Form Approved
0MB No. 0938-0266

AMBULATORY SURGICAL CENTER REQUEST FOR INITIAL CERTIFICATION OR UPDATE OF CERTIFICATION INFORMATION IN THE MEDICARE PROGRAM

(Please read the following instructions before completing this form)

Submission of this form will initiate the process of obtaining a decision as to whether the Conditions for Coverage are met. Assistance in completing the form is available from the State agency. The ASC completes and signs this form for initial certifications and upon request of the State agency for the periodic recertification.

Answer all questions as of the current date. Return the original and first two copies to the State agency; retain the last copy for your files. If a return envelope is not provided, the name and address of the State agency may be obtained from the appropriate Regional Office. Please see the following link for additional information: http://www.cms.gov/RegionalOffices/

Detailed instructions are given for questions other than those considered self-explanatory.

CMS Certification Number (CCN): Insert the facility's ten-digit CCN. Leave blank on initial requests for certification.

State/County and State Region Codes The ASC leaves this blank.

Item III: If a service is provided directly by the facility, place a ' 1' in the appropriate block. If a service is provided under an arrangement with an outside source, place a '2' in the appropriate block. If the service is provided in combination, place a '3' in the appropriate block. If the service is not provided, leave blank.

Item IV: Place an 'X' in the appropriate blocks representing categories of surgery offered by the ASC. Under "Other," include only broad categories (i.e., not subspecialties). More than one block may be checked.

CMS Certification Number AS1	State/County Code AS2	State Region Code AS3

I. **IDENTIFYING INFORMATION**	Name of Facility	Street Address	
	City, County, and State	Zip Code	Telephone No. *(Include Area Code)* AS4

II. TYPE OF CONTROL (Check one box) ASS

1. ☐ Proprietary 2. ☐ Non-Profit 3. ☐ Government

III. ANCILLARY SERVICES (Place '1', '2' or '3' in blocks) AS6

1. ☐ Laboratory 2. ☐ Radiology 3. ☐ Pharmaceutical Services

IV. SURGICAL SPECIALTIES (X appropriate blocks) AS7

1. ☐ Dental 4. ☐ Ob/Gyn 7. ☐ Pain 10. ☐ Other(Specify) _____
2. ☐ Endoscopy 5. ☐ Ophthalmologic 8. ☐ Plastic/reconstructive
3. ☐ Ear/Nose/Throat 6. ☐ Orthopedic 9. ☐ Podiatry

V. FACILITY CHARACTERISTICS

1. Number of Operating Rooms/Procedure Rooms _____ ASS

2. Date Center Began Providing Services ___/___/_____ AS9

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION ON THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS.

Signature of Authorized Official (sign in ink) *(required only for initial certification)*	Title	Date AS10