DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0027

REQUEST FOR CERTIFICATION AS SUPPLIER OF PORTABLE X-RAY SERVICES UNDER THE MEDICARE/MEDICAID 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 of coverage are met. Do not delay returning the form even though certain information is not now available. Assistance in completing the form is available from the State agency.

Answer all questions as of the current date. Return the original and first two copies to the State agency in the envelope provided, 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 nearest Social Security office.

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

Medicare/Medicaid Provider Number — Leave blank on all initial certifications. On all recertifications, insert the supplier's assigned six-digit provider number.

State/County Code and State Region — Leave blank. The Centers for Medicare & Medicaid Services Regional Office will complete.

Question II — The director is the owner or person having administrative control and responsibility for the operation of portable X-ray equipment. If more than one degree is held, check the highest degree; e.g., director holds both an M.D. and an M.P.H., check *physician*; director holds Ph.D. and M.S., check *Ph.D*. Check block 1 if a physician is licensed to practice medicine or osteopathy.

Question IV — Include only those persons regularly employed. Do not include director. Count each technologist only once; e.g., technologist holds a B.S. degree in radiologic technology and is also a graduate of a 24-month approved school, place his full-time equivalents in block A. To determine full-time equivalents, divide the total number of hours worked by all employees in each classification in the week prior to the week of filing the request by the number of hours in the standard work week. If the result for each classification is not a whole number, express it as a quarter fraction; e.g., .00, .25, .50, or .75.

Completion of the Request at Resurvey — At the time of resurvey, the surveyor will bring this form and either, request that a facility representative complete, sign, date and return it at the completion of the onsite visit (at which time the surveyor will review it for completeness and accuracy); *or* the surveyor may complete the form and have the facility representative review and sign it. In either case, the surveyor will initial after the facility representative's signature.

REQUEST TO ESTABLISH ELIGIBILITY IN ☐ MEDICARE ☐ MEDICAID ☐ BOTH (S22)	MEDICARE/MEDICAID PROVIDER NUMBER (S1)	STATE/COUNTY (S2)	STATE REGION (S3)

I. Identifying Information	NAME OF SUPPLIER	STREET ADDRESS	
	CITY, COUNTY, AND STATE	ZIP CODE	TELEPHONE NUMBER *(Including area code)* (S6)

II. Qualifications of Director *(Check one)* (S7)

☐ 1. PHYSICIAN ☐ 3. M.S./M.A. ☐ 5. OTHER
☐ 2. PH.D/SC.D. ☐ 4. B.S./B.A.

III. Type of Ownership or Control *(Check one)* (S14)

☐ INDIVIDUAL ☐ CORPORATION
☐ PARTNERSHIP ☐ OTHER THAN PRIVATE *(Specify)* _____

IV. Number of Technologists *(Full time equivalents)*	(a) BS/BA IN RADIOLOGIC TECHNOLOGY (S15)	(b) ASSOCIATE DEGREE RADIOLOGIC TECHNOLOGY (S16)	(c) GRADUATE OF 24 MO. APPROVED SCHOOL OF RADIOLOGIC TECHNOLOGY (S17)	(d) ALL OTHER *(Specify)* (S18)

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 0938-0273. Expiration Date: XX-XX-XXXX. 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, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. *****CMS Disclaimer***** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact SCG@cms.hhs.gov.

SIGNATURE OF AUTHORIZED OFFICIAL	TITLE	DATE (S20)