- The Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or
- Submit the paper CMS-855R application. Be sure you are using the most current version.

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

INSTRUCTIONS FOR COMPLETING AND SUBMITTING THIS APPLICATION

- Type or print all information so that it is legible. Do not use pencil.
- Sign and date the certification statement(s) as appropriate.
- Enter all NPIs in the applicable section(s).
- Keep a copy of your completed Medicare reassignment package for your own records.

ADDITIONAL INFORMATION

When establishing a new reassignment, Section 6A must be completed by the individual practitioner **and** Section 6B must be completed by an authorized or delegated official of the organization/group. If the reassignment is to an individual, that person must sign Section 6B. When terminating a reassignment, **either** Section 6A **or** Section 6B can be completed. Reassigned claims for services rendered by the individual will no longer be paid to the organization/group after the effective date of the termination.

The MAC may request, at any time during the enrollment or reassignment process, documentation to support and validate information reported on the application. You are responsible for providing this documentation in a timely manner, usually 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.

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 and processed your initial enrollment application is responsible for processing your reassignment application. To locate the mailing address for your designated MAC, go to **www.cms.gov/MedicareProviderSupEnroll.**

SECTION 1: BASIC INFORMATION

REASON FOR SUBMITTING THIS APPLICATION

Check the applicable box and complete the required sections.

☐ You are enrolling or are currently enrolled in Medicare and will be reassigning your benefits	Effective Date *(mm/dd/yyyy)*:	**Complete all sections**
☐ You are an individual practitioner terminating a reassignment with an organization	Effective Date *(mm/dd/yyyy)*:	Complete sections **1, 2, 3, 5,** and **6A**
☐ You are the organization terminating a reassignment with an individual	Effective Date *(mm/dd/yyyy)*:	Complete sections **1, 2, 3, 5,** and **6B**

SECTION 2: INDIVIDUAL PRACTITIONER WHO IS REASSIGNING BENEFITS

Individual Practitioner Identification

Provide the information below for the individual who will be reassigning his/her benefits, or who will be terminating a reassignment. If the individual's initial enrollment application is being submitted concurrently with this reassignment application, write "pending" in the Medicare identification number block.

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

Social Security Number	Medicare Identification Number (PTAN) *(if issued)*	National Provider Identifier (NPI)

SECTION 3: ORGANIZATION/GROUP RECEIVING THE REASSIGNED BENEFITS

Organization/Group Identification

Provide the information below for the organization/group to whom benefits are being reassigned, or a reassignment is being terminated. If the organization/group's initial enrollment application is being submitted concurrently with this reassignment application, write "pending" in the Medicare identification number block. The organization/group's name as reported to the IRS must be the same as reported on the organization/group's CMS-855B when it enrolled.

Organization/Group Legal Business Name *(as Reported to the Internal Revenue Service)*

Tax Identification Number	Medicare Identification Number (PTAN) *(if issued)*	National Provider Identifier (NPI)

SECTION 4: PRIMARY PRACTICE LOCATION

Primary Practice Location

Identify the primary practice location of the organization/group where the individual practitioner will render services most of the time.

Practice Location Name *("Doing Business As" Name)*

Practice Location Address Line 1 *(Street Name and Number)*

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

City/Town	State	Zip Code +4

PTAN for this location *(if different than Section 3)*	NPI for this location *(if different than Section 3)*

SECTION 5: CONTACT PERSON

If questions arise during the processing of this reassignment, the designated MAC will contact the individual indicated below. If no one is listed below, the MAC will contact the individual practitioner is Section 2.

☐ Contact person listed below.

First Name	Middle Initial	Last Name	Jr., Sr., 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)*	Email Address *(if applicable)*

Relationship or Affiliation to Individual or Group

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

SECTION 6: CERTIFICATION STATEMENTS AND SIGNATURES

Title XVIII of the Social Security Act prohibits payment for services provided by an individual practitioner to be paid to another individual or organization/group unless the individual practitioner who provided the services specifically authorizes another individual or organization/group to receive said payments in accordance with 42 C.F.R. 424.73 and 42 C.F.R. 424.80. All individual practitioners who allow another individual or organization/group to receive payment for their services must sign the Reassignment of Medicare Benefits Statement below. By signing this Reassignment of Medicare Benefits Statement, you are authorizing the organization/group identified in Section 3 to receive Medicare payments on your behalf.

The signature(s) below authorize the reassignment of benefits, or the termination of a reassignment of benefits between, the individual shown in Section 2 and the organization/group shown in Section 3.

The employment of, or contract between the individual and organization/group must be in compliance with CMS regulations and applicable Medicare program safeguard standards described in 42 C.F.R. 424.80.

These signatures also serve as an attestation and acknowledgment to the compliance with all laws and regulations pertaining to the reassignment of Medicare benefits.

A. Individual Practitioner Certification Statement and Signature

I certify that I have examined the above information and that it is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws.

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

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

B. Authorized or Delegated Official of Organization/Group Certification Statement and Signature

I certify that I have examined the above information and that it is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws.

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

Authorized or Delegated Official's Signature *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*	Date Signed *(mm/dd/yyyy)*

All signatures must be original and signed in blue ink. 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 section 1833(e) of the Social Security Act and section 31001(1) of the Debt Collection Improvement Act 31 U.S.C. § 7701(c).

The purpose of collecting this information is to determine or verify the eligibility of individuals and organizations to reassign benefits in the Medicare program and to assist in the administration of the Medicare program. All information on this form is required. 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 System is unable to establish identity after matching contractor submitted data to the data extract provided by the AMA;
8. An individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, or to the restoration or maintenance of health;
9. Other Federal agencies that administer a Federal health care benefit program to enumerate/enroll providers of medical services or to detect fraud or abuse;
10. State Licensing Boards for review of unethical practices or non-professional conduct;
11. States for the purpose of administration of health care programs; and/or
12. Insurance companies, self insurers, health maintenance organizations, multiple employer trusts, and other health care groups providing health care claims processing, when a link to Medicare or Medicaid claims is established, and data are used solely to process supplier's health care claims.

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

Protection of Proprietary Information

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

Protection of Confidential Commercial and/or Sensitive Personal Information

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0685. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

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