MEDICARE ENROLLMENT APPLICATION

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

CMS-855S

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

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

SEE PAGE 4 FOR INFORMATION ON WHERE TO MAIL THIS APPLICATION.

SEE SECTION 12 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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
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DMEPOS SUPPLIER STANDARDS FOR MEDICARE ENROLLMENT

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

1. A supplier must be in compliance with all applicable federal and state licensure and regulatory requirements.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. A supplier must have an authorized individual whose signature is binding sign the enrollment application for billing privileges.
4. A supplier must fill orders from its own inventory or contract with other companies for the purchase of items necessary to fill orders. A supplier cannot contract with any entity that is currently excluded from the Medicare program, any state health care programs, or any other federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable state law, and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site and must maintain a visible sign with posted hours of operation. The location must be accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records.
8. A supplier must permit CMS or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items this insurance must also cover product liability and completed operations.
11. A supplier is prohibited from direct solicitation to Medicare beneficiaries. For complete details on this prohibition see 42 C.F.R. section 424.57(c)(11).
12. A supplier is responsible for delivery of and must instruct beneficiaries on the use of Medicare covered items, and maintain proof of delivery and beneficiary instruction.
13. A supplier must answer questions and respond to complaints of beneficiaries and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair cost either directly or through a service contract with another company, any Medicare-covered items it has rented to beneficiaries.
15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these standards to each beneficiary it supplies a Medicare-covered item.
17. A supplier must disclose any person having ownership, financial or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number; i.e., the supplier may not sell or allow another entity to use its Medicare billing number.
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
21. A supplier must agree to furnish CMS any information required by the Medicare statute and regulations.
22. A supplier must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services for which the supplier is accredited in order for the supplier to receive payment for those specific products and services (unless an exception applies).
23. A supplier must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
25. A supplier must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
26. A supplier must meet the surety bond requirements specified in 42 C.F.R. section 424.57(d) (unless an exception applies).
27. A supplier must obtain oxygen from a state-licensed oxygen supplier.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 C.F.R. section 424.516(f).
29. A supplier is prohibited from sharing a practice location with other Medicare providers and suppliers.
30. A supplier must remain open to the public for a minimum of 30 hours per week except physicians (as defined in section 1848(j) (3) of the Act), physical and occupational therapists or DMEPOS suppliers working with custom made orthotics and prosthetics.

WHO SHOULD SUBMIT THIS APPLICATION

The following types of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers must complete this application to enroll in the Medicare program and receive a Medicare Billing number:

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

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

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

- Enrolling in Medicare for the first time as a DMEPOS supplier.
- Currently enrolled in Medicare as a DMEPOS supplier and need to report changes to your current business, (e.g., you are adding, removing, or changing existing information under this Medicare supplier billing number). Changes must be reported within 30 days of the change.
- Currently enrolled in Medicare as a DMEPOS supplier and need to enroll a new business location using the same tax identification number already enrolled with the NSC MAC.
- Currently enrolled in Medicare as a DMEPOS supplier and need to enroll a new business location using a tax identification number not currently enrolled with the NSC MAC.
- Currently enrolled in Medicare as a DMEPOS supplier and received notice to revalidate your enrollment.
- Reactivating your Medicare DMEPOS supplier billing number.
- Voluntarily terminating your Medicare DMEPOS supplier billing number.

DMEPOS suppliers 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-855S enrollment application. Be sure you are using the most current version.

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

BILLING NUMBER AND NATIONAL PROVIDER IDENTIFIER INFORMATION

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

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

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

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 C.F.R. section 424.516. However, it is highly recommended that if reported, these fields 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.

TIPS TO AVOID DELAYS IN YOUR ENROLLMENT

- Complete all required sections as shown in Section 1;
- Complete Section 9 for all delegated and authorized officials reported in Sections 14 and 15;
- Report at least one owner and one managing employee for each location;
- Enter your NPI in the applicable sections;
- Include the Electronic Funds Transfer (EFT) Agreement (CMS-588), when applicable, with your enrollment application;
- Respond timely to development/information requests; and
- Be sure the Legal Business Name shown in Section 1B matches the name on your tax documents.

Additional information and reasons for processing delays can be found at **www.palmettogba.com/nsc**.

PROCESS FOR OBTAINING MEDICARE APPROVAL

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

1. The supplier obtains the required National Provider Identification Number (NPI), surety bond and/or accreditation **PRIOR** to completing and submitting this application to the NSC MAC.
2. The supplier pays the required application fee (via **www.pay.gov**) upon initial enrollment, the addition of a new business location, revalidation and, if requested, reactivation **PRIOR** to completing and submitting this application to the NSC MAC.
3. The supplier completes and submits this enrollment application (CMS-855S) and all supporting documentation to the NSC MAC.
4. If requested by the NSC MAC, the supplier submits a fingerprint background check. **NOTE:** Contact Accurate Biometrics for fingerprinting procedures, to find a fingerprint collection site, and to ensure the fingerprint results are accurately submitted to the Federal Bureau of Investigation (FBI) and properly returned to CMS. Accurate Biometrics can be contacted at 866-361-9944 or visit their website at **www.cmsfingerprinting.com**.
5. The NSC MAC reviews the application and conducts a site visit to verify compliance with the supplier standards found at 42 C.F.R. sections 424.57, 424.58, and 424.500 et seq.
6. After completing its review, the NSC MAC notifies the supplier in writing about its enrollment decision.

ADDITIONAL INFORMATION

The NSC 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 is protected under 5 U.S.C. section 552(b)(4) and/or (b)(6), respectively. For more information, see the last page of this application to read the Privacy Act Statement.

ACRONYMS COMMONLY USED IN THIS APPLICATION

C.F.R.: Code of Federal Regulations

DME MAC: Durable Medical Equipment Medicare Administrative Contractor

DMEPOS: Durable Medical Equipment, Prosthetics, Orthotics and Supplies

EFT: Electronic Funds Transfer

IRS: Internal Revenue Service

LBN: Legal Business Name

LLC: Limited Liability Corporation

NPI: National Provider Identifier

NPPES: National Plan and Provider Enumeration System

NSC MAC: National Supplier Clearinghouse Medicare Administrative Contractor

PECOS: Provider Enrollment Chain and Ownership System

SSN: Social Security Number

TIN: Tax Identification Number

WHERE TO MAIL YOUR APPLICATION

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

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

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

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

SECTION 1: BASIC INFORMATION

This section captures basic information and information about the reason you are submitting this application.

A. BUSINESS LOCATION

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

☐☐

B. BUSINESS IDENTIFICATION

DMEPOS suppliers must furnish their Legal Business Name (LBN) as reported to the Internal Revenue Service (IRS), National Provider Identifier (NPI), Tax Identification Number (TIN), and supplier billing number (if issued) below.

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

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

Read this in full prior to indicating the reason for submission in Section 1C.

NEW ENROLLEES AND THOSE REPORTING A NEW TAX ID NUMBER

You are considered a new enrollee if you are:

- Enrolling in the Medicare program as a DMEPOS supplier for the first time under the tax identification number reported in Section 1B.
- Currently enrolled in the Medicare program as a DMEPOS supplier but have a new tax identification number. If you are reporting a change to your tax identification number, you must complete a new CMS-855S enrollment application in its entirety.
- A currently enrolled DMEPOS supplier under new ownership with a different tax identification number. (**NOTE:** New owners of existing DMEPOS suppliers must submit a dated bill of sale with the effective date of the new ownership.)

CURRENTLY ENROLLED MEDICARE DMEPOS SUPPLIERS

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

Change of information other than adding a new location
If you are adding, removing, or changing information under your current Medicare supplier billing number, including a change of ownership that does not change the current tax identification number, you will need to complete the appropriate sections as instructed and submit any new documentation. Any change to your existing enrollment data must be reported within 30 days of the effective date of the change.

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

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

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

NOTE: Enrollment applications submitted for "NEW ENROLLEES" **MUST** be signed by an Authorized Official.

SECTION 1: BASIC INFORMATION *(Continued)*

C. REASON FOR SUBMITTING THIS APPLICATION
Check one box and complete the sections as indicated.

☐ You are a **new enrollee** in Medicare or are enrolling a new business location with a tax identification number not previously enrolled with the NSC MAC.	**Complete all sections**
☐ You are **adding a new business location** using a tax identification number currently enrolled with the NSC MAC.	**Complete sections 1–7, 9 (for managing employee only), 11 (optional), 12, and either 14 or 15**
☐ You are **reactivating** your Medicare supplier billing number.	**Complete all sections**
☐ You are **revalidating** your Medicare enrollment.	**Complete all sections**
☐ You are **voluntarily terminating your Medicare enrollment**. Effective date of termination: _____	**Complete sections 1, 2a, 4b, 4D, 11 (optional), and either 14 or 15**
☐ You are **changing your Medicare enrollment information** other than your tax identification number.	**Go to Section 1D**
☐ You are **changing your Tax Identification Number**.	**Complete all sections**

D. WHAT INFORMATION IS CHANGING?
Check all that apply and complete the required sections.

PLEASE NOTE: When reporting ANY information, sections 1B, 7 and either 14 or 15 **MUST** always be Completed in addition to completing the information that is changing within the required section.

CHECK ALL THAT APPLY	REQUIRED SECTIONS
☐ Current Business Location	**1, 2, 7, 11 (optional), 12 (if applicable), and either 14 or 15**
☐ Supplier Type *(submit licensure if applicable)* ☐ Products and Services *(submit accreditation if applicable)*	**1, 3, 7, 11 (optional), 12 (if applicable), and either 14 or 15**
☐ Accreditation Information	**1, 3, 7, 11 (optional), 12 (if applicable), and either 14 or 15**
☐ Address Information ☐ 1099 Mailing Address ☐ Correspondence Mailing Address ☐ Revalidation Mailing Address ☐ Remittance/Special Payment Mailing Address ☐ Record Storage Address	**1, 4 as applicable for the address that is being changed, 7, 11 (optional), 12 (if applicable), and either 14 or 15.**
☐ Comprehensive Liability Insurance Information	**1, 5, 7, 11 (optional), 12, and either 14 or 15**
☐ Surety Bond Information	**1, 6, 7, 11 (optional), 12, and either 14 or 15**
☐ Final Adverse Legal Actions	**1, 7, 11 (optional), 12, and either 14 or 15**
☐ Ownership and/or Managing Control Information (Organizations and/or Individuals)	**1, 7, 8 and/or 9, 11 (optional), 12 (if applicable), and either 14 or 15**
☐ Billing Agency Information	**1, 7, 10, 11 (optional), and either 14 or 15**
☐ Delegated Official	**1, 7, 9, 11 (optional), 12, 14 and 15**
☐ Authorized Official	**1, 7, 9, 11 (optional), 12 (if applicable), 15**
☐ Any other information not specified above	**1, 7, 11 (optional), 12 (if applicable), and either 14 or 15 and the applicable section or sub-section that is changing.**

SECTION 2: IDENTIFYING INFORMATION

A. BUSINESS LOCATION INFORMATION

- DMEPOS suppliers must complete and submit a separate CMS-855S enrollment application to enroll each physical location (i.e., store or other retail establishment) used to furnish Medicare covered DMEPOS to Medicare beneficiaries, except for locations only used as warehouses or repair facilities.
- The address must be a specific street address as recorded by the United States Postal Service. Do not furnish a P.O. Box. If you are located in a hospital and/or other health care facility and you provide services to patients at that facility, furnish the name and address of the hospital or facility.
- A change to the business location address requires submission of professional and business licenses for the new address, and proof of insurance covering the new address.

If you are reporting a change of information to your current business location, check the box below and furnish the effective date.

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

Business Location Name/Doing Business As Name		
Business Location Address Line 1 *(Street Name and Number)*		
Business Location Address Line 2 *(Suite, Room, Apt. #, etc.)*		
City/Town	State	ZIP Code + 4
Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*
Date this Business Started at this Location *(mm/dd/yyyy)*	Date this Business Terminated at this Location *(if applicable) (mm/dd/yyyy)*	

B. HOURS OF OPERATION

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

If you are reporting a change to your hours of operation, check the box below and furnish the effective date.

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

You must list all hours of each day you are open to the public.

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

☐ Open 24/7 (Open 24 hours a day, 7 days a week)

☐ By Appointment Only (no fixed days or hours)

NOTE: "By Appointment Only" can only be checked if you meet the exemption requirements stated in 42 C.F.R. section 424.57(c)(30).

Day of Week	Hours (indicate A.M. or P.M.)		Hours (indicate A.M. or P.M.)		Total Hours Open to the Public Each Day
	Open	Close	Open	Close	
Sunday					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
				Total Hours Open to the Public Weekly	

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

C. BUSINESS STRUCTURE INFORMATION

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

☐ Publicly Traded Corporation (regardless of whether supplier is "for-profit" or "non-profit")
☐ Non-Publicly Traded Corporation (regardless of whether supplier is "for-profit" or "non-profit")
☐ Limited Liability Company (LLC)
☐ Partnership ("general" or "limited")
☐ Sole Proprietor/Sole Proprietorship
☐ Government-Owned
☐ Other (Specify) _____

D. INTERNAL REVENUE SERVICE REGISTRATION INFORMATION

Identify how your business is registered with the IRS.

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

NOTE: Government owned entities do not need to provide an IRS Form 501(c)(3).

NOTE: If your business is a federal and/or state government supplier, indicate "Non-Profit" below.

☐ Proprietary ☐ Non-Profit ☐ Disregarded Entity

E. STATES WHERE ITEMS PROVIDED

Select all State(s)/Territory(ies) where you provide items or services to Medicare beneficiaries from the business location in Section 2A. For each State/Territory selected, submit all required licenses for the products and services being provided. The NSC MAC website at **http://www.palmettogba.com/nsc** may offer guidance on licensure requirements.

Jurisdiction A:

☐ All States in Jurisdiction A

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

Jurisdiction B:

☐ All States in Jurisdiction B

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

Jurisdiction C:

☐ All States and Territories in Jurisdiction C

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

Jurisdiction D:

☐ All States and Territories in Jurisdiction D

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

SECTION 3: PRODUCTS/ACCREDITATION INFORMATION

A. TYPE OF SUPPLIER

The supplier must meet all Medicare requirements for the DMEPOS supplier type checked. Any specialty personnel including, but not limited to, respiratory therapists, and orthotics/prosthetics personnel, must meet all licensure requirements applicable to its supplier type and applicable to the products and services checked in sections 3C and 3D.

Check all that apply:

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

B. ACCREDITATION INFORMATION

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

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

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

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

Name of Accrediting Organization

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

C. NON-ACCREDITED PRODUCTS

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

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

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

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

D. PRODUCTS AND SERVICES FURNISHED BY THIS SUPPLIER

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

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

- ☐ Automatic External Defibrillators (AEDs) and/or Supplies
- ☐ Blood Glucose Monitors and/or Supplies (mail order)
- ☐ Blood Glucose Monitors and/or Supplies (non-mail order)
- ☐ Breast Prostheses and/or Accessories
- ☐ Canes and/or Crutches
- ☐ Cochlear Implants
- ☐ Commodes/Urinals/Bedpans
- ☐ Continuous Passive Motion (CPM) Devices
- ☐ Continuous Positive Airway Pressure (CPAP) Devices and/or Supplies
- ☐ Contracture Treatment Devices: Dynamic Splint
- ☐ Diabetic Shoes/Inserts
- ☐ Diabetic Shoes/Inserts—Custom
- ☐ Enteral Nutrients
- ☐ Enteral Equipment and/or Supplies
- ☐ External Infusion Pumps
- ☐ External Infusion Pump Supplies
- ☐ Facial Prostheses
- ☐ Gastric Suction Pumps
- ☐ Heat & Cold Applications
- ☐ High Frequency Chest Wall Oscillation (HFCWO) Devices and/or Supplies
- ☐ Hospital Beds—Electric
- ☐ Hospital Beds—Manual
- ☐ Implanted Infusion Pumps and/or Supplies
- ☐ Infrared Heating Pad Systems and/or Supplies
- ☐ Insulin Infusion Pumps
- ☐ Insulin Infusion Pump Supplies
- ☐ Intermittent Positive Pressure Breathing (IPPB) Devices
- ☐ Intrapulmonary Percussive Ventilation Devices
- ☐ Limb Prostheses
- ☐ Mechanical In-Exsufflation Devices
- ☐ Nebulizer Equipment and/or Supplies
- ☐ Negative Pressure Wound Therapy Pumps and/or Supplies
- ☐ Neuromuscular Electrical Stimulators (NMES) and/or Supplies
- ☐ Neurostimulators and/or Supplies
- ☐ Ocular Prostheses
- ☐ Orthoses: Custom Fabricated
- ☐ Orthoses: Prefabricated (custom fitted)
- ☐ Orthoses: Off-the-Shelf
- ☐ Osteogenesis Stimulators
- ☐ Ostomy Supplies
- ☐ Oxygen Equipment and/or Supplies
- ☐ Parenteral Nutrients
- ☐ Parenteral Equipment and/or Supplies
- ☐ Patient Lifts
- ☐ Penile Pumps
- ☐ Pneumatic Compression Devices and/or Supplies
- ☐ Power Operated Vehicles (Scooters)
- ☐ Prosthetic Lenses: Conventional Contact Lenses
- ☐ Prosthetic Lenses: Conventional Eyeglasses
- ☐ Prosthetic Lenses: Prosthetic Cataract Lenses
- ☐ Respiratory Assist Devices
- ☐ Respiratory Suction Pumps
- ☐ Seat Lift Mechanisms
- ☐ Somatic Prostheses
- ☐ Speech Generating Devices
- ☐ Support Surfaces: Pressure Reducing Beds/ Mattresses/Overlays/Pads – New
- ☐ Support Surfaces: Pressure Reducing Beds/ Mattresses/Overlays/Pads – Used
- ☐ Surgical Dressings
- ☐ Tracheostomy Supplies
- ☐ Traction Equipment
- ☐ Transcutaneous Electrical Nerve Stimulators (TENS) and/or Supplies
- ☐ Ultraviolet Light Devices and/or Supplies
- ☐ Urological Supplies
- ☐ Ventilators: All Types–Not CPAP or RAD
- ☐ Voice Prosthetics
- ☐ Walkers
- ☐ Wheelchair Seating/Cushions
- ☐ Wheelchairs—Complex Rehabilitative Manual Wheelchairs
- ☐ Wheelchairs—Complex Rehabilitative Manual Wheelchair Related Accessories
- ☐ Wheelchairs—Complex Rehabilitative Power Wheelchairs
- ☐ Wheelchairs—Complex Rehabilitative Power Wheelchair Related Accessories
- ☐ Wheelchairs—Standard Manual
- ☐ Wheelchairs—Standard Manual Related Accessories and Repairs
- ☐ Wheelchairs—Standard Power
- ☐ Wheelchairs—Standard Power Related Accessories and Repairs

SECTION 4: IMPORTANT ADDRESS INFORMATION

A. 1099 MAILING ADDRESS

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

If you are reporting a change to your 1099 mailing address, check the box below and furnish the effective date.

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

Organizational Suppliers: 1099 Mailing Address

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

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

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

If you are reporting a change to your 1099 mailing address, check the box below and furnish the effective date.

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

Sole Proprietors: 1099 Mailing Address

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

SECTION 4: IMPORTANT ADDRESS INFORMATION *(Continued)*

B. CORRESPONDENCE MAILING ADDRESS

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

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

If you are reporting a change to your Correspondence Mailing Address, check the box below and furnish the effective date.

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

Business Location Name

Attention *(optional)*

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

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

City/Town	State	ZIP Code + 4

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

C. REVALIDATION REQUEST PACKAGE MAILING ADDRESS

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

☐ Check here if your revalidation request package should be mailed to your Business Location Address in Section 2A and skip this section, **OR**

☐ Check here if your revalidation request package should be mailed to your Correspondence Mailing Address in Section 4B and skip this section.

If you are reporting a change to your Revalidation Request Package Mailing Address, check the box below and furnish the effective date.

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

Business Location Name

Attention *(optional)*

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

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

City/Town	State	ZIP Code + 4

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

SECTION 4: IMPORTANT ADDRESS INFORMATION *(Continued)*

D. REMITTANCE NOTICES/SPECIAL PAYMENTS MAILING ADDRESS

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

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

☐ Check here if your Remittance Notices/Special Payments should be mailed to your Correspondence Mailing Address in Section 4B 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 DME MAC.

If you are reporting a change to your Remittance Notice/Special Payment Mailing Address, check the box below and furnish the effective date.

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

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

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

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

City/Town	State	ZIP Code + 4

E. MEDICARE BENEFICIARY MEDICAL RECORDS STORAGE ADDRESS

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

Post office boxes and drop boxes are not acceptable as a physical address where Medicare beneficiaries' records are maintained. The records must be the supplier's records, not the records of another supplier. If all records are stored at the Business Location Address reported in Section 2A, check the box below and skip this section.

☐ Records are stored at the Business Location Address reported in Section 2A.

If you are adding or removing a storage location, check the 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 NSC MAC if necessary.

Name of Storage Facility

SECTION 5: COMPREHENSIVE LIABILITY INSURANCE INFORMATION

As required in 42 C.F.R. section 424.57(c)(10), all DMEPOS suppliers must have comprehensive liability insurance in the amount of at least $300,000 (for each incident) and the insurance must remain in force at all times. The NSC MAC, with full mailing address as shown on page 3, must be listed on the policy as a certificate holder. You must submit a copy of the liability insurance policy or evidence of self-insurance with this application. Failure to maintain the required insurance at all times will result in revocation of your Medicare supplier billing number retroactive to the date the insurance lapsed, and/or overpayment collection.

Malpractice insurance is not the same as comprehensive liability insurance and does not meet compliance for this requirement.

If you are changing your comprehensive 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 Company Name			
Underwriter's Telephone Number	Underwriter's Fax Number *(if applicable)*		Underwriter's E-mail Address *(if applicable)*

SECTION 6: SURETY BOND INFORMATION

As required in 42 C.F.R. section 424.57(d), DMEPOS suppliers who are required to obtain a surety bond must complete this section. Furnish all requested information about the surety bond company and the surety bond. Submit a copy of the original surety bond, signed by a Delegated or Authorized Official, with this application.

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

A. NAME AND ADDRESS OF SURETY BOND COMPANY

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

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

Legal Business Name of Surety Bond Company as Reported to the IRS		Tax Identification Number	
Business Address Line 1 *(Street Name and Number)*			
Business Address Line 2 *(Suite, Room, Apt. #, etc.)*			
City/Town		State	ZIP Code + 4
Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*	

B. SURETY BOND INFORMATION

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

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

SECTION 7: FINAL ADVERSE LEGAL ACTIONS

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

A. CONVICTIONS

1. Any federal or state felony within the preceding 10 years.
2. Any misdemeanor conviction, under federal or state law, related to: (a) the delivery of an item or service under Medicare or a state health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
3. Any misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. section 1001.101 or 1001.201.
5. Any felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

B. EXCLUSIONS, REVOCATIONS, OR SUSPENSIONS

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

C. FINAL ADVERSE LEGAL ACTION HISTORY

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 supplier identified in sections 1B/2A, 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 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 documents.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

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

Only report organizations in this section. Individuals must be reported in Section 9. the supplier MUST have at least one owner or controlling entity and one managing employee reported in Section 8 and/or Section 9.

Complete this section with information about all organizations that have 5 percent or more (direct or indirect) ownership interest of, any partnership interest in, and/or managing control of, the supplier identified in Sections 1B/2A, as well as any information on final adverse legal actions that have been imposed against that organization. For more information on "direct" and "indirect" owners and examples of organizations that must be reported in this section, go to: **https://www.cms.gov/MedicareproviderSupenroll**. If there is more than one organization with ownership interest or managing control, copy and complete this section for each.

OWNERSHIP INTEREST (ORGANIZATIONS)

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

- 5 percent or more direct or indirect ownership of the DMEPOS supplier
- A partnership interest in the DMEPOS supplier, regardless of the partner's percentage of ownership
- Managing control of the DMEPOS 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

MANAGING CONTROL (ORGANIZATIONS)

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

SPECIAL TYPES OF ORGANIZATIONS

Governmental/Tribal Facilities:
If a federal, state, county, city or other level of government, the Indian Health Service (IHS), or an Indian tribe will be legally and financially responsible for Medicare payments received (including any potential overpayments), the name of that government, the IHS or Indian tribe must be reported as an owner or controlling entity. The DMEPOS 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 9.

Indian Health Service or Tribal Facilities:
Special rules concerning insurance and licenses apply. Contact the NSC MAC concerning these rules.

Non-Profit, Charitable and Religious Organizations:
Many non-profit organizations are charitable or religious in nature, and are operated and/or managed by a Board of Trustees or other governing body. The actual name of the Board of Trustees or other governing body must be reported in this section. While the organization must be reported in Section 8, individual board members must be reported in Section 9. Each non-profit organization must submit a copy of the IRS Form 501(c)(3) verifying its non-profit status. **NOTE:** Government owned entities do not need to provide an IRS Form 501(c)(3).

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

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

☐ Check here if this section is not applicable for the supplier reported in Sections 1B/2A, and skip to Section 9.

If you are changing information about a currently reported owning or managing organization or adding or removing an owning or managing organization, 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)*	NPI *(if issued)*	Medicare Identification Number(s) *(if issued)*

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

2. What is the above organization's ownership interest in the supplier reported in Section 1B/2A?
   ☐ 5% or Greater Direct/Indirect Owner ☐ Partner ☐ Government/Tribal Owner
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 1B/2A? (Check all that apply)
   ☐ Managing Organization ☐ Board of Trustees ☐ Governing Body ☐ Controlling Entity (Gov't/Tribe)
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 8A.

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

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

1. Has the organization in Section 8A above, under any current or former name or business identity, ever had a final adverse legal action listed in Section 7 of this application imposed against it?
   ☐ **YES**–Continue Below ☐ **NO**–Skip to Section 9
2. If YES, report each final adverse legal action, when it occurred, the federal or state agency or the court/administrative body that imposed the action, and the resolution, if any.

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

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

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

Only report individuals in this section. Organizations must be reported in Section 8. The supplier MUST have at least one owner or officer/director and one managing employee reported in Section 8 and/or Section 9.

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 Sections 1B/2A, as well as any information on final adverse legal actions that have been imposed against that individual. For more information on "direct" and "indirect" owners and examples of individuals that must be reported in this section, go to: **https://www.cms.gov/MedicareproviderSupenroll**. If there is more than one individual with ownership interest or managing control, copy and complete this section for each.

The following individuals must be reported in Section 9A:

- All persons who have a 5 percent or greater ownership (direct or indirect) interest in the DMEPOS supplier
- All officers, directors and board members if the DMEPOS supplier is a corporation (whether for-profit or non-profit)
- All managing employees of the DMEPOS supplier
- All individuals with a partnership interest, regardless of the partner's percentage of ownership; and
- All delegated and authorized officials reported in Sections 14 and 15

  Example: A supplier is 100 percent owned by Company C, which itself is 100 percent owned by Individual D. Assume that Company C is reported in Section 8 as an owner of the supplier. Assume further that Individual D, as an indirect owner of the supplier, is reported in Section 9A1. Based on this example, the suppler would check the "5 Percent or Greater Direct/Indirect Owner" box in Section 9A2.

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

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

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

NOTE: If a governmental or tribal organization will be legally and financially responsible for Medicare payments received (per the instructions for Governmental/Tribal Organizations in Section 8), the supplier is only required to report the appointed/elected official who signed the required letter legally and financially binding the Government/Tribal Organization and its managing employees in Section 9. Owners, partners, officers, and directors do not need to be reported.

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

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

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

If you are changing information about a currently reported individual owner or manager or adding or removing an individual owner or manager, 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)*

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

Telephone Number	Fax Number *(if applicable)*	Email 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 1B/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 supplier reported in Section 1B/2A? (Check all that apply).
   ☐ Officer ☐ Contracted Managing Employee ☐ 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)*: _____

5. Is the above individual also a Delegated Official or Authorized Official reported in Sections 14 or 15?
   ☐ Delegated Official ☐ Authorized Official ☐ Neither

B. FINAL ADVERSE LEGAL ACTION HISTORY

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

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

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

1. Has the individual reported in Section 9A, under any current or former name or business entity, ever had a final adverse legal action listed in Section 7 of this application imposed against him/her?
   ☐ **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 documents.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

SECTION 10: 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; you remain responsible for the accuracy of the claims submitted on your behalf.

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

If you are changing information about your current billing agency 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)*: _____

BILLING AGENCY NAME AND ADDRESS

Legal Business 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 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)*

SECTION 11: CONTACT PERSON INFORMATION

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

☐ Contact any Delegated Official reported in Section 14

☐ Contact any Authorized Official reported in Section 15

☐ Contact the person 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, etc.)*

City/Town	State	ZIP Code + 4

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

Relationship or Affiliation to this Supplier *(Spouse, Secretary, Attorney, Billing Agent, etc.)*

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

SECTION 12: SUPPORTING DOCUMENTS

This section lists the documents that, if applicable, must be submitted with this completed enrollment application. If you are newly enrolling, adding a new location, reactivating or revalidating, you must provide all applicable documents. For changes, only submit documents that are applicable to the change requested. All enrolling DMEPOS suppliers are required to furnish information on all federal, state, and local professional and business licenses, certifications, and/or registrations required to practice as a DMEPOS supplier in the state of the business location as reported in Section 1A. Check the NSC MAC website for further guidance on supplier requirements. You are responsible for furnishing and adhering to all required licensure and/or certification requirements, etc. for the supplies/services you provide.

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

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

MANDATORY FOR ALL NEW APPLICATIONS AND/OR ADDITIONAL LOCATIONS

- ☐ Copies of all federal, state, and/or local (city/county) professional and business licenses, certifications and/or registrations for applicable specialty supplier types, products and services
- ☐ Copy of Certification of Insurance for comprehensive liability policy
  NOTE: The NSC MAC must be listed as a certificate holder with the NSC MAC's full address (Post Office Box address listed on p. 4 of this application)
- ☐ Written confirmation from the IRS confirming your Tax Identification Number and Legal Business Name provided in Section 1B (e.g., IRS Form CP-575)
  NOTE: This information is needed if the applicant is enrolling a professional corporation, professional association, or limited liability corporation with this application or enrolling as a sole proprietor using an Employer Identification Number.
- ☐ Completed Form CMS-588, Electronic Funds Transfer Authorization Agreement. Include a voided check.
- ☐ Copy of receipt of payment of application fee from **www.pay.gov**

MANDATORY, IF APPLICABLE

- ☐ Copy of IRS Determination Letter, if supplier is registered with the IRS as non-profit (e.g., IRS Form 501(c)(3))
  NOTE: Government owned entities do not need to provide an IRS Form 501(c)(3).
- ☐ Copies of all final adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters)
- ☐ If Medicare payments due a supplier are being sent to a bank (or similar financial institution) where the supplier has a lending relationship (that is, any type of loan), the supplier must provide a statement in writing **from the bank** (which must be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.
- ☐ Copy of delegated official's W-2 if one has been designated
- ☐ Copy of your bill of sale if you purchased an existing DMEPOS supplier with an active Medicare supplier billing number
- ☐ Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement, if you want to be a participating supplier
- ☐ Copy of Surety Bond
- ☐ Copy of attestation letter for government entities and tribal facilities
- ☐ Copy of receipt of payment of application for revalidation or reactivation from **www.pay.gov**

SECTION 13: PENALTIES FOR FALSIFYING INFORMATION ON THIS ENROLLMENT APPLICATION

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

1. 18 U.S.C. section 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. section 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. section 3729, imposes civil liability, in part, on any person who:
   a) knowingly presents, or causes to be presented, to an officer or any employee of the United States Government a false or fraudulent claim for payment or approval;
   b) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or
   c) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

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

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

SECTION 14: 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 official.

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 13 and the Certification Statement in Section 15A and agrees to adhere to all of the stated requirements. The delegated official also certifies that he/she meets the definition of a delegated official. When making changes and/or updates to the supplier's enrollment information, the delegated official certifies that the information provided is true, correct and complete.

The signature of an authorized official in Section 14 constitutes a legal delegation of authority to all delegated official(s) assigned in Section 14. If you are delegating more than two individuals, copy and complete this section for each 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 9 of this application.

If you are adding or removing 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 15A 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 15A 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. Applications with signatures deemed not original or not dated will not be processed. Stamped, faxed or copied signatures will not be accepted.

SECTION 15: 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 have its billing privileges revoked from the Medicare program if any requirements are not met. All signatures must be original and in blue ink. Faxed, photocopied, or stamped signatures will not be accepted.

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

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

A. CERTIFICATION STATEMENT

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

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

1. I have read the contents of this application, and the information contained herein is true, correct and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the NSC MAC of this fact immediately.
2. I agree to notify the NSC MAC of any current or future changes to the information contained in this application in accordance with the timeframes established in 42 C.F.R. section 424.57. I understand that any change in the business structure of this supplier may require the submission of a new application.
3. I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare identification number(s), and/or the imposition of fines, civil damages, and/or imprisonment.
4. I agree to abide by the Medicare laws, regulations and program instructions that apply to me or to the organization listed in Section 1B of this application. The Medicare laws, regulations, and program instructions are available through the fee-for-service 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 Stature, 42 U.S.C. section 1320a-7b(b) (section 1128B(b) of the Social security Act) and the Physician Self-Referral Law (Stark Law), 42 U.S.C. section 1395nn (section 1877 of the Social Security Act)).
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 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 Medicare a copy of my most recent accreditation survey, together with any information related to the survey that Medicare may require (including corrective action plans).

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

B. AUTHORIZED OFFICIAL SIGNATURE(S)

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

1st Authorized Official
I have read the contents of this application and the certification statement in Section 15A of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize the NSC MAC to verify this information.

1st Authorized Official's Information and Signature

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

First Name (Print)	Middle Initial	Last Name (Print)	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. Applications with signatures deemed not original or not dated will not be processed. Stamped, faxed or copied signatures will not be accepted.

2nd Authorized Official
I have read the contents of this application and the certification statement in Section 15A of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize the NSC MAC to verify this information.

2nd Authorized Official's Information and Signature

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

First Name (Print)	Middle Initial	Last Name (Print)	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. 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
I have read the contents of this application and the certification statement in Section 15A of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize the NSC MAC to verify this information.

3rd Authorized Official's Information and Signature

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

First Name (Print)	Middle Initial	Last Name (Print)	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. Applications with signatures deemed not original or not dated will not be processed. Stamped, faxed or copied signatures will not be accepted.

MEDICARE SUPPLIER 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, 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 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 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. section 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 0938-1056. 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.