2018 CMS-855B Application Revisions

Section Number	Revision
Entire 855A	Punctuation, grammar and spelling corrections were made throughout the CMS-855B as necessary (e.g., upper case/lower case corrections, apostrophe corrections, etc.).
Entire 855A	Section references were updated to coincide with new section sequencing where necessary.
Entire 855A	Minor text corrections were made to clarify instructions and delete redundancy.
Entire 855A	All website links and legal references were reviewed and updated where necessary.
Entire 855A	Removed all references to "Medicare fee-for-service contractor(s)" and replaced language to "Medicare Administrative Contractors (MACs)."
Entire 855A	Removed all references to "CMS Regional Office" and replaced language to "CMS Location".
Entire 855A	Removed instruction requiring all signatures to be original and in ink. Faxed, photocopied, or stamped signatures will not be accepted.
Entire 855A	All acronyms were reviewed and updated where necessary.
Entire 855A	All section symbols (§) were replaced with the word "section" or "sections".
Entire 855A	All section and subsection headers were made to a standard (numbering, bold, upper and lower case, etc.) to create a uniform format throughout the CMS-855B.
Entire 855A	Reformatted checkboxes for "change," "add," and "remove," with effective date line.
INSTRUCTION PAGES	Added, "Institutional providers must complete this application to enroll in the Medicare program and receive a Medicare billing number."
INSTRUCTION PAGES	Added, "Be sure you are using the most current version." and the links to where to obtain the current version fo the CMS-855A.

2018 CMS-855B Application Revisions

Section Number	Revision
INSTRUCTION PAGES	Added a note: **NOTE:** Applicants using this application require a Type 2 NPI. See below for more information.
INSTRUCTION PAGES	Removed language: "Institutional providers who are enrolled in the Medicare program, but have not submitted the CMS 855A since 2003, are required to submit a Medicare enrollment application (i.e., Internet-based PECOS or the CMS 855A) as an initial application when reporting a change for the first time."
INSTRUCTION PAGES	Added "Opioid Treatment Program" and "Rural Emergency Hospital" to the list of organizations that must complete this application. Added notes: (1) "NOTE: Opioid Treatment Programs may complete the CMS-855A or CMS-855B enrollment application. (2) NOTE: Per Section 125 of the Consolidated Appropriations Act of 2021 (CAA) an action plan is required to be submitted with the enrollment application."
INSTRUCTION PAGES	Clarified instructions/bullets for completeing and submitting this application.
INSTRUCTION PAGES	Changed title of Instructions subsection "Billing Number Information" to "Billing Number and National Provider Identifier Information"
INSTRUCTION PAGES	Added the phrase, "The Provider Transaction Access Number (PTAN), often referred to as a Medicare Provider Number, Medicare Billing Number, CMS Certification Number (CCN), or Medicare “legacy” number, is a generic term for any number other than the National Provider Identifier (NPI) that is used by a providrer to bill the Medicare program.."
INSTRUCTION PAGES	Added a note explaining the Legal Business Name (LBN) and Tax Identification Number (TIN) the provider furnishes in section 2A must be the same LBN and TIN used to obtain the provider's NPI.

2018 CMS-855B Application Revisions

Section Number	Revision
INSTRUCTION PAGES	Added information regarding Type 2 NPI.
INSTRUCTION PAGES	Added note to "Instructions for Completing and Submitting This Application" subsection stating all information on this form is required with the exception of those fields specifically marked as “optional.”
INSTRUCTION PAGES	Added bullet to "Instructions for Completing and Submitting This Application" subsection, "This form must be typed. It may not be handwritten."
INSTRUCTION PAGES	Added bullet to "Instructions for Completing and Submitting This Application" subsection, "When necessary to report additional information, copy and complete the applicable section as needed."
INSTRUCTION PAGES	Changed "Avoid Delays in Your Enrollment" to Tips to Avoid Delays in Your Enrollment"
INSTRUCTION PAGES	Added application fee requirement, Electronic Funds Transfer (EFT) Authorization Requirement, and reminders to sign section 15 and include supporting documentation in "Tips To Avoid Delays In Your Enrollment" subsection.
INSTRUCTION PAGES	Revised subsection for "Additional Information" to include helpful website links, C.F.R. citations and Privacy Act Information regarding the information submitted in this application.
INSTRUCTION PAGES	Added a list of acronyms used throughout the CMS-855A.
INSTRUCTION PAGES	Added a list of definitions specific to the checkboxes for "add", "change", "remove", "private equity company (for Medicare purposes)", "real estate investment trust (for Medicare purposes)" and "holding company".

2018 CMS-855B Application Revisions

Section Number	Revision
INSTRUCTION PAGES	Changed "Mail Your Application" to "Where to Mail Your Application and revised the mailing instructions.
SECTION 1	Deleted subsection "New Enrollees And Enrolled Medicare Providers. "Moved the previous language to the "Who Should Submit This Application" subsection.
1	Moved the definitions for "Acquisitions/Mergers", "Consolidation", "Change of Information", and "Revalidation." to the "Who Should Submit This Application" subsection.
1A	Removed middle column, "Billing Number Information" with the exception of the "Voluntary Withdrawal" option (where the "Billing Number Information" data field was moved to the first column).
1A	Moved the "You are revalidating your Medicare enrollment" and You are changing your Medicare information" option further up.
1B	Added "What Information is Changing?" and a note to complete certain sections regardless of the change being made.
1B	Expanded choices of "What information is changing?" column.

2018 CMS-855B Application Revisions

Section Number	Revision
1B	Added the "Provider Specific Information." option.
1B	Added "Business" before Identifying Information.
1B	Added "Final" before Adverse Legal Actions and removed "Convictions"
1B	Renamed "Practice Location Information, Payment Address & Medical Record Storage Information" to "Address Information" and expanded to capture the different addresses.
1B	Added "Opioid Treatment Program Personnel" to "What Information is Changing" section and the applicable sections to complete.
1B	Removed subsection "New Enrollee."
1B	Under "Special Enrollment Notes", removed "If you are adding an HHA sub-unit (as opposed to a branch), this requires an initial enrollment application for the sub-unit."
1B	or an immediate family member of a physician has an ownership or investment interest in the hospital. The ownership or investment interest may be through equity, debt, or other means, and includes an interest in an entity that holds an ownership or investment interest in the hospital. This definition does not include a
1A and 1B	Updated "Required Sections" column to reflect the application revisions.

2018 CMS-855B Application Revisions

Section Number	Revision
SECTION 2A1	Added "Opioid Treatment Program" and "Rural Emergency Hospital" to the list of organizations that must complete this application.
2A1	Remove HHA (sub-unit)
2A2	Added "Hospital – Transplant Program (Identify organ type(s):"
2A3	Removed references to Physician Owned Hospital.
2A4	Initially removed but re- added "4. Is the provider a physician-owned hospital (as defined in the Special Enrollment Notes on page 8)? -yes -no"
2B1	Simplified instructions and reordered sections and applicable subsections. Created checkboxes to identify how the individual's business is registered with the IRS (Proprietary, Non-Profit, or Disregarded Entity). Created checkboces to identify government-owned entities and their level. Also added note, "In addition, government-owned entities do not need to provide an IRS Form 501(c)(3)."
2B2	Reformatted the "License/Certification/Registration Information" subsection.
2B2	Changed title from "LICENSE/CERTIFICATION INFORMATION" to "LICENSE/CERTIFICATION/REGISTRATION INFORMATION."

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Section Number	Revision
2B2	Added instructions under title - "Complete the appropriate subsection(s) below for your provider type as you will report in section 2A1. If no subsection is associated with your provider type, check the box stating the information is not applicable."
2B2	Added the word "Active" before "License Information."
2B2	Added the word "Active" before "Certification Information."
2B2	Added a bolded note, "Complete the appropriate subsection(s) below for your provider type as you will report in section 2A1. If no subsection is associated with your provider type, check the box stating the information is not applicable. If you are certified by a national entity, put the word “all” in the “State Where Issued” data field.
2B2	Added data field for "Certifying Entity (Specialty Board, State, Other)" to collect where the certification is coming from.
2B2	Added note: "Please note: if you are certified by a national entity, put the word "all" in the "State Where Issued" data field."
2C	Revised current instruction, "This is the address where correspondence will be sent to the provider listed in section 2B1 by your designated MAC. This address cannot be a billing agent or agency’s address or a medical management company address. If you are reporting a change to your Correspondence Mailing Address, check the box below. This will replace any current Correspondence Mailing Address on file."
2C	Added an optional "Attention" field.

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Section Number	Revision
2C	Added "Change" and "Effective Date" fields.
2C	Renamed "Mailing Address" fields to "Correspondence Mailling Address" and PO Box and Apt. # as examples.
2D	Renamed section 2D to Medical Record Correspondence Address. Included instructions "This is the address where the medical record correspondence will be sent to the provider listed in section 2B1 by your designated MAC. This information would be used for any medical record review requests." Data fields also included are a checkbox to use the provider's regular correspondence address, a checkbox to change the Medical Record Correspondence Address, and the address data fields (Attention (optional), 2 Address lines, City/Town, State, Zip Code, Telephone Number, Fax Number, and E-mail Address).
2E	Moved existing section 2D Accreditation to 2E Accreditation.
2F	Moved existing section 2E Comments to 2F Comments.
2G	Moved existing section 2F Change of Ownership (CHOW) Information to 2G Change of Ownership (CHOW) Information.
2H	Moved existing section 2G Acquisitions/Mergers to section 2H Acquisitions/Mergers.
2I	Moved existing section 2H Consolidations to section 2I Consolidations

2018 CMS-855B Application Revisions

Section Number	Revision
SECTION 3	Removed references to "Medicare" throughout section.
3	Added note to the end of the section description under section title: "To satisfy the reporting requirement, section 3 must be filled out in its entirety, and all applicable attachments must be included."
3A	Changed subtitle to read "FEDERAL AND STATE CONVICTIONS (Conviction as defined in 42 C.F.R. Section 1001.2) WITHIN THE PRECEDING 10 YEARS."
3A	Simplified "1. Any federal or state felony conviction(s) by the provider, provider, or any owner or managing employee of the provider or supplier." and added "2. Any crime, under Federal or State law, where an individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld, or the criminal conduct has been expunged or otherwise removed, or there is a post-trial motion or appeal pending, or the court has made a finding of guilt or accepted a plea of guilty or nolo contendere."
3B	Revised the reporting requirements for exclusions, revocations or suspensions.
3B	Added "…Medicaid or any federal health care program " to the reporting requirement for revocations or suspensions.

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Section Number	Revision
3C	Removed "History" from Final Adverse Legal Action subsection.
3C	Removed "Resolution, if any" column from adverse legal action history table.
SECTION 4	Expanded and simplified instructions for practice location information.
4A	Added data fields for "Medicare Identification Number for this location - CCN (if issued)," "Is this your primary practice locations?" with yes/no checkboxes, "Date you saw your first Medicare patient at this practice location (mm/dd/yyyy)" and data fields for CLIA number and FDA/Radiology Certification Number.
4A	Rewrote and reformatted the Hospital and HHA practice location types. Expanded location types to include provider-based locations.
4A	in hospital only section (2nd and 5th check box in right column)the verbiage "and satisfies applicable requirements at 42 CFR 413.65" was removed.
4B	Added instruction, "Furnish an address where remittance notices and special payments should be sent for services rendered at the practice location(s) reported in section 4A. Please note that payments will be made in your name or, if a business is reported in section 4A, payments will be made in the name of the business."

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Section Number	Revision
4B	Added checkbox, "Check here if your Remittance Notice/Special Payments should be mailed to your Primary Practice Location Address in Section 4A above and skip this section, OR Check here if your Remittance Notice/Special Payments should be mailed to your Correspondence Address in Section 2C and skip this section."
4B	Added "Change" and "Effective Date" fields.
4C	Renamed section to "Medicare Beneficiary Medical Records Storage Address"
4C	Added instructions and checkbox, "If all records are stored at the Practice Location reported in section 4A, check the box below and skip this section..."
4C	Added "Add", "Remove" and "Effective Date" fields.
4C	Add "Name of Storage Facility" under Paper Storage subsection.
4C	Added electronic storage subsection under "Medicare Beneficiary Medical Records Storage Address."
4C2	Revised verbiage to: “If yes, identify the service used to store these records below. This can be an in-house software program, online service, vendor, etc.” and field below to read “Service used to store electronic records”

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Section Number	Revision
4D	Added "NOTE: When necessary to report more than one base of operations, copy and complete this section for each base of operations."
4D	Added "Change", "Add", "Remove" and "Effective Date" fields.
4D	Added checkbox, "The “Base of Operations” is the same as the “Practice Location” reported in Section 4A."
4D	Added "Base of Operation" before Street Address information.
4E	Added note "For each vehicle, submit a copy of all health care related permits/licenses/registrations" and remove checkbox for vehicle information.
4E	Removed the option for the provider to change vehicle information, leaving only the options to add or remove vehicle information.

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Section Number	Revision
4F	Added "/Territory" next to State column so it reads "State/Territory" throughout the section.
4F1	Added column for "County" in table showing where the providers render mobile services .
4F2	Added column for "County" in table showing where the providers render mobile services .
SECTION 5	Clarified instructions on who needs to be reported in this section.
5	Added "NOTE: It is not necessary for the organization reported in 2A1 to report itself in this section."
5	Included note in instructions: "The provider must submit an organizational structure diagram/flowchart identifying all the entities listed in section 5 and their relationships with the provider and each other."
5	Added "Private equity company" and "Real estate investment trusts" in **5. Additional Information on Ownership.**
5A	Renamed 5A to Organization with Ownership Interest and/or Managing Control - Identification Information

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Section Number	Revision
5A	Added language "If you are changing, adding or removing information about your current ownership interest and/or managing control information for this organization, check the applicable box, furnish the effective date, and complete the appropriate fields in this section." Added checkboxes adn effective date field.
5A	Added telephone number, fax number and email address fields to the section.
5A	Added instructions under identifying information section - "Identify the type of ownership and/or managing control the individual identified above has in the provider identified in Section 2B1 of this application. Check all that apply. Complete all information for each type of ownership and/or managing control applicable, including the exact percentage of ownership. Combined percentage totals for direct owners should not exceed one hundred percent."
5A	Reformatted the ownership/managing control tables and the percentage of ownership.
5A	Added the question "Is this organization itself owned by any other organization or by any individual? Yes No" to all the ownership roles.
5A	Incorporated the previous Chain Home Office section (section 7) into Section 5.
5B	Revised instructions to capture information about the structure of the organization reported in the previous section (IRS business designation, business structure, type of organization). Included definitions for "Private equity company (for Medicare purposes)", "Real estate investment trust (for Medicare purposes)", and "Holding company".
5C	Moved the Chain Home office information from section 7 to section 5C. Added change, remove checkboces and effective date field. Removed the effective date column in the table.

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Section Number	Revision
5D	Renamed subsection to "Final Adverse Legal Action".
5D	Added instruction under final adverse legal action, "Complete this section for the organization reported in section 5A above. If you need additional information regarding what to report, please refer to section 3 of this application. All supporting documentation must be included as described in section 3."
5D	Added: "NOTE: If reporting more than one organization, copy and complete sections 5A and 5B for each organization reported."
5D	Added: "NOTE: To satisfy the reporting requirement, section 5D must be filled out in its entirety, and all applicable attachments must be included."
5D	Removed "Resolution, if any" column from adverse legal action history table.
SECTION 6A	Added "limited" to the following sentence "All general and limited partnership interests, regardless of the percentage. This includes: (1) all interests in a non-limited partnership, and (2) all general and limited partnership interests in a limited partnershipanguage that partnership interest includes general and limited."
6A	Added "medical director" to the list of managing employee examples.
6A	Revised the instructions to "If you are changing, adding, or removing information about your current ownership interest and/or managing control information for this individual, check the applicable box, furnish the effective date, and complete the appropriate fields in this section."
6A	Added "Change", Add", "Remove" and "Effective Date" fields.
6A	Deleted data fields: Place of Birth, Country of Birth, Medicare Identification Number (if issued) and NPI (if issued).
6A	Added data field: Title.

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Section Number	Revision
6A	Added ITIN to Social Security Number data field so it now reads, "Social Security Number (SSN) or Individual Tax Identification Number (ITIN)"
6A	Added telephone number, fax number and email address fields to the section.
6A	Added instructions under identifying information section to "Identify the type of ownership and/or managing control the individual identified above has in the provider identified in Section 2B1 of this application. Check all that apply. Complete all information for each type of ownership and/or managing control applicable, including the exact percentage of ownership. Combined percentage totals for direct owners should not exceed one hundred percent."
6A	Reformatted the ownership/managing control tables and the percentage of ownership.
6B	Renamed subsection to "Final Adverse Legal Action".
6B	Added instruction under final adverse legal action, "Complete this section for the organization reported in section 5A above. If you need additional information regarding what to report, please refer to section 3 of this application. All supporting documentation must be included as described in section 3."
6B	Added: "NOTE: If reporting more than one individual, copy and complete sections 6A and 6B for each individual reported."
6B	Added: "To satisfy the reporting requirement, section 6B must be filled out in its entirety, and all applicable attachments must be included."
6B	Removed "Resolution, if any" column from adverse legal action history table.
SECTION 7	Moved Chain Home Office Information to section 5.
SECTION 8	Added "/Agent" after the word "Agency" to include individuals in the instructions.

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Section Number	Revision
8	Added "NOTE: The billing agency/agent address cannot be the correspondence mailing address completed in section 2C of this application."
8	Added "If you are changing information about your current billing agency/agent or adding or removing billing agency/agent information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section."
8	Added "Change", "Add", "Remove" and "Effective Date" fields.
8	Replaced "Individual Billing Agent" with "If Billing Agent".
SECTION 10	Replaced "For Future Use (This Section Not Applicable)" with "Opioid Treatment Program Personnel".
10	Added instructions to capture information for individuals legally authorized to order and/or dispense controlled substances at OTP facility
10A	Added subsection "Ordering Personnel Identification" to capture ordering personnel information.
10B	Added subsection "Dispensing Personnel Identfication" to capture dispensing personnel information.
SECTION 12	In the instructions, removed the references to HHA sub units in the instructions and updated instructions for HHA initial reserve operating funds.

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Section Number	Revision
12B	Adding language, "If you are changing information about your current nursing registries or adding or removing nursing registries information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section."
12B	Added checkboxes for "change", "add", and "remove", with effective date.
SECTION 13	Made section optional.
13	Added "Contact Person" before Address Line 1 and Address Line 2 fields.
13	Added "NOTE: The Contact Person listed in this section will only be authorized to discuss issues concerning this or any other enrollment application. Your designated MAC will not discuss any other Medicare issues about you with the above Contact Person."
SECTION 14 #3	Replaced current number 3 with updated language and references concerning the Civil False Claims Act.
SECTION 15	Revised the language regarding authorized official signatures, "Only an authorized official has the authority to sign (1) the initial enrollment application on behalf of the provider and (2) add or remove additional authorized officials and delegated officials. Once the delegation of authority has been established all other enrollment application submissions can be signed by either an authorized official or delegated official."

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Section Number	Revision
15	Added in bold "EACH AUTHORIZED AND DELEGATED OFFICIAL MUST HAVE AND DISCLOSE HIS/HER SOCIAL SECURITY NUMBER."
15	Replaced paragraph 6 of instructions from "Only an authorized official has the authority to sign (1) the initial enrollment application on behalf of the provider or (2) the enrollment application that must be submitted as part of the periodic revalidation process. A delegated official does not have this authority." to "Only an authorized official has the authority to sign (1) the initial enrollment application on behalf of the provider and (2) add or remove additional authorized officials and delegated officials. Once the delegation of authority has been established all other enrollment application submissions can be signed by either an authorized official or delegated official."
15A #1	Added, "I authorize the Medicare contractor to verify the information contained herein."
15A #2	Removed "deliberate" from #2.
15A #3	Replaced #3 of the certification statement with updated language from OGC.
15A #4	Added "five percent or greater" and removed "physician owner or investor or any other"
15B	Renamed section to "Authorized Official Signature(s)"
15B1/15B2	Added "Add", "Remove" and "Effective Date" fields.

2018 CMS-855B Application Revisions

Section Number	Revision
15B1/15B2	Added, "In order to process this application it MUST be signed and dated."
15C	Combined sections 15 and 16 and updated headers and numbering.
15C	Renamed to "Additional Requirements for Medicare Enrollment for Delegated Officials"
15C	Added "NOTE: Delegated Officials are optional.
15D	Moved Delegated Officials (optional) signatures from section 16.
15D	Added "Add", "Remove" and "Effective Date" fields.
15D	Added, "In order to process this application it MUST be signed and dated."
15B	Removed instruction, "All applications must be original and signed in blue ink. Applications with signatures deemed not original or not dated will not be processed. Stamped, faxed, or copied signatures will not be accepted." Replaced with instruction, "In order to process this application, it must be signed and dated."
SECTION 16	Deleted section 16 and combined sections 15 and 16.

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Section Number	Revision
15D	Relocated OMB Statement from end of section 17 to end of section 15.
SECTION 17	Renamed title to "Supporting Documentation Information"
17	Combined the first two paragrahps of the instructions.
17	Removed the "Mandatory for all Provider/Supplier Types", "Mandatory for Selected Provider/Supplier Types", and Mandatory, If Applicable" headings and consolidated the list if supporting documentation.
17	Added "Territory" to "Federal, State, and/or local (city/county) business licenses, certifications and/or registrations required to operate a health care facility".
17	Revised to, "Copy(s) of all bills of sale or sales agreements for all ownership changes. This includes, CHOWS, Acquisition/Mergers, and Consolidations, and all other ownership changes that are required to be reported, regardless of the percentage involved (e.g., new 15 percent owner).
17	Added "final" to "Copy(s) of all adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters)."
17	Added "(e.g., IRS Form 501(c)(3))." to "Copy of IRS Determination Letter, if provider is registered with the IRS as non-profit."
17	Added "Organizational structure diagram/flowchart identifying all of the entities listed in section 5 and their relationships with the provider and each other, Copy of all mobile vehicle registrations (all mobile services) and Rural Emergency Hospital (REH) Action Plan to the list of supporting documentation.

2018 CMS-855B Application Revisions

Section Number	Revision
PRIVACY ACT STATEMENT (Last page)	Updated Privacy Act Statement.

2018 CMS-855B Application Revisions

Justification
Error corrections.
Formatting corrections.
Error corrections.
Error corrections.
Error correction - updated language.
Error correction - updated language.
Removed because it was an unnecessary requirement causing processing delays for Medicare contractors.
Error corrections.
This creates a uniform standard across the CMS-855 applications.
Formatting corrections.
Data fields reformatted to simplify for better provider understanding and creates a uniform wording standard across the CMS-855 applications.
Added to allow for better provider understanding of how much of the 855A form to complete and reduces MAC development.
Added to allow for better provider understanding of how much of the 855A form to complete and reduces MAC development.

2018 CMS-855B Application Revisions

Justification
Notes added for better provider understanding.
All providers should not be enrolled in PECOS. This language is not needed.
CMS-1715(published in the Federal Register on November 15, 2019 (84 FR 62567)), established a new 42 CFR § 424.67 containing requirements that OTPs must meet and continually adhere to in order to enroll (and remain enrolled) in Medicare effective January 1, 2020. In 2020, Congress established rural emergency hospitals (REHs) as a new provider type. CMS-1772-P incorporates parts of section 1866(kkk)(4) of the Act into 42 CFR Part 424, subpart P.
Added for better provider understanding.
This creates a uniform standard across the CMS-855 applications.
Added by MAC request to tell providers that NPIs are not considered Medicare billing numbers which allows better provider understanding and reduces MAC development.
This will allow for better understanding of the requirements for providers and result in less MAC development.

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Justification
Notes added for better provider understanding.
This will allow for better understanding of the requirements for providers and result in less MAC development.
CR 10571 requires applications to be typed.
This creates a uniform standard across the CMS-855 applications.
This creates a uniform standard across the CMS-855 applications.
Updated requirements since last application revision.
Clarified information for provider understanding and creates uniform wording standard across CMS-855 applications.
Clarified information for provider understanding and creates uniform wording standard across CMS-855 applications.
rule (CMS-6084) establishes the ownership disclosure requirements for Part A facilities. The data collection provides greater transparency regarding the owners and managers of Part A facilities, given concerns about the credentials and commitment

2018 CMS-855B Application Revisions

Justification
Clarified information for provider understanding and creates uniform wording standard across CMS-855 applications.
Redundant information, removing it reduces provider burden. (This information is included in the subsection "Who Should Complete This Application.")
Redundant information, removing it reduces provider burden. (This information is included in the subsection "Who Should Complete This Application.")
CMS can derive the billing number information from the next section and therefore the collection would be redundant. Deleting this reduces provider burden and creates a uniform standard across the CMS-855 applications. If the provider is voluntarily withdrawing from the Medicare program, the section that identifies the Medicare billing number doesn't apply. Therefore, it was added to the first column for the reason of voluntary withdraw only.
This creates a uniform standard across the CMS-855 applications.
Added to provide better provider understanding and reduces MAC development.
Expanded choices for ease of completing application, and to minimize provider burden and duplication of information.

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Justification
Expanded choices for ease of completing application, and to minimize provider burden and duplication of information.
Expanded choices for ease of completing application, and to minimize provider burden and duplication of information.
This creates a uniform standard across the CMS-855 applications.
Simplified information for provider understanding and creates uniform wording standard across CMS-855 applications.
innovative approaches to improve quality and accessibility.
Redundant information, removing it reduces provider burden. (This information is included in the subsection "Who Should Complete This Application.")
HHA subunits have been discontinued.
Added to clarify the 2A4 question that references the Special Enrollment Notes.
Updated information to coincide with the new sections and subsections required by providers, to decrease provider burden, and reduce the collection of duplicative information.

2018 CMS-855B Application Revisions

Justification
CMS-1715(published in the Federal Register on November 15, 2019 (84 FR 62567)), established a new 42 CFR § 424.67 containing requirements that OTPs must meet and continually adhere to in order to enroll (and remain enrolled) in Medicare effective January 1, 2020. In 2020, Congress established rural emergency hospitals (REHs) as a new provider type. CMS-1772-P incorporates parts of section 1866(kkk)(4) of the Act into 42 CFR Part 424, subpart P.
Removed the HHA sub-units option as they were eliminated several years ago from being able to enroll.
Added for better clarity. Providers are currently required to check “other” and list the organ types. This option is clearer.
Initially physician owned hospital reporting was no longer required via the CMS-855 applications but was re-added in 2A4 to address OL and CM's concerns and the political implications with the removal of this checkbox.
To address OL and CM's concerns and the political implications with the removal of this checkbox.
These sections and applicable subsections were reformatted to create a more logical flow of information and uniform sequence to the data collected within this section and the PECOS system. The instructions and note were simplified for greater provider understanding and to minimize provider burden and duplication of information. This also creates a uniform standard across the CMS-855 applications.
This creates a uniform standard across the CMS-855 applications.
Renamed to accurately reflect the data collection and for language to be in sync with other 855 applications.

2018 CMS-855B Application Revisions

Justification
This note will clarify the instructions for providers to report the certification that is related to their provider type, as applicable.
This ensures the license being reported is active.
This ensures the certification being reported is active.
This note will clarify the instructions for providers to report the certification that is related to their provider type, as applicable.
This information will tell CMS where the certification was obtained to ensure it is legitimate.
This clarifies instructions for those providers certified nationally. This will allow providers who have been certified by a national entity to write "all" in the "State Where Issued" data field, showing the certification is national and accepted in all states.
The correspondence address is solely used for correspondence between the Medicare Administrative Contractor and the provider.
Added data field in case provider wants correspondence to be addressed and received by a specific person.

2018 CMS-855B Application Revisions

Justification
This creates a uniform standard across the CMS-855 applications.
This creates a uniform standard across the CMS-855 applications.
This address was added due to an overwhelming request from the provider/provider community to add a separate field to collect this specific information. MACs requested adding the reason for this address as seen in the first sentence.
Formatting change to accommodate new section 2D.
Formatting change to accommodate new section 2D.
Formatting change to accommodate new section 2D.
Formatting change to accommodate new section 2D.
Formatting change to accommodate new section 2D.

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Justification
CMS has Medicare Adverse Legal Action information. Not collecting Medicare information reduces the reporting burden of the provider.
Clarified information for provider understanding regarding what documents to submit and to help reduce MAC processing denials for "False or Misleading Information" when a provider fails to completely disclose prior adverse actions.
Included "(as defined in 42 C.F.R. section 1001.2) within the preceding 10 years" in the title instead of repeating it in numbers 1 through 5 below it. Including the reference in the title simplifies the remaining information and allows for better provider understanding.
Language simplification is to align the language with CMS-6045 (“Medicare Program; Requirements for the Medicare Incentive Reward Program and Provider Enrollment”).
Language simplification is to align the language with CMS-6045 (“Medicare Program; Requirements for the Medicare Incentive Reward Program and Provider Enrollment”).
CMS can revoke Medicare enrollment under 424.535(a)(12) if the provider’s Medicaid billing privileges are terminated or revoked by a State Medicaid Agency. Expanded to to include any federal health care program to account for our recently established denial and revocation authorities.

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Justification
This creates a uniform standard across the CMS-855 applications.
CMS has the resolution information. Not collecting adverse legal action resolution information reduces the reporting burden of the provider.
The instructions were simplified for greater provider understanding and to minimize provider burden and duplication of information. Also creates section standard across CMS-855 applications.
Added for greater provider identification and will result in less MAC development.
Section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114–74)), enacted on November 2, 2015, amended section 1833(t) of the Act and relates to payment for certain items and services furnished by off-campus provider-based departments of a hospital. Requires that we correctly identify off-campus providers and those excepted. New practice location choice added. Reduces provider burden of having to explain this circumstance in section 4D3 (Comments/Special Circumstances).
Deleted verbiage from the applicable checkboxes to avoid confusion and provider concerns.
Note added for provider clarification.

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Justification
Added checkbox to reduce possible duplication of reporting for the providers and the other information about the business can be found elsewhere in the application.
This creates a uniform standard across the CMS-855 applications.
This creates a uniform standard across the CMS-855 applications.
Added checkbox to reduce possible duplication of reporting for the providers and the other information about the business can be found elsewhere in the application.
This creates a uniform standard across the CMS-855 applications.
Allows CMS to identify where Medicare beneficiary records are stored if needed.
Some providers no longer store paper beneficiary records. Adding an electronic storage data field option allows CMS to identify where Medicare beneficiary records are stored if needed.
URL, in-house software program, online service, vendor, etc. This must be an electronic storage site to which CMS or its designees can be provided access if necessary." to "If yes, identify the service used to store these records below. This can be an in-house software program, online service, vendor, etc." in response to a commenters concern of verbiage related to electronic medical

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Justification
Clarified information for provider understanding regarding what is requried to be included in this section.
This creates a uniform standard across the CMS-855 applications.
Added checkbox to reduce possible duplication of reporting for the providers and the other information about the business can be found elsewhere in the application.
This creates a uniform standard across the CMS-855 applications.
This creates a uniform standard across the CMS-855 applications.
Adding and removing vehicle information is actually changing the information. CMS found the change option to be misleading and confusing to the provider so CMS simplified the information for better provider understanding.

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Justification
Added if "State" was not applicable and will be a section standard across CMS-855 applications.
Added if "City/Town" was not applicable and creates section standard across CMS-855 applications.
Added if "City/Town" was not applicable and creates section standard across CMS-855 applications.
This will allow for better understanding of the requirements for providers and results in less MAC development.
Added by MAC request, an entity cannot own itself, if the entity completes this section, it is duplicate information. This note reduces provider burden and MAC processing.
This will allow for better understanding of the requirements for providers and results in less MAC development.
The PI rule (CMS-6084) establishes the ownership disclosure requirements for Part A facilities. The data collection provides greater transparency regarding the owners and managers of Part A facilities, given concerns about the credentials and commitment to high-quality patient care of certain types of nursing home ownership, including private equity firms.
This creates a uniform standard across the CMS-855 applications.

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Justification
This creates a uniform standard across the CMS-855 applications.
Added at the request of DOJ, to collect contact information of owners to notify them of changes made to the enrollment information.
This will clarify what information needs to be reported in this section.
Added for greater provider identification and will result in less MAC development.
Added at the request of HHS/ASPE to identify organizations, such as SNFs or hospitals, with the same ultimate parent. This would facilitate investigating whether a program integrity issue found in one provider was prevalent in other providers under the same ultimate parent, further expanding CPI's ability to investigate patterns of program integrity issues.
Reformatted the section to incorporate chain home office information as an ownership or managing control type. No new data elements are being captured.
The PI rule (CMS-6084) establishes the ownership disclosure requirements for Part A facilities. The data collection provides greater transparency regarding the owners and managers of Part A facilities, given concerns about the credentials and commitment to high-quality patient care of certain types of nursing home ownership, including private equity firms.
Reformatted the section to incorporate chain home office information as an ownership or managing control type. No new data elements are being captured.

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Justification
This creates a uniform standard across the CMS-855 applications.
Gave a reference for greater provider understanding.
Note added for provider clarification and will allow for less MAC development.
Note added for provider clarification and will allow for less MAC development.
CMS has the resolution information. Not collecting adverse legal action resolution information reduces the reporting burden of the provider.
Added for provider clarification.
Added for provider clarification.
This creates a uniform standard across the CMS-855 applications.
This creates a uniform standard across the CMS-855 applications.
CMS no longer collects location birth data and CMS can discern identification numbers and NPI (if issued) elsewhere on the application therefore decreasing provider burden.
This creates a uniform standard across the CMS-855 applications.

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Justification
Updated data collection to include ITINs to include providers with special circumstances.
Added at the request of DOJ, to collect contact information of owners to notify them of changes made to the enrollment information.
This will clarify what information needs to be reported in this section.
Added for greater provider identification and will result in less MAC development.
This creates a uniform standard across the CMS-855 applications.
Gave a reference for greater provider understanding.
Note added for provider clarification and will allow for less MAC development.
Note added for provider clarification and will allow for less MAC development.
CMS has the resolution information. Not collecting adverse legal action resolution information reduces the reporting burden of the provider.
Chain home office information has been consolidated with section 5.
Error correction - individual agents were included in the data fields, but not in the instructions for the section.

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Justification
Note added for provider clarification.
Added for provider clarification.
This creates a uniform standard across the CMS-855 applications.
Note added for provider clarification.
Added to be in compliance with the SUPPORT Act of 2018.
Added to be in compliance with the SUPPORT Act of 2018.
Added to be in compliance with the SUPPORT Act of 2018.
Added to be in compliance with the SUPPORT Act of 2018.
On January 13, 2017, CMS published a final rule revising the Conditions of Participation (CoPs) for HHAs which was scheduled to become effective on July 13, 2017. A subsequent rule delayed the implementation of these CoPs until January 13, 2018. The final rule eliminated the definition for “subunit,” previously set forth at §484.2.

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Justification
Added for provider clarification.
Data field added to sync to the PECOS system.
Section was made optional to reduce the reporting burden on the provider and because it was an unnecessary requirement causing processing delays for Medicare contractors.
This creates a uniform standard across the CMS-855 applications.
Added information for greater provider understanding about what role the contact person has.
The Department of Justice requested this language to be updated from the older summary language. OGC confirmed the revised language. Language has been/will be updated across all CMS-855 applications.
Added for greater provider identification and will result in less MAC development.

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Justification
Added note for clarity that an SSN is required to be disclosed.
Updated instructions to better clarify distinct roles of providers for better provider understanding.
OGC updated certification statement language to include additional regulation references.
At the request of OGC. AUSA has advised their inability to prosecute, in some cases, because they were unable to prove ‘deliberate’ in context of false or misleading information.
OGC updated certification statement language to include additional regulation references.
This clarifies the requirements that the provider must meet and maintain in order to bill the Medicare program.
This creates a uniform standard across the CMS-855 applications.
Data fields reformatted to simplify for better provider understanding and creates a uniform wording standard across the CMS-855 applications.

2018 CMS-855B Application Revisions

Justification
This creates a uniform standard across the CMS-855 applications.
CMS-855A ends at Section 15 (Certification Statement and Signature) and creates section standard across CMS-855 applications.
This creates a uniform standard across the CMS-855 applications.
Creates section standard across CMS-855 applications.
CMS-855B ends at Section 15 (Certification Statement and Signature) and creates section standard across CMS-855 applications.
Data fields reformatted to simplify for better provider understanding and creates a uniform wording standard across the CMS-855 applications.
This creates a uniform standard across the CMS-855 applications.
Removed because the color of ink was an unnecessary requirement causing processing delays for Medicare contractors. In addition, information technology has allowed many new submission avenues for providers to submit this application.
CMS-855B ends at Section 15 (Certification Statement and Signature) and creates section standard across CMS-855 applications.

2018 CMS-855B Application Revisions

Justification
CMS-855B ends at Section 15 (Certification Statement and Signature) and creates section standard across CMS-855 applications.
This creates a uniform standard across the CMS-855 applications.
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Justification
Error correction.