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# MEDICARE ENROLLMENT APPLICATION

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## Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers

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### CMS-855S

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

SEE PAGE 3 FOR INFORMATION ON WHERE TO MAIL THIS APPLICATION.

SEE PAGE 35 FOR A LIST OF SUPPORTING DOCUMENTS THAT MUST BE SUBMITTED WITH THIS APPLICATION.

SEE PAGE 36 FOR A LINK TO THE LIST OF THE DMEPOS SUPPLIER STANDARDS. EVERY APPLICANT MUST MEET AND MAINTAIN THESE ENROLLMENT STANDARDS.



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## WHO SHOULD SUBMIT THIS APPLICATION

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Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) 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
- The paper enrollment application process (e.g., CMS 855S).

For additional information regarding the Medicare enrollment process, including Internet-based PECOS, go to <http://www.cms.gov/MedicareProviderSupEnroll>.

DMEPOS suppliers who are enrolled in the Medicare program, but have not submitted the CMS 855S since 2005, are required to submit a Medicare enrollment application (i.e., Internet-based PECOS or the CMS 855S) as an initial application when reporting a change for the first time.

The following types of DMEPOS suppliers must complete this application to initiate the enrollment process:

- Ambulatory Surgical Center
- Department Store
- Grocery Store
- Home Health Agency
- Hospital
- Indian Health Service
- Intermediate Care Nursing Facility
- Medical Supply Company
- Nursing Facility (other)
- Occupational Therapist
- Optician
- Orthotics Personnel
- Oxygen and/or Oxygen Related Equipment Supplier
- Pedorthic Personnel
- Pharmacy
- Physical Therapist
- Physician, including Optometrist
- Prosthetics Personnel
- Prosthetic/Orthotic Personnel
- Rehabilitation Agency
- Skilled Nursing Facility

If your DMEPOS supplier type is not listed, contact the National Supplier Clearinghouse (NSC) before you submit your application.

Complete this application if you plan to bill Medicare for DMEPOS and you are:

- Enrolling in Medicare for the first time as a DMEPOS supplier.
- Currently enrolled in Medicare as a DMEPOS supplier and need to report changes to your business, other than enrolling a new business location (e.g., you are adding, deleting, or changing existing information under this Medicare supplier billing number). Changes must be reported within 30 days of the effective date of the change.
- Currently enrolled in Medicare as a DMEPOS supplier but need to enroll a new business location. This is to add a new location to an organization with a tax identification number already listed with the NSC. (This differs from changing information on an already existing location.)
- Currently enrolled in Medicare as a DMEPOS supplier and have been asked to revalidate your information. This includes situations where you have been asked to attest that your organization is still eligible to receive Medicare payments.
- Reactivating your Medicare DMEPOS supplier billing number.
- Voluntarily terminating your Medicare DMEPOS supplier billing number.

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## BILLING NUMBER INFORMATION

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The Medicare Identification Number, often referred to as a Medicare supplier number, is a generic term for any number other than the National Provider Identifier (NPI) that is used by a supplier to bill the Medicare program.

The National Provider Identifier (NPI) is the standard unique health identifier for health care providers and is assigned by the National Plan and Provider Enumeration System (NPPES). **As a new Medicare DMEPOS supplier, you must obtain an NPI and submit it with this application prior to enrolling in Medicare or before 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](http://www.cms.gov/NationalProvIdentStand).

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## INSTRUCTIONS FOR COMPLETING AND SUBMITTING THIS APPLICATION

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- Type or print all information so that it is legible. Do not use pencil.
- Attach all supporting documentation.
- Keep a copy of your completed Medicare enrollment package for your own records and for updating your information.

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## AVOID DELAYS IN YOUR ENROLLMENT

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To avoid delays in the initial enrollment process, you should:

- Complete all required sections as shown in section 1B;
- Complete section 6 for all authorized and delegated officials listed in sections 15 and 16;
- List a managing employee for each location;
- Enter your NPI in the applicable sections;
- Include the EFT agreement with your enrollment application; and
- Respond timely to development/information requests.

Additional information and reasons for enrollment processing delays can be found on the NSC website at [www.palmettogba.com/nsc](http://www.palmettogba.com/nsc).

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## OBTAINING MEDICARE APPROVAL

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The usual process for becoming a Medicare DMEPOS supplier is as follows:

1. The applicant completes and submits an enrollment application (CMS-855S) and all supporting documentation to the NSC.
2. The NSC reviews the application and conducts a site visit to verify compliance with the supplier standards found at 42 C.F.R. 424.57, 424.58, and 42 C.F.R. 424.500–565.
3. After completing its review, the NSC notifies the applicant in writing about its enrollment decision.

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## ADDITIONAL INFORMATION

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For additional information regarding the Medicare enrollment process, visit:

[www.cms.gov/MedicareProviderSupEnroll](http://www.cms.gov/MedicareProviderSupEnroll)

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

The information you provide on this form will not be shared. It is considered to be protected under 5 U.S.C. Section 552(b)(4) and/or (b)(6), respectively. For more information, see the last page for the Privacy Act Statement.

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## MAIL YOUR APPLICATION

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The NSC is responsible for processing your enrollment application.

National Supplier Clearinghouse

Post Office Box 100142

Columbia, SC 29202-3142

Phone: 1-866-238-9652

Web: [www.palmettogba.com/nsc](http://www.palmettogba.com/nsc)

**Overnight Mailing Address:**

National Supplier Clearinghouse

Palmetto GBA\* AG-495

2300 Springdale Drive, Bldg. 1

Camden, SC 29020

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## SECTION 1: BASIC INFORMATION

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This section captures information regarding the reason you are submitting this application. Read this section in full prior to indicating the reason for submission on page 5.

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### NEW ENROLLEES

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You are considered a new enrollee if you are:

- Enrolling in the Medicare program as a DMEPOS supplier for the first time under this tax identification number.
- Enrolling in the Medicare program as a DMEPOS supplier but have a new tax identification number. If you are reporting a change to your tax identification number, you must complete a new CMS 855S enrollment application.
- A currently enrolled DMEPOS supplier that has come under new ownership. (Note: New owners of existing DMEPOS suppliers must submit a dated bill of sale with an effective date of the new ownership.)
- Enrolling a new location with a tax identification number not previously enrolled with the NSC.

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### EXISTING MEDICARE DMEPOS SUPPLIERS

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#### **Adding a New Location**

If you are currently enrolled as a Medicare DMEPOS supplier and are applying to enroll a new business location using a tax identification number that is already enrolled with the NSC, you will need to complete only the required sections listed in Section 1B of this CMS-855S application for the new location.

#### **Reactivation**

If your Medicare DMEPOS supplier billing number was deactivated, you may be required to either submit an updated CMS-855S or certify to the accuracy of your enrollment information currently on file with the NSC in order to reactivate billing privileges. (This differs from reenrollment: the NSC will contact you when you need to reenroll.) You must also meet all current requirements for your supplier type, regardless of how you were previously enrolled in the program.

#### **Revalidation**

If you have been contacted by the NSC to revalidate your Medicare enrollment, you will be required to either submit an updated enrollment application or certify to the accuracy of the enrollment information currently on file with the NSC. Do not submit this application until you have been contacted by the NSC.

#### **Voluntary Termination**

If you will no longer provide DMEPOS items or services to Medicare beneficiaries, you should voluntarily terminate your enrollment in the Medicare program as a DMEPOS supplier.

#### **Change of Information Other Than Adding a New Location**

If you are adding, deleting, or changing information under your current Medicare supplier billing number. Any change to your existing enrollment data must be reported within 30 days of the effective date of the change.

## SECTION 1: BASIC INFORMATION

**A. Provide the two-letter State Code (e.g., TX for Texas) where your business is located**

 

**B. Check one box and provide the necessary information where requested**

DMEPOS suppliers must furnish their Medicare Identification Number, often referred to as a supplier number, and their NPI below. Note: Unless enrolling as a sole proprietorship with multiple locations, each enrolled supplier of DMEPOS must obtain an NPI for each practice location.

However, if the applicant is the sole owner of more than one incorporated DMEPOS supplier location (i.e., a sole proprietor with multiple locations) only one NPI will be issued.

Medicare Identification Number <i>(if issued)</i>	NPI
<input type="checkbox"/> You are a <b>new enrollee</b> in Medicare or are enrolling a new location with a tax identification number not previously enrolled with the NSC	<b>Complete all applicable sections</b>
<input type="checkbox"/> You are <b>adding a new business location</b> using a tax identification number already enrolled with the NSC	<b>1A, 1B, 2, 4, 6 (for managing/directing employee only), 12, 13, 15, 16 (if applicable)</b>
<input type="checkbox"/> You are <b>reactivating</b> your Medicare Supplier Billing Number	<b>Complete all applicable sections</b>
<input type="checkbox"/> You are <b>revalidating</b> your Medicare enrollment	<b>Complete all applicable sections</b>
<input type="checkbox"/> You are <b>voluntarily terminating your Medicare enrollment.</b>  Effective date of termination: _____	<b>1B, 4A (page 15 only), 13, and either 15 or 16</b>
<input type="checkbox"/> You are <b>changing your Medicare information</b>	<b>Go to Section 1C</b>

**SECTION 1: BASIC INFORMATION (Continued)**

**C. Check the item(s) listed that is changing and complete the applicable sections**

MARK ALL THAT APPLY	REQUIRED SECTIONS
<input type="checkbox"/> Supplier Type (submit licensure if applicable) <input type="checkbox"/> Products and Services (submit accreditation if applicable)	<b>1C, 2</b> (complete <b>2A1</b> and those data elements that are changing), <b>3, 13</b> , and either <b>15</b> (if you are the authorized official) or <b>16</b> (if you are the delegated official), and <b>6</b> for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
<input type="checkbox"/> Accreditation Information	<b>1C, 2A1, 2G, 3, 13</b> , and either <b>15</b> (if you are the authorized official), or <b>16</b> (if you are the delegated official), and <b>6</b> for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
<input type="checkbox"/> Surety Bond Information	<b>1C, 2A1, 3, 12, 13</b> , and either <b>15</b> (if you are the authorized official), or <b>16</b> (if you are the delegated official), and <b>6</b> for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
<input type="checkbox"/> Final Adverse Actions/Convictions	<b>1C, 2A1, 3, 13</b> , and either <b>15</b> (if you are the authorized official) or <b>16</b> (if you are the delegated official), and <b>6</b> for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
<input type="checkbox"/> Current Business Location	<b>1C, 2A1, 3, 4, 12, 13</b> , and either <b>15</b> (if you are the authorized official) or <b>16</b> (if you are the delegated official), and <b>6</b> for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
<input type="checkbox"/> Ownership and/or Managing Control Information (Organizations)	<b>1C, 2A1, 3, 5, 13</b> , and either <b>15</b> (if you are the authorized official) or <b>16</b> (if you are the delegated official), and <b>6</b> for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
<input type="checkbox"/> Ownership and/or Managing Control Information (Individuals)	<b>1C, 2A1, 3, 6, 13</b> , and either <b>15</b> (if you are the authorized official) or <b>16</b> (if you are the delegated official), and <b>6</b> for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
<input type="checkbox"/> Billing Agency Information	<b>1, 2A1, 3, 8</b> (complete only those data elements that are changing), <b>13</b> , and either <b>15</b> (if you are the authorized official) or <b>16</b> (if you are the delegated official), and <b>6</b> for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
<input type="checkbox"/> Authorized Official	<b>1C, 2A1, 3, 6, 13</b> and <b>15</b>
<input type="checkbox"/> Delegated Official	<b>1C, 2A1, 3, 6, 13, 15</b> and <b>16</b>

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## SECTION 2: IDENTIFYING INFORMATION

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### SECTION 2A1 INSTRUCTIONS

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#### A. SUPPLIER IDENTIFICATION

All applicants new to Medicare or suppliers that are making changes to their Medicare information must complete this section. DO NOT PROVIDE BILLING AGENT INFORMATION HERE.

##### 1. Where should we mail your 1099?

###### Organizational Suppliers (e.g., Corporations, Partnerships, LLCs, Sub-Chapter S)

If you are an organizational supplier, furnish the supplier's legal name (as reported to the IRS) and TIN. Furnish 1099 mailing address information where indicated. A copy of the IRS CP-575 or other correspondence issued by the IRS showing the TIN for this business MUST be submitted. Complete only item A on this page.

###### Sole Proprietors

If you are a sole proprietor (only owner of a business that is not incorporated) list your Social Security Number (SSN) and the full legal name associated with the SSN as reported to the IRS in the appropriate fields. If you want your Medicare payments reported under your Employer Identification Number (EIN) furnish it in the appropriate space below. Furnish 1099 mailing address information where indicated. Complete only item B on this page.

**NOTE: Sole Proprietors:** If you furnish an EIN in Section B, payment will be made to your EIN. If you do not furnish an EIN in Section B, payment will be made to your SSN. You can not use both an SSN and EIN. You can only use one number to bill Medicare. If furnishing an EIN, a copy of the IRS CP-575 or other correspondence issued by the IRS showing the EIN for this business MUST be submitted.

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#### A. Organizational Suppliers (e.g., Corporations, Partnerships, LLCs, Sub-Chapter S)

Legal Name as Reported to the IRS		Tax Identification Number	
1099 Mailing Address Line 1 ( <i>Street Name and Number</i> )		Former Tax Identification Number ( <i>if changed</i> )	
1099 Mailing Address Line 2 ( <i>Suite, Room, etc.</i> )		Medicaid Number ( <i>if applicable</i> )	
1099 Mailing Address City	1099 Mailing Address State	1099 Mailing Address ZIP Code + 4	

#### B. Sole Proprietors

Social Security Number		Full Legal Name Associated with this Social Security Number	
Employer Identification Number			
1099 Mailing Address Line 1 ( <i>Street Name and Number</i> )		Former Tax Identification Number ( <i>if changed</i> )	
1099 Mailing Address Line 2 ( <i>Suite, Room, etc.</i> )		Medicaid Number ( <i>if applicable</i> )	
1099 Mailing Address City	1099 Mailing Address State	1099 Mailing Address ZIP Code + 4	



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**SECTION 2: IDENTIFYING INFORMATION (Continued)**

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

Proprietary    Non-Profit

**NOTE:** If a checkbox indicating Proprietaryship or non-profit status is not completed, the provider/supplier will be defaulted to "Proprietary."

**2. Where should correspondence be mailed?**

This is the address to which correspondence will be sent to you by the NSC and/or the DME MAC.

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

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Mailing Address Line 1 (*Street Name and Number*)

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

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City/Town	State	ZIP Code + 4
Telephone Number	Fax Number ( <i>if applicable</i> )	E-mail Address ( <i>if applicable</i> )

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**3. Where should we mail your revalidation request package if different from Section 2A2 (correspondence address) above?**

This is the address to which the NSC will send your reenrollment request package.

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

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Mailing Address Line 1 (*Street Name and Number*)

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

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City/Town	State	ZIP Code + 4
Telephone Number	Fax Number ( <i>if applicable</i> )	E-mail Address ( <i>if applicable</i> )

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**4. Is this supplier currently enrolled in the Medicare program other than as a DMEPOS supplier?**

YES    NO

If yes, please provide the following for each enrolled supplier:

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Medicare Contractor Name	Provider/Supplier Type	NPI
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**5. Is this supplier an Indian Health Facility?**

YES    NO

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**SECTION 2: IDENTIFYING INFORMATION (Continued)**

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**B. TYPE OF SUPPLIER**

The supplier must meet all Medicare requirements for the DMEPOS supplier type checked. Any specialty personnel including, but not limited to, Respiratory Therapists, and Orthotics/Prosthetics personnel, must have current licensure as applicable to the specialty supplier type checked as well as for products and services checked in section 2D.

**Check all that apply:**

- |  |  |
|--|--|
| <input type="checkbox"/> Ambulatory Surgical Center                                    | <input type="checkbox"/> Nursing Facility (other)                        |
| <input type="checkbox"/> Department Store  | <input type="checkbox"/> Ocularists                                      |
| <input type="checkbox"/> Grocery Store   | <input type="checkbox"/> Occupational Therapist                          |
| <input type="checkbox"/> Home Health Agency  | <input type="checkbox"/> Optician  |
| <input type="checkbox"/> Hospital  | <input type="checkbox"/> Orthotics Personnel                             |
| <input type="checkbox"/> Indian Health Service   | <input type="checkbox"/> Oxygen and/or Oxygen Related Equipment Supplier |
| <input type="checkbox"/> Intermediate Care Nursing Facility                            | <input type="checkbox"/> Pedorthic Personnel                             |
| <input type="checkbox"/> Medical Supply Company  | <input type="checkbox"/> Pharmacy  |
| <input type="checkbox"/> Medical Supply Company with Orthotics Personnel               | <input type="checkbox"/> Physical Therapist                              |
| <input type="checkbox"/> Medical Supply Company with Pedorthic Personnel               | <input type="checkbox"/> Physician/Dentist                               |
| <input type="checkbox"/> Medical Supply Company with Prosthetics Personnel             | <input type="checkbox"/> Physician, other than Optometrist or Dentist    |
| <input type="checkbox"/> Medical Supply Company with Prosthetic and Orthotic Personnel | <input type="checkbox"/> Physician/Optometrist                           |
| <input type="checkbox"/> Medical Supply Company with Registered Pharmacist             | <input type="checkbox"/> Prosthetics Personnel                           |
| <input type="checkbox"/> Medical Supply Company with Respiratory Therapist             | <input type="checkbox"/> Prosthetic and Orthotic Personnel               |
|  | <input type="checkbox"/> Rehabilitation Agency                           |
|  | <input type="checkbox"/> Skilled Nursing Facility                        |
|  | <input type="checkbox"/> Other _____                                     |

**C. NON-ACCREDITED PRODUCTS****Check all that apply.**

- Epoetin
- Immunosuppressive Drugs
- Infusion Drugs
- Nebulizer Drugs
- Oral Anticancer Drugs
- Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)
- Check here if the supplier does not furnish any of the products and/or services listed in Section 2D and provides one or more of the products shown below. If checked, skip Section 2D and continue to Section 2E (Liability Insurance Information).

If you are adding/changing any supplies for which you plan to bill, you must notify the NSC. Consistent with 42 CFR § 424.57 (c)(2), a supplier has not made or caused to be made, any false statement or misrepresentation of a material fact on its application for billing privileges. (The supplier must provide complete and accurate information in response to questions on its application for billing privileges. The supplier must report to CMS any changes in information supplied on the application within 30 days of the change.) Failure to do so could result in revocation and/or overpayment collection.

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## SECTION 2: IDENTIFYING INFORMATION (Continued)

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### D. PRODUCTS AND SERVICES TO BE FURNISHED BY THIS SUPPLIER

Check all that apply. If you are adding/changing any supplies for which you plan to bill, you must notify the NSC. Consistent with 42 CFR § 424.57 (c)(2), a supplier has not made or caused to be made, any false statement or misrepresentation of a material fact on its application for billing privileges. (The supplier must provide complete and accurate information in response to questions on its application for billing privileges. The supplier must report to CMS any changes in information supplied on the application within 30 days of the change.) Failure to do so could result in revocation and/or overpayment collection.

If you are unsure of the licensure and/or certification and/or accreditation requirements for your product(s), services(s), and/or State, check the NSC website at [www.palmettogba.com/nsc](http://www.palmettogba.com/nsc). Failure to attach applicable licensure and/or certification could result in denial or revocation of your Medicare billing number and/or overpayment collection.

- |  |   |
|--|---|
| <input type="checkbox"/> Automatic External Defibrillators (AEDs) and/or Supplies              | <input type="checkbox"/> Osteogenesis Stimulators   |
| <input type="checkbox"/> Blood Glucose Monitors and/or Supplies (mail order)                   | <input type="checkbox"/> Ostomy Supplies  |
| <input type="checkbox"/> Blood Glucose Monitors and/or Supplies (non-mail order)               | <input type="checkbox"/> Oxygen Equipment and/or Supplies   |
| <input type="checkbox"/> Breast Prostheses and/or Accessories                                  | <input type="checkbox"/> Parenteral Nutrients   |
| <input type="checkbox"/> Canes and/or Crutches   | <input type="checkbox"/> Parenteral Equipment and/or Supplies                                     |
| <input type="checkbox"/> Cochlear Implants   | <input type="checkbox"/> Patient Lifts  |
| <input type="checkbox"/> Commodes/Urinals/Bedpans  | <input type="checkbox"/> Penile Pumps   |
| <input type="checkbox"/> Continuous Passive Motion (CPM) Devices                               | <input type="checkbox"/> Pneumatic Compression Devices and/or Supplies                            |
| <input type="checkbox"/> Continuous Positive Airway Pressure (CPAP) Devices and/or Supplies    | <input type="checkbox"/> Power Operated Vehicles (Scooters)                                       |
| <input type="checkbox"/> Contracture Treatment Devices: Dynamic Splint                         | <input type="checkbox"/> Prosthetic Lenses: Conventional Contact Lenses                           |
| <input type="checkbox"/> Diabetic Shoes/Inserts  | <input type="checkbox"/> Prosthetic Lenses: Conventional Eyeglasses                               |
| <input type="checkbox"/> Diabetic Shoes/Inserts—Custom   | <input type="checkbox"/> Prosthetic Lenses: Prosthetic Cataract Lenses                            |
| <input type="checkbox"/> Enteral Nutrients   | <input type="checkbox"/> Respiratory Assist Devices   |
| <input type="checkbox"/> Enteral Equipment and/or Supplies                                     | <input type="checkbox"/> Respiratory Suction Pumps  |
| <input type="checkbox"/> External Infusion Pumps and/or Supplies                               | <input type="checkbox"/> Seat Lift Mechanisms   |
| <input type="checkbox"/> Facial Prostheses   | <input type="checkbox"/> Somatic Prostheses   |
| <input type="checkbox"/> Gastric Suction Pumps   | <input type="checkbox"/> Speech Generating Devices  |
| <input type="checkbox"/> Heat & Cold Applications  | <input type="checkbox"/> Support Surfaces: Pressure Reducing Beds/Mattresses/Overlays/Pads        |
| <input type="checkbox"/> Hemodialysis Equipment and/or Supplies                                | <input type="checkbox"/> Surgical Dressings   |
| <input type="checkbox"/> High Frequency Chest Wall Oscillation (HFCWO) Devices and/or Supplies | <input type="checkbox"/> Tracheostomy Supplies  |
| <input type="checkbox"/> Home Dialysis Equipment and/or Supplies                               | <input type="checkbox"/> Traction Equipment   |
| <input type="checkbox"/> Hospital Beds—Electric  | <input type="checkbox"/> Transcutaneous Electrical Nerve Stimulators (TENS) and/or Supplies       |
| <input type="checkbox"/> Hospital Beds—Manual  | <input type="checkbox"/> Ultraviolet Light Devices and/or Supplies                                |
| <input type="checkbox"/> Implanted Infusion Pumps and/or Supplies                              | <input type="checkbox"/> Urological Supplies  |
| <input type="checkbox"/> Infrared Heating Pad Systems and/or Supplies                          | <input type="checkbox"/> Ventilators Accessories and/or Supplies                                  |
| <input type="checkbox"/> Insulin Infusion Pumps and/or Supplies                                | <input type="checkbox"/> Voice Prosthetics  |
| <input type="checkbox"/> Intermittent Positive Pressure Breathing (IPPB) Devices               | <input type="checkbox"/> Walkers  |
| <input type="checkbox"/> Intrapulmonary Percussive Ventilation Devices                         | <input type="checkbox"/> Wheelchair Seating/Cushions  |
| <input type="checkbox"/> Invasive Mechanical Ventilation Devices                               | <input type="checkbox"/> Wheelchairs—Complex Rehabilitative Manual Wheelchairs                    |
| <input type="checkbox"/> Limb Prostheses   | <input type="checkbox"/> Wheelchairs—Complex Rehabilitative Manual Wheelchair Related Accessories |
| <input type="checkbox"/> Mechanical In-Exsufflation Devices                                    | <input type="checkbox"/> Wheelchairs—Complex Rehabilitative Power Wheelchairs                     |
| <input type="checkbox"/> Nebulizer Equipment and/or Supplies                                   | <input type="checkbox"/> Wheelchairs—Complex Rehabilitative Power Wheelchair Related Accessories  |
| <input type="checkbox"/> Negative Pressure Wound Therapy Pumps and/or Supplies                 | <input type="checkbox"/> Wheelchairs—Standard Manual  |
| <input type="checkbox"/> Neuromuscular Electrical Stimulators (NMES) and/or Supplies           | <input type="checkbox"/> Wheelchairs—Standard Manual Related Accessories                          |
| <input type="checkbox"/> Neurostimulators and/or Supplies                                      | <input type="checkbox"/> Wheelchairs—Standard Power   |
| <input type="checkbox"/> Ocular Prostheses   | <input type="checkbox"/> Wheelchairs—Standard Power Related Accessories                           |
| <input type="checkbox"/> Orthoses: Custom Fabricated   |   |
| <input type="checkbox"/> Orthoses: Prefabricated (non-custom fabricated)                       |   |
| <input type="checkbox"/> Orthoses: Off-the-Shelf   |   |

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**SECTION 2: IDENTIFYING INFORMATION (Continued)**

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**E. COMPREHENSIVE LIABILITY INSURANCE INFORMATION**

Consistent with DMEPOS supplier standards found in 42 CFR § 424.57(c)(10), all DMEPOS suppliers enrolling in Medicare must have a comprehensive liability insurance policy in the amount of at least \$300,000. The NSC must be listed on the policy as a Certificate Holder. The insurance policy must remain in force at all times and provide coverage of at least \$300,000 per incident. Failure to maintain the required insurance at all times will result in revocation of the Medicare supplier billing number, retroactive to the date the insurance lapsed.

Malpractice insurance policies do not demonstrate compliance with this requirement.

All DMEPOS suppliers must have comprehensive liability insurance and must submit a complete copy of their liability insurance policy or evidence of self-insurance with this application. You must provide the name and telephone number for both your insurance agent and your underwriter. The underwriter is with the company providing your insurance coverage. This contact information is necessary for the NSC to verify your policy. We will not verify this information with your insurance agent.

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Name of Insurance Company

Insurance Policy Number	Date Policy Issued (mm/dd/yyyy)		Expiration Date of Policy (mm/dd/yyyy)
Insurance Agent's First Name	Middle Initial	Last Name	Jr., Sr., etc.
Agent's Telephone Number	Agent's Fax Number (if applicable)		Agent's E-mail Address (if applicable)
Underwriter's Agent's First Name	Middle Initial	Last Name	Jr., Sr., etc.
Underwriter's Telephone Number	Underwriter's Fax Number (if applicable)		Underwriter's E-mail Address (if applicable)

Is the insurance agent also the underwriter for this policy?

Yes (Submit written proof from the insurance company attesting the agent is also the underwriter.)

No

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**SECTION 2: IDENTIFYING INFORMATION (Continued)**

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**F. ORGANIZATIONAL STRUCTURE**

Identify the type of organizational structure for this supplier (Check one):

- Not Publically Traded Corporation (regardless of whether supplier is “for-profit” or “non-profit”)
- Publically Traded Corporation (regardless of whether supplier is “for-profit” or “non-profit”)
- Partnership (“general” or “limited”)
- Sole Proprietor/Sole Proprietorship
- Other (Specify) \_\_\_\_\_

**G. ACCREDITATION INFORMATION**

**NOTE: Copy and complete this section if more than one accreditation needs to be reported.**

Check one of the following and furnish any additional information as requested:

- The enrolling supplier is accredited.
- The enrolling supplier is exempt from accreditation requirements.

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Name of Accrediting Organization

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Effective Date of Current Accreditation (*mm/dd/yyyy*)

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Expiration Date of Current Accreditation (*mm/dd/yyyy*)

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## **SECTION 3: FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS**

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This section captures information regarding final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All final adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

### **Convictions**

1. The DMEPOS supplier, or any owner of the DMEPOS supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include:
  - 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.

### **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 current Medicare payment suspension under any Medicare billing number.
5. Any Medicare revocation of any Medicare billing number.

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**SECTION 3: FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS (Continued)**

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**FINAL ADVERSE LEGAL ACTION HISTORY**

1. Have you or your organization, under any current or former name or business identity, ever had a final adverse legal action listed on page 13 of this application imposed against you/it?

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.

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

<b>FINAL ADVERSE LEGAL ACTION</b>	<b>DATE</b>	<b>TAKEN BY</b>	<b>RESOLUTION</b>

## SECTION 4: CURRENT BUSINESS LOCATION

### A. BUSINESS LOCATION INFORMATION

This section captures information regarding your business location.

- A separate application must be submitted for each physical business location that intends to bill Medicare for items sold to Medicare beneficiaries from that location. Locations that serve only as warehouses or repair facilities should not be reported.
- The address must be a specific street address as recorded by the United States Postal Service. Do not furnish a P.O. Box. If you are in a hospital and/or other health care facility and you provide services to patients at that facility, furnish the name and address of the hospital or facility.
- A change to the business location address requires submission of professional and business licenses for the new address, and proof of insurance covering the new address.

**NOTE: You must separately enroll each Medicare DMEPOS supplier business location.**

**If you are making a change in this section, please check the box and list effective date below.**

<input type="checkbox"/> <b>CHANGE</b>	<b>DATE</b> (mm/dd/yyyy) _____
--	--------------------------------

Business Location Name/Doing Business As Name (NOT your billing agent, staffing company, or managing organization)

Business Location Address Line 1 (Street Name and Number)

Business Location Address Line 2 (Suite, Room, etc.)

City/Town		State	ZIP Code + 4
Telephone Number	Fax Number (if applicable)	E-mail Address (if applicable)	
Date this Business Started at this Location (mm/dd/yyyy)		Date this Business Terminated at this Location (if applicable) (mm/dd/yyyy)	

List your posted hours of operation as shown at your business location.

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY	TOTAL HOURS Available to the Public



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**SECTION 4: CURRENT BUSINESS LOCATION (Continued)**

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Select the State(s)/Territory(ies) where the majority of claims for this location will be submitted. Claims submissions are based on where the Medicare beneficiary resides.

**Jurisdiction A:**

- |   |  |                                       |
|---|--|---------------------------------------|
| <input type="checkbox"/> Connecticut          | <input type="checkbox"/> Maryland      | <input type="checkbox"/> New York     |
| <input type="checkbox"/> Delaware             | <input type="checkbox"/> Massachusetts | <input type="checkbox"/> Pennsylvania |
| <input type="checkbox"/> District of Columbia | <input type="checkbox"/> New Hampshire | <input type="checkbox"/> Rhode Island |
| <input type="checkbox"/> Maine                | <input type="checkbox"/> New Jersey    | <input type="checkbox"/> Vermont      |

**Jurisdiction B:**

- |                                   |                                    |                                    |
|-----------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> Illinois | <input type="checkbox"/> Michigan  | <input type="checkbox"/> Wisconsin |
| <input type="checkbox"/> Indiana  | <input type="checkbox"/> Minnesota |                                    |
| <input type="checkbox"/> Kentucky | <input type="checkbox"/> Ohio      |                                    |

**Jurisdiction C:**

- |                                    |   |   |
|------------------------------------|---|---|
| <input type="checkbox"/> Alabama   | <input type="checkbox"/> Mississippi    | <input type="checkbox"/> Tennessee      |
| <input type="checkbox"/> Arkansas  | <input type="checkbox"/> New Mexico     | <input type="checkbox"/> Texas          |
| <input type="checkbox"/> Colorado  | <input type="checkbox"/> North Carolina | <input type="checkbox"/> Virgin Islands |
| <input type="checkbox"/> Florida   | <input type="checkbox"/> Oklahoma       | <input type="checkbox"/> Virginia       |
| <input type="checkbox"/> Georgia   | <input type="checkbox"/> Puerto Rico    | <input type="checkbox"/> West Virginia  |
| <input type="checkbox"/> Louisiana | <input type="checkbox"/> South Carolina |   |

**Jurisdiction D:**

- |                                     |                                       |   |
|-------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Alaska     | <input type="checkbox"/> Kansas       | <input type="checkbox"/> South Dakota             |
| <input type="checkbox"/> Arizona    | <input type="checkbox"/> Missouri     | <input type="checkbox"/> Utah                     |
| <input type="checkbox"/> California | <input type="checkbox"/> Montana      | <input type="checkbox"/> Washington               |
| <input type="checkbox"/> Guam       | <input type="checkbox"/> Nebraska     | <input type="checkbox"/> Wyoming                  |
| <input type="checkbox"/> Hawaii     | <input type="checkbox"/> Nevada       | <input type="checkbox"/> Northern Mariana Islands |
| <input type="checkbox"/> Idaho      | <input type="checkbox"/> North Dakota | <input type="checkbox"/> American Samoa           |
| <input type="checkbox"/> Iowa       | <input type="checkbox"/> Oregon       |   |

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**SECTION 4: CURRENT BUSINESS LOCATION (Continued)**

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**B. WHERE DO YOU WANT REMITTANCE NOTICES OR SPECIAL PAYMENTS SENT?**

**Medicare will issue 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, special payments) should be sent.

**NOTE:** If you are a new enrollee or are adding a new business location, you must submit an EFT Authorization Agreement (CMS-588) with this application.

If you are reenrolling and/or making changes to your current EFT Authorization Agreement (CMS-588), contact your DME MAC. DME MAC contact information can be found at [www.palmettogba.com/nsc](http://www.palmettogba.com/nsc).

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

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			

- “Special Payments” address is the same as the business location in Section 4A. Skip to Section 4C.
- “Special Payments” address is different than that listed in Section 4A. Provide address below.

**NOTE:** Payment will be made in the supplier’s “legal business name” shown in Section 2A1.

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“Special Payments” Address Line 1 (PO Box or Street Name and Number)

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“Special Payments” Address Line 2 (Suite, Room, etc.)

---

City/Town	State	ZIP Code + 4

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**SECTION 4: CURRENT BUSINESS LOCATION (Continued)**

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**C. WHERE DO YOU KEEP MEDICARE BENEFICIARY MEDICAL RECORDS?**

If the Medicare beneficiaries' medical records are stored at a location other than the location shown in Section 4A, 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 physical addresses where Medicare beneficiaries' records are maintained. The records must be the supplier's records, not the records of another supplier. If all records are stored at the business location reported in Section 4A, please indicate below.

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

**First Medical Record Storage Facility (for current and former Medicare beneficiaries)**

<b>CHECK ONE</b>	<input type="checkbox"/> <b>CHANGE</b>	<input type="checkbox"/> <b>ADD</b>	<input type="checkbox"/> <b>DELETE</b>
<b>DATE</b> (mm/dd/yyyy)			

Records are stored at the business location reported in Section 4A.

---

Storage Facility Address Line 1 (Street Name and Number)

---

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

---

City/Town	State	ZIP Code + 4
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---

**Second Medical Record Storage Facility (for current and former Medicare beneficiaries)**

<b>CHECK ONE</b>	<input type="checkbox"/> <b>CHANGE</b>	<input type="checkbox"/> <b>ADD</b>	<input type="checkbox"/> <b>DELETE</b>
<b>DATE</b> (mm/dd/yyyy)			

---

Storage Facility Address Line 1 (Street Name and Number)

---

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

---

City/Town	State	ZIP Code + 4
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## SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS)

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**NOTE: Only report organizations in this section. Individuals must be reported in Section 6.**

Complete this section with information about all organizations that have 5 percent or more (direct or indirect) ownership interest of, any partnership interest in, and/or managing control of, the supplier identified in Section 4A, as well as any information on final adverse actions that have been imposed against that organization. For examples of organizations that should be reported in this section, you should visit the following Web site: [www.cms.gov/MedicareProviderSupEnroll](http://www.cms.gov/MedicareProviderSupEnroll). If there is more than one organization, copy and complete this section for each.

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### MANAGING CONTROL (ORGANIZATIONS)

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Any organization that exercises operational or managerial control over the DMEPOS supplier, or conducts the day-to-day operations of the DMEPOS supplier, is a managing organization and must be reported. The organization need not have an ownership interest in the DMEPOS supplier in order to qualify as a managing organization. For instance, it could be a management services organization under contract with the DMEPOS supplier to furnish management services for this business location.

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### SPECIAL TYPES OF ORGANIZATIONS

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#### **Governmental/Tribal Organizations:**

If a Federal, State, county, city or other level of government, or an Indian tribe, will be legally and financially responsible for Medicare payments received (including any potential overpayments), the name of that government or Indian tribe should be reported as an owner. The DMEPOS supplier must submit a letter on the letterhead of the responsible government (e.g., government agency) or tribal organization that attests that the government or tribal organization will be legally and financially responsible in the event that there is any outstanding debt owed to CMS. This letter must be signed by an appointed or elected official of the government or tribal organization who has the authority to legally and financially bind the government or tribal organization to the laws, regulations, and program instructions of Medicare.

#### **Indian Health Service Facilities:**

Special rules concerning insurance and licenses apply. Contact the NSC concerning these rules.

#### **Non-Profit, Charitable and Religious Organizations:**

Many non-profit organizations are charitable or religious in nature, and are operated and/or managed by a Board of Trustees or other governing body. The actual name of the Board of Trustees or other governing body should be reported in this section. While the organization should be listed in Section 5, individual board members should be listed in Section 6. Each non-profit organization should submit a copy of a 501(c)(3) document verifying its non-profit status.

All organizations that have any of the following must be reported:

- 5 percent or more ownership of the DMEPOS supplier,
- Managing control of the DMEPOS supplier, or
- A partnership interest in the DMEPOS supplier, regardless of the percentage of ownership the partner has.

**SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS) (Continued)**

Owning/Managing organizations are generally one of the following types:

- Corporations (including non-profit corporations)
- Partnerships and Limited Partnerships (as indicated above)
- Limited Liability Companies
- Charitable and/or Religious organizations, or
- Governmental and/or Tribal organizations

If there is more than one organization, copy and complete this section for each.

**A. ORGANIZATION WITH OWNERSHIP INTEREST AND/OR MANAGING CONTROL— IDENTIFICATION INFORMATION**

Not Applicable

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

<b>CHECK ONE</b>	<input type="checkbox"/> <b>CHANGE</b>	<input type="checkbox"/> <b>ADD</b>	<input type="checkbox"/> <b>DELETE</b>
<b>DATE</b> (mm/dd/yyyy)			

Check all that apply:

- 5 Percent or More Ownership Interest       Partner       Managing Control

Legal Business Name as Reported to the Internal Revenue Service

"Doing Business As" Name (if applicable)

Business Address Line 1 (Street Name and Number)

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

City/Town	State	ZIP Code + 4
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Tax Identification Number (Required)

Medicare Identification Number(s) (if issued)	NPI (if issued)
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What is the effective date this owner acquired ownership of the supplier identified in Section 2A1 of this application? (mm/dd/yyyy) \_\_\_\_\_

What is the effective date this organization acquired managing control of the supplier identified in Section 2A1 of this application? (mm/dd/yyyy) \_\_\_\_\_

**NOTE:** Furnish both dates if applicable.

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**SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION  
(ORGANIZATIONS) (Continued)**

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**B. FINAL ADVERSE LEGAL ACTION HISTORY**

If you are reporting a change to existing information, check “Change,” provide the effective date of the change, and complete the appropriate fields in this section.

Change       Effective Date: \_\_\_\_\_

1. Has this organization in Section 5A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 13 of this application imposed against it?

YES – Continue Below       NO – Skip to Section 6

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.

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

<b>FINAL ADVERSE LEGAL ACTION</b>	<b>DATE</b>	<b>TAKEN BY</b>	<b>RESOLUTION</b>

---

## SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS)

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**NOTE:** Only individuals should be reported in Section 6. Organizations must be reported in Section 5. For more information on “direct” and “indirect” owners, go to *cms.gov/MedicareProviderSupEnroll*.

**The supplier MUST have at least ONE owner and ONE managing employee.**

**NOTE:** An owner may also be the managing employee.

The following individuals must be reported in Section 6A:

- All persons who have a 5 percent or greater ownership (direct or indirect) interest in the DMEPOS supplier.
- If (and only if) the DMEPOS supplier is a corporation (whether for-profit or non-profit), all officers and directors of the DMEPOS supplier.
- All managing employees of the DMEPOS supplier.
- All individuals with a partnership interest in the DMEPOS supplier, regardless of the percentage of ownership the partner has; and
- Authorized and delegated officials.

**Example:** A supplier is 100 percent owned by Company C, which itself is 100 percent owned by Individual D. Assume that Company C is reported in Section 5A as an owner of the supplier. Assume further that Individual D, as an indirect owner of the supplier, is reported in Section 6A1. Based on this example, the supplier would check the “5 Percent or Greater Direct/Indirect Owner” box in Section 6A2.

**NOTE:** All partners within a partnership must be reported in this application. This applies to both “General” and “Limited” partnerships. For instance, if a limited partnership has several limited partners and each of them only has a 1 percent interest in the DMEPOS supplier, each limited partner must be reported in this application, even though each owns less than 5 percent. The 5 percent threshold primarily applies to corporations and other organizations that are not partnerships.

For purposes of this application, the terms “officer,” “director,” and “managing employee” are defined as follows:

- The term “Officer” is defined as any person whose position is listed as being that of an officer in the DMEPOS supplier’s “articles of incorporation” or “corporate bylaws,” OR anyone who is appointed by the board of directors as an officer in accordance with the DMEPOS supplier’s corporate bylaws.
- The term “Director” is defined as a member of the DMEPOS supplier’s “board of directors.” It does not necessarily include a person who may have the word “Director” in his/her job title (e.g., Departmental Director, Director of Operations).
- The term “managing employee” means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operations of the DMEPOS supplier, either under contract or through some other arrangement, whether or not the individual is a W-2 employee of the DMEPOS supplier.

**NOTE:** If a governmental or tribal organization will be legally and financially responsible for Medicare payments received (per the instructions for Governmental/Tribal Organizations in Section 5), the supplier is only required to report its managing employees in Section 6. Owners, partners, officers, and directors do not need to be reported.

Any information on final adverse actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each individual.

**The supplier MUST have at least ONE owner and ONE managing employee.**

**NOTE:** An owner may also be the managing employee.

**SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)**

**A. INDIVIDUALS WITH OWNERSHIP INTEREST AND/OR MANAGING CONTROL— IDENTIFICATION 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.

<b>CHECK ONE</b>	<input type="checkbox"/> <b>CHANGE</b>	<input type="checkbox"/> <b>ADD</b>	<input type="checkbox"/> <b>DELETE</b>
<b>DATE</b> (mm/dd/yyyy)			

1. First Name	Middle Initial	Last Name	Jr., Sr., etc.	Title
Date of Birth (mm/dd/yyyy)		Place of Birth (State)		Country of Birth
Social Security Number (Required)		Medicare Identification Number (if issued)	NPI (if issued)	

2. What is the above individual’s relationship with the supplier in Section 2A1? (Check all that apply.)

- 5 Percent or Greater Direct/Indirect Owner
- Partner
- Managing Employee (W-2)
- Director/Officer
- Contracted Managing Employee
- Authorized Official
- Delegated Official
- Other \_\_\_\_\_

What is the effective date this owner acquired ownership of the supplier identified in Section 2A1 of this application? (mm/dd/yyyy) \_\_\_\_\_

What is the effective date this individual acquired managing control of the supplier identified in Section 2A1 of this application? (mm/dd/yyyy) \_\_\_\_\_

**NOTE:** Furnish both dates if applicable.

**B. FINAL ADVERSE LEGAL ACTION HISTORY**

Complete this section for the individual reported in Section 6A above.

If reporting a change to existing information, check “Change,” provide the effective date of the change, and complete the appropriate fields in this section.

Change       Effective Date: \_\_\_\_\_

1. Has this individual listed in Section 6A, under any current or former name or business entity, ever had a final adverse legal action listed on page 13 of this application imposed against it?

<input type="checkbox"/> YES—Continue Below	<input type="checkbox"/> NO—Skip to Section 8
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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.

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

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION



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**SECTION 7: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)**

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**SECTION 8: BILLING AGENCY INFORMATION**

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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 are responsible for the claims submitted on your behalf.

Check here  if this section does not apply and skip to Section 12.

**BILLING AGENCY NAME AND ADDRESS**

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

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE <i>(mm/dd/yyyy)</i>			

---

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

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

---

Tax Identification Number or Social Security Number *(required)*

---

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

---

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

---

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

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City/Town	State	ZIP Code + 4
Telephone Number	Fax Number <i>(if applicable)</i>	E-mail Address <i>(if applicable)</i>
Medicare Identification Number(s) <i>(if issued)</i>	NPI <i>(if issued)</i>	

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**SECTION 9: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)**

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**SECTION 10: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)**

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**SECTION 11: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)**

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## **SECTION 12: SURETY BOND INFORMATION**

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This section is to be completed by DMEPOS suppliers mandated by law to obtain a surety bond in order to enroll in and bill the Medicare program. Furnish all requested information about the supplier's insurance agent, surety company, and the surety bond. The surety bond must be a continuous bond. A copy of the original surety bond must be submitted with this application.

### **A. CHECK BOX:**

Check the box if this DMEPOS supplier believes it is not required to obtain a surety bond for Medicare enrollment. Information on supplier types exempt from getting a surety bond can be found at [www.palmettogba.com/nsc](http://www.palmettogba.com/nsc) or by calling the NSC customer service line at (866) 238-9652.

### **B. NAME AND ADDRESS OF SURETY BOND COMPANY:**

If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. Furnish the legal business name and tax identification number of the surety bond company liable for this bond.
2. Furnish the complete business address, telephone number and e-mail address of the surety bond company.

### **C. SURETY BOND INFORMATION:**

If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise, complete this section with specific information about the bond as follows:

1. State the dollar amount of the bond and the bond number.
2. Furnish the effective date of the bond. If reporting a new bond or new surety bond company, furnish the expiration date of the current bond.

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**SECTION 12: SURETY BOND INFORMATION (Continued)**

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This section is to be completed by all DMEPOS suppliers required by regulation (see 424.57 (c)(26) and 42 C.F.R. § 424.57 (d)) to obtain a surety bond in order to enroll and maintain Medicare billing privileges. Furnish all requested information about the supplier's insurance agent, surety company, and the surety bond.

**A. Check here  if this supplier is not required to obtain a surety bond for Medicare enrollment and skip to Section 13.** See instructions for surety bond requirements.

---

**B. Name and Address of Surety Bond Company**     **Change**    **Effective Date:** \_\_\_\_\_

Legal Business Name of Surety Bond Company as Reported to the IRS

Tax Identification Number

---

Business Address Line 1 (*Street Name and Number*)

---

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

---

City/Town

State

ZIP Code + 4

---

Telephone Number (*Ext.*)

Fax Number (*if applicable*)

E-mail Address (*if applicable*)

---

**C. Surety Bond Information**

**Change**    **Effective Date:** \_\_\_\_\_

Amount of Surety Bond

Surety Bond Number

**\$**

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Effective Date of Surety Bond (*mm/dd/yyyy*)

If reporting a new bond, give cancellation date of the current bond  
(*mm/dd/yyyy*)

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**SECTION 13: CONTACT PERSON**

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If questions arise during the processing of this application, the NSC will contact the individual shown below. If no one is listed below, we will contact you directly.

Contact the Authorized Official listed in Section 15.

Contact the Delegated Official listed in Section 16.

First Name	Middle Initial	Last Name	Jr., Sr., etc.
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Address Line 1 (*Street Name and Number*)

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

City/Town	State	ZIP Code + 4
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Telephone Number	Fax Number ( <i>if applicable</i> )	E-mail Address ( <i>if applicable</i> )
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## SECTION 14: PENALTIES FOR FALSIFYING INFORMATION ON THIS ENROLLMENT APPLICATION

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**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.

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**SECTION 14: PENALTIES FOR FALSIFYING INFORMATION ON THIS ENROLLMENT APPLICATION** *(Continued)*

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

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## SECTION 15: CERTIFICATION STATEMENT

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An **AUTHORIZED OFFICIAL** means an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program.

A **DELEGATED OFFICIAL** means an individual who is delegated by an authorized official the authority to report changes and updates to the supplier's enrollment record. The delegated official must be an individual with "ownership or control interest in" (as that term is defined in Section 1124(a)(3) of the Social Security Act) or be a W-2 managing employee of the supplier.

Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the supplier's Medicare status. Even when delegated officials are reported in this application, an authorized official retains the authority to make any such changes and/or updates by providing his or her printed name, signature, and date of signature as required in Section 15B.

**NOTE:** Authorized officials and delegated officials **must** be reported in Section 6 on this application.

By his/her signature, an authorized official binds the supplier to all of the requirements listed in the Certification Statement and acknowledges that the supplier may be denied entry to or revoked from the Medicare program if any requirements are not met. All signatures must be original and in ink. Faxed, photocopied, or stamped signatures will not be accepted.

During the reenrollment process, either an authorized official or delegated official can sign the certification statement.

By signing this application, an authorized official agrees to immediately notify the NSC if any information in this application is not true, correct, or complete. In addition, an authorized official, by his/her signature, agrees to notify the NSC of any future changes to the information contained in this application, after the supplier is enrolled in Medicare, within 30 days of the effective date of the change.

The supplier can have as many authorized officials as it wants. If the supplier has more than two authorized officials, it should copy and complete this section as needed.

**Each authorized and delegated official must have and disclose his/her Social Security Number.**

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## SECTION 15: CERTIFICATION STATEMENT *(Continued)*

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### A. ADDITIONAL REQUIREMENTS FOR MEDICARE ENROLLMENT

These are additional requirements that the supplier must meet and maintain to bill the Medicare program. Read these requirements carefully. By signing, the supplier is attesting to having read the requirements and understanding them.

By your signature(s), the authorized official(s) named below and the delegated official(s) named in Section 16 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.

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#### Certification Statement

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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.

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 the NSC of this fact in accordance with the time frames established in 42 CFR § 424.57.
2. I agree to notify the NSC of any future changes to the information contained in this application in accordance with the time frames established in 42 CFR § 424.57. I understand that any change in the business structure of this supplier 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 identification number(s), 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 this supplier. The Medicare laws, regulations, and program instructions are available through the Medicare 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 on the supplier's compliance with all applicable conditions of participation in Medicare.
5. Neither this supplier, nor any five percent or greater owner, partner, officer, director, managing employee, authorized official, or delegated official thereof is currently sanctioned, suspended, debarred, or excluded by the Medicare or State Health Care Program, e.g., Medicaid program, or any other Federal program, or is otherwise prohibited from supplying services to Medicare or other Federal program beneficiaries.
6. I agree that any existing or future overpayment made to the supplier by the Medicare program may be recouped by Medicare through the withholding of future payments.
7. 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.
8. I authorize any national accrediting body whose standards are recognized by the Secretary as meeting the Medicare program participation requirements, to release to any authorized representative, employee, or agent of the Centers for Medicare & Medicaid Services (CMS) a copy of my most recent accreditation survey, together with any information related to the survey that CMS may require (including corrective action plans).



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**SECTION 15: CERTIFICATION STATEMENT (Continued)**

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**B. 1<sup>ST</sup> AUTHORIZED OFFICIAL SIGNATURE**

I have read the contents of this application and the certification statement in section 15 of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize the NSC to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the NSC of this fact in accordance with the time frames established in 42 CFR § 424.57.

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

**NOTE:** Authorized officials must be reported in Section 6 of this application.

<b>CHECK ONE</b>	<input type="checkbox"/> <b>CHANGE</b>	<input type="checkbox"/> <b>ADD</b>	<input type="checkbox"/> <b>DELETE</b>
<b>DATE</b> (mm/dd/yyyy)			

**Authorized Official's Information and Signature**

First Name	Middle Initial	Last Name	Suffix (e.g., Jr., Sr.)
Telephone Number	E-mail Address	Title/Position	
Authorized Official Signature (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)			Date Signed (mm/dd/yyyy)

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

**C. 2<sup>ND</sup> AUTHORIZED OFFICIAL SIGNATURE**

I have read the contents of this application and the certification statement in section 15 of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize the NSC to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the NSC of this fact in accordance with the time frames established in 42 CFR § 424.57.

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

**NOTE:** Authorized officials must be reported in Section 6 of this application.

<b>CHECK ONE</b>	<input type="checkbox"/> <b>CHANGE</b>	<input type="checkbox"/> <b>ADD</b>	<input type="checkbox"/> <b>DELETE</b>
<b>DATE</b> (mm/dd/yyyy)			

**Authorized Official's Information and Signature**

First Name	Middle Initial	Last Name	Suffix (e.g., Jr., Sr.)
Telephone Number	E-mail Address	Title/Position	
Authorized Official Signature (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)			Date Signed (mm/dd/yyyy)

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

**SECTION 16: DELEGATED OFFICIAL(S) (Optional)**

- You are not required to have a delegated official. However, if no delegated official is assigned, the authorized official(s) will be the only person(s) who can make changes and/or updates to the supplier’s status in the Medicare program.
- The signature of a delegated official shall have the same force and effect as that of an authorized official, and shall legally and financially bind the supplier to the laws, regulations, and program instructions of the Medicare program. By his or her signature, a delegated official certifies that he or she has read the Certification Statement in Section 15 and agrees to adhere to all of the stated requirements. The delegated official also certifies that he/she meets the definition of a delegated official. When making changes and/or updates to the supplier’s enrollment information maintained by the Medicare program, the delegated official certifies that the information provided is true, correct, and complete.
- A delegated official who is being deleted does not have to sign or date this application.
- Independent contractors are not considered “employed” by the supplier. Therefore, an independent contractor cannot be a delegated official.
- The signature of an authorized official in Section 16 constitutes a legal delegation of authority to all delegated official(s) assigned in Section 16.
- If there are more than two individuals, copy and complete this section for each individual.
- Delegated officials must be reported in section 6 of this application.

**A. 1<sup>ST</sup> DELEGATED OFFICIAL SIGNATURE**

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

**NOTE:** Delegated officials must be reported in Section 6 of this application.

<b>CHECK ONE</b>	<input type="checkbox"/> <b>CHANGE</b>	<input type="checkbox"/> <b>ADD</b>	<input type="checkbox"/> <b>DELETE</b>
<b>DATE</b> (mm/dd/yyyy)			

Delegated Official First Name	Middle Initial	Last Name	Suffix (e.g., Jr., Sr.)
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Delegated Official Signature (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)	Date Signed (mm/dd/yyyy)
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Telephone Number	E-mail Address
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Authorized Official’s Signature Assigning this Delegation (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)	Date Signed (mm/dd/yyyy)
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Check here if Delegated Official is a W-2 Employee

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**SECTION 16: DELEGATED OFFICIAL(S) (Optional)**

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**B. 2<sup>ND</sup> DELEGATED OFFICIAL SIGNATURE**

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

**NOTE:** Delegated officials must be reported in Section 6 of this application.

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			

Delegated Official First Name	Middle Initial	Last Name	Suffix (e.g., Jr., Sr.)
Delegated Official Signature (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)			Date Signed (mm/dd/yyyy)
Telephone Number	E-mail Address		
Authorized Official's Signature Assigning this Delegation (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)			Date Signed (mm/dd/yyyy)

Check here if Delegated Official is a W-2 Employee

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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 0938-1056. The time required to complete this information collection is estimated to 6.5 hours 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.

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## SECTION 17: SUPPORTING DOCUMENTS

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This section lists the documents that, if applicable, must be submitted with this completed enrollment application. If you are newly enrolling, adding a new location, reactivating or reenrolling, you must provide all applicable documents. For changes, only submit documents that are applicable to the change requested. All enrolling DMEPOS suppliers are required to furnish information on all Federal, State, and local professional and business licenses, certifications, and/or registrations required to practice as a DMEPOS supplier in the DMEPOS supplier's State of business location as reported in Section 4A. Check the NSC website for further guidance on supplier requirements. You are responsible for supplying and adhering to all required licensure/ certification, requirements, etc. for the supplies/services you provide.

The enrolling DMEPOS supplier may submit a notarized Certificate of Good Standing from the DMEPOS supplier's business location's State licensing/certification board or other medical associations, in lieu of copies of the requested documents. This certification cannot be more than 30 days old.

If the enrolling DMEPOS supplier has had a previously revoked or suspended license, certification, or registration reinstated, attach a copy of the reinstatement notice with this application.

### MANDATORY

- Copy(s) of all Federal, State, and/or local (city/county) professional licenses, certifications and/or registrations, including licensure, certifications and/or registrations for applicable specialty supplier types, products and services.
- Copy(s) of all Federal, State, and/or local (city/county) business licenses, certifications and/or registrations.
- Copy(s) of all liability insurance policies.
- Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name (e.g., IRS form CP 575) provided in Section 2.  
(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.)
- Completed Form CMS-588, Electronic Funds Transfer Authorization Agreement.  
(Note: If a supplier already receives payments electronically and is not making a change to its banking information, the CMS-588 is not required.)

### MANDATORY, IF APPLICABLE

- Copy of IRS Determination Letter, if supplier is registered with the IRS as non-profit.
- 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 treated as an entity not separate from its single owner for income tax purposes.)
- Copy(s) of all final adverse action documentation (e.g., notifications, resolutions, and reinstatement letters).
- Copy(s) of all State pharmacy licenses
- Statement in writing from the bank. If Medicare payment due a supplier is being sent to a bank (or similar financial institution) where the supplier has a lending relationship (that is, any type of loan), then the supplier 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.
- Copy of delegated official's W-2 if one has been designated.
- Copy of your bill of sale if you purchased an existing DMEPOS supplier with an active Medicare supplier billing number.
- Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement.
- Copy of Surety Bond.

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## **CMS MEDICARE DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS) SUPPLIER STANDARDS**

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A complete list of the DMEPOS supplier standards, including the surety bond provisions, can be found at [http://www.cms.gov/MedicareProviderSupEnroll/10\\_DMEPOSSupplierStandards.asp#TopOfPage](http://www.cms.gov/MedicareProviderSupEnroll/10_DMEPOSSupplierStandards.asp#TopOfPage). An abbreviated list of the Supplier Standards can be viewed and downloaded from the National Supplier Clearinghouse Medicare Administrative Contractor (NSC-MAC) at <http://www.palmettogba.com/nsc>.

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## MEDICARE SUPPLIER ENROLLMENT APPLICATION PRIVACY ACT STATEMENT

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The Centers for Medicare & Medicaid Services (CMS) is authorized to collect the information requested on this form by sections 1124(a)(1), 1124A(a)(3), 1128, 1814, 1815, 1833(e), and 1842(r) of the Social Security Act [42 U.S.C. §§ 1320a-3(a)(1), 1320a-7, 1395f, 1395g, 1395(l)(e), and 1395u(r)] 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 enroll in the Medicare program as 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 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 (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.