Provider Enrollment: Submitting Revalidations via PECOS

10/21/2021

Today's Presenters

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  - Provider Outreach and Education

- Susan Stafford

  - Provider Outreach and Education

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Objectives

- Complete and submit revalidation application via PECOS

- Understand how to upload supporting documents including any signed certification statements (if applicable)

Agenda

- What is PECOS
- Locate Enrollment and Start Application
- Tabs and Topic View Examples
- Unfinished Application
- Signature Method
- E-signature
- Verify and Manage Signatures
- Process after Submission
- Application Status
- Resources

What Is PECOS?

- Provider Enrollment, Chain and Ownership System (PECOS)
- CMS Internet-based Medicare enrollment system used to
  - Submit Medicare enrollment applications
  - Update, view and print
  - Revalidate
  - Voluntarily withdraw
  - Track status

Access

- System requirements

- Identity & Access Management System

  - Individual

  - Groups

- Understanding users login and passwords

  - Getting Access to PECOS

    - [Our website] > Events > Current Events

[PECOS](#) Home Page to Login

Welcome

Existing Associates

Enrollment Box to Revalidate

Existing Enrollments

Contractor: NATIONAL GOVERNMENT SERVICES, INC.
State: NEW YORK
Type/Specialty: CLINIC/GROUP PRACTICE

VIEW ▶
REVALIDATE ▶
MORE OPTIONS ▶

Enrollment Type: 855B
Medicare ID: View Medicare ID Report 🗗
Status: APPROVED   View Approved Enrollment Record 🗗

Current ADI Accreditation?: No
Revalidation Status: Revalidation Due ⓘ
   Sample Revalidation Notice 🗗
Revalidation Due Date: 02/28/2017
Practice Location: ROCHESTER, NY

Existing Reassignments: 2
Pending Reassignments Applications: 0
View/Manage Reassignments

Start Application

Fast Track View

Click the "Go To Topic" button to access the topic

Topic View

Topic View

✓ **License and Certification Information** ⊞ more information about License and Certification Information

✓ **Final Adverse Actions** ⊞ more information about Final Adverse Actions

✓ **Individual Control** ⊞ more information about Individual Control

✓ **Patient Records Storage Location** ⊞ more information about Patient Records Storage Location

✓ **Billing Agency** ⊞ more information about Billing Agency

✓ **Contact Person** ⊞ more information about Contact Person

✓ **Electronic Funds Transfer** ⊞ more information about Electronic Funds Transfer

✓ **Required and/or Supporting Documentation** ⊞ more information about Required and/or Supporting Documentation

Note:

- Once you have completed all the topics and no errors are present, the 'Begin Submission' button will be enabled. You may review errors at any time by clicking the 'Error Check' tab. Clicking 'Begin Submission' will initiate the Submission Process.

BEGIN SUBMISSION »

NEXT PAGE »

Individuals with Managing Control

Individuals with Ownership Interest and/or Managing Control

(*) Red asterisk indicates a required field.

Personal Information for Individual with Ownership Interest and/or Managing Control

Note: Please enter the individual name associated with the SSN and Date of Birth. Any Authorized or Delegated Official with an ITIN will not be able to submit electronic signatures. Please mail a paper signature if an Authorized or Delegated Official with an ITIN is entered on this application.

* First Name

Middle Name

* Last Name

Suffix
Select Suffix ∨

* TIN Type
Select TIN Type ∨

* Tax Identification Number (TIN)

XXX-XX-XXXX

* Date of Birth

MM/DD/YYYY

Title

National Provider Identifier (NPI) (of individual with ownership interest/managing control)

10 Digits

Individuals with Managing Control

Individuals with Managing Control

Individuals with Ownership Interest and/or Managing Control

(*) Red asterisk indicates a required field.

Individual's Relationship to the Applicant

* Check all roles that are applicable to this individual's relationship:

☐ 5% or Greater Direct/Indirect Owner

* Effective Date of 5% or Greater Direct/Indirect Owner

[   ]
MM/DD/YYYY

☐ Partner (regardless of percentage of ownership)

* Effective Date of Partner

[   ]
MM/DD/YYYY

☐ Managing Employee (W-2)

* Effective Date of Managing Employee (W-2)

[   ]
MM/DD/YYYY

☐ Director/Officer (if and only if the applicant is a corporation, whether for profit or non-profit)

* Effective Date of Director/Officer

[   ]
MM/DD/YYYY

☐ Contracted Managing Employee

* Effective Date of Contracted Managing Employee

[   ]
MM/DD/YYYY

[◄ PREVIOUS PAGE]   [NEXT PAGE ►]

[◄ CANCEL]

Individual with Managing Control

Individuals with Ownership Interest and/or Managing Control

(*) Red asterisk indicates a required field.

Authorized/Delegated Official

* Please indicate below if the individual is an Authorized or Delegated official. Authorized Officials are granted legal authority by the organization to enroll it in the Medicare program and make changes and updates. Delegated Officials are appointed by an Authorized Official to make changes and updates to the organization's enrollment. The delegated official must have ownership, controlling interest or be a W-2 managing employee of the organization.

○ **Neither an Authorized nor a Delegated Official**

○ **Authorized Official**

◉ **Delegated Official**

* Telephone

[   ]

No Format Required

* Is the Delegated Official a W-2 employee?

◉ **Yes**

○ **No**

* Effective Date ⓘ

[   ]

MM/DD/YYYY

◄ PREVIOUS PAGE   NEXT PAGE ►

◄◄ CANCEL

Physical Location and "Special Payment"

Physical Location and "Special Payments Address" Information

Location Type: Practice Location

Practice Location Type: Private Practice Office Setting [EDIT]

Physical Location Address

Physical Address:
300 GEORGE ST
FL
NEW HAVEN, CT 06511 -6624

Effective Date of Information:
01/01/2018

[EDIT] [DELETE]

Physical Location Contact Information:

Telephone Number:

Fax Number:

E-mail address:
        @ANTHEM.COM

[EDIT]

CLIA and FDA Certification Number(s):
[ADD]

Special Payment Address

Payment Address:
300 GEORGE ST
FL
NEW HAVEN, CT 06511 -6624

Effective Date of Information:
01/01/2018

[EDIT] [DELETE]

Claims Information:
[ADD]

Medicare Identification Number:

Effective Date of this Practice Location: 01/01/2018
[EDIT] [DELETE]

Records 1 - 1 of 1

[◄ PREVIOUS TOPIC]   [GO TO ERROR CHECK ►►]   [NEXT TOPIC ►►]

Contact Person Information

Contact Person

Topic Summary

The topic requests information about the person or persons that the Medicare contractor should contact if any questions exist about the application. ➕(**more information about Contact Person**)

ADD INFORMATION ≫

Contact Person Information

XXXXX XXXXXX

Relationship/Affiliation to Provider/Supplier: Employee
Address: 2400 Thea Drive
　　　　　　Harrisburg, PA 17110 -9436
Telephone: (555) 555-5554

➡ **EDIT ▶**　　**DELETE ▶**

REVIEW COMPLETE ▶

≪ PREVIOUS TOPIC　　**GO TO ERROR CHECK ≫**　　**NEXT TOPIC ≫**

Review and Verify

Contact Person

(*) Red asterisk indicates a required field.

Contact Name

Relationship/Affiliation to Provider/Supplier:

[Authorized Official ▾]

Other(Specify)

* First Name

Middle Name

* Last Name

[NEXT PAGE ▶]

[◀ CANCEL]

Contact Person

(*) Red asterisk indicates a required field.

Contact Information

Previously Entered Address Information

Select an address or enter a new address in the fields below:
[Select address ▾]
[APPLY ▶]

* Address Line 1
2400 Thea Drive

Address Line 2

* City
Harrisburg

* State/Territory:
[PENNSYLVANIA ▾]

* Zip Code +4
17110   9436

* Telephone
(555) 555-5555   x Extension
(555) 555-5556   x

Fax
(555) 555-5555

E-mail Address

[◀ PREVIOUS PAGE]   [SAVE ▶]

Topic View

Electronic Funds Transfer

Electronic Funds Transfer

(*) Red asterisk indicates a required field.

Topic Summary

This topic requests information about the Electronic Funds Transfer (EFT) authorization agreement. This topic is the electronic CMS-588 Form. Data collected in this topic includes financial institution and account information, and information for the contact person for the electronic funds transfer. ➕ (more information about Electronic Funds Transfer)

* Does the applicant have any EFT information to report?

○ Yes

○ No

[ADD INFORMATION ⨠]

Electronic Funds Transfer Information

No EFT authorization information has been entered. Please answer the question above.

[⨞ PREVIOUS TOPIC]   [GO TO ERROR CHECK ⨠]   [NEXT TOPIC ⨠]

Electronic Funds Transfer

Electronic Funds Transfer

(*) Red asterisk indicates a required field.

Financial Institution Information

Please enter the information for the financial institution where the account was opened.

*Name

*Street Address Line 1:

Street Address Line 2:

*City

*State/Territory
Select State/Territory

*Zip Code +4

XXXXX   XXXX

Contact Person First Name

Contact Person Last Name

*Telephone Number   x Extension
                    X
No Format Required

*Routing Transit Number

9 Digits

* Depositor Account Number

Maximum of 17 Digits

* Type of Account
Select Account Type

Account Holder Information

Please enter the information for the account holder.

Legal Business Name: LLC
TIN:

* National Provider Identifier (NPI)

10 Digits

Medicare Identification Number (if issued)

Either select an address from the 'Select address' dropdown field and click the Apply button or enter a new address in the fields below.

Select a previously entered address:

Select address

APPLY

*Street Address Line 1

Street Address Line 2

*City

*State/Territory
Select State/Territory

*Zip Code +4

XXXXX   XXXX

NEXT PAGE

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Electronic Funds Transfer

Electronic Funds Transfer

(*) Red asterisk indicates a required field.

Contact Person

Please enter the contact person who should contacted for any questions regarding this EFT Authorization Agreement submission.

* First Name

* Last Name

* Title

* Telephone   Extension
              X
No Format Required

* E-mail Address

[PREVIOUS PAGE]   [SAVE]

[CANCEL]

Electronic Funds Transfer

Electronic Funds Transfer

(*) Red asterisk indicates a required field.

Information

- Electronic Funds Transfer Information was successfully added.

Topic Summary

This topic requests information about the Electronic Funds Transfer (EFT) authorization agreement. This topic is the electronic CMS-588 Form. Data collected in this topic includes financial institution and account information, and information for the contact person for the electronic funds transfer. ⊞ (more information about Electronic Funds Transfer)

Electronic Funds Transfer Information

Electronic Funds Transfer

Financial Institution Information

Financial Institution Name: America Bank
Financial Institution Contact Person:
Financial Institution Telephone Number: (919) 999-9994

Financial Institution Routing Transit Number: XXXXX
Depositor Account Number: XXXXXXXXXXXXX
Type of Account: Checking

Financial Institution Address:
        LaSalle St
    Chicago, IL 60602

Note: To update the Routing Transit Number or Depositor Account Number you must delete this EFT Agreement and enter a new one.

Account Holder Information

Legal Business Name: LLC
TIN:
NPI:
Medicare Identification Number: pending

Account Holder Address:
        LaSalle Street
    Chicago, IL 60602

Contact Person Information:

Title: President
First Name:
Last Name:
Telephone Number: (919) 999-9995
E-mail Address: nppes.test@cms.gov

[EDIT ⊡]   [DELETE ⊡]

[⬛ PREVIOUS TOPIC]   [GO TO ERROR CHECK ⬛]   [NEXT TOPIC ⬛]

Required and/or Supporting Documentation

Required and/or Supporting Documentation

Required and/or Supporting Documentation Information

▼ Expand to display the Required and/or Supporting Documentation. Checklist for this Medicare enrollment application submission.

Note: Expand ➕ for document details.

Required Documentation	Delivery Method	Comments
➕ Form CMS-460, Medicare Participating Physician or Supplier Agreement	View and Print 🖥️ ☐ Mail ☐ Upload	Maximum of 500 characters. You have 500 characters remaining.

Supporting Documentation	Delivery Method	Comments
➕ Other Documentation requested by your Medicare Contractor(s)	☐ Mail ☐ Upload	Maximum of 500 characters. You have 500 characters remaining.

Documentation Requiring Signatures: MUST E-SIGN or UPLOAD	View and Print Documentation	Comments
➕ Authorized Official Certification Statement for Clinics and Group Practices [PDF] Note: Please do not mail a signed Certification Statement. Signature documents must be either e-signed or uploaded.	View and Print [PDF] 🖥️	Maximum of 500 characters. You have 500 characters remaining.
➕ Certification Statement for Individual Practitioners [PDF] Note: Please do not mail a signed Certification Statement. Signature documents must be either e-signed or uploaded.	View and Print [PDF] 🖥️	Maximum of 500 characters. You have 500 characters remaining.
➕ Form CMS-855R, Authorization Statement for Reassignment of Medicare Benefits Note: Please do not mail a signed Certification Statement. Signature documents must be either e-signed or uploaded.	View and Print [PDF] 🖥️	Maximum of 500 characters. You have 500 characters remaining.

Note: Documents in PDF format require the Adobe Acrobat Reader® 🖥️. If you experience problems with PDF documents, please download the latest version of the Reader® 🖥️.

[SAVE CHECKLIST 💾]

Uploaded Documents

Step 3: Upload digital copies of the documents.

Instructions for this step: This step is required only if you selected the Upload delivery method for any documents you identified in Step 1. Complete Step 2 before Step 3.

Please select any required or supporting documents you identified in Step 1 with the Upload delivery method and upload them below as attachments to your Medicare enrollment application. Please select the document type, the document name, and click the UPLOAD button to attach each file to your Medicare enrollment application.

Documents you upload appear in the Current Uploaded Documents table.

Send hard copies of the documents you identified with the Mail delivery method in Step 1 to your MAC via U.S. Mail.

Note: Please do not upload your signed documents in this section. You will be able to upload them on the Manage Signatures page of the submission process.

Please do not upload the following documentation. Doing so might delay processing your application and could require further action:

- **Form CMS-855A, Form CMS-855B, Form CMS-855I, Form CMS-855R, Form CMS-855S, or Form CMS-855O.**

File Upload Constraints:

- You may upload only PDF or TIFF formatted document files that are 10MB or less.
- You may upload only 100 or fewer documents per application submission.
- Each uploaded file may only contain one document. Files with multiple documents are not valid.

* Document Type	* Document Name
Select Document Type ⌄	Browse...
	UPLOAD »

« PREVIOUS TOPIC   GO TO ERROR CHECK »   RETURN TO TOPICS »

Current Uploaded Documents

Document Type	File Name	Document ID	Date Uploaded	Actions
Voided Check/Account Verification	2018_Test Document - Void Check.pdf	VPECOS000CA 1802131513220 660E120H2271 52T1011	02/13/2018	VIEW ▶ REMOVE ▶

« PREVIOUS TOPIC   GO TO ERROR CHECK »   RETURN TO TOPICS »

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Error/Warning Check

Enrollment ID:
PacID:
Web Tracking ID:
Individual Provider NPI:

Errors for this Enrollment

Errors were found for this enrollment application or the enrollment on file with Medicare. Please review the errors listed below and verify that the information entered is correct.

Verification of this information is required; the submission process will not continue without verification of this information.

Topic	Error
Personal Information	Personal Information is required.
Individual Control	Individual Control is required.
Billing Agency	Billing Agency is required.
Contact Person	At least one contact person listed should have an e-mail address.

Warnings for this Enrollment

No Warnings were found for this enrollment application.

32

Unfinished Application

Existing Enrollments

Contractor: NATIONAL GOVERNMENT SERVICES, INC
State: MAINE
Type/Specialty: HEMATOLOGY

Enrollment Type: 855I
Medicare ID: View Medicare ID Report
Status: APPROVED   View Approved Enrollment Record

Current ADI Accreditation?: No

Active Reassignments: 1
Pending Reassignments Applications: 0
View/Manage Reassignments

Type of Update	Status	Tracking ID	Action
Revalidation	EDIT View Edit Application	TXXXXXXXXXX	VIEW ▶ MORE OPTIONS ▶

Unfinished Application

Home > My Associates > My Enrollments > Application Questionnaire

(*) Red asterisk indicates a required field.

Approved Existing Provider Enrollment

* What type of action is the applicant trying to perform?

◉ Continue Working on Application

○ Delete Application

NEXT PAGE ▶

◀◀ RETURN TO MY ENROLLMENTS

Topic View

Home > My Associates > My Enrollments > Revalidation

| Topic View | **Fast Track View** | Error/Warning Check **3** |

Enrollment ID:
PacID:
Web Tracking ID:
Individual Provider NPI:

✓   **License and Certification Information**   ⊞ more information about License and Certification Information

✓   **Final Adverse Actions**   ⊞ more information about Final Adverse Actions

✓   **Individual Control**   ⊞ more information about Individual Control

✓   **Patient Records Storage Location**   ⊞ more information about Patient Records Storage Location

✓   **Billing Agency**   ⊞ more information about Billing Agency

✓   **Contact Person**   ⊞ more information about Contact Person

✓   **Electronic Funds Transfer**   ⊞ more information about Electronic Funds Transfer

✓   **Required and/or Supporting Documentation**   ⊞ more information about Required and/or Supporting Documentation

Note:
- Once you have completed all the topics and no errors are present, the 'Begin Submission' button will be enabled. You may review errors at any time by clicking the 'Error Check' tab. Clicking 'Begin Submission' will initiate the Submission Process.

BEGIN SUBMISSION ⊠

NEXT PAGE ⊠

Error/Warning Check

Topic View | **Fast Track View** | **Error/Warning Check 2**

Enrollment Submission

Note: Your application is ready for submission with warning messages. Please review the warning messages and select the Begin Submission button.

BEGIN SUBMISSION »

Enrollment ID:
PacID:
Web Tracking ID:
Individual Provider NPI:

Errors for this Enrollment

No Errors were found for this enrollment application.

Warnings for this Enrollment

Warnings were found for this enrollment application. Please review the warnings listed below and verify that the information entered is correct.

Verification of this information is optional; the submission process may continue without verification of this information.

Topic	Warning
Individual Control	Each enrollment is recommended to have at least one individual designated as the managing employee.
Reassignment	Reassignment of Benefits exist that are missing a primary and/or secondary practice location. It is recommended that a primary and secondary practice location be specified, but are not required.

Signature Method

- Authorized/Delegated Official Selection

Manage Signatures

Manage Signatures

(*) Red asterisk indicates a required field.

Name:
Web Tracking ID: **TIN:** XX-XXXXXXX

NEW! PECOS now allows users to upload signed documents. Please upload your certification statement(s),authorization statement(s), and CMS-588 forms on this page, or after submission, by navigating to the My Enrollments page and selecting the Manage Signatures option.

Note: Users will no longer be able to mail in signature documents. Please select either Electronic or Upload.

NEW! - Any Authorized or Delegated Officials with an ITIN will not be able to submit electronic signatures. Authorized or Delegated Officials with an ITIN entered on this application **must now upload their signature documents**.

Please select a signature method for each signer:

Name: Donald Duck
SSN: XXX-XX-XXXX   **Role:** AUTHORIZED OFFICIAL
* Signature Method for Donald Duck: **Document:** AUTHORIZATION STATEMENT
                                              FOR ORGANIZATIONS (855R)
○ Electronic
○ Upload

Name: [You]
SSN: XXX-XX-XXXX   **Role:** PRACTITIONER
* Signature Method for   **Document:** CERTIFICATION STATEMENT
                                              FOR INDIVIDUAL PRACTITIONERS
○ E-Sign (Sign Now)
○ Upload
                                              Role: PRACTITIONER
                                              Document: AUTHORIZATION STATEMENT
                                              FOR INDIVIDUAL PRACTITIONERS (855R)

[◄ PREVIOUS PAGE]   [NEXT PAGE ►]

[« RETURN TO MY ENROLLMENTS]

National Government Services.

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Manage Signatures

Name: [You]
SSN: XXX-XX-XXXX
* **Signature Method for**

◉ E-Sign (Sign Now)
○ Upload

Role: PRACTITIONER
Document: CERTIFICATION STATEMENT FOR INDIVIDUAL PRACTITIONERS

Role: PRACTITIONER
Document: AUTHORIZATION STATEMENT FOR INDIVIDUAL PRACTITIONERS (855R)

☐ **Sign Now**

◀ PREVIOUS PAGE   NEXT PAGE ▶

◀◀ RETURN TO MY ENROLLMENTS

E-Signature Submission

(*) Red asterisk indicates a required field.

E-Signature Instructions

To e-sign the enrollment application, follow the steps below:

1. Review all documentation prior to e-signing.
2. Review all applicable terms and conditions.
3. Acceptance of all applicable terms and conditions is a requirement to e-sign.
4. Enter required identifying information listed under Complete Your E-Signature.

Certification Statement Terms and Conditions

Certification Statement for Individual Practitioners

As an individual practitioner, you are the only one who may sign this application. The authority to sign the application on your behalf may not be delegated to any other person. The Certification Statement contains certain standards that must be met for initial and continuous enrollment in the Medicare program. Review these requirements carefully.

Do you accept the Terms and Conditions?

☐ Yes, I agree to the certification statement terms and conditions. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my traditional handwritten signature.

Authorization Statement Terms and Conditions

AUTHORIZATION STATEMENT (855R)

The signatures below authorize the reassignment of benefits to a supplier or the termination of a reassignment of benefits to a supplier, as indicated in Section 1. Title XVIII of the Social Security Act prohibits payment for services provided by an individual practitioner to be paid to another individual or supplier unless the individual practitioner who provided the services specifically authorizes another individual or supplier (employer.

Do you accept the Terms and Conditions?

☐ Yes, I agree to the Authorization statement terms and conditions. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my traditional handwritten signature.

◀ PREVIOUS PAGE   NEXT PAGE ▶

◀ CANCEL

Manage Signatures

Name:
SSN: XXX-XX-XXXX
* Signature Method for   :
◉ Electronic
○ Upload

Role: PRACTITIONER
Document: CERTIFICATION STATEMENT
FOR INDIVIDUAL PRACTITIONERS

* Email Address
[   ]
*Confirm Email Address
[   ]

Role: PRACTITIONER
Document: AUTHORIZATION STATEMENT
FOR INDIVIDUAL PRACTITIONERS (855R)

[◄ PREVIOUS PAGE]   [NEXT PAGE ►]

[■ RETURN TO MY ENROLLMENTS]

Name: [You]
SSN: XXX-XX-XXXX
* Signature Method for

○ E-Sign (Sign Now)
◉ Upload

Role: PRACTITIONER
Document: CERTIFICATION STATEMENT
FOR INDIVIDUAL PRACTITIONERS

Role: PRACTITIONER
Document: AUTHORIZATION STATEMENT
FOR INDIVIDUAL PRACTITIONERS (855R)

Note: You may upload a signature document now, prior to application submission, or after the submission of this application. To upload a signature document after submission, or to change the signature method, navigate to the My Enrollments page, find this application, and select the Manage Signatures option.

The following documents can be used to upload a signature:

- Signature page from the corresponding Medicare provider/supplier enrollment application form available on the CMS website.

- Signature page from the Required/Supporting Documentation topic, or from the My Enrollments Page select this application then select View > View Printable Certification

To upload a signature document now, browse for the file then select the Upload button.

Document: CERTIFICATION STATEMENT FOR INDIVIDUAL PRACTITIONERS ⓘ

[Browse...] [UPLOAD ■]

Document: AUTHORIZATION STATEMENT FOR INDIVIDUAL PRACTITIONERS (855R)
ⓘ

[Browse...] [UPLOAD ■]

[◄ PREVIOUS PAGE]   [NEXT PAGE ►]

[■ RETURN TO MY ENROLLMENTS]

40

Submission Page

▼ Expand to display the Required and/or Supporting Documentation. Checklist for this Medicare enrollment application submission.

Documentation Requiring Signatures: MUST E-SIGN or UPLOAD	View and Print Documentation	Comments
➕ Authorized Official Certification Statement for Clinics and Group Practices [PDF]	View and Print [PDF] 🖨	
Note: Please do not mail a signed Certification Statement. Signature documents must be either e-signed or uploaded.		
➕ Certification Statement for Individual Practitioners [PDF]	View and Print [PDF] 🖨	
Note: Please do not mail a signed Certification Statement. Signature documents must be either e-signed or uploaded.		
➕ Form CMS-855R, Authorization Statement for Reassignment of Medicare Benefits	View and Print [PDF] 🖨	
Note: Please do not mail a signed Certification Statement. Signature documents must be either e-signed or uploaded.		

Note: Documents in PDF format require the Adobe Acrobat Reader® 🖨. If you experience problems with PDF documents, please download the latest version of the Reader® 🖨.

◄ PREVIOUS PAGE   COMPLETE SUBMISSION ►

◄ CANCEL

Submission Page

(*) Red asterisk indicates a required field.

Medicare Contractor

The Medicare Contractor(s) listed here would be responsible for processing your electronic and printed application materials. If more than one contractor is listed, you must mail copies of print documents to each contractor listed. **You must mail all required print documents within 15 days of submitting the electronic part of your application.**

Medicare Contractor: NATIONAL GOVERNMENT SERVICES, INC.

NATIONAL GOVERNMENT SERVICES, INC.
PO BOX
INDIANAPOLIS, IN

Reason(s) for submission:

- A Medicare Part B practitioner is revalidating Medicare enrollment information

Submission Confirmation

IMPORTANT!

Your enrollment application with any uploaded documentation has been submitted to your fee-for-service contractor.

Required and/or supporting documentation not e-signed or uploaded must be mailed in to the fee-for-service contractor.

You indicated the following documentation will be provided by mail/paper:
• Form CMS-460, Medicare Participating Physician or Supplier Agreement
• Copy of IRS Form CP 575 or other official IRS communication confirming Tax Identification Number and Legal Business Name

Your application may be delayed or not processed if any required/supporting documentation is missing.

OK

My Application Progress   100%

Submission Confirmation - Print Your Receipt

Submission Complete

You have successfully submitted your application! ←

Remember to:

• Make sure all required and supporting documents that require a signature are signed.
• Mail all required and supporting documents that has not been uploaded to your Medicare Contractor within 15 days of submitting the electronic part of your application. Your application is not complete until the Medicare Contractor(s) receives the signed required documentation of your application in the mail.
• Any required and/or supporting documentation not uploaded must be mailed in to the fee-for-service contractor.
• Your application may be delayed or not processed if any required/supporting documentation is missing.
• If you are submitting an application with Electronic Funds Transfer (EFT) Information, please include confirmation of account information on bank letterhead or a voided check.
• Print this page for your records. **Note**: You can print and/or save copies of the application and required documents for your records by visiting the "My Enrollments" page.
• You will receive e-mails about your application status. Make sure to add "customerservice-donotreply@cms.hhs.gov" to your safe sender list.

You have successfully submitted your application!

E-Signature Email

To: _____@anthem.com
Subject: PECOS E-Signature Request
Sent: 02/21/2018 13:19 PM

A Medicare application for _____ LLC for Reassignment has been submitted by: _____ @anthem.com. You have been identified as an authorized signer for this application for which CMS allows you to provide an electronic signature using the instructions below. Please disregard this email if you have already submitted a signature.

Enrollment Application Information:
  Provider/Supplier Name: _____ LLC
  Provider/Supplier Specialty Type: CLINIC/GROUP PRACTICE
  State: CT
  Form Type: 855R
  Practice Location: _____ NEW HAVEN, CT 065113010
  NPI:
  Web Tracking ID:

Instructions:
You may provide an electronic signature using your PECOS user ID at (https://urldefense.proofpoint.com/v2/url?u=http-3A__pecos.cms.hhs.gov&d=DwICAg&c=A-GX6P9ovB1qTBp7iQve2Q&r=De4c3C0DavxQnxVOzU2u9lv-Opd0bN7dNDjI5rWxhAs&m=9clmcEExjiJId-BkZ70Hf99T9uSP2255J6ruGHJIVXw&s=zaa2-vEIQ7mUVW3DeUhrwG88oSJAJsZ7kkwZBecGK0&e=) OR through the PECOS E-Signature website https://urldefense.proofpoint.com/v2/url?u=https-3A__pecos.cms.cmsval_pecos_eSignLogin.do&d=DwICAg&c=A-GX6P9ovB1qTBp7iQve2Q&r=De4c3C0DavxQnxVOzU2u9lv-Opd0bN7dNDjI5rWxhAs&m=9clmcEExjiJId-BkZ70Hf99T9uSP2255J6ruGHJIVXw&s=ZTRw9Hh1ggkOlwvaF3cWg2QNlmb2PWwcq6okXpXXy58&e=, using your identifying information, e-mail address, and unique PIN XXXXXXX . Continue to the 'Pending Signatures' section and locate the respective enrollment application to review and apply your E-Signature.

Please note the PIN is valid for 14 days from the time the submitter completed the application. If 14 days or more have elapsed, you can access the PECOS E-Signature website to request a new PIN or contact the submitter identified above.

This email message is an automated notification. Do not reply to this message as it is sent from an unmonitored account. If you require assistance at any point in the process, please refer to https://urldefense.proofpoint.com/v2/url?u=https-3A__eus.custhelp.com&d=DwICAg&c=A-GX6P9ovB1qTBp7iQve2Q&r=De4c3C0DavxQnxVOzU2u9lv-Opd0bN7dNDjI5rWxhAs&m=9clmcEExjiJId-BkZ70Hf99T9uSP2255J6ruGHJIVXw&s=vJYrEDOHkzVIVcE5qJt_5hsw5yN8CT7fMC5B5uZq81I&e= or call 1-866-484-8049/TTY: 1-866-523-4759

Unauthorized interception of this communication could be a violation of Federal and State Law. This communication and any files transmitted with it are confidential and may contain protected health information. This communication is solely for the use of the person or entity to which it was addressed. If you are not the intended recipient, any use, distribution, printing or acting in reliance on the contents for this message is strictly prohibited. If you have received this message in error, please notify the sender and destroy all copies of the message.

The email will provide 2 options for e-signing the application:
1. *Log into Internet-based PECOS using your existing PECOS ID and password*
2. *2. E-sign via the PECOS e-signature website if you don't have an existing PECOS ID and password*

Welcome

Release Notes

Want to learn what's new in the latest PECOS release? Please review the Release Notes[PDF].

System Notifications

Note: JavaScript must be enabled in your internet browser for PECOS to work properly. If JavaScript is currently disabled in your browser, refer to the Accessibility section in PECOS Help for instructions on enabling JavaScript.

Details
•   There are no notifications at this time.

Manage Medicare and Account Information

MY ASSOCIATES ⟩⟩

- Enroll in Medicare for the first time
- View and update existing Medicare information
- Continue working on saved applications

ACCOUNT MANAGEMENT ⟩⟩

- Update your user account information, request or remove access to organizations
- Manage access to Medicare enrollments

REVALIDATION NOTIFICATION CENTER ⟩⟩

- View All Applications requiring revalidation
- Start or continue revalidation application

Manage Signatures

Applications Requiring Signatures

Applicant Name:
TIN (EIN):
Web Tracking ID:
Form Type: 855R
Application Submitted: 02/21/2018
Organization:
Role: AUTHORIZED OFFICIAL
Document: AUTHORIZATION STATEMENT FOR ORGANIZATIONS (855R)

VIEW AND SIGN ⟩⟩

VIEW ALL SIGNATURES ⟩⟩

E-Signature

- **Provider/AO or DO**
  - First and last name
  - Date of birth
  - SSN
  - Telephone
  - Email
  - PIN

Verify and Manage Signatures

- Print Certification Statement

Verify and Manage Signatures

- View Printable Certification Statement

View and Print Certification Statement

View and Print Application

Printing Instructions

Each document listed below may be saved to your computer and/or printed for your personal records by clicking the "View and Print"link next to each document. Only the required supporting documentation must be printed and mailed to the Medicare contractor. Certification / Authorization Statement(s) must be printed and uploaded if not e-signed.

Please do not mail a copy of this application or the Certification / Authorization Statement(s)to the Medicare contractor if you are submitting it electronically.

View and Print [PDF]   Authorized Official Certification Statement for Clinics and Group Practices
Note: Please do not mail a signed Certification Statement. Signature documents must be either e-signed or uploaded.

View and Print   Medicare Supplier Enrollment Application Privacy Act Statement for Clinics and Group Practices

View and Print   Supporting Documentation

View and Print [PDF]   CMS-588 Electronic Funds Transfer (EFT) Authorization Agreement
Note: Please do not mail a signed Certification Statement. Signature documents must be either e-signed or uploaded.

View and Print   CMS-460 Medicare Participating Physician or Supplier Agreement

Note:

- Documents in PDF format require the Adobe Acrobat Reader®. If you experience problems with PDF documents, please download the latest version of the Reader®.

◄ PREVIOUS PAGE

✖ CANCEL

Verify Signature Status

Update Signature Record

Electronic Signature Status

(*) Red asterisk indicates a required field.

Update Signature Record

NEW! - Any Authorized or Delegated Officials with an ITIN will not be able to submit electronic signatures. Authorized or Delegated Officials with an ITIN entered on this application **must now upload their signature documents**.

Name

Role
AUTHORIZED OFFICIAL

Document
AUTHORIZED OFFICIAL CERTIFICATION STATEMENT FOR CLINICS AND GROUP PRACTICES

E-Sign Status
Pending

Selected Signature Method
Upload

Update Signature Method to:

○ Electronic

The following documents can be used to upload a signature:

- Signature page from the corresponding Medicare provider/supplier enrollment application form available on the CMS website.

- Signature page from the Required/Supporting Documentation topic, or from the My Enrollments Page select this application then select View > View Printable Certification

To upload a signature document now, browse for the file then select the Upload button.
ⓘ

[Browse...]   **UPLOAD »**

« CANCEL   **CONFIRM »**

« RETURN TO MY ENROLLMENTS

Process After Submission

- **Contact person on application will receive by email**
  - Acknowledgement Notice
    - Add to safe sender list
      - customerservice-donotreply@cms.hhs.gov
      - NGS-PE-Communications@anthem.com
  - Development requests for additional information
    - Respond within 30 days
    - Log into PECOS to make necessary corrections or upload the required documents, view and manage signatures
  - Response letter
    - Deactivation for incomplete/no response to development request
    - Approval

Application Status

PECOS Application Status

PECOS Self-Service Application
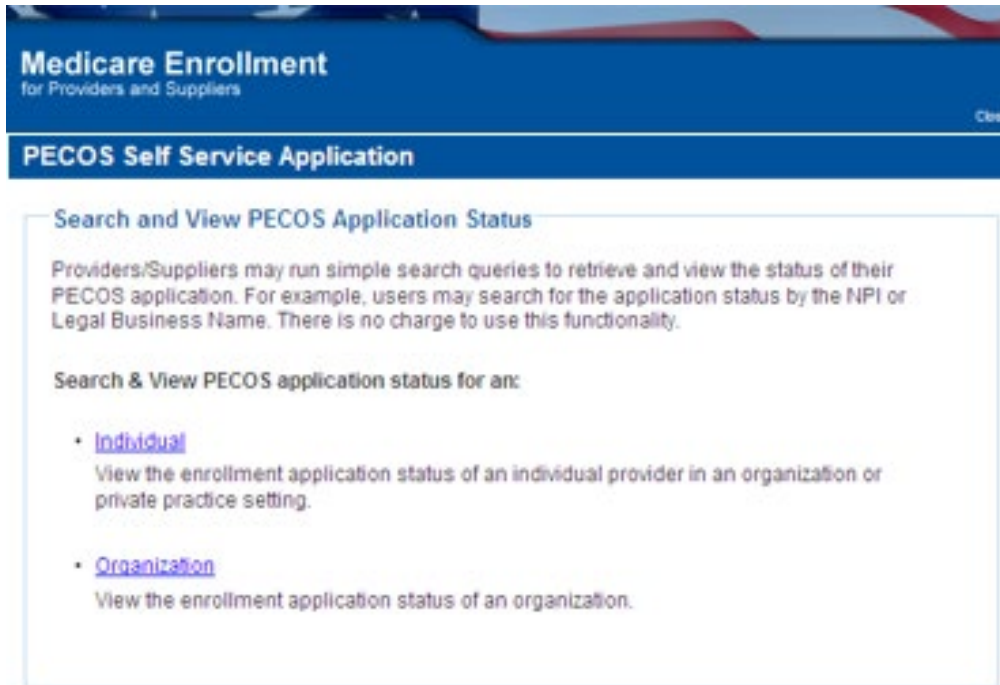
- **Check Status**
  - Individual
  - Organization

PECOS Application Status

- **Status section**
  - Steps 1, 2, 3, 4
  - One will be highlighted with current status
  - If Application Fee is required another Step is added

Resources

Internet-Based PECOS Tutorials

Enrollment Tutorials

- **Initial Enrollment:**
  Step-by-step demonstration of an initial enrollment application in PECOS.
  Individual Provider - WMV [ZIP, 52MB] or Organization/Supplier - WMV [ZIP, 53MB]

- **Change of Information:**
  Step-by-step demonstration of how to update or change information for an existing enrollment already on file with CMS.
  Individual Provider - WMV [ZIP, 46MB] or Organization/Supplier - WMV [ZIP, 48MB]

- **Revalidation:**
  Step-by-step demonstration on how to submit your revalidation application using PECOS.
  Individual Provider - WMV [ZIP, 29MB] or Organization/Supplier - WMV [ZIP, 32MB]

- **Deactivated:**
  Example of how to deactivate an existing enrollment record.
  Individual Provider - WMV [ZIP, 11MB]

- **Reactivation:**
  Step-by-step demonstration of how to re-enroll based on enrollment information that already exists in PECOS.
  Organization/Supplier - WMV [ZIP, 39MB]

- **Adding a Practice Location (DMEPOS Only):**
  Demonstration of how to add a new practice location for DMEPOS supplier who is already enrolled with CMS.
  DME Supplier - WMV [ZIP, 64MB]

Online Account Self-Service Features

Welcome to the Medicare Provider Enrollment, Chain, and Ownership System (PECOS)

(*) Red asterisk indicates a required field.

PECOS supports the Medicare Provider and Supplier enrollment process by allowing registered users to securely and electronically submit and manage Medicare enrollment information.

New to PECOS? View our videos at the bottom of this page.

USER LOGIN

Please use your I&A (Identity & Access Management System) user ID and password to log in.

* User ID

* Password

LOG IN »

Forgot Password?

Forgot User ID?

Manage/Update User Profile

Who Should I Call? [PDF, 155KB] - CMS Provider Enrollment Assistance Guide

BECOME A REGISTERED USER

You may register for a user account if you are: an Individual Practitioner, Authorized or Delegated Official for a Provider or Supplier Organization, or an individual who works on behalf of Providers or Suppliers.

Register for a user account

Questions? Learn more about registering for an account

Note: If you are a Medical Provider or Supplier, you must register for an NPI before enrolling with Medicare.

Helpful Links

Application Status - Self Service Kiosk to view the status of an application submitted within the last 90 days.

Important Note: CMS is using its authority under Section 1135 of the Social Security Act to waive the application fee for any applications submitted on or after March 1, 2020 in response to COVID-19. Please do not submit an application fee with your application. For more information on provider enrollment flexibilities related to COVID-19, please visit the CMS website [PDF].

Pay Application Fee - Pay your application fee online.

View the list of Providers and Suppliers [PDF, 94KB] who are required to pay an application fee.

E-Sign your PECOS application - Access the PECOS E-Signature website using your identifying information, email address, and unique PIN to electronically sign your application.

Resources

For Assistance With	Contact	Contact Information
• Changing an NPPES password • Establishing a new user ID and password for NPPES • Questions related to the NPI application	NPI Enumerator	Phone: 800-465-3203 TTY: 800-692-2326 Email: customerservice@npienumerator.com
• Errors encountered while accessing or entering information in PECOS • Forgotten PECOS user IDs and passwords	EUS Help Desk	Phone: 866-484-8049 TTY: 866-523-4759 Email: EUSSupport@cgi.com Live Chat: https://eus.custhelp.com/

NGSMedicare.com

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

Resources

- Prevent Revalidation Processing Delays
- Supporting Documentation Required for Enrollment Revalidations

Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

We're on Twitter! @NGSMedicare

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mu
medicare university