MEDICARE ENROLLMENT APPLICATION

REGISTRATION FOR ELIGIBLE ENTITIES THAT PROVIDE HEALTH INSURANCE COVERAGE COMPLEMENTARY TO MEDICARE PART B AND PURSUANT TO 42 CFR § 424.66

CMS-855C

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

WHO SHOULD COMPLETE AND SUBMIT THIS APPLICATION

This Medicare registration application is to be completed by all entities that provide health insurance coverage complementary to Medicare Part B and intend to bill Medicare as an indirect payment procedure (IPP) biller and the entity meets all Medicare requirements to submit claims using the indirect payment procedure. The entity must furnish the name of at least one authorized official, preferably the administrator of the entity providing the complementary health plan, who must sign this registration application attesting that the registering entity meets the requirements to register as an indirect payment procedure entity and will also abide by the requirements stated in the Certification & Attestation Statement in Section 10 of this application.

As stated in 42 CFR § 424.66, an entity must meet all of the following conditions to be eligible to submit claims using the indirect payment procedure.

1. Provides coverage of the service under a complementary health benefit plan (this is, the coverage that the plan provides is complementary to Medicare benefits and covers only the amount by which the Part B payment falls short of the approved charge for the service under the plan).
2. Has paid the person who provided the service an amount (including the amount payable under the Medicare program) that the person accepts as full payment.
3. Has the written authorization of the beneficiary (or of a person authorized to sign claims on his behalf under § 424.36) to receive the Part B payment for the services for which the entity pays.
4. Relieves the beneficiary of liability for payment for the service and will not seek any reimbursement from the beneficiary, his or her survivors or estate.
5. Submits any information CMS or the carrier may request, including an itemized physician or supplier bill, in order to apply the requirements under the Medicare program.
6. Identifies and excludes from its requests for payment all services for which Medicare is the secondary payer.

If this registration is approved, the entity will be deemed eligible to submit claims to Medicare as an indirect payment procedure biller.

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

GENERAL INSTRUCTIONS FOR COMPLETING THIS APPLICATION

All information on this form is required. If any information changes, it must be reported within 90 days.

- Type or print all information so that it is legible. Do not use pencil. Blue ink is preferred.
- Complete all sections and include your other entity identifier (OEID) or health plan identifier (HPID).
- Keep a copy of your completed Medicare registration application for your records.
- Sign and date Section 11 of this application using blue ink.

NOTE: Medicare may request, at any time during the registration process, documentation to support and validate information reported on this application. You are responsible for providing this documentation in a timely manner, usually within 30 days.

ACRONYMS COMMONLY USED IN THIS APPLICATION

HPID: Health Plan Identifier
IPP: Indirect Payment Procedure
MAC: Medicare Administrative Contractor
NPI: National Provider Identifier
OEID: Other Entity Identifier
PTAN: Provider Transaction Account Number
SSN: Social Security Number
TIN: Tax Identification Number

***An Entity that successfully registers in the Medicare program may also be referred to as an "IPP Biller."**

SPECIFIC INSTRUCTIONS FOR COMPLETING EACH SECTION OF THIS APPLICATION

SECTION 1: BASIC INFORMATION
Check the appropriate box indicating the reason for submitting this registration application.

SECTION 2: IDENTIFYING INFORMATION
A. Entity's Identification Information
Furnish the legal business name and tax identification number of the Entity/Organization that is providing coverage of services under a complementary health benefits plan to its members, in addition to the name of the health plan and either the Entity's OEID or the Health Plan's HPID.

B. Resident Agent Name and Contact Information
If this entity has a Resident Agent, furnish complete contact information for the agent.

C. Business Structure Information
Check the appropriate box indicating the Entity's business structure and when and where it is incorporated/registered if applicable.

D. Internal Revenue Service Registration Information
Check the appropriate box as it applies to the Entity.

SECTION 3: HEADQUARTERS ADDRESS AND CLAIMS SUBMISSION INFORMATION
A. Headquarters Address Information
Furnish complete address information for the headquarters or administrative/central office of the Entity providing the complementary health benefits plan.

B. States Where the Entity will Submit Claims
For each State where the registering entity will be submitting claims, Medicare will issue a unique Medicare billing number (PTAN). If services are rendered and a claim submitted within a State that does not have a corresponding PTAN, the claim will be denied. Check every State and US Territory where the entity will be submitting claims under the Indirect Payment Procedure (IPP). If removing a previously reported State or Territory, check the appropriate box. Also note that if a claim is not submitted against an issued PTAN in a 12 month period, that specific PTAN will be deactivated.

SECTION 4: IMPORTANT ADDRESS INFORMATION
A. Correspondence Mailing Address
Furnish a complete address and other contact information where CMS or the MAC can get in direct contact with the Administrator/Manager of the Health Plan. This address may be the same as the Entity's Headquarters address.

B. Remittance Notices/Special Payments Mailing Address
Furnish a complete mailing address where the Entity would like to receive claims and payment related notices and non-routine payments.

SECTION 5: FINAL ADVERSE LEGAL ACTIONS
As an Entity registering in the Medicare program to submit claims and be reimbursed from the Medicare trust fund, the Entity must complete this section. If there are no final adverse legal actions to report you MUST check the "NO" box.

SECTION 6: OWNERSHIP AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS)
A. 1. Identifying Information: Furnish all requested identifying information including any National Provider Identifiers (NPIs) or Medicare Identification Numbers (PTANs) of the organization(s) that have 5% or more ownership or managing control of the Entity reported in Section 2.

2 & 3. Type of Ownership and Applicable Dates: Check the appropriate box indicating the type of ownership and when it occurred or ended as appropriate.

4 & 5. Type of Managing Control: Check the appropriate box indicating the type of managing control and when it occurred or ended as appropriate.

B. Final Adverse Legal Action History
Furnish any reportable final adverse legal actions that have occurred against the organization reported in this section. If there are no final adverse legal actions to report, check the "NO" box.

SECTION 7: OWNERSHIP AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS)
C. 1. Identifying Information: Furnish all requested identifying information including any National Provider Identifiers (NPIs) or Medicare Identification Numbers (PTANs) of any individual(s) that have 5% or more ownership or managing control of the Entity reported in Section 2.

2. Title of Individual: Furnish the title of the individual reported above.

3 & 4. Type of Ownership and Applicable Dates: Check the appropriate box indicating the type of ownership and when it occurred or ended as appropriate.

5 & 6. Type of Managing Control: Check the appropriate box indicating the type of managing control and when it occurred or ended as appropriate.

7. Authorized Official: Check the appropriate box indicating if the individual will also be reported in Section 11 as the authorized official of the Entity.

D. Final Adverse Legal Action History
Furnish any reportable final adverse legal actions that have occurred against the individual reported in this section. If there are no final adverse legal actions to report, check the "NO" box.

SECTION 8: BILLING AGENCY INFORMATION
If the Entity will use a billing agency to submit claims on its behalf, furnish all requested information about the billing agency/agent.

SECTION 9: CONTACT PERSON INFORMATION
If this entity does not have a resident agent, furnish a contact person for CMS to contact if CMS has questions regarding the information in this application.

SECTION 10: PENALTIES FOR FALSIFYING INFORMATION ON THIS APPLICATION
Read and understand these penalties before signing and submitting this application.

SECTION 11: AUTHORIZED OFFICIAL CERTIFICATION/ ATTESTATION STATEMENT & SIGNATURE
Read and understand the Certification/Attestation statement before signing this application. This section lists the conditions and requirements which must be met and attested to in order to register in Medicare as an Entity using the Indirect Payment Procedure for purposes of Medicare claims reimbursement.

The Authorized Official must also be reported in Section 7 of the application.

SECTION 1: BASIC INFORMATION

REASON FOR SUBMITTING THIS APPLICATION

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

☐ You are registering in Medicare as an indirect payment procedure (IPP) biller	Complete all sections
☐ You are currently registered in Medicare as an IPP biller and are updating your information	Complete Section 2, all other applicable sections and Section 11
☐ You are voluntarily withdrawing your Medicare registration as an IPP biller	Complete Section 2 and Section 11

SECTION 2: IDENTIFYING INFORMATION

A. ENTITY'S IDENTIFICATION INFORMATION

Legal Business Name of the Entity as reported to the IRS

Tax Identification Number (TIN)	Other Entity Identifier (OEID) *(if issued)*	Health Plan Identifier (HPID) *(if issued)*

Name of Health Plan

B. RESIDENT AGENT NAME AND ADDRESS INFORMATION

If applicable, identify the Resident Agent for the registering Entity reported in Section 2A above.
If adding or removing a resident agent, check the applicable box and furnish the effective date.

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

Resident Agent Legal Business Name

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

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

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

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

City/Town	State	ZIP Code + 4

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

C. ENTITY'S BUSINESS STRUCTURE INFORMATION

Identify the organizational structure for this Entity *(Check one)*

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

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

D. ENTITY'S INTERNAL REVENUE SERVICE REGISTRATION INFORMATION

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

NOTE: If the Entity is a Federal and/or State government entity, indicate "Non-Profit."

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

SECTION 3: HEADQUARTERS ADDRESS AND CLAIMS SUBMISSION INFORMATION

A. ENTITY'S HEADQUARTERS ADDRESS INFORMATION

Furnish the Entity's physical address where the administrative office (headquarters) is located.

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

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

Headquarters Location Name

Headquarters Location Street Address Line 1 *(Street Name and Number – Not a P.O. Box)*

Headquarters 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)*

B. STATES WHERE THE ENTITY WILL SUBMIT CLAIMS

Check all States and Territories where the Entity will submit or cease submitting claims and the effective date.

Alabama ☐ Add ☐ Remove Effective Date: _____	Idaho ☐ Add ☐ Remove Effective Date: _____	Montana ☐ Add ☐ Remove Effective Date: _____	Puerto Rico ☐ Add ☐ Remove Effective Date: _____
Alaska ☐ Add ☐ Remove Effective Date: _____	Illinois ☐ Add ☐ Remove Effective Date: _____	Nebraska ☐ Add ☐ Remove Effective Date: _____	Rhode Island ☐ Add ☐ Remove Effective Date: _____
American Samoa ☐ Add ☐ Remove Effective Date: _____	Indiana ☐ Add ☐ Remove Effective Date: _____	Nevada ☐ Add ☐ Remove Effective Date: _____	South Carolina ☐ Add ☐ Remove Effective Date: _____
Arizona ☐ Add ☐ Remove Effective Date: _____	Iowa ☐ Add ☐ Remove Effective Date: _____	New Hampshire ☐ Add ☐ Remove Effective Date: _____	South Dakota ☐ Add ☐ Remove Effective Date: _____
Arkansas ☐ Add ☐ Remove Effective Date: _____	Kansas ☐ Add ☐ Remove Effective Date: _____	New Jersey ☐ Add ☐ Remove Effective Date: _____	Tennessee ☐ Add ☐ Remove Effective Date: _____
California ☐ Add ☐ Remove Effective Date: _____	Kentucky ☐ Add ☐ Remove Effective Date: _____	New Mexico ☐ Add ☐ Remove Effective Date: _____	Texas ☐ Add ☐ Remove Effective Date: _____
Colorado ☐ Add ☐ Remove Effective Date: _____	Louisiana ☐ Add ☐ Remove Effective Date: _____	New York ☐ Add ☐ Remove Effective Date: _____	Utah ☐ Add ☐ Remove Effective Date: _____
Connecticut ☐ Add ☐ Remove Effective Date: _____	Maine ☐ Add ☐ Remove Effective Date: _____	North Carolina ☐ Add ☐ Remove Effective Date: _____	Vermont ☐ Add ☐ Remove Effective Date: _____
Delaware ☐ Add ☐ Remove Effective Date: _____	Maryland ☐ Add ☐ Remove Effective Date: _____	North Dakota ☐ Add ☐ Remove Effective Date: _____	Virginia ☐ Add ☐ Remove Effective Date: _____
District of Columbia ☐ Add ☐ Remove Effective Date: _____	Massachusetts ☐ Add ☐ Remove Effective Date: _____	Northern Marianas Islands ☐ Add ☐ Remove Effective Date: _____	Virgin Islands ☐ Add ☐ Remove Effective Date: _____
Florida ☐ Add ☐ Remove Effective Date: _____	Michigan ☐ Add ☐ Remove Effective Date: _____	Ohio ☐ Add ☐ Remove Effective Date: _____	Washington ☐ Add ☐ Remove Effective Date: _____
Georgia ☐ Add ☐ Remove Effective Date: _____	Minnesota ☐ Add ☐ Remove Effective Date: _____	Oklahoma ☐ Add ☐ Remove Effective Date: _____	West Virginia ☐ Add ☐ Remove Effective Date: _____
Guam ☐ Add ☐ Remove Effective Date: _____	Mississippi ☐ Add ☐ Remove Effective Date: _____	Oregon ☐ Add ☐ Remove Effective Date: _____	Wisconsin ☐ Add ☐ Remove Effective Date: _____
Hawaii ☐ Add ☐ Remove Effective Date: _____	Missouri ☐ Add ☐ Remove Effective Date: _____	Pennsylvania ☐ Add ☐ Remove Effective Date: _____	Wyoming ☐ Add ☐ Remove Effective Date: _____

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 Headquarters Location Address in Section 3 and skip this section.

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

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

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. REMITTANCE NOTICES/SPECIAL PAYMENTS MAILING ADDRESS

Medicare will issue all routine payments via electronic funds transfer (EFT). Since payment will be made via 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 Headquarters 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 the effective date.

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

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

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

SECTION 5: FINAL ADVERSE LEGAL ACTIONS

This section captures information regarding final adverse legal actions that have been taken against the IPP Entity such as convictions, exclusions, revocations and suspensions. All final adverse legal actions listed below must be reported, regardless of whether any records were expunged or any appeals are pending.

A. CONVICTIONS

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

C. FINAL ADVERSE LEGAL ACTION HISTORY

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

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

1. Has this entity, under any current or former name or business identity, ever had a final adverse legal action listed in Section 5A or 5B above imposed against it?
   ☐ YES–Continue Below ☐ NO–Skip to Section 6
2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/ administrative body that imposed the action, and the resolution, if any.

Attach a copy of the relevant final legal adverse action documents.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

SECTION 6: OWNERSHIP AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS)

Report all organizations that have 5% or greater ownership and/or managing control of the Entity reported in Section 2A.

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

☐ Check here if this section is not applicable for the Entity reported in Section 2A, and skip to Section 7.

If you need to report more than one owning/managing organization, copy and complete this page 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.

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 Entity reported in Section 2A**?**
   ☐ 5% or Greater Direct/Indirect Owner ☐ Partnership Interest ☐ 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 Entity reported in Section 2A? *(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)*: _____

B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for each organization reported in Section 6A.

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 6A above, under any current or former name or business identity, ever had a final adverse legal action listed in Section 5 of this application imposed against it?
   ☐ YES–Continue Below ☐ NO–Skip to Section 7
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 7: OWNERSHIP AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS)

Report all individuals who have 5% or greater ownership and/or managing control of the Entity in Section 2A including the Resident Agent and Other Administrators of the Complementary Health Plan.

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 Entity reported in Section 2A**?**
   ☐ 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 Entity reported in Section 2A?
(Check all that apply)
   ☐ Officer ☐ Contracted Managing Employee ☐ Appointed/Elected Official
   ☐ Director ☐ W-2 Managing Employee ☐ Administrator

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 an Authorized Official reported in Section 11**?** ☐ Yes ☐ No

B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for each individual reported in Section 7A.

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 7A above, under any current or former name or business entity, ever had a final adverse legal action listed in Section 5 of this application imposed against them?
   ☐ YES–Continue Below ☐ NO–Skip to Section 8

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

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

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

SECTION 8: BILLING AGENCY INFORMATION

A billing agency/agent is a company or individual that the Entity contracts with to prepare and submit claims. If the Entity uses a billing agency/agent it must complete this section. Even if it uses a billing agency/agent, it is responsible for the accuracy of claims submitted on its behalf.

☐ **Check here if this section does not apply and skip to Section 9.**

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 Other Entity Identifier (OEID) *(if issued)*

SECTION 9: CONTACT PERSON INFORMATION

If questions arise during the processing of this application, CMS will attempt to contact your resident agent. If you do not have a resident agent, CMS will contact the individual reported below.

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

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

Contact Person 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 You *(Spouse, Secretary, Attorney, Billing Agent, etc.)*

SECTION 10: PENALTIES FOR FALSIFYING INFORMATION ON THIS APPLICATION

Read and understand these penalties before signing and submitting this application.

This section explains the penalties for deliberately furnishing false information in this application to gain or maintain registration 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 entities 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;
   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 entity, 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.
5. 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.
6. 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.
7. 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.
8. The government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment."

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

SECTION 11: AUTHORIZED OFFICIAL CERTIFICATION/ATTESTATION STATEMENT AND SIGNATURE

Read and understand the Certification/Attestation statement before signing this application. This section lists the conditions and requirements which must be met and attested to in order to register in Medicare as an Entity using the Indirect Payment Procedure for Medicare claims reimbursement.

The Authorized Official must also be reported in Section 7 of this application. A Resident Agent cannot be an authorized official unless they are also 5% or greater owners of the Entity reported in Section 2A.

You **MUST SIGN AND DATE** Section 11B of this certification statement in order to be registered in the Medicare program. In doing so, you are attesting to meeting and maintaining the Medicare requirements stated below.

An AUTHORIZED OFFICIAL means an appointed official (for example, administrator, chief executive officer, chief financial officer, or chairman of the board) to whom the Entity has granted the legal authority to register it in the Medicare program, to make changes or updates to the Entity's registration information in the Medicare program, and to commit the Entity to fully abide by the statutes, regulations, and program instructions of the Medicare program.

By his/her signature, an authorized official binds the Entity to all of the conditions and requirements listed in the Certification/Attestation Statement and acknowledges that the Entity may be denied registration in the Medicare program or have its registration revoked if any conditions or 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, the authorized official agrees to immediately notify Medicare if any information in the application is not true, correct, or complete. In addition, the authorized official, by his/her signature, agrees to notify Medicare of any future changes to the information contained in this application within 90 days. All applications must be signed by an authorized official or they will be rejected.

The certification/attestation in Section 11A includes the requirements and conditions the Entity must meet and maintain to bill Medicare using the indirect payment procedure. Read these requirements and conditions carefully. By signing Section 11B, you are attesting to having read the requirements and conditions and understanding them.

Your signature further stipulates that you agree to adhere to all of the requirements listed below and acknowledge that this Entity may be denied registration or have its registration revoked if any requirements and conditions are not met.

SECTION 11: AUTHORIZED OFFICIAL CERTIFICATION/ATTESTATION STATEMENT AND SIGNATURE *(Continued)*

A. CERTIFICATION/ATTESTATION STATEMENT

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 and complete, I agree to notify Medicare of this immediately.
2. I agree to notify Medicare of any current or future changes to the information contained in this application within 90 days of the change.
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 and/ or administrative penalties including, but not limited to, 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 Entity, including all of the conditions of 42 CFR § 424.66. The Medicare laws, regulations, and program instructions are available through Medicare. 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 this Entity's compliance with the conditions of 42 CFR § 424.66 below:
    a) Provides coverage of the service under a complementary health benefit plan (this is, the coverage that the plan provides is complementary to Medicare benefits and covers only the amount by which the Part B payment falls short of the approved charge for the service under the plan).
    b) Has paid the person who provided the service an amount (including the amount payable under the Medicare program) that the person accepts as full payment.
    c) Has the written authorization of the beneficiary (or of a person authorized to sign claims on his behalf under § 424.36) to receive the Part B payment for the services for which the Entity pays.
    d) Relieves the beneficiary of liability for payment for the service and will not seek any reimbursement from the beneficiary, his or her survivors or estate.
    e) Submits any information CMS or the carrier may request, including an itemized physician or supplier bill, in order to apply the requirements under the Medicare program.
    f) Identifies and excludes from its requests for payment all services for which Medicare is the secondary payer.
5. Neither this Entity or the authorized official is currently sanctioned, suspended, debarred, or excluded by Medicare or any State health care program (e.g., Medicaid program), or any other Federal program, or is otherwise prohibited from participating in Medicare or other Federal programs.
6. I agree that any existing or future overpayment made to the Entity by the Medicare program may be recouped by Medicare through the withholding of future Medicare 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.

B. AUTHORIZED OFFICIAL SIGNATURE(S)

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

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

Authorized Official Attestation

I have read the contents of this application and the certification/attestation statement in Section 11A. My signature legally and financially binds this Entity 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.

Authorized Official Name and Signature

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.

MEDICARE REGISTRATION PRIVACY ACT STATEMENT

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

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. 1395l(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.

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, 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), national provider identifier (NPI), other entity identifier (OEID) and health plan identifier (HPID) for each disclosing entity, owners with 5 percent or more ownership or control interest, as well as managing/ directing employees. 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., CCN, PTAN, OEID, HPID and the NPI), demographic data, professional data, past and present history as well as information regarding any adverse legal 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/Regulations-and-Guidance/Guidance/PrivacyActSystemofRecords/Systems-of-Records-Items/CMS023307.html**.

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.

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 1 hour 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.