REQUEST FOR IDENTIFICATION OF OPT/OSP PROVIDER'S PRIMARY & EXTENSION LOCATIONS (CMS-381)

To: _____
(Name of OPT/OSP Facility Director)

_____
(Name of OPT/OSP Facility)

_____
(Address of OPT/OSP Facility)

Our records indicate that your OPT/OSP facility is approved in the Medicare program as an outpatient physical therapy/speech pathology (OPT/OSP) provider. In addition to rendering services at their already approved premises, OPT/OSP providers may also render services at the premises of other institutions (e.g., skilled nursing facilities) or at a premise owned/leased/rented by the OPT/OSP. If the OPT/OSP bills the Medicare program for these services and renders these services in an area within the institution set aside for rehabilitation care, these premises are considered extension locations of the OPT/OSP. **A patient's home is not considered an extension location.**

Extension locations are considered part of the OPT/OSP provider's facility and are subject to the same approval policy as is applicable to the OPT/OSP. In addition to meeting applicable sections of the conditions of participation for all outpatient physical therapy/speech pathology providers, these extension locations fall under the OPT/OSP provider agreement and are identified under the OPT/OSP provider number.

INSTRUCTIONS FOR COMPLETING FORM CMS-381

- We request that you use the form below to identify all of the extension locations used by your OPT/OSP. Facility.
- Please complete this form and return it to the State Survey Agency listed below within 30 days.
- If at any time following completion of this form you plan to delete or add a service, or close or add an extension unit, please notify the State Survey Agency immediately.
- If you have any questions about or problems with completing the CMS-381 form, please call the State Survey Agency listed below.

Name Of State Survey Agency Representative Sending Notice:	**State Survey Agency Name:**
Address Of State Survey Agency:	**Signature Of State Survey Agency Representative Sending Notice:**
Date of Notice:	**Telephone No. of State Survey Agency Representative:**

Form Approved
OMB NO. 0938-0273

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IDENTIFICATION OF THE OPT / OSP PROVIDER'S PRIMARY AND EXTENSION LOCATIONS

A. Indicate the name, address and provider number for your primary approved outpatient physical therapy/speech pathology provider (OPT/OSP) site.

NAME	PROVIDER NO.
ADDRESS	TELEPHONE (Area Code)

B. Indicate the name, address, and provider number for any extension site where your OPT/OSP services are provided on the premises of an institution.

NAME	ADDRESS	PROVIDER NO.
NAME	ADDRESS	PROVIDER NO.
NAME	ADDRESS	PROVIDER NO.

C. Indicate the name, address, and provider number for any extension sites that are owned, leased, or rented by your OPT/OSP facility, (other than the primary site) where OPT/OSP services are provided.

NAME	ADDRESS	PROVIDER NO.
NAME	ADDRESS	PROVIDER NO.
NAME	ADDRESS	PROVIDER NO.

D. List the type of OPT/OSP services rendered from your primary site.

_____ OPT _____OSP _____OOT Other: _____(specify)

E. List the type of OPT/OSP services rendered from the premises of all extension location(s).

_____ OPT _____OSP _____OOT Other: _____(specify)

F. Do your extension locations operate: (check one) _____ Full-time _____ Part-time

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AFFIRMATION STATEMENT

I hereby affirm that the above responses are truthful to the best of my knowledge, information and belief. I further acknowledge that knowingly and willfully making or causing to be made a false statement may lead to prosecution under applicable Federal or State laws. In addition, I acknowledge that knowingly and/or willfully failing to fully and accurately disclose the information requested above may result in a denial of a request to participate, or where the entity already participates, a termination of its agreement or contract with the State agency or the Secretary, as appropriate.

SIGNATURE OFAUTHORIZED PERSON AT OPT/OSP FACILITY	TITLE	DATE

PRA Disclosure Statement

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 QSOG_OPT@cms.hhs.gov**