MEDICARE ENROLLMENT APPLICATION

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

CMS-855S

SEE PAGE 1 FOR A LIST OF THE DMEPOS SUPPLIER STANDARDS. TO ENROLL IN THE MEDICARE PROGRAM AND BE ELIGIBLE TO SUBMIT CLAIMS AND RECEIVE PAYMENTS, EVERY DMEPOS SUPPLIER APPLICANT MUST MEET AND MAINTAIN THESE ENROLLMENT STANDARDS.

SEE PAGE 2 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION.

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

SEE SECTION 12 FOR A LIST OF SUPPORTING DOCUMENTATION TO BE SUBMITTED WITH THIS APPLICATION.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-1056

DMEPOS SUPPLIER STANDARDS FOR MEDICARE ENROLLMENT

This is an abbreviated list of the standards every Medicare DMEPOS supplier must meet in order to obtain and retain their billing privileges. These standards, in their entirety, including the surety bond provisions, are listed in 42 C.F.R. 424.57(c) and can be found at http://www.cms.gov/MedicareProviderSupEnroll/10_DMEPOSSupplierStandards.asp#TopOfPage.

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse Medicare Administrative Contractor within 30 days.
3. An authorized individual (one whose signature is binding) must sign the application for billing privileges.
4. A supplier must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from any other Federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site. This standard requires that the location is accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records. The supplier location must be accessible to beneficiaries during reasonable business hours, and must maintain a visible sign and posted hours of operation.
8. A supplier must permit CMS, or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations.
11. A supplier must agree not to initiate telephone contact with beneficiaries, with a few exceptions allowed. This standard prohibits suppliers from contacting a Medicare beneficiary based on a physician's oral order unless an exception applies.
12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items, and maintain proof of delivery.
13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair directly, or through a service contract with another company, Medicare-covered items it has rented to beneficiaries.
15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these supplier standards to each beneficiary to whom it supplies a Medicare-covered item.
17. A supplier must disclose to the government any person having ownership, financial, or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number; i.e., the supplier may not sell or allow another entity to use its Medicare billing number.
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
21. A supplier must agree to furnish CMS any information required by the Medicare statute and implementing regulations.
22. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment of those specific products and services (except for certain exempt pharmaceuticals).
23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
26. Must meet the surety bond requirements specified in 42 C.F.R. 424.57(d).
27. A supplier must obtain oxygen from a state- licensed oxygen supplier.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 C.F.R. 424.516(f).
29. DMEPOS suppliers are prohibited from sharing a practice location with certain other Medicare providers and suppliers.
30. DMEPOS suppliers must remain open to the public for a minimum of 30 hours per week with certain exceptions.

WHO SHOULD COMPLETE AND SUBMIT THIS APPLICATION

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)
- Ocularist
- Occupational Therapist
- Optician
- Orthotics Personnel
- Oxygen and/or Oxygen Related Equipment Supplier
- Pedorthic Personnel
- Pharmacy
- Physical Therapist
- Physician, including Dentist and Optometrist
- Prosthetics Personnel
- Prosthetic/Orthotic Personnel
- Rehabilitation Agency
- Skilled Nursing Facility
- Sleep Laboratory/Medicine
- Sports Medicine

If your DMEPOS supplier type is not listed, contact the National Supplier Clearinghouse Medicare Administrative Contractor (NSC MAC) 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 current business, (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 change.
- Currently enrolled in Medicare as a DMEPOS supplier and need to enroll a new business location using the same tax identification number already enrolled with the NSC MAC.
- Currently enrolled in Medicare as a DMEPOS supplier and need to enroll a new business location using a tax identification number not currently enrolled with the NSC MAC.
- Currently enrolled in Medicare as a DMEPOS supplier and received notice to revalidate your enrollment.
- Reactivating your Medicare DMEPOS supplier billing number.
- Voluntarily terminating your Medicare DMEPOS supplier billing number.

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
- submitting the paper CMS-855S enrollment application. When submitting the paper CMS-855S application, be sure you are using the most current version.

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

BILLING NUMBER AND NATIONAL PROVIDER IDENTIFIER INFORMATION

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

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

NOTE: The Legal Business Name (LBN) and Tax Identification Number (TIN) that you furnish in Section 1B of this application must be the same LBN and TIN you used to obtain your National Provider Identifier (NPI). Your Legal Business Name, Tax Identification Number and National Provider Identifier ***must*** match exactly in both the Medicare Provider Enrollment Chain and Ownership System (PECOS) and the National Plan and Provider Enumeration System (NPPES).

INSTRUCTIONS FOR COMPLETING THIS APPLICATION

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

TIPS TO AVOID DELAYS IN YOUR ENROLLMENT

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

- Complete all required sections as shown in Section 1;
- Complete Section 9 for all delegated and authorized officials reported in Sections 14 and 15;
- List at least one managing employee for each location;
- Enter your NPI in the applicable sections;
- Include the Electronic Funds Transfer (EFT) Agreement with your enrollment application;
- Respond timely to development/information requests; and
- Be sure the Legal Business Name shown in Section 1B matches the name on your tax documents.

Additional information and reasons for enrollment processing delays can be found on the NSC MAC website at **www.palmettogba.com/nsc.**

PROCESS FOR OBTAINING MEDICARE APPROVAL

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

1. The supplier obtains the required National Provider Identification Number (NPI), surety bond and/or accreditation **PRIOR** to completing and submitting this application to the NSC MAC.
2. The supplier completes and submits an enrollment application (CMS-855S) and all supporting documentation to the NSC MAC.
3. The NSC MAC 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.
4. After completing its review, the NSC MAC notifies the applicant in writing about its enrollment decision.

ADDITIONAL INFORMATION

The NSC MAC 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 within 30 days of the request.

The information you provide on this form will only be disclosed according to the routine uses found in the Privacy Act Statement on the last page of this application. It is considered to be protected under 5 U.S.C. Section 552(b)(4) and/or (b)(6), respectively. For more information, read the Privacy Act Statement.

ACRONYMS COMMONLY USED IN THIS APPLICATION

C.F.R: Code of Federal Regulation

DME MAC: Durable Medical Equipment Medicare Administrative Contractor

DMEPOS: Durable Medical Equipment, Prosthetics, Orthotics and Supplies

EFT: Electronic Funds Transfer

IRS: Internal Revenue Service

LBN: Legal Business Name

LLC: Limited Liability Corporation

NPI: National Provider Identifier

NPPES: National Plan and Provider Enumeration System

NSC MAC: National Supplier Clearinghouse Medicare Administrative Contractor

PECOS: Provider Enrollment Chain and Ownership System

SSN: Social Security Number

TIN: Tax Identification Number

U.S.C.: United States Code

WHERE TO MAIL YOUR APPLICATION

The NSC MAC is responsible for processing your enrollment application. Mail this application to:

National Supplier Clearinghouse
Post Office Box 100142
Columbia, SC 29202-3142

Customer Service: 1-866-238-9652
Web: **https://www.palmettogba.com/nsc**

Overnight Mailing Address:
National Supplier Clearinghouse
Palmetto GBA* AG-495
2300 Springdale Drive, Bldg. 1
Camden, SC 29020

SECTION 1: BASIC INFORMATION

This section captures information regarding the reason you are submitting this application. Read this section in full prior to indicating the reason for submission in Section 1B.

NEW ENROLLEES AND THOSE REPORTING A NEW TAX ID NUMBER

You are considered a new enrollee if you are:

- Enrolling in the Medicare program as a DMEPOS supplier for the first time under the tax identification number reported in Section 1B.
- Currently enrolled 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 in it's entirety.
- A currently enrolled DMEPOS supplier under new ownership with a different tax identification number. **NOTE:** New owners of existing DMEPOS suppliers must submit a dated bill of sale with the effective date of the new ownership.

CURRENTLY ENROLLED MEDICARE DMEPOS SUPPLIERS

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 MAC, you will need to complete only the required sections listed in Section 1C of this application for the new location.

Change of Information Other Than Adding a New Location
If you are adding, deleting, or changing information under your current Medicare supplier billing number, including a change of ownership that does not change the current tax identification number. Any change to your existing enrollment data must be reported within 30 days of the effective date of the change.

Reactivation
If your Medicare DMEPOS supplier billing number was deactivated, you will be required to submit an updated CMS-855S. You must also meet all current requirements for your supplier type to reactivate your supplier billing number.

Revalidation
If you have been contacted by the NSC MAC to revalidate your Medicare enrollment you will be required to submit an updated enrollment application. Do not submit an application for revalidation until you have been contacted by the NSC MAC.

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.

NOTE: Enrollment applications submitted for "NEW ENROLLEES" **MUST** be signed by an Authorized Official, otherwise they will be returned unprocessed.

SECTION 1: BASIC INFORMATION *(Continued)*

A. BUSINESS LOCATION

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

☐☐

B. BUSINESS IDENTIFICATION

DMEPOS suppliers must furnish their National Provider Identifier (NPI), Tax Identification Number (TIN), and Supplier Billing Number (if issued) below.

NOTE: Each practice location **MUST** have it's own NPI, unless enrolling as a sole proprietor/proprietorship with multiple locations. See Section 2C.

Legal Business Name (LBN)		
National Provider Identifier (NPI)	Tax Identification Number (TIN)	Supplier Billing Number *(if issued)*

C. REASON FOR SUBMITTING THIS APPLICATION

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

☐ You are a **new enrollee** in Medicare or are enrolling a new location with a tax identification number not previously enrolled with the NSC MAC.	**Complete all sections**
☐ You are **adding a new business location** using a tax identification number currently enrolled with the NSC MAC.	**1–4, 6–7, 9 *(for managing employee only)*, 11, and either 14 or 15**
☐ You are **adding a new business location** using a tax identification number **NOT** currently enrolled with the NSC MAC.	**Complete all sections**
☐ You are **reactivating** your Medicare Supplier Billing Number.	**Complete all sections**
☐ You are **revalidating** your Medicare enrollment.	**Complete all sections**
☐ You are **voluntarily terminating your Medicare enrollment**. Effective date of termination: _____	**1, 2A, 4B, 4D, 11, and either 14 or 15**
☐ You are **changing your Medicare enrollment information** other than your tax identification number.	**Go to Section 1D**
☐ You are **changing your Tax Identification Number**.	**Complete all sections**

SECTION 1: BASIC INFORMATION *(Continued)*

D. WHAT INFORMATION IS CHANGING?

Check all that apply and complete the required sections.

PLEASE NOTE: When reporting ANY change of information, Sections 1B, 7 and either 14 or 15 MUST always be completed. Otherwise, only complete the information that is changing within the required Section or Sub-Section.

CHECK ALL THAT APPLY	REQUIRED SECTIONS
☐ Current Business Location	**1, 2A, 2B, 5, 7, 11 (optional), and either 14 or 15**
☐ Supplier Type *(submit licensure if applicable)* ☐ Products and Services *(submit accreditation if applicable)*	**1, 3, 7, 11 (optional), and either 14 or 15**
☐ Accreditation Information	**1, 3, 7, 11 (optional), and either 14 or 15**
☐ Address Information ☐ 1099 Mailing Address ☐ Correspondence Mailing Address ☐ Revalidation Mailing Address ☐ Remittance/Special Payment Mailing Address ☐ Record Storage Address	**1, 4 as applicable for the address that is being changed, 7, 11 (optional), and either 14 or 15.**
☐ Comprehensive Liability Insurance Information	**1, 5, 7, 11 (optional), and either 14 or 15**
☐ Surety Bond Information	**1, 6, 7, 11 (optional), and either 14 or 15**
☐ Final Adverse Legal Actions	**1, 7, 11 (optional), and either 14 or 15**
☐ Ownership and/or Managing Control Information (Organizations and/or Individuals)	**1, 7, 8 and/or 9, 11 (optional), and either 14 or 15**
☐ Billing Agency Information	**1, 7, 10, 11 (optional), and either 14 or 15**
☐ Delegated Official	**1, 7, 9, 11 (optional), 14 and 15**
☐ Authorized Official	**1, 7, 9, 11 (optional), 15**
☐ Any other information not specified above	**1, 7, 11 (optional), and either 14 or 15 and the applicable section or sub-section that is changing.**

SECTION 2: IDENTIFYING INFORMATION

A. BUSINESS LOCATION INFORMATION

This section captures information regarding your business location.

- **A separate application must be submitted for each physical business location** that you intend to bill Medicare for items sold or services rendered 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 located 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.

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

☐ **Change** **Effective Date** *(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, Apt. #, 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)*

B. HOURS OF OPERATION

List your ***posted*** hours of operation as displayed at the business location in Section 2A above.

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

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

You must list all hours of each day you are open or available to the public, including "By Appointment" times.

Check and/or complete all boxes and/or sections for each day as appropriate.

☐ Open 24/7 (Open 24 hours a day, 7 days a week)
☐ By Appointment Only (no fixed days or hours), or
☐ By Appointment Only (days and times indicated below)

Day of Week	By Appointment Only	Hours		Hours		Closed All Day	Total Hours Available to Public for Day
		Open	Close	Open	Close		
Sunday	☐ Yes ☐ No					☐ Yes ☐ No	
Monday	☐ Yes ☐ No					☐ Yes ☐ No	
Tuesday	☐ Yes ☐ No					☐ Yes ☐ No	
Wednesday	☐ Yes ☐ No					☐ Yes ☐ No	
Thursday	☐ Yes ☐ No					☐ Yes ☐ No	
Friday	☐ Yes ☐ No					☐ Yes ☐ No	
Saturday	☐ Yes ☐ No					☐ Yes ☐ No	
Please indicate A.M. or P.M next to each time.					**Total Hours Available to Public for Week**		

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

C. BUSINESS STRUCTURE INFORMATION

Identify the type of business 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")
☐ Limited Liability Company (LLC)
☐ Partnership ("general" or "limited")
☐ Sole Proprietor/Sole Proprietorship
☐ Government Owned
☐ Other (Specify) _____

D. INTERNAL REVENUE SERVICE REGISTRATION INFORMATION

Identify how your business is registered with the IRS.

If you check Non-Profit submit a copy of your IRS 501(c)(3).

If you check Disregarded Entity submit a copy of your IRS Form 8832.

NOTE: If your business is a Federal and/or State government supplier indicate "Non-Profit" below.

☐ Proprietary ☐ Non-Profit ☐ Disregarded Entity

E. STATES WHERE ITEMS PROVIDED

Select all State(s)/Territory(ies) where you provide items or services to Medicare beneficiaries from the business location in Section 2A. For each State/Territory selected, submit all required licenses for the products and services being provided.

Jurisdiction A:
☐ All States in Jurisdiction A

☐ Connecticut	☐ Maine	☐ New Hampshire	☐ Pennsylvania
☐ Delaware	☐ Maryland	☐ New Jersey	☐ Rhode Island
☐ District of Columbia	☐ Massachusetts	☐ New York	☐ Vermont

Jurisdiction B:
☐ All States in Jurisdiction B

☐ Illinois	☐ Michigan	☐ Wisconsin
☐ Indiana	☐ Minnesota	
☐ Kentucky	☐ Ohio	

Jurisdiction C:
☐ All States and Territories in Jurisdiction C

☐ Alabama	☐ Louisiana	☐ Puerto Rico	☐ Virginia
☐ Arkansas	☐ Mississippi	☐ South Carolina	☐ West Virginia
☐ Colorado	☐ New Mexico	☐ Tennessee	
☐ Florida	☐ North Carolina	☐ Texas	
☐ Georgia	☐ Oklahoma	☐ Virgin Islands	

Jurisdiction D:
☐ All States and Territories in Jurisdiction D

☐ Alaska	☐ Idaho	☐ Nebraska	☐ Utah
☐ Arizona	☐ Iowa	☐ Nevada	☐ Washington
☐ California	☐ Kansas	☐ North Dakota	☐ Wyoming
☐ Guam	☐ Missouri	☐ Oregon	☐ Northern Mariana Islands
☐ Hawaii	☐ Montana	☐ South Dakota	☐ American Samoa

SECTION 3: PRODUCTS/ACCREDITATION INFORMATION

A. 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 Sections 3C and 3D.

Check all that apply:

- ☐ Ambulatory Surgical Center
- ☐ Department Store
- ☐ Grocery Store
- ☐ Home Health Agency
- ☐ Hospital
- ☐ Indian Health Service
- ☐ Intermediate Care Nursing Facility
- ☐ Medical Supply Company
- ☐ Medical Supply Company with Orthotics Personnel
- ☐ Medical Supply Company with Pedorthic Personnel
- ☐ Medical Supply Company with Prosthetics Personnel
- ☐ Medical Supply Company with Prosthetic and Orthotic Personnel
- ☐ Medical Supply Company with Registered Pharmacist
- ☐ Medical Supply Company with Respiratory Therapist
- ☐ Nursing Facility (other)
- ☐ Ocularist
- ☐ Occupational Therapist
- ☐ Optician
- ☐ Orthotics Personnel
- ☐ Oxygen and/or Oxygen Related Equipment Supplier
- ☐ Pedorthic Personnel
- ☐ Pharmacy
- ☐ Physical Therapist
- ☐ Physician
- ☐ Physician/Dentist
- ☐ Physician/Optometrist
- ☐ Prosthetics Personnel
- ☐ Prosthetic and Orthotic Personnel
- ☐ Rehabilitation Agency
- ☐ Skilled Nursing Facility
- ☐ Sleep Laboratory/Medicine
- ☐ Sports Medicine
- ☐ Other_____

B. ACCREDITATION INFORMATION

NOTE: If more than one accreditation needs to be reported, copy and complete this section for each.

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

- ☐ The enrolling supplier business location in Section 2A is accredited.
- ☐ The enrolling supplier business location in Section 2A is exempt from accreditation requirements.

To determine if you qualify for exemption, go to **https://www.palmettogba.com/NSC**.

Name of Accrediting Organization

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

C. NON-ACCREDITED PRODUCTS

Check all that apply. These products do not require accreditation.

- ☐ Epoetin
- ☐ Immunosuppressive Drugs
- ☐ Infusion Drugs
- ☐ Nebulizer Drugs
- ☐ Oral Anticancer Drugs
- ☐ Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)

NOTE: ☐ Check here if the supplier provides one or more of the products shown above but does not furnish any of the products and/or services listed in Section 3D. If checked, skip Section 3D and continue to Section 4.

SECTION 3: PRODUCTS/ACCREDITATION INFORMATION *(Continued)*

D. PRODUCTS AND SERVICES FURNISHED BY THIS SUPPLIER

Check all that apply and submit all applicable licenses and/or certifications.

If you are unsure of the licensure and/or certification and/or accreditation requirements for your product(s) or services(s), check with your State. The NSC MAC website at **https://www.palmettogba.com/nsc** may offer guidance. Failure to attach applicable licensure and/or certification could result in denial or revocation of your Medicare billing privileges and/or overpayment collection.

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

SECTION 4: IMPORTANT ADDRESS INFORMATION

DO NOT PROVIDE ANY INFORMATION ABOUT YOUR BILLING AGENT ANYWHERE IN SECTION 4. SEE SECTION 10 TO REPORT ALL BILLING AGENT INFORMATION.

A. 1099 MAILING ADDRESS

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

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

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

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

Organizational Suppliers: 1099 Mailing Address

Legal Business Name as Reported to the IRS		
Tax Identification Number	Prior Tax Identification Number *(if applicable)*	
1099 Mailing Address Line 1 *(P.O. Box or Street Name and Number)*		
1099 Mailing Address Line 2 *(Suite, Room, Apt. #, etc.)*		
1099 Mailing Address City/Town	1099 Mailing Address State	1099 Mailing Address ZIP Code + 4

2. Sole Proprietors

If you are a sole proprietor (the only owner of a business that is not incorporated), list your Social Security Number (SSN) and the full legal name associated with your 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.

NOTE: Sole Proprietors: If you furnish an EIN, payment will be made to your EIN. If you do not furnish an EIN, 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 document issued by the IRS showing the EIN and legal name for this business MUST be submitted.

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

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

Sole Proprietors: 1099 Mailing Address

Full Legal Name Associated with this Social Security Number		
Social Security Number	Employer Identification Number	Prior Employer Identification Number *(if applicable)*
1099 Mailing Address Line 1 *(P.O. Box or Street Name and Number)*		
1099 Mailing Address Line 2 *(Suite, Room, Apt. #, etc.)*		
1099 Mailing Address City/Town	1099 Mailing Address State	1099 Mailing Address ZIP Code + 4

SECTION 4: IMPORTANT ADDRESS INFORMATION *(Continued)*

B. CORRESPONDENCE MAILING ADDRESS

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

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

☐ Check here if you want all Correspondence mailed to your Business Location Address in Section 2A and skip this section.

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

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

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

Attention

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

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

City/Town	State	ZIP Code + 4

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

C. REVALIDATION REQUEST PACKAGE MAILING ADDRESS

This is the address where the NSC MAC will send your enrollment revalidation request package.

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

☐ Check here if your Revalidation Request Package should be mailed to your Business Location Address in Section 2A and skip this section.

☐ Check here if your Revalidation Request Package should be mailed to your Correspondence Address in Section 4B and skip this section.

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

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

Business Location Name

Attention

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

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

City/Town	State	ZIP Code + 4

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

SECTION 4: IMPORTANT ADDRESS INFORMATION *(Continued)*

D. REMITTANCE NOTICES/SPECIAL PAYMENTS MAILING ADDRESS

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

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

☐ Check here if your Remittance Notices/Special Payments should be mailed to your Business Location Address in Section 2A and skip this section.

☐ Check here if your Remittance Notices/Special Payments should be mailed to your Correspondence Address in Section 4B and skip this section.

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 need to make changes to your current EFT Authorization Agreement (CMS-588), contact the DME MAC.

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

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

NOTE: Payments will be made in the supplier's "legal business name" as shown in Section 1B.

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

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

City/Town	State	ZIP Code + 4

E. MEDICARE BENEFICIARY MEDICAL RECORDS STORAGE ADDRESS

If the Medicare beneficiaries' (current and former) medical records are stored at a location other than the location shown in Section 2A in accordance with 42 C.F.R. 424.57 (c)(7)(E), complete this section with the name and address of the storage location. This includes the records for both current and former Medicare beneficiaries.

Post office boxes and drop boxes are not acceptable as a physical address where Medicare beneficiaries' records are maintained. The records must be the supplier's records, not the records of another supplier. If all records are stored at the business location reported in Section 2A, please indicate below.

☐ Records are stored at the business location reported in Section 2A.

If you are adding or deleting a storage location, please check the box and furnish the effective date below.

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

1. Paper Storage

Name of Storage Facility

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

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

City/Town	State	ZIP Code + 4

2. Electronic Storage

Do you store your patient medical records electronically? ☐ **Yes** ☐ **No**

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

Site where electronic records stored

SECTION 5: COMPREHENSIVE LIABILITY INSURANCE INFORMATION

Consistent with DMEPOS supplier standard #10, all DMEPOS suppliers must have comprehensive liability insurance in the amount of at least $300,000 per occurrence and remain in force at all times. The NSC MAC, with full mailing address as shown on page 3, must be listed on the policy as a Certificate Holder. You must submit a copy of the liability insurance policy or evidence of self-insurance with this application. 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 is not the same as Comprehensive Liability Insurance and does not meet compliance for this requirement.

If you are changing insurance information, check the applicable box and furnish the effective date.

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

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., M.D., etc.
Agent's Telephone Number	Agent's Fax Number *(if applicable)*		Agent's E-mail Address *(if applicable)*
Underwriter's Company Name			
Underwriter's Telephone Number	Underwriter's Fax Number *(if applicable)*		Underwriter's E-mail Address *(if applicable)*

SECTION 6: SURETY BOND INFORMATION

This section is to be completed by all DMEPOS suppliers as required by regulation 42 C.F.R. § 424.57(d) to obtain a surety bond. Furnish all requested information about the surety bond company, and the surety bond. A copy of the original surety bond, signed by the Delegated or Authorized Official, must be submitted with this application.

☐ Check here if this supplier is not required to obtain a surety bond and skip to Section 7.

A. NAME AND ADDRESS OF SURETY BOND COMPANY

If you are changing surety bond information, check the applicable box and furnish the effective date.

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

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, Apt. #, etc.)*	

City/Town	State	ZIP Code + 4

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

B. SURETY BOND INFORMATION

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

Amount of Surety Bond **$**	Surety Bond Number
Effective Date of Surety Bond *(mm/dd/yyyy)*	If reporting a new bond, give cancellation date of the current bond *(mm/dd/yyyy)*

SECTION 7: FINAL ADVERSE LEGAL ACTIONS

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

A. CONVICTIONS

1. The DMEPOS supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense. Reportable offenses include, but are not limited to:
   - Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions;
   - Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions;
   - Any felony that placed the Medicare program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and
   - Any felony that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
2. Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
5. Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

B. EXCLUSIONS, REVOCATIONS OR SUSPENSIONS

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation or suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any past or current Medicare payment suspension under any Medicare billing number.
5. Any Medicare revocation of any Medicare billing number.

C. FINAL ADVERSE LEGAL ACTION HISTORY

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

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

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

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

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

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

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

SECTION 8: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS)

NOTE: Only report organizations in this section. Individuals must be reported in Section 9.

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 2A, as well as any information on final adverse legal actions that have been imposed against that organization. For more information on "direct" and "indirect" owners and examples of organizations that must be reported in this section, go to: **https://www.cms.gov/MedicareProviderSupEnroll.** If there is more than one organization with ownership interest or managing control, copy and complete this section for each.

OWNERSHIP INTEREST (ORGANIZATIONS)

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.

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

MANAGING CONTROL (ORGANIZATIONS)

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.

SPECIAL TYPES OF ORGANIZATIONS

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 must 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 MAC 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 must be reported in this section. While the organization must be reported in Section 8, individual board members must be reported in Section 9. Each non-profit organization must submit a copy of the IRS document 501(c)(3) verifying its non-profit status.

SECTION 8: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS) *(Continued)*

A. ORGANIZATION IDENTIFICATION INFORMATION (OWNERSHIP AND/OR MANAGING CONTROL)

☐ Check here if this section is not applicable for the supplier reported in Section 2A, and skip to Section 9.

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

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

1. Complete all identifying information below.

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, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

Tax Identification Number *(Required)*	NPI *(if issued)*	Medicare Identification Number(s) *(if issued)*

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

2. What is the above organization's relationship with the supplier in Section 2A? (Check all that apply.)
   ☐ 5 Percent or More Ownership Interest ☐ Partner ☐ Managing Control

3. What is the effective date this organization acquired and/or ended ownership or a partnership of the supplier identified in Section 2A of this application? Furnish both dates if applicable.
   ☐ **Acquired** **Effective Date** *(mm/dd/yyyy)*: _____
   ☐ **Ended** **Effective Date** *(mm/dd/yyyy)*: _____

4. What is the effective date this organization acquired and/or ended managing control of the supplier identified in Section 2A of this application? Furnish both dates if applicable.
   ☐ **Acquired** **Effective Date** *(mm/dd/yyyy)*: _____
   ☐ **Ended** **Effective Date** *(mm/dd/yyyy)*: _____

B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for each organization reported in Section 8A.

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

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

1. Has this organization in Section 8A above, under any current or former name or business identity, ever had a final adverse legal action listed in Section 7 of this application imposed against it?
   ☐ YES–Continue Below ☐ NO–Skip to Section 9

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

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

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

SECTION 9: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS)

NOTE: Only report individuals in this section. Organizations must be reported in Section 8.

Complete this section with information about all individuals 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 2A, as well as any information on final adverse legal actions that have been imposed against that individual. For more information on "direct" and "indirect" owners and examples of individuals that must be reported in this section, go to: **https://www.cms.gov/MedicareProviderSupEnroll.** If there is more than one individual with ownership interest or managing control, copy and complete this section for each.

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 9A:

- 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 8 as an owner of the supplier. Assume further that Individual D, as an indirect owner of the supplier, is reported in Section 9A1. Based on this example, the suppler would check the "5 Percent or Greater Direct/Indirect Owner" box in Section 9A2.

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 8), the supplier is only required to report its managing employees in Section 9. Owners, partners, officers, and directors do not need to be reported.

SECTION 9: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) *(Continued)*

A. INDIVIDUAL IDENTIFICATION INFORMATION (OWNERSHIP AND/OR MANAGING CONTROL)

If you need to report more than one individual, copy and complete this section for each.

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

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

1. Complete all identifying information below.

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

Social Security Number *(Required)*	Date of Birth *(mm/dd/yyyy)*

Supplier Billing Number *(if issued)*	NPI *(if issued)*

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

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

☐ 5 Percent or Greater Direct/Indirect Owner
☐ Partner
☐ Director/Officer
☐ Contracted Managing Employee
☐ Managing Employee (W-2)

3. What is the above individual's title? _____

4. What is the effective date this individual acquired and/or ended ownership or a partnership of the supplier identified in Section 2A of this application? Furnish both dates if applicable.

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

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

5. What is the effective date this individual acquired and/or ended managing control (Director, Officer, Managing Employee) of the supplier identified in Section 2A of this application? Furnish both dates if applicable.

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

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

6. Is the above individual also an Delegated Official or Authorized Official?

☐ Delegated Official ☐ Authorized Official ☐ Neither

B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for the individual reported in Section 9A above.

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

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

1. Has this individual listed in Section 9A, under any current or former name or business entity, ever had a final adverse legal action listed in Section 7 of this application imposed against it?

☐ YES–Continue Below ☐ NO–Skip to Section 10

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

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

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

SECTION 10: BILLING AGENCY INFORMATION

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

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

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.

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

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

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

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

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

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

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

City/Town	State	ZIP Code + 4

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

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

SECTION 11: CONTACT PERSON INFORMATION

If questions arise during the processing of this application, the NSC MAC will contact the individual checked below.

☐ Contact the Delegated Official reported in Section 14.
☐ Contact the Authorized Official reported in Section 15.
☐ Contact the person reported below.

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

Address Line 1 *(Street Name and Number)*

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

City/Town	State	ZIP Code + 4

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

Relationship or Affiliation to this Supplier

NOTE: The Contact Person reported in this section will only be authorized to discuss issues concerning this enrollment application. The NSC MAC will not discuss any other enrollment issues for this supplier with the above Contact Person.

SECTION 12: SUPPORTING DOCUMENTATION INFORMATION

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 revalidating, 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 State of the business location as reported in Section 1A. Check the NSC MAC website for further guidance on supplier requirements. You are responsible for furnishing and adhering to all required licensure and/or 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 FOR ALL NEW APPLICATIONS AND/OR ADDITIONAL LOCATIONS

- ☐ Copies of all Federal, State, and/or local (city/county) professional and business licenses, certifications and/or registrations for applicable specialty supplier types, products and services.
- ☐ Copy of comprehensive liability insurance policy.
  NOTE: The NSC MAC must be listed as the certificate holder.
- ☐ Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name provided in Section 1B (e.g., IRS form CP 575).
  NOTE: This information is needed if the applicant is enrolling a 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 for each new location.
  Include a voided check or letter from your bank.

MANDATORY, IF APPLICABLE

- ☐ Copy of IRS Determination Letter, if supplier is registered with the IRS as non-profit (e.g., IRS 501(c)(3)).
- ☐ Written confirmation from the IRS confirming your business is automatically classified as a Disregarded Entity, (e.g., IRS Form 8832).
  NOTE: A Disregarded Entity is an eligible entity that is not treated as a separate entity from its single owner for income tax purposes.
- ☐ Copies of all final adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters).
- ☐ Statement in writing from the bank, if Medicare payments due a supplier are being sent to a bank (or similar financial institution) where the supplier has a lending relationship (that is, any type of loan), 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, if you want to be a participating supplier.
- ☐ Copy of Surety Bond.

SECTION 13: PENALTIES FOR FALSIFYING INFORMATION ON THIS APPLICATION

This section explains the penalties for deliberately furnishing false information in this application to gain or maintain enrollment in the Medicare program.

1. 18 U.S.C. § 1001 authorizes criminal penalties against an individual who, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious, or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000 (18 U.S.C. § 3571). Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.
2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against any individual who, "knowingly and willfully," makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program. The offender is subject to fines of up to $25,000 and/or imprisonment for up to five years.
3. The Civil False Claims Act, 31 U.S.C. § 3729, imposes civil liability, in part, on any person who:
   a) knowingly presents, or causes to be presented, to an officer or any employee of the United States Government a false or fraudulent claim for payment or approval;
   b) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or
   c) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

   The Act imposes a civil penalty of $5,000 to $10,000 per violation, plus three times the amount of damages sustained by the Government
4. Section 1128A(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency…a claim…that the Secretary determines is for a medical or other item or service that the person knows or should know:
   a) was not provided as claimed; and/or
   b) the claim is false or fraudulent.

   This provision authorizes a civil monetary penalty of up to $10,000 for each item or service, an assessment of up to three times the amount claimed, and exclusion from participation in the Medicare program and State health care programs.
5. 18 U.S.C. 1035 authorizes criminal penalties against individuals in any matter involving a health care benefit program who knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact; or makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items or services. The individual shall be fined or imprisoned up to 5 years or both.
6. 18 U.S.C. 1347 authorizes criminal penalties against individuals who knowing and willfully execute, or attempt, to executive a scheme or artifice to defraud any health care benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by or under the control of any, health care benefit program in connection with the delivery of or payment for health care benefits, items, or services. Individuals shall be fined or imprisoned up to 10 years or both. If the violation results in serious bodily injury, an individual will be fined or imprisoned up to 20 years, or both. If the violation results in death, the individual shall be fined or imprisoned for any term of years or for life, or both.
7. The government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment."

   Remedies include compensatory and punitive damages, restitution, and recovery of the amount of the unjust profit.

SECTION 14: DELEGATED OFFICIAL(S) *(Optional)*

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 enrollment information. Even when delegated officials are reported in this application, the authorized official retains the authority to make changes and/or updates.

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 enrollment information.

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 15A 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.

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 14 constitutes a legal delegation of authority to all delegated official(s) assigned in Section 14. If you are delegating more than two individuals, copy and complete this section for each individual.

NOTE: A delegated official who is being deleted does not have to sign or date this application.

ASSIGNMENT OF DELEGATED OFFICIAL

All Delegated officials must be reported in Section 9 of this application.

If you are adding or deleting a delegated official, check the applicable box and furnish the effective date.

1st Delegated Official's Signature

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

Under penalty of perjury, I the undersigned, certify that I understand and accept the role of Delegated Official.

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

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

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

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

2nd Delegated Official's Signature

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

Under penalty of perjury, I the undersigned, certify that I understand and accept the role of Delegated Official.

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

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

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

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

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

SECTION 15: CERTIFICATION STATEMENT AND AUTHORIZED OFFICIAL SIGNATURE

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 enrollment information in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program.

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 blue ink. Faxed, photocopied, or stamped signatures will not be accepted.

By signing this application, an authorized official agrees to immediately notify the NSC MAC 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 MAC 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.

For CMS-855S Enrollment Application(s) submitted for initial enrollment, only the signature of an Authorized Official will be acceptable for processing the application.

The certification below includes additional requirements that the supplier must meet and maintain to bill the Medicare program. Read these requirements carefully. By signing, you are attesting to having read the requirements and understanding them.

Your signature further stipulates that you agree to adhere to all of the requirements listed below and acknowledge that you may be denied entry into or revoked from the Medicare program if any requirements are not met.

A. CERTIFICATION STATEMENT

You **MUST SIGN AND DATE** Section 15B of this certification statement below in order to be enrolled in the Medicare program. In doing so, you are attesting to meeting and maintaining the Medicare requirements stated below.

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

1. I have read the contents of this application, and the information contained herein is true, correct and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the NSC MAC of this fact immediately.
2. I agree to notify the NSC MAC of any current or future changes to the information contained in this application in accordance with the time frames established in 42 C.F.R. § 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 Social Security Act and all applicable 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 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 Medicare a copy of my most recent accreditation survey, together with any information related to the survey that Medicare may require (including corrective action plans).

SECTION 15: CERTIFICATION STATEMENT AND AUTHORIZED OFFICIAL SIGNATURE *(Continued)*

B. AUTHORIZED OFFICIAL SIGNATURE(S)

All Authorized officials must be reported in Section 9 of this application.
If you are adding or deleting an Authorized Official check the applicable box and furnish the effective date.

1st Authorized Official
I have read the contents of this application and the certification statement in Section 15A 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 MAC to verify this information.

1st Authorized Official's Information and Signature

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

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

Telephone Number	E-mail Address *(if applicable)*	Title/Position

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

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

2nd Authorized Official
I have read the contents of this application and the certification statement in Section 15A 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 MAC to verify this information.

2nd Authorized Official's Information and Signature

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

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

Telephone Number	E-mail Address *(if applicable)*	Title/Position

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

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

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

MEDICARE SUPPLIER ENROLLMENT APPLICATION PRIVACY ACT STATEMENT

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

The purpose of collecting this information is to determine or verify the eligibility of individuals and organizations to enroll in the Medicare program as providers and suppliers of goods and services to Medicare beneficiaries and to assist in the administration of the Medicare program. This information will also be used to ensure that no payments will be made to providers or suppliers who are excluded from participation in the Medicare program. All information on this form is required, with the exception of those sections marked as "optional" on the form. Without this information, the ability to make payments will be delayed or denied.

The information collected will be entered into the Provider Enrollment, Chain and Ownership System (PECOS). The information in this application will be disclosed according to the routine uses described below.

Information from these systems may be disclosed under specific circumstances to:

1. CMS contractors to carry out Medicare functions, collating or analyzing data, or to detect fraud or abuse;
2. A congressional office from the record of an individual health care provider in response to an inquiry from the congressional office at the written request of that individual health care practitioner;
3. The Railroad Retirement Board to administer provisions of the Railroad Retirement or Social Security Acts;
4. Peer Review Organizations in connection with the review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XVIII of the Social Security Act;
5. To the Department of Justice or an adjudicative body when the agency, an agency employee, or the United States Government is a party to litigation and the use of the information is compatible with the purpose for which the agency collected the information;
6. To the Department of Justice for investigating and prosecuting violations of the Social Security Act, to which criminal penalties are attached;
7. To the American Medical Association (AMA), for the purpose of attempting to identify medical doctors when the National Plan and Provider Enumeration System is unable to establish identity after matching contractor submitted data to the data extract provided by the AMA;
8. An individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, or to the restoration or maintenance of health;
9. Other Federal agencies that administer a Federal health care benefit program to enumerate/enroll providers of medical services or to detect fraud or abuse;
10. State Licensing Boards for review of unethical practices or non-professional conduct;
11. States for the purpose of administration of health care programs; and/or
12. Insurance companies, self insurers, health maintenance organizations, multiple employer trusts, and other health care groups providing health care claims processing, when a link to Medicare or Medicaid claims is established, and data are used solely to process supplier's health care claims.

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

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

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