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NGS PROVIDER EXPERIENCE
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Submitting Revalidation via CMS-855A Paper Application for Part A Providers

5/9/2023

NGSMU

1857_0223

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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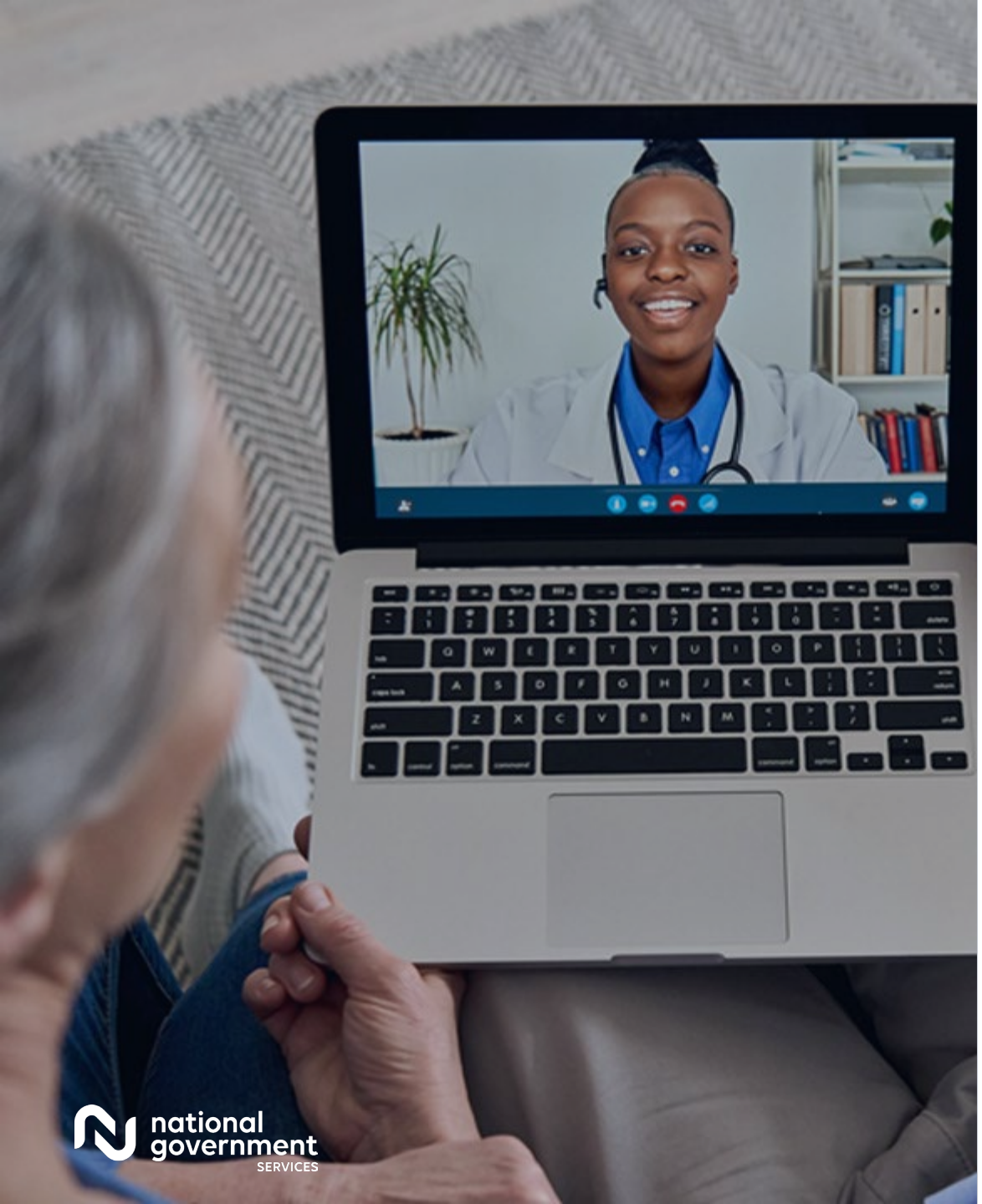

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Today's Presenters

NGS PROVIDER EXPERIENCE
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- Laura Brown, CPC
- Susan Stafford PMP, COA, AMR

Agenda

- Completing Each Section and Tips to Avoid Processing Delays
- Supporting Documentation
- Process After Submission
- Check Application Status
- Resources

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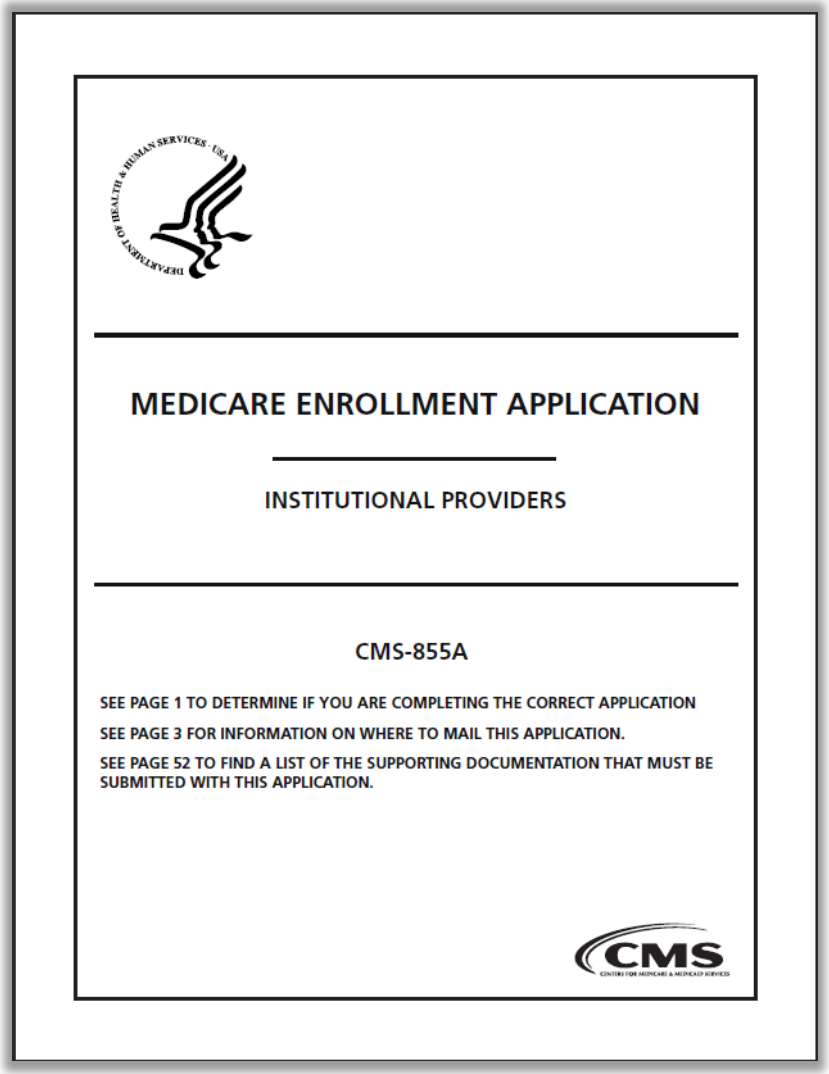
CMS-855A Paper Application

CMS-855A



MEDICARE ENROLLMENT APPLICATION

INSTITUTIONAL PROVIDERS

CMS-855A

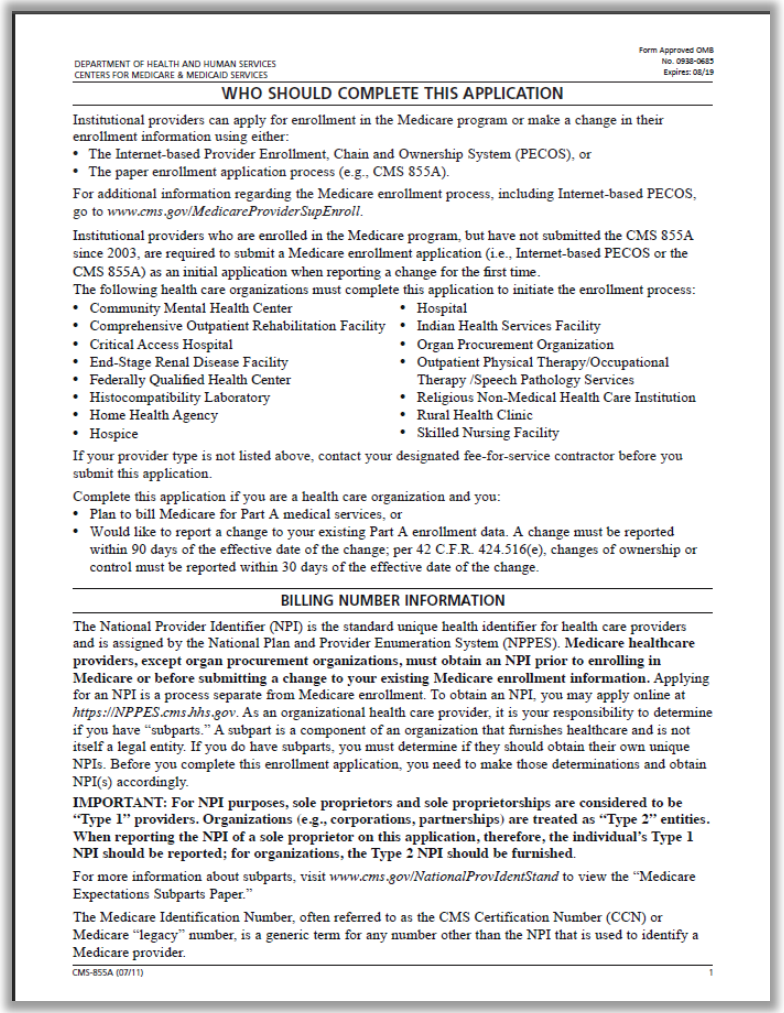
SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION

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

SEE PAGE 52 TO FIND A LIST OF THE SUPPORTING DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION.

Who Should Complete This Application

- All institutional providers, including
  - HHA
  - Hospice
  - FQHC
- Billing Number Information
  - National Provider Identifier (NPI)
    - ✓ Sole Proprietors NPI Type 1
    - ✓ Organizations NPI Type 2
  - Medicare Identification Number
    - ✓ CMS Certification Number (CCN)



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

Form Approved OMB
No. 0938-0685
Expires: 08/19

WHO SHOULD COMPLETE THIS APPLICATION

Institutional providers can apply for enrollment in the Medicare program or make a change in their enrollment information using either:

- The Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or
- The paper enrollment application process (e.g., CMS 855A).

For additional information regarding the Medicare enrollment process, including Internet-based PECOS, go to *www.cms.gov/MedicareProviderSupEnroll*.

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.

The following health care organizations must complete this application to initiate the enrollment process:

- Community Mental Health Center
- Comprehensive Outpatient Rehabilitation Facility
- Critical Access Hospital
- End-Stage Renal Disease Facility
- Federally Qualified Health Center
- Histocompatibility Laboratory
- Home Health Agency
- Hospice
- Hospital
- Indian Health Services Facility
- Organ Procurement Organization
- Outpatient Physical Therapy/Occupational Therapy /Speech Pathology Services
- Religious Non-Medical Health Care Institution
- Rural Health Clinic
- Skilled Nursing Facility

If your provider type is not listed above, contact your designated fee-for-service contractor before you submit this application.

Complete this application if you are a health care organization and you:

- Plan to bill Medicare for Part A medical services, or
- Would like to report a change to your existing Part A enrollment data. A change must be reported within 90 days of the effective date of the change; per 42 C.F.R. 424.516(e), changes of ownership or control must be reported within 30 days of the effective date of the change.

BILLING NUMBER INFORMATION

The National Provider Identifier (NPI) is the standard unique health identifier for health care providers and is assigned by the National Plan and Provider Enumeration System (NPPES). **Medicare healthcare providers, except organ procurement organizations, must obtain an NPI prior to enrolling in Medicare or before submitting a change to your existing Medicare enrollment information.** Applying for an NPI is a process separate from Medicare enrollment. To obtain an NPI, you may apply online at *https://NPPES.cms.hhs.gov*. As an organizational health care provider, it is your responsibility to determine if you have "subparts." A subpart is a component of an organization that furnishes healthcare and is not itself a legal entity. If you do have subparts, you must determine if they should obtain their own unique NPIs. Before you complete this enrollment application, you need to make those determinations and obtain NPI(s) accordingly.

IMPORTANT: For NPI purposes, sole proprietors and sole proprietorships are considered to be "Type 1" providers. Organizations (e.g., corporations, partnerships) are treated as "Type 2" entities. When reporting the NPI of a sole proprietor on this application, therefore, the individual's Type 1 NPI should be reported; for organizations, the Type 2 NPI should be furnished.

For more information about subparts, visit *www.cms.gov/NationalProvIdentStand* to view the "Medicare Expectations Subparts Paper."

The Medicare Identification Number, often referred to as the CMS Certification Number (CCN) or Medicare "legacy" number, is a generic term for any number other than the NPI that is used to identify a Medicare provider.

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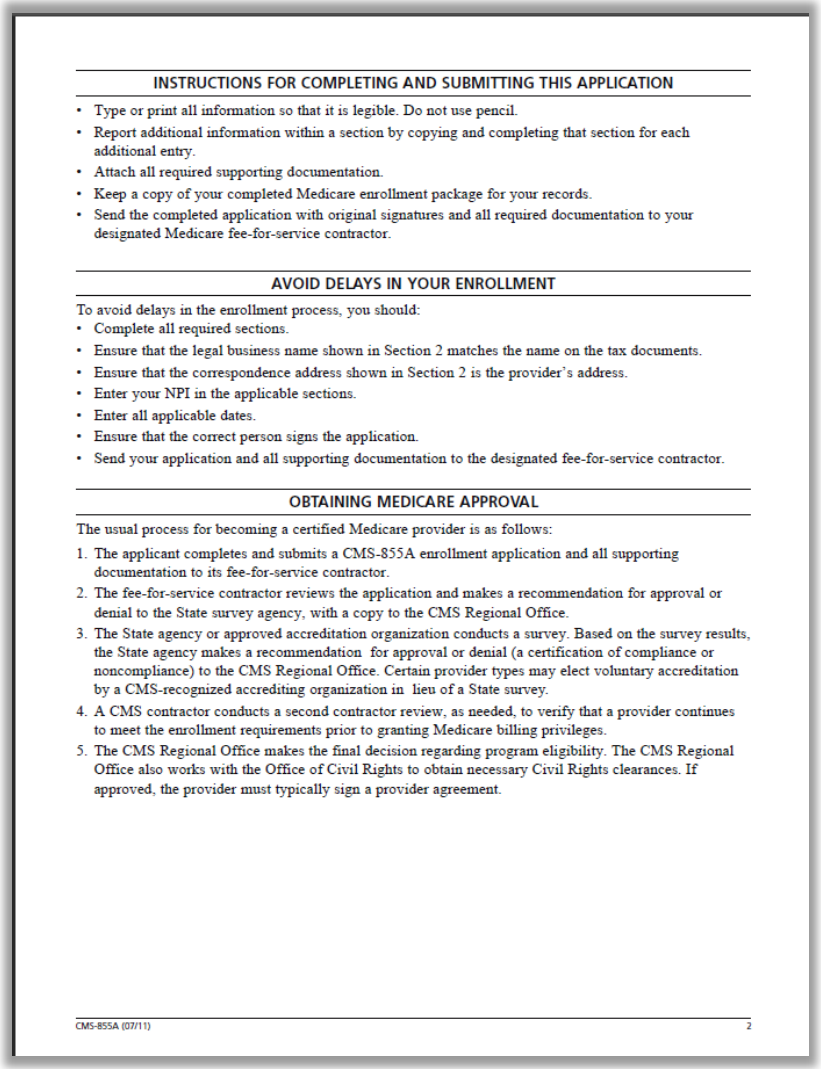
Additional Instructions



INSTRUCTIONS FOR COMPLETING AND SUBMITTING THIS APPLICATION

- Type or print all information so that it is legible. Do not use pencil.
- Report additional information within a section by copying and completing that section for each additional entry.
- Attach all required supporting documentation.
- Keep a copy of your completed Medicare enrollment package for your records.
- Send the completed application with original signatures and all required documentation to your designated Medicare fee-for-service contractor.

AVOID DELAYS IN YOUR ENROLLMENT

To avoid delays in the enrollment process, you should:

- Complete all required sections.
- Ensure that the legal business name shown in Section 2 matches the name on the tax documents.
- Ensure that the correspondence address shown in Section 2 is the provider's address.
- Enter your NPI in the applicable sections.
- Enter all applicable dates.
- Ensure that the correct person signs the application.
- Send your application and all supporting documentation to the designated fee-for-service contractor.

OBTAINING MEDICARE APPROVAL

The usual process for becoming a certified Medicare provider is as follows:

1. The applicant completes and submits a CMS-855A enrollment application and all supporting documentation to its fee-for-service contractor.
2. The fee-for-service contractor reviews the application and makes a recommendation for approval or denial to the State survey agency, with a copy to the CMS Regional Office.
3. The State agency or approved accreditation organization conducts a survey. Based on the survey results, the State agency makes a recommendation for approval or denial (a certification of compliance or noncompliance) to the CMS Regional Office. Certain provider types may elect voluntary accreditation by a CMS-recognized accrediting organization in lieu of a State survey.
4. A CMS contractor conducts a second contractor review, as needed, to verify that a provider continues to meet the enrollment requirements prior to granting Medicare billing privileges.
5. The CMS Regional Office makes the final decision regarding program eligibility. The CMS Regional Office also works with the Office of Civil Rights to obtain necessary Civil Rights clearances. If approved, the provider must typically sign a provider agreement.

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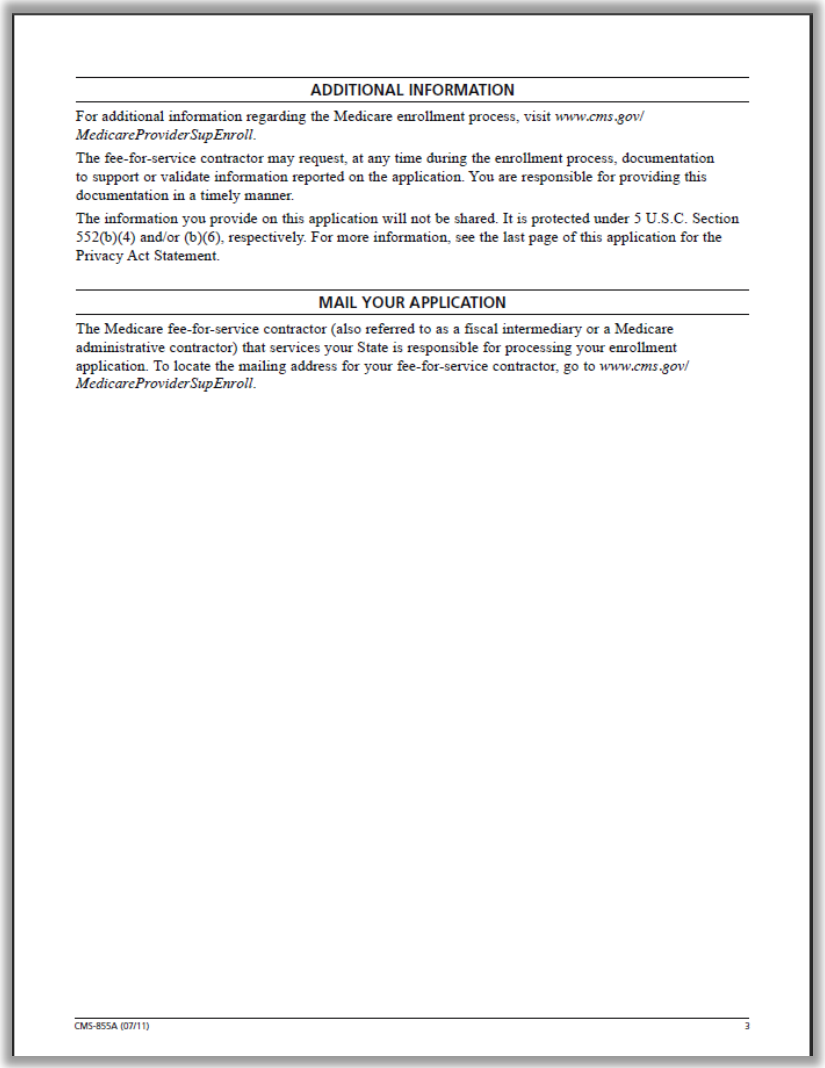

ADDITIONAL INFORMATION

For additional information regarding the Medicare enrollment process, visit *www.cms.gov/MedicareProviderSupEnroll*.

The fee-for-service contractor may request, at any time during the enrollment process, documentation to support or validate information reported on the application. You are responsible for providing this documentation in a timely manner.

The information you provide on this application will not be shared. It is protected under 5 U.S.C. Section 552(b)(4) and/or (b)(6), respectively. For more information, see the last page of this application for the Privacy Act Statement.

MAIL YOUR APPLICATION

The Medicare fee-for-service contractor (also referred to as a fiscal intermediary or a Medicare administrative contractor) that services your State is responsible for processing your enrollment application. To locate the mailing address for your fee-for-service contractor, go to *www.cms.gov/MedicareProviderSupEnroll*.

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Obtaining Medicare Approval

- Submit application to MAC, who will review and make a recommendation for approval or denial to the State Survey Agency (SA) and CMS Regional Office (CMS RO), who makes final decision regarding program eligibility
- MAC sends letter to provider informing the application was forwarded and all inquiries about the application must be directed to the SA or CMS RO using the contact information in the recommendation letter
- Once the MAC and the provider receives the approval survey results (tie in notice), a second review will be conducted by the MAC to verify that a provider continues to meet the enrollment requirements prior to granting Medicare billing privileges and may request a site visit, if needed. If denied, the MAC will deny application and identify why in the denial letter
- Resource
  - Understanding the Approval Recommendation Process For Certified Provider

Section 1: Basic Information

SECTION 1: BASIC INFORMATION

NEW ENROLLEES

If you are:

- Enrolling with a particular fee-for-service contractor for the first time.
- Undergoing a change of ownership where the new owner will not be accepting assignment of the Medicare assets and liabilities of the seller/former owner.

ENROLLED MEDICARE PROVIDERS

The following actions apply to Medicare providers already enrolled in the program:

Reactivation
To reactivate your Medicare billing privileges, submit this enrollment application. In addition, you must be able to submit a valid claim and meet all current requirements for your provider type before reactivation can occur.

Voluntary Termination
A provider should voluntarily terminate its Medicare enrollment when:

- It will no longer be rendering services to Medicare patients,
- It is planning to cease (or has ceased) operations,
- There has been an acquisition/merger and the new owner will not be using the identification number of the entity it has acquired,
- There has been a consolidation and the identification numbers of the consolidating providers will no longer be used, or
- There has been a change of ownership and the new owner will not be accepting assignment of the Medicare assets and liabilities of the seller/former owner, meaning that the number of the seller/former owner will no longer be used.

NOTE: A voluntary identification number termination cannot be used to circumvent any corrective action plan or any pending/ongoing investigation, nor can it be used to avoid a period of reasonable assurance, where a provider must operate for a certain period without recurrence of the deficiencies that were the basis for the termination. The provider will not be reinstated until the completion of the reasonable assurance period.

Change of Ownership (CHOW)
A CHOW typically occurs when a Medicare provider has been purchased (or leased) by another organization. The CHOW results in the transfer of the old owner's Medicare Identification Number and provider agreement (including any outstanding Medicare debt of the old owner) to the new owner. The regulatory citation for CHOWs can be found at 42 C.F.R. 489.18. If the purchaser (or lessee) elects not to accept a transfer of the provider agreement, then the old agreement should be terminated and the purchaser or lessee is considered a new applicant.

SECTION 1: BASIC INFORMATION *(Continued)*

Acquisition/Merger
An acquisition/merger occurs when a currently enrolled Medicare provider is purchasing or has been purchased by another enrolled provider. Only the purchaser's Medicare Identification Number and tax identification number remain.

Acquisitions/mergers are different from CHOWs. In the case of an acquisition/merger, the seller/former owner's Medicare Identification Number dissolves. In a CHOW, the seller/former owner's provider number typically remains intact and is transferred to the new owner.

Consolidation
A consolidation occurs when two or more enrolled Medicare providers consolidate to form a new business entity.

Consolidations are different from acquisitions/mergers. In an acquisition/merger, two entities combine but the Medicare Identification Number and tax identification number (TIN) of the purchasing entity remain intact. In a consolidation, the TINs and Medicare Identification Numbers of the consolidating entities dissolve and a new TIN and Medicare Identification Number are assigned to the new, consolidated entity.

> Because of the various situations in which a CHOW, acquisition/merger, or consolidation can occur, it is recommended that the provider contact its fee-for-service contractor or its CMS Regional Office if it is unsure as to whether such a transaction has occurred. The provider should also review the applicable federal regulation at 42 C.F.R. 489.18 for additional guidance.

Change of Information
A change of information should be submitted if you are changing, adding, or deleting information under your current tax identification number. Changes in your existing enrollment data must be reported to the Medicare fee-for-service contractor in accordance with 42 C.F.R. 424.516(e).

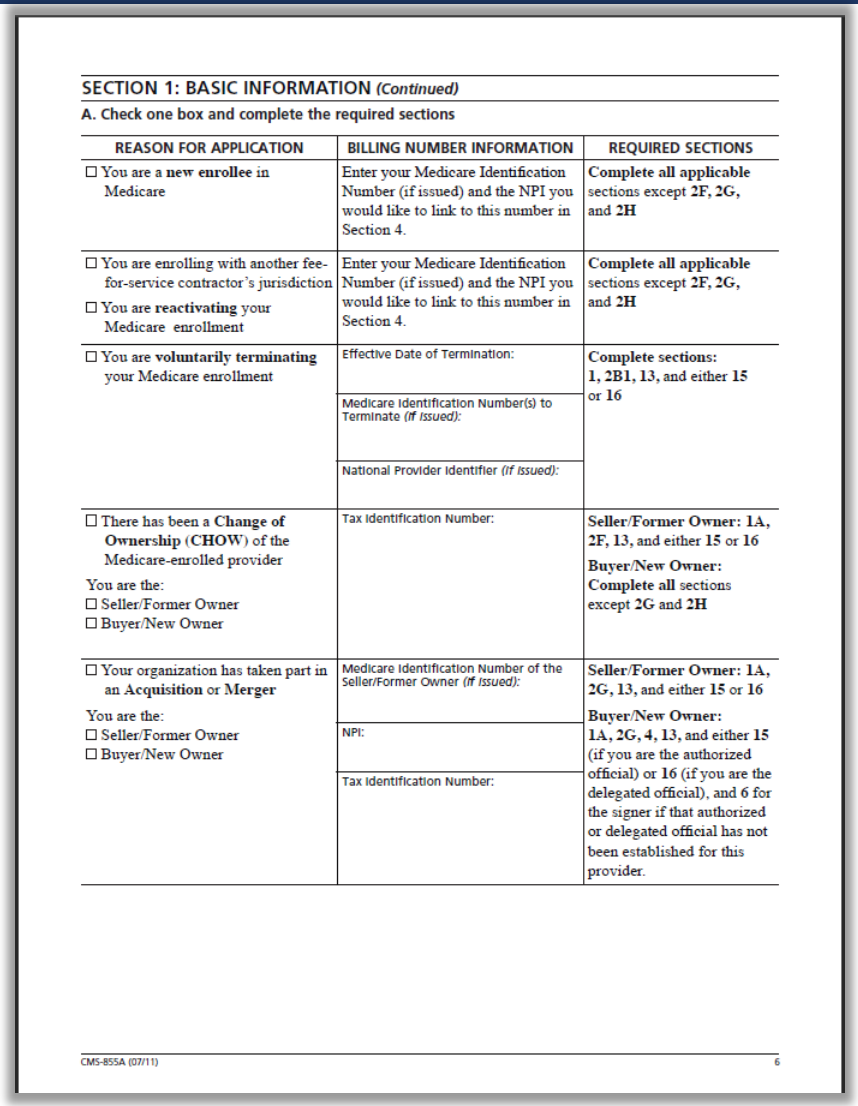
NOTE: Ownership changes that do not qualify as CHOWs, acquisitions/mergers, or consolidations should be reported here. The most common example involves stock transfers. For instance, assume that a business entity's stock is owned by A, B, and C. A sells his stock to D. While this is an ownership change, it is generally not a formal CHOW under 42 C.F.R. 489.18. Thus, the ownership change from A to D should be reported as a change of information, not a CHOW. If you have any questions on whether an ownership change should be reported as a CHOW or a change of information, contact your fee-for-service contractor or CMS Regional Office.

If you are already enrolled in Medicare and are not receiving Medicare payments via EFT, any change to your enrollment information will require you to submit a CMS-588 application. All future payments will then be made via EFT.

Revalidation
CMS may require you to submit or update your enrollment information. The fee-for-service contractor will notify you when it is time for you to revalidate your enrollment information. Do not submit a revalidation application until you have been contacted by the fee-for-service contractor.

Section 1: Basic Information A.

- A: Reason for Application



SECTION 1: BASIC INFORMATION *(Continued)*

A. Check one box and complete the required sections

REASON FOR APPLICATION	BILLING NUMBER INFORMATION	REQUIRED SECTIONS
☐ You are a **new enrollee** in Medicare	Enter your Medicare Identification Number (if issued) and the NPI you would like to link to this number in Section 4.	**Complete all applicable** sections except **2F, 2G,** and **2H**
☐ You are enrolling with another fee-for-service contractor's jurisdiction ☐ You are **reactivating** your Medicare enrollment	Enter your Medicare Identification Number (if issued) and the NPI you would like to link to this number in Section 4.	**Complete all applicable** sections except **2F, 2G,** and **2H**
☐ You are **voluntarily terminating** your Medicare enrollment	Effective Date of Termination: Medicare Identification Number(s) to Terminate *(if issued)*: National Provider Identifier *(if issued)*:	**Complete sections: 1, 2B1, 13,** and either **15** or **16**
☐ There has been a **Change of Ownership (CHOW)** of the Medicare-enrolled provider You are the: ☐ Seller/Former Owner ☐ Buyer/New Owner	Tax Identification Number:	**Seller/Former Owner: 1A, 2F, 13,** and either **15** or **16** **Buyer/New Owner: Complete all** sections except **2G** and **2H**
☐ Your organization has taken part in an **Acquisition** or **Merger** You are the: ☐ Seller/Former Owner ☐ Buyer/New Owner	Medicare Identification Number of the Seller/Former Owner *(if issued)*: NPI: Tax Identification Number:	**Seller/Former Owner: 1A, 2G, 13,** and either **15** or **16** **Buyer/New Owner: 1A, 2G, 4, 13,** and either **15** (if you are the authorized official) or **16** (if you are the delegated official), and **6** for the signer if that authorized or delegated official has not been established for this provider.

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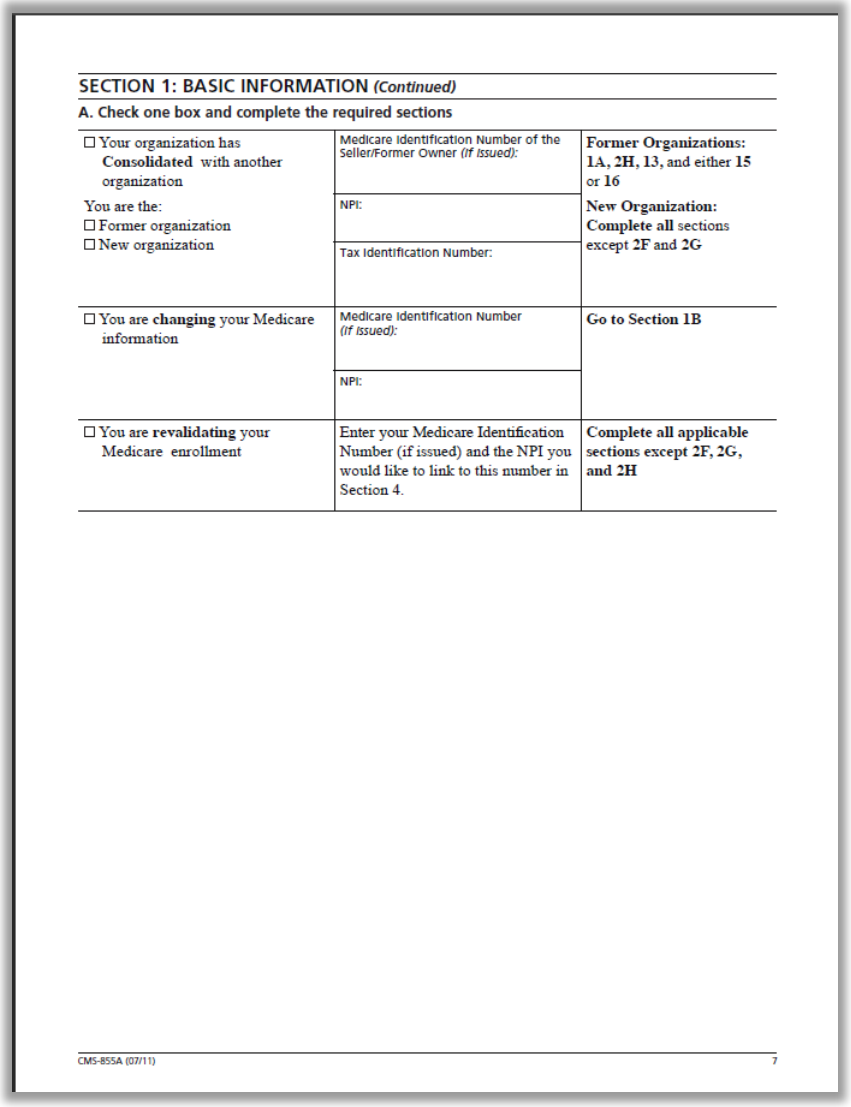
Section 1: Basic Information A.

- A: Reason for Application
  - Select “You are revalidating your Medicare enrollment”



SECTION 1: BASIC INFORMATION *(Continued)*

A. Check one box and complete the required sections

☐ Your organization has **Consolidated** with another organization You are the: ☐ Former organization ☐ New organization	Medicare Identification Number of the Seller/Former Owner *(If issued)*: NPI: Tax Identification Number:	**Former Organizations: 1A, 2H, 13,** and either **15** or **16** **New Organization: Complete all** sections except **2F** and **2G**
☐ You are **changing** your Medicare information	Medicare Identification Number *(If issued)*: NPI:	**Go to Section 1B**
☐ You are **revalidating** your Medicare enrollment	Enter your Medicare Identification Number (if issued) and the NPI you would like to link to this number in Section 4.	**Complete all applicable sections except 2F, 2G, and 2H**

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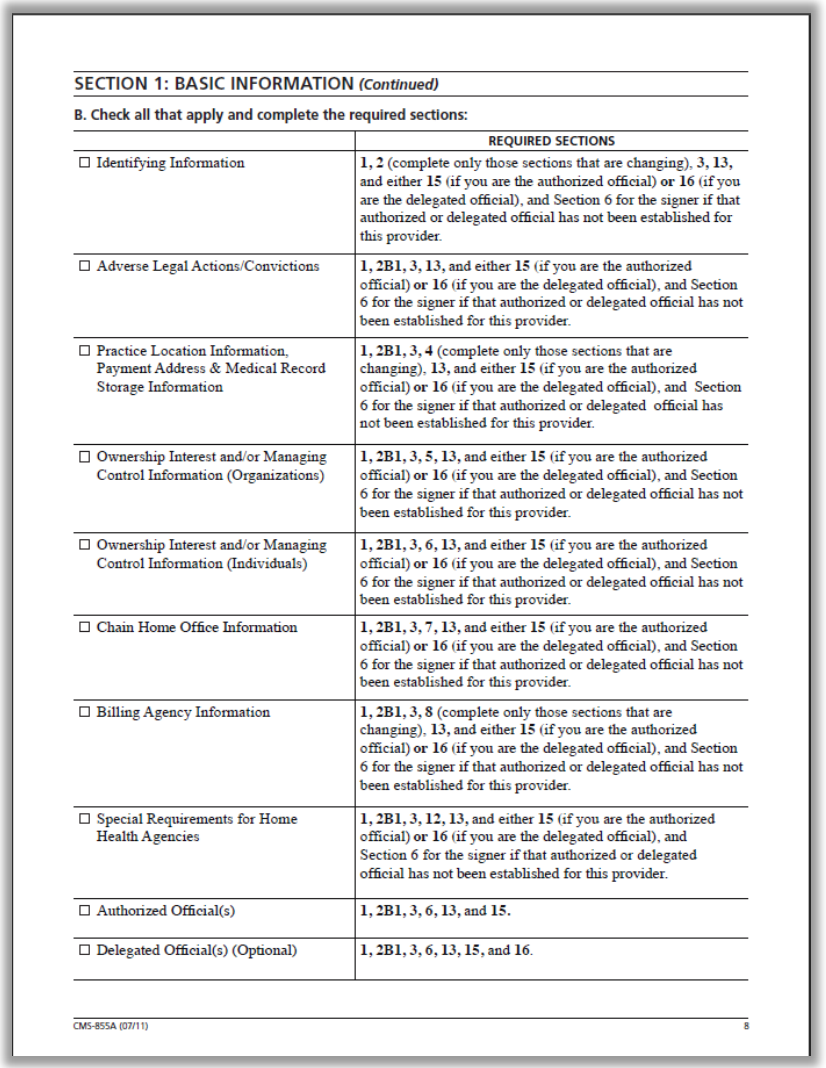
Section 1: Basic Information B.

- B: Changes and Updates
  - Optional during revalidation
  - Check all that apply



SECTION 1: BASIC INFORMATION *(Continued)*

B. Check all that apply and complete the required sections:

	REQUIRED SECTIONS
☐ Identifying Information	**1, 2** (complete only those sections that are changing), **3, 13,** and either **15** (if you are the authorized official) **or 16** (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Adverse Legal Actions/Convictions	**1, 2B1, 3, 13,** and either **15** (if you are the authorized official) **or 16** (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Practice Location Information, Payment Address & Medical Record Storage Information	**1, 2B1, 3, 4** (complete only those sections that are changing), **13,** and either **15** (if you are the authorized official) **or 16** (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Ownership Interest and/or Managing Control Information (Organizations)	**1, 2B1, 3, 5, 13,** and either **15** (if you are the authorized official) **or 16** (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Ownership Interest and/or Managing Control Information (Individuals)	**1, 2B1, 3, 6, 13,** and either **15** (if you are the authorized official) **or 16** (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Chain Home Office Information	**1, 2B1, 3, 7, 13,** and either **15** (if you are the authorized official) **or 16** (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Billing Agency Information	**1, 2B1, 3, 8** (complete only those sections that are changing), **13,** and either **15** (if you are the authorized official) **or 16** (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Special Requirements for Home Health Agencies	**1, 2B1, 3, 12, 13,** and either **15** (if you are the authorized official) **or 16** (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Authorized Official(s)	**1, 2B1, 3, 6, 13,** and **15.**
☐ Delegated Official(s) (Optional)	**1, 2B1, 3, 6, 13, 15,** and **16.**

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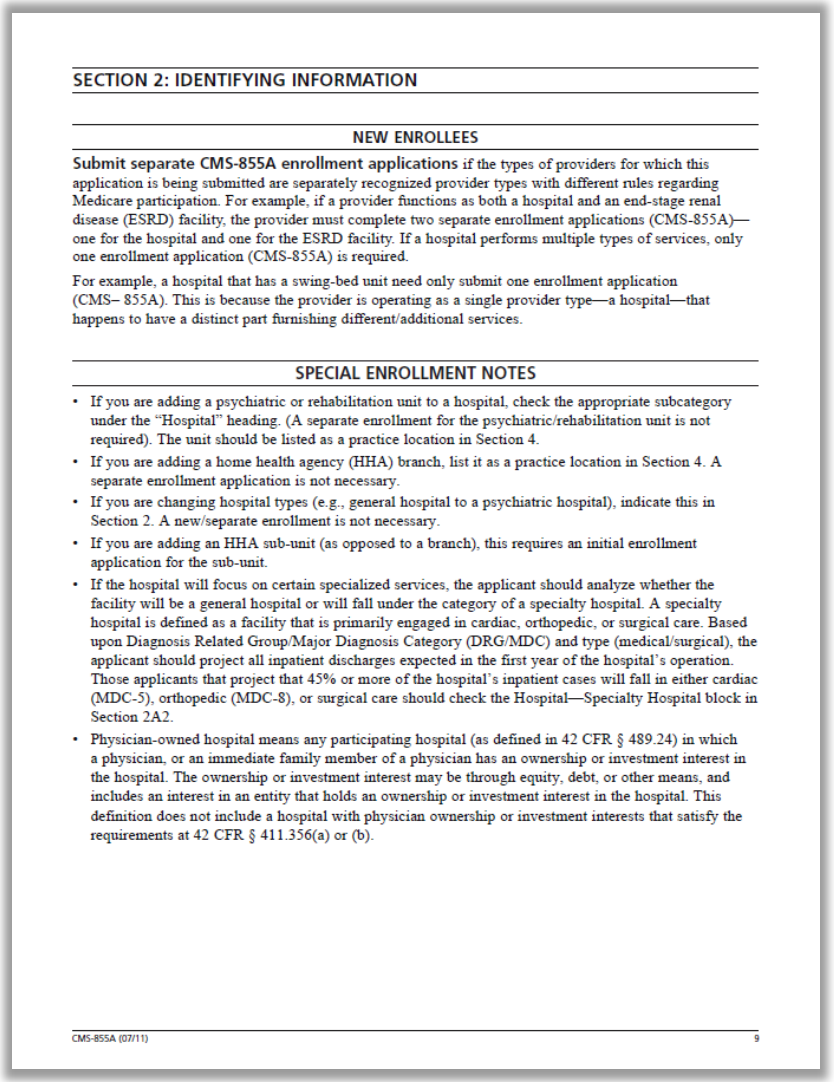
Section 2: Identifying Information

- New Enrollees Information
- Special Enrollment Notes



SECTION 2: IDENTIFYING INFORMATION

NEW ENROLLEES

Submit separate CMS-855A enrollment applications if the types of providers for which this application is being submitted are separately recognized provider types with different rules regarding Medicare participation. For example, if a provider functions as both a hospital and an end-stage renal disease (ESRD) facility, the provider must complete two separate enrollment applications (CMS-855A)—one for the hospital and one for the ESRD facility. If a hospital performs multiple types of services, only one enrollment application (CMS-855A) is required.

For example, a hospital that has a swing-bed unit need only submit one enrollment application (CMS– 855A). This is because the provider is operating as a single provider type—a hospital—that happens to have a distinct part furnishing different/additional services.

SPECIAL ENROLLMENT NOTES

- If you are adding a psychiatric or rehabilitation unit to a hospital, check the appropriate subcategory under the "Hospital" heading. (A separate enrollment for the psychiatric/rehabilitation unit is not required). The unit should be listed as a practice location in Section 4.
- If you are adding a home health agency (HHA) branch, list it as a practice location in Section 4. A separate enrollment application is not necessary.
- If you are changing hospital types (e.g., general hospital to a psychiatric hospital), indicate this in Section 2. A new/separate enrollment is not necessary.
- If you are adding an HHA sub-unit (as opposed to a branch), this requires an initial enrollment application for the sub-unit.
- If the hospital will focus on certain specialized services, the applicant should analyze whether the facility will be a general hospital or will fall under the category of a specialty hospital. A specialty hospital is defined as a facility that is primarily engaged in cardiac, orthopedic, or surgical care. Based upon Diagnosis Related Group/Major Diagnosis Category (DRG/MDC) and type (medical/surgical), the applicant should project all inpatient discharges expected in the first year of the hospital's operation. Those applicants that project that 45% or more of the hospital's inpatient cases will fall in either cardiac (MDC-5), orthopedic (MDC-8), or surgical care should check the Hospital—Specialty Hospital block in Section 2A2.
- Physician-owned hospital means any participating hospital (as defined in 42 CFR § 489.24) in which a physician, 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 hospital with physician ownership or investment interests that satisfy the requirements at 42 CFR § 411.356(a) or (b).

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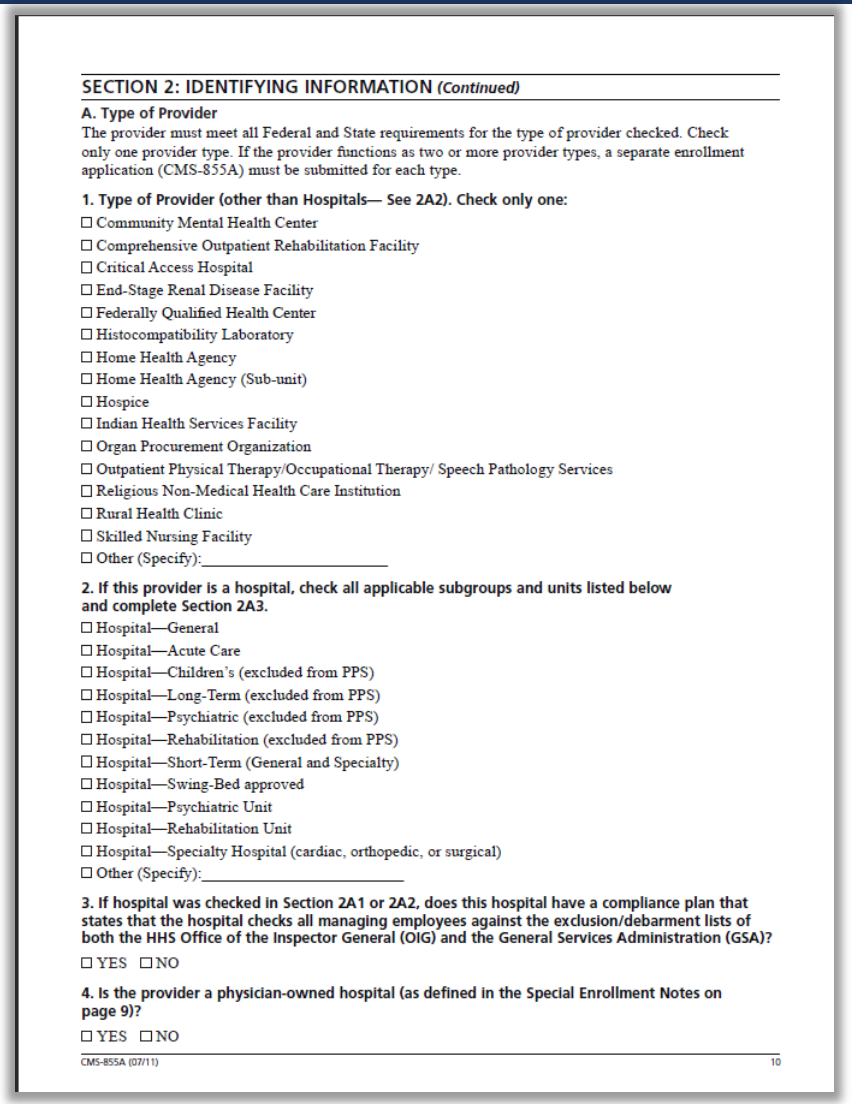
Section 2: Identifying Information A.

- A: Type of Provider
  - 1. Provider, other than hospital
  - 2. Hospital
  - 3 and 4. Answer “Yes” or ‘No” if applicable



SECTION 2: IDENTIFYING INFORMATION *(Continued)*

A. Type of Provider

The provider must meet all Federal and State requirements for the type of provider checked. Check only one provider type. If the provider functions as two or more provider types, a separate enrollment application (CMS-855A) must be submitted for each type.

1. Type of Provider (other than Hospitals— See 2A2). Check only one:

☐ Community Mental Health Center
☐ Comprehensive Outpatient Rehabilitation Facility
☐ Critical Access Hospital
☐ End-Stage Renal Disease Facility
☐ Federally Qualified Health Center
☐ Histocompatibility Laboratory
☐ Home Health Agency
☐ Home Health Agency (Sub-unit)
☐ Hospice
☐ Indian Health Services Facility
☐ Organ Procurement Organization
☐ Outpatient Physical Therapy/Occupational Therapy/ Speech Pathology Services
☐ Religious Non-Medical Health Care Institution
☐ Rural Health Clinic
☐ Skilled Nursing Facility
☐ Other (Specify):_____

2. If this provider is a hospital, check all applicable subgroups and units listed below and complete Section 2A3.

☐ Hospital—General
☐ Hospital—Acute Care
☐ Hospital—Children’s (excluded from PPS)
☐ Hospital—Long-Term (excluded from PPS)
☐ Hospital—Psychiatric (excluded from PPS)
☐ Hospital—Rehabilitation (excluded from PPS)
☐ Hospital—Short-Term (General and Specialty)
☐ Hospital—Swing-Bed approved
☐ Hospital—Psychiatric Unit
☐ Hospital—Rehabilitation Unit
☐ Hospital—Specialty Hospital (cardiac, orthopedic, or surgical)
☐ Other (Specify):_____

3. If hospital was checked in Section 2A1 or 2A2, does this hospital have a compliance plan that states that the hospital checks all managing employees against the exclusion/debarment lists of both the HHS Office of the Inspector General (OIG) and the General Services Administration (GSA)?

☐ YES ☐ NO

4. Is the provider a physician-owned hospital (as defined in the Special Enrollment Notes on page 9)?

☐ YES ☐ NO

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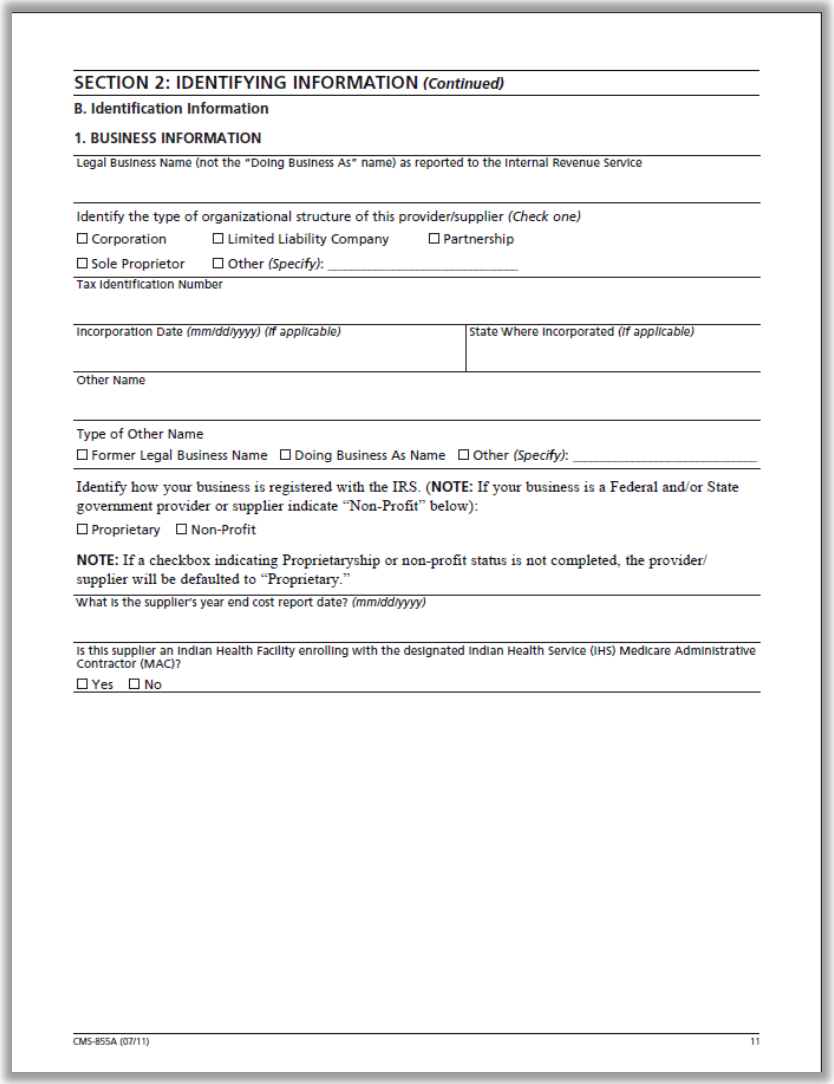
Section 2: Identifying Information B.

- B: Identification Information
  - 1. Business Information
    - ✓ Indicate legal business name and TIN as it appears on the IRS document
    - ✓ Indicate other name and identify the type of organizational structure



SECTION 2: IDENTIFYING INFORMATION *(Continued)*

B. Identification Information

1. BUSINESS INFORMATION

Legal Business Name (not the "Doing Business As" name) as reported to the Internal Revenue Service

Identify the type of organizational structure of this provider/supplier *(Check one)*

☐ Corporation ☐ Limited Liability Company ☐ Partnership

☐ Sole Proprietor ☐ Other *(Specify)*: _____

Tax Identification Number

Incorporation Date *(mm/dd/yyyy) (if applicable)* | State Where Incorporated *(if applicable)*

Other Name

Type of Other Name

☐ Former Legal Business Name ☐ Doing Business As Name ☐ Other *(Specify)*: _____

Identify how your business is registered with the IRS. (**NOTE:** If your business is a Federal and/or State government provider or supplier indicate "Non-Profit" below):

☐ Proprietary ☐ Non-Profit

NOTE: If a checkbox indicating Proprietaryship or non-profit status is not completed, the provider/supplier will be defaulted to "Proprietary."

What is the supplier's year end cost report date? *(mm/dd/yyyy)*

Is this supplier an Indian Health Facility enrolling with the designated Indian Health Service (IHS) Medicare Administrative Contractor (MAC)?

☐ Yes ☐ No

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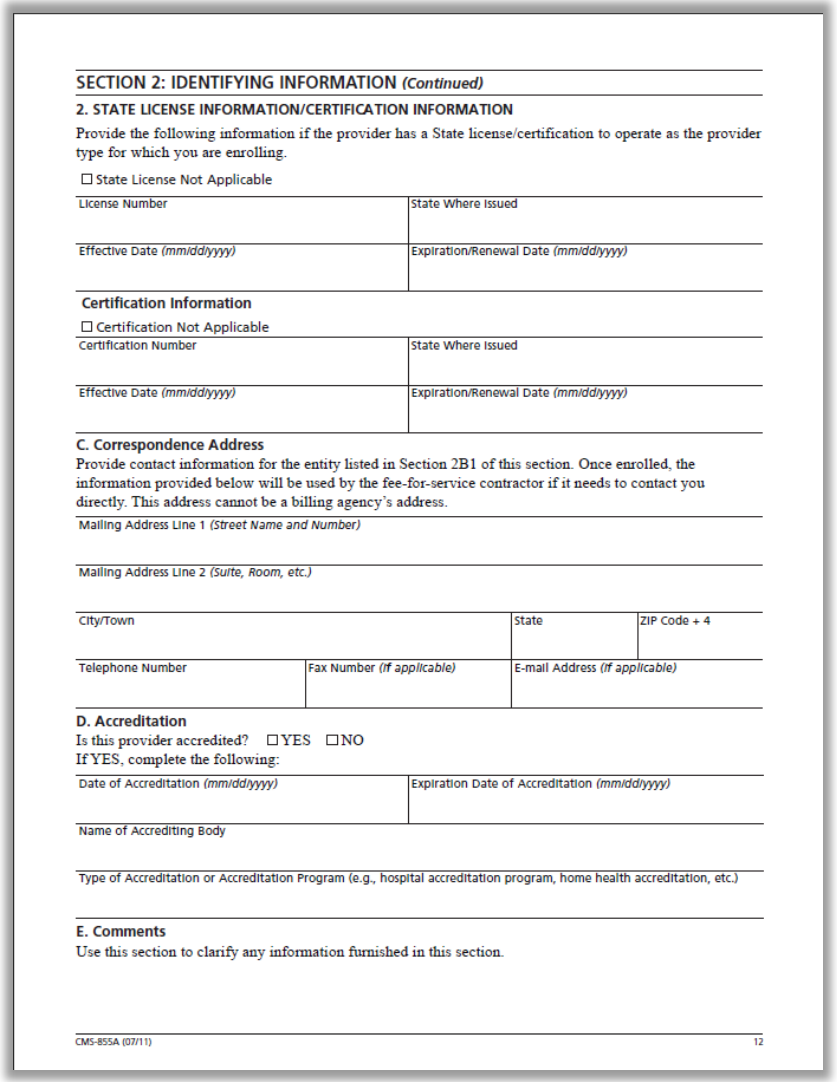
Section 2: Identifying Information B.C.D.E.

- B: Identification Information
  - 2. State License/ Certification Information
- C: Correspondence Address
  - Cannot be a billing agency address
- D: Accreditation
- E: Comments
  - Use this section to clarify any information that was furnished in this section



SECTION 2: IDENTIFYING INFORMATION *(Continued)*

2. STATE LICENSE INFORMATION/CERTIFICATION INFORMATION

Provide the following information if the provider has a State license/certification to operate as the provider type for which you are enrolling.

☐ State License Not Applicable

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

Certification Information

☐ Certification Not Applicable

Certification Number	State Where Issued
Effective Date *(mm/dd/yyyy)*	Expiration/Renewal Date *(mm/dd/yyyy)*

C. Correspondence Address

Provide contact information for the entity listed in Section 2B1 of this section. Once enrolled, the information provided below will be used by the fee-for-service contractor if it needs to contact you directly. This address cannot be a billing agency's address.

Mailing Address Line 1 *(Street Name and Number)*

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

City/Town	State	ZIP Code + 4

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

D. Accreditation

Is this provider accredited? ☐YES ☐NO

If YES, complete the following:

Date of Accreditation *(mm/dd/yyyy)*	Expiration Date of Accreditation *(mm/dd/yyyy)*

Name of Accrediting Body

Type of Accreditation or Accreditation Program (e.g., hospital accreditation program, home health accreditation, etc.)

E. Comments

Use this section to clarify any information furnished in this section.

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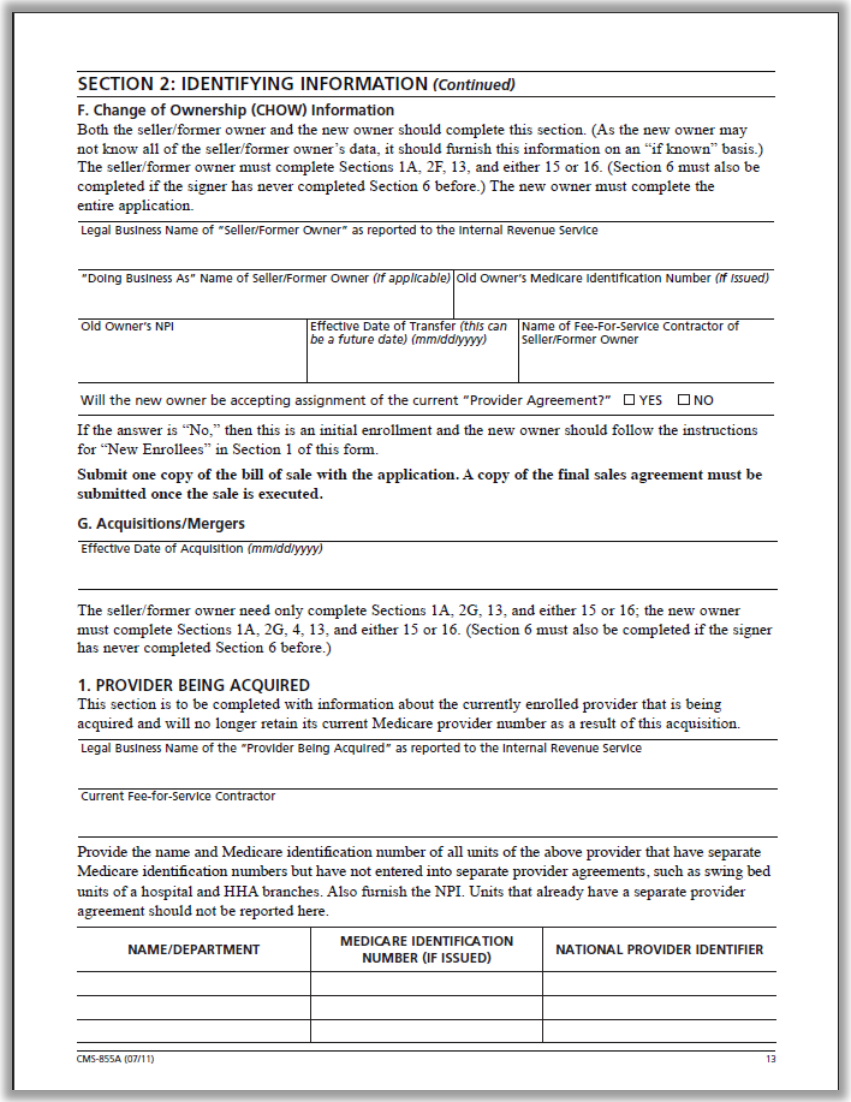
Section 2: Identifying Information F.G.

(Do not complete during revalidation)

- F: Change of Ownership (CHOW) Information
- G: Acquisition/Mergers



SECTION 2: IDENTIFYING INFORMATION *(Continued)*

F. Change of Ownership (CHOW) Information

Both the seller/former owner and the new owner should complete this section. (As the new owner may not know all of the seller/former owner's data, it should furnish this information on an "if known" basis.) The seller/former owner must complete Sections 1A, 2F, 13, and either 15 or 16. (Section 6 must also be completed if the signer has never completed Section 6 before.) The new owner must complete the entire application.

Legal Business Name of "Seller/Former Owner" as reported to the Internal Revenue Service

"Doing Business As" Name of Seller/Former Owner *(if applicable)*	Old Owner's Medicare Identification Number *(if issued)*

Old Owner's NPI	Effective Date of Transfer *(this can be a future date) (mm/dd/yyyy)*	Name of Fee-For-Service Contractor of Seller/Former Owner

Will the new owner be accepting assignment of the current "Provider Agreement?" ☐ YES ☐ NO

If the answer is "No," then this is an initial enrollment and the new owner should follow the instructions for "New Enrollees" in Section 1 of this form.

Submit one copy of the bill of sale with the application. A copy of the final sales agreement must be submitted once the sale is executed.

G. Acquisitions/Mergers

Effective Date of Acquisition *(mm/dd/yyyy)*

The seller/former owner need only complete Sections 1A, 2G, 13, and either 15 or 16; the new owner must complete Sections 1A, 2G, 4, 13, and either 15 or 16. (Section 6 must also be completed if the signer has never completed Section 6 before.)

1. PROVIDER BEING ACQUIRED

This section is to be completed with information about the currently enrolled provider that is being acquired and will no longer retain its current Medicare provider number as a result of this acquisition.

Legal Business Name of the "Provider Being Acquired" as reported to the Internal Revenue Service

Current Fee-for-Service Contractor

Provide the name and Medicare identification number of all units of the above provider that have separate Medicare identification numbers but have not entered into separate provider agreements, such as swing bed units of a hospital and HHA branches. Also furnish the NPI. Units that already have a separate provider agreement should not be reported here.

NAME/DEPARTMENT	MEDICARE IDENTIFICATION NUMBER (IF ISSUED)	NATIONAL PROVIDER IDENTIFIER

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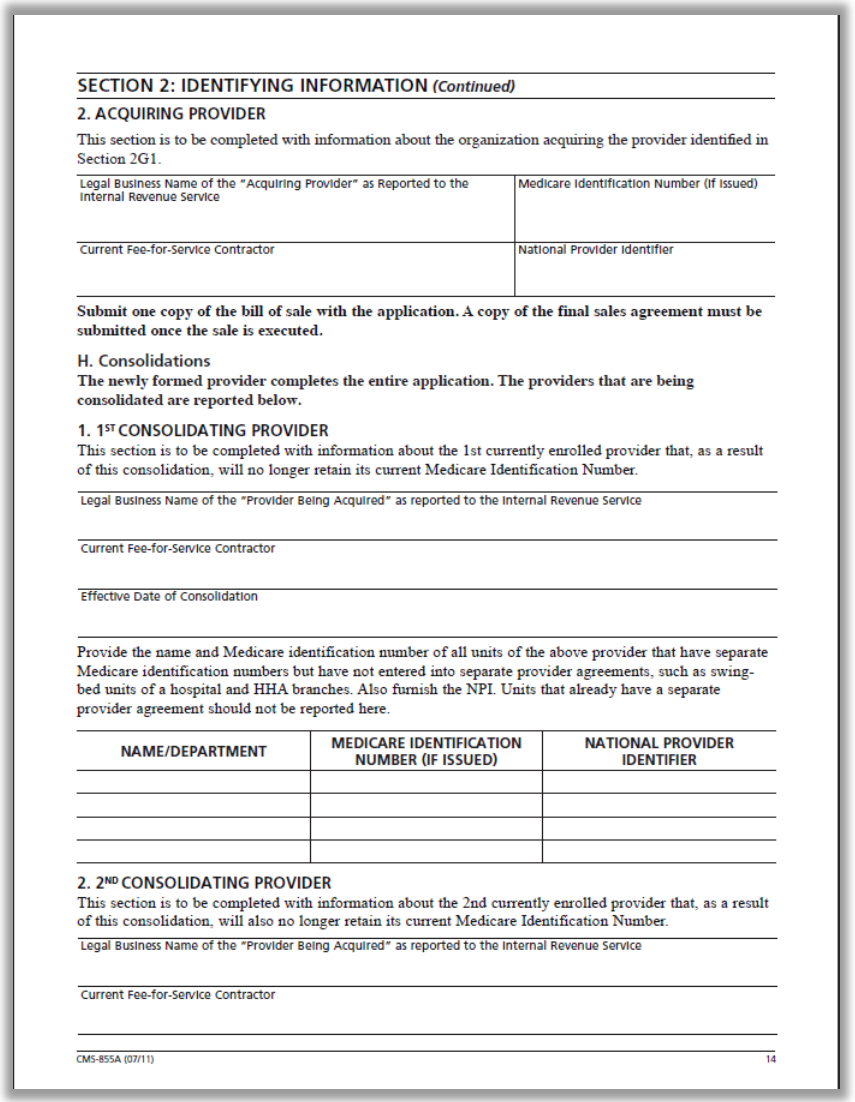
Section 2: Identifying Information H.

(Do not complete during revalidation)

- H: Consolidations



SECTION 2: IDENTIFYING INFORMATION *(Continued)*

2. ACQUIRING PROVIDER

This section is to be completed with information about the organization acquiring the provider identified in Section 2G1.

Legal Business Name of the "Acquiring Provider" as Reported to the Internal Revenue Service	Medicare Identification Number (If Issued)
Current Fee-for-Service Contractor	National Provider Identifier

Submit one copy of the bill of sale with the application. A copy of the final sales agreement must be submitted once the sale is executed.

H. Consolidations

The newly formed provider completes the entire application. The providers that are being consolidated are reported below.

1. 1ST CONSOLIDATING PROVIDER

This section is to be completed with information about the 1st currently enrolled provider that, as a result of this consolidation, will no longer retain its current Medicare Identification Number.

Legal Business Name of the "Provider Being Acquired" as reported to the Internal Revenue Service

Current Fee-for-Service Contractor

Effective Date of Consolidation

Provide the name and Medicare identification number of all units of the above provider that have separate Medicare identification numbers but have not entered into separate provider agreements, such as swing-bed units of a hospital and HHA branches. Also furnish the NPI. Units that already have a separate provider agreement should not be reported here.

NAME/DEPARTMENT	MEDICARE IDENTIFICATION NUMBER (IF ISSUED)	NATIONAL PROVIDER IDENTIFIER

2. 2ND CONSOLIDATING PROVIDER

This section is to be completed with information about the 2nd currently enrolled provider that, as a result of this consolidation, will also no longer retain its current Medicare Identification Number.

Legal Business Name of the "Provider Being Acquired" as reported to the Internal Revenue Service

Current Fee-for-Service Contractor

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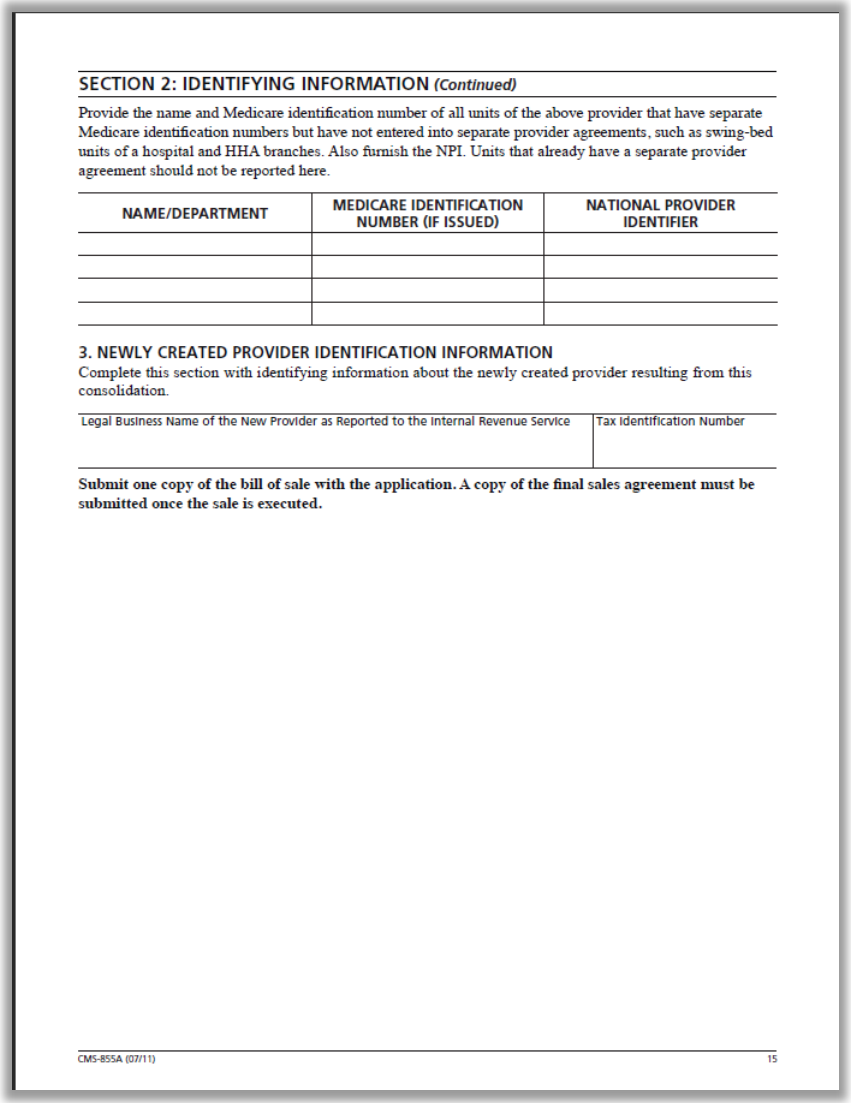
Section 2: Identifying Information H.

(Do not complete during revalidation)

- H: Consolidations



SECTION 2: IDENTIFYING INFORMATION *(Continued)*

Provide the name and Medicare identification number of all units of the above provider that have separate Medicare identification numbers but have not entered into separate provider agreements, such as swing-bed units of a hospital and HHA branches. Also furnish the NPI. Units that already have a separate provider agreement should not be reported here.

NAME/DEPARTMENT	MEDICARE IDENTIFICATION NUMBER (IF ISSUED)	NATIONAL PROVIDER IDENTIFIER

3. NEWLY CREATED PROVIDER IDENTIFICATION INFORMATION

Complete this section with identifying information about the newly created provider resulting from this consolidation.

Legal Business Name of the New Provider as Reported to the Internal Revenue Service	Tax Identification Number

Submit one copy of the bill of sale with the application. A copy of the final sales agreement must be submitted once the sale is executed.

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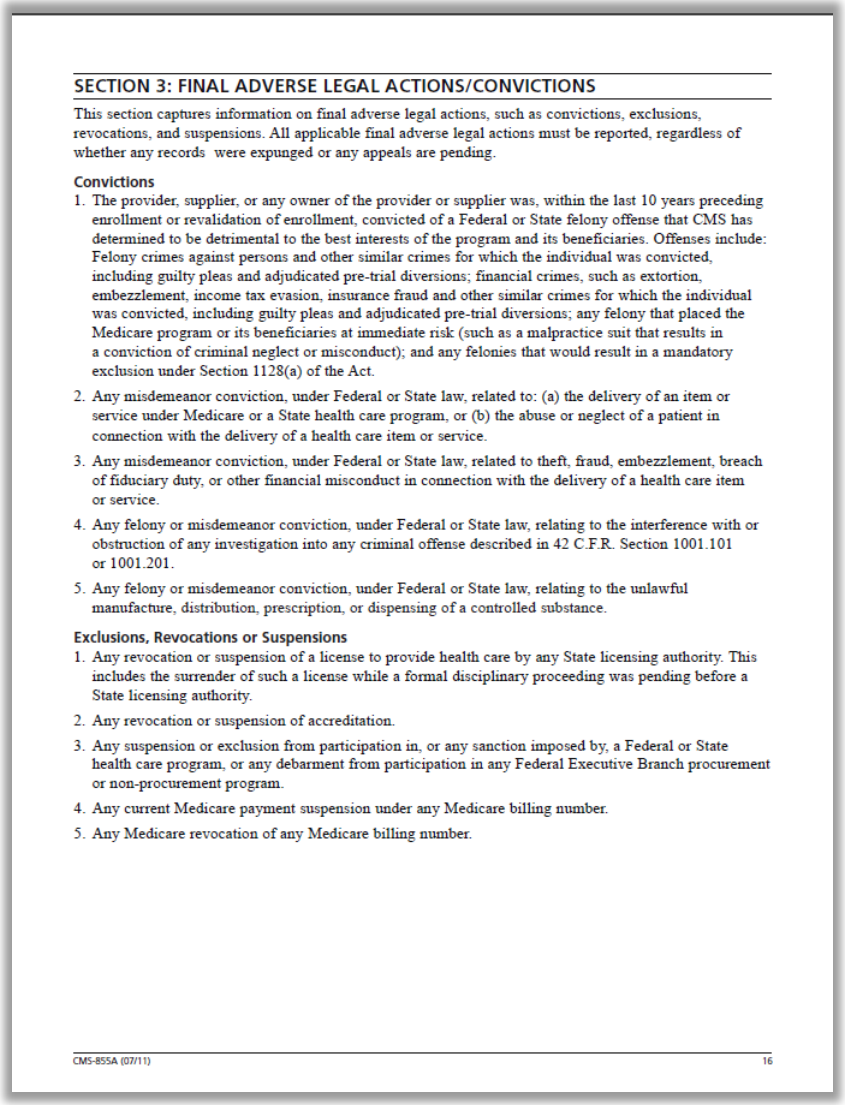
Section 3: Final Adverse Legal Actions / Convictions

- All final adverse legal action must report
  - convictions
  - exclusions
  - revocations
  - suspensions



SECTION 3: FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS

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

Convictions

1. The provider, supplier, or any owner of the provider or supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include: Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicare program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Act.
2. 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.
3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
5. Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations or Suspensions

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation or suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any current Medicare payment suspension under any Medicare billing number.
5. Any Medicare revocation of any Medicare billing number.

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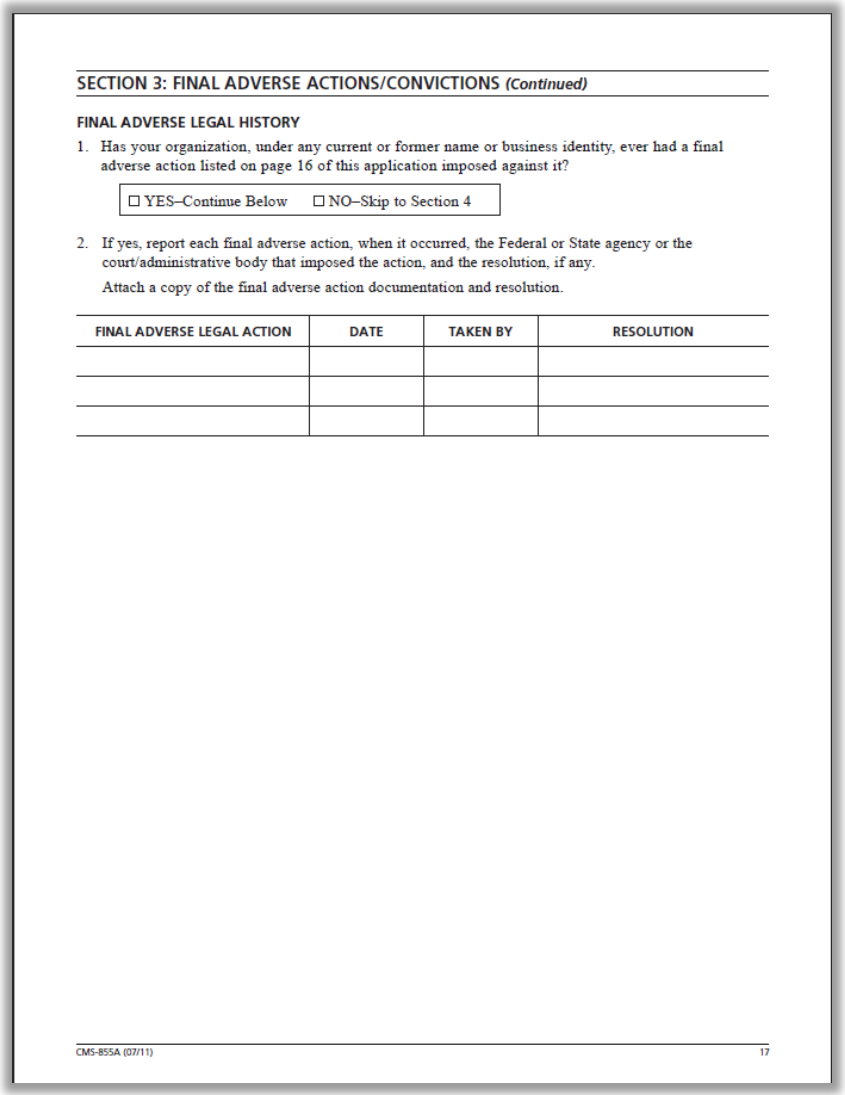
Section 3: Final Adverse Legal Actions / Convictions

- If none, check “No”
- If any, check “Yes”
  - List details in section 3.2 and attach final adverse legal action documentation and/or resolutions



SECTION 3: FINAL ADVERSE ACTIONS/CONVICTIONS *(Continued)*

FINAL ADVERSE LEGAL HISTORY

1. Has your organization, under any current or former name or business identity, ever had a final adverse action listed on page 16 of this application imposed against it?

☐ YES–Continue Below ☐ NO–Skip to Section 4

2. If yes, report each final adverse action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the final adverse action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

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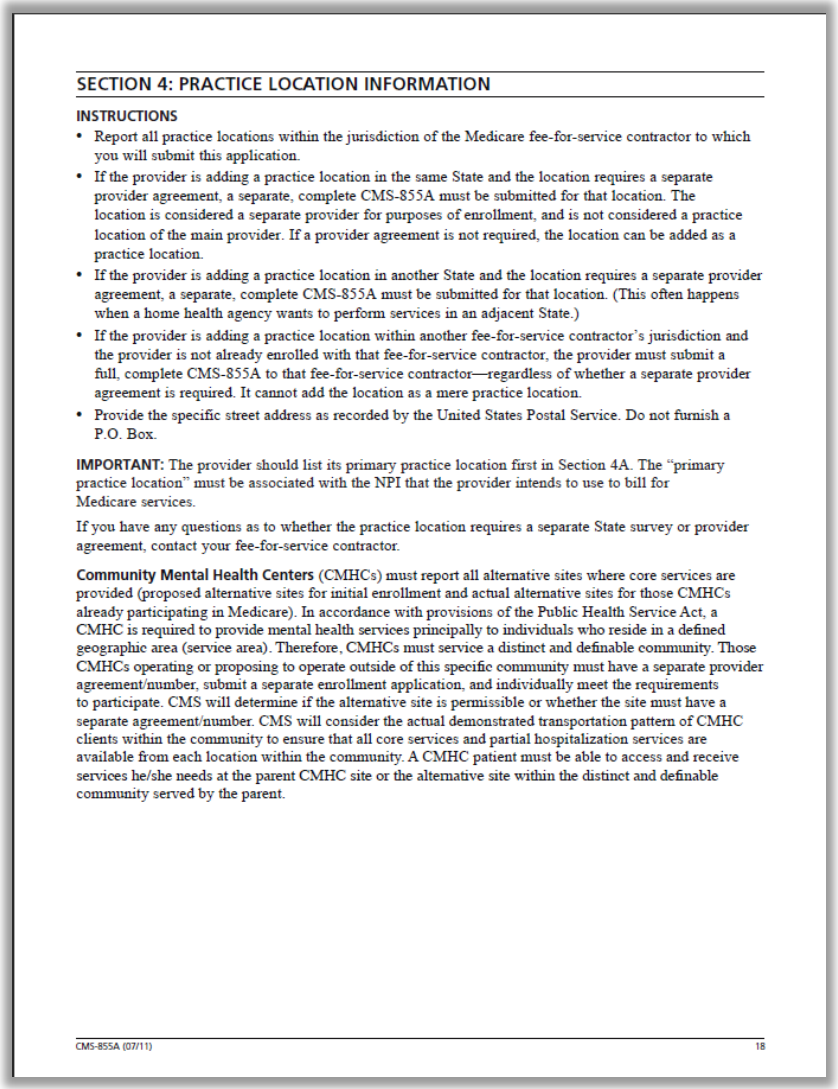
Section 4: Practice Location Information

- Instructions on reporting practice locations in this section



SECTION 4: PRACTICE LOCATION INFORMATION

INSTRUCTIONS

- Report all practice locations within the jurisdiction of the Medicare fee-for-service contractor to which you will submit this application.
- If the provider is adding a practice location in the same State and the location requires a separate provider agreement, a separate, complete CMS-855A must be submitted for that location. The location is considered a separate provider for purposes of enrollment, and is not considered a practice location of the main provider. If a provider agreement is not required, the location can be added as a practice location.
- If the provider is adding a practice location in another State and the location requires a separate provider agreement, a separate, complete CMS-855A must be submitted for that location. (This often happens when a home health agency wants to perform services in an adjacent State.)
- If the provider is adding a practice location within another fee-for-service contractor's jurisdiction and the provider is not already enrolled with that fee-for-service contractor, the provider must submit a full, complete CMS-855A to that fee-for-service contractor—regardless of whether a separate provider agreement is required. It cannot add the location as a mere practice location.
- Provide the specific street address as recorded by the United States Postal Service. Do not furnish a P.O. Box.

IMPORTANT: The provider should list its primary practice location first in Section 4A. The "primary practice location" must be associated with the NPI that the provider intends to use to bill for Medicare services.

If you have any questions as to whether the practice location requires a separate State survey or provider agreement, contact your fee-for-service contractor.

Community Mental Health Centers (CMHCs) must report all alternative sites where core services are provided (proposed alternative sites for initial enrollment and actual alternative sites for those CMHCs already participating in Medicare). In accordance with provisions of the Public Health Service Act, a CMHC is required to provide mental health services principally to individuals who reside in a defined geographic area (service area). Therefore, CMHCs must service a distinct and definable community. Those CMHCs operating or proposing to operate outside of this specific community must have a separate provider agreement/number, submit a separate enrollment application, and individually meet the requirements to participate. CMS will determine if the alternative site is permissible or whether the site must have a separate agreement/number. CMS will consider the actual demonstrated transportation pattern of CMHC clients within the community to ensure that all core services and partial hospitalization services are available from each location within the community. A CMHC patient must be able to access and receive services he/she needs at the parent CMHC site or the alternative site within the distinct and definable community served by the parent.

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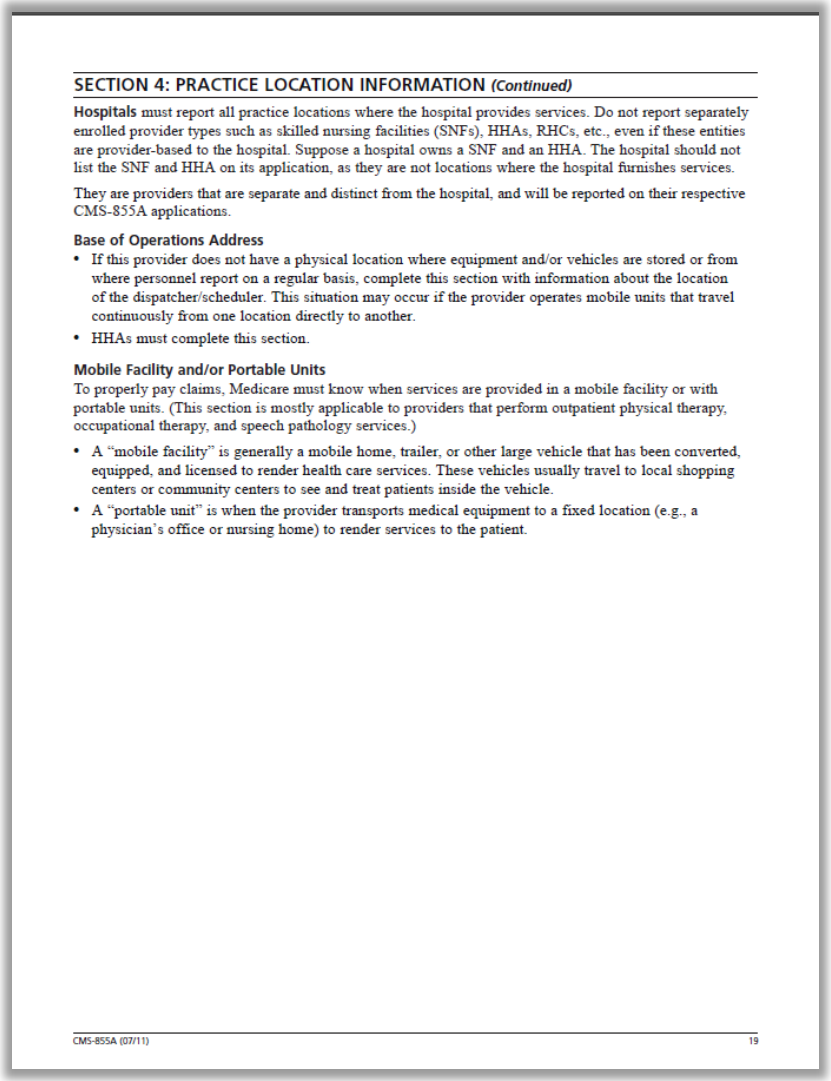
Section 4: Practice Location Information

- Instructions on reporting practice locations in this section



SECTION 4: PRACTICE LOCATION INFORMATION ***(Continued)***

Hospitals must report all practice locations where the hospital provides services. Do not report separately enrolled provider types such as skilled nursing facilities (SNFs), HHAs, RHCs, etc., even if these entities are provider-based to the hospital. Suppose a hospital owns a SNF and an HHA. The hospital should not list the SNF and HHA on its application, as they are not locations where the hospital furnishes services.

They are providers that are separate and distinct from the hospital, and will be reported on their respective CMS-855A applications.

Base of Operations Address

- If this provider does not have a physical location where equipment and/or vehicles are stored or from where personnel report on a regular basis, complete this section with information about the location of the dispatcher/scheduler. This situation may occur if the provider operates mobile units that travel continuously from one location directly to another.
- HHAs must complete this section.

Mobile Facility and/or Portable Units

To properly pay claims, Medicare must know when services are provided in a mobile facility or with portable units. (This section is mostly applicable to providers that perform outpatient physical therapy, occupational therapy, and speech pathology services.)

- A "mobile facility" is generally a mobile home, trailer, or other large vehicle that has been converted, equipped, and licensed to render health care services. These vehicles usually travel to local shopping centers or community centers to see and treat patients inside the vehicle.
- A "portable unit" is when the provider transports medical equipment to a fixed location (e.g., a physician's office or nursing home) to render services to the patient.

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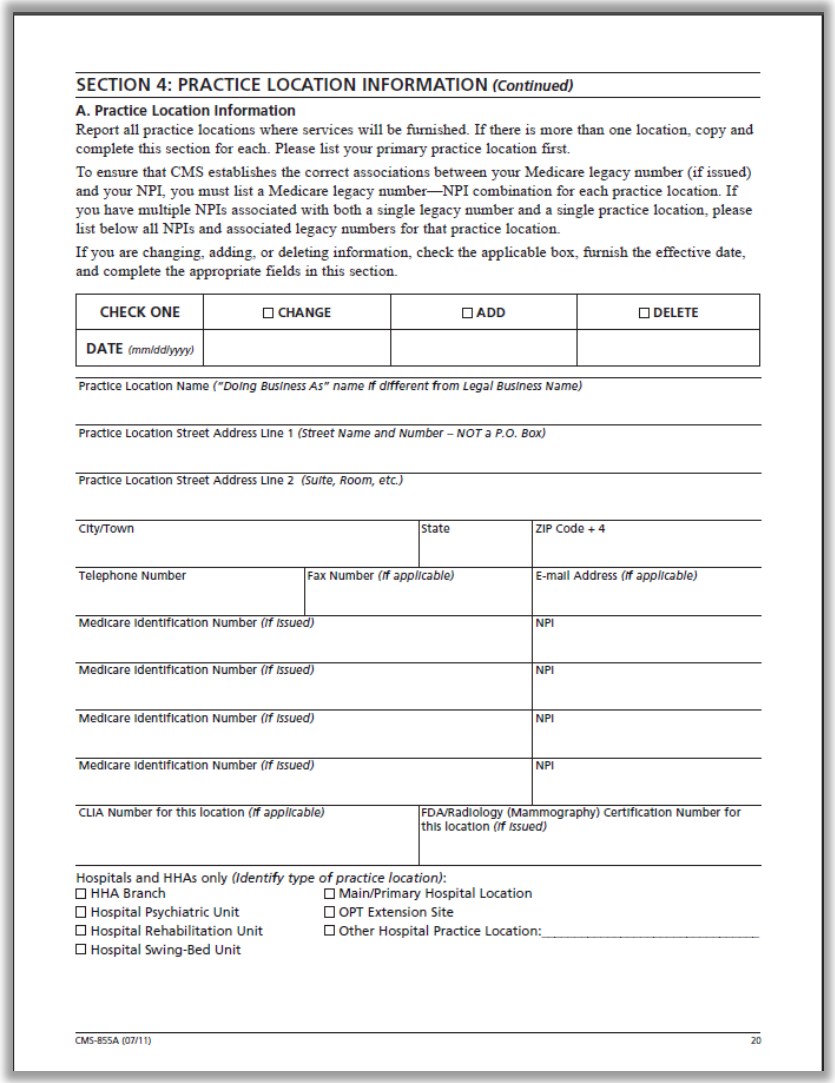
Section 4: Practice Location Information A.

- A: Practice location Information
  - Copy and complete section for each practice location where services are rendered
    - ✓ List all NPIs and PTANs associated
  - Hospital and HHA
    - ✓ Identify type of practice location
  - If add or delete, furnish effective date



SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

A. Practice Location Information

Report all practice locations where services will be furnished. If there is more than one location, copy and complete this section for each. Please list your primary practice location first.

To ensure that CMS establishes the correct associations between your Medicare legacy number (if issued) and your NPI, you must list a Medicare legacy number—NPI combination for each practice location. If you have multiple NPIs associated with both a single legacy number and a single practice location, please list below all NPIs and associated legacy numbers for that practice location.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Practice Location Name *("Doing Business As" name if different from Legal Business Name)*

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

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

City/Town	State	ZIP Code + 4

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

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

CLIA Number for this location *(if applicable)*	FDA/Radiology (Mammography) Certification Number for this location *(if issued)*

Hospitals and HHAs only *(Identify type of practice location)*:

☐ HHA Branch
☐ Hospital Psychiatric Unit
☐ Hospital Rehabilitation Unit
☐ Hospital Swing-Bed Unit
☐ Main/Primary Hospital Location
☐ OPT Extension Site
☐ Other Hospital Practice Location:_____

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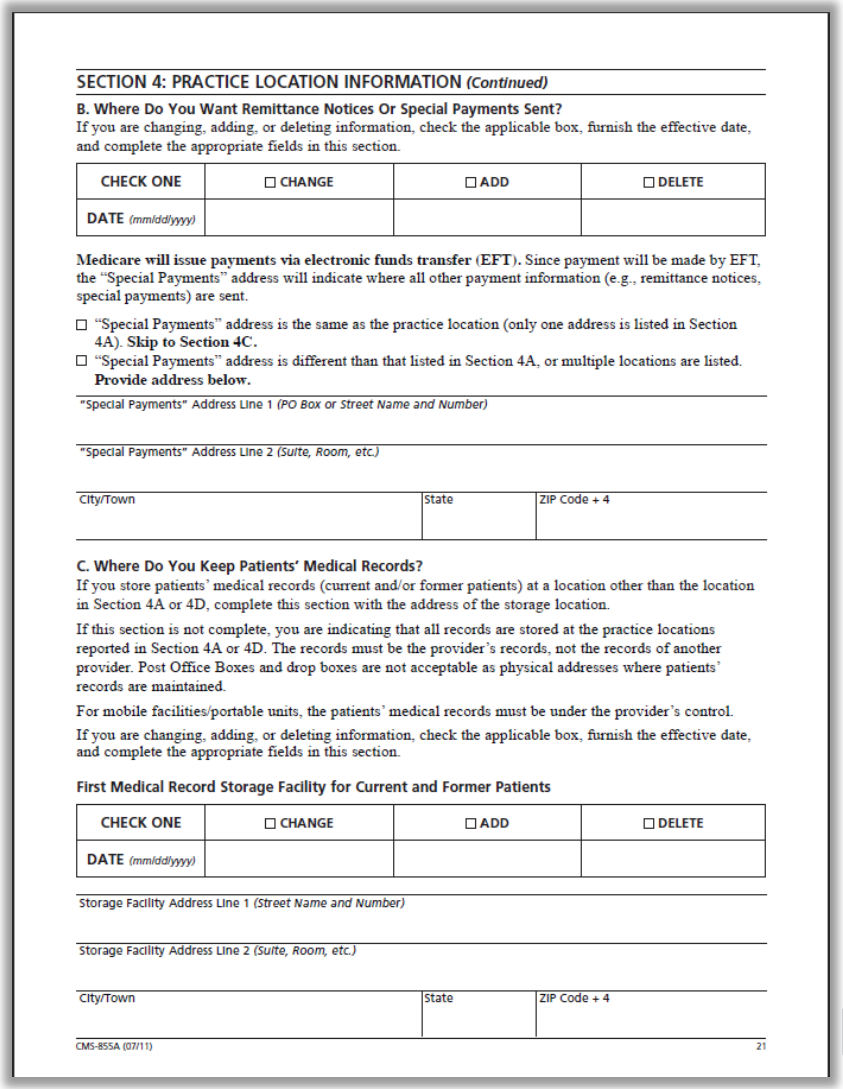
Section 4: Practice Location Information B.C.

- B: Remittance notices or special payment
  - Check the appropriate “special payment” box and follow instructions
  - If add or delete, furnish effective date
- C: Medical Record Storage
  - Complete if patient medical records are stored at a location other than the practice location
  - Address cannot be P.O. Box/Drop Box
  - If add or delete, furnish effective date



SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

B. Where Do You Want Remittance Notices Or Special Payments Sent?
If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Medicare will issue payments via electronic funds transfer (EFT). Since payment will be made by EFT, the “Special Payments” address will indicate where all other payment information (e.g., remittance notices, special payments) are sent.

☐ “Special Payments” address is the same as the practice location (only one address is listed in Section 4A). **Skip to Section 4C.**
☐ “Special Payments” address is different than that listed in Section 4A, or multiple locations are listed. **Provide address below.**

“Special Payments” Address Line 1 *(PO Box or Street Name and Number)*

“Special Payments” Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

C. Where Do You Keep Patients’ Medical Records?
If you store patients’ medical records (current and/or former patients) at a location other than the location in Section 4A or 4D, complete this section with the address of the storage location.

If this section is not complete, you are indicating that all records are stored at the practice locations reported in Section 4A or 4D. The records must be the provider’s records, not the records of another provider. Post Office Boxes and drop boxes are not acceptable as physical addresses where patients’ records are maintained.

For mobile facilities/portable units, the patients’ medical records must be under the provider’s control.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

First Medical Record Storage Facility for Current and Former Patients

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

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

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

City/Town	State	ZIP Code + 4

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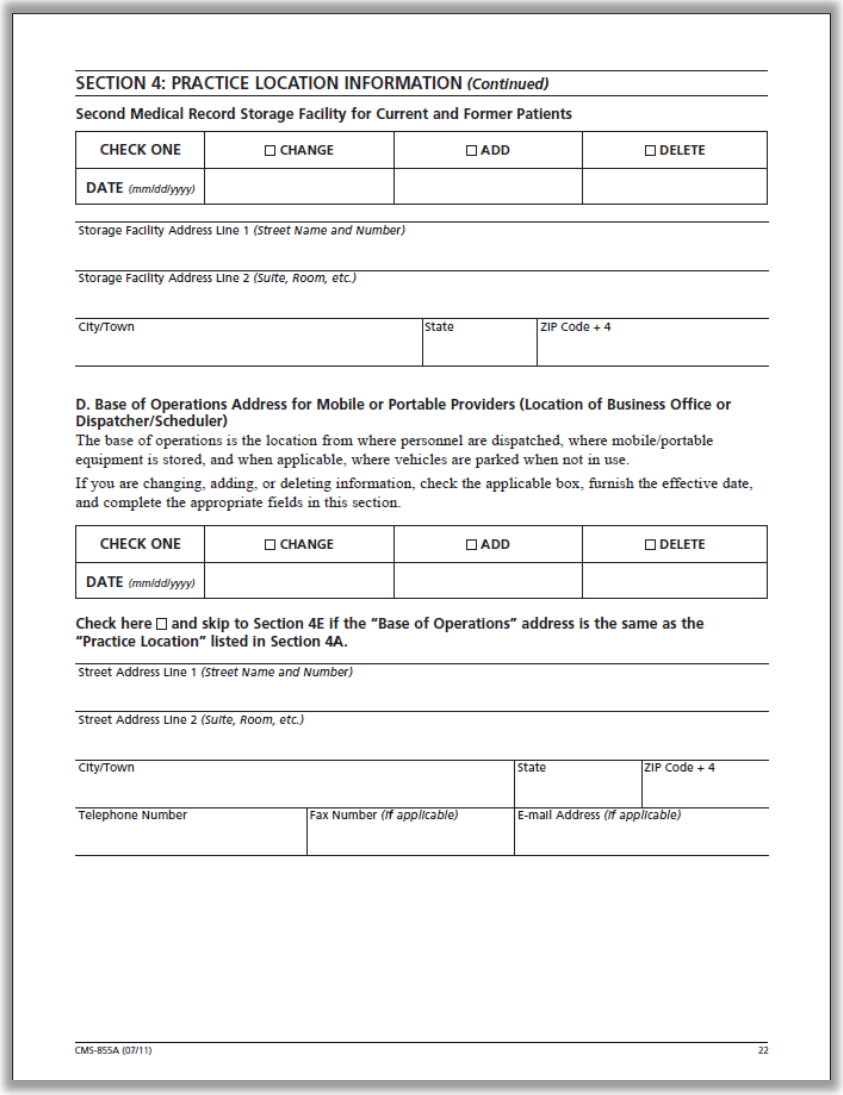
Section 4: Practice Location Information D.

- D: Base of Operation Address for Mobile or Portable Providers
  - Check box if address is the same as the practice location, otherwise furnish address of business office or dispatcher/scheduler
  - If add or delete, furnish effective date



SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

Second Medical Record Storage Facility for Current and Former Patients

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

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

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

City/Town	State	ZIP Code + 4

D. Base of Operations Address for Mobile or Portable Providers (Location of Business Office or Dispatcher/Scheduler)

The base of operations is the location from where personnel are dispatched, where mobile/portable equipment is stored, and when applicable, where vehicles are parked when not in use.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Check here ☐ and skip to Section 4E if the "Base of Operations" address is the same as the "Practice Location" listed in Section 4A.

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

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

City/Town	State	ZIP Code + 4

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

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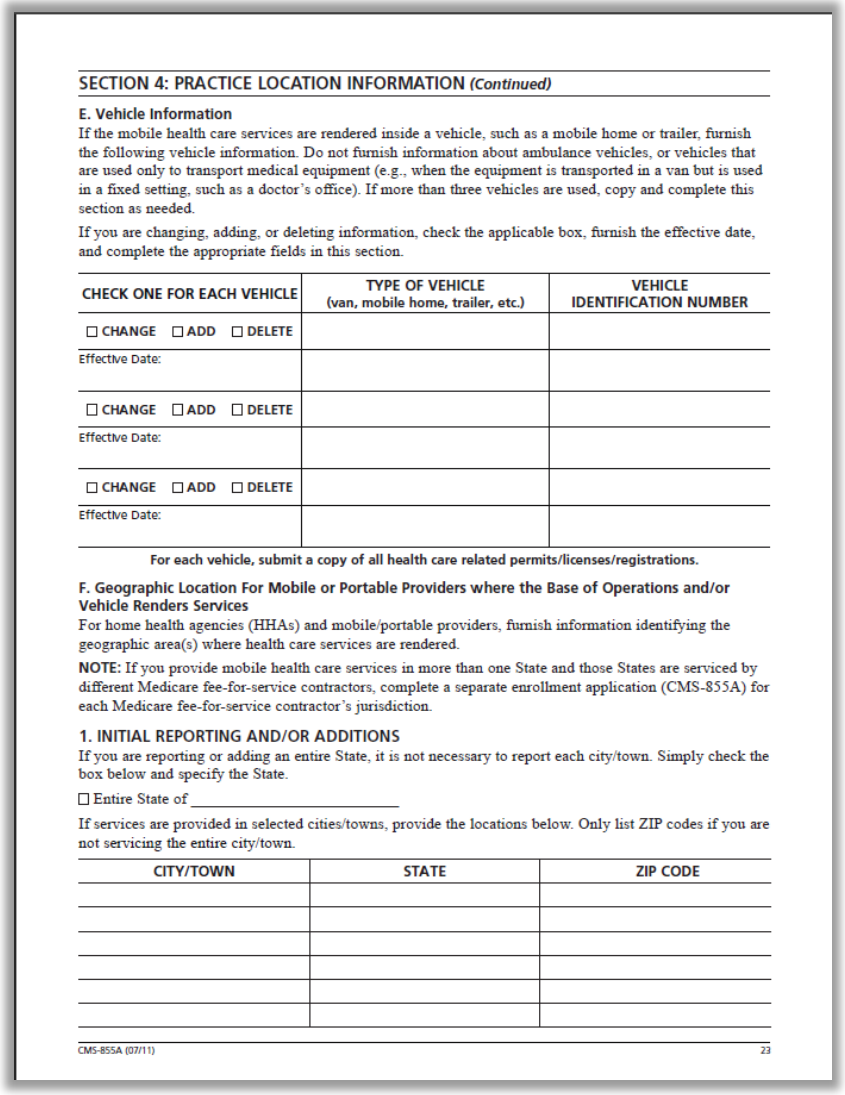
Section 4: Practice Location Information E.F.

- E: Vehicle Information for Mobile or Portable providers
  - If add or delete, furnish effective date
- F: Geographic Locations for Mobile or Portable providers
  - HHAs will need to complete
  - 1. Initial Reporting and/or Additions
    - ✓ Indicate entire state or city/town and/or Zip codes



SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

E. Vehicle Information

If the mobile health care services are rendered inside a vehicle, such as a mobile home or trailer, furnish the following vehicle information. Do not furnish information about ambulance vehicles, or vehicles that are used only to transport medical equipment (e.g., when the equipment is transported in a van but is used in a fixed setting, such as a doctor's office). If more than three vehicles are used, copy and complete this section as needed.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE FOR EACH VEHICLE	TYPE OF VEHICLE (van, mobile home, trailer, etc.)	VEHICLE IDENTIFICATION NUMBER
☐ CHANGE ☐ ADD ☐ DELETE		
Effective Date:		
☐ CHANGE ☐ ADD ☐ DELETE		
Effective Date:		
☐ CHANGE ☐ ADD ☐ DELETE		
Effective Date:		

For each vehicle, submit a copy of all health care related permits/licenses/registrations.

F. Geographic Location For Mobile or Portable Providers where the Base of Operations and/or Vehicle Renders Services

For home health agencies (HHAs) and mobile/portable providers, furnish information identifying the geographic area(s) where health care services are rendered.

NOTE: If you provide mobile health care services in more than one State and those States are serviced by different Medicare fee-for-service contractors, complete a separate enrollment application (CMS-855A) for each Medicare fee-for-service contractor's jurisdiction.

1. INITIAL REPORTING AND/OR ADDITIONS

If you are reporting or adding an entire State, it is not necessary to report each city/town. Simply check the box below and specify the State.

☐ Entire State of _____

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

CITY/TOWN	STATE	ZIP CODE

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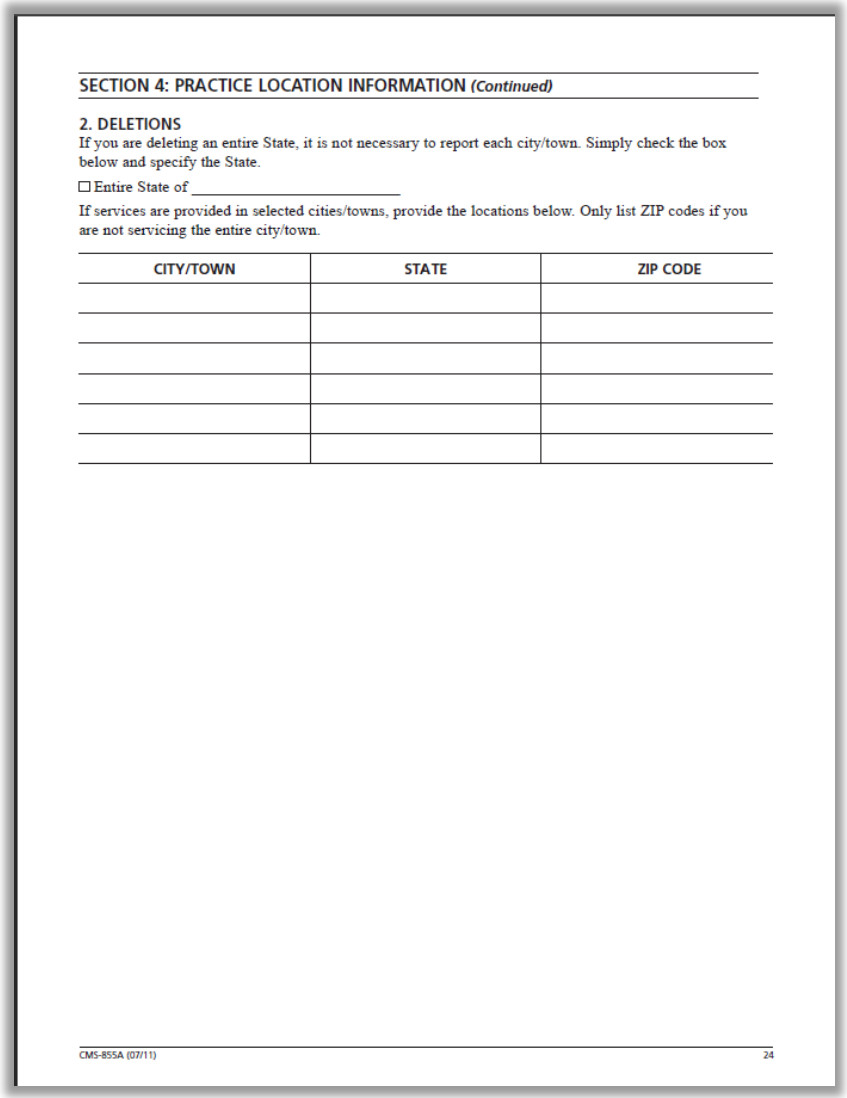
Section 4: Practice Location Information F.

- F: Geographic Locations for Mobile or Portable providers
  - HHAs will need to complete if applicable
  - 2. Deletions
    - ✓ Indicate areas deleting from existing enrollment



SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

2. DELETIONS

If you are deleting an entire State, it is not necessary to report each city/town. Simply check the box below and specify the State.

☐ Entire State of _____

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

CITY/TOWN	STATE	ZIP CODE

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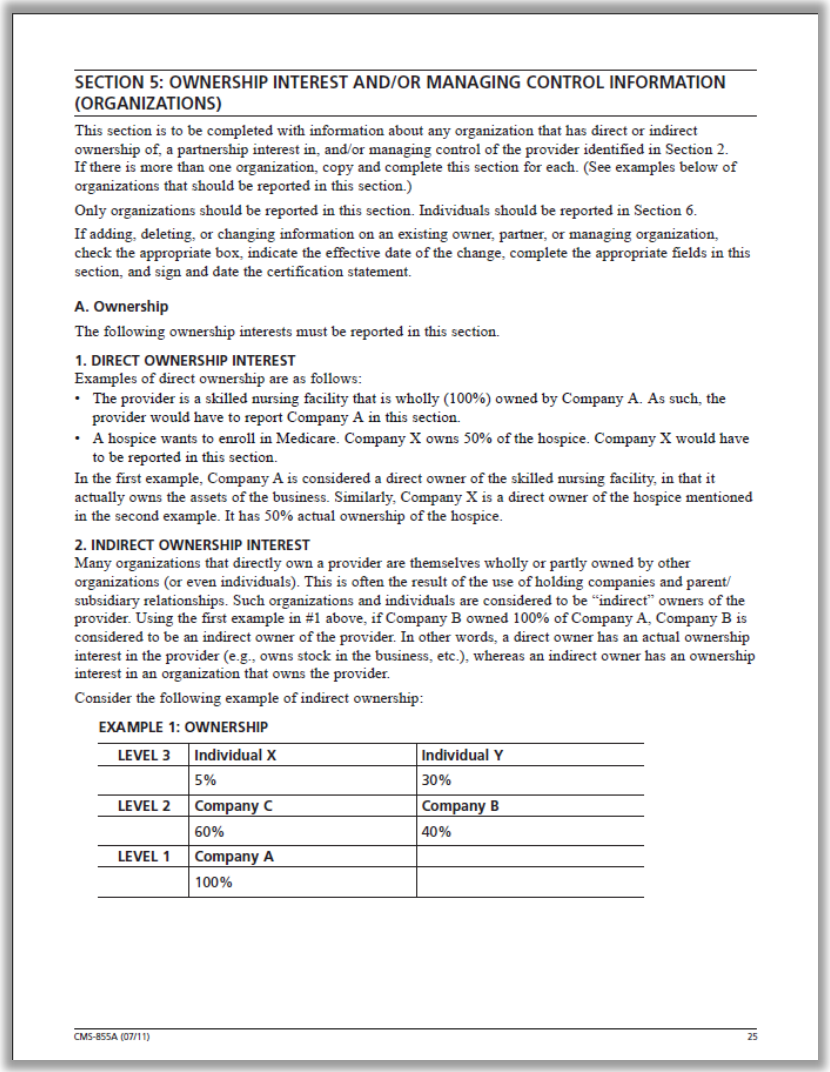
Section 5: Ownership Interest and/or Managing Control Information (Organizations) A1.A2.

- Instructions on organizations to report in this section
  - Individual(s) report in Section 6



SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS)

This section is to be completed with information about any organization that has direct or indirect ownership of, a partnership interest in, and/or managing control of the provider identified in Section 2. If there is more than one organization, copy and complete this section for each. (See examples below of organizations that should be reported in this section.)

Only organizations should be reported in this section. Individuals should be reported in Section 6.

If adding, deleting, or changing information on an existing owner, partner, or managing organization, check the appropriate box, indicate the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement.

A. Ownership

The following ownership interests must be reported in this section.

1. DIRECT OWNERSHIP INTEREST

Examples of direct ownership are as follows:

- The provider is a skilled nursing facility that is wholly (100%) owned by Company A. As such, the provider would have to report Company A in this section.
- A hospice wants to enroll in Medicare. Company X owns 50% of the hospice. Company X would have to be reported in this section.

In the first example, Company A is considered a direct owner of the skilled nursing facility, in that it actually owns the assets of the business. Similarly, Company X is a direct owner of the hospice mentioned in the second example. It has 50% actual ownership of the hospice.

2. INDIRECT OWNERSHIP INTEREST

Many organizations that directly own a provider are themselves wholly or partly owned by other organizations (or even individuals). This is often the result of the use of holding companies and parent/subsidiary relationships. Such organizations and individuals are considered to be "indirect" owners of the provider. Using the first example in #1 above, if Company B owned 100% of Company A, Company B is considered to be an indirect owner of the provider. In other words, a direct owner has an actual ownership interest in the provider (e.g., owns stock in the business, etc.), whereas an indirect owner has an ownership interest in an organization that owns the provider.

Consider the following example of indirect ownership:

EXAMPLE 1: OWNERSHIP

LEVEL 3	**Individual X**	**Individual Y**
	5%	30%
LEVEL 2	**Company C**	**Company B**
	60%	40%
LEVEL 1	**Company A**	
	100%	

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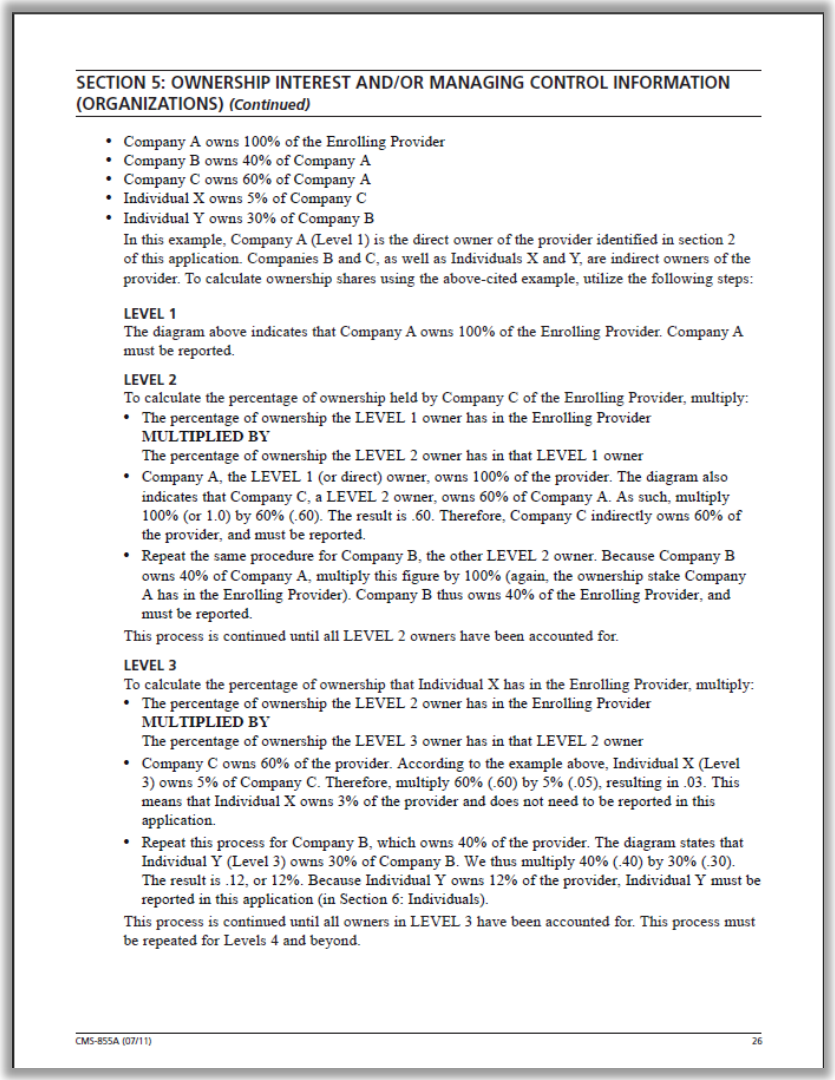
Section 5: Ownership Interest and/or Managing Control Information (Organizations) A2.

- Instructions on organizations to report in this section



SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS) ***(Continued)***

- Company A owns 100% of the Enrolling Provider
- Company B owns 40% of Company A
- Company C owns 60% of Company A
- Individual X owns 5% of Company C
- Individual Y owns 30% of Company B

In this example, Company A (Level 1) is the direct owner of the provider identified in section 2 of this application. Companies B and C, as well as Individuals X and Y, are indirect owners of the provider. To calculate ownership shares using the above-cited example, utilize the following steps:

LEVEL 1

The diagram above indicates that Company A owns 100% of the Enrolling Provider. Company A must be reported.

LEVEL 2

To calculate the percentage of ownership held by Company C of the Enrolling Provider, multiply:

- The percentage of ownership the LEVEL 1 owner has in the Enrolling Provider
  MULTIPLIED BY
  The percentage of ownership the LEVEL 2 owner has in that LEVEL 1 owner
- Company A, the LEVEL 1 (or direct) owner, owns 100% of the provider. The diagram also indicates that Company C, a LEVEL 2 owner, owns 60% of Company A. As such, multiply 100% (or 1.0) by 60% (.60). The result is .60. Therefore, Company C indirectly owns 60% of the provider, and must be reported.
- Repeat the same procedure for Company B, the other LEVEL 2 owner. Because Company B owns 40% of Company A, multiply this figure by 100% (again, the ownership stake Company A has in the Enrolling Provider). Company B thus owns 40% of the Enrolling Provider, and must be reported.

This process is continued until all LEVEL 2 owners have been accounted for.

LEVEL 3

To calculate the percentage of ownership that Individual X has in the Enrolling Provider, multiply:

- The percentage of ownership the LEVEL 2 owner has in the Enrolling Provider
  MULTIPLIED BY
  The percentage of ownership the LEVEL 3 owner has in that LEVEL 2 owner
- Company C owns 60% of the provider. According to the example above, Individual X (Level 3) owns 5% of Company C. Therefore, multiply 60% (.60) by 5% (.05), resulting in .03. This means that Individual X owns 3% of the provider and does not need to be reported in this application.
- Repeat this process for Company B, which owns 40% of the provider. The diagram states that Individual Y (Level 3) owns 30% of Company B. We thus multiply 40% (.40) by 30% (.30). The result is .12, or 12%. Because Individual Y owns 12% of the provider, Individual Y must be reported in this application (in Section 6: Individuals).

This process is continued until all owners in LEVEL 3 have been accounted for. This process must be repeated for Levels 4 and beyond.

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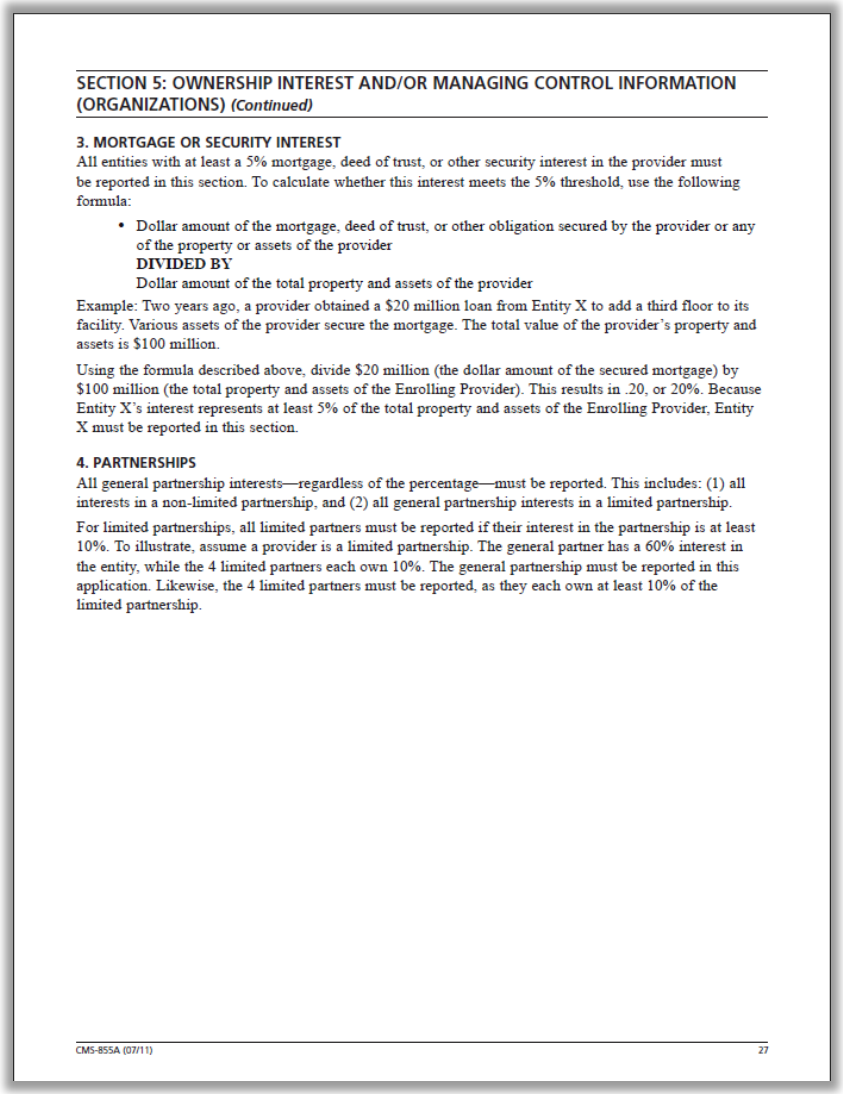
Section 5: Ownership Interest and/or Managing Control Information (Organizations) A3.A4.

- Instructions on organizations to report in this section



SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS) *(Continued)*

3. MORTGAGE OR SECURITY INTEREST

All entities with at least a 5% mortgage, deed of trust, or other security interest in the provider must be reported in this section. To calculate whether this interest meets the 5% threshold, use the following formula:

- Dollar amount of the mortgage, deed of trust, or other obligation secured by the provider or any of the property or assets of the provider
  DIVIDED BY
  Dollar amount of the total property and assets of the provider

Example: Two years ago, a provider obtained a $20 million loan from Entity X to add a third floor to its facility. Various assets of the provider secure the mortgage. The total value of the provider's property and assets is $100 million.

Using the formula described above, divide $20 million (the dollar amount of the secured mortgage) by $100 million (the total property and assets of the Enrolling Provider). This results in .20, or 20%. Because Entity X's interest represents at least 5% of the total property and assets of the Enrolling Provider, Entity X must be reported in this section.

4. PARTNERSHIPS

All general partnership interests—regardless of the percentage—must be reported. This includes: (1) all interests in a non-limited partnership, and (2) all general partnership interests in a limited partnership.

For limited partnerships, all limited partners must be reported if their interest in the partnership is at least 10%. To illustrate, assume a provider is a limited partnership. The general partner has a 60% interest in the entity, while the 4 limited partners each own 10%. The general partnership must be reported in this application. Likewise, the 4 limited partners must be reported, as they each own at least 10% of the limited partnership.

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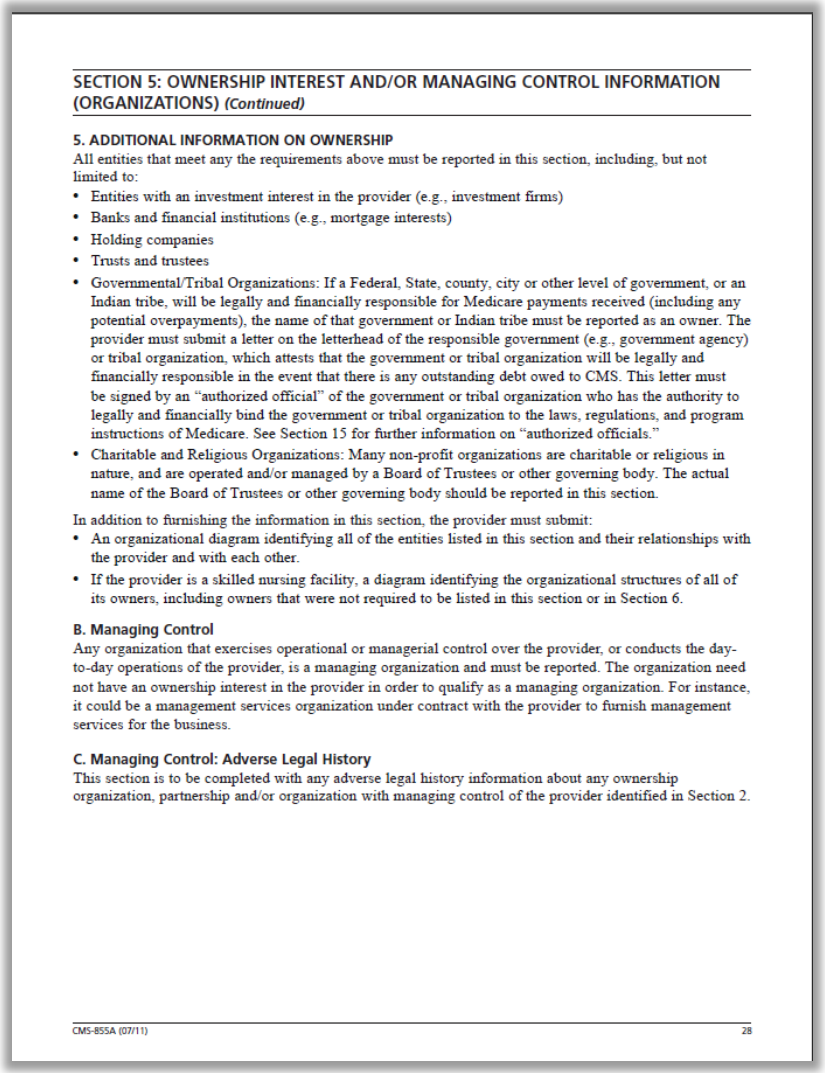
Section 5: Ownership Interest and/or Managing Control Information (Organizations) A5.B.C.

- Instructions on organizations to report in this section



SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS) ***(Continued)***

5. ADDITIONAL INFORMATION ON OWNERSHIP

All entities that meet any the requirements above must be reported in this section, including, but not limited to:

- Entities with an investment interest in the provider (e.g., investment firms)
- Banks and financial institutions (e.g., mortgage interests)
- Holding companies
- Trusts and trustees
- Governmental/Tribal Organizations: If a Federal, State, county, city or other level of government, or an Indian tribe, will be legally and financially responsible for Medicare payments received (including any potential overpayments), the name of that government or Indian tribe must be reported as an owner. The provider must submit a letter on the letterhead of the responsible government (e.g., government agency) or tribal organization, which attests that the government or tribal organization will be legally and financially responsible in the event that there is any outstanding debt owed to CMS. This letter must be signed by an "authorized official" of the government or tribal organization who has the authority to legally and financially bind the government or tribal organization to the laws, regulations, and program instructions of Medicare. See Section 15 for further information on "authorized officials."
- Charitable and Religious Organizations: Many non-profit organizations are charitable or religious in nature, and are operated and/or managed by a Board of Trustees or other governing body. The actual name of the Board of Trustees or other governing body should be reported in this section.

In addition to furnishing the information in this section, the provider must submit:

- An organizational diagram identifying all of the entities listed in this section and their relationships with the provider and with each other.
- If the provider is a skilled nursing facility, a diagram identifying the organizational structures of all of its owners, including owners that were not required to be listed in this section or in Section 6.

B. Managing Control

Any organization that exercises operational or managerial control over the provider, or conducts the day-to-day operations of the provider, is a managing organization and must be reported. The organization need not have an ownership interest in the provider in order to qualify as a managing organization. For instance, it could be a management services organization under contract with the provider to furnish management services for the business.

C. Managing Control: Adverse Legal History

This section is to be completed with any adverse legal history information about any ownership organization, partnership and/or organization with managing control of the provider identified in Section 2.

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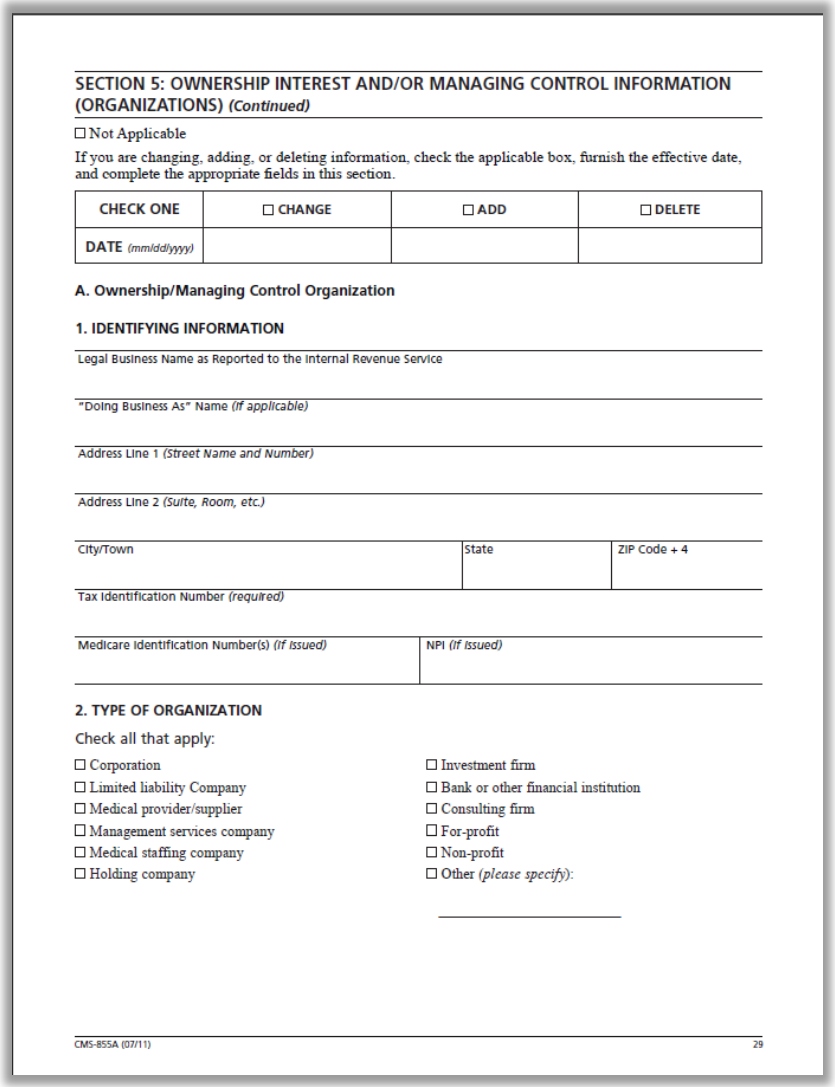
Section 5: Ownership Interest and/or Managing Control Information (Organizations) A.

- A: Ownership/Managing Control Organization
  - Check the box “not applicable”
  - Complete entire section for each organization
    - ✓ Five percent or more direct or indirect ownership
    - ✓ Managing control
    - ✓ Partnership interest
  - Type of organization
  - If add or delete, furnish effective date



SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS) *(Continued)*

☐ Not Applicable

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

A. Ownership/Managing Control Organization

1. IDENTIFYING INFORMATION

Legal Business Name as Reported to the Internal Revenue Service

"Doing Business As" Name *(If applicable)*

Address Line 1 *(Street Name and Number)*

Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Tax Identification Number *(required)*

Medicare Identification Number(s) *(If issued)*	NPI *(If issued)*

2. TYPE OF ORGANIZATION

Check all that apply:

☐ Corporation
☐ Limited liability Company
☐ Medical provider/supplier
☐ Management services company
☐ Medical staffing company
☐ Holding company
☐ Investment firm
☐ Bank or other financial institution
☐ Consulting firm
☐ For-profit
☐ Non-profit
☐ Other *(please specify)*:

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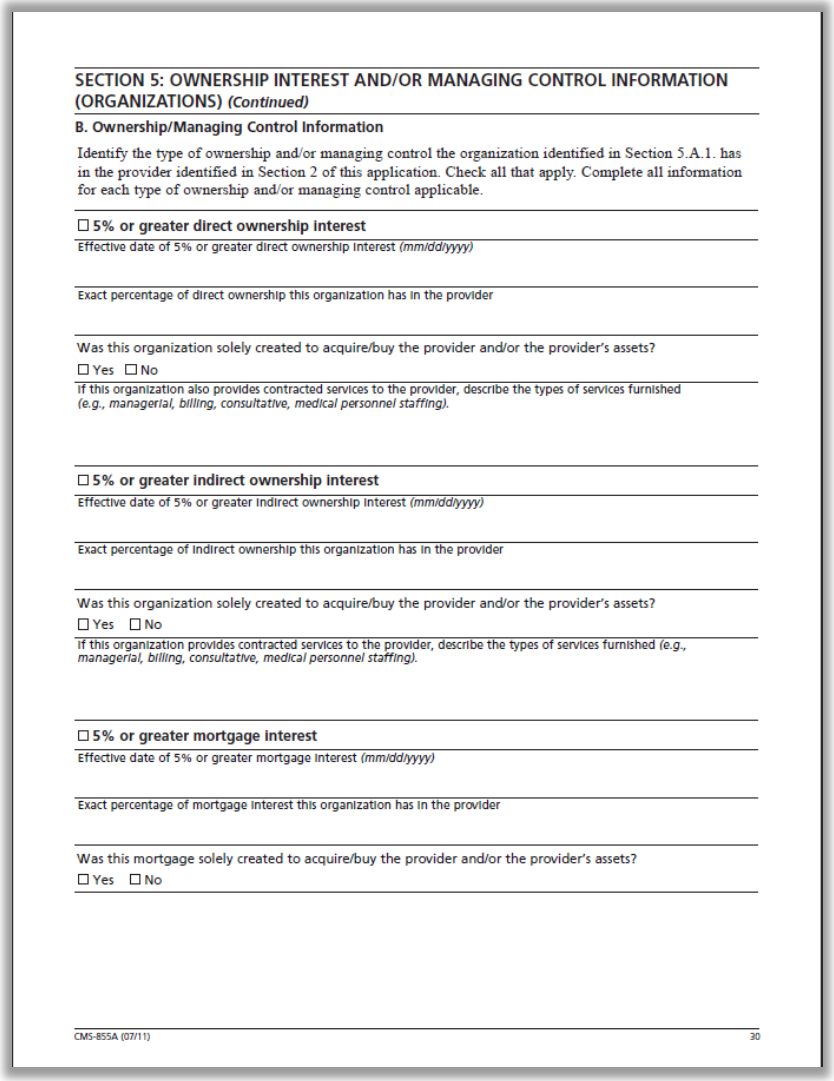
Section 5: Ownership Interest and/or Managing Control Information (Organizations) B.

- B: Ownership/Managing Control Information
  - Identify the relationship to provider (select all that apply)



SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS) *(Continued)*

B. Ownership/Managing Control Information

Identify the type of ownership and/or managing control the organization identified in Section 5.A.1. has in the provider identified in Section 2 of this application. Check all that apply. Complete all information for each type of ownership and/or managing control applicable.

☐ **5% or greater direct ownership interest**

Effective date of 5% or greater direct ownership interest *(mm/dd/yyyy)*

Exact percentage of direct ownership this organization has in the provider

Was this organization solely created to acquire/buy the provider and/or the provider's assets?

☐ Yes ☐ No

If this organization also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing).*

☐ **5% or greater indirect ownership interest**

Effective date of 5% or greater indirect ownership interest *(mm/dd/yyyy)*

Exact percentage of indirect ownership this organization has in the provider

Was this organization solely created to acquire/buy the provider and/or the provider's assets?

☐ Yes ☐ No

If this organization provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing).*

☐ **5% or greater mortgage interest**

Effective date of 5% or greater mortgage interest *(mm/dd/yyyy)*

Exact percentage of mortgage interest this organization has in the provider

Was this mortgage solely created to acquire/buy the provider and/or the provider's assets?

☐ Yes ☐ No

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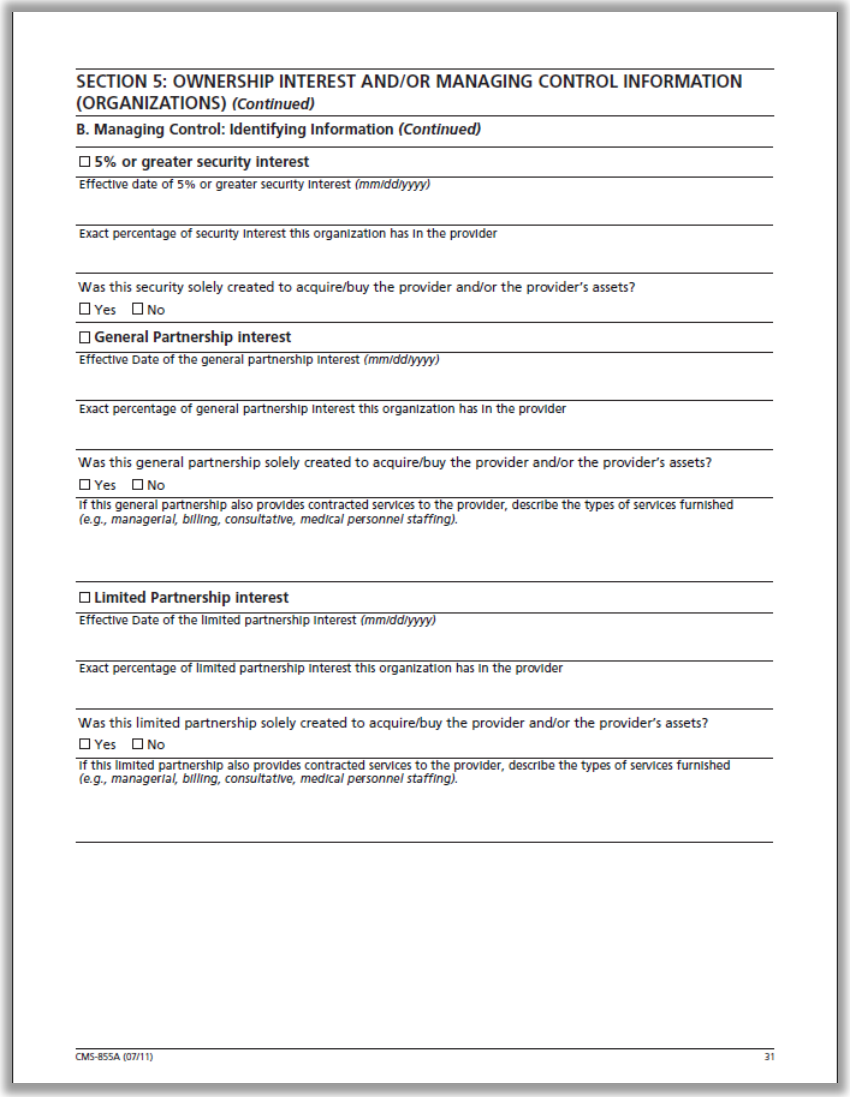
Section 5: Ownership Interest and/or Managing Control Information (Organizations) B.

- B: Ownership/Managing Control Information
  - Identify the relationship to provider (select all that apply)



SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS) *(Continued)*

B. Managing Control: Identifying Information *(Continued)*

☐ **5% or greater security interest**

Effective date of 5% or greater security interest *(mm/dd/yyyy)*

Exact percentage of security interest this organization has in the provider

Was this security solely created to acquire/buy the provider and/or the provider's assets?

☐ Yes ☐ No

☐ **General Partnership interest**

Effective Date of the general partnership interest *(mm/dd/yyyy)*

Exact percentage of general partnership interest this organization has in the provider

Was this general partnership solely created to acquire/buy the provider and/or the provider's assets?

☐ Yes ☐ No

If this general partnership also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing).*

☐ **Limited Partnership interest**

Effective Date of the limited partnership interest *(mm/dd/yyyy)*

Exact percentage of limited partnership interest this organization has in the provider

Was this limited partnership solely created to acquire/buy the provider and/or the provider's assets?

☐ Yes ☐ No

If this limited partnership also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing).*

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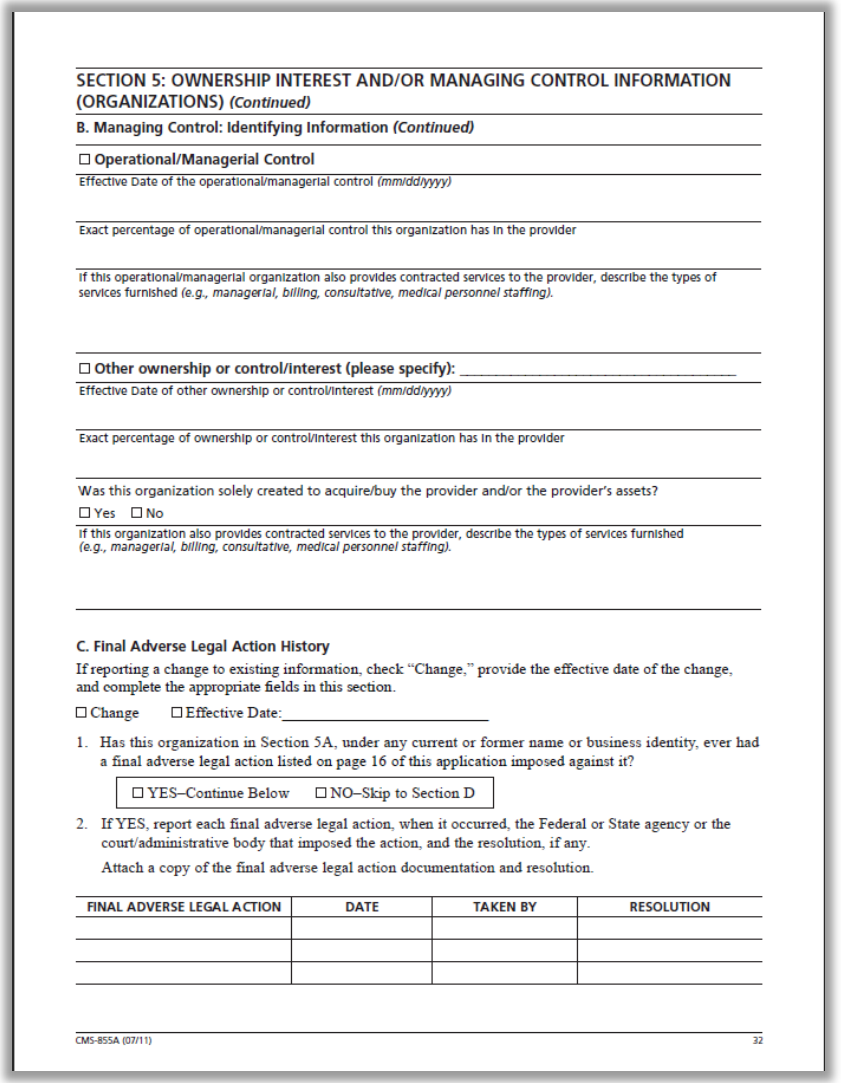
Section 5: Ownership Interest and/or Managing Control Information (Organizations) B.C.

- C: Final Adverse Legal Action History
  - Check the box “change” and furnish effective date
  - If no adverse legal action, check “No”
  - If any, check “Yes”, then list details in section C2 and attach final adverse legal action documentation and/or resolutions



SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS) ***(Continued)***

B. Managing Control: Identifying Information ***(Continued)***

☐ **Operational/Managerial Control**

Effective Date of the operational/managerial control *(mm/dd/yyyy)*

Exact percentage of operational/managerial control this organization has in the provider

If this operational/managerial organization also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing).*

☐ **Other ownership or control/interest (please specify):** _____

Effective Date of other ownership or control/interest *(mm/dd/yyyy)*

Exact percentage of ownership or control/interest this organization has in the provider

Was this organization solely created to acquire/buy the provider and/or the provider's assets?

☐ Yes ☐ No

If this organization also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing).*

C. Final Adverse Legal Action History

If reporting a change to existing information, check "Change," provide the effective date of the change, and complete the appropriate fields in this section.

☐ Change ☐ Effective Date:_____

1. Has this organization in Section 5A, under any current or former name or business identity, ever had a final adverse legal action listed on page 16 of this application imposed against it?

   ☐ YES–Continue Below ☐ NO–Skip to Section D

2. If YES, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

   Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

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Organizational Diagram or Flowchart

- Provider must submit an organizational diagram identifying all of the entities and individuals and their relationships with the provider and with each other

In additional to furnishing the information in this section, the provider must submit:

- An organizational diagram identifying all of the entities listed in this section and their relationships with the provider and with each other.
- A diagram identifying the organizational structures of all of its owners, including owners that were not required to be listed in this section or in Section 6, only if the provider is a skilled nursing facility.

Note that the diagrams must include all individuals with any of the ownership interests indicated in Section 6.

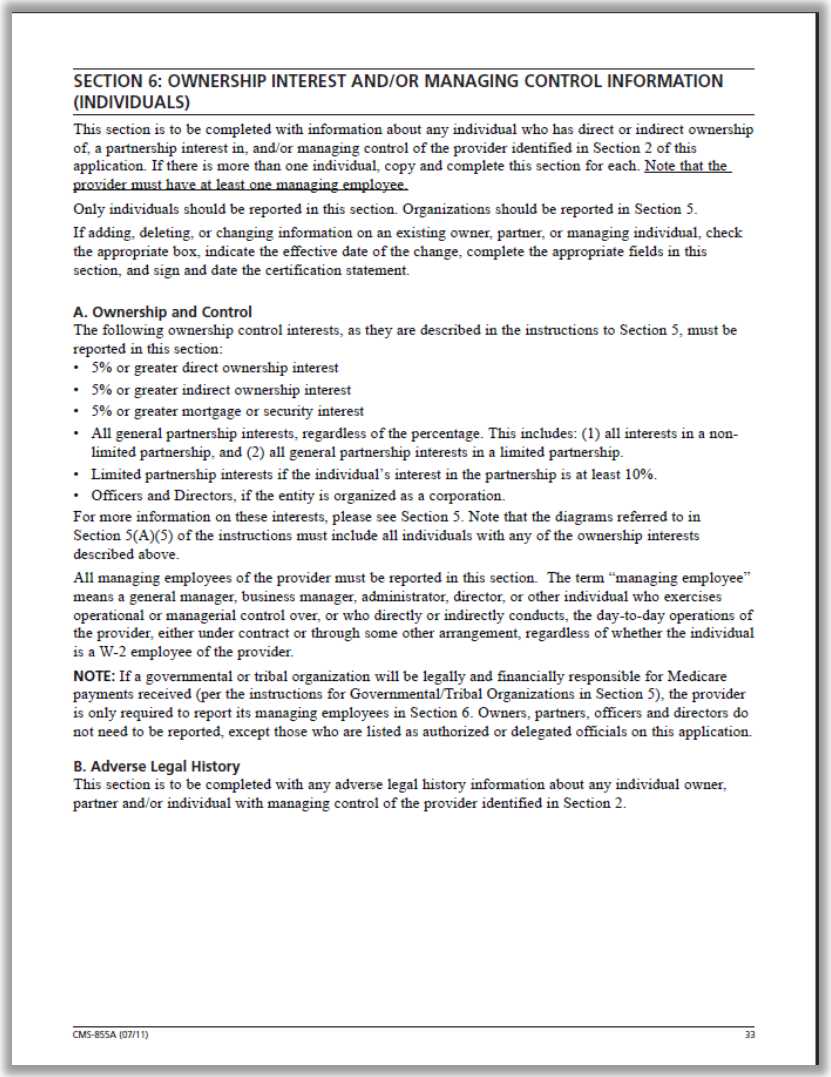
Diagram Sample:

Level 0	**Provider (Applicant)**
Level 1	**Company A** – owns 100% of provider (direct owner) 100% x 100% = **100%**
Level 2	**Company B** – owns 40% of company A (Indirect owner) 100% x 40% = **40%** **Company C** – owns 60% of company A (indirect owner) 100% x 60% = **60%**
Level 3	**Individual Y** – owns 30% of company B (indirect owner) 40% x 30% = **12%** **Individual X** – owns 5% of company C (indirect owner) 60% X 5% = **3%**

Using the information above Company A (100%), B (40%) and C (60%) is at least 5% or greater direct or indirect ownership they must be indicated in section 5. Individual Y (12%) is at least 5% or greater indirect ownership they must be indicated in section 6. Since Individual X (3%) is less than 5% indirect owner, they do not need to be listed in section 6 but **must** be indicated in diagram.

Section 6: Ownership Interest and/or Managing Control Information (Individuals) A.B.

- Instructions on individuals to report in this section
  - Organizations report in Section 5



SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS)

This section is to be completed with information about any individual who has direct or indirect ownership of, a partnership interest in, and/or managing control of the provider identified in Section 2 of this application. If there is more than one individual, copy and complete this section for each. Note that the provider must have at least one managing employee.

Only individuals should be reported in this section. Organizations should be reported in Section 5.

If adding, deleting, or changing information on an existing owner, partner, or managing individual, check the appropriate box, indicate the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement.

A. Ownership and Control

The following ownership control interests, as they are described in the instructions to Section 5, must be reported in this section:

- 5% or greater direct ownership interest
- 5% or greater indirect ownership interest
- 5% or greater mortgage or security interest
- All general partnership interests, regardless of the percentage. This includes: (1) all interests in a non-limited partnership, and (2) all general partnership interests in a limited partnership.
- Limited partnership interests if the individual's interest in the partnership is at least 10%.
- Officers and Directors, if the entity is organized as a corporation.

For more information on these interests, please see Section 5. Note that the diagrams referred to in Section 5(A)(5) of the instructions must include all individuals with any of the ownership interests described above.

All managing employees of the provider must be reported in this section. The term "managing employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operations of the provider, either under contract or through some other arrangement, regardless of whether the individual is a W-2 employee of the provider.

NOTE: If a governmental or tribal organization will be legally and financially responsible for Medicare payments received (per the instructions for Governmental/Tribal Organizations in Section 5), the provider is only required to report its managing employees in Section 6. Owners, partners, officers and directors do not need to be reported, except those who are listed as authorized or delegated officials on this application.

B. Adverse Legal History

This section is to be completed with any adverse legal history information about any individual owner, partner and/or individual with managing control of the provider identified in Section 2.

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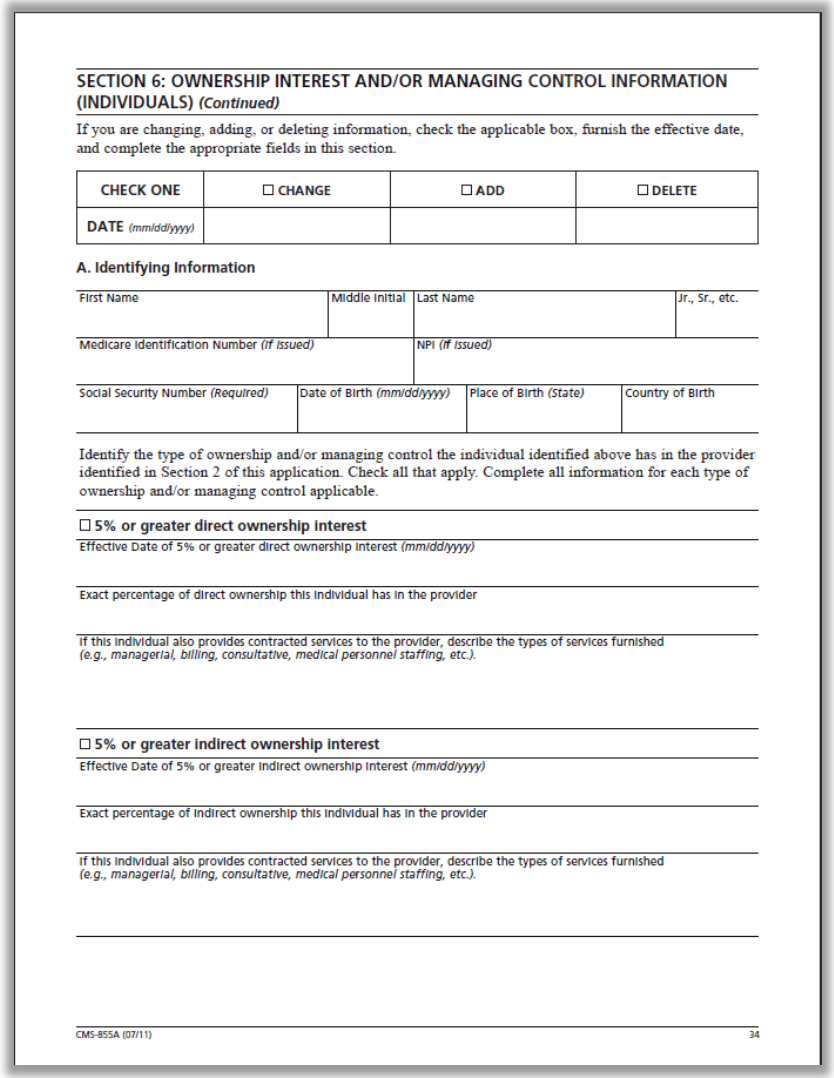
Section 6: Ownership Interest and/or Managing Control Information (Individuals) A.

- A: Individual Identifying Information
  - Complete entire section for each Individual
    - ✓ Five percent or more ownership
    - ✓ Managing control
    - ✓ Partnership interest
  - If add or delete, furnish effective date
  - Identify the relationship to provider (select all that apply)



SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) ***(Continued)***

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

A. Identifying Information

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

Medicare Identification Number *(If Issued)*	NPI *(If Issued)*

Social Security Number *(Required)*	Date of Birth *(mm/dd/yyyy)*	Place of Birth *(State)*	Country of Birth

Identify the type of ownership and/or managing control the individual identified above has in the provider identified in Section 2 of this application. Check all that apply. Complete all information for each type of ownership and/or managing control applicable.

☐ **5% or greater direct ownership interest**

Effective Date of 5% or greater direct ownership interest *(mm/dd/yyyy)*

Exact percentage of direct ownership this individual has in the provider

If this individual also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing, etc.).*

☐ **5% or greater indirect ownership interest**

Effective Date of 5% or greater indirect ownership interest *(mm/dd/yyyy)*

Exact percentage of indirect ownership this individual has in the provider

If this individual also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing, etc.).*

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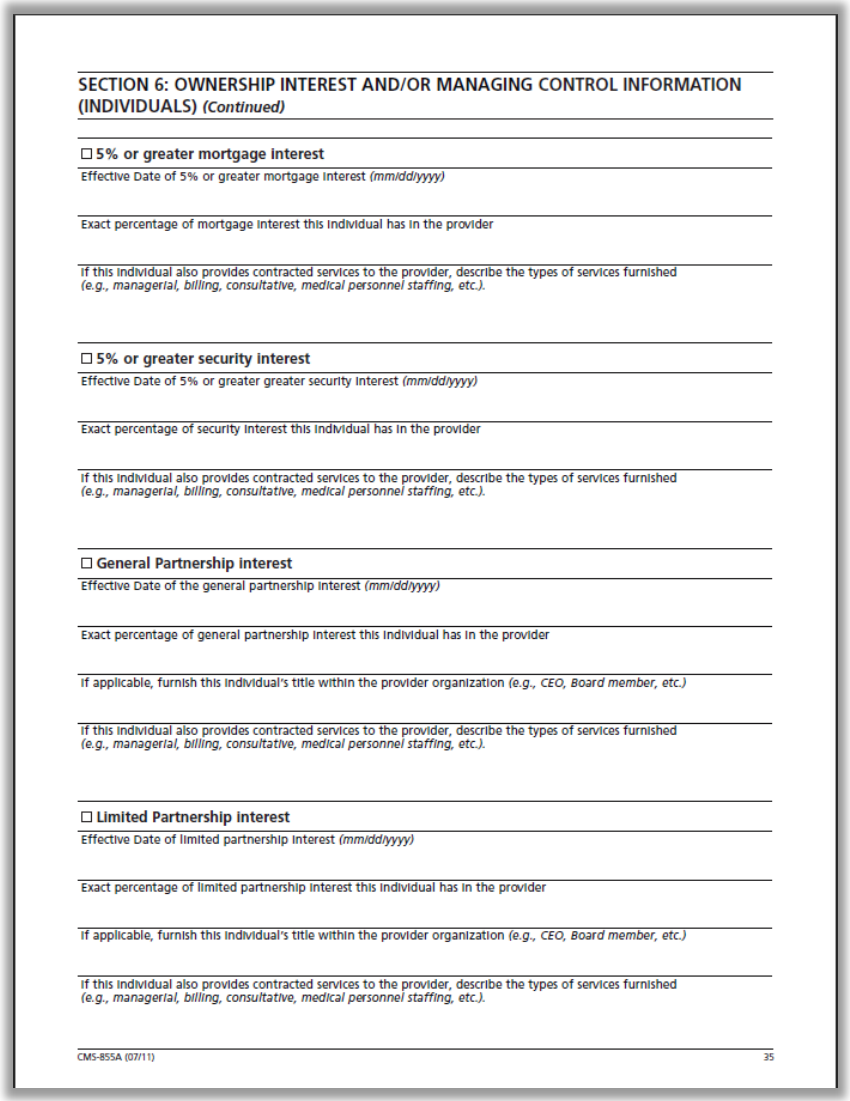
Section 6: Ownership Interest and/or Managing Control Information (Individuals) A.

- A: Individual Identifying Information
  - Identify the relationship to provider (select all that apply)



SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) ***(Continued)***

☐ **5% or greater mortgage interest**

Effective Date of 5% or greater mortgage interest *(mm/dd/yyyy)*

Exact percentage of mortgage interest this individual has in the provider

If this individual also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing, etc.).*

☐ **5% or greater security interest**

Effective Date of 5% or greater greater security interest *(mm/dd/yyyy)*

Exact percentage of security interest this individual has in the provider

If this individual also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing, etc.).*

☐ **General Partnership interest**

Effective Date of the general partnership interest *(mm/dd/yyyy)*

Exact percentage of general partnership interest this individual has in the provider

If applicable, furnish this individual's title within the provider organization *(e.g., CEO, Board member, etc.)*

If this individual also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing, etc.).*

☐ **Limited Partnership interest**

Effective Date of limited partnership interest *(mm/dd/yyyy)*

Exact percentage of limited partnership interest this individual has in the provider

If applicable, furnish this individual's title within the provider organization *(e.g., CEO, Board member, etc.)*

If this individual also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing, etc.).*

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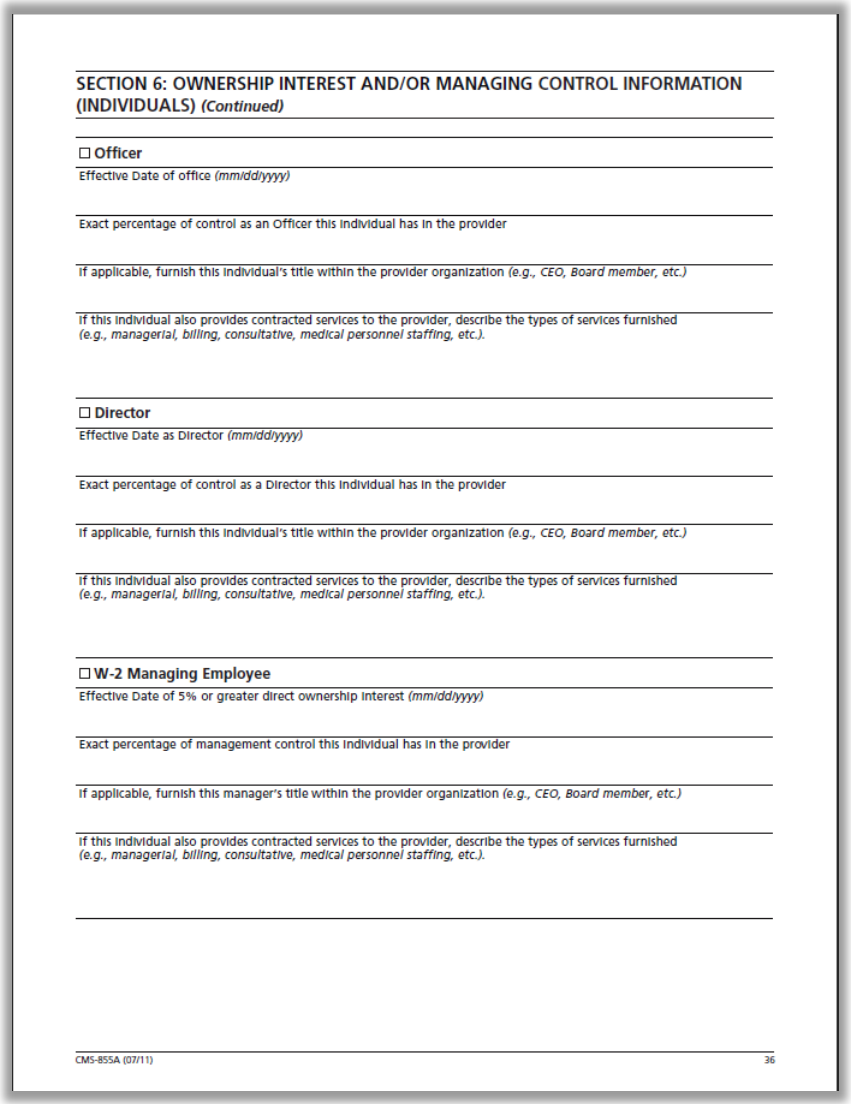
Section 6: Ownership Interest and/or Managing Control Information (Individuals) A.

- A: Individual Identifying Information
  - Identify the relationship to provider (select all that apply)



SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) *(Continued)*

☐ **Officer**

Effective Date of office *(mm/dd/yyyy)*

Exact percentage of control as an Officer this individual has in the provider

If applicable, furnish this individual's title within the provider organization *(e.g., CEO, Board member, etc.)*

If this individual also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing, etc.).*

☐ **Director**

Effective Date as Director *(mm/dd/yyyy)*

Exact percentage of control as a Director this individual has in the provider

If applicable, furnish this individual's title within the provider organization *(e.g., CEO, Board member, etc.)*

If this individual also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing, etc.).*

☐ **W-2 Managing Employee**

Effective Date of 5% or greater direct ownership interest *(mm/dd/yyyy)*

Exact percentage of management control this individual has in the provider

If applicable, furnish this manager's title within the provider organization *(e.g., CEO, Board member, etc.)*

If this individual also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing, etc.).*

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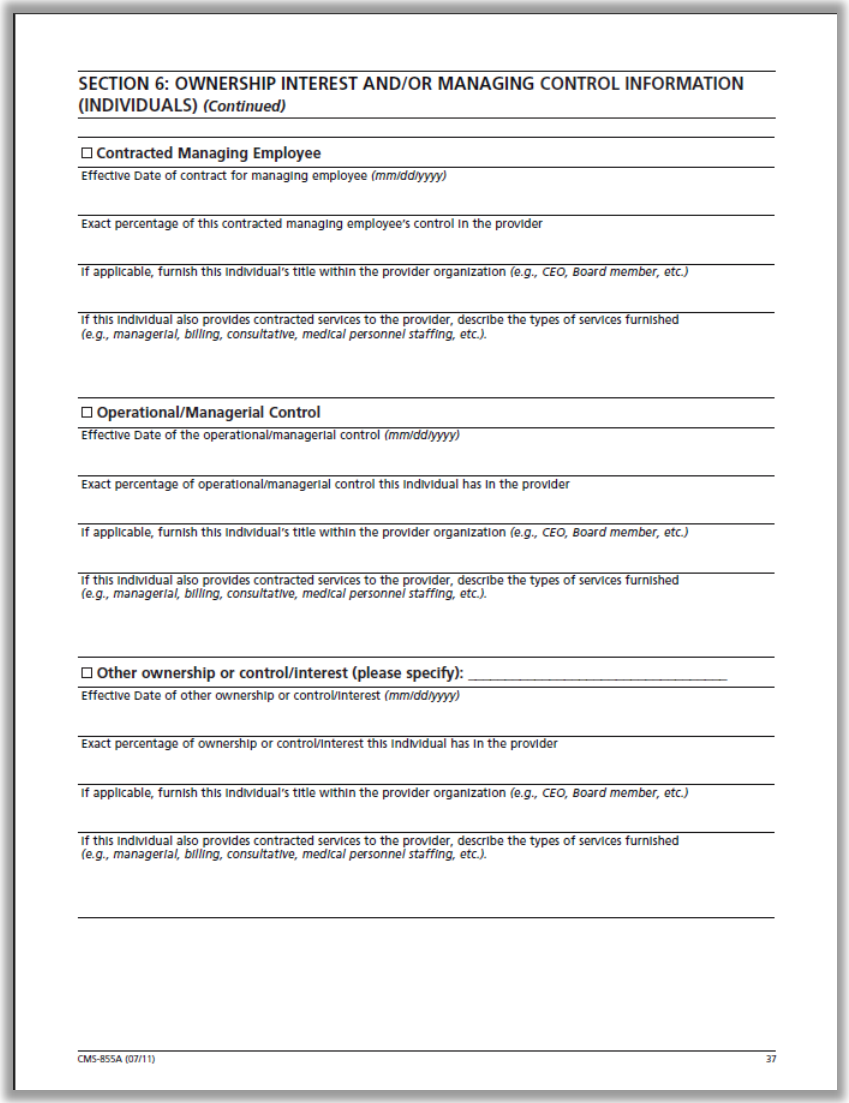
Section 6: Ownership Interest and/or Managing Control Information (Individuals) A.

- A: Individual Identifying Information
  - Identify the relationship to provider (select all that apply)



SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) ***(Continued)***

☐ **Contracted Managing Employee**

Effective Date of contract for managing employee *(mm/dd/yyyy)*

Exact percentage of this contracted managing employee's control in the provider

If applicable, furnish this individual's title within the provider organization *(e.g., CEO, Board member, etc.)*

If this individual also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing, etc.).*

☐ **Operational/Managerial Control**

Effective Date of the operational/managerial control *(mm/dd/yyyy)*

Exact percentage of operational/managerial control this individual has in the provider

If applicable, furnish this individual's title within the provider organization *(e.g., CEO, Board member, etc.)*

If this individual also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing, etc.).*

☐ **Other ownership or control/interest (please specify):** _____

Effective Date of other ownership or control/interest *(mm/dd/yyyy)*

Exact percentage of ownership or control/interest this individual has in the provider

If applicable, furnish this individual's title within the provider organization *(e.g., CEO, Board member, etc.)*

If this individual also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing, etc.).*

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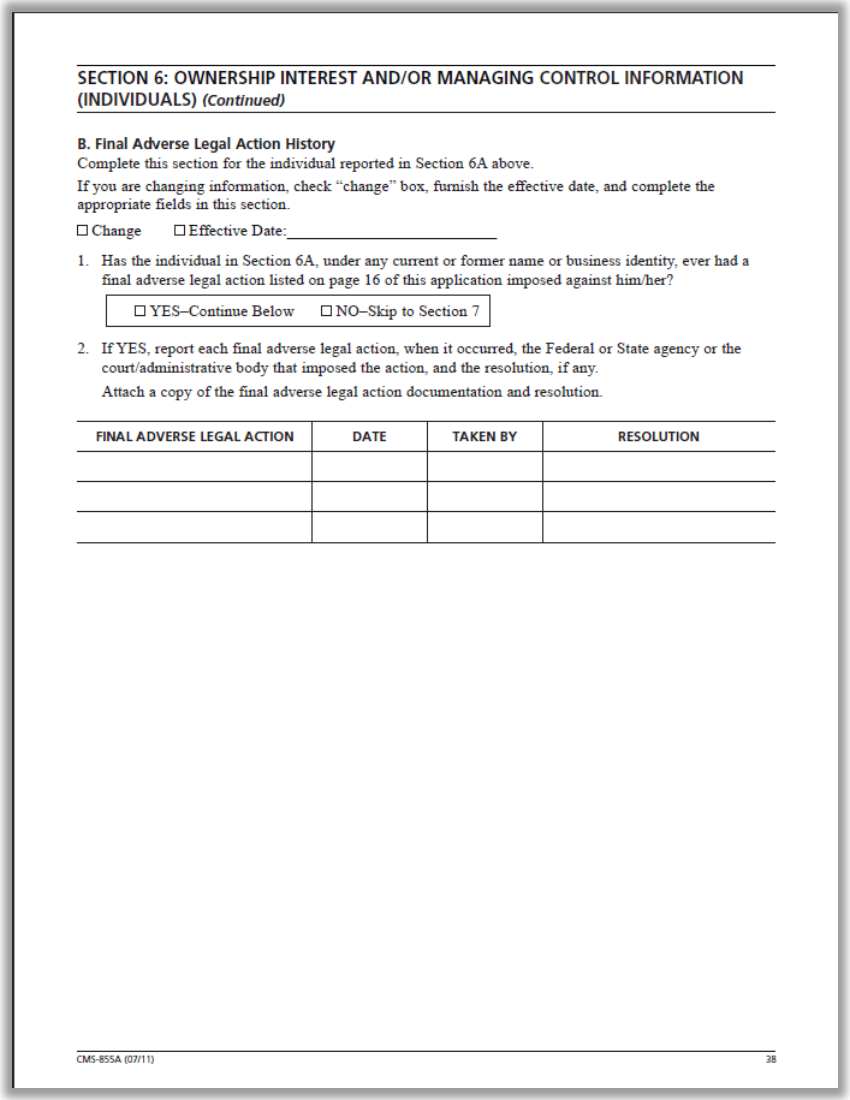
Section 6: Ownership Interest and/or Managing Control Information (Individuals) B.

- B: Final Adverse Legal Action History
  - Check the box “change” and furnish effective date
  - If no adverse legal action, check “No”
  - If any, check “Yes”, then list details in section B2 and attach final adverse legal action documentation and/or resolutions



SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) ***(Continued)***

B. Final Adverse Legal Action History

Complete this section for the individual reported in Section 6A above.

If you are changing information, check “change” box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☐ Effective Date:_____

1. Has the individual in Section 6A, under any current or former name or business identity, ever had a final adverse legal action listed on page 16 of this application imposed against him/her?

   ☐ YES–Continue Below ☐ NO–Skip to Section 7

2. If YES, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

   Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

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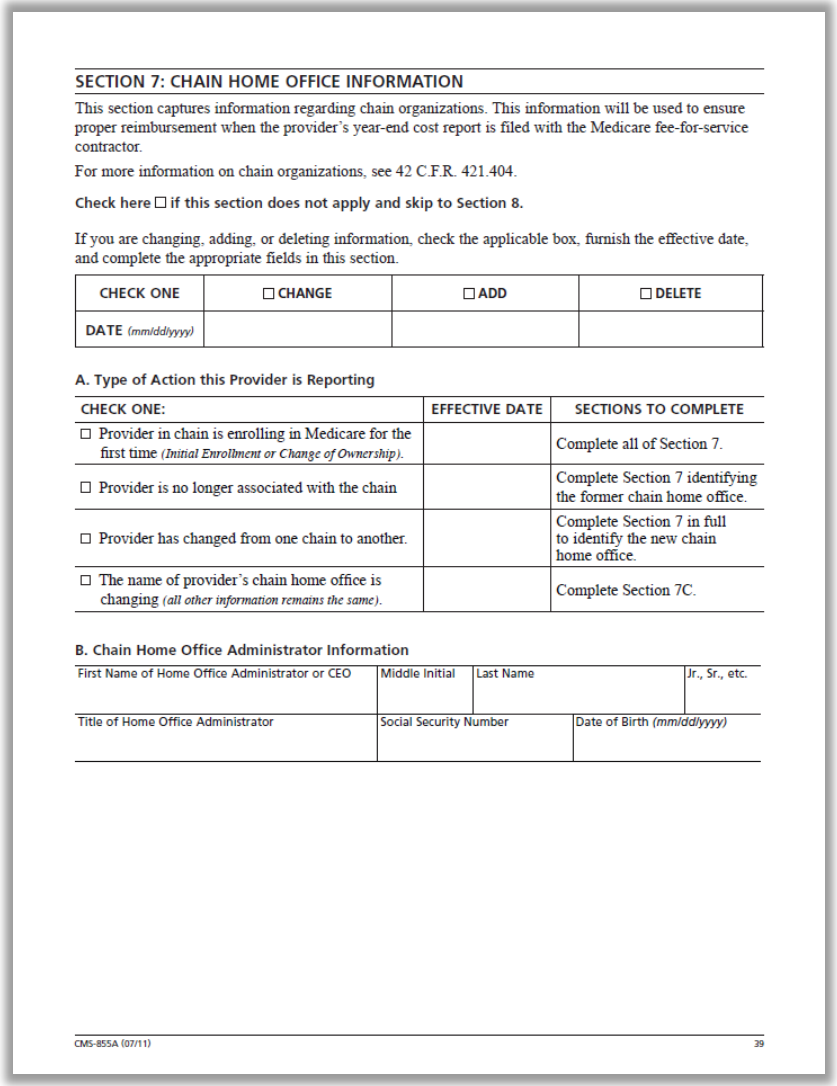
Section 7: Chain Home Office Information A.B.

- Check box if section does not apply
- A. Type of Action this Provider is Reporting
- B. Chain Home Office Administrator Information
- If add or delete, furnish effective date



SECTION 7: CHAIN HOME OFFICE INFORMATION

This section captures information regarding chain organizations. This information will be used to ensure proper reimbursement when the provider's year-end cost report is filed with the Medicare fee-for-service contractor.

For more information on chain organizations, see 42 C.F.R. 421.404.

Check here ☐ if this section does not apply and skip to Section 8.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

A. Type of Action this Provider is Reporting

CHECK ONE:	EFFECTIVE DATE	SECTIONS TO COMPLETE
☐ Provider in chain is enrolling in Medicare for the first time *(Initial Enrollment or Change of Ownership)*.		Complete all of Section 7.
☐ Provider is no longer associated with the chain		Complete Section 7 identifying the former chain home office.
☐ Provider has changed from one chain to another.		Complete Section 7 in full to identify the new chain home office.
☐ The name of provider's chain home office is changing *(all other information remains the same)*.		Complete Section 7C.

B. Chain Home Office Administrator Information

First Name of Home Office Administrator or CEO	Middle Initial	Last Name	Jr., Sr., etc.
Title of Home Office Administrator	Social Security Number	Date of Birth *(mm/dd/yyyy)*	

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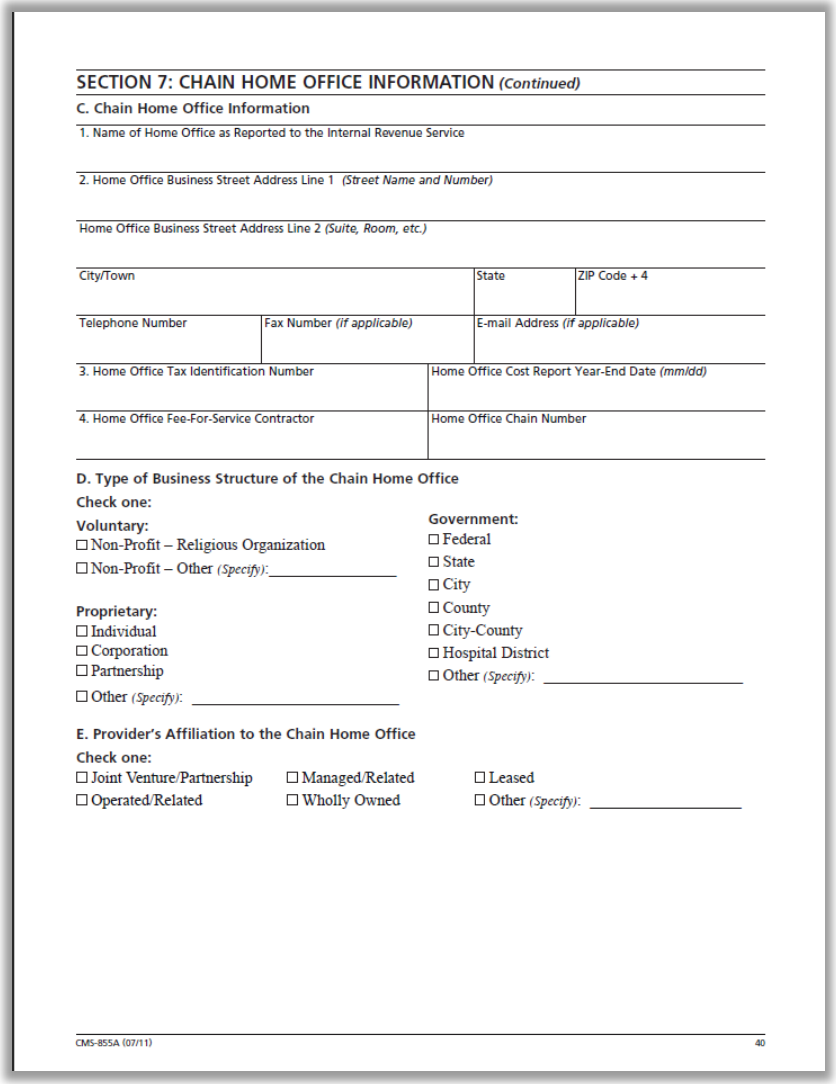
Section 7: Chain Home Office Information C.D.E.

- C. Chain Home Office Information
- D. Type of Business Structure of the Chain Home Office
- E. Provider's Affiliation to the Chain Home Office



SECTION 7: CHAIN HOME OFFICE INFORMATION *(Continued)*

C. Chain Home Office Information

1. Name of Home Office as Reported to the Internal Revenue Service

2. Home Office Business Street Address Line 1 *(Street Name and Number)*

Home Office Business Street Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

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

3. Home Office Tax Identification Number	Home Office Cost Report Year-End Date *(mm/dd)*
4. Home Office Fee-For-Service Contractor	Home Office Chain Number

D. Type of Business Structure of the Chain Home Office

Check one:

Voluntary:
- ☐ Non-Profit – Religious Organization
- ☐ Non-Profit – Other *(Specify)*: _____

Proprietary:
- ☐ Individual
- ☐ Corporation
- ☐ Partnership
- ☐ Other *(Specify)*: _____

Government:
- ☐ Federal
- ☐ State
- ☐ City
- ☐ County
- ☐ City-County
- ☐ Hospital District
- ☐ Other *(Specify)*: _____

E. Provider's Affiliation to the Chain Home Office

Check one:

- ☐ Joint Venture/Partnership
- ☐ Managed/Related
- ☐ Leased
- ☐ Operated/Related
- ☐ Wholly Owned
- ☐ Other *(Specify)*: _____

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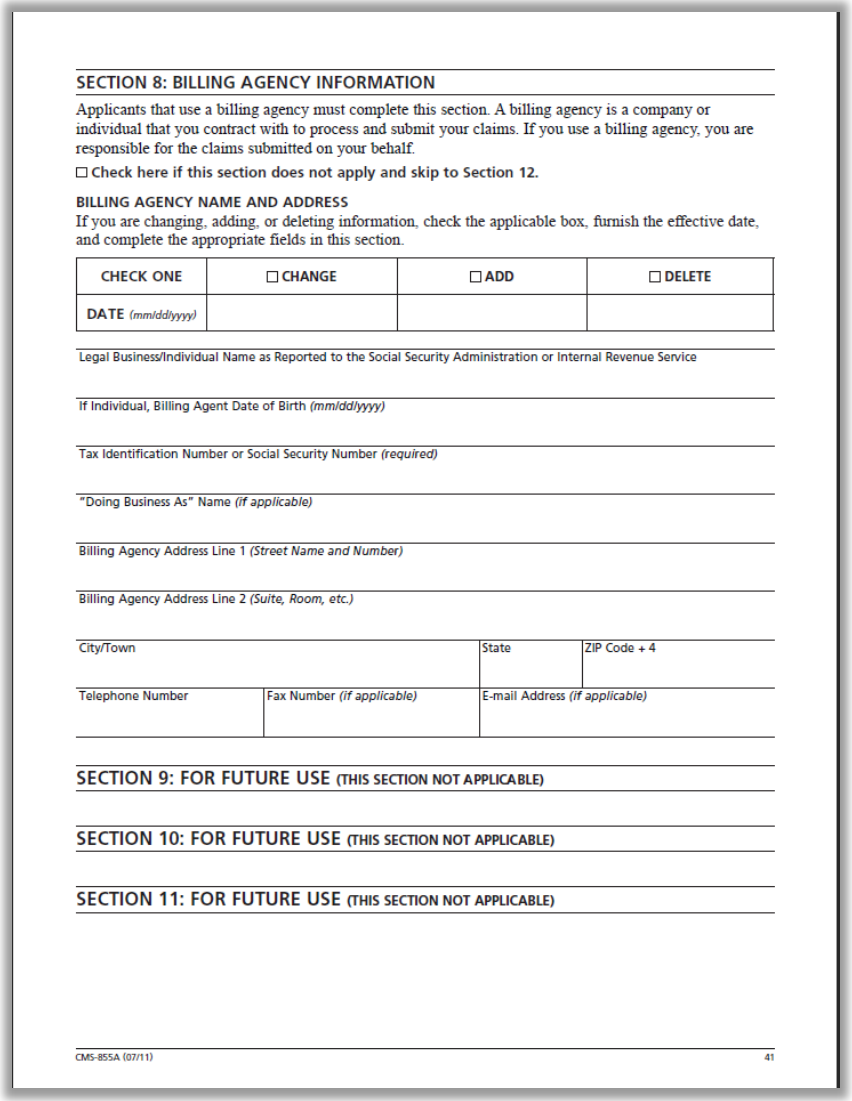
Section 8: Billing Agency Information

- Check box if section does not apply, otherwise furnish billing agency information
- If add or delete, furnish effective date
- Note: Entities using a billing agency are responsible for claims submitted on their behalf



SECTION 8: BILLING AGENCY INFORMATION

Applicants that use a billing agency must complete this section. A billing agency is a company or individual that you contract with to process and submit your claims. If you use a billing agency, you are responsible for the claims submitted on your behalf.

☐ **Check here if this section does not apply and skip to Section 12.**

BILLING AGENCY NAME AND ADDRESS

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

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

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

Tax Identification Number or Social Security Number *(required)*

"Doing Business As" Name *(if applicable)*

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

Billing Agency Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

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

SECTION 9: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 10: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 11: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

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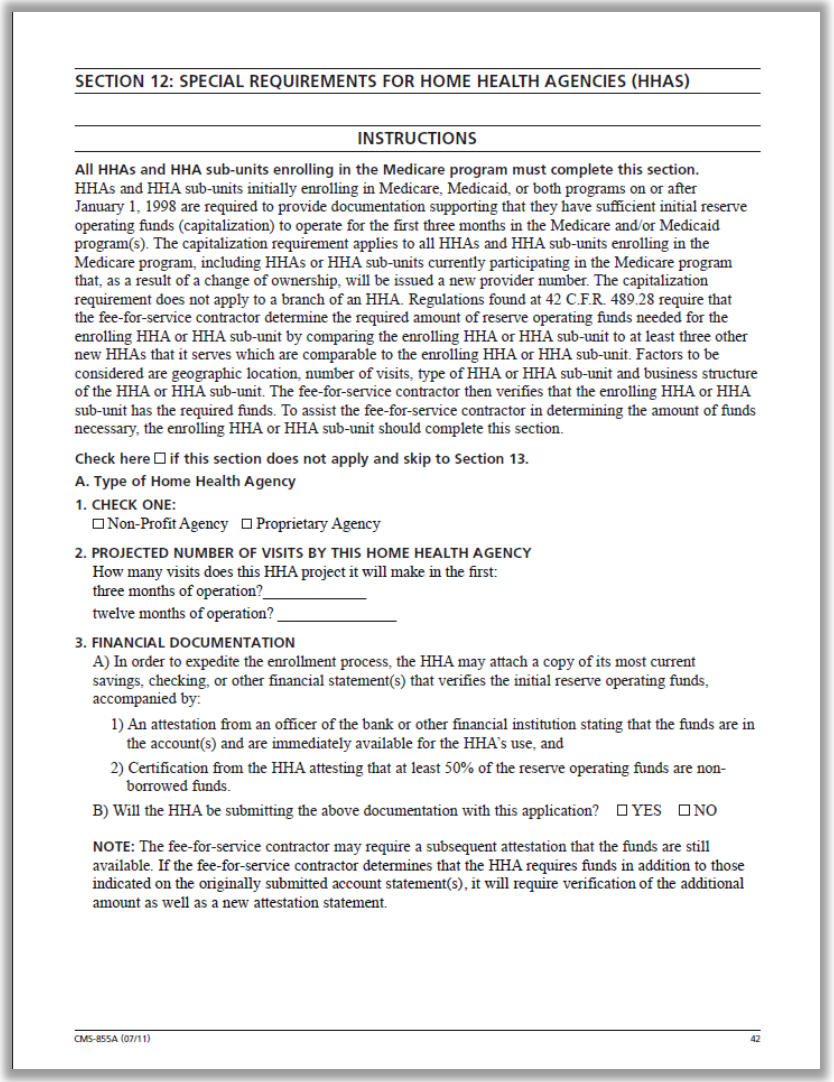
Section 12: Special Requirements for Home Health Agencies (HHAs)

(Do not complete during revalidation)



SECTION 12: SPECIAL REQUIREMENTS FOR HOME HEALTH AGENCIES (HHAS)

INSTRUCTIONS

All HHAs and HHA sub-units enrolling in the Medicare program must complete this section. HHAs and HHA sub-units initially enrolling in Medicare, Medicaid, or both programs on or after January 1, 1998 are required to provide documentation supporting that they have sufficient initial reserve operating funds (capitalization) to operate for the first three months in the Medicare and/or Medicaid program(s). The capitalization requirement applies to all HHAs and HHA sub-units enrolling in the Medicare program, including HHAs or HHA sub-units currently participating in the Medicare program that, as a result of a change of ownership, will be issued a new provider number. The capitalization requirement does not apply to a branch of an HHA. Regulations found at 42 C.F.R. 489.28 require that the fee-for-service contractor determine the required amount of reserve operating funds needed for the enrolling HHA or HHA sub-unit by comparing the enrolling HHA or HHA sub-unit to at least three other new HHAs that it serves which are comparable to the enrolling HHA or HHA sub-unit. Factors to be considered are geographic location, number of visits, type of HHA or HHA sub-unit and business structure of the HHA or HHA sub-unit. The fee-for-service contractor then verifies that the enrolling HHA or HHA sub-unit has the required funds. To assist the fee-for-service contractor in determining the amount of funds necessary, the enrolling HHA or HHA sub-unit should complete this section.

Check here ☐ if this section does not apply and skip to Section 13.

A. Type of Home Health Agency

1. CHECK ONE:
☐ Non-Profit Agency ☐ Proprietary Agency

2. PROJECTED NUMBER OF VISITS BY THIS HOME HEALTH AGENCY
How many visits does this HHA project it will make in the first:
three months of operation?_____
twelve months of operation? _____

3. FINANCIAL DOCUMENTATION
A) In order to expedite the enrollment process, the HHA may attach a copy of its most current savings, checking, or other financial statement(s) that verifies the initial reserve operating funds, accompanied by:

1) An attestation from an officer of the bank or other financial institution stating that the funds are in the account(s) and are immediately available for the HHA's use, and

2) Certification from the HHA attesting that at least 50% of the reserve operating funds are non-borrowed funds.

B) Will the HHA be submitting the above documentation with this application? ☐ YES ☐ NO

NOTE: The fee-for-service contractor may require a subsequent attestation that the funds are still available. If the fee-for-service contractor determines that the HHA requires funds in addition to those indicated on the originally submitted account statement(s), it will require verification of the additional amount as well as a new attestation statement.

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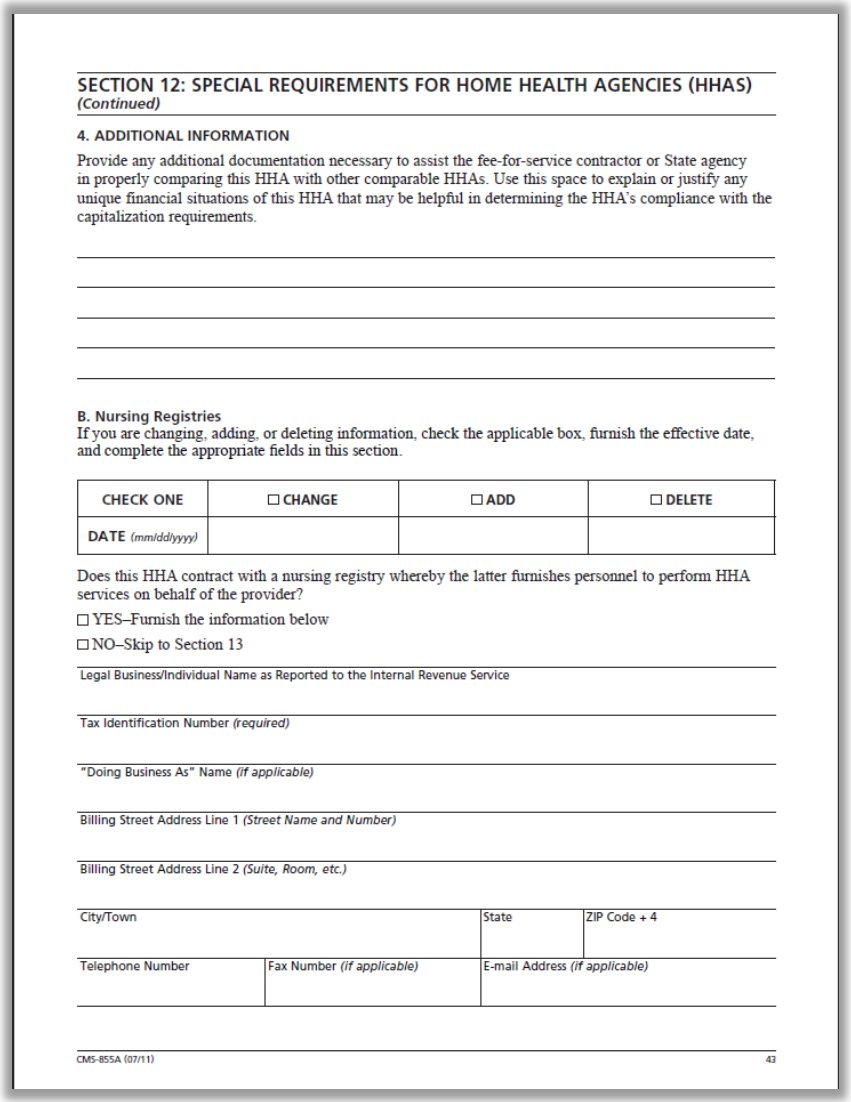
Section 12: Special Requirements for Home Health Agencies (HHAs)

(Do not complete during revalidation)



SECTION 12: SPECIAL REQUIREMENTS FOR HOME HEALTH AGENCIES (HHAS)
(Continued)

4. ADDITIONAL INFORMATION

Provide any additional documentation necessary to assist the fee-for-service contractor or State agency in properly comparing this HHA with other comparable HHAs. Use this space to explain or justify any unique financial situations of this HHA that may be helpful in determining the HHA's compliance with the capitalization requirements.

B. Nursing Registries
If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Does this HHA contract with a nursing registry whereby the latter furnishes personnel to perform HHA services on behalf of the provider?

☐ YES–Furnish the information below

☐ NO–Skip to Section 13

Legal Business/Individual Name as Reported to the Internal Revenue Service

Tax Identification Number *(required)*

"Doing Business As" Name *(if applicable)*

Billing Street Address Line 1 *(Street Name and Number)*

Billing Street Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

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

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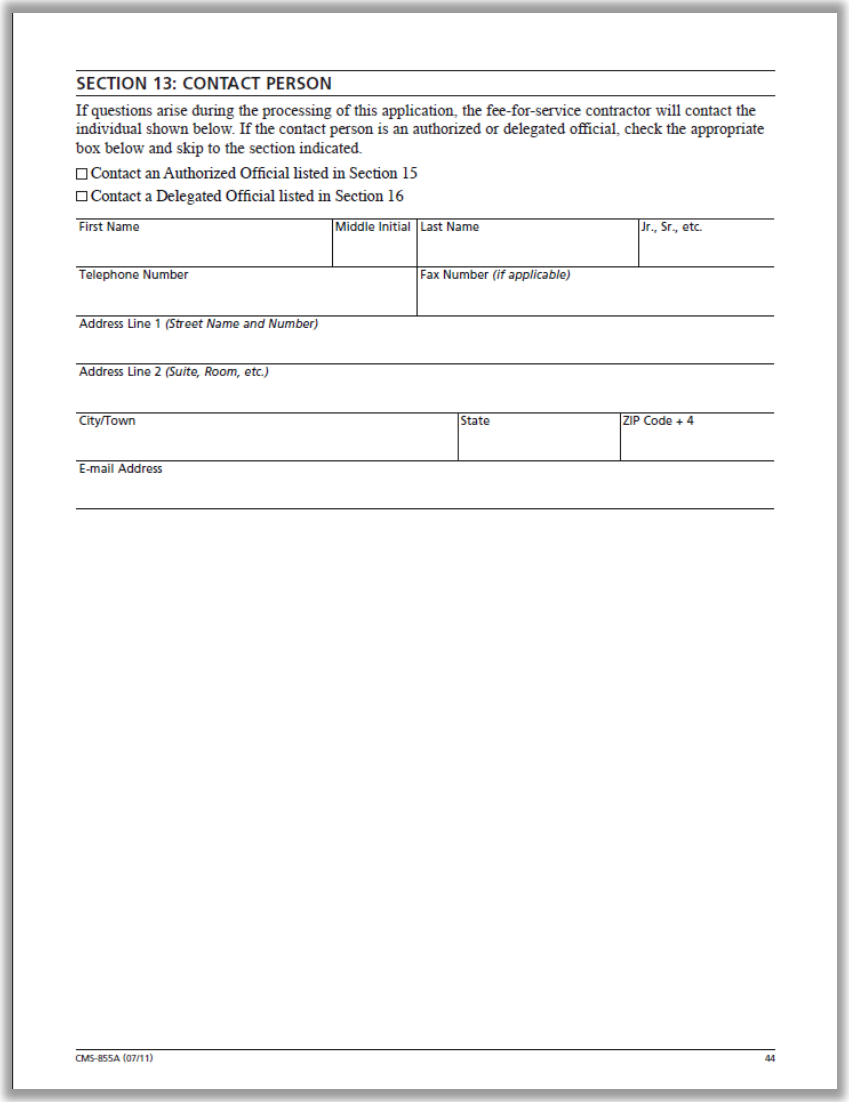
Section 13: Contact Person

- Copy and complete section for each contact person
  - Contact will be authorized to discuss issues concerning enrollment only
  - First contact person listed will receive acknowledge notice and be notified if any additional information is needed by email



SECTION 13: CONTACT PERSON

If questions arise during the processing of this application, the fee-for-service contractor will contact the individual shown below. If the contact person is an authorized or delegated official, check the appropriate box below and skip to the section indicated.

☐ Contact an Authorized Official listed in Section 15

☐ Contact a Delegated Official listed in Section 16

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

Telephone Number	Fax Number *(if applicable)*

Address Line 1 *(Street Name and Number)*

Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

E-mail Address

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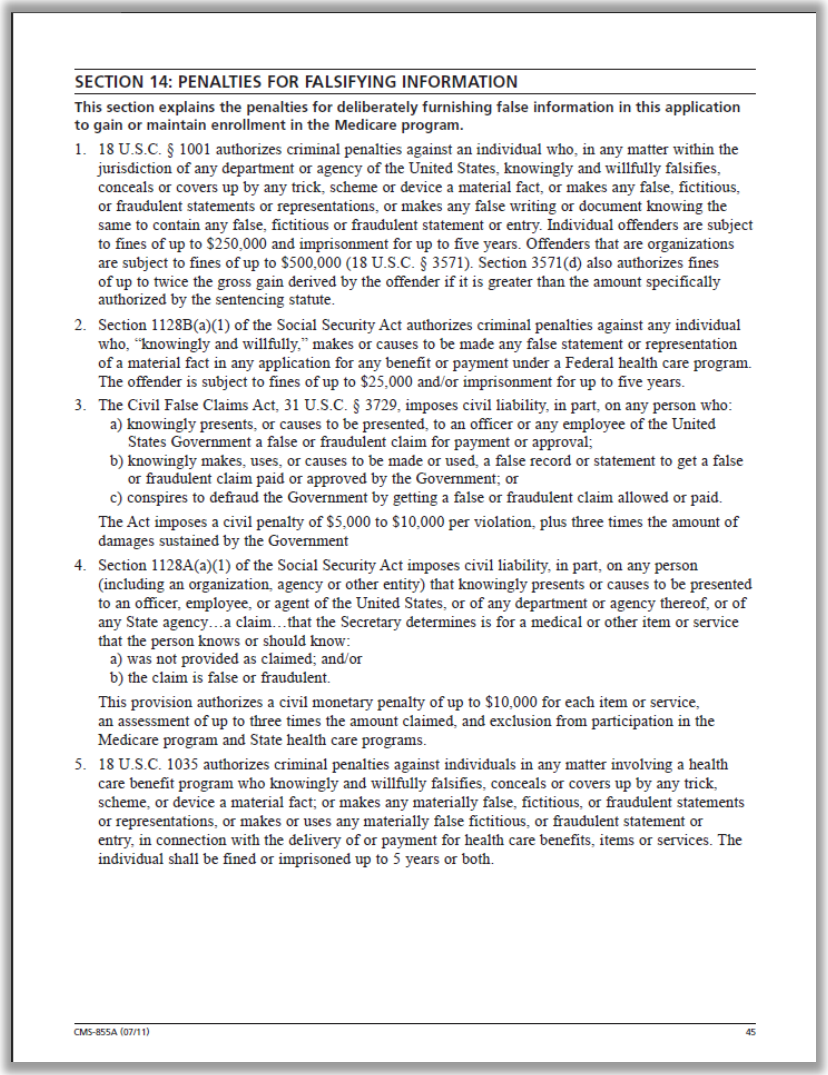
Section 14: Penalties for Falsifying Information

- Explains penalties for deliberately falsifying information on this application to gain or maintain enrollment in the Medicare Program



SECTION 14: PENALTIES FOR FALSIFYING INFORMATION

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. § 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. § 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:
   a) knowingly presents, or causes to be presented, to an officer or any employee of the United States Government a false or fraudulent claim for payment or approval;
   b) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or
   c) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

   The Act imposes a civil penalty of $5,000 to $10,000 per violation, 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.

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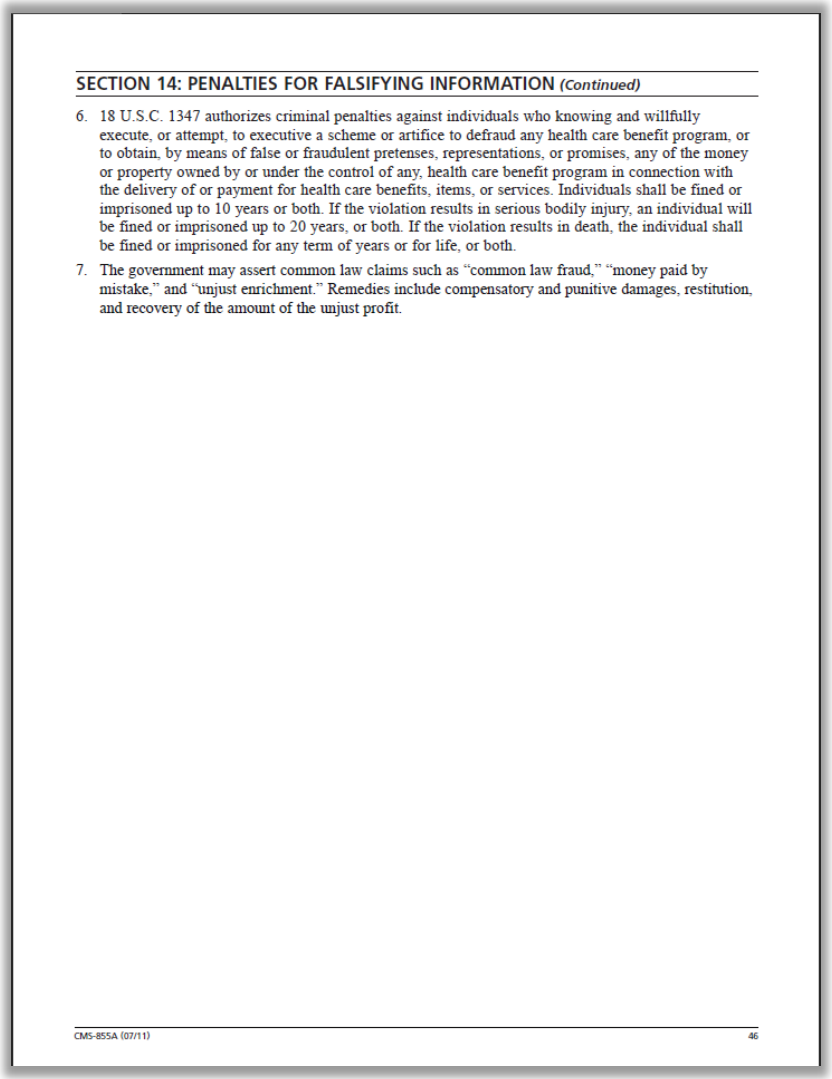
Section 14: Penalties for Falsifying Information



SECTION 14: PENALTIES FOR FALSIFYING INFORMATION *(Continued)*

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 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.

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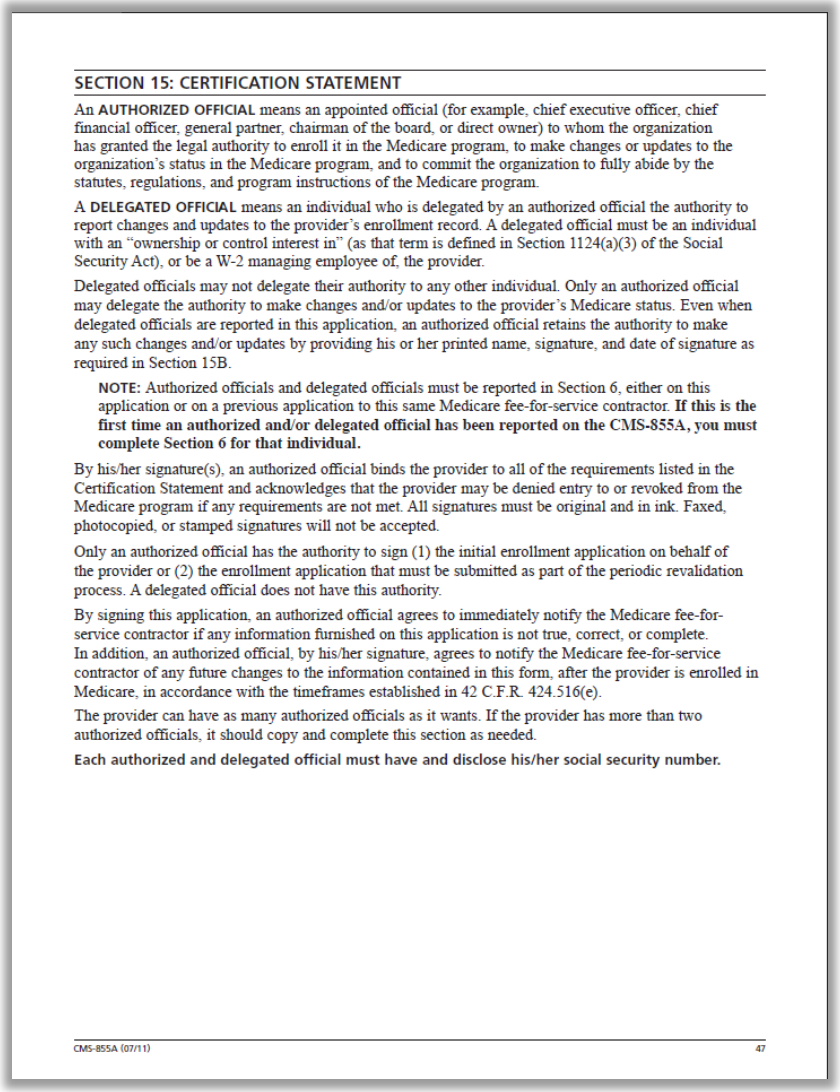
Section 15: Certification Statement

- Definitions
  - Authorized official is an appointed official
  - Delegated official is an individual delegated by an authorized official to report changes and updates



SECTION 15: CERTIFICATION STATEMENT

An **AUTHORIZED OFFICIAL** means an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program.

A **DELEGATED OFFICIAL** means an individual who is delegated by an authorized official the authority to report changes and updates to the provider's enrollment record. A delegated official must be an individual with an "ownership or control interest in" (as that term is defined in Section 1124(a)(3) of the Social Security Act), or be a W-2 managing employee of, the provider.

Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the provider's Medicare status. Even when delegated officials are reported in this application, an authorized official retains the authority to make any such changes and/or updates by providing his or her printed name, signature, and date of signature as required in Section 15B.

NOTE: Authorized officials and delegated officials must be reported in Section 6, either on this application or on a previous application to this same Medicare fee-for-service contractor. **If this is the first time an authorized and/or delegated official has been reported on the CMS-855A, you must complete Section 6 for that individual.**

By his/her signature(s), an authorized official binds the provider to all of the requirements listed in the Certification Statement and acknowledges that the provider may be denied entry to or revoked from the Medicare program if any requirements are not met. All signatures must be original and in ink. Faxed, photocopied, or stamped signatures will not be accepted.

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.

By signing this application, an authorized official agrees to immediately notify the Medicare fee-for-service contractor if any information furnished on this application is not true, correct, or complete. In addition, an authorized official, by his/her signature, agrees to notify the Medicare fee-for-service contractor of any future changes to the information contained in this form, after the provider is enrolled in Medicare, in accordance with the timeframes established in 42 C.F.R. 424.516(e).

The provider can have as many authorized officials as it wants. If the provider has more than two authorized officials, it should copy and complete this section as needed.

Each authorized and delegated official must have and disclose his/her social security number.

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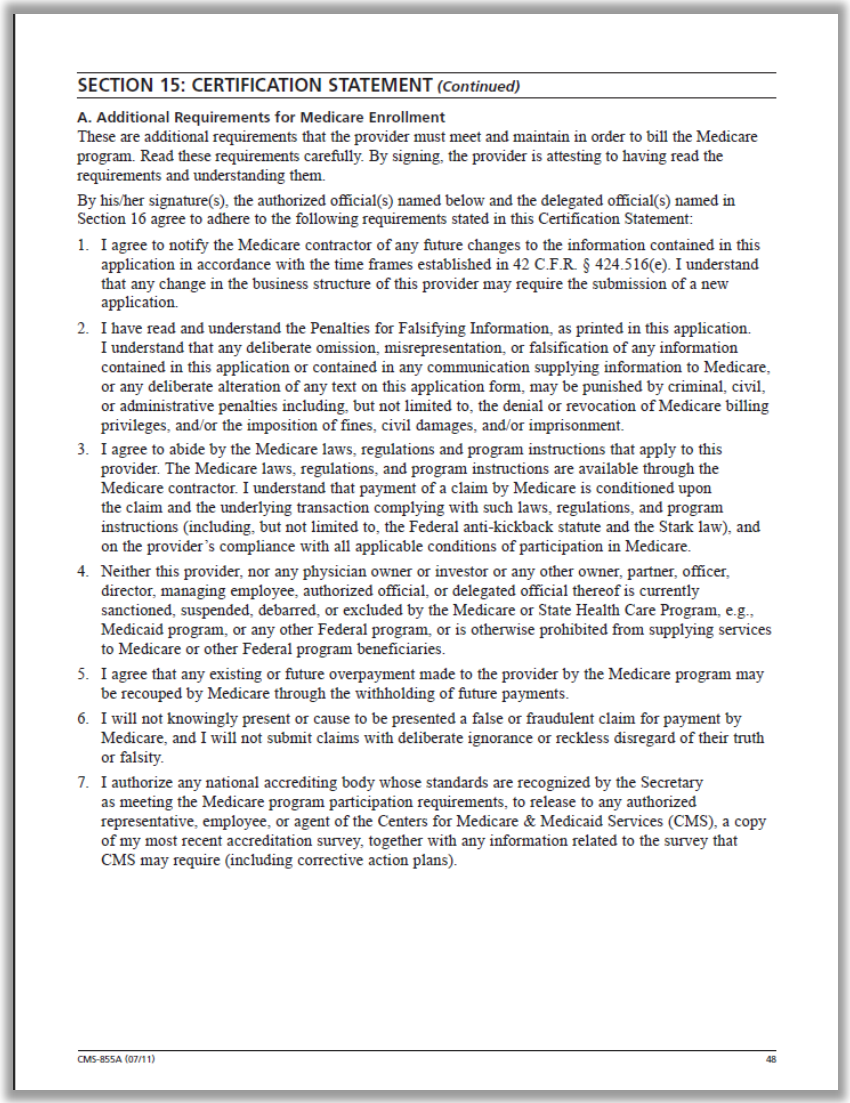
Section 15: Certification Statement A.

- A: Additional Requirements for Medicare Enrollment
  - Medicare requirements providers must meet and maintain in order to bill Medicare
  - By signing the form the authorized or delegated official agrees to adhere to the requirements listed



SECTION 15: CERTIFICATION STATEMENT *(Continued)*

A. Additional Requirements for Medicare Enrollment

These are additional requirements that the provider must meet and maintain in order to bill the Medicare program. Read these requirements carefully. By signing, the provider is attesting to having read the requirements and understanding them.

By his/her signature(s), the authorized official(s) named below and the delegated official(s) named in Section 16 agree to adhere to the following requirements stated in this Certification Statement:

1. I agree to notify the Medicare contractor of any future changes to the information contained in this application in accordance with the time frames established in 42 C.F.R. § 424.516(e). I understand that any change in the business structure of this provider may require the submission of a new application.
2. I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this application form, may be punished 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.
3. I agree to abide by the Medicare laws, regulations and program instructions that apply to this provider. The Medicare laws, regulations, and program instructions are available through the Medicare 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 and the Stark law), and on the provider's compliance with all applicable conditions of participation in Medicare.
4. Neither this provider, nor any physician owner or investor or any other owner, partner, officer, director, managing employee, authorized official, or delegated official thereof is currently sanctioned, suspended, debarred, or excluded by the Medicare or State Health Care Program, e.g., Medicaid program, or any other Federal program, or is otherwise prohibited from supplying services to Medicare or other Federal program beneficiaries.
5. I agree that any existing or future overpayment made to the provider by the Medicare program may be recouped by Medicare through the withholding of future payments.
6. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and I will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.
7. I authorize any national accrediting body whose standards are recognized by the Secretary as meeting the Medicare program participation requirements, to release to any authorized representative, employee, or agent of the Centers for Medicare & Medicaid Services (CMS), a copy of my most recent accreditation survey, together with any information related to the survey that CMS may require (including corrective action plans).

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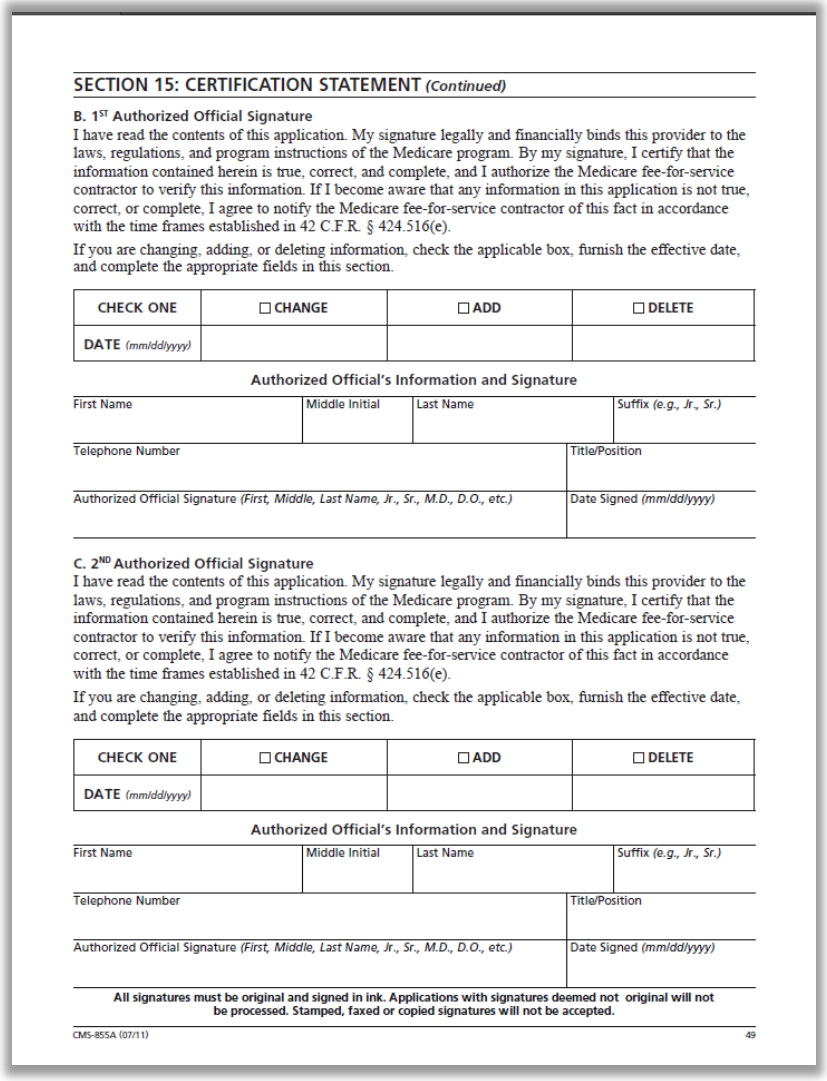
Section 15: Certification Statement B.

- B: 1st Authorized Official Signature
  - Authorized official sign and date
  - Must be original signature in ink
  - Stamped signatures are not acceptable
  - Copy and complete section for each new authorized official added during revalidation



SECTION 15: CERTIFICATION STATEMENT *(Continued)*

B. 1ST Authorized Official Signature

I have read the contents of this application. My signature legally and financially binds this provider to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize the Medicare fee-for-service contractor to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare fee-for-service contractor of this fact in accordance with the time frames established in 42 C.F.R. § 424.516(e).

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Authorized Official's Information and Signature

First Name	Middle Initial	Last Name	Suffix *(e.g., Jr., Sr.)*

Telephone Number	Title/Position

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

C. 2ND Authorized Official Signature

I have read the contents of this application. My signature legally and financially binds this provider to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize the Medicare fee-for-service contractor to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare fee-for-service contractor of this fact in accordance with the time frames established in 42 C.F.R. § 424.516(e).

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Authorized Official's Information and Signature

First Name	Middle Initial	Last Name	Suffix *(e.g., Jr., Sr.)*

Telephone Number	Title/Position

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

All signatures must be original and signed in ink. Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

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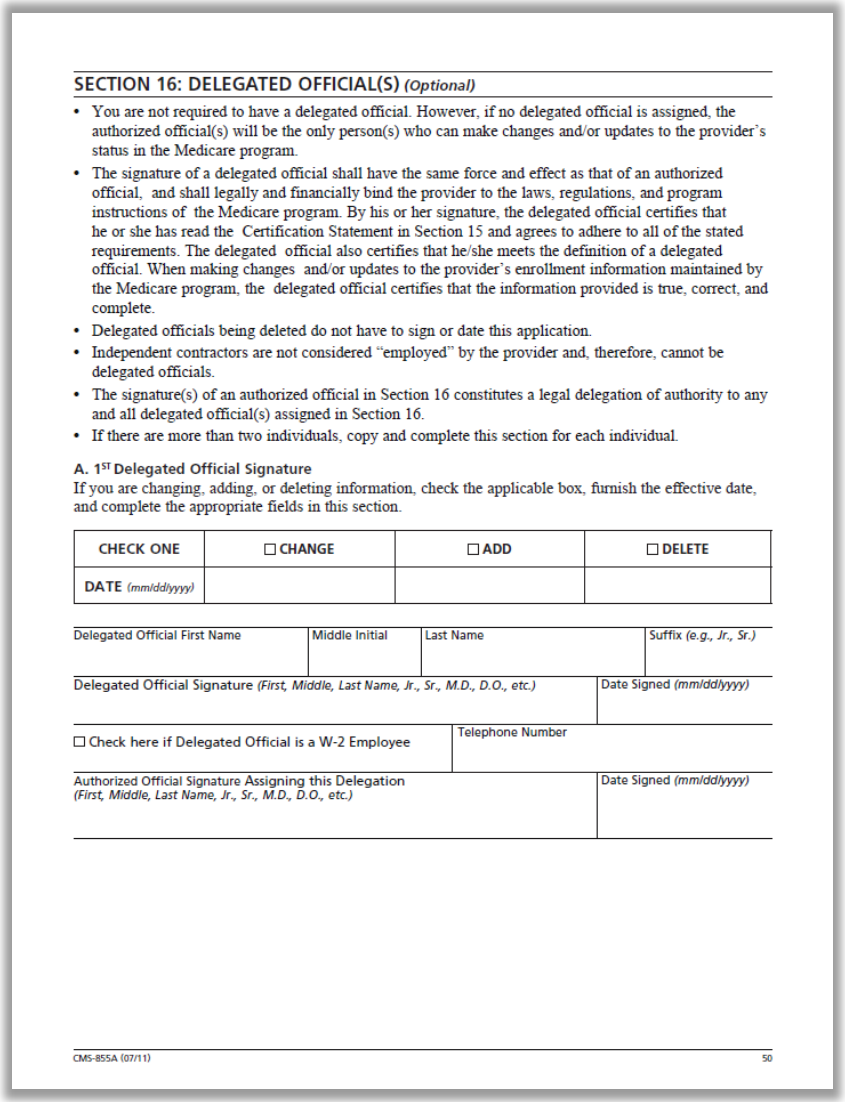
Section 16: Delegated Official (Optional) A.

- A: 1st Delegated Official Signature
  - Delegated official sign and date
  - Must be original signature in ink
  - Stamp signatures are not acceptable
  - Copy and complete section for each new delegated official added during revalidation
  - Authorized official signature is also required for new delegated officials



SECTION 16: DELEGATED OFFICIAL(S) *(Optional)*

- You are not required to have a delegated official. However, if no delegated official is assigned, the authorized official(s) will be the only person(s) who can make changes and/or updates to the provider's status in the Medicare program.
- The signature of a delegated official shall have the same force and effect as that of an authorized official, and shall legally and financially bind the provider to the laws, regulations, and program instructions of the Medicare program. By his or her signature, the delegated official certifies that he or she has read the Certification Statement in Section 15 and agrees to adhere to all of the stated requirements. The delegated official also certifies that he/she meets the definition of a delegated official. When making changes and/or updates to the provider's enrollment information maintained by the Medicare program, the delegated official certifies that the information provided is true, correct, and complete.
- Delegated officials being deleted do not have to sign or date this application.
- Independent contractors are not considered "employed" by the provider and, therefore, cannot be delegated officials.
- The signature(s) of an authorized official in Section 16 constitutes a legal delegation of authority to any and all delegated official(s) assigned in Section 16.
- If there are more than two individuals, copy and complete this section for each individual.

A. 1ST Delegated Official Signature

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Delegated Official First Name	Middle Initial	Last Name	Suffix *(e.g., Jr., Sr.)*

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

☐ Check here if Delegated Official is a W-2 Employee	Telephone Number

Authorized Official Signature Assigning this Delegation *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

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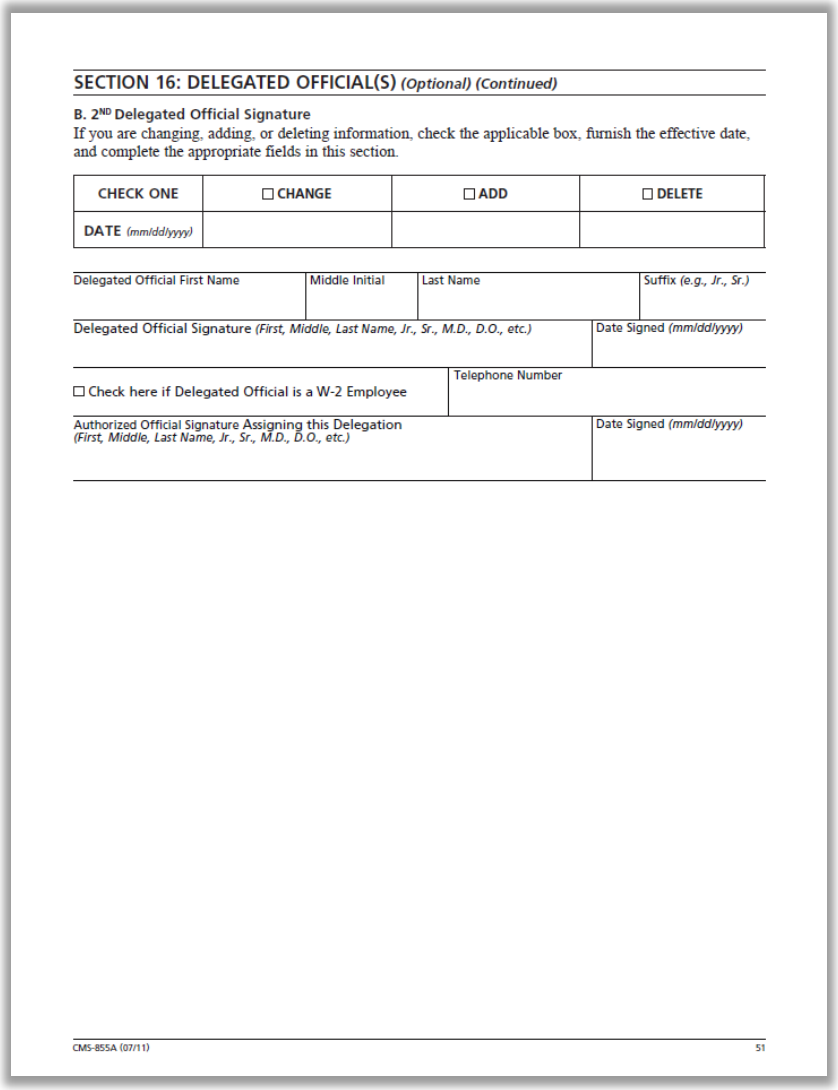
Section 16: Delegated Official (Optional) B.

- B: 2nd Delegated Official Signature



SECTION 16: DELEGATED OFFICIAL(S) *(Optional) (Continued)*

B. 2ND Delegated Official Signature

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Delegated Official First Name	Middle Initial	Last Name	Suffix *(e.g., Jr., Sr.)*

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

☐ Check here if Delegated Official is a W-2 Employee	Telephone Number

Authorized Official Signature Assigning this Delegation *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

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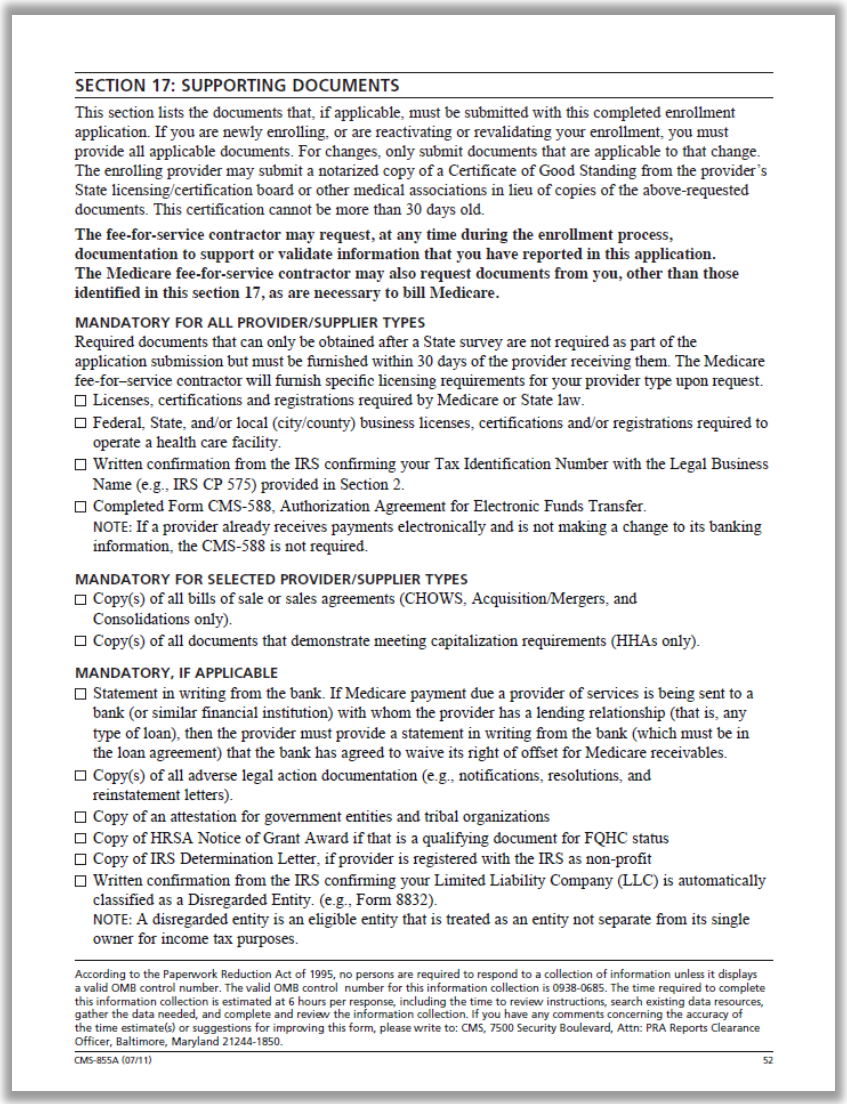
Section 17: Supporting Documentation

- Required documentation



SECTION 17: SUPPORTING DOCUMENTS

This section lists the documents that, if applicable, must be submitted with this completed enrollment application. If you are newly enrolling, or are reactivating or revalidating your enrollment, you must provide all applicable documents. For changes, only submit documents that are applicable to that change. The enrolling provider may submit a notarized copy of a Certificate of Good Standing from the provider's State licensing/certification board or other medical associations in lieu of copies of the above-requested documents. This certification cannot be more than 30 days old.

The fee-for-service contractor may request, at any time during the enrollment process, documentation to support or validate information that you have reported in this application. The Medicare fee-for-service contractor may also request documents from you, other than those identified in this section 17, as are necessary to bill Medicare.

MANDATORY FOR ALL PROVIDER/SUPPLIER TYPES

Required documents that can only be obtained after a State survey are not required as part of the application submission but must be furnished within 30 days of the provider receiving them. The Medicare fee-for–service contractor will furnish specific licensing requirements for your provider type upon request.

- ☐ Licenses, certifications and registrations required by Medicare or State law.
- ☐ Federal, State, and/or local (city/county) business licenses, certifications and/or registrations required to operate a health care facility.
- ☐ Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name (e.g., IRS CP 575) provided in Section 2.
- ☐ Completed Form CMS-588, Authorization Agreement for Electronic Funds Transfer.
  NOTE: If a provider already receives payments electronically and is not making a change to its banking information, the CMS-588 is not required.

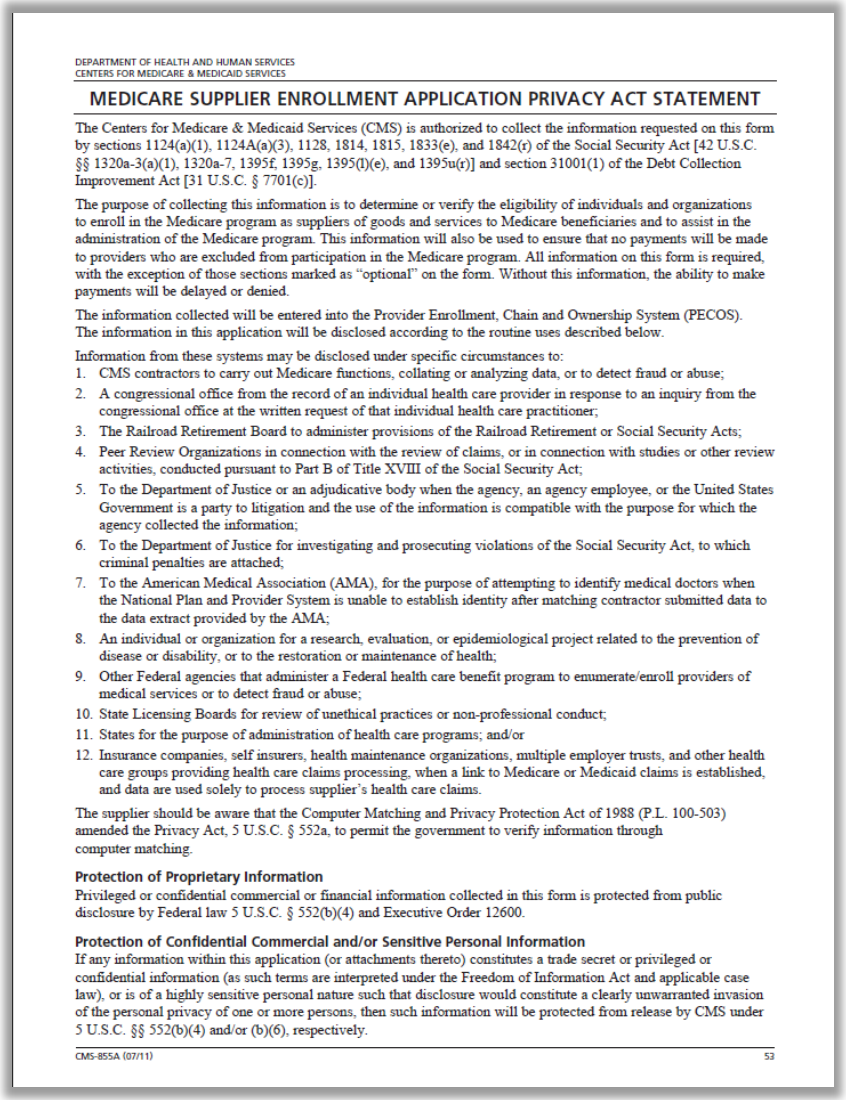
MANDATORY FOR SELECTED PROVIDER/SUPPLIER TYPES

- ☐ Copy(s) of all bills of sale or sales agreements (CHOWS, Acquisition/Mergers, and Consolidations only).
- ☐ Copy(s) of all documents that demonstrate meeting capitalization requirements (HHAs only).

MANDATORY, IF APPLICABLE

- ☐ Statement in writing from the bank. If Medicare payment due a provider of services is being sent to a bank (or similar financial institution) with whom the provider has a lending relationship (that is, any type of loan), then the provider 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.
- ☐ Copy(s) of all adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters).
- ☐ Copy of an attestation for government entities and tribal organizations
- ☐ Copy of HRSA Notice of Grant Award if that is a qualifying document for FQHC status
- ☐ Copy of IRS Determination Letter, if provider is registered with the IRS as non-profit
- ☐ Written confirmation from the IRS confirming your Limited Liability Company (LLC) is automatically classified as a Disregarded Entity. (e.g., Form 8832).
  NOTE: A disregarded entity is an eligible entity that is treated as an entity not separate from its single owner for income tax purposes.

Medicare Supplier Enrollment Application Privacy Act Statement



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

MEDICARE SUPPLIER ENROLLMENT APPLICATION PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) is authorized to collect the information requested on this form by sections 1124(a)(1), 1124A(a)(3), 1128, 1814, 1815, 1833(e), and 1842(r) of the Social Security Act [42 U.S.C. §§ 1320a-3(a)(1), 1320a-7, 1395f, 1395g, 1395(l)(e), and 1395u(r)] and section 31001(1) of the Debt Collection Improvement Act [31 U.S.C. § 7701(c)].

The purpose of collecting this information is to determine or verify the eligibility of individuals and organizations to enroll in the Medicare program as suppliers of goods and services to Medicare beneficiaries and to assist in the administration of the Medicare program. This information will also be used to ensure that no payments will be made to providers who are excluded from participation in the Medicare program. All information on this form is required, with the exception of those sections marked as "optional" on the form. Without this information, the ability to make payments will be delayed or denied.

The information collected will be entered into the Provider Enrollment, Chain and Ownership System (PECOS). The information in this application will be disclosed according to the routine uses described below.

Information from these systems may be disclosed under specific circumstances to:

1. CMS contractors to carry out Medicare functions, collating or analyzing data, or to detect fraud or abuse;
2. A congressional office from the record of an individual health care provider in response to an inquiry from the congressional office at the written request of that individual health care practitioner;
3. The Railroad Retirement Board to administer provisions of the Railroad Retirement or Social Security Acts;
4. Peer Review Organizations in connection with the review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XVIII of the Social Security Act;
5. To the Department of Justice or an adjudicative body when the agency, an agency employee, or the United States Government is a party to litigation and the use of the information is compatible with the purpose for which the agency collected the information;
6. To the Department of Justice for investigating and prosecuting violations of the Social Security Act, to which criminal penalties are attached;
7. To the American Medical Association (AMA), for the purpose of attempting to identify medical doctors when the National Plan and Provider System is unable to establish identity after matching contractor submitted data to the data extract provided by the AMA;
8. An individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, or to the restoration or maintenance of health;
9. Other Federal agencies that administer a Federal health care benefit program to enumerate/enroll providers of medical services or to detect fraud or abuse;
10. State Licensing Boards for review of unethical practices or non-professional conduct;
11. States for the purpose of administration of health care programs; and/or
12. Insurance companies, self insurers, health maintenance organizations, multiple employer trusts, and other health care groups providing health care claims processing, when a link to Medicare or Medicaid claims is established, and data are used solely to process supplier's health care claims.

The supplier 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. § 552a, to permit the government to verify information through computer matching.

Protection of Proprietary Information
Privileged or confidential commercial or financial information collected in this form is protected from public disclosure by Federal law 5 U.S.C. § 552(b)(4) and Executive Order 12600.

Protection of Confidential Commercial and/or Sensitive Personal Information
If any information within this application (or attachments thereto) constitutes a trade secret or privileged or confidential information (as such terms are interpreted under the Freedom of Information Act and applicable case law), or is of a highly sensitive personal nature such that disclosure would constitute a clearly unwarranted invasion of the personal privacy of one or more persons, then such information will be protected from release by CMS under 5 U.S.C. §§ 552(b)(4) and/or (b)(6), respectively.

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Supporting Documentation

Supporting Documentation

- The following key documents are required when applicable
  - CMS-588 Electronic Funds Transfer Authorization Agreement and voided check or bank letter
  - IRS CP-575, IRS 147c or other written IRS document with legal business name and TIN or EIN confirmation
  - Final adverse legal action documentation and resolution
  - Application fee receipt (2023 application fee = **$688**)

Process After Submission

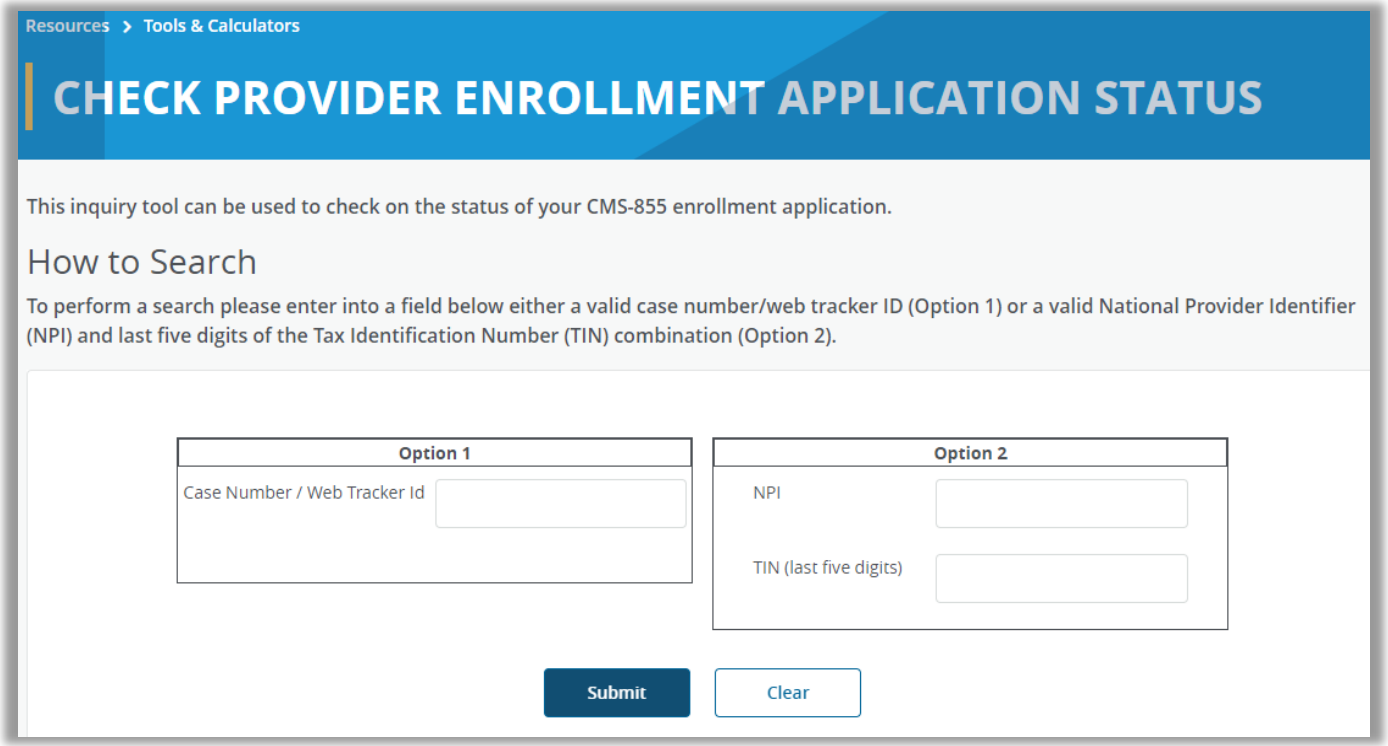
Process After Submission

- Contact person on application will receive by email
  - Acknowledgement Notice
    - ✓ Add to safe sender list
      - NGS-PE-Communications@elevancehealth.com
  - Development requests for additional information
    - ✓ Respond within 30 days
  - Response letter
    - ✓ Deactivation for incomplete/no response to development request
    - ✓ Approval

Check Application Status

Check Application Status

- Go to our website > Resources > Tools & Calculators > Check Provider Enrollment Application Status

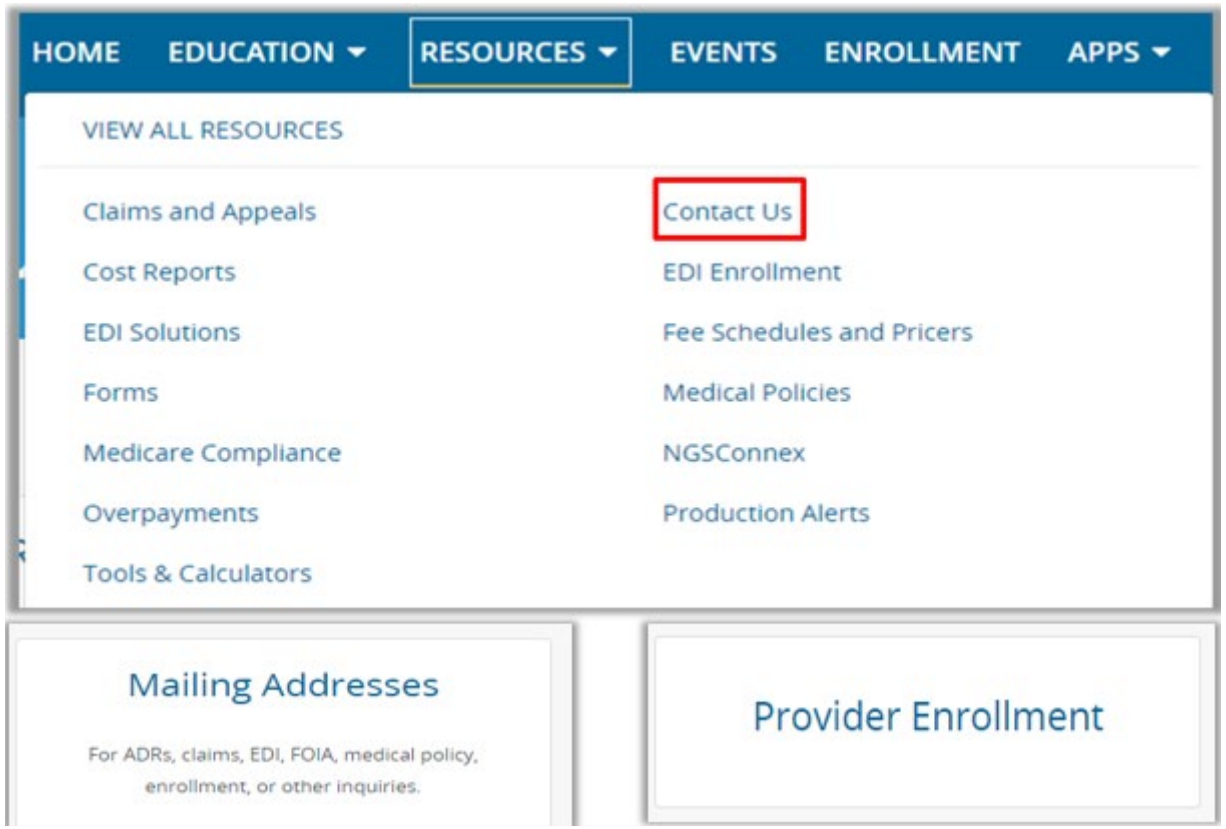


Check Application Status

- IVR system
  - Our website > Resources > Contact Us > Interactive Voice Response System
  - IVR will request following information after selecting Provider Enrollment
    - ✓ Case number/web tracker ID; or
    - ✓ National Provider Identifier (NPI) and Tax Identification Number (TIN of group) or Social Security Number (SSN of individual)

Resources

NGS Website


HOME
EDUCATION
RESOURCES
EVENTS
ENROLLMENT
APPS
VIEW ALL RESOURCES
Claims and Appeals
Cost Reports
EDI Solutions
Forms
Medicare Compliance
Overpayments
Tools & Calculators
Contact Us
EDI Enrollment
Fee Schedules and Pricers
Medical Policies
NGSConnex
Production Alerts
Mailing Addresses
For ADRs, claims, EDI, FOIA, medical policy, enrollment, or other inquiries.
Provider Enrollment

Questions?

Thank you! A follow-up email will be sent to attendees with the Medicare University Course Code.

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