MEDICARE ENROLLMENT APPLICATION

Medicare Part B Organizations, Group Practices and Certain Other Medicare Providers and Suppliers

CMS-855B

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

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

AMBULANCE SERVICE SUPPLIERS – SEE SECTION 11 FOR A SUMMARY OF THE REQUIREMENTS TO QUALIFY AS AN AMBULANCE SERVICE SUPPLIER IN THE MEDICARE PROGRAM.

INDEPENDENT DIAGNOSTIC TESTING FACILITIES (IDTFs) – SEE SECTION 12 FOR A SUMMARY OF THE PERFORMANCE STANDARDS ALL IDTFs MUST MEET TO ENROLL IN THE MEDICARE PROGRAM.

SEE SECTION 15 FOR A LIST OF SUPPORTING DOCUMENTATION TO BE SUBMITTED WITH THIS APPLICATION.

TO VIEW YOUR CURRENT MEDICARE ENROLLMENT RECORD GO TO: HTTPS://PECOS.CMS.HHS.GOV

WHO SHOULD COMPLETE AND SUBMIT THIS APPLICATION

The following type of suppliers must complete and submit this application to enroll in the Medicare program and receive a Medicare billing number–PTAN:

- Ambulance Service Supplier
- Ambulatory Surgical Center
- Centralized Flu Biller
- Clinic/Group Practice
- Hospital Department(s)
- Independent Clinical Laboratory
- Independent Diagnostic Testing Facility (IDTF)
- Intensive Cardiac Rehabilitation Supplier
- Mammography Center
- Mass Immunization (Roster Biller Only)
- Occupational Therapy Group in Private Practice
- Pharmacy
- Physical Therapy Group in Private Practice
- Portable X-ray Supplier
- Radiation Therapy Center

NOTE: Hospitals and other certified providers such as Skilled Nursing Facilities and Home Health Agencies must submit the CMS-855B and obtain a Medicare Part B PTAN to allow receipt of reassigned benefits from a physician, nurse practitioner or other eligible professional per 42 CFR § 424.80(b)(1) and (b)(2).

ALL PROVIDERS AND SUPPLIERS submitting this enrollment application must meet all Federal and State requirements for the type of provider or supplier check in Section 2A1 or 2A2 prior to being issued a PTAN.

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

This application must be submitted if you are an organization/group that plans to bill Medicare and you are:

- A medical practice or clinic that will bill for Medicare Part B services (e.g., group practices, clinics, independent laboratories, portable x-ray suppliers).
- A hospital or other medical practice or clinic that may bill for Medicare Part A services but will also bill for Medicare Part B practitioner services or provide purchased laboratory tests to other entities that bill Medicare Part B.
- Currently enrolled in Medicare but need to enroll in another MAC's jurisdiction (e.g., you have opened a practice location in a geographic territory serviced by another Medicare Administrative Contractor).
- Currently enrolled in Medicare and need to make changes or updates to your enrollment data (e.g., you have added or changed a practice location). Changes must be reported in accordance with the reporting timeframes established in 42 CFR § 424.516(d). IDTF changes of information must be reported in accordance with 42 CFR § 410.33.

Medicare Part B organizations and group practices 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 CMS-855B 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-855B, go to **http://www.cms.gov/MedicareProviderSupEnroll**.

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BILLING NUMBER AND NATIONAL PROVIDER IDENTIFIER INFORMATION

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

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

NOTE: The Legal Business Name (LBN) and Tax Identification Number (TIN) that you furnish in Section 2B 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

All information on this form is required with the exception of those fields specifically marked as "optional." Any field marked as optional is not required to be completed nor does it need to be updated or reported as a "change of information" as required in 42 CFR § 424.516. However, it is highly recommended that if reported, these field be kept up-to-date.

- Type or print all information so that it is legible. Do not use pencil. Blue ink is 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.

IMPORTANT INFORMATION ABOUT INDIVIDUAL VERSES ORGANIZATIONAL NPIs

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

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

TIPS TO AVOID DELAYS IN YOUR ENROLLMENT

- Complete all required sections as shown in Section 1;
- Complete Section 10 for all delegated and authorized officials reported in Sections 17 and 18;
- Furnish at least one owner or controlling entity and one managing employee for each location;
- Enter all NPIs in the applicable sections;
- Include the Electronic Funds Transfer (EFT) Agreement with your application when required;
- Respond timely to development/information requests; and
- Be sure the Legal Business Name shown in Section 2B matches the name on your tax documents.

ADDITIONAL INFORMATION

The MAC may request additional documentation to support or validate information reported on this 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

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

WHERE TO MAIL YOUR APPLICATION

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

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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.

NEW ENROLLEES AND THOSE REPORTING A NEW TAX ID NUMBER

Complete and submit this application if you are:

- Enrolling in Medicare for the first time under the tax identification number reported in Section 2B.
- Already enrolled in Medicare but are establishing a practice location in another MAC's jurisdiction.
- Enrolled in Medicare but have a new tax identification number.
- An enrolled hospital that has to enroll individual hospital department(s) to bill for Medicare Part B services.
- A hospital or other certified provider (i.e., skilled nursing facility) and need a Medicare Part B PTAN to receive reassigned benefits from a physician, nurse practitioner or other eligible professional.

CURRENTLY ENROLLED MEDICARE SUPPLIERS

The following actions apply to Medicare suppliers already enrolled in the program:

Reactivation
If your Medicare billing number (PTAN) was deactivated, you will be required to submit an updated CMS-855B to reactivate it. In addition, you must be able to submit a valid claim and meet all current requirements for your supplier type before reactivation may occur.

Revalidation
If you have been notified by your designated MAC to revalidate your Medicare enrollment, you will be required to submit an updated CMS-855B. Do not submit a revalidation application until you have been contacted by your designated MAC to do so.

Voluntary Termination
A supplier should voluntarily terminate its PTAN and Medicare enrollment when it:

- Will no longer be rendering services to Medicare patients, or
- Is planning to cease (or has ceased) operations.

Change of Information
Use this application to report if you are changing, adding or removing information under your current PTAN and tax identification number. Changes in your existing enrollment data must be reported to your designated MAC in accordance with 42 CFR § 424.516.

NOTE: IDTFs must report changes of information and comply with the provisions found at 42 CFR § 410.33.

NOTE: If you are already enrolled in Medicare and are not receiving Medicare payments via Electronic Funds Transfer (EFT), any submitted change to your enrollment information will require you to submit a CMS-588 (Electronic Funds Transfer Authorization Agreement). All future payments will then be made via EFT.

Change of Ownership (CHOW)
If you are a hospital with a separately enrolled hospital department, an ambulatory surgical center, or a portable X-ray supplier and are undergoing a change of ownership (CHOW) in accordance with the principles outlined in 42 C.F.R. 489.18, you must submit a new application reporting the new ownership.

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SECTION 1: BASIC INFORMATION

A. REASON FOR SUBMITTING THIS APPLICATION

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

☐ You are a **new enrollee** in Medicare or, ☐ You are reporting a **new Tax Identification Number** or, ☐ You are a **certified provider** and need a PART B PTAN to receive reassigned benefits Furnish the certified provider's CCN CCN	**Complete all applicable sections**
☐ You are **enrolling in another Medicare Administrative Contractor's jurisdiction**	**Complete all applicable sections**
☐ You are **reactivating** your Medicare Billing Number	**Complete all applicable sections**
☐ You are **revalidating** your Medicare enrollment	**Complete all applicable sections**
☐ You are **voluntarily terminating** your Medicare enrollment. Effective Date of Termination *(mm/dd/yyyy)*	**Sections 1**, **2B**, **14** (optional), and either **17 or 18**
☐ You are **changing** your Medicare information Furnish the NPI and PTAN for the enrollment record that you are reporting a change NPI / PTAN	Go to **Section 1B**
☐ You are undergoing a **Change of Ownership (CHOW)** *Hospital departments, ambulatory surgical centers and portable x-ray suppliers only	**Complete all applicable sections and submit a copy of the sales agreement.**

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SECTION 1: BASIC INFORMATION *(Continued)*

B. WHAT INFORMATION IS CHANGING?

Check all that apply and complete the required sections:

	REQUIRED SECTIONS
☐ Identifying Information	**1, 2** (complete only those sub-sections that need to be updated), **8, 14** (optional), and either **17 or 18**
☐ Practice Location Information	**1, 2B, 3, 8, 14** (optional), and either **17 or 18**
☐ Address Information ☐ Correspondence Mailing Address ☐ Revalidation Package Mailing Address ☐ Remittance/Special Payment Mailing Address ☐ Medical Record Storage Address	**1, 2B, 4** as applicable to the address being changed, **14** (optional), and either **17 and 18**
☐ Supplier Specific Information	**1, 2B, 5, 8, 14** (optional), and either **17 or 18**
☐ In-Home Services Information	**1, 2B, 6, 8, 14** (optional), and either **17 or 18**
☐ Mobile and/or Portable Services Information	**1, 2B, 7, 8, 14** (optional), and either **17 or 18**
☐ Final Adverse Actions/Convictions	**1, 2B, 8, 14** (optional), and either **17 or 18**
☐ Ownership Interest and/or Managing Control Information (Organizations)	**1, 2B, 8, 9, 14** (optional), and either **17 or 18**
☐ Ownership Interest and/or Managing Control Information (Individuals)	**1, 2B, 8, 10, 14** (optional), and either **17 or 18**
☐ Billing Agency Information	**1, 2B, 8, 13, 14** (optional), and either **17 or 18**
☐ Delegated Official(s) (Optional)	**1, 2B, 8, 14** (optional), **17 and 18**
☐ Authorized Official(s)	**1, 2B, 8, 14** (optional), and **18**

AMBULANCE SERVICE SUPPLIERS ONLY	SECTION 11
☐ Base of Operations	**1, 2B, 8, 11A, 14** (optional), and either **17 or 18**
☐ Geographic Area	**1, 2B, 8, 11B, 14** (optional), and either **17 or 18**
☐ State License Information	**1, 2B, 8, 11C, 14** (optional), and either **17 or 18**
☐ Paramedic Intercept Services Information	**1, 2B, 8, 11D, 14** (optional), and either **17 or 18**
☐ Vehicle Information	**1, 2B, 8, 11E, 14** (optional), and either **17 or 18**

INDEPENDENT DIAGNOSTIC TESTING FACILITIES ONLY	SECTION 12
☐ Liability Insurance Information	**1, 2B, 8, 12B, 14** (optional), and either **17 or 18**
☐ CPT-4 and HCPCS Codes	**1, 2B, 8, 12C, 14** (optional), and either **17 or 18**
☐ Interpreting Physician Information	**1, 2B, 8, 12D, 14** (optional), and either **17 or 18**
☐ Personnel (Technicians) Who Perform Tests	**1, 2B, 8, 12E, 14** (optional), and either **17 or 18**
☐ Supervising Physician(s)	**1, 2B, 8, 12F, 14** (optional), and either **17 or 18**

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SECTION 2: IDENTIFYING INFORMATION

A. TYPE OF PROVIDER OR SUPPLIER

Check the appropriate box to identify the type of provider or supplier organization enrolling in Medicare. If this organization qualifies as more than one type of provider **and/or** supplier, submit a separate application for each type. If the organization changes the type of service it providers (i.e., becomes a different provider or supplier type), it must submit a new application and enroll as the new provider or supplier type.

1. Type of Supplier *(Check one)*

- ☐ Ambulance Service Supplier (See Section 11)
- ☐ Ambulatory Surgical Center (See Section 5A3)
- ☐ Centralized Flu Biller (CFB)*
- ☐ Clinic/Group Practice
- ☐ Hospital Department(s) (See Section 5D)
- ☐ Independent Clinical Laboratory (See Section 5B)
- ☐ Independent Diagnostic Testing Facility (See Section 12)
- ☐ Intensive Cardiac Rehabilitation
- ☐ Mammography Center
- ☐ Mass Immunization (Roster Biller Only)**
- ☐ Occupational Therapy Group in Private Practice (See Section 5C)
- ☐ Pharmacy
- ☐ Physical Therapy Group in Private Practice (See Section 5C)
- ☐ Portable X-ray Supplier
- ☐ Radiation Therapy Center
- ☐ Other *(Specify)*: ______________________________

*Centralized Flu Billers are large volume mass immunizers who have applied to be, and are pre-approved to enroll as a centralized flu biller. Enrollment as a centralized flu biller is limited to one year and must be renewed annually by contacting the CMS central office by June 1st each year to request participation for the upcoming year. All enrollment applications and claims for centralized flu billers are processed by the CFB Medicare specialty contractor. Contact your local designated MAC for additional information on obtaining pre-approval as a CFB. Once approved, you must submit your approval letter with this application.

**Mass Immunization (Roster Billers Only) are suppliers who enroll in the Medicare program to offer the influenza vaccinations to a large number of individuals. Enrollment applications for mass immunizers are processed by the local designated MAC and your enrollment in Medicare does not need to be renewed annually. Mass immunizers will submit their claims via roster billing to their local designated MAC.

2. Type of Provider *(Check one)*

If this provider is submitting this application to obtain a PTAN to be eligible to receive reassigned benefits per 42 CFR § 424.80(b)(1) and (b)(2) it must be enrolled in Medicare as a Part A provider. The provider type checked below **MUST** be the same as the Part A provider type currently enrolled.

- ☐ Community Mental Health Center
- ☐ Comprehensive Outpatient Rehabilitation Facility
- ☐ Critical Access Hospital
- ☐ End-Stage Renal Disease Facility
- ☐ Federally Qualified Health Center
- ☐ Histocompatibility Laboratory
- ☐ Home Health Agency
- ☐ Hospice
- ☐ Hospital
- ☐ Indian Health Services Facility
- ☐ Organ Procurement Organization
- ☐ Outpatient Physical Therapy Services
- ☐ Outpatient Speech Pathology Services
- ☐ Religious Non-Medical Health Care Institution
- ☐ Rural Health Clinic
- ☐ Skilled Nursing Facility

SPECIAL INSTRUCTIONS FOR PART A CERTIFIED PROVIDERS REQUESTING A PART B PTAN TO ACCEPT REASSIGNED BENEFITS FROM ELIGIBLE PROFESSIONALS: When completing this application to obtain a Part B PTAN that will allow you to accept reassigned benefits from eligible professionals, you must complete this entire application (where appropriate) and furnish responses that are directly related to the CCN furnished in Section 1 **AND** the practice location(s) where the eligible professionals will be rendering services for which the benefits (payment) will be reassigned to this provider.

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SECTION 2: IDENTIFYING INFORMATION *(Continued)*

B. BUSINESS IDENTIFICATION INFORMATION

Legal Business Name (not the "Doing Business As" name) as reported to the I.R.S.		
Tax Identification Number (TIN)	National Provider Identifier (NPI)	Medicare Identification Number (PTAN) *(if issued)*

Other Name	Type of Other Name ☐ Former LBN ☐ DBA Name ☐ Other *(Specify)*: ___________

C. BUSINESS STRUCTURE INFORMATION

Identify the organizational structure for this provider/supplier *(Check one)*

☐ Corporation ☐ Limited Liability Company ☐ Partnership ☐ Government-Owned Facility
☐ Sole Proprietorship ☐ Limited Partnership ☐ Other *(Specify)*: ___________

Incorporation Date *(mm/dd/yyyy) (if applicable)*	State Where Incorporated *(if applicable)*

D. INTERNAL REVENUE SERVICE REGISTRATION

Identify how your business is registered with the IRS. *(Check one)*

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

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.

☐ Proprietary ☐ Non-Profit ☐ Disregarded Entity

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SECTION 3: PRACTICE LOCATION INFORMATION

This section captures information about the physical location(s) where you currently provide health care services. If you see patients in more than one practice location, copy and complete this section for each.

Only report those practice locations within the jurisdiction of the MAC to which you will submit this application. If you have practice locations in other MAC jurisdictions, complete a separate enrollment application (CMS-855B) for those practice locations and submit it to the appropriate MAC.

NOTE: If you operate a mobile facility or portable unit, see Section 7, Mobile and/or Portable Services Information.

Provide the specific street address as recorded by the United States Postal Service. Do not provide a P.O. Box. If you provide services in a hospital and/or other health care facility for which you bill Medicare directly for the services rendered at that facility, provide the name and address of the hospital or facility.

To ensure that CMS establishes the correct association between your Medicare billing number (PTAN) and your NPI, you must list a PTAN/NPI combination for each practice location. If you have multiple NPIs associated with both a single PTAN and a single practice location, please list all NPIs and associated PTANs for that practice location below.

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

☐ **Change** ☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: ______________________________

Practice Location Name *("Doing Business As" name if different from Legal Business Name)*		
Practice Location Street Address Line 1 *(Street Name and Number – Not a P.O. Box)*		
Practice Location Street Address Line 2 *(Suite, Room, Apt. #, etc.)*		
City/Town	State	ZIP Code + 4
Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*
Date you saw your first Medicare patient at this practice location *(mm/dd/yyyy)*		

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

Is this practice location a:

☐ Critical Access Hospital
☐ Group Practice Office/Clinic
☐ Hospital
☐ Indian Health Services Facility (IHS) or Tribal Provider
☐ Retirement/Assisted Living Community
☐ Skilled Nursing Facility
☐ Other Nursing Facility and/or Nursing Facility
☐ Other Health Care Facility *(Specify)*:____________________

NOTE: If this supplier is an Indian Health Services facility or Tribal Provider it must enroll with the designated IHS MAC. Go to **www.cms.gov/MedicareProviderSupEnroll** for the mailing address of the designated IHS MAC.

Is this supplier wholly owned or wholly operated by a hospital? (See instructions in Section 9) ☐ YES ☐ NO

CLIA Number for this location *(if applicable)*

Attach a copy of the CLIA certification for this practice location.

FDA/Radiology (Mammography) Certification Number for this location *(if issued)*

Attach a copy of the FDA certification for this practice location.

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SECTION 4: IMPORTANT ADDRESS INFORMATION

A. CORRESPONDENCE MAILING ADDRESS

This is the address where correspondence will be sent to you by the MAC, **OR**

☐ Check here if you want all Correspondence mailed to your Practice Location Address in Section 3 and skip this section.

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

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

Business Location Name				
Attention (optional)				
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)*	

B. REVALIDATION REQUEST PACKAGE MAILING ADDRESS

This is the address where the MAC will send your enrollment revalidation request package, **OR**

☐ Check here if your Revalidation Request Package should be mailed to your Practice Location Address in Section 3 and skip this section, **OR**

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

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

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

Business Location Name				
Attention (optional)				
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)*	

DRAFT

SECTION 4: IMPORTANT ADDRESS INFORMATION *(Continued)*

C. 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, non-routine special payments) should be sent, **OR**

☐ Check here if your Remittance Notices/Special Requests should be mailed to your Practice Location Address in Section 3 and skip this section, **OR**

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

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

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

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

NOTE: Payments will be made in the supplier's legal business name as shown in Section 2B.

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

DRAFT

D. MEDICARE BENEFICIARY MEDICAL RECORDS STORAGE ADDRESS

If the Medicare beneficiaries' medical records are stored at a location other than the practice location shown in Section 3, complete this section with the name and address of the storage location. This includes 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 this supplier's records, not the records of another supplier. If all records are stored at the practice location reported in Section 3, check the box below and skip this section.

☐ Records are stored at the practice location reported in Section 3.

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

☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: ______________________________

1. Paper Storage

Name of Storage Facility		
Storage Facility Address Line 1 *(Street Name and Number)*		
Storage Facility Address Line 2 *(Suite, Room, Apt. #, etc.)*		
City/Town	State	ZIP Code + 4

2. Electronic Storage

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

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

Site where electronic records stored

SECTION 5: SUPPLIER SPECIFIC INFORMATION

A. LICENSE/CERTIFICATION/ACCREDITATION INFORMATION

Provide the following information if it is required by the State for the practice location reported in Section 3 to operate as the supplier type checked in Section 2A.

1. License Information

☐ State License Not Applicable

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

2. Certification Information

☐ Certification Not Applicable

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

3. Accreditation for Ambulatory Surgical Centers (ASCs) Only *(Check one)*

☐ The enrolling ASC supplier is accredited (furnish the information requested below).

☐ The enrolling ASC supplier is not accredited (includes exempt ASCs).

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

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

DRAFT

B. INDEPENDENT CLINICAL LABORATORIES ONLY

Provide the name and identifying information for the Medical Director, including the State License and/or Certification information **and** the name and identifying information for the Supervising Physician of the Independent Clinical Laboratory reported in Section 2B.

1. Medical Director Information

First Name	Middle Initial	Last Name	Jr., Sr., M.D., etc.
Social Security Number *(Required)*		Date of Birth *(mm/dd/yyyy) (Required)*	
Medicare Identification Number *(PTAN) (if issued)*		National Provider Number (NPI) *(if issued)*	
State License or Certification Number		*State Where Issued*	Effective Date *(mm/dd/yyyy)*

2. Supervising Physician information

First Name	Middle Initial	Last Name	Jr., Sr., M.D., etc.
Social Security Number *(Required)*		Date of Birth *(mm/dd/yyyy) (Required)*	
Medicare Identification Number *(PTAN) (if issued)*		National Provider Number (NPI) *(if issued)*	

C. PHYSICAL THERAPY (PT) AND OCCUPATIONAL THERAPY (OT) GROUPS ONLY

1. Does this group maintain private office space? ☐ YES ☐ NO
2. Is this private office space used exclusively for the group's practice? ☐ YES ☐ NO
3. Does this group lease or rent its private office space? ☐ YES ☐ NO
   If **YES**, submit a copy of the lease agreement that gives the group exclusive use of the facility for PT/OT services.
4. Does this group render all of it's PT/OT services in either the group's private office space or in the patients' home? ☐ YES ☐ NO
5. Does this group also provide PT/OT services outside of its office and/or patients' homes? ☐ YES ☐ NO

SECTION 5: SUPPLIER SPECIFIC INFORMATION *(Continued)*

D. HOSPITALS ONLY

This section should only be completed by hospitals that are currently enrolled or enrolling with a Medicare Part A MAC and will be billing for Medicare Part B services, such as:

- Hospitals that need a departmental billing number(s) to bill for Part B practitioner services.
- Hospitals requiring a Part B billing number to provide pathology services.
- Hospitals requiring a Medicare Part B billing number to provide purchased tests to other Medicare Part B billers.

NOTE: If your hospital is enrolling a clinic that is not provider-based, do not complete this section. Check "Clinic/Group Practice" in Section 2A and complete this entire application for the clinic.

If the hospital requires more than one departmental Part B billing number, list each department needing a separate billing number in Section 5D2 below.

1. Are you going to:

☐ Bill for the entire hospital with one billing number? ☐ YES ☐ NO (If **YES**, continue to Section 6.)

☐ Separately bill for each hospital department? ☐ YES ☐ NO (If **YES**, complete number 2 below.)

2. List the hospital departments for which you plan to bill separately:

DEPARTMENT	DEPARTMENT PTAN (if issued)	DEPARTMENT NPI

E. TERMINATION OF PHYSICIAN ASSISTANTS ONLY

Complete this section to remove physician assistants no longer employed by this group or clinic.

PHYSICIAN ASSISTANT'S NAME	EFFECTIVE DATE OF DEPARTURE	PHYSICIAN ASSISTANT'S PTAN	PHYSICIAN ASSISTANT'S NPI

F. COMMENTS/SPECIAL CIRCUMSTANCES

Explain any unique circumstances concerning the practice location or the method by which health care services are rendered (eg., house calls, mobile units, etc.)

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SECTION 6: IN-HOME SERVICES INFORMATION

RENDERING MEDICAL SERVICES IN PATIENTS' HOMES

If the enrolling supplier organization sends medical personnel/staff to render health care services in a patients' home, complete this section identifying the geographic areas covered by the in-home services.

Furnish the city/town, county, State or ZIP code for all locations where health care services are rendered in patients' homes.

1. Initial Reporting and/or Additions

If you are reporting or adding an entire State, check the box below and specify the State.

☐ Entire State of ___________________________

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

CITY/TOWN	COUNTY	STATE	ZIP CODE

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2. Deletions

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

☐ Entire State of ___________________________

If you are no longer furnishing in-home services in select cities/towns or counties, provide the locations below. Only list ZIP codes if you are not deleting the entire city/town or county.

CITY/TOWN	COUNTY	STATE	ZIP CODE

SECTION 7: MOBILE AND/OR PORTABLE SERVICES INFORMATION

ATTENTION AMBULANCE SERVICE SUPPLIERS: Do **NOT** complete this Section. See Section 11.

A “mobile facility” is generally a mobile home, trailer, or other large vehicle that has been converted, equipped, and licensed to render health care services. These vehicles usually travel to local shopping centers or community centers to see and treat patients inside the vehicle.

A “portable unit” is when the supplier transports medical equipment to a fixed location (e.g., physician’s office, nursing home) to render services to the patient.

The most common types of mobile facilities/portable units are mobile IDTFs, portable X-ray suppliers, portable mammography, and mobile clinics. Physicians and non-physician practitioners (e.g., nurse practitioners, physician assistants) who perform services at multiple locations (e.g., house calls, assisted living facilities) are not considered to be mobile facilities/portable units.

A. BASE OF OPERATIONS ADDRESS FOR MOBILE OR PORTABLE SUPPLIERS

The base of operations is the location or business office from where personnel are dispatched, where mobile/portable equipment is stored, and when applicable, where vehicles are parked when not in use.

NOTE: Mobile IDTF Facilities Only: If the mobile facility primarily operates and furnishes services at a location or within a geographic area greater than 50 miles from the base of operations as defined above, and the mobile facility does not routinely return to the IDTF practice location or base of operations, furnish the address where the mobile facility would most likely be located for mandatory site inspections as required per 42 CFR § 410.33(g)(14).

If you are adding or removing a base of operation, check the applicable box and furnish the effective date.

☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: ______________________________

☐ **Check here and skip to Section 7B if the “Base of Operations” address is the same as the “Practice Location” address reported in Section 3.**

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

B. VEHICLE INFORMATION

If the mobile health care services are rendered inside a vehicle, such as a mobile home or trailer, furnish the vehicle information requested below. Do not provide information about ambulance vehicles or vehicles that are used only to transport medical equipment (e.g., when the equipment is transported in a van but is used in a fixed setting, such as a doctor’s office). If services are rendered inside more than four vehicles, copy and complete this section as needed.

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

CHECK ONE FOR EACH VEHICLE	TYPE OF VEHICLE *(van, mobile home, trailer, etc.)*	VEHICLE IDENTIFICATION NUMBER
☐ ADD ☐ DELETE Effective Date: ________________		
☐ ADD ☐ DELETE Effective Date: ________________		
☐ ADD ☐ DELETE Effective Date: ________________		
☐ ADD ☐ DELETE Effective Date: ________________		

For each vehicle, submit a copy of all health care related permits/licenses/registrations.

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SECTION 7: MOBILE AND/OR PORTABLE SERVICES INFORMATION *(Continued)*

C. GEOGRAPHIC AREA COVERED BY THE MOBILE AND/OR PORTABLE SERVICES

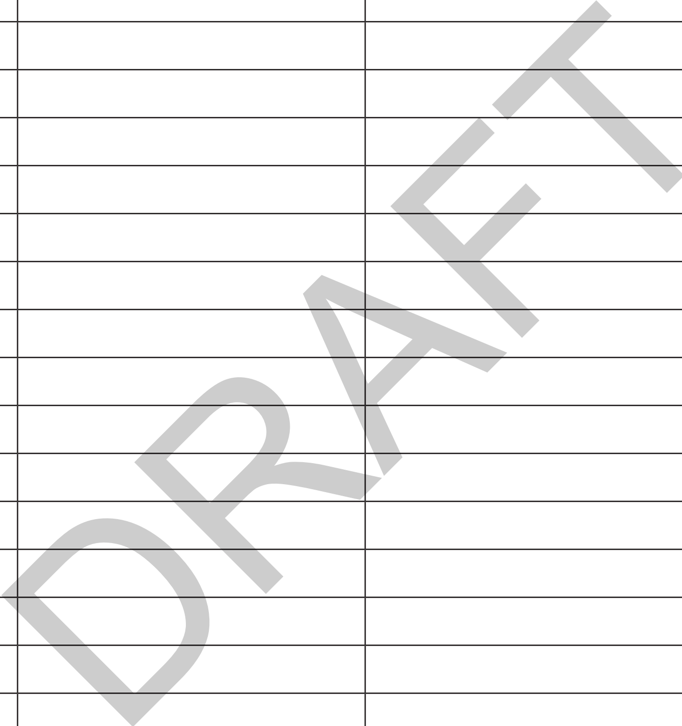
Furnish the city/town, county, State, or ZIP Code for all geographic areas where mobile and/or portable services are rendered.

1. Initial Reporting and/or Additions

If you are reporting or adding an entire State, check the box below and specify the State.

☐ Entire State of ___________________________

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



CITY/TOWN	COUNTY	STATE	ZIP CODE

2. Deletions

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

☐ Entire State of ___________________________

If you are no longer furnishing mobile/portable services in select cities/towns or counties, provide the locations below. Only list ZIP codes if you are not deleting the entire city/town or county.

CITY/TOWN	COUNTY	STATE	ZIP CODE

SECTION 8: FINAL ADVERSE LEGAL ACTIONS

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

A. CONVICTIONS

1. If this supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense it must be reported below. 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 CFR § 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.

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C. FINAL ADVERSE LEGAL ACTION HISTORY

If you are reporting a new final adverse legal action, please check the box and furnish the effective date below.

☐ **New** **Effective Date** *(mm/dd/yyyy)*: ______________________________

1. Has this organization, under any current or former name or business identity, ever had a final adverse legal action listed above 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.

Attach a copy of the relevant final legal adverse action document(s).

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

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

Only report organizations in this section. Individuals must be reported in Section 10. The supplier MUST have at least one owner or controlling entity and one managing employee reported in either Section 9 and/or Section 10.

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 2B, as well as any information on final adverse legal actions that have been imposed against the owning or managing organization. For examples of organizations that should 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 direct or indirect ownership of the supplier
- A partnership interest in the supplier, regardless of the partners' percentage of ownership
- Managing control of the supplier

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
- Governmental and/or Tribal organizations
- Hospitals that wholly own or wholly operate the supplier

MANAGING CONTROL (ORGANIZATIONS)

Any organization that exercises operational or managerial control over the supplier, or conducts the day-to-day operations of the supplier, is a managing organization and must be reported. The organization need not have an ownership interest in the supplier in order to qualify as a managing organization. For instance, it could be a management services organization under contract with the 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 should be reported as a controlling entity. The supplier must submit a letter on the letterhead of the responsible 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. The appointed/elected official who signed the letter must be reported in Section 10.

Indian Health Service Or Tribal Facilities:
Special rules concerning insurance and licenses apply. Contact your designated 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 governing body must be reported in Section 9, individual members must be reported in Section 10. Each non-profit organization should submit a copy of the IRS Form 501(c)(3) verifying its non-profit status.

Medicare Part B Entities that are Wholly Owned or Wholly Operated by a Hospital
An entity is considered wholly owned or wholly operated by a hospital if the hospital has direct ownership or control over the entities operations. Specifically, an entity is wholly owned by the hospital if the hospital is the sole owner of the entity. An entity is wholly operated by a hospital if the hospital has exclusive responsibilities for conducting and overseeing the entity's routine operations, regardless of whether the hospital also has policy making authority over the entity.

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SECTION 9: 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 2B, and skip to Section 10.

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

☐ **Change** ☐ **Add** ☐ **Remove** **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)*	National Provider Number (NPI) *(if issued)*	Medicare Identification Number *(PTAN)* *(if issued)*
Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

2. What is the above organization's ownership interest in the supplier reported in Section 2B**?**
   ☐ 5% or Greater Direct/Indirect Owner ☐ Partner ☐ Wholly Own
3. What is the effective date the above organization acquired and/or ended the above ownership interest?
   ☐ **Acquired** **Effective Date** *(mm/dd/yyyy)*: ____________________
   ☐ **Ended** **Effective Date** *(mm/dd/yyyy)*: ____________________
4. What is the above organization's managing control of the supplier reported in Section 2B? *(Check all that apply)*
   ☐ Managing Organization ☐ Governing Body ☐ Wholly Operate ☐ Controlling Entity
   ☐ Board of Trustees
5. What is the effective date the above organization acquired and/or ended the above managing control?
   ☐ **Acquired** **Effective Date** *(mm/dd/yyyy)*: ____________________
   ☐ **Ended** **Effective Date** *(mm/dd/yyyy)*: ____________________

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B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for each organization reported in Section 9A.
If you are reporting a new final adverse legal action, check the box below and furnish the effective date.

☐ **New** **Effective Date** *(mm/dd/yyyy)*: ____________________

1. Has the organization in Section 9A above, under any current or former name or business identity, ever had a final adverse legal action listed in Section 8 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.

Attach a copy of the relevant final adverse legal action document(s).

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

SECTION 10: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS)

Only report individuals in this section. Organizations must be reported in section 9. The supplier MUST have at least ONE owner or controlling entity and one managing employee reported in either Section 9 and/or Section 10.

NOTE: An individual owner may also be the managing employee to satisfy this requirement.

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 2B, as well as any information on final adverse legal actions that have been imposed against this owning and managing individual. For examples of individuals that should 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 following individuals must be reported in Section 10A:

- All persons who have a 5 percent or greater ownership interest (direct or indirect) in the supplier
- All individuals with a partnership interest, regardless of the partners' percentage of ownership
- All officers, directors, and board members if the supplier is a corporation (whether for-profit or non-profit)
- All managing employees of the supplier
- All delegated and authorized officials reported in Sections 17 and 18

  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 9 as an owner of the supplier. Assume further that Individual D, as an indirect owner of the supplier, is reported in Section 10A1. Based on this example, the supplier would check the "5 Percent or Greater Direct/Indirect Owner" box in Section 10A2.

NOTE: All partners within a partnership must be reported in this section. 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 supplier, each limited partner must be reported, even though each owns less than 5 percent. The 5 percent threshold primarily applies to corporations and other organizations.

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

- The term **"Officer"** is defined as any person whose position is reported as being that of an officer in the 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 supplier's corporate bylaws.
- The term **"Director"** is defined as a member of the 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 supplier, either under contract or through some other arrangement, whether or not the individual is a W-2 employee of the 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 9, the supplier is only required to report the appointed/elected official who signed the required letter legally and financially binding the Governmental/Tribal Organization and its managing employees in Section 10. Owners, partners, officers, and directors do not need to be reported.

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SECTION 10: 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 removing ownership or managing control information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ **Change** ☐ **Add** ☐ **Remove** **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)*
Medicare Identification Number *(PTAN) (if issued)*	National Provider Number (NPI) *(if issued)*

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

2. What is the above individual's title? ______________________________

3. What is the above individual's ownership interest in the supplier reported in Section 2B**?**
   ☐ 5% or Greater Direct/Indirect Owner ☐ Partner

4. What is the effective date the above individual acquired and/or ended the above ownership interest?
   ☐ **Acquired** **Effective Date** *(mm/dd/yyyy)*: ______________________________
   ☐ **Ended** **Effective Date** *(mm/dd/yyyy)*: ______________________________

5. What is the above individual's managing control of the supplier reported in Section 2B?
   (Check all that apply)
   ☐ Officer ☐ Contracted Managing Employee ☐ Appointed/Elected Official ☐ Director
   ☐ W-2 Managing Employee

6. What is the effective date the above individual acquired and/or ended the above managing control?
   ☐ **Acquired** **Effective Date** *(mm/dd/yyyy)*: ______________________________
   ☐ **Ended** **Effective Date** *(mm/dd/yyyy)*: ______________________________

7. Is the above individual also a Delegated Official or Authorized Official reported in Sections 17 or 18**?**
   ☐ Delegated Official ☐ Authorized Official ☐ Neither

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B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for each individual reported in Section 10A.

If you are reporting a new final adverse legal action, check the box below and furnish the effective date.

☐ **New** **Effective Date** *(mm/dd/yyyy)*: ______________________________

1. Has the individual reported in Section 10A above, under any current or former name or business entity, ever had a final adverse legal action listed in Section 8 of this application imposed against them?
   ☐ YES–Continue Below ☐ NO–Skip to Section 11

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 relevant final adverse legal action document(s).

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

SECTION 11: AMBULANCE SERVICE SUPPLIERS ONLY

SUMMARY OF AMBULANCE SERVICE SUPPLIER ENROLLMENT REQUIREMENTS

Medicare covers ambulance services, including fixed wing and rotary wing ambulance services, only if they are furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated. Below is a brief summary of the requirements which must be met to enroll in Medicare.

A. TYPES OF AMBULANCE SERVICES

There are several types of ambulance services covered by Medicare. They are defined in 42 CFR § 414.605 as follows:

1. Advanced Life Support, level 1 (ALS1): Transportation by ground ambulance vehicle, medically necessary supplies and services, and either an ALS assessment by ALS personnel or the provision of at least one ALS intervention.

NOTE: Per 42 CFR § 414.605, ALS personnel means an individual trained to the level of the emergency medical technician-intermediate (EMT-Intermediate) or paramedic. The EMT-Intermediate is defined as an individual who is qualified, in accordance with State and local laws, as an EMT-Basic and who is also qualified in accordance with State and local laws to perform essential advanced techniques and to administer a limited number of medications.

2. Advanced Life Support, level 2 (ALS2): Either transportation by ground ambulance vehicle, medically necessary supplies and services, and the administration of at least three medications by intravenous push/bolus or by continuous infusion, excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate); or transportation, medically necessary supplies and services, and the provision of at least one of the seven ALS procedures specified in 42 CFR § 414.605.

3. Air Ambulance (Fixed-Wing and Rotary-Wing): Air ambulance is furnished when the patient's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, this type of transport may be necessary because: (1) the patient's condition requires rapid transport to a treatment facility and either greater distances or other obstacles (e.g., heavy traffic) preclude such rapid delivery to the nearest appropriate facility; or (2) the patient is inaccessible by ground or water vehicle.

4. Basic Life Support (BLS): Transportation by ground ambulance vehicle and medically necessary supplies and services, plus the provision of BLS ambulance services. The ambulance must be staffed by an individual who is qualified in accordance with State and local laws as an emergency medical technician-basic (EMT-Basic).

5. Paramedic ALS Intercept Services (PI): Per 42 CFR § 414.605, EMT-Paramedic services furnished by an entity that does not furnish the ground transport, provided that the services meet the requirements in 42 CFR § 410.40(c). PI typically involves an arrangement between a BLS ambulance supplier and an ALS ambulance supplier, whereby the latter provides the ALS services and the BLS supplier provides the transportation component. Per 42 CFR § 410.40(c), PI must meet the following requirements:

- Be furnished in an area that is designated as a rural area;
- Be furnished under contract with one or more volunteer ambulance services that meet the following conditions;
- Are certified to furnish ambulance services as required under 42 CFR § 410.41;
- Furnish services only at the BLS level;
- Be prohibited by State law from billing for any service; and
- Be furnished by a paramedic ALS intercept supplier that meets the following conditions;
  - Is certified to furnish ALS services as required in 42 CFR § 410.41(b)(2); and
  - Bills of all the recipients who receive ALS intercept services from the entity, regardless of whether or not those recipients are Medicare beneficiaries.

6. Specialty Care Transport (SCT): Inter-facility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area (e.g., nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training.)

B. AMBULANCE QUALIFICATIONS

1. Vehicle Design and Equipment: As specified in 42 CFR § 410.41(a), a vehicle used as an ambulance must meet the following requirements:

- Be specially designed to respond to medical emergencies or provide acute medical care to transport the sick and injured and comply with all State and local laws governing an emergency transportation vehicle.
- Be equipped with emergency warning lights and sirens, as required by State or local laws.
- Be equipped with telecommunications equipment as required by State or local law to include, at a minimum, one two-way voice radio or wireless telephone.
- Be equipped with a stretcher, linens, emergency medical supplies, oxygen equipment, and other lifesaving emergency medical equipment as required by State or local laws.

2. Vehicle Personnel: Per 42 CFR § 410.41(b)(1)(i) & (ii), a BLS vehicle must be staffed by at least two people, one of whom must be: (1) certified as an emergency medical technician by the State or local authority where the services are furnished, and (2) legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle.

An ALS vehicle, in addition to meeting the BLS vehicle staff requirements described in 42 CFR § 410.41(b)(2), must also have one of the two staff members be certified as a paramedic or an emergency medical technician, by the State or local authority where the services are being furnished, to perform one or more ALS services.

3. Air Ambulance Certification: The air ambulance supplier shall maintain all applicable Federal and State licenses and certifications to include pilot certification, instrument and medical certifications and air worthiness certification. Acceptable proof of the above is:

- If the air ambulance supplier or provider owns the aircraft, the owner's name on the FAA Part 135 certificate must be the same as the supplier's or provider's name on the enrollment application.
- If the air ambulance supplier or provider owns the aircraft but contracts with an air services vendor to supply pilots, training and/or vehicle maintenance, the FAA Part 135 certificate must be issued in the name of the air services vendor. A certification from the supplier or provider must also attest that it has an agreement with the air services vendor and must list the date of that agreement. A copy of the FAA Part 135 Certificate must accompany the enrollment application.
- If the air ambulance supplier or provider leases the aircraft from another entity, a copy of the lease agreement must accompany the enrollment application. The name of the company leasing the aircraft from that other entity must be the same as the supplier's or provider's name on the enrollment application.

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SECTION 11: AMBULANCE SERVICE SUPPLIERS ONLY *(Continued)*

All ambulance service suppliers enrolling in the Medicare program must complete this section.

NOTE: The Medicare Administrative Contractor responsible for processing this enrollment application and paying claims submitted by this Ambulance Company is determined based on where the Ambulance Company houses and maintains its vehicles. Claims payment amounts are based on the "Point-of-Pickup" ZIP code.

A. BASE OF OPERATIONS FOR AMBULANCE COMPANY

The base of operations is the physical location where the ambulance vehicles are garaged, hangared or docked when not in use or on a run. If vehicles are housed in more than one MAC jurisdiction a separate CMS-855B must be submitted for each MAC jurisdiction. This address cannot be a Post Office (P.O.) box.

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

☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: ______________________________

☐ **Check here and skip to Section 11B if the "Base of Operations" address is the same as the "Practice Location" address reported in Section 3.**

Name of Location		
Street Address Line 1 *(Street Name and Number)*		
Street Address Line 2 *(Suite, Room, Apt. #, etc.)*		
City/Town	State	ZIP Code + 4
Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

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B. GEOGRAPHIC SERVICE AREA(S)

This section is to be completed with information about the geographic area in which this company renders ambulance services. Provide the city/town, county, State or ZIP code for all locations where services are rendered. Services are considered rendered at the Point-of-Pickup.

1. Initial Reporting and/or Additions

If you are reporting or adding an entire State, check the box below and specify the State.

☐ Entire State of ________________________

If services are only provided in selected cities/towns or counties, provide the locations below. List ZIP codes only if they are not within the entire city/town or county.

CITY/TOWN	COUNTY	STATE	ZIP CODE

2. Deletions

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

☐ Entire State of ________________________

If services are no longer provided in select cities/towns or counties, provide the locations below. List ZIP codes only if they are not within the entire city/town or county.

CITY/TOWN	COUNTY	STATE	ZIP CODE

SECTION 11: AMBULANCE SERVICE SUPPLIERS ONLY *(Continued)*

C. STATE LICENSE INFORMATION

If applicable, furnish any State required license information below.

NOTE: Crew members must complete continuing education requirements in accordance with State and local licensing laws. Evidence of re-certification must be retained with the employer in the event it needs to be reviewed by the Medicare Administrative Contractor.

If you are changing license information, check the box below and furnish the effective date.

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

Is this ambulance company licensed in the State where services are rendered and billed for? ☐ YES ☐ NO

If **YES**, provide the license information for the State where this ambulance service supplier will be rendering services and billing Medicare. Attach a copy of the current State license.

License Number	Effective Date *(mm/dd/yyyy)*

Issuing State *(if applicable)*	Issuing City/Town *(if applicable)*

If **NO**, explain why:

D. PARAMEDIC INTERCEPT SERVICES INFORMATION

Paramedic Intercept Services involve an arrangement between a Basic Life Support (BLS) ambulance company and an Advanced Life Support (ALS) ambulance company whereby the latter provides the ALS services and the BLS ambulance company provides the transportation component. If such an arrangement exists between the enrolling ambulance company and another ambulance company, the enrolling ambulance company must attach a copy of the signed contract. For more information, see 42 CFR 410.40.

If reporting a change to information about a previously reported agreement/contract, check the box below, furnish the effective date, and submit a copy of the new agreement/contract.

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

Does this ambulance company currently participate in a paramedic intercept services arrangement?

☐ YES ☐ NO If **YES**, submit a copy of the signed agreement/contract.

E. VEHICLE INFORMATION

Complete this section with information about the vehicles used by this ambulance company and the services they provide. If there is more than one vehicle, copy and complete this section for each. Attach a copy of each vehicle registration.

To qualify as an air ambulance supplier, the following is required:

- A written statement, signed by the President, Chief Executive Officer or Chief Operating Officer of the airport from where the aircraft is hangared that gives the name and address of the facility, and
- Proof that the enrolling ambulance company, or the company leasing the air ambulance vehicle to the enrolling ambulance company, possesses a valid charter flight license (FAA 135 Certificate) for the aircraft being used as an air ambulance. If the enrolling ambulance company owns the aircraft, the owner's name on the FAA 135 Certificate must be the same as the enrolling ambulance company's name (or the ambulance company owner as reported in Sections 9 or 10) in this application. If the enrolling ambulance company leases the aircraft from another company, a copy of the lease agreement must accompany this enrollment application.

Check if you are adding or removing this vehicle and furnish the effective date.

☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: _______________________________

Type *(automobile, aircraft, boat, etc.)*	Vehicle Identification Number

Make *(e.g., Ford)*	Model *(e.g., 350T)*	Year *(yyyy)*

Does this vehicle provide:

Advanced life support (Level 1)	☐ YES	☐ NO	Specialty care transport	☐ YES	☐ NO
Advanced life support (Level 2)	☐ YES	☐ NO	Land ambulance	☐ YES	☐ NO
Basic life support	☐ YES	☐ NO	Air ambulance–fixed wing	☐ YES	☐ NO
Emergency runs	☐ YES	☐ NO	Air ambulance–rotary wing	☐ YES	☐ NO
Non-emergency runs	☐ YES	☐ NO	Marine ambulance	☐ YES	☐ NO

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E. VEHICLE INFORMATION *(Continued)*

Check if you are adding or removing this vehicle and furnish the effective date.

☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: ______________________________

Type *(automobile, aircraft, boat, etc.)*		Vehicle Identification Number
Make *(e.g., Ford)*	Model *(e.g., 350T)*	Year *(yyyy)*

Does this vehicle provide:

Advanced life support (Level 1)	☐ YES	☐ NO	Specialty care transport	☐ YES	☐ NO
Advanced life support (Level 2)	☐ YES	☐ NO	Land ambulance	☐ YES	☐ NO
Basic life support	☐ YES	☐ NO	Air ambulance–fixed wing	☐ YES	☐ NO
Emergency runs	☐ YES	☐ NO	Air ambulance–rotary wing	☐ YES	☐ NO
Non-emergency runs	☐ YES	☐ NO	Marine ambulance	☐ YES	☐ NO

Check if you are adding or removing this vehicle and furnish the effective date.

☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: ______________________________

Type *(automobile, aircraft, boat, etc.)*		Vehicle Identification Number
Make *(e.g., Ford)*	Model *(e.g., 350T)*	Year *(yyyy)*

Does this vehicle provide:

Advanced life support (Level 1)	☐ YES	☐ NO	Specialty care transport	☐ YES	☐ NO
Advanced life support (Level 2)	☐ YES	☐ NO	Land ambulance	☐ YES	☐ NO
Basic life support	☐ YES	☐ NO	Air ambulance–fixed wing	☐ YES	☐ NO
Emergency runs	☐ YES	☐ NO	Air ambulance–rotary wing	☐ YES	☐ NO
Non-emergency runs	☐ YES	☐ NO	Marine ambulance	☐ YES	☐ NO

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Check if you are adding or removing this vehicle and furnish the effective date.

☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: ______________________________

Type *(automobile, aircraft, boat, etc.)*		Vehicle Identification Number
Make *(e.g., Ford)*	Model *(e.g., 350T)*	Year *(yyyy)*

Does this vehicle provide:

Advanced life support (Level 1)	☐ YES	☐ NO	Specialty care transport	☐ YES	☐ NO
Advanced life support (Level 2)	☐ YES	☐ NO	Land ambulance	☐ YES	☐ NO
Basic life support	☐ YES	☐ NO	Air ambulance–fixed wing	☐ YES	☐ NO
Emergency runs	☐ YES	☐ NO	Air ambulance–rotary wing	☐ YES	☐ NO
Non-emergency runs	☐ YES	☐ NO	Marine ambulance	☐ YES	☐ NO

Check if you are adding or removing this vehicle and furnish the effective date.

☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: ______________________________

Type *(automobile, aircraft, boat, etc.)*		Vehicle Identification Number
Make *(e.g., Ford)*	Model *(e.g., 350T)*	Year *(yyyy)*

Does this vehicle provide:

Advanced life support (Level 1)	☐ YES	☐ NO	Specialty care transport	☐ YES	☐ NO
Advanced life support (Level 2)	☐ YES	☐ NO	Land ambulance	☐ YES	☐ NO
Basic life support	☐ YES	☐ NO	Air ambulance–fixed wing	☐ YES	☐ NO
Emergency runs	☐ YES	☐ NO	Air ambulance–rotary wing	☐ YES	☐ NO
Non-emergency runs	☐ YES	☐ NO	Marine ambulance	☐ YES	☐ NO

SECTION 12: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (IDTFs) ONLY

INDEPENDENT DIAGNOSTIC TESTING FACILITY (IDTF) PERFORMANCE STANDARDS

Below is an abbreviated summary of the performance standards every IDTF must meet in order to obtain and retain their Medicare billing privileges. These standards, in their entirety, can be found in 42 CFR § 410.33(g).

1. Operate its business in compliance with all applicable Federal and State licensure and regulatory requirements for the health and safety of patients.
2. Provides complete and accurate information on its enrollment application. Changes in ownership, changes of location, changes in general supervision, and adverse legal actions must be reported to the MAC on the CMS-855B within 30 calendar days of the change. All other changes to the enrollment information must be reported within 90 calendar days.
3. Maintain a physical facility on an appropriate site. For the purposes of this standard, a post office box, commercial mail box, hotel or motel is not considered an appropriate site.
   - (i) The physical facility, including mobile units, must contain space for equipment appropriate to the services designated on the enrollment application, facilities for hand washing, adequate patient privacy accommodations, and the storage of both business records and current medical records within the office setting of the IDTF, or IDTF home office, not within the actual mobile unit.
   - (ii) IDTF suppliers that provide services remotely and do not see beneficiaries at their practice location are exempt from providing hand washing and adequate patient privacy accommodations.
4. Have all applicable diagnostic testing equipment available at the physical site excluding portable diagnostic testing equipment. A catalog of portable diagnostic equipment, including diagnostic testing equipment serial numbers, must be maintained at the physical site. In addition, portable diagnostic testing equipment must be available for inspection within two business days of a CMS inspection request. The IDTF must maintain a current inventory of the diagnostic testing equipment, including serial and registration numbers, provide this information to the designated MAC upon request, and notify the MAC of any changes in equipment within 90 days.
5. Maintain a primary business phone under the name of the business. The primary business phone must be located at the designated site of the business, or within the home office of the mobile IDTF units. The telephone number or toll free numbers must be available in a local directory and through directory assistance.
6. Have a comprehensive liability insurance policy of at least $300,000 per location that covers both the place of business and all customers and employees of the IDTF. The policy must be carried by a non-relative owned company. Failure to maintain required insurance at all times will result in revocation of the IDTF's billing privileges retroactive to the date the insurance lapsed. IDTF suppliers are responsible for providing the contact information for the issuing insurance agent and the underwriter. In addition, the IDTF must:
   - (i) Ensure that the insurance policy remain in force at all times and provide coverage of at least $300,000 per incident; and
   - (ii) Notify the CMS designated MAC in writing of any policy changes or cancellations.
7. Agree not to directly solicit patients, which include, but is not limited to, a prohibition on telephone, computer, or in-person contacts. The IDTF must accept only those patients referred for diagnostic testing by an attending physician, who is furnishing a consultation or treating a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Non-physician practitioners may order tests as set forth in § 410.32(a)(3).
8. Answer, document, and maintain documentation of a beneficiary's written clinical complaint at the physical site of the IDTF. For mobile IDTFs, this documentation would be stored at their home office. This includes, but is not limited to, the following:
   - (i) The name, address, telephone number, and health insurance claim number of the beneficiary.
   - (ii) The date the complaint was received; the name of the person receiving the complaint; and a summary of actions taken to resolve the complaint.
   - (iii) If an investigation was not conducted, the name of the person making the decision and the reason for the decision.
9. Openly post these standards for review by patients and the public.
10. Disclose to the government any person having ownership, financial or control interest or any other legal interest in the IDTF at the time of enrollment or within 30 days of a change.
11. Have its testing equipment calibrated and maintained per equipment instructions and in compliance with applicable manufacturers suggested maintenance and calibration standards.
12. Have technical staff on duty with the appropriate credentials to perform tests. The IDTF must be able to produce the applicable Federal or State licenses or certifications of the individuals performing these services.
13. Have proper medical record storage and be able to retrieve medical records upon request from CMS or the MAC within 2 business days.
14. Permit CMS, including its agents, or the MAC, to conduct unannounced, on-site inspections to confirm the IDTF's compliance with these standards. The IDTF must be accessible during regular business hours to CMS and beneficiaries and must maintain a visible sign posting the normal business hours of the IDTF.
15. With the exception of hospital-based and mobile IDTFs, a fixed base IDTF does not include the following:
   - (i) Sharing a practice location with another Medicare-enrolled individual or organization.
   - (ii) Leasing or subleasing its operations or its practice location to another Medicare enrolled individual or organization.
   - (iii) Sharing diagnostic testing equipment used in the initial diagnostic test with another Medicare-enrolled individual or organization.
16. Enrolls in Medicare for any diagnostic testing services that it furnishes to a Medicare beneficiary, regardless of whether the service is furnished in a mobile or fixed base location.
17. Bills for all mobile diagnostic services that are furnished to a Medicare beneficiary, unless the mobile diagnostic service is part of a service provided under arrangement as described in Section 1861(w)(1) of the Social Security Act.

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SECTION 12: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (IDTFs) ONLY *(Continued)*

All Independent Diagnostic Facilities enrolling in the Medicare program must complete this section.

If you perform diagnostic tests, other than clinical laboratory or pathology tests, and are required to enroll as an IDTF, you must complete this section. CMS requires the information in this section to determine whether the enrolling supplier meets all IDTF performance standards including, but not limited to those listed in this Section. Not all suppliers that perform diagnostic tests are required to enroll as an IDTF.

NOTE: Each IDTF practice location, including base of operations for mobile and portable operations, must meet the performance standards and undergo a site inspection prior to enrollment.

Diagnostic Radiology

Many diagnostic tests are radiological procedures that require the professional services of a radiologist. A radiologist's practice is generally different from those of other physicians because radiologists usually do not bill E&M codes or treat a patient's medical condition on an ongoing basis. Therefore a radiologist or group practice of radiologists is not necessarily required to enroll as an IDTF. If enrolling as a diagnostic radiology group practice or clinic and billing for the technical component of diagnostic radiological tests (if the entity is a free standing diagnostic facility), you should contact the MAC to determine if you need to enroll as an IDTF.

NOTE: A mobile IDTF that provides X-ray services is not classified as a portable X-ray supplier.

A. DATE IDTF MET STANDARDS QUALIFICATIONS

Provide the date this Independent Diagnostic Testing Facility met all current CMS IDTF Performance Standards *(mm/dd/yyyy)*

B. COMPREHENSIVE LIABILITY INSURANCE INFORMATION

Consistent with IDTF Performance Standard #6, all IDTFs enrolling in Medicare must have a comprehensive liability insurance policy of at least $300,000 per location, that covers both the place of business and all customers and employees of the IDTF. The policy must be carried by a non-relative owned company. 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 IDTFs must submit a copy of the Comprehensive Liability Insurance Policy with this application. The policy must list the designated Medicare Administrative Contractor who you will mail this application to for processing as a Certificate Holder on the policy.

If you are changing liability insurance information, check the box below 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 First Name	Middle Initial	Last Name	Jr., Sr., M.D., etc.
Underwriter's Telephone Number	Underwriter's Fax Number *(if applicable)*		Underwriter's E-mail Address *(if applicable)*

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SECTION 12: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (IDTFs) ONLY *(Continued)*

C. CPT-4 AND HCPCS CODES

The IDTF must report all Current Procedural Terminology, Version 4 (CPT-4) codes, Healthcare Common Procedural Coding System codes (HCPCS), and types of equipment (including the model number), for which it will perform tests, supervise, interpret, and/or bill. All codes reported must be for diagnostic tests that an IDTF is allowed to perform. Diagnostic tests that are clearly surgical in nature, which must be performed in a hospital or ambulatory surgical center, should not be reported.

If you are adding or removing CPT-4 or HCPCS codes, check the applicable box and furnish the effective date.

Copy and complete this page as needed to report all CPT-4 and HCPCS codes.

CHECK ONE FOR EACH CPT-4 OR HCPCS CODE	CPT–4 OR HCPCS CODE	EQUIPMENT	MODEL NUMBER *(Required)*
☐ ADD ☐ DELETE Effective Date: ________			
☐ ADD ☐ DELETE Effective Date: ________			
☐ ADD ☐ DELETE Effective Date: ________			
☐ ADD ☐ DELETE Effective Date: ________			
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SECTION 12: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (IDTFs) ONLY *(Continued)*

D. INTERPRETING PHYSICIAN INFORMATION

☐ Check here if this section does not apply because all interpreting physicians will bill separate from the IDTF.

All physicians whose interpretations will be billed by this IDTF for the technical component of the test (i.e., global billing) must be reported in this section. All interpreting physicians must be currently enrolled in the Medicare program. If there are more than four interpreting physicians, copy and complete this page as needed.

If you are billing for interpretations from an individual physician who is reassigning his/her benefits, the physician must complete the Reassignment of Benefits Form (CMS 855R). Note: Both the IDTF and individual physician must be enrolled with the MAC where the IDTF is located.

If you are billing for purchased interpretations, all requirements for purchased interpretations must be met.

When a mobile unit of the IDTF performs a technical component of a diagnostic test and the interpretive physician is the same physician who ordered the test, the IDTF cannot bill for the interpretation. Therefore, these interpreting physicians should not be reported since the interpretive physician must submit his/her own claims for these tests.

When adding or removing an interpreting physician, check the applicable box and furnish the effective date.

1st Interpreting Physician Information

☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: ________________________________

First Name	Middle Initial	Last Name	Jr., Sr., M.D., etc.
Social Security Number *(Required)*		Date of Birth *(mm/dd/yyyy) (Required)*	
Medicare Identification Number (PTAN)		National Provider Identifier (NPI)	

2nd Interpreting Physician Information

☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: ________________________________

First Name	Middle Initial	Last Name	Jr., Sr., M.D., etc.
Social Security Number *(Required)*		Date of Birth *(mm/dd/yyyy) (Required)*	
Medicare Identification Number (PTAN)		National Provider Identifier (NPI)	

3rd Interpreting Physician Information

☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: ________________________________

First Name	Middle Initial	Last Name	Jr., Sr., M.D., etc.
Social Security Number *(Required)*		Date of Birth *(mm/dd/yyyy) (Required)*	
Medicare Identification Number (PTAN)		National Provider Identifier (NPI)	

4th Interpreting Physician Information

☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: ________________________________

First Name	Middle Initial	Last Name	Jr., Sr., M.D., etc.
Social Security Number *(Required)*		Date of Birth *(mm/dd/yyyy) (Required)*	
Medicare Identification Number (PTAN)		National Provider Identifier (NPI)	

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SECTION 12: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (IDTFs) ONLY *(Continued)*

E. TECHNICIANS WHO PERFORM TESTS

Complete this section with information about all non-physician personnel who perform tests for this IDTF. Notarized or certified true copies of the State license or certificate must be submitted for each technician. If there are more than three technicians, copy and complete this page as needed.

When adding or removing a technician, check the applicable box and furnish the effective date.

1st Technician Information

☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: ______________________

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

Social Security Number *(Required)*	Date of Birth *(mm/dd/yyyy) (Required)*	National Provider Identifier (NPI) *(if issued)*

Is this technician State licensed or State certified? ☐ YES ☐ NO

License/Certification Number *(if applicable)*	License/Certification Issue Date *(mm/dd/yyyy) (if applicable)*

Is this technician certified by a national credentialing organization? ☐ YES ☐ NO

Name of credentialing organization *(if applicable)*	Type of Credentials *(if applicable)*

Is this technician employed by a hospital? ☐ YES ☐ NO

If **YES**, provide the name of the hospital here: ______________________

2nd Technician Information

☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: ______________________

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

Social Security Number *(Required)*	Date of Birth *(mm/dd/yyyy) (Required)*	National Provider Identifier (NPI) *(if issued)*

Is this technician State licensed or State certified? ☐ YES ☐ NO

License/Certification Number *(if applicable)*	License/Certification Issue Date *(mm/dd/yyyy) (if applicable)*

Is this technician certified by a national credentialing organization? ☐ YES ☐ NO

Name of credentialing organization *(if applicable)*	Type of Credentials *(if applicable)*

Is this technician employed by a hospital? ☐ YES ☐ NO

If **YES**, provide the name of the hospital here: ______________________

3rd Technician Information

☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: ______________________

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

Social Security Number *(Required)*	Date of Birth *(mm/dd/yyyy) (Required)*	National Provider Identifier (NPI) *(if issued)*

Is this technician State licensed or State certified? ☐ YES ☐ NO

License/Certification Number *(if applicable)*	License/Certification Issue Date *(mm/dd/yyyy) (if applicable)*

Is this technician certified by a national credentialing organization? ☐ YES ☐ NO

Name of credentialing organization *(if applicable)*	Type of Credentials *(if applicable)*

Is this technician employed by a hospital? ☐ YES ☐ NO

If **YES**, provide the name of the hospital here: ______________________

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SECTION 12: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (IDTFs) ONLY *(Continued)*

F. SUPERVISING PHYSICIANS

Complete this section with identifying information about the physician(s) who supervise the operation of the IDTF and who provides the personal, direct, or general supervision per 42 CFR § 410.32(b)(3). The supervising physician must also attest to his/her supervising responsibilities for the enrolling IDTF.

Information concerning the type of supervision (personal, direct, or general) required for performance of specific IDTF tests can be obtained from your MAC. All IDTFs must report at least one supervisory physician and at least one supervising physician must perform the supervision requirements stated in 42 CFR § 410.32(b)(3). All supervisory physician(s) must be currently enrolled in Medicare.

Definitions of the types of supervision are as follows:

- **Personal Supervision** means a physician must be in attendance in the room during the performance of the procedure.
- **Direct Supervision** means the physician must be present in the office suite and immediately available to provide assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.
- **General Supervision** means the procedure is provided under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. General supervision also includes the responsibility that the non-physician personnel (technicians) who perform the tests are qualified and properly trained and that the equipment is properly operated, maintained and calibrated and that necessary supplies are available.

1. Identifying Information for Supervising Physician

When adding or deleting a supervising physician, check the applicable box and furnish the effective date.

If adding and/or removing more than one supervising physician, copy and complete Section 12F in its entirety for each.

☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: ______________________

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

Social Security Number *(Required)*	Date of Birth *(mm/dd/yyyy) (Required)*
Medicare Identification Number (PTAN)	**National Provider Identifier (NPI)**

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

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2. Type of Supervision Provided

Check the appropriate box below indicating the type of supervision provided by the physician reported above for the tests performed by the IDTF in accordance with 42 CFR 410.32 (b)(3) (See instructions for definitions).

☐ Personal Supervision ☐ Direct Supervision ☐ General Supervision

For each physician performing General Supervision, at least one of the three functions listed below must be checked. However, to meet the General Supervision requirement, in accordance with 42 CFR § 410.33(b), the enrolling IDTF must have at least one supervisory physician for each of the three functions. For example, two physicians may be responsible for function 1, a third physician may be responsible for function 2, and a fourth physician may be responsible for function 3. All four supervisory physicians must complete and sign the supervisory physician section of this application (Section 12F, 1–5). Each physician should only check the function(s) he/she actually performs.

☐ Assumes responsibility for the overall direction and control of the quality of testing performed.

☐ Assumes responsibility for assuring that the non-physician personnel who actually perform the diagnostic procedures are properly trained and meet required qualifications.

☐ Assumes responsibility for the proper maintenance and calibration of the equipment and the supplies necessary to perform the diagnostic procedures.

SECTION 12: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (IDTFs) ONLY *(Continued)*

3. Other Supervision Sites

Does this supervising physician provide supervision at any other IDTF? ☐ YES ☐ NO

If **YES**, list all other IDTFs for which this physician provides supervision. If more than five, copy and complete this section as needed.

When adding or removing another supervision site, check the applicable box and furnish the effective date.

	NAME OF FACILITY	PTAN	NPI	TIN	LEVEL OF SUPERVISION
1. ☐ ADD ☐ Remove Effective Date: ______________					☐ Personal ☐ Direct ☐ General
2. ☐ ADD ☐ Remove Effective Date: ______________					☐ Personal ☐ Direct ☐ General
3. ☐ ADD ☐ Remove Effective Date: ______________					☐ Personal ☐ Direct ☐ General
4. ☐ ADD ☐ Remove Effective Date: ______________					☐ Personal ☐ Direct ☐ General
5. ☐ ADD ☐ Remove Effective Date: ______________					☐ Personal ☐ Direct ☐ General

4. Attestation Statement for Supervising Physicians

a. Under penalty of perjury, I, the undersigned, hereby acknowledge that I have agreed to provide (Name of IDTF)__________________________ with the Supervisory Physician services checked in Section 12F2 for all CPT-4 and HCPCS codes reported in Section 12C. **See (b) below if all reported CPT-4 and HCPCS codes do not apply.** I also hereby certify that I have the required proficiency in the performance and interpretation of each type of diagnostic procedure, as reported by CPT-4 or HCPCS codes in Section 12C (except for those CPT-4 or HCPCS codes identified in (b) below). I have read and understand the Penalties for Falsifying Information on this Enrollment Application, as stated in Section 16 of this application. I am aware that falsifying information may result in fines and/or imprisonment. If I undertake supervisory responsibility at any additional IDTFs, I understand that it is my responsibility to notify this IDTF at that time.

b. I am not the Supervising Physician for the following CPT-4 and/or HCPCS codes reported in Section 12C.

CPT–4 OR HCPCS CODE	CPT–4 OR HCPCS CODE	CPT–4 OR HCPCS CODE

5. Supervising Physician's Name and Signature

All Physicians rendering supervisory services for the IDTF reported in Section 2B must sign and date below.

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

Supervising Physician 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.

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SECTION 13: BILLING AGENCY INFORMATION

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

☐ **Check here if this section does not apply and skip to Section 14.**

BILLING AGENCY NAME AND ADDRESS

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

☐ **Change** ☐ **Add** ☐ **Remove** **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 Agency/Agent Medicare Identification Number (PTAN) *(if issued)*		Billing Agency/Agent National Provider Identifier (NPI) *(if issued)*	

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SECTION 14: CONTACT PERSON INFORMATION

If questions arise while processing this application, the MAC will contact the individual checked below.

☐ Contact any Delegated Official listed in Section 17

☐ Contact any Authorized Official listed in Section 18

☐ Contact person listed 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 listed in this section will only be authorized to discuss issues concerning this enrollment application. The MAC will not discuss any other enrollment issues for this supplier with the above Contact Person.

SECTION 15: SUPPORTING DOCUMENTATION INFORMATION

This section lists documents that, if applicable, must be submitted with this enrollment application. If you are newly enrolling, or are reactivating or revalidating your enrollment, you must provide all applicable documents. When reporting a change of information, only submit documents that are applicable to that change.

The enrolling supplier may submit a notarized copy of a Certificate of Good Standing from the supplier's State licensing/certification board or other medical association in lieu of the required documents. This certificate cannot be more than 30 days old.

At any time during the enrollment process the MAC may request additional documentation to support or validate information reported on this application. The MAC may also request documents other than those identified below when necessary to process your claims.

MANDATORY FOR ALL SUPPLIER TYPES

- ☐ Written confirmation from the IRS confirming your Tax Identification Number and Legal Business Name provided in Section 2B. (e.g., IRS form CP 575)
- ☐ Completed Form CMS-588, Electronic Funds Transfer Authorization Agreement. Include a voided check. **NOTE:** If you already receive payments electronically and are not making a change to your banking information, the CMS-588 is not required.
- ☐ Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement

MANDATORY FOR SELECTED SUPPLIER TYPES

- ☐ Copy(s) of all documentation verifying IDTF Supervisory Physician(s) proficiency and/or State licenses or certification for IDTF non-physician personnel (technicians)
- ☐ Copy of comprehensive liability insurance policy (IDTFs only)
- ☐ Copy(s) of all documentation verifying the State licenses or certifications of the laboratory Director of an Independent Clinical Laboratory
- ☐ Copy of FAA 135 certificate (air ambulance suppliers)
- ☐ Copy of Paramedic Intercept Services contract (ambulance suppliers)
- ☐ Copy of Centralized Flu Biller approval letter

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.
- ☐ 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 also be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.
- ☐ Copy(s) of all final adverse legal action documentation (e.g., notifications, resolutions and reinstatement letters)
- ☐ Copy of an attestation letter for government entities and tribal organizations
- ☐ Copy of delegated official's W-2 if one has been designated
- ☐ Copy of all health care related permits/licenses/registrations for vehicles used to furnish mobile and or portable services

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SECTION 16: PENALTIES FOR FALSIFYING INFORMATION ON THIS ENROLLMENT APPLICATION

This section outlines the penalties for deliberately falsifying 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.

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SECTION 17: ASSIGNMENT OF DELEGATED OFFICIAL(S) *(Optional)*

A **DELEGATED OFFICIAL** means an individual who is delegated the authority to report changes and updates to the supplier's enrollment record by an authorized official. 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. An independent contractor is not considered employed by the supplier and therefore cannot be a delegated offical.

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 Penalties for Falsifying Information in Section 16 and the Certification Statement in Section 18A 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, the delegated official certifies that the information provided is true, correct and complete.

The signature of an authorized official in Section 17 constitutes a legal delegation of authority to all delegated official(s) assigned in Section 17. If you are delegating more than two individuals, copy and complete this section for each additional delegated individual.

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

ASSIGNMENT OF DELEGATED OFFICIAL

All delegated officials must be reported in Section 10 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 Name and Signature

☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: ______________________________

Under penalty of perjury, I, the undersigned, certify that I have read and understand the Certification Statement in Section 18A 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 Name and Signature

☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: ______________________________

Under penalty of perjury, I, the undersigned, certify that I have read and understand the Certification Statement in Section 18A 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.

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SECTION 18: AUTHORIZED OFFICIAL CERTIFICATION STATEMENT AND SIGNATURE

An **AUTHORIZED OFFICIAL** means an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or 5% or greater 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 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 MAC of any future changes to the information contained in this application, after the supplier is enrolled in Medicare, within the applicable timeframes specified in 42 CFR § 424.516.

Applications submitted for initial enrollment must be signed by an Authorized Official or they will be rejected and returned unprocessed.

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 this supplier may be denied entry into or have its billing privileges revoked from the Medicare program if any requirements are not met.

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A. CERTIFICATION STATEMENT

You **MUST SIGN AND DATE** Section 18B of this certification statement 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 MAC of this fact immediately.
2. I agree to notify the MAC of any current or future changes to the information contained in this application in accordance with the timeframes established in 42 CFR § 424.516. 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, delegated official, or authorized official thereof is currently sanctioned, suspended, debarred, or excluded by the Medicare or any 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).

B. AUTHORIZED OFFICIAL SIGNATURE(S)

All Authorized Officials must be reported in Section 10 of this application.

If you are adding or removing an Authorized Official, check the applicable box and furnish the effective date.

1st Authorized Official Attestation
I have read the contents of this application and the certification statement in Section 18A 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 MAC to verify this information.

1st Authorized Official Name 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 Attestation
I have read the contents of this application and the certification statement in Section 18A 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 MAC to verify this information.

2nd Authorized Official Name 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.

3rd Authorized Official Attestation
I have read the contents of this application and the certification statement in Section 18A 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 MAC to verify this information.

3rd Authorized Official Name 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.

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MEDICARE PROVIDER ENROLLMENT APPLICATION PRIVACY ACT STATEMENT

The Authority for maintenance of the system is given under provisions of sections 1102(a) (Title 42 U.S.C. 1302(a)), 1128 (42 U.S.C. 1320a–7), 1814(a)) (42 U.S.C. 1395f(a)(1), 1815(a) (42 U.S.C. 1395g(a)), 1833(e) (42 U.S.C. 1395I(3)), 1871 (42 U.S.C. 1395hh), and 1886(d)(5)(F), (42 U.S.C. 1395ww(d)(5)(F) of the Social Security Act; 1842(r) (42 U.S.C. 1395u(r)); section 1124(a)(1) (42 U.S.C. 1320a–3(a)(1), and 1124A (42 U.S.C. 1320a–3a), section 4313, as amended, of the BBA of 1997; and section 31001(i) (31 U.S.C. 7701) of the DCIA (Pub. L. 104–134), as amended.

The information collected here will be entered into the Provider Enrollment, Chain and Ownership System (PECOS).

PECOS will collect information provided by an applicant related to identity, qualifications, practice locations, ownership, billing agency information, reassignment of benefits, electronic funds transfer, the NPI and related organizations. PECOS will also maintain information on business owners, chain home offices and provider/chain associations, managing/ directing employees, partners, authorized and delegated officials, supervising physicians of the supplier, staffing companies, ambulance vehicle information, and/or interpreting physicians and related technicians. This system of records will contain the names, social security numbers (SSN), date of birth (DOB), and employer identification numbers (EIN) and NPI's for each disclosing entity, owners, as well as managing/ directing employees, with 5 percent or more ownership or control interest. Managing/directing employees include general manager, business managers, administrators, directors, and other individuals who exercise operational or managerial control over the provider/ supplier. The system will also contain Medicare identification numbers (i.e., OSCAR, CCN, PTAN and the NPI), demographic data, professional data, past and present history as well as information regarding any adverse actions such as exclusions, sanctions, and felonious behavior.

The Privacy Act permits CMS to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. Any such disclosure of data is known as a "routine use." The CMS will only release PECOS information that can be associated with an individual as provided for under Section III "Proposed Routine Use Disclosures of Data in the System." Both identifiable and non-identifiable data may be disclosed under a routine use. CMS will only collect the minimum personal data necessary to achieve the purpose of PECOS. Below is an abbreviated summary of the six routine uses. To view the routine uses in their entirety go to: **http://www.cms.gov/RegulationsandGuidance/Guidance/PrivacyActSystemofRecords/downloads/0532.pdf**.

1. To support CMS contractors, consultants, or grantees, who have been engaged by CMS to assist in the performance of a service related to this collection and who need to have access to the records in order to perform the activity.
2. To assist another Federal or state agency, agency of a state government or its fiscal agent to:
   a. Contribute to the accuracy of CMS's proper payment of Medicare benefits,
   b. Enable such agency to administer a Federal health benefits program that implements a health benefits program funded in whole or in part with federal funds, and/or
   c. Evaluate and monitor the quality of home health care and contribute to the accuracy of health insurance operations.
3. To assist an individual or organization for research, evaluation or epidemiological projects related to the prevention of disease or disability, or the restoration or maintenance of health, and for payment related projects.
4. To support the Department of Justice (DOJ), court or adjudicatory body when:
   a. The agency or any component thereof, or
   b. Any employee of the agency in his or her official capacity, or
   c. Any employee of the agency in his or her individual capacity where the DOJ has agreed to represent the employee, or
   d. The United States Government, is a party to litigation and that the use of such records by the DOJ, court or adjudicatory body is compatible with the purpose for which CMS collected the records.
5. To assist a CMS contractor that assists in the administration of a CMS administered health benefits program, or to combat fraud, waste, or abuse in such program.
6. To assist another Federal agency to investigate potential fraud, waste, or abuse in, a health benefits program funded in whole or in part by Federal funds.

The applicant 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.

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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-xxxx. The time required to complete this information collection is estimated to be 4 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.