

# MEDICARE ENROLLMENT APPLICATION

# **REASSIGNMENT OF MEDICARE BENEFITS**

# CMS-855R

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



#### 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 <a href="https://www.cms.gov/MedicareProviderSupEnroll">https://www.cms.gov/MedicareProviderSupEnroll</a>.

#### 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 <a href="https://www.cms.gov/BedicareProviderSupEnroll">www.cms.gov/BedicareProviderSupEnroll</a>.

#### **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 Identi	fication 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)			
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# **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.

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	on (if different than Section 3)			

SECTION 5: CONTACT PERSO	N						
If questions arise during the processir indicated below. If no one is listed be	ng of this reas	signme	ent, the do	esignated MAC will individual practition	conta oner is	ct the individual Section 2.	
☐ Contact person listed below.							
First Name	Middle Initial	Last N	ame			Jr., Sr., etc.	
Address Line 1 (Street Name And Number)						<u>I</u>	
Address Line 2 (Suite, Room, etc.)							
City/Town			State		Zip Cod	de +4	
Telephone Number F	ax Number (if ap <sub>l</sub>	plicable,	)	Email Address (if applie	cable)		
Relationship or Affiliation to Individual or Gro	pup						
<b>NOTE:</b> The Contact Person listed in the reassignment. The designated MAC we beyond this application with the above	ill not discuss	any o					
SECTION 6: CERTIFICATION ST	TATEMENT	S AN	D SIGN	ATURES			
Title XVIII of the Social Security Act populated to another individual or organizes specifically authorizes another individual of C.F.R. 424.73 and 42 C.F.R. 424.80. Agroup to receive payment for their sessigning this Reassignment of Medicar in Section 3 to receive Medicare payment for their session of the signature (s) below authorize the between, the individual shown in Section 3.	ation/group udual or organized All individual ervices must signed Benefits Statements on your reassignment tion 2 and the	nless t zation, practit gn the temen behalt of bei	he individe /group to ioners whe Reassign t, you are f. nefits, or to nization/g	lual practitioner who receive said payme to allow another incoment of Medicare Be authorizing the orticle the termination of a proup shown in Section 2015.	nts in dividual enefits ganiza a reass	vided the services accordance with all or organization/s Statement below. By ation/group identified ignment of benefits	
	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 atte pertaining to the reassignment of Me			ledgment	to the compliance	with a	ll laws and regulations	
A. Individual Practitioner Certifical Certify that I have examined the about any misrepresentation or concealment under civil and criminal laws.  Individual Practitioner First Name	ove information	on and	I that it is n request	true, accurate and			
Individual Practitioner Signature (First, Middle,	. Last Name, Jr., Si	r., M.D.,	etc.)		Date S	Signed (mm/dd/yyyy)	
B. Authorized or Delegated Official I certify that I have examined the about any misrepresentation or concealment under civil and criminal laws.	ve informatio	n and	that it is	true, accurate and c	omple	te. I understand that	
First Name	Middle Initial	Last N	ame			Jr., Sr., M.D., etc.	
Authorized or Delegated Official's Signature (A	 First, Middle, Last	Name, .	Ir., Sr., M.D.,	etc.)	Date	Signed <i>(mm/dd/yyyy)</i>	

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;
- 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;
- 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;
- 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.