

# 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** 02

# 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:	NPI: <b>VIEW ENROLLMENTS</b>

#### Organizations

Records 1 - 1 of 1	
Name:	TIN: <b>VIEW ENROLLMENTS</b>

### 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: <b>VIEW ENROLLMENTS</b>

#### Organizations

Records 1 - 1 of 1	
Name:	TIN: <b>VIEW ENROLLMENTS</b>

# 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:

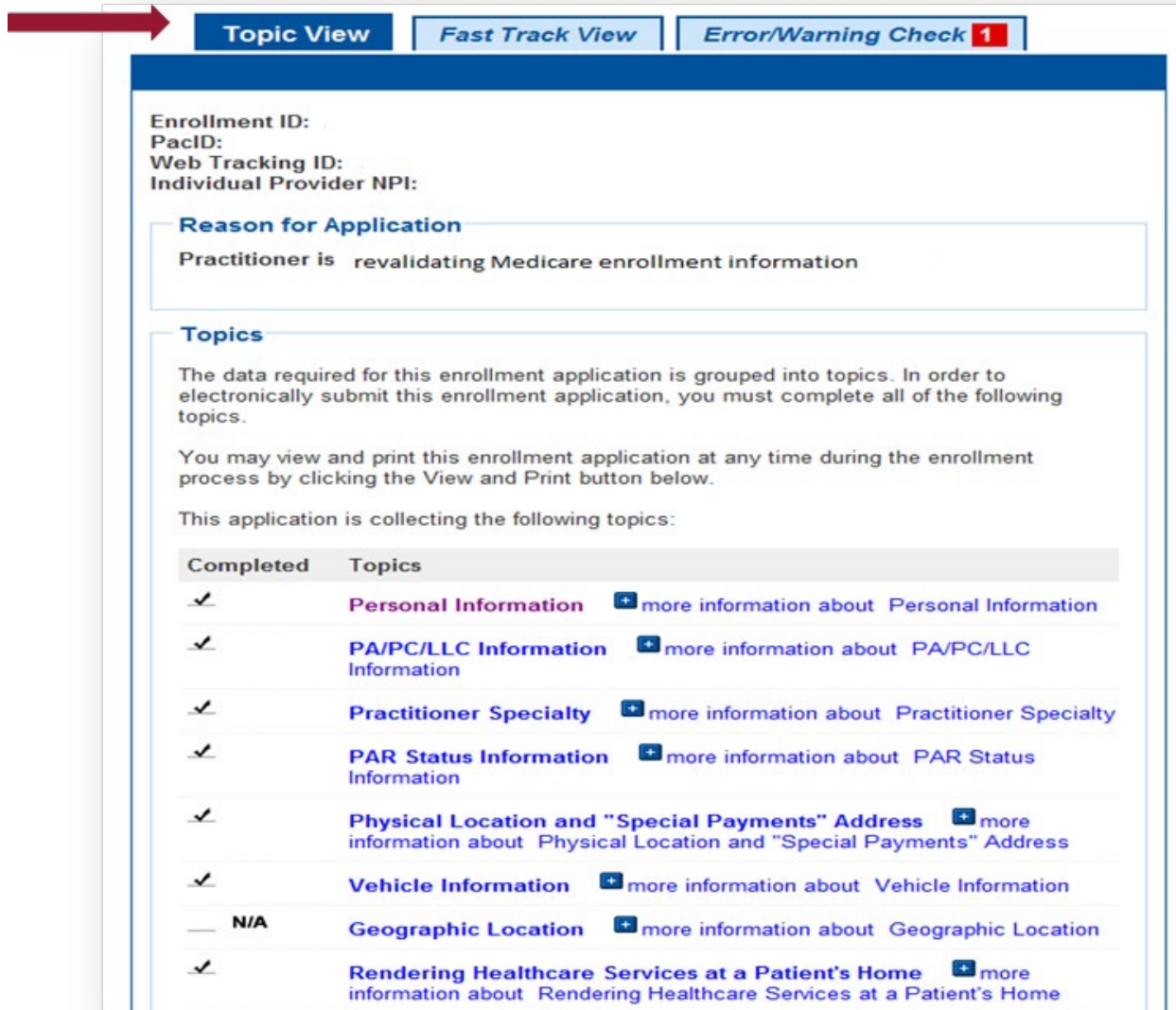
**Reason for Application**  
Enrolled Practitioner is Revalidating their Enrollment Information  
[EDIT REASON](#)

**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:  
PaclD:  
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
✓	<b>Personal Information</b> <a href="#">+ more information about Personal Information</a>
✓	<b>PA/PC/LLC Information</b> <a href="#">+ more information about PA/PC/LLC Information</a>
✓	<b>Practitioner Specialty</b> <a href="#">+ more information about Practitioner Specialty</a>
✓	<b>PAR Status Information</b> <a href="#">+ more information about PAR Status Information</a>
✓	<b>Physical Location and "Special Payments" Address</b> <a href="#">+ more information about Physical Location and "Special Payments" Address</a>
✓	<b>Vehicle Information</b> <a href="#">+ more information about Vehicle Information</a>
N/A	<b>Geographic Location</b> <a href="#">+ more information about Geographic Location</a>
✓	<b>Rendering Healthcare Services at a Patient's Home</b> <a href="#">+ more information about Rendering Healthcare Services at a Patient's Home</a>

# Topic View

✓	<b>License and Certification Information</b> <a href="#">+ more information about License and Certification Information</a>
✓	<b>Final Adverse Actions</b> <a href="#">+ more information about Final Adverse Actions</a>
✓	<b>Individual Control</b> <a href="#">+ more information about Individual Control</a>
✓	<b>Patient Records Storage Location</b> <a href="#">+ more information about Patient Records Storage Location</a>
✓	<b>Billing Agency</b> <a href="#">+ more information about Billing Agency</a>
✓	<b>Contact Person</b> <a href="#">+ more information about Contact Person</a>
✓	<b>Electronic Funds Transfer</b> <a href="#">+ more information about Electronic Funds Transfer</a>
✓	<b>Required and/or Supporting Documentation</b> <a href="#">+ more information about Required and/or Supporting Documentation</a>

**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 2

#### \* 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

# 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 <sup>①</sup>

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:**

—


✓


✓


✓


✓


—


**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



# 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	<a href="#">View and Print </a> <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 \[PDF\] !\[\]\(73002692dd5e7a64e60946be3158e719\_img.jpg\)](#)

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 \[PDF\] !\[\]\(104fbf564e2e5a8fbd84f31656d114c7\_img.jpg\)](#)

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 \[PDF\] !\[\]\(21226b58c700e5231ab98d27101bac58\_img.jpg\)](#)

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 !\[\]\(111c5272ee3f91361f0d2e3665dd6ad0\_img.jpg\)](#). If you experience problems with PDF documents, please [download the latest version of the Reader !\[\]\(dd5454c4d207a4aa4d11478485236c46\_img.jpg\)](#).

[SAVE CHECKLIST !\[\]\(6befd466863f06afb75445d91429f055\_img.jpg\)](#)



# 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	<a href="#">VIEW</a> <a href="#">REMOVE</a>

[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	<a href="#">EDIT</a> <a href="#">View Edit Application</a> 	TXXXXXXXXXX	<a href="#">VIEW</a>  <a href="#">MORE OPTIONS</a> 



# 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=De4c3C0DaxvQnxVQzU2u9lv-Opd0bN7dNDi5rWxhAs&m=9dmctExjllid-BkZ70Hf99T9uSP2255J6ruGHIVXw&s=zaa2-vEQ7mUVW3DeUhrwG88o5IAh5Z7kkwZ8ecGX0&e=>) OR through the PECOS E-Signature website <https://urldefense.proofpoint.com/v2/url?u=https-3A-pecos.cms.cmsxval-pecos-eSignLogin.do&d=DwICAg&c=A-GX6P9ovB1qTBp7IQve2Q&r=De4c3C0DaxvQnxVQzU2u9lv-Opd0bN7dNDi5rWxhAs&m=9dmctExjllid-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=De4c3C0DaxvQnxVQzU2u9lv-Opd0bN7dNDi5rWxhAs&m=9dmctExjllid-BkZ70Hf99T9uSP2255J6ruGHIVXw&s=vYrEDOHkzVIVc5qRt-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

- 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

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 <a href="#">View Awaiting Processing Application</a>	TXXXXXXX	<a href="#">VIEW</a> <a href="#">MANAGE SIGNATURES</a>

# 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	

[UPDATE](#) [RE-SEND EMAIL](#)

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
Date Uploaded: 10/04/2018	

[REMOVE](#)

File Name: [test revalidation add AO.pdf](#)

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).

[UPDATE](#)

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.

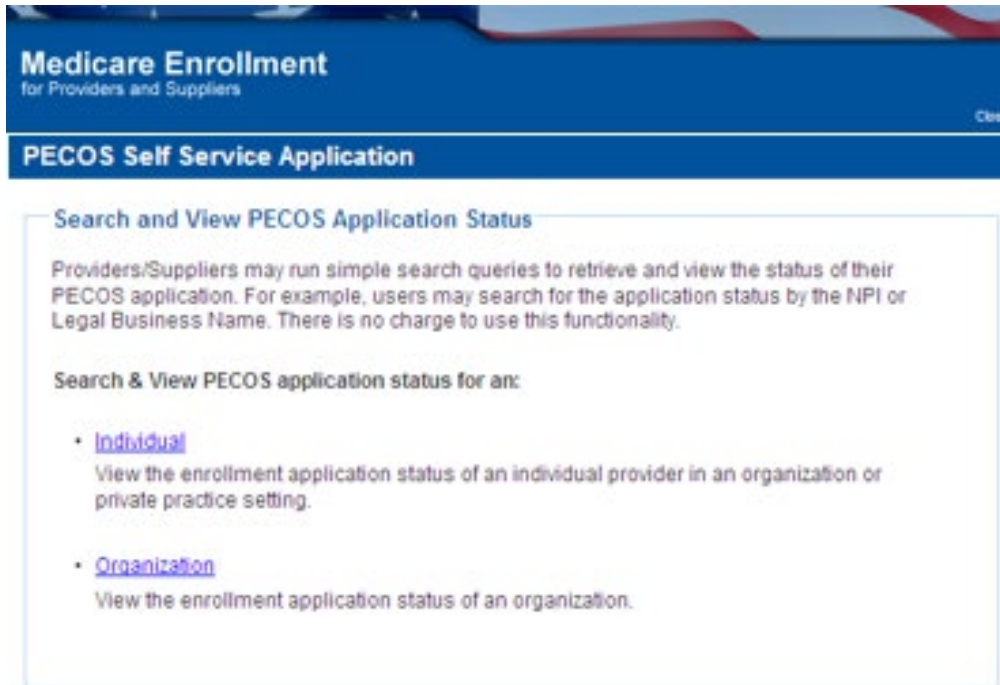
#### Provider & Supplier Resources

- [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"><li>• Changing an NPPEs password</li><li>• Establishing a new user ID and password for NPPEs</li><li>• Questions related to the NPI application</li></ul>	NPI Enumerator	Phone: 800-465-3203 TTY: 800-692-2326 Email: <a href="mailto:customerservice@npienumerator.com">customerservice@npienumerator.com</a>
<ul style="list-style-type: none"><li>• Errors encountered while accessing or entering information in PECOS</li><li>• Forgotten PECOS user IDs and passwords</li></ul>	EUS Help Desk	Phone: 866-484-8049 TTY: 866-523-4759 Email: <a href="mailto:EUSSupport@cgi.com">EUSSupport@cgi.com</a> Live Chat: <a href="https://eus.custhelp.com/">https://eus.custhelp.com/</a>

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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

[Follow us](#)