

Provider Enrollment: Submitting Revalidations via PECOS

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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

Medicare Enrollment

for Providers and Suppliers

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

You may use your NPES or PECOS username and password to login.

* User ID

* Password

[LOGIN](#)

[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.

[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.

Provider & Supplier Resources

- [CMS.gov/Providers](#) - Section of the CMS.gov website that is designed to provide Medicare enrollment information for providers, physicians, non-physician practitioners, and other suppliers.
- [Enrollment Checklists](#) - Review checklists of information needed to complete an application for various provider and supplier types.
- [Medicare Learning Network® \(MLN\)](#) - Helpful articles and tutorials about changes in Medicare enrollment.
- [Revalidation Notice Sent List](#) - Check to see if you have been sent a notice to revalidate your information on file with Medicare.
- [Ordering, Certifying, or Prescribing Practitioners List](#) - View the Ordering, Certifying, or Prescribing Practitioners List to verify eligibility to order or certify items or services to Medicare beneficiaries, or prescribe part D drugs.
- [Ordering, Certifying, or Prescribing Information \[PDF, 1.64MB\]](#) - Learn about the Ordering, Certifying, or Prescribing enrollment process.

Enrollment Tutorials

- **Initial Enrollment:**
Step-by-step demonstration of an initial enrollment application in PECOS.
[Individual Provider](#) or [Organization/Supplier](#)
- **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](#) or [Organization/Supplier](#)
- **Revalidation:**
Step-by-step demonstration on how to submit your revalidation application using PECOS.
[Individual Provider](#) or [Organization/Supplier](#)
- **Deactivated:**
Example of how to deactivate an existing enrollment record.
[Individual Provider](#)
- **Reactivation:**
Step-by-step demonstration of how to re-enroll based on enrollment information that already exists in PECOS.
[Organization/Supplier](#)
- **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](#)

Welcome

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

- PECOS users are no longer able to mail documents that require a signature. When submitting your application, be prepared to provide an e-signature or upload your documents that require a signature.

Manage Medicare and Account Information

MY ASSOCIATES 02

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

ACCOUNT MANAGEMENT 04

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

REVALIDATION NOTIFICATION CENTER 03

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

Manage Signatures

Applications Requiring Signatures

You currently have no pending signatures.

VIEW ALL SIGNATURES 04

Existing Associates

My Associates

New Application

Before you get started, please review the following checklists of information necessary to complete an enrollment via internet based PECOS.

- [Checklist for Sole Proprietor or Solely Owned Organizations \(eg. LLC, PC\) using PECOS](#)
- [Checklist for Individual Physician and Non-Physician Practitioners using PECOS](#)
- [Checklist for Provider or Supplier Organization using PECOS](#)

To enroll in the Medicare program for the first time or to create a new enrollment, please click the "New Application" button below

NEW APPLICATION

Existing Associates

In order to view Medicare applications and enrollments for an associate, please click on the "View Enrollments" button next to an associate listed below

Individuals

Records 1 - 1 of 1

Name:	John Provider	NPI:	VIEW ENROLLMENTS
-------	---------------	------	-------------------------

Organizations

Records 1 - 1 of 1

Name:		TIN:	VIEW ENROLLMENTS
-------	--	------	-------------------------

Existing Associates

Please provide one or more of the following options to filter your associates. Selecting the reset button will clear the options selected and load the full list of associates.

Enrollment Type
All Types **SELECT**

Provider/Supplier Type
All Provider/Supplier Types

Associate Legal Business Name
TIN
XXXX-XX-XXXX

Associate Last Name
NPI
10 Digits

Associate First Name
State
All States

FILTER **RESET**

In order to view Medicare applications and enrollments for an associate, please select the "View Enrollments" button next to an associate listed below.

Individuals

Records 1 - 1 of 1

Name:		NPI:	VIEW ENROLLMENTS
-------	--	------	-------------------------

Organizations

Records 1 - 1 of 1

Name:		TIN:	VIEW ENROLLMENTS
-------	--	------	-------------------------

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

Medicare Enrollment
for Providers and Suppliers

Home | Help | Logoff

My Application Progress

0%

Confirm Reason for Application

Medicare Part B Enrollment

Based on your responses, the following reason for application was identified.

- A Medicare Part B practitioner is currently enrolled in the Medicare program using their social security number (SSN). The practitioner is revalidating Medicare enrollment information.

The application is for:

Name	Social Security Number (SSN)	Practitioner Specialty	State
JENNY LEWIS	XXX-XX-XXXX	INTERNAL MEDICINE	GEORGIA

Clicking on the 'Start Application' button will create a Medicare application using the above information.
Please note: After you click 'Start Application' a Web Tracking ID will be created. This does not mean that your application has been submitted.

At the conclusion of this process:

- The application is submitted to the appropriate Medicare fee-for-service contractor(s) for processing
- The practitioner must sign a statement certifying the submitted information
- The certification statement, additional required signatures, and required attachments must be electronically signed or mailed to the identified fee-for-service contractor(s)
- The Medicare enrollment is finalized after the fee-for-service contractor processes this application and approves the information
- Any required and/or supporting documentation not uploaded must be mailed in to the fee-for-service contractor

START APPLICATION

Help

- Practitioner Specialty
- Fee-for-Service Contractor
- Certification Statement

Fast Track View

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

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

Reason for Application

Enrolled Practitioner is Revalidating their Enrollment Information

[EDIT REASON](#)

Reports

Select the hyperlink to view the Application being edited:
[View Application being edited](#)

Select the hyperlink to view the Medicare ID Report:
[View Medicare ID Report](#)

Topics

Personal Information

MD

Date of Birth: XXXX
Social Security Number: XXX-XX-XXXX
Gender:
IRS Proprietary/Non-Profit Status: Proprietary
Accepting New Patients: Yes
Country of Birth: United States
State/Territory of Birth: PENNSYLVANIA
Medical School or other Professional School: PENNSYLVANIA STATE UNIVERSITY COLLEGE OF MEDICINE
Year of Graduation:

[GO TO TOPIC](#)

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

Topic View

Topic View | Fast Track View | Error/Warning Check 1

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

Reason for Application

Practitioner is revalidating Medicare enrollment information

Topics

The data required for this enrollment application is grouped into topics. In order to electronically submit this enrollment application, you must complete all of the following topics.

You may view and print this enrollment application at any time during the enrollment process by clicking the View and Print button below.

This application is collecting the following topics:

Completed	Topics
✓	Personal Information + more information about Personal Information
✓	PA/PC/LLC Information + more information about PA/PC/LLC Information
✓	Practitioner Specialty + more information about Practitioner Specialty
✓	PAR Status Information + more information about PAR Status Information
✓	Physical Location and "Special Payments" Address + more information about Physical Location and "Special Payments" Address
✓	Vehicle Information + more information about Vehicle Information
— N/A	Geographic Location + more information about Geographic Location
✓	Rendering Healthcare Services at a Patient's Home + more information about Rendering Healthcare Services at a Patient's Home

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

[Home](#) > [My Associates](#) > [My Enrollments](#) > [Initial Enrollment](#) > [Individual Control](#) > ADD

Individuals with Ownership Interest and/or Managing Control

(*) Red asterisk indicates a required field.

Place of Birth Information

Country of Birth
Select Country ▼

SELECT

*** State/Territory of Birth**
Select State/Territory of Birth ▼

PREVIOUS PAGE

NEXT PAGE

CANCEL

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 ^①
MM/DD/YYYY

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 -8624

Special Payment Address

Payment Address:
300 GEORGE ST
FL
NEW HAVEN, CT 06511 -8624

Effective Date of Information:
01/01/2018

[EDIT](#) [DELETE](#)

Physical Location Contact Information:

Telephone Number:

Fax Number:

E-mail address:
@ANTHEM.COM
[EDIT](#)

Claims Information:
[ADD](#)
Medicare Identification Number:

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

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

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 XXXXX

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

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

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

<input type="checkbox"/>	Individual Control more information about Individual Control
<input checked="" type="checkbox"/>	Patient Records Storage Location more information about Patient Records Storage Location
<input checked="" type="checkbox"/>	Billing Agency more information about Billing Agency
<input checked="" type="checkbox"/>	Contact Person more information about Contact Person
<input checked="" type="checkbox"/>	Electronic Funds Transfer more information about Electronic Funds Transfer
<input type="checkbox"/>	Required and/or Supporting Documentation more information about Required and/or Supporting Documentation

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**

***Zip Code +4**

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**

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:

***Street Address Line 1**

Street Address Line 2

***City**

***State/Territory**

***Zip Code +4**

Electronic Funds Transfer

[Home](#) > [My Associates](#) > [My Enrollments](#) > [Initial Enrollment](#) > [Electronic Funds Transfer](#) > ADD

Electronic Funds Transfer

(*) Red asterisk indicates a required field.

Contact Person

Please enter the contact person who should be 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: XXXXXXXXXXXXXXX
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: npes.test@cms.gov

Required and/or Supporting Documentation

Required and/or Supporting Documentation
(*) Red asterisk indicates a required field.

Topic Summary

This topic covers information pertaining to required and/or supporting documentation you will need to furnish to your Medicare Administrative Contractor (MAC) to process your Medicare enrollment application. Based on information you provide in your enrollment application, PECOS displays a checklist of the types of required and/or supporting documentation you need to provide to your MAC.

For each document, you have the option of selecting which delivery method to use - upload a digital copy or send a hard copy via U.S. Mail. PECOS provides a feature to upload digital copies of documents from your computer that you want to deliver to your MAC with the Internet-based PECOS enrollment application.

Medicare Administrative Contractor Information:
N/A

Please remember that your application could be delayed or not processed if any required and/or supporting documentation is missing from your Medicare enrollment application. If you have questions about required and/or supporting documentation, please contact your MAC.

Instructions for Completing This Topic

There are three steps to complete for this topic. Step 1 and Step 2 are required. Step 3 is required only if you are uploading digital copies of documents identified in Step 1 now.

Step 1: Review the required and/or supporting documentation, optionally, identify the delivery method for each document; optionally, print the other required documentation, and save the checklist.

Step 2: Confirm that you want to upload digital copies of the required or supporting documents.

Step 3: Upload digital copies of the documents. (Step 3 might not appear depending on your response in Step 2)

Step 1: Review the required and/or supporting documentation; optionally identify the delivery method for each document; and save the checklist.

Instructions for this step: Please review the Required and/or Supporting Documentation Checklist pertaining to your enrollment application. For each type of documentation, you may select the delivery method-Mail or Upload. If more than one document is submitted, you may choose either the Upload or the Mail delivery method for each document. Please note that supporting documentation might include other documentation requested by your MAC to validate information reported on your Medicare enrollment application. Please remember that you cannot change the selected delivery method for a document once your Medicare enrollment application has been submitted to your MAC.

Please review the list of Documentation Requiring Signatures. They will need to be included with your application. You have two options for handling these documents:

- Print the document(s) requiring a signature, provide a wet signature, and upload digital copies of the document(s) during the Submission process.
- E-sign the document(s) requiring a signature during the Submission process.

Please select the SAVE CHECKLIST button after selecting the delivery method for each required and supporting document, and after reviewing Documentation Requiring Signatures that must be e-signed or uploaded. Use the saved checklist to track the delivery method(s) of the documentation as well as the Certification Statement(s) or Authorization Statement(s) needed for your application. To convey to your MAC additional information pertaining to a document, please use the Comments box.

Whether or not you identify the delivery method(s) in Step 1, please complete Step 2, which is required. In addition, if you select the Upload delivery method and you want to upload

Whether or not you identify the delivery method(s) in Step 1, please complete Step 2, which is required. In addition, if you select the Upload delivery method and you want to upload documents now, please complete Steps 2 and 3 to upload the documents from your computer and attach them to your Medicare enrollment application. If you select the Mail delivery method, please mail the documents to your MAC via U.S. Mail.

Required and/or Supporting Documentation Information

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

Step 2: Confirm that you want to upload digital copies of the documents now

Instructions for this step: If you selected the Upload delivery method for any documentation selected in Step 1, and you want to upload them now, please select "Yes". If you did not select the Upload delivery method for any documentation Step 1, you did not complete Step 1, or you do not want to upload the documents now, please select "No".

You may return to this topic at a later time - but before application submission - to upload documents.

* Do you want to upload one or more documents with your Medicare enrollment application now?

☐ Yes, I would like to upload one or more documents now.

☐ No, I do not want to upload any documents now. (You may upload documents at a later time.)

Document Information

No documents have been listed. Please answer the question above.

PREVIOUS TOPIC

GO TO ERROR CHECK




RETURN TO TOPICS

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-480, Medicare Participating Physician or Supplier Agreement	View and Print  <input type="checkbox"/> Mail <input type="checkbox"/> Upload	<input type="text"/> Maximum of 500 characters. You have 500 characters remaining.
Supporting Documentation	Delivery Method	Comments
 Other Documentation requested by your Medicare Contractor(s)	<input type="checkbox"/> Mail <input type="checkbox"/> Upload	<input type="text"/> 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]

[View and Print \[PDF\] !\[\]\(86b1b52fb4b2e5ef84ee1bcb7fce3537_img.jpg\)](#)

Maximum of 500 characters. You have 500 characters remaining.

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 \[PDF\] !\[\]\(a895f1cfc2a4586a576707ad87b41f18_img.jpg\)](#)

Maximum of 500 characters. You have 500 characters remaining.

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 \[PDF\] !\[\]\(4945c270a84299e830fccf8bc8af6c34_img.jpg\)](#)

Maximum of 500 characters. You have 500 characters remaining.

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 !\[\]\(9be65690e0a3e50309412529b9106826_img.jpg\)](#). If you experience problems with PDF documents, please [download the latest version of the Reader !\[\]\(62b514222003e068750a99e76f54a39e_img.jpg\)](#).

[SAVE CHECKLIST !\[\]\(8cc37e2144b45404c8329d31e3ef4122_img.jpg\)](#)

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

Select Document Type

* Document Name

Browse...

UPLOAD

PREVIOUS TOPIC

GO TO ERROR CHECK

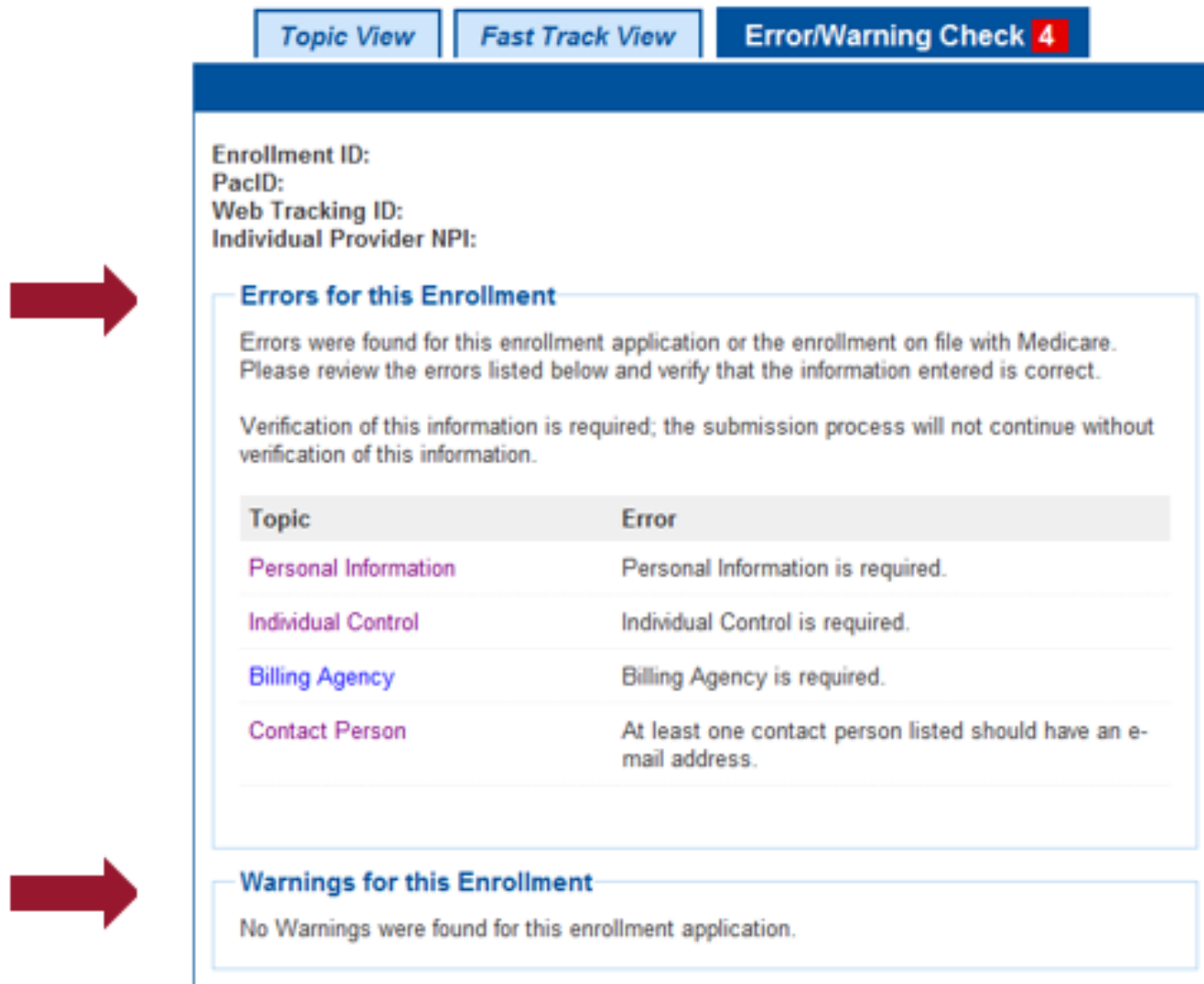
RETURN TO TOPICS

Current Uploaded Documents

Document Type	File Name	Document ID	Date Uploaded	Actions
Voided Check/Account Verification	2018_Test Document - Void Check.pdf	VPECOS000CA1802131513220660E120H227152T1011	02/13/2018	VIEW REMOVE

[PREVIOUS TOPIC](#)[GO TO ERROR CHECK](#)[RETURN TO TOPICS](#)

Error/Warning Check



Topic View Fast Track View **Error/Warning Check 4**

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.

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:
PaclID:
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 10

NEXT PAGE 20

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:
PaclID:
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

Select Signatories

(*) Red asterisk indicates a required field.

Signatory for Organization Enrollment

The selected Signer will be responsible the Electronic Funds Transfer Agreement and Certification Statement for the Organization Enrollment.

*** Authorized Signer**

Please select authorized signer ▼

NEXT PAGE >

<< RETURN TO MY ENROLLMENTS

Manage Signatures

[Home](#) > [My Associates](#) > [My Enrollments](#) > [Reassignment](#) > Submission Process

Manage Signatures

(*) Red asterisk indicates a required field.

Name:

Web Tracking ID:

TIN: XX-XXXXXX

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

* Signature Method for Donald Duck:

☐ Electronic

☐ Upload

Role: AUTHORIZED OFFICIAL

Document: AUTHORIZATION STATEMENT
FOR ORGANIZATIONS (855R)

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)

[PREVIOUS PAGE](#)

[NEXT PAGE](#)

[RETURN TO MY ENROLLMENTS](#)

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 (B55R)

☐ 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 (B55R)

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: [You]
 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](#)

Submission Page

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

Required and/or Supporting Documentation Information

▼ 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 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=De4c3C0DaxvQnxVOzU2u9lv-Opd0bN7dNDi5rWxhAs&m=9dmctExjld-BkZ70Hf99T9uSP2255J6ruGHIVXw&s=zaa2-vEQ7mUVW3DeUhrwG88o5IAh5Z7kwwZ8ecGX0&e=) OR through the PECOS E-Signature website https://urldefense.proofpoint.com/v2/url?u=https-3A__pecos.cms.cmsva1_pecos_eSignLogin.do&d=DwICAg&c=A-GX6P9ovB1qTBp7IQve2Q&r=De4c3C0DaxvQnxVOzU2u9lv-Opd0bN7dNDi5rWxhAs&m=9dmctExjld-BkZ70Hf99T9uSP2255J6ruGHIVXw&s=ZTRw9Hh1ggkOlwvaF3cWg2QNlmb2PWwcq6okXpXXyS8&e=, using your identifying information, e-mail address, and unique PIN **XXXXXXXX**. 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 completes 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=De4c3C0DaxvQnxVOzU2u9lv-Opd0bN7dNDi5rWxhAs&m=9dmctExjld-BkZ70Hf99T9uSP2255J6ruGHIVXw&s=vYrEDOHkzV/Nc5qRt_ShsW5yN8CT7MCS85uZq81I&e= or 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. E-sign via the PECOS e-signature website if you don't have an existing PECOS ID and password

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 03

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

ACCOUNT MANAGEMENT 03

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

REVALIDATION NOTIFICATION CENTER 03

- 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 03](#)[VIEW ALL SIGNATURES 03](#)

E-Signature

Welcome to PECOS E-Signature Application

(*) Red asterisk indicates a required field.

Remote Authentication Page

You have been directed to this site in order to electronically sign certain required documents related to Medicare enrollment application recently submitted on your behalf.

WARNING: If you believe you have been directed to this site by mistake, please close this page immediately. Only authorized users have the right to access this site. By accessing and using this system you expressly consent to system monitoring. Any misuse will be documented as evidence of possible criminal activity and reported to the appropriate law enforcement officials.

Verify Your Identity and Validate Your Application Record

Enter the required identity information:

* First Name

* Last Name

* Date of Birth
MM/DD/YYYY

* SSN
No Format Required

Enter the email address and PIN you received in the PECOS emails:

* Email Address

* PIN

If your PIN is lost or expired, click here to generate a new one.

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

Verify and Manage Signatures

- Print Certification Statement

Existing Enrollments

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

Enrollment Type: 855B

Medicare ID: TEST [View Medicare ID Report](#) 


Status: APPROVED [View Approved Enrollment Record](#) 

Current ADI Accreditation?: No

Existing Reassignments: 1

Pending Reassignments Applications: 0

[View/Manage Reassignments](#)

Type of Up date	Status	Tracking ID	Action
Revalidation	AWAITING PROCESSING View Awaiting Processing Application 	TXXXXXXXX	VIEW  MANAGE SIGNATURES 

Verify and Manage Signatures

■ View Printable Certification Statement

[Home](#) > [My Associates](#) > [My Enrollments](#) > Application Questionnaire

Application Questionnaire

(*) Red asterisk indicates a required field.

Submitted Application

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

☐ View Printable Mailing Instructions

☐ View Printable Supporting Documentation

☐ View Printable Certification Statements

☐ View Printable Submission History Report

NEXT PAGE >

<< RETURN TO MY ENROLLMENTS

View and Print Certification Statement

[Home](#) > [My Associates](#) > [My Enrollments](#) > [Application Questionnaire](#)

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

Name:	Role: AUTHORIZED OFFICIAL
Organization:	Document: AUTHORIZATION STATEMENT FOR ORGANIZATIONS (855R)
SSN: XXX-XX-XXXX	Status: Complete
Signature Method: ELECTRONIC	Date: 09/26/2018
Email: npes.test@yahoo.com	
Medicare Supplier Enrollment Application Privacy Act Statement for Clinics and Group Practices	

Name:	Role: AUTHORIZED OFFICIAL
Organization:	Document: AUTHORIZATION STATEMENT FOR ORGANIZATIONS (855R)
SSN: XXX-XX-XXXX	Status: Pending
Signature Method: ELECTRONIC	
Email: npes.test@yahoo.com	
<div>UPDATE RE-SEND EMAIL</div> Medicare Supplier Enrollment Application Privacy Act Statement for Individual Practitioners	

Home > My Associates > My Enrollments > Signatures

Manage Signatures

Name:	TIN:
Web Tracking ID:	

Note: If a Reassignment of Benefits was submitted with this enrollment application, the status of the Authorization Statement signature(s) can be viewed and updated by accessing the View/Manage Reassignments page.

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
SSN: XXX-XX-XXXX	Document: AUTHORIZED OFFICIAL CERTIFICATION STATEMENT FOR CLINICS AND GROUP PRACTICES
Signature Method: UPLOAD	Status: Complete
File Name: test revalidation add	Date: 10/04/2018
AO.pdf	
Date Uploaded: 10/04/2018	
REMOVE	

Name:	Role: AUTHORIZED OFFICIAL
SSN: XXX-XX-XXXX	Document: AUTHORIZED OFFICIAL CERTIFICATION STATEMENT FOR CLINICS AND GROUP PRACTICES
Signature Method: UPLOAD	Status: Pending
Note: One or more signature documents have not been uploaded. To upload a signature document or change the signature method, please select the Update button for the appropriate document(s).	
<div>UPDATE</div> Medicare Supplier Enrollment Application Privacy Act Statement for Clinics and Group Practices	

RETURN TO MY ENROLLMENTS

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.











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

Medicare Enrollment for Providers and Suppliers

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

You may use your NPPES or PECOS username and password to login.

* User ID

* Password

LOGIN

[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.

[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.

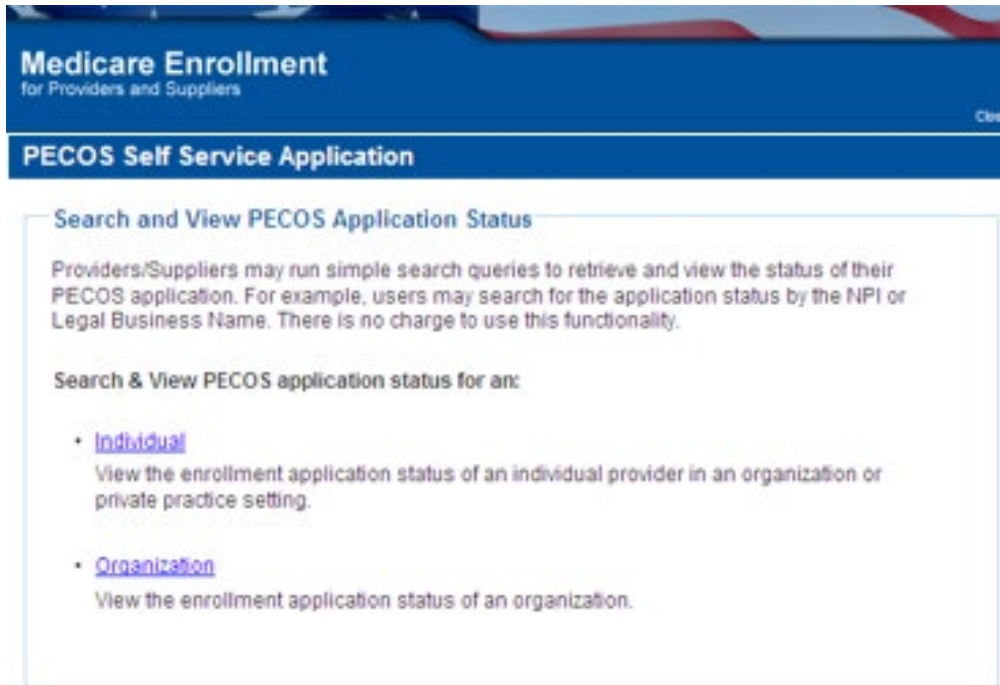
Provider & Supplier Resources

- [CMS.gov/Providers](#) - Section of the CMS.gov website that is designed to provide Medicare enrollment information for providers, physicians, non-physician practitioners, and other suppliers.
- [Enrollment Checklists](#) - Review checklists of information needed to complete an application for various provider and supplier types.
- [CMS.gov/Providers](#) - Section of the CMS.gov website that is designed to provide Medicare enrollment information for providers, physicians, non-physician practitioners, and other suppliers.
- [Revalidation Notice Sent List](#) - Check to see if you have been sent a notice to revalidate your information on file with Medicare.
- [Ordering, Certifying, or Prescribing Practitioners List](#) - View the Ordering, Certifying, or Prescribing Practitioners List to verify eligibility to order or certify items or services to Medicare beneficiaries, or prescribe part D drugs.
- [Ordering, Certifying, or Prescribing Information \[PDF, 1.64MB\]](#) - Learn about the Ordering, Certifying, or Prescribing enrollment process.
- [Medicare Learning Network® \(MLN\)](#) - Helpful articles and tutorials about changes in Medicare enrollment.

Enrollment Tutorials

- **Initial Enrollment:**
Step-by-step demonstration of an initial enrollment application in PECOS.
[Individual Provider](#) or [Organization/Supplier](#)
- **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](#) or [Organization/Supplier](#)
- **Revalidation:**
Step-by-step demonstration on how to submit your revalidation application using PECOS.
[Individual Provider](#) or [Organization/Supplier](#)
- **Deactivated:**
Example of how to deactivate an existing enrollment record.
[Individual Provider](#)
- **Reactivation:**
Step-by-step demonstration of how to re-enroll based on enrollment information that already exists in PECOS.
[Organization/Supplier](#)
- **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](#)

PECOS Self-Service Application



- Check Status
 - Individual
 - Organization

PECOS Application Status

PECOS Self Service Application

PECOS Application Status

Enrollment Information:

Name:
Application Type: 855I
Specialty: CLINICAL SOCIAL WORKER
State: MAINE
L&T ID
Web Tracking ID:
Submittal Reason: A provider or supplier is revalidating their Medicare enrollment by resubmitting and recertifying the accuracy of their enrollment information to maintain Medicare billing privileges.
Date Submitted/Received: 01/23/2014

Status of your PECOS application:

Note: The status of your application is indicated by the step that is highlighted below.

Step 1. Your application was successfully submitted/received on 01/23/2014	Step 2. Your application is being reviewed.	Step 3. Your application is being processed.	Step 4. Your application has been processed.
---	--	---	---

For additional information about the status of your PECOS application, please contact your Fee-For-Service Medicare Contractor:

NATIONAL GOVERNMENT SERVICES, INC
PO BOX 6230
INDIANAPOLIS, IN 46206-6230

[PREVIOUS PAGE](#)

- 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



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](#).

[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
<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> 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/

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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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