MEDICARE ENROLLMENT APPLICATION

REASSIGNMENT OF MEDICARE BENEFITS

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CMS-855R

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

GENERAL INFORMATION

Physicians and non-physician practitioners can reassigning Medicare payments or terminate a reassignment of Medicare benefits after enrollment in the Medicare program or make a change in their reassignment of Medicare benefit information using either:

- The Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or
- The paper enrollment application process (e.g., CMS 855R).

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

NOTE: Physicians and non-physician practitioners who are enrolled in the Medicare program, but have not submitted the CMS 855I since 2003, are required to submit a Medicare enrollment application (i.e., Internet-based PECOS or the CMS 855I) as an initial application prior to completing a CMS 855R application.

Complete this application if you are reassigning your right to bill the Medicare program and receive Medicare payments, or are terminating a reassignment of benefits. Reassigning your Medicare benefits allows an eligible supplier to submit claims and receive payment for Medicare Part B services that you have provided. Such an eligible supplier may be an individual, a clinic/group practice or other organization.

Both the individual practitioner and the eligible supplier must be currently enrolled (or concurrently enrolling via submission of the CMS-855B for the eligible supplier and the CMS-855I for the practitioner) in the Medicare program before the reassignment can take effect. Generally, this application is completed by a supplier, signed by the individual practitioner, and submitted by the supplier. When terminating a current reassignment, either the supplier or the individual practitioner may submit this application with the appropriate sections completed.

The individual or authorized/delegated official, by his/her signature, agrees to notify the Medicare fee-for-service contractor of any future changes to the reassignment in accordance with 42 C.F.R. 424.520(b).

NOTE: An individual will not need to reassign benefits to a corporation, limited liability company, professional association, etc., of which he/she is the sole owner. See the CMS-855I Application for Physicians and Non-Physician Practitioners for more information.

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INSTRUCTIONS FOR COMPLETING AND SUBMITTING THIS APPLICATION

- Type or print all information so that it is legible. Do not use pencil.
- Sign and date the certification statement.
- Keep a copy of your completed Medicare enrollment package for your own records and for updating your information.
- Send the completed application with original signatures and all required documentation to your designated Medicare fee-for-service contractor.

ADDITIONAL INFORMATION

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

For additional information regarding the Medicare enrollment process, visit *www.cms.hhs.gov/ MedicareProviderSupEnroll*.

The NPI is the standard unique health identifier for health care providers and is assigned by the National Plan and Provider Enumeration System (NPPES). **As a Medicare health supplier, you must obtain an NPI prior to enrolling in Medicare or before submitting a change to your existing Medicare enrollment information.** Applying for the NPI is a process separate from Medicare enrollment. To obtain an NPI, you may apply online at *https://NPPES.cms.hhs.gov*. For more information regarding NPIenumeration, visit *www.cms.hhs.gov/ NationalProvIdentStand*.

The Medicare Identification Number is a generic term for any number, other than the NPI, that is used to identify a Medicare supplier.

MAIL YOUR APPLICATION

The Medicare fee-for-service contractor that services your State is responsible for processing your enrollment application. If you do not know who your fee-for-service contractor is, you can locate it on the CMS web site at *www.cms.hhs.gov/MedicareProviderSupEnroll*.

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SECTION 1: BASIC INFORMATION

ADDING A NEW REASSIGNMENT

If you are:

- Enrolling for the first time in the Medicare program (and have completed the CMS-855I and are reassigning your benefits to an eligible supplier.
- Currently enrolled in the Medicare program and are reassigning your benefits to an eligible supplier.

NOTE: The supplier must be enrolled or currently enrolling in Medicare (submitting the CMS-855B and/or CMS-855I) before the reassignment can take effect.

TERMINATING A CURRENT REASSIGNMENT

If you are an:

- Individual practitioner who is terminating a reassignment of benefits to the supplier identified in Section 2. No reassigned claims will be paid to the supplier for services rendered by the practitioner after the effective date of deletion.
- Organization that is terminating a reassignment of benefits from the individual practitioner identified in Section 3. No reassigned claims will be paid to the supplier for services rendered by the practitioner after the effective date of deletion.

NOTE: When adding a reassignment, Section 4A must be completed by the individual practitioner **and** Section 4B must be completed by an authorized or delegated official of the supplier. (If the supplier is an individual, that person must sign Section 4B.) When terminating a reassignment, **either** Section 4A must be completed by the individual practitioner **or** Section 4B must be completed by an authorized or delegated official of the supplier.

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SECTION 1: BASIC INFORMATION

ALL APPLICANTS MUST COMPLETE THIS SECTION

Check the applicable box and complete the required sections.

REASON FOR APPLICATION	PROVIDE INFORMATION	REQUIRED SECTIONS
☐ You are enrolling or are currently enrolled in Medicare and will be **reassigning your benefits to this supplier for the first time**	Effective Date *(mm/dd/yyyy)*:	**Complete all sections**
☐ You are an individual practitioner **terminating a reassignment**	Effective Date *(mm/dd/yyyy)*:	Sections **1, 2, 3,** and **4A**
☐ You are the organization **terminating a reassignment**	Effective Date *(mm/dd/yyyy)*:	Sections **1, 2, 3, 4B,** and **7**

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SECTION 2: ORGANIZATION RECEIVING THE REASSIGNED BENEFITS

Organization/Group Identification

Provide the requested information below for the supplier to whom benefits are being reassigned, or with whom a reassignment is being terminated. If the supplier's initial enrollment application is being submitted concurrently with this reassignment application, write "pending" in the Medicare identification number block. The supplier's name as reported to the IRS must be the same as reported on the supplier's CMS-855B when it enrolled.

Supplier's Legal Business Name *(as Reported to the Internal Revenue Service)*		
Tax Identification Number	Medicare Identification Number *(if issued)*	National Provider Identifier

SECTION 3: INDIVIDUAL PRACTITIONER WHO IS REASSIGNING BENEFITS

Individual Practitioner Identification

Provide the information below for the individual who will be reassigning his/her benefits to this supplier, or who will be terminating such a reassignment. If your initial enrollment application is being submitted concurrently with this reassignment application, write "pending" in the Medicare identification number block.

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

Social Security Number	Medicare Identification Number *(if issued)*	National Provider Identifier

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SECTION 4: AUTHORIZATION STATEMENTS

The signatures below authorize the reassignment of benefits to a supplier or the termination of a reassignment of benefits to a supplier, as indicated in Section 1.

Title XVIII of the Social Security Act prohibits payment for services provided by an individual practitioner to be paid to another individual or supplier unless the individual practitioner who provided the services specifically authorizes another individual or supplier (employer, facility, or health care delivery system) to receive said payments in accordance with 42 C.F.R. 424.73 and 42 C.F.R. 424.80. By signing this

Reassignment of Benefits Statement, you are authorizing the supplier identified in Section 2 to receive Medicare payments on your behalf.

Your employment or contract with this individual or supplier must be in compliance with CMS regulations and you must be in compliance with applicable Medicare program safeguard standards described in 42 C.F.R.

424.80. All individual practitioners who allow another supplier (employer, facility, or health care delivery system) to receive payment for their services must sign the Reassignment of Benefits Statement.

The signatures below acknowledge that you will abide by all laws and regulations pertaining to the reassignment of benefits.

A. Individual Practitioner

I certify that I have examined the above information and that it is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws.

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

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

B. Authorized or Delegated Official of Group Practice/Clinic

I certify that I have examined the above information and that it is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws.

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

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

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

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SECTION 5: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 6: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 7: CONTACT PERSON

This section captures information regarding the person you would like for us to contact regarding this application.

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

Address Line 1 *(Street Name And Number)*

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

City/Town	State	Zip Code +4

Telephone	Fax Number *(optional)*

Email Address *(if available)*

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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 0938-0685. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

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

MEDICARE SUPPLIER ENROLLMENT APPLICATION PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) is authorized to collect the information requested on this form by sections 1124(a)(1), 1124A(a)(3), 1128, 1814, 1815, 1833(e), and 1842(r) of the Social Security Act [42 U.S.C. §§ 1320a-3(a)(1), 1320a-7, 1395f, 1395g, 1395(l)(e), and 1395u(r)] and section 31001(1) of the Debt Collection Improvement Act [31 U.S.C. § 7701(c)].

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

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

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

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

The supplier should be aware that the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503) amended the Privacy Act, 5 U.S.C. § 552a, to permit the government to verify information through computer matching.

Protection of Proprietary Information

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

Protection of Confidential Commercial and/or Sensitive Personal Information

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

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