Ambulatory Surgical Center Request for Initial Certification or Update of Certification`Information in the Medicare Program (CMS-377)

CMS Certification Number: AS1	**State/County Code:** AS2	**State/Region Code:** AS3	
I. Identifying Information	**Name of ASC:**	**Street Address;**	
	City, State:	**Zip Code:**	**Telephone Number (10 digits):** AS4
II. Type of Control (Check only one box) AS5	☐ **Proprietary**	☐ **Government**	☐ **Non-Profit**
III. Ancillary Services (Select only one item from the dropdown menu for each service listed) AS6	**Laboratory Services** Select one of the following optio	**Radiology Services** Select one of the following options	**Pharmaceutical Services** Select one of the following optio
IV. Surgical Specialties (Check all that apply) AS7	☐ **1. Dental** ☐ **2. Endoscopy** ☐ **3. Ear, Nose & Throat**	☐ **4. OB/GYN** ☐ **5. Ophthalmologic** ☐ **6. Orthopedic**	☐ **7. Pain** ☐ **8. Podiatry** ☐ **9. Plastic/Reconstruction**
			☐ **10. Other (Specify)** **Other Specify:**
V. Facility Characteristics	A. Number of Operating Rooms: B. Number of Procedure Rooms: AS8	**C. Date this ASC began providing services:** AS9	

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ATTESTATION STATEMENT

I hereby certify that the responses in this form are true and correct to the best of my knowledge, information and belief. 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.

Printed Name of ASC Representative:	**Title of ASC Representative:**
Signature of ASC Representative:	**Date Signed by ASC Representative:** **AS10**

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 **0938-0266 (Expires XX/XX/20XX)**. This is a **mandatory** information collection. The time required to complete this information collection is estimated to average **30 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 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, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS Disclosure*

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 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 **Caroline Gallaher** at **caroline.gallaher@cms.hhs.gov.**

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INSTRUCTIONS

1. Submission of this form will initiate the process of obtaining a decision as to whether the Conditions for Coverage are met.
2. Assistance in completing the form is available from the State Survey agency for area in which the ASC is located.
3. The ASC must complete and sign the CMS-377 form for initial certifications and upon request of the State agency for the periodic recertification.
4. Answer all questions as of the current date.
5. Return the original and two copies of the completed CMS-377 form to the State Survey Agency. Retain a copy for your files.
6. The name and address of the State Survey agency for the area in which the ASC is located may be obtained from the appropriate CMS Location (formerly called CMS Regional Office). Please see the following link for additional information: http://www.cms.gov/RegionalOfices/
7. **CMS Certification Number (CCN):** Insert the facility's ten-digit CCN. Leave blank on initial requests for certification.
8. **State/County and State Region Codes -** The ASC should leave these fields blank.
9. **For Item Ill:**
   a. If a service is provided directly by the facility, select **"1"** from the drop down list.
   b. If a service is provided by an outside source by arrangement with the facility, select **"2'** from the drop down list.
   c. If the service is provided by both the facility and an outside source by arrangement with the facility, select **"3"** from the drop down list.
   d. If the service is not provided, do not make a selection.
10. **For 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