MEDICARE ENROLLMENT APPLICATION

PHYSICIANS AND NON-PHYSICIAN PRACTITIONERS

CMS-855I

SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION.

SEE PAGE 3 FOR INFORMATION ON WHERE TO MAIL THIS COMPLETED APPLICATION.

SEE SECTION 12 FOR A LIST OF SUPPORTING DOCUMENTATION TO BE SUBMITTED WITH THIS APPLICATION.

TO VIEW YOUR CURRENT MEDICARE ENROLLMENT RECORD GO TO:
PECOS.CMS.HHS.GOV

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

SECTION 1: BASIC INFORMATION

A. REASON FOR SUBMITTING THIS APPLICATION

Check one box and complete the sections of this application as indicated.

☒ You are a **new enrollee** in Medicare	**Complete all applicable sections**
☐ You are **currently enrolled in Medicare to order and certify** and want to **enroll as an Individual Practitioner**	**Complete all applicable sections**
☐ You are **enrolling with another Medicare Administrative Contractor (MAC)**	**Complete all applicable sections**
☐ You are **revalidating** your Medicare enrollment	**Complete all applicable sections**
☐ You are **reactivating** your Medicare enrollment	**Complete all applicable sections**
☐ You are **reporting a change** to your Medicare enrollment information (includes establishing or terminating a reassignment)	**Go to section 1B below**
☐ You are **voluntarily terminating** your Medicare enrollment Effective date of termination *(mm/dd/yyyy)*: _____	**Sections 1A, 2A, 13 (optional), and 15**

B. WHAT INFORMATION IS CHANGING?

Check all that apply and complete the required sections.

Please note: When reporting ANY information, sections 1, 2A, 3 and 15 MUST always be completed in addition to the information that is changing within the required section.

☐ Personal Identifying Information	**1, 2A, 3, 12, 13 (optional)** and **15**
☐ Final Adverse Legal Actions	**1, 2A, 3, 12, 13 (optional)** and **15**
☐ Medical Specialty Information	**1, 2A, 2G or 2H, 3, 4, 12, 13 (optional),** and **15**
☐ Practitioner Specific Information	**1, 2A, 2B–2F, 2I–2K (as applicable), 3, 12, 13 (optional),** and **15**
☐ Reassignment of Benefits Information	**1, 2A, 4F, 12, 13 (optional)** and **15**
☐ Private Practice Business Information	**1, 2A, 3, 4A, 12, 13 (optional)** and **15**
☐ Managing Employee Information	**1, 2A, 3, 6, 12, 13 (optional),** and **15**
☐ Address Information ☐ Correspondence Mailing Address ☐ Medical Record Correspondence Mailing Address ☐ Remittance Notices/Special Payment Mailing Address ☐ Medicare Beneficiary Medical Records Storage Address ☐ Practice Location Address	**1, 2A, 3, 12, 13 (optional) and 15 AND sections 2D, 2E, 4B, 4C, and/or 4D as applicable for the address that is being changed**
☐ Billing Agency Information	**1, 2A, 3, 6, 8, 13 (optional)** and **15**
☐ Any other information not specified above	**1, 2A, 3, 13 (optional)** and **15 and the applicable section or sub-section that is changing**

SECTION 2: PERSONAL IDENTIFYING INFORMATION

A. INDIVIDUAL INFORMATION

The provider's Name, Date of Birth, and Social Security Number must match his/her social security record.

First Name	Middle Initial	Last Name	Jr., Sr., M.D., etc.
Other Name, First	Middle Initial	Last Name	Jr., Sr., M.D., etc.

Type of Other Name

☐ Former or Maiden Name ☐ Professional Name ☐ Other *(Describe)*: _____

Social Security Number (SSN)	Date of Birth *(mm/dd/yyyy)*
Medicare Identification Number (PTAN) *(if issued)*	National Provider Identifier (NPI) (Type 1 – Individual)

Medical or other Professional School *(Training Institution, if non-MD)*	Year of Graduation *(yyyy)*

B. LICENSE/CERTIFICATION/REGISTRATION INFORMATION

Complete the appropriate subsection(s) below for your primary specialty type as you will report it in section 2G or 2H below, as applicable. If no subsection is associated with your primary specialty, report information relevant to your secondary specialty, as applicable. Report if you have a compact license. See definition on page 3.

1. Active License Information

☐ Active License ☐ Not Applicable

License Number	Effective Date *(mm/dd/yyyy)*	State Where Issued

Is this a compact license? ..... ○ Yes ○ No

2. Active Certification Information

NOTE: For physicians and non-physician practitioners with multiple certifications, report the active certification relating to your primary specialty as you report it in section 2G or 2H (below), as applicable. If no certification is associated with your primary specialty, report the certification(s) relevant to your secondary specialty, as applicable.

NOTE: If you are certified by a national entity, put the word "all" in the "State Where Issued" data field.

☐ Active Certification ☐ Not Applicable

Certification Number	Effective Date *(mm/dd/yyyy)*
Certifying Entity (Specialty Board, State, Other)	State Where Issued*

3. Drug Enforcement Agency (DEA) Registration Information

☐ Active DEA Registration ☐ Not Applicable

DEA Registration Number	Effective Date *(mm/dd/yyyy)*	State Where Issued

C. NEW PATIENT INFORMATION

Accepting New Patient Status: *(optional)*

Your response will be annotated in the Medicare Physician Compare Directory.

Are you currently accepting new Medicare patients? ..... ○ Yes ○ No

SECTION 2: PERSONAL IDENTIFYING INFORMATION *(Continued)*

D. CORRESPONDENCE MAILING ADDRESS

This is the address where correspondence will be sent directly to you 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.

☐ **Change** **Effective Date *(mm/dd/yyyy)*:** _____

Attention *(optional)*

Correspondence Mailing Address Line 1 *(P.O. Box or Street Name and Number)*

Correspondence Mailing Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number *(if applicable)*	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

E. MEDICAL RECORD CORRESPONDENCE ADDRESS

This is the address where the medical record correspondence will be sent to the provider listed in section 2A by your designated MAC. This information would be used for any medical record review requests.

NOTE: This section is not applicable for providers who reassign all of their benefits to an organization/group.

☐ Check here if your Medical Record Correspondence should be mailed to your Correspondence Address in section 2D (above) and skip this section.

If you are reporting a change to your Medical Record Correspondence Address, check the box below. This will replace any current Medical Record Correspondence Address on file.

☐ **Change** **Effective Date *(mm/dd/yyyy)*:** _____

Attention *(optional)*

Medical Record Correspondence Address Line 1 *(P.O. Box or Street Name and Number)*

Medical Record Correspondence Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number *(if applicable)*	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

F. RESIDENT INFORMATION

NOTE: Resident is defined as an individual who participates in an approved medical residency program.

1. Provide the name and address of the hospital/facility where you are a resident.

Name of Hospital or Facility

Street Address

City/Town	State	ZIP Code + 4

2. Are the services that you render at the hospital/facility shown in section 2F1 part of your requirements for graduation from a formal residency or program? ..... ○ Yes ○ No

Date of Completion: *(mm/dd/yyyy)* _____

SECTION 2: PERSONAL IDENTIFYING INFORMATION *(Continued)*

F. RESIDENT INFORMATION *(Continued)*

3. Do you also render services at other facilities or practice locations? ○ Yes ○ No

If yes, you must report these practice locations in section 4B and/or section 4F.

4. Are the services that you render in any of the practice locations you will be reporting in section 4B and/or section 4F part of your requirements for graduation from a residency program? ○ Yes ○ No

If yes, has the teaching hospital/facility reported in section 2F1 above agreed to incur all or substantially all of the costs of your training in the non-hospital/facility location? ○ Yes ○ No

G. PHYSICIAN SPECIALTY

Designate your primary specialty and all secondary specialty(s) below using:

P=Primary S=Secondary

You can only select one primary specialty. If you have multiple primary specialties, you must complete and submit a separate CMS-855I application for each primary specialty. You may select multiple secondary specialties. A physician must meet all federal and state requirements for the type of specialty(s) checked.

- ☐ Addiction Medicine
- ☐ Adult Congenital Heart Disease
- ☐ Advanced Heart Failure and Transplant Cardiology
- ☐ Allergy/Immunology
- ☐ Anesthesiology
- ☐ Cardiac Electrophysiology
- ☐ Cardiac Surgery
- ☐ Cardiovascular Disease (Cardiology)
- ☐ Chiropractic
- ☐ Colorectal Surgery (Proctology)
- ☐ Critical Care (Intensivists)
- ☐ Dentist
- ☐ Dermatology
- ☐ Diagnostic Radiology
- ☐ Emergency Medicine
- ☐ Endocrinology
- ☐ Family Medicine
- ☐ Gastroenterology
- ☐ General Practice
- ☐ General Surgery
- ☐ Geriatric Medicine
- ☐ Geriatric Psychiatry
- ☐ Gynecological Oncology
- ☐ Hand Surgery
- ☐ Hematology
- ☐ Hematology/Oncology
- ☐ Hematopoietic Cell Transplantation and Cellular Therapy
- ☐ Hospice/Palliative Care
- ☐ Hospitalist
- ☐ Infectious Disease
- ☐ Internal Medicine
- ☐ Interventional Cardiology
- ☐ Interventional Pain Management
- ☐ Interventional Radiology
- ☐ Maxillofacial Surgery
- ☐ Medical Genetics and Genomics
- ☐ Medical Oncology
- ☐ Medical Toxicology
- ☐ Micrographic Dermatologic Surgery
- ☐ Nephrology
- ☐ Neurology
- ☐ Neuropsychiatry
- ☐ Neurosurgery
- ☐ Nuclear Medicine
- ☐ Obstetrics/Gynecology
- ☐ Ophthalmology
- ☐ Optometry
- ☐ Oral Surgery
- ☐ Orthopedic Surgery
- ☐ Osteopathic Manipulative Medicine
- ☐ Otolaryngology
- ☐ Pain Management
- ☐ Pathology
- ☐ Pediatric Medicine
- ☐ Peripheral Vascular Disease
- ☐ Physical Medicine and Rehabilitation
- ☐ Plastic and Reconstructive Surgery
- ☐ Podiatry
- ☐ Preventive Medicine
- ☐ Psychiatry
- ☐ Pulmonary Disease
- ☐ Radiation Oncology
- ☐ Rheumatology
- ☐ Sleep Medicine
- ☐ Sports Medicine
- ☐ Surgical Oncology
- ☐ Thoracic Surgery
- ☐ Undersea and Hyperbaric Medicine
- ☐ Urology
- ☐ Vascular Surgery
- ☐ Undefined Physician Specialty *(Specify)*:_____

1. Does the physician identified in section 2A provide acupuncture services and meet all state laws and requirements regarding such services? ○ Yes ○ No

SECTION 2: PERSONAL IDENTIFYING INFORMATION *(Continued)*

H. ELIGIBLE PROFESSIONAL OR OTHER NON-PHYSICIAN SPECIALTY TYPE

If you are an eligible professional, check the appropriate box below to indicate your specialty.

Check only one of the following: If you have multiple non-physician specialty types, you must complete and submit a separate CMS-855I application for each non-physician specialty type.

All individuals must meet specific licensing, educational, and work experience requirements. Include copies of educational and certification information with this application. If you need information concerning the specific requirements for your specialty, contact your designated MAC.

- ☐ Anesthesiology Assistant
- ☐ Certified Nurse Midwife (CNM)
- ☐ Certified Registered Nurse Anesthetist (CRNA)
- ☐ Clinical Nurse Specialist (CNS) (See section 2K)
- ☐ Clinical Social Worker
- ☐ Mass Immunization Roster Biller
- ☐ Nurse Practitioner (See section 2K)
- ☐ Occupational Therapist in Private Practice (See section 2J)
- ☐ Physical Therapist in Private Practice (See section 2J)
- ☐ Physician Assistant
- ☐ Psychologist, Clinical (See section 2I)
- ☐ Psychologist Billing Independently (See section 2I2)
- ☐ Qualified Audiologist
- ☐ Qualified Speech Language Pathologist
- ☐ Registered Dietitian or Nutrition Professional
- ☒ Undefined Non-Physician Practitioner Specialty *(Specify)*: MARRIAGE AND FAMILY THERAPIST

1. Does the physician assistant, nurse practitioner, or clinical nurse specialist identified in section 2A provide acupuncture services and have: ..... ○ Yes ○ No

- A masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and
- A current, full, active, and unrestricted license to practice acupuncture in a state, territory, or commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia.

If yes, provide a current copy of certification and proof of educational requirements.

I. PSYCHOLOGIST INFORMATION

1. Clinical Psychologists

Identify the type of your doctoral psychology degree (e.g., Ph.D., Ed.D., Psy. D.)_____

A copy of the degree may be requested by the MAC.

NOTE: Federal regulations at 42 C.F.R. section 410.71(d) state that to qualify as a clinical psychologist, a practitioner must hold a doctoral degree in psychology, and be licensed or certified, on the basis of the doctoral degree in psychology, by the state in which he or she practices, at the independent practice level of psychology, to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

2. Psychologists Billing Independently

NOTE: CMS requires that independently practicing psychologists have a more limited benefit under the Medicare program than clinical psychologists. With a degree starting at the master's level of psychology, independently practicing psychologists are authorized to bill the program directly solely for diagnostic psychological and neuropsychological tests that have been ordered by a physician, clinical psychologist or non-physician practitioner who is authorized to order diagnostic tests. Independently practicing psychologists are not authorized to supervise diagnostic psychological and neuropsychological tests. Any tests performed by an independently practicing psychologist must fall under the psychologist's state scope of practice. Additional information can be found in Pub. 100–02, the Medicare Benefits Policy Manual.

a. Do you render services of your own responsibility free from the administrative control of an employer such as a physician, institution, or agency? ..... ○ Yes ○ No

b. Do you treat your own patients? ..... ○ Yes ○ No

c. Do you have the right to bill directly, and to collect and retain the fee for your services? ○ Yes ○ No

d. Is your private practice located in an institution or other facility? ○ Yes ○ No

If YES to question (d) above, answer questions 1 and 2 below.

1. If your private practice is located in an institution or other facility, is your office confined to a separately identified part of the institution/facility that is used solely as your office and cannot be construed as extending throughout the entire institution/facility? ○ Yes ○ No
2. If your private practice is located in an institution/facility, do you also render services to patients from outside the institution or facility where your office is located? ○ Yes ○ No

J. PHYSICAL/OCCUPATIONAL THERAPIST INFORMATION

Physical Therapists/Occupational Therapists in Private Practice (PT/OT)

The following questions only apply to your individual private practice. Do not complete this section if you are reassigning ***all*** of your benefits to a group/clinic/organization.

1. Do you **ONLY** render PT/OT services in the patients' homes? ○ Yes ○ No
2. Do you maintain private office space? ○ Yes ○ No
3. Do you own, lease, or rent your private office space? ○ Yes ○ No
4. Is this private office space used exclusively for your private practice? ○ Yes ○ No
5. Do you provide PT/OT services outside of your office and/or patients' homes? ○ Yes ○ No

If you responded YES to questions 2, 3 or 4 above, you must have and attach a copy of any written agreement that gives you exclusive use of the office space for PT/OT services.

K. CLINICAL NURSE SPECIALIST/NURSE PRACTITIONER INFORMATION

Clinical Nurse Specialists/Nurse Practitioners

Are you an employee of a skilled nursing facility (SNF) or of another entity that has an agreement to provide nursing services to a SNF? ○ Yes ○ No

If yes, furnish the SNF's name and address below.

Skilled Nursing Facility Name

Skilled Nursing Facility Street Address Line 1 *(Street Name and Number – Not a P.O. Box)*

Skilled Nursing Facility Street Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code +4

Tax Identification Number of SNF

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

NOTE: All individuals must meet specific licensing and educational requirements. Include copies of educational and certification information with this application.

SECTION 3: FINAL ADVERSE LEGAL ACTIONS

This section captures information regarding final adverse legal actions, such as convictions, exclusions, license revocations and license suspensions. All applicable final adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

NOTE: To satisfy the reporting requirement, section 3 must be filled out in its entirety, **and** all applicable attachments must be included.

A. FEDERAL AND STATE CONVICTIONS (CONVICTION AS DEFINED IN 42 C.F.R. SECTION 1001.2) WITHIN THE PRECEDING 10 YEARS

1. Any federal or state felony conviction(s) by the provider, supplier, or any owner or managing employee of the provider or supplier.
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.
3. Any misdemeanor conviction, under federal or state law, related to: (a) the delivery of an item or service under Medicare or a state health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
4. Any misdemeanor conviction, under federal or state law, related to the theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
5. Any misdemeanor conviction, under federal or state law, related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.
6. Any misdemeanor conviction, under federal or state law, related to the interference with or obstruction of any investigation into any criminal offence described in 42 C.F.R. section 1001.101 or 1001.201.

B. EXCLUSIONS, REVOCATIONS OR SUSPENSIONS

1. Any current or past revocation, suspension, or voluntary surrender of a medical license in lieu of further disciplinary action.
2. Any current or past revocation or suspension of accreditation.
3. Any current or past suspension or exclusion imposed by the U.S. Department of Health and Human Service's Office of Inspector General (OIG).
4. Any current or past debarment from participation in any Federal Executive Branch procurement or non-procurement program.
5. Any other current or past Federal Sanctions (A penalty imposed by a Federal governing body (e.g. Civil Monetary Penalties (CMP))).
6. Any current or past Medicaid exclusion, revocation, or termination of any billing number.

C. FINAL ADVERSE LEGAL ACTION HISTORY

1. Have you, under any current or former name, had a final adverse legal action **listed above** imposed against you?

   ○ YES – continue below

   ● NO – skip to section 4

2. If yes, report each final adverse legal action, when it occurred, and the federal or state agency or the court/ administrative body that imposed the action.

FINAL ADVERSE LEGAL ACTION	DATE	ACTION TAKEN BY

SECTION 4: BUSINESS INFORMATION

☒ If you do **NOT** have a private practice but you reassign **ALL** of your benefits to an organization/group or individual, check this box and only complete section 4F.

☐ If you **DO** have a private practice and you also reassign **ANY** of your benefits to an organization/group or individual, check this box and complete sections 4A – 4F.

☐ If you **DO** have a private practice and **ONLY** render services in your own private practice, check this box and complete sections 4A – 4E.

A. PRIVATE PRACTICE BUSINESS INFORMATION

Business Structure Information

Identify how your business is registered with the IRS:

☐ Proprietary ☐ Non-Profit (Submit IRS Form 501(c)(3) ☐ Disregarded Entity (Submit IRS Form 8832)

For the purposes of section 4A, if you are a:

- Professional Corporation, complete 4A1 and 4A2
- Professional Association, complete 4A1 and 4A2
- Limited Liability Company (LLC), including a single member LLC, complete 4A1 and 4A2
- Sole proprietor/Sole proprietorship, complete 4A3

1. Corporations, Associations and Limited Liability Company (LLC)

If your private practice is established as a professional corporation, professional association or limited liability company, including single member LLCs and you are the sole owner and will bill Medicare through this business entity, complete this section with information about your business entity.

NOTE: If you are filling out section 4A, you do not need to complete section 4F to reassign your benefits as a practitioner to your business entity.

NOTE: The LBN and TIN you furnish in section 4A must be the same LBN and TIN you used to obtain your NPI.

Legal Business Name as Reported to the Internal Revenue Service

Tax Identification Number	Medicare Identification Number (PTAN) *(if issued)*	NPI (Type 2 – Organization)

2. Final Adverse Legal Action History

Complete this section for your business as reported in section 4A1 above. If you need additional information regarding what to report, please refer to section 3 of this application.

NOTE: This section not required for Sole Proprietor/Sole Proprietorships.

a. Has your business, under any current or former name or business identity, had a final adverse legal action listed in section 3 of this application imposed against it?

○ YES – continue below

○ NO – skip to section 4

b. If yes, report each final adverse legal action, when it occurred, and the federal or state agency or the court/administrative body that imposed the action.

NOTE: To satisfy the reporting requirement, section 4A2 must be filled out in its entirety, **and** all applicable attachments must be included.

FINAL ADVERSE LEGAL ACTION	DATE	ACTION TAKEN BY

SECTION 4: BUSINESS INFORMATION *(Continued)*

3. Sole Proprietor/Sole Proprietorship

To qualify for this payment arrangement, you:

- Must be a sole proprietor;
- Must use **either** your EIN or SSN for all Medicare payments;
- Cannot reassign all of your Medicare payments, and
- Must submit a copy of your IRS Form CP-575 showing the LBN and EIN, if applicable.

☐ If you want your Medicare payments to be paid under your SSN, check this box and continue to section 4B.

☐ If you are a sole proprietor and want Medicare payments to be paid under your EIN, please check this box and fill in the EIN information below. Continue to section 4B.

Employer Identification Number (EIN)

B. PRACTICE LOCATION INFORMATION

NOTE: You do not need to complete this section if you are reassigning 100% of your Medicare benefits.

Complete this section for each of your practice locations where you render services to Medicare beneficiaries, including any distant site(s) where you render telehealth services. This includes all locations you will disclose on claims forms for reimbursement. If you have and see patients at more than one private practice location or health care facility, **copy and complete this section for each location.**

All reported practice location addresses must be a specific street address as recorded by the United States Postal Service. Your practice location must be the physical location where you render services to Medicare beneficiaries. Your practice location address cannot be a Post Office (P.O.) Box.

If you render services in a hospital, retirement or assisted living community, and/or other health care facilities, furnish the name, address and telephone number for those facilities.

If you only render services in patients' homes (house calls only), you may supply your home address in this section if you do not have a separate office. In section 4E3 explain that this address is for administrative purposes only and that all services are rendered in patients' homes. You must then also complete section 4E1 as appropriate.

Only report those practice locations that are within the jurisdiction of the designated MAC to which you will be submitting this application. If you have to report practice locations outside the jurisdiction of the designated MAC to which you are submitting this application you must submit a separate CMS-855I Enrollment Application to the MAC that has jurisdiction for those locations.

If you are changing information about a currently reported practice location or adding or removing practice location information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ **Change** ☐ **Add** ☐ **Remove** **Effective Date *(mm/dd/yyyy)*:** _____

Practice Location Name *("Doing Business As" Name)*

Practice Location Street Address Line 1 *(Street Name and Number – NOT a P.O. Box)*

Practice Location Street Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

Medicare Identification Number for this location – PTAN *(if issued)*	Date you saw or will see your first Medicare patient at this practice location *(mm/dd/yyyy)*

SECTION 4: BUSINESS INFORMATION *(Continued)*

B. PRACTICE LOCATION INFORMATION *(Continued)*

Is this your primary practice location?..... ○ Yes ○ No

Is your private practice location reported above located in a:

- ☐ Ambulatory Surgical Center
- ☐ Business Office for Administrative/Telehealth Use Only
- ☐ Home Office for Administrative/ Telehealth Use Only
- ☐ Hospital/Hospital Department
- ☐ Indian Health Services (IHS) or Tribal Facility
- ☐ Private Office Setting
- ☐ Retirement or Assisted Living Community
- ☐ Skilled Nursing Facility or Other Nursing Facility
- ☐ Other Health Care Facility (Specify):_____

C. REMITTANCE NOTICES/SPECIAL PAYMENTS MAILING ADDRESS

Furnish an address where remittance notices and special payments should be sent for services rendered at the practice location(s) reported in section 4B. 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.

Medicare will issue all routine payments via electronic funds transfer (EFT). Since payments will be made by EFT, the special payments address below should indicate where all other payment information (e.g., remittance notices, non-routine special payments) should be sent, **OR**,

- ☐ Check here if your Remittance Notice/Special Payments should be mailed to your Practice Location Address in section 4B and skip this section, **OR**
- ☐ Check here if your Remittance Notice/Special Payments should be mailed to your Correspondence Address in section 2D and skip this section.

If you are reporting a change to your Remittance Notice/Special Payments Mailing Address, check the box below and furnish the effective date.

☐ **Change** **Effective Date (mm/dd/yyyy):** _____

Special Payments Address Line 1 *(P.O. Box or Street Name and Number)*

Special Payments Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

SECTION 4: BUSINESS INFORMATION *(Continued)*

D. MEDICARE BENEFICIARY MEDICAL RECORDS STORAGE ADDRESS

If your Medicare beneficiaries' medical records are stored at a location other than the Practice Location Address shown in section 4B complete this section with the name and address of the storage location. This includes the records for both current and former Medicare beneficiaries.

Post office boxes and drop boxes are not acceptable as a physical address where Medicare beneficiaries' records are maintained. The records must be your records and not the records of another practitioner. If all records are stored at the practice location reported in section 4B, check the box below and skip this section.

☐ Records are stored at the practice location reported in section 4B.

If you are adding or removing a storage location, check the applicable box below and furnish the effective date.

☐ **Add** ☐ **Remove** **Effective Date *(mm/dd/yyyy)*:** _____

1. Paper Storage

Do you store your patient medical records in a physical location? ..... ○ Yes ○ No

Name of Storage Facility

Storage Facility Address Line 1 *(Street Name and Number)*

Storage Facility Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

2. Electronic Storage

Do you store your patient medical records electronically? ..... ○ Yes ○ No

If yes, identify where/how these records are stored below. This can be a website, URL, in-house software program, online service, vendor, etc. This must be a site that can be accessed by CMS or its designees if necessary.

Site where electronic records are stored

SECTION 4: BUSINESS INFORMATION *(Continued)*

E. RENDERING SERVICES IN PATIENTS' HOMES

List the city/town, county, state, or ZIP code for all locations where you render health care services in patients' homes or, if previously reported, where you no longer render health care services in patients' homes.

☐ **Change** **Effective Date *(mm/dd/yyyy)*:** _____

1. Initial Reporting and/or Additions

If you are reporting or adding an entire state, check the box below and specify the state.

☐ Entire State of _____

If services are only provided in selected cities/towns or counties, provide the locations below. Only list ZIP codes if you are not servicing the entire city/town or county.

CITY/TOWN	COUNTY	STATE/TERRITORY	ZIP CODE

2. Deletions

If you are deleting an entire state, check the box below and specify the state.

☐ Entire State of _____

If services are no longer provided in selected cities/towns or counties, provide the locations below. Only list ZIP codes if you are not deleting service in the entire city/town or county.

CITY/TOWN	COUNTY	STATE/TERRITORY	ZIP CODE

3. Comments/Special Circumstances

Explain any unique circumstances concerning your practice location(s) or the method by which you render health care services (e.g., practice on certain days of the week).

SECTION 4: BUSINESS INFORMATION *(Continued)*

F. INDIVIDUAL/ORGANIZATION/GROUP RECEIVING THE REASSIGNED BENEFITS

NOTE: All reassignment actions should now be reported via the CMS-855I. The CMS-855R (Reassignment of Medicare Benefits) form has been discontinued.

Complete this section if you are:

1. An individual practitioner reassigning your right to bill the Medicare program and receive Medicare payments for some or all of the services you render to Medicare beneficiaries, terminating a currently established reassignment of benefits, making a change in reassignment of Medicare benefit information; or
2. An organization/group accepting a new reassignment of Medicare benefits from the individual practitioner identified in section 2A, terminating a currently established reassignment of benefits from the individual practitioner identified in section 2A, or making a change in reassignment of Medicare benefit information, between the organization/group and the individual practitioner identified in section 2A.

The individual or delegated/authorized official, by his/her signature, agrees to notify the Medicare Administrative Contractor (MAC) of any future changes to this reassignment in accordance with 42 C.F.R. section 424.516(d)(2).

Both the individual practitioner and the eligible organization/group must be currently enrolled (or concurrently enrolling via submission of the CMS-855B for the eligible organization/group and the CMS-855I for the individual practitioner) in the Medicare program before the reassignment can take effect.

If you reassign benefits to more than one organization/group, copy and complete this page as necessary.

NOTE: Revalidation applications must list all active reassignments.

1. Individual Practitioner Receiving Reassigned Benefits Identification

Provide the information below for the individual to whom benefits are being reassigned, or a reassignment is being terminated. If the individual's initial enrollment application is being submitted concurrently with this reassignment, write "pending" in the Medicare identification number block. The individual's name as reported to the Social Security Administration must be the same as reported on the individual's CMS-855I when the individual enrolled. If the individual is a sole proprietor with an Employee Identification Number (EIN), check the appropriate box and report the EIN.

☐ **Change** ☐ **Add** ☐ **Terminate** **Effective Date *(mm/dd/yyyy)*:** _____

First Name	Middle Initial	Last Name	Jr., Sr., M.D., etc.

☐ Social Security Number (SSN) (List number below if applicable)	☐ Employer Identification Number (EIN) (List number below if applicable)
Medicare Identification Number (PTAN) (if issued)	**National Provider Identifier (NPI)**

2. Organization/Group Receiving Reassigned Benefits Identification

Provide the information below for the organization/group to which benefits are being reassigned, or a reassignment is being terminated. If the organization/group's initial enrollment application is being submitted concurrently with this reassignment application, write "pending" in the Medicare identification number block. The organization/group's name as reported to the IRS must be the same as reported on the organization/group's CMS-855B when it enrolled.

☐ **Change** ☒ **Add** ☐ **Terminate** **Effective Date (*mm/dd/yyyy*):** 01/01/2024

Organization/Group Legal Business Name (as Reported to the Internal Revenue Service)

SAN MATEO COUNTY

Tax Identification Number (TIN)	Medicare Identification Number (PTAN) (if issued)	National Provider Identifier (NPI)
946000532	ZZZ80499Z	1053367854
946000532	ZZZ80500Z	1710908272
946000532	ZZZ80501Z	1912926692

SECTION 4: BUSINESS INFORMATION *(Continued)*

3. Primary Practice Location(s) *(Optional)*

a. Primary Practice Location
Identify the primary practice location of the organization/group where the individual practitioner will render in-person services most of the time. This practice location must be currently enrolled or enrolling in Medicare.

If you are changing information about a currently reported primary practice location or adding or removing primary practice location information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ **Change** ☐ **Add** ☐ **Remove** **Effective Date *(mm/dd/yyyy)*:** _____

Practice Location Name *("Doing Business As" Name)*

Practice Location Street Address Line 1 *(Street Name and Number – NOT a P.O. Box)*

Practice Location Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

Medicare Identification Number for this location – PTAN *(if issued)*	National Provider Identifier (NPI)

b. Secondary Practice Location
Identify a secondary practice location of the organization/group where the individual practitioner will render in-person services most of the time. This practice location must be currently enrolled or enrolling in Medicare.

If you are changing information about a currently reported additional practice location or adding or removing an additional practice location information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ **Change** ☐ **Add** ☐ **Remove** **Effective Date *(mm/dd/yyyy)*:** _____

Practice Location Name *("Doing Business As" Name)*

Practice Location Street Address Line 1 *(Street Name and Number – NOT a P.O. Box)*

Practice Location Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

Medicare Identification Number for this location – PTAN *(if issued)*	National Provider Identifier (NPI)

SECTION 5: THIS SECTION INTENTIONALLY LEFT BLANK

SECTION 6: MANAGING EMPLOYEE INFORMATION

This section captures information about your managing employees. A managing employee means an individual who furnishes operational or managerial services, or who directly or indirectly conducts the day-to-day operations for your private practice, either as an employee or through some other arrangement.

NOTE: You do not need to complete this section if you are reassigning 100% of your Medicare benefits.

All managing employees at all of your practice locations reported in section 4 must be reported in this section. If there is more than one managing employee, copy and complete this section as needed.

NOTE: If you completed section 4 reporting that your private practice is established as a business entity, you must report at least one managing employee in accordance with Medicare policy for enrolling a business entity.

☐ I am the managing employee. Skip to section 8.

A. MANAGING EMPLOYEE IDENTIFYING INFORMATION

If you are changing information about your current managing employee or adding or removing a managing employee, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ **Change** ☐ **Add** ☐ **Remove** **Effective Date *(mm/dd/yyyy)*:** _____

First Name	Middle Initial	Last Name	Jr., Sr., M.D., etc.

Social Security Number	Date of Birth *(mm/dd/yyyy)*

Medicare Identification Number *(if issued)*	NPI *(if issued)*

Telephone Number	Fax Number *(if applicable)*	E-mail Address

1. What is the above individual's relationship with the practitioner in section 2A?

☐ Contracted Managing Employee

☐ W-2 Managing Employee

B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for the individual reported in section 6A above. If you need additional information regarding what to report, please refer to section 3 of this application.

1. Has this individual in section 6A above, under any current or former name, had a final adverse legal action listed in section 3 of this application imposed against him/her?

   ○ YES – continue below

   ● NO – skip to section 8.

2. If yes, report each final adverse legal action, when it occurred, and the federal or state agency or the court/administrative body that imposed the action.

NOTE: To satisfy the reporting requirement, section 6B2 must be filled out in its entirety, **and** all applicable attachments must be included.

FINAL ADVERSE LEGAL ACTION	DATE	ACTION TAKEN BY

SECTION 7: THIS SECTION INTENTIONALLY LEFT BLANK

SECTION 8: BILLING AGENCY/AGENT INFORMATION

A billing agency/agent is a company or individual that you contract with to prepare and submit your claims. If you use a billing agency/agent you must complete this section. Even if you use a billing agency/agent, you remain responsible for the accuracy of the claims submitted on your behalf.

NOTE: The billing agency/agent address cannot be the correspondence mailing address completed in section 2D of this application.

NOTE: You do not need to complete this section if you are reassigning 100% of your Medicare benefits.

☒ Check here if this section does not apply and skip to section 12.

If you are changing information about your current billing agency/agent or adding or removing a billing agency/agent information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ **Change** ☐ **Add** ☐ **Remove** **Effective Date *(mm/dd/yyyy)*:** _____

BILLING AGENCY/AGENT NAME AND ADDRESS

Legal Business Name as Reported to the Internal Revenue Service **or** Individual Name as reported to the Social Security Administration

If Individual Billing Agent: Date of Birth *(mm/dd/yyyy)*

Billing Agency Tax Identification Number **or** Billing Agent Social Security Number **(required)**

Billing Agency/Agent "Doing Business As" Name *(if applicable)*

Billing Agency/Agent Address Line 1 *(Street Name and Number)*

Billing Agency/Agent Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town		State	ZIP Code + 4
Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*	

SECTION 9: THIS SECTION INTENTIONALLY LEFT BLANK

SECTION 10: THIS SECTION INTENTIONALLY LEFT BLANK

SECTION 11: THIS SECTION INTENTIONALLY LEFT BLANK

SECTION 12: SUPPORTING DOCUMENTATION INFORMATION

This section lists the documents that, if applicable, must be submitted with this completed enrollment application. If you are enrolling for the first time, or reactivating or revalidating your enrollment you must submit applicable documents. When reporting a change of information, only submit documents that applicable the change reported. Your designated Medicare Administrative Contractor (MAC) may request, at any time during the enrollment process, documentation to support or validate information reported on this application. In addition, your designated MAC may also request documents from you other than those identified in this section as are necessary to ensure correct billing of Medicare.

☐ Copy(s) of all final adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters).

☐ Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement.

NOTE: The CMS-460 must be submitted for all initial enrollments or reactivations only if you want to be a Participating Practitioner in Medicare.

☐ Completed Form CMS-588, Electronic Funds Transfer Authorization Agreement. Include a voided check or bank letter.

NOTE: If you currently receive payments electronically and are not making a change to your banking information, the CMS-588 is not required. Physicians and non-physician practitioners who are reassigning all of their payments to a group/clinic or other health care organization are not required to submit the CMS-588.

☐ If Medicare payments due to you are being sent to a bank (or similar financial institution) where you have a lending relationship (that is, any type of loan), you must provide a statement in writing from the bank (which must be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.

☐ Written confirmation from the IRS confirming your Tax Identification Number and Legal Business Name provided in section 4A (e.g., IRS form CP-575).

NOTE: This information is needed if the applicant is enrolling their professional corporation, professional association, or limited liability corporation with this application or enrolling as a sole proprietor using an Employer Identification Number.

NOTE: Government-owned entities do not need to provide an IRS Form 501(c)(3).

☐ Written confirmation from the IRS if your business is registered as a Limited Liability Company (LLC), including single member LLCs, confirming your LLC is automatically classified as a Disregarded Entity (e.g., IRS Form 8832).

NOTE: A Disregarded Entity is an eligible entity that is not treated as a separate entity from its single owner for income tax purposes.

☐ Copy of IRS Determination Letter if you are registered with the IRS as non-profit (e.g., IRS Form 501(c)(3)).

NOTE: Government-owned entities do not need to provide an IRS Form 501(c)(3).

☒ Current copy of certification and proof of educational requirements for eligible professionals or other non-physician specialty types who provide acupuncture services.

SECTION 13: CONTACT PERSON INFORMATION *(Optional)*

If questions arise during the processing of this application, your designated MAC will contact the individual reported below.

☐ Assign the individual listed in section 2A of this application as the designated contact person.

☐ **Change** ☐ **Add** ☐ **Remove** **Effective Date *(mm/dd/yyyy)*:** _____

First Name	Middle Initial	Last Name	Jr., Sr., MD., etc.

Contact Person Address Line 1 *(Street Name and Number)*

Contact Person Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

Relationship or Affiliation to Individual or Organization/Group *(Spouse, Secretary, Attorney, Billing Agent, etc.)*

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: PENALTIES FOR FALSIFYING INFORMATION ON THIS APPLICATION

This section explains the penalties for deliberately furnishing false information in this application to gain or maintain enrollment in the Medicare program.

1. 18 U.S.C. section 1001 authorizes criminal penalties against an individual who, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious, or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000 (18 U.S.C. section 3571). section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.
2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against any individual who, "knowingly and willfully," makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a federal health care program. The offender is subject to fines of up to $25,000 and/or imprisonment for up to five years.
3. The Civil False Claims Act, 31 U.S.C. § 3729, imposes civil liability, in part, on any person who, with actual knowledge, deliberate ignorance or reckless disregard of truth or falsity (a) presents or causes to be presented to the United States Government or its contractor or agent a false or fraudulent claim for payment or approval; (b) uses or causes to be used a false record or statement material either to a false or fraudulent claim or to an obligation to pay the Government; (c) conceals or improperly avoids or decreases an obligation to pay or transmit money or property to the Government; or (d) conspires to violate any provision of the False Claims Act. The False Claims Act imposes a civil penalty of between $5,000 and $10,000 per violation, as adjusted for inflation by the Federal Civil Penalties Inflation Adjustment Act, 28 U.S.C. 2461, plus three times the amount of damages sustained by the Government.
4. Section 1128A(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any state agency…a claim…that the Secretary determines is for a medical or other item or service that the person knows or should know:
   a) was not provided as claimed; and/or
   b) the claim is false or fraudulent.

   This provision authorizes a civil monetary penalty of up to $10,000 for each item or service, an assessment of up to three times the amount claimed, and exclusion from participation in the Medicare program and state health care programs.
5. 18 U.S.C. 1035 authorizes criminal penalties against individuals in any matter involving a health care benefit program who knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact; or makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items or services. The individual shall be fined or imprisoned up to 5 years or both.
6. 18 U.S.C. 1347 authorizes criminal penalties against individuals who knowing and willfully execute, or attempt, to executive a scheme or artifice to defraud any health care benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by or under the control of any, health care benefit program in connection with the delivery of or payment for health care benefits, items, or services. Individuals shall be fined or imprisoned up to 10 years or both. If the violation results in serious bodily injury, an individual will be fined or imprisoned up to 20 years, or both. If the violation results in death, the individual shall be fined or imprisoned for any term of years or for life, or both.
7. The United States Government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment."

   Remedies include compensatory and punitive damages, restitution, and recovery of the amount of the unjust profit.

SECTION 15: CERTIFICATION STATEMENT AND SIGNATURE

As an individual practitioner, you are the only person who can sign this application. The authority to sign the application on your behalf may not be delegated to any other person.

The Certification Statement contains certain standards that must be met for initial and continuous enrollment in the Medicare program. Review these requirements carefully.

By signing this Certification Statement, you agree to adhere to all of the requirements listed therein and acknowledge that you may be denied entry into or have your billing privileges revoked from the Medicare program if any requirements are not met.

Title XVIII of the Social Security Act prohibits payment for services provided by an individual practitioner to be paid to another individual or organization/group unless the individual practitioner who provided the services specifically authorizes another individual or organization/group to receive said payments in accordance with 42 C.F.R. section 424.73 and 42 C.F.R. section 424.80. By signing this Certification Statement, you are authorizing the organization/group or individual identified in Section 4F to receive Medicare payments on your behalf. The signature(s) below authorize the reassignment of benefits, or the termination of a reassignment of benefits, between the individual practitioner shown in Section 2A and the organization/group or individual shown in Section 4F. The employment of, or contract between, the individual practitioner and organization/group or individual must be in compliance with CMS regulations and applicable Medicare program safeguard standards described in 42 C.F.R. section 424.80. These signatures also serve as an attestation and acknowledgment to the compliance with all laws and regulations pertaining to the reassignment of Medicare benefits. **NOTE: this language only applies if the application is submitted to establish, change or terminate a reassignment of benefits.**

A. CERTIFICATION STATEMENT

You **MUST** sign and date the certification statement below in order to be enrolled in the Medicare program. In doing so, you are attesting to meeting and maintaining the Medicare requirements stated below.

Under the penalty of perjury, I, the undersigned, certify to the following:

1. I have read the contents of this application, and the information contained herein is true, correct, and complete. If I become aware that any information in this application is not true, correct or complete, I agree to notify my designated Medicare Administrative Contractor of this fact in accordance with the time frames established in 42 C.F.R. section 424.516.
2. I authorize the Medicare Administrative Contractor to verify the information contained herein. I agree to notify the Medicare Administrative Contractor of any change in practice location, final adverse legal action, or any other changes to the information in this form in accordance with the timeframes established in 42 C.F.R. section 424.516. I understand that any change to my status as an individual practitioner may require the submission of a new application. I understand that any change in the business structure of my private practice may require the submission of a new application.
3. I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any alteration of any text on this application, may be punishable by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare billing privileges, and/or the imposition of fines, civil damages, and/or imprisonment.
4. I agree to abide by the Medicare laws, regulations and program instructions that apply to me or to the organization listed in section 4A of this application. The Medicare laws, regulations, and program instructions are available through the Medicare Administrative Contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations and program instructions (including, but not limited to, the Federal Anti-Kickback Statute, 42 U.S.C. section 1320a-7b(b) (section 1128B(b) of the Social Security Act) and the Physician Self-Referral Law (Stark Law), 42 U.S.C. section 1395nn (section 1877 of the Social Security Act)).
5. Neither I, nor any managing employee reported in this application, is currently sanctioned, suspended, debarred or excluded by Medicare or a State Health Care Program (e.g., Medicaid program), or any other Federal program, or is otherwise prohibited from providing services to Medicare or other federal program beneficiaries.

SECTION 15: CERTIFICATION STATEMENT AND SIGNATURE *(Continued)*

6. I agree that any existing or future overpayment made to me, or to my business as reported in section 4A, by the Medicare program, may be recouped by Medicare through the withholding of future payments.
7. I understand that the Medicare identification number (PTAN) issued to me can only be used by me or by a Medicare enrolled provider or supplier to whom I have reassigned my benefits under current Medicare regulations when billing for services rendered by me.
8. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.
9. I further certify that I am the individual practitioner who is applying for Medicare billing privileges and the signature below is my signature.

B. SIGNATURE AND DATE

First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.

Practitioner Signature ***(First, Middle, Last Name, Jr., Sr., M.D., etc.)***	**Date Signed** ***(mm/dd/yyyy)***

In order to process this application it MUST be signed and dated.

C. DELEGATED OR AUTHORIZED OFFICIAL OF INDIVIDUAL/ORGANIZATION/GROUP CERTIFICATION STATEMENT AND SIGNATURE

Only complete this section if you are a Delegated/Authorized Official of an organization/group or an individual practitioner receiving reassigned benefits and are accepting a new reassignment of Medicare benefits, terminating a reassignment of Medicare benefits, or making a change in reassignment of Medicare benefit information in Section 4F, between yourself and the individual practitioner listed in Section 2A.

Under penalty of perjury, I, the undersigned, certify that the above information is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me and/or the organization/group to liability under civil and criminal laws.

Delegated or Authorized Official's First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.

Delegated or Authorized Official's Signature ***(First, Middle, Last Name, Jr., Sr., M.D., etc.)***	**Date Signed** ***(mm/dd/yyyy)***

In order to process this application it MUST be signed and dated.

MEDICARE SUPPLIER ENROLLMENT APPLICATION PRIVACY ACT STATEMENT

The Authority for maintenance of the system is given under provisions of sections 1102(a) (Title 42 U.S.C. 1302(a)), 1128 (42 U.S.C. 1320a–7), 1814(a)) (42 U.S.C. 1395f(a)(1), 1815(a) (42 U.S.C. 1395g(a)), 1833(e) (42 U.S.C. 1395I(3)), 1871 (42 U.S.C. 1395hh), and 1886(d)(5)(F), (42 U.S.C. 1395ww(d)(5)(F) of the Social Security Act; 1842(r) (42 U.S.C. 1395u(r)); section 1124(a)(1) (42 U.S.C. 1320a–3(a)(1), and 1124A (42 U.S.C. 1320a–3a), section 4313, as amended, of the BBA of 1997; and section 31001(i) (31 U.S.C. 7701) of the DCIA (Pub. L. 104–134), as amended.

The information collected here will be entered into the Provider Enrollment, Chain and Ownership System (PECOS).

PECOS will collect information provided by an applicant related to identity, qualifications, practice locations, ownership, billing agency information, reassignment of benefits, electronic funds transfer, the NPI and related organizations. PECOS will also maintain information on business owners, chain home offices and provider/chain associations, managing/directing employees, partners, authorized and delegated officials, supervising physicians of the supplier, ambulance vehicle information, and/or interpreting physicians and related technicians. This system of records will contain the names, social security numbers (SSN), date of birth (DOB), and employer identification numbers (EIN) and NPI's for each disclosing entity, owners with 5 percent or more ownership or control interest, as well as managing/directing employees. Managing/directing employees include general manager, business managers, administrators, directors, and other individuals who exercise operational or managerial control over the provider/ supplier. The system will also contain Medicare identification numbers (i.e., CCN, PTAN and the NPI), demographic data, professional data, past and present history as well as information regarding any adverse legal actions such as exclusions, sanctions, and felonious behavior.

The Privacy Act permits CMS to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. Any such disclosure of data is known as a "routine use." The CMS will only release PECOS information that can be associated with an individual as provided for under Section III "Proposed Routine Use Disclosures of Data in the System." Both identifiable and non-identifiable data may be disclosed under a routine use. CMS will only collect the minimum personal data necessary to achieve the purpose of PECOS. Below is an abbreviated summary of the six routine uses. To view the routine uses in their entirety go to: **CMS.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/Downloads/0532-PECOS.pdf**.

1. To support CMS contractors, consultants, or grantees, who have been engaged by CMS to assist in the performance of a service related to this collection and who need to have access to the records in order to perform the activity.
2. To assist another Federal or state agency, agency of a state government or its fiscal agent to:
   a. Contribute to the accuracy of CMS's proper payment of Medicare benefits,
   b. Enable such agency to administer a Federal health benefits program that implements a health benefits program funded in whole or in part with federal funds, and/or
   c. Evaluate and monitor the quality of home health care and contribute to the accuracy of health insurance operations.
3. To assist an individual or organization for research, evaluation or epidemiological projects related to the prevention of disease or disability, or the restoration or maintenance of health, and for payment related projects.
4. To support the Department of Justice (DOJ), court or adjudicatory body when:
   a. The agency or any component thereof, or
   b. Any employee of the agency in his or her official capacity, or
   c. Any employee of the agency in his or her individual capacity where the DOJ has agreed to represent the employee, or
   d. The United States Government, is a party to litigation and that the use of such records by the DOJ, court or adjudicatory body is compatible with the purpose for which CMS collected the records.
5. To assist a CMS contractor that assists in the administration of a CMS administered health benefits program, or to combat fraud, waste, or abuse in such program.
6. To assist another Federal agency to investigate potential fraud, waste, or abuse in, a health benefits program funded in whole or in part by Federal funds.

The applicant should be aware that the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503) amended the Privacy Act, 5 U.S.C. section 552a, to permit the government to verify information through computer matching.

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 0938-1355 (Expires 05/2026). The time required to complete this information collection is estimated to average 0.5 – 3 hours 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 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 visit CMS.gov/Medicare/Provider-Enrollment-and-Certification.**