Submitting Revalidation via CMS-855I Paper Application for Part B Providers

9/28/2021

Today's Presenters

- Laura Brown, CPC
  - Provider Outreach and Education
- Susan Stafford
  - Provider Outreach and Education

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- Attendees/providers are **never** permitted to record (tape record or **any** other method) our educational events
  - This applies to our webinars, teleconferences, live events and any other type of National Government Services educational events

Objectives

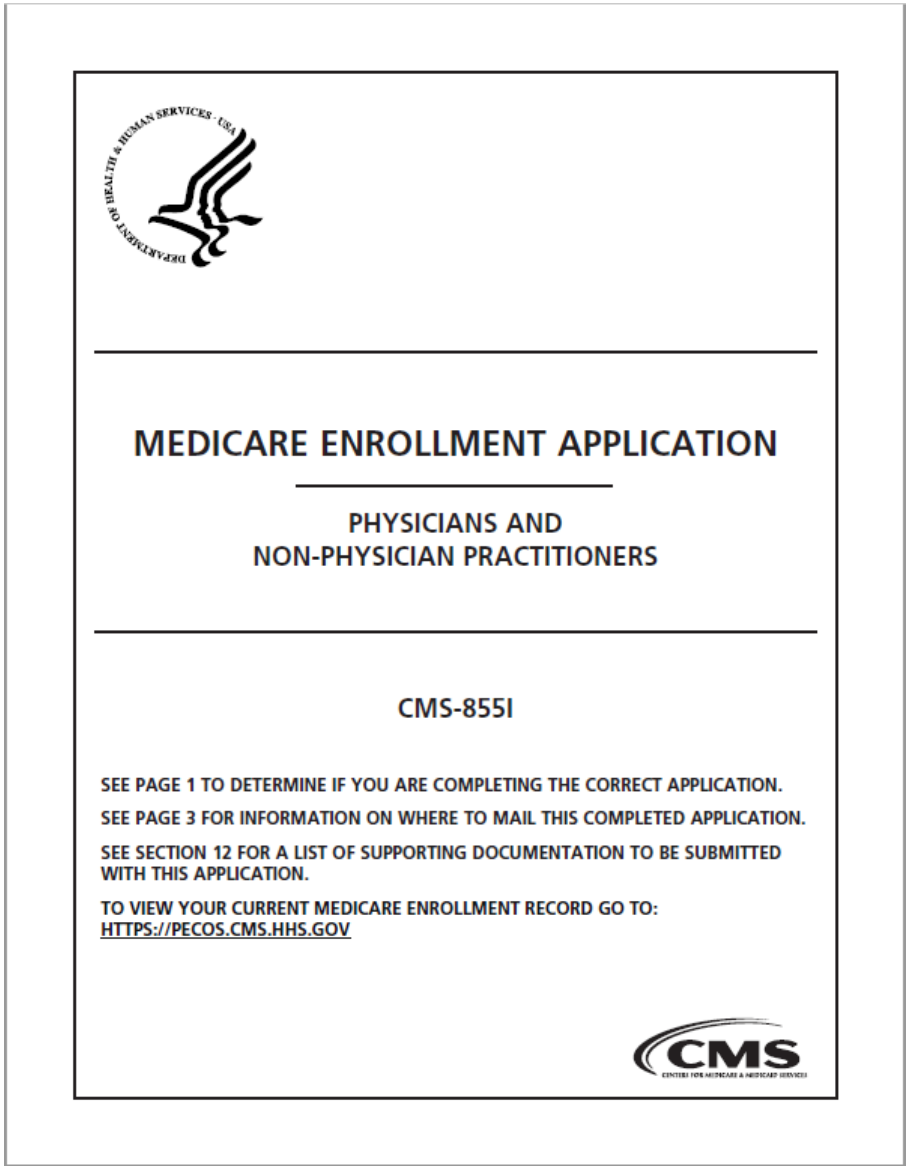
- Complete the appropriate sections of the CMS-855I paper application for revalidation
- Submit the application along with the necessary supporting documents

Agenda

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

CMS-855I Paper Application

CMS-855I



MEDICARE ENROLLMENT APPLICATION

PHYSICIANS AND
NON-PHYSICIAN PRACTITIONERS

CMS-855I

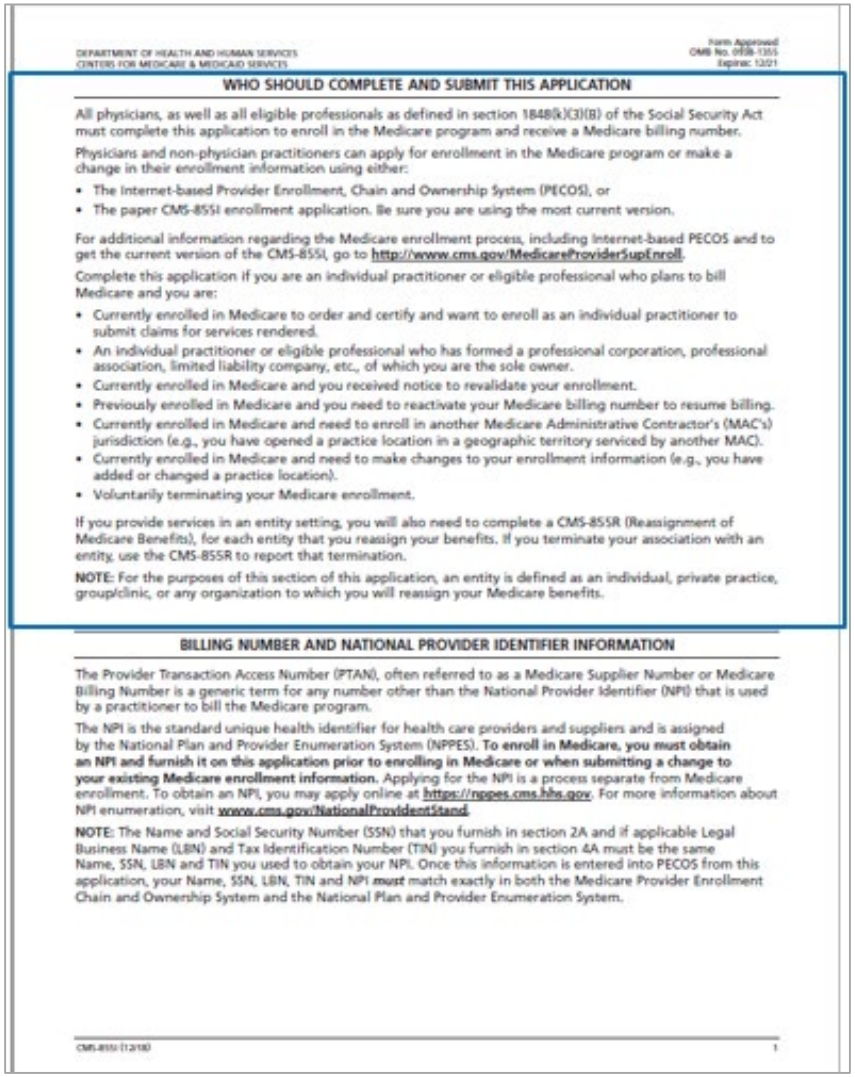
SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION.

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

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

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

Who Should Complete This Application



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

Form Approved
OMB No. 0938-1355
Expires: 12/31

WHO SHOULD COMPLETE AND SUBMIT THIS APPLICATION

All physicians, as well as all eligible professionals as defined in section 1848(k)(3)(B) of the Social Security Act must complete this application to enroll in the Medicare program and receive a Medicare billing number.

Physicians and non-physician practitioners can apply for enrollment in the Medicare program or make a change in their enrollment information using either:

- The Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or
- The paper CMS-855I enrollment application. Be sure you are using the most current version.

For additional information regarding the Medicare enrollment process, including Internet-based PECOS and to get the current version of the CMS-855I, go to http://www.cms.gov/MedicareProviderSupEnroll.

Complete this application if you are an individual practitioner or eligible professional who plans to bill Medicare and you are:

- Currently enrolled in Medicare to order and certify and want to enroll as an individual practitioner to submit claims for services rendered.
- An individual practitioner or eligible professional who has formed a professional corporation, professional association, limited liability company, etc., of which you are the sole owner.
- Currently enrolled in Medicare and you received notice to revalidate your enrollment.
- Previously enrolled in Medicare and you need to reactivate your Medicare billing number to resume billing.
- Currently enrolled in Medicare and need to enroll in another Medicare Administrative Contractor's (MAC's) jurisdiction (e.g., you have opened a practice location in a geographic territory serviced by another MAC).
- Currently enrolled in Medicare and need to make changes to your enrollment information (e.g., you have added or changed a practice location).
- Voluntarily terminating your Medicare enrollment.

If you provide services in an entity setting, you will also need to complete a CMS-855R (Reassignment of Medicare Benefits), for each entity that you reassign your benefits. If you terminate your association with an entity, use the CMS-855R to report that termination.

NOTE: For the purposes of this section of this application, an entity is defined as an individual, private practice, group/clinic, or any organization to which you will reassign your Medicare benefits.

BILLING NUMBER AND NATIONAL PROVIDER IDENTIFIER INFORMATION

The Provider Transaction Access Number (PTAN), often referred to as a Medicare Supplier Number or Medicare Billing Number is a generic term for any number other than the National Provider Identifier (NPI) that is used by a practitioner to bill the Medicare program.

The NPI is the standard unique health identifier for health care providers and suppliers and is assigned by the National Plan and Provider Enumeration System (NPPES). **To enroll in Medicare, you must obtain an NPI and furnish it on this application prior to enrolling in Medicare or when submitting a change to your existing Medicare enrollment information.** Applying for the NPI is a process separate from Medicare enrollment. To obtain an NPI, you may apply online at https://nppes.cms.hhs.gov. For more information about NPI enumeration, visit www.cms.gov/NationalProvIdentStand.

NOTE: The Name and Social Security Number (SSN) that you furnish in section 2A and if applicable Legal Business Name (LBN) and Tax Identification Number (TIN) you furnish in section 4A must be the same Name, SSN, LBN and TIN you used to obtain your NPI. Once this information is entered into PECOS from this application, your Name, SSN, LBN, TIN and NPI *must* match exactly in both the Medicare Provider Enrollment Chain and Ownership System and the National Plan and Provider Enumeration System.

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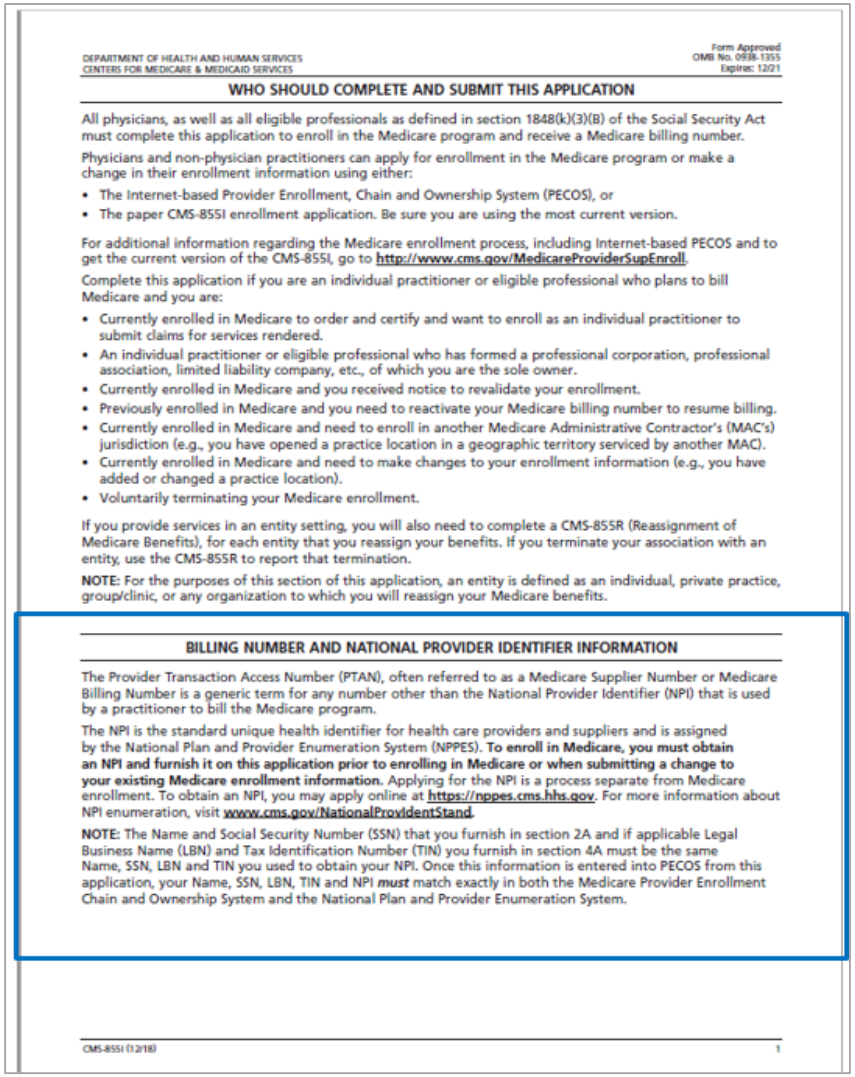
- All individuals (physicians and NPPs) in private practice as a sole owner or sole proprietorship
- All individuals (physician and NPPs) who reassign benefits or have employee arrangements with a entity

Billing Number and NPI Information



DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Complete this application if you are an individual practitioner or eligible professional who plans to bill Medicare and you are:

- Currently enrolled in Medicare to order and certify and want to enroll as an individual practitioner to submit claims for services rendered.
- An individual practitioner or eligible professional who has formed a professional corporation, professional association, limited liability company, etc., of which you are the sole owner.
- Currently enrolled in Medicare and you received notice to revalidate your enrollment.
- Previously enrolled in Medicare and you need to reactivate your Medicare billing number to resume billing.
- Currently enrolled in Medicare and need to enroll in another Medicare Administrative Contractor's (MAC's) jurisdiction (e.g., you have opened a practice location in a geographic territory serviced by another MAC).
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NOTE: The Name and Social Security Number (SSN) that you furnish in section 2A and if applicable Legal Business Name (LBN) and Tax Identification Number (TIN) you furnish in section 4A must be the same Name, SSN, LBN and TIN you used to obtain your NPI. Once this information is entered into PECOS from this application, your Name, SSN, LBN, TIN and NPI ***must*** match exactly in both the Medicare Provider Enrollment Chain and Ownership System and the National Plan and Provider Enumeration System.

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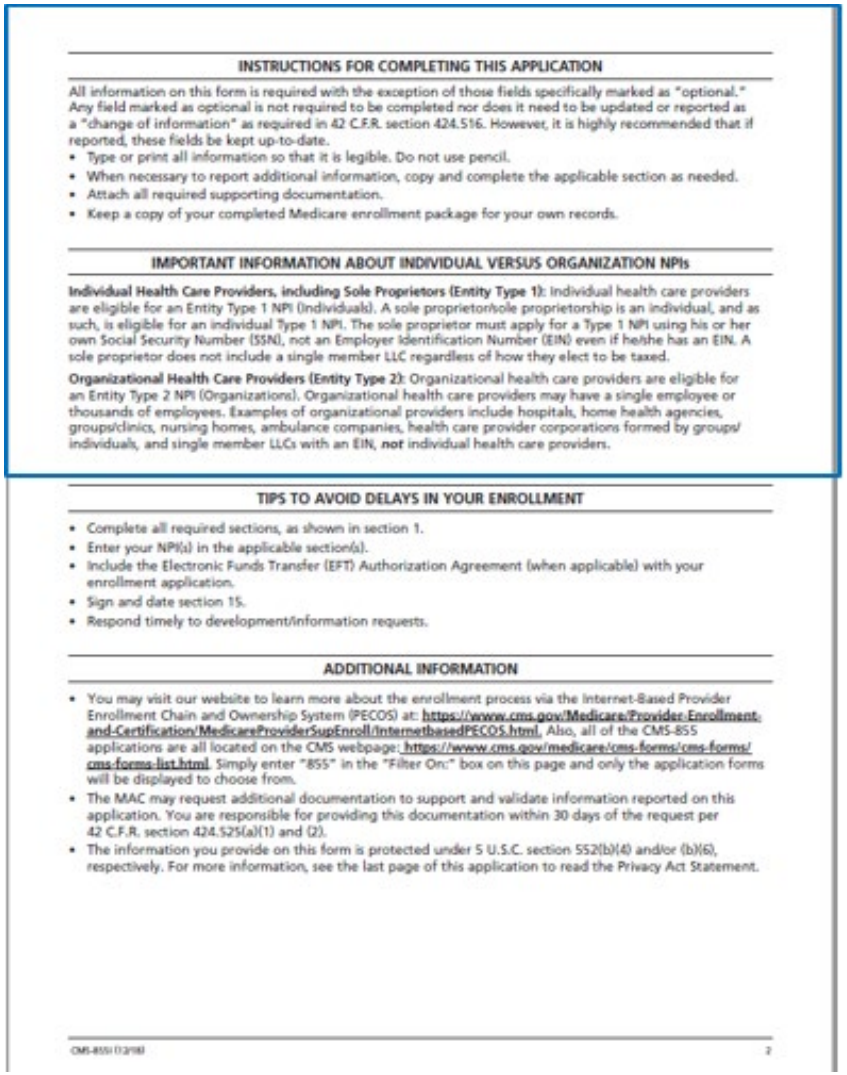
- Provider Transaction Access Number (PTAN)
- National Provider Identifier (NPI)
  - Verify NPI information matches exactly with the information used in section 2A (required) and 4A (if applicable)

Additional Information



INSTRUCTIONS FOR COMPLETING THIS APPLICATION

All information on this form is required with the exception of those fields specifically marked as "optional." Any field marked as optional is not required to be completed nor does it need to be updated or reported as a "change of information" as required in 42 C.F.R. section 424.516. However, it is highly recommended that if reported, these fields be kept up-to-date.

- Type or print all information so that it is legible. Do not use pencil.
- When necessary to report additional information, copy and complete the applicable section as needed.
- Attach all required supporting documentation.
- Keep a copy of your completed Medicare enrollment package for your own records.

IMPORTANT INFORMATION ABOUT INDIVIDUAL VERSUS ORGANIZATION NPIs

Individual Health Care Providers, including Sole Proprietors (Entity Type 1): Individual health care providers are eligible for an Entity Type 1 NPI (Individuals). A sole proprietor/sole proprietorship is an individual, and as such, is eligible for an individual Type 1 NPI. The sole proprietor must apply for a Type 1 NPI using his or her own Social Security Number (SSN), not an Employer Identification Number (EIN) even if he/she has an EIN. A sole proprietor does not include a single member LLC regardless of how they elect to be taxed.

Organizational Health Care Providers (Entity Type 2): Organizational health care providers are eligible for an Entity Type 2 NPI (Organizations). Organizational health care providers may have a single employee or thousands of employees. Examples of organizational providers include hospitals, home health agencies, groups/clinics, nursing homes, ambulance companies, health care provider corporations formed by groups/individuals, and single member LLCs with an EIN, **not** individual health care providers.

TIPS TO AVOID DELAYS IN YOUR ENROLLMENT

- Complete all required sections, as shown in section 1.
- Enter your NPI(s) in the applicable section(s).
- Include the Electronic Funds Transfer (EFT) Authorization Agreement (when applicable) with your enrollment application.
- Sign and date section 15.
- Respond timely to development/information requests.

ADDITIONAL INFORMATION

- You may visit our website to learn more about the enrollment process via the Internet-Based Provider Enrollment Chain and Ownership System (PECOS) at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/InternetbasedPECOS.html. Also, all of the CMS-855 applications are all located on the CMS webpage: https://www.cms.gov/medicare/cms-forms/cms-forms/cms-forms-list.html. Simply enter "855" in the "Filter On:" box on this page and only the application forms will be displayed to choose from.
- The MAC may request additional documentation to support and validate information reported on this application. You are responsible for providing this documentation within 30 days of the request per 42 C.F.R. section 424.525(a)(1) and (2).
- The information you provide on this form is protected under 5 U.S.C. section 552(b)(4) and/or (b)(6), respectively. For more information, see the last page of this application to read the Privacy Act Statement.

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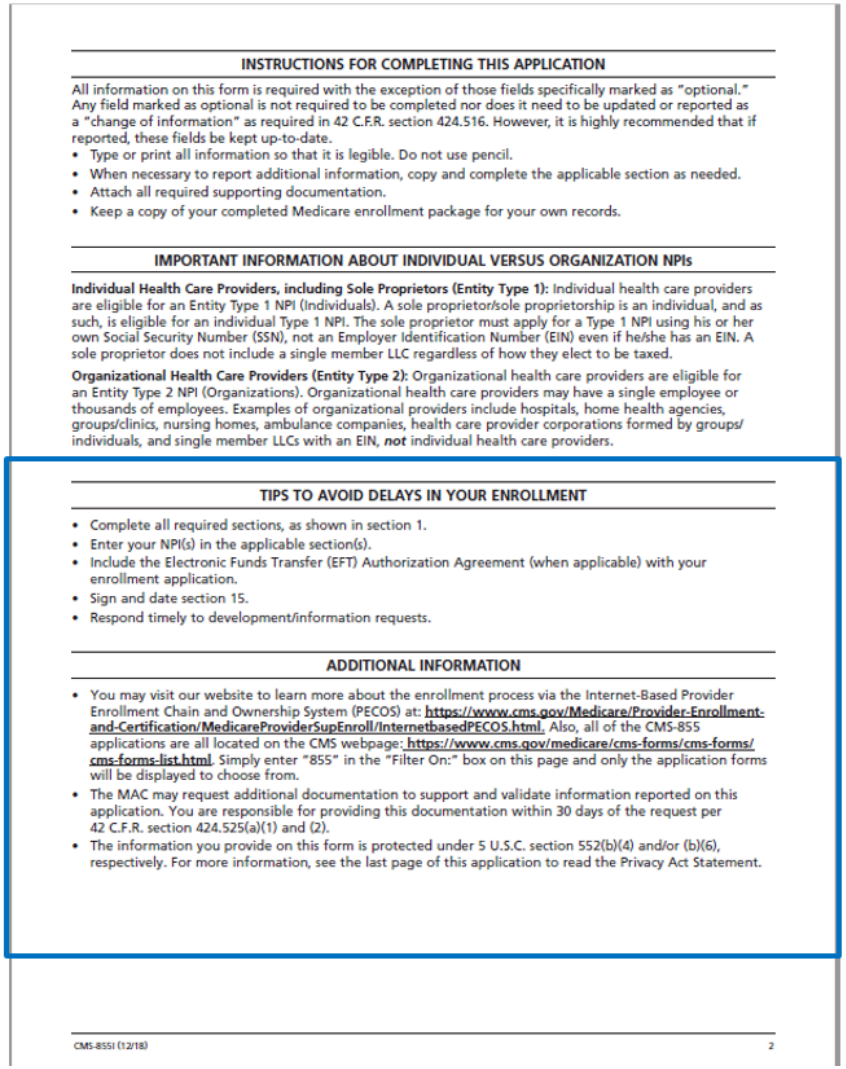
- Instructions for completing application
  - All sections are required, except for the fields marked "optional"
  - Type information so that it is legible, do not use pencil
  - Attach all required documents
  - Keep a copy for your own records
- Individual versus Organization
  - Type 1 NPI – Individual
  - Type 2 NPI – Organization

Additional Information



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- Include the Electronic Funds Transfer (EFT) Authorization Agreement (when applicable) with your enrollment application.
- Sign and date section 15.
- Respond timely to development/information requests.

ADDITIONAL INFORMATION

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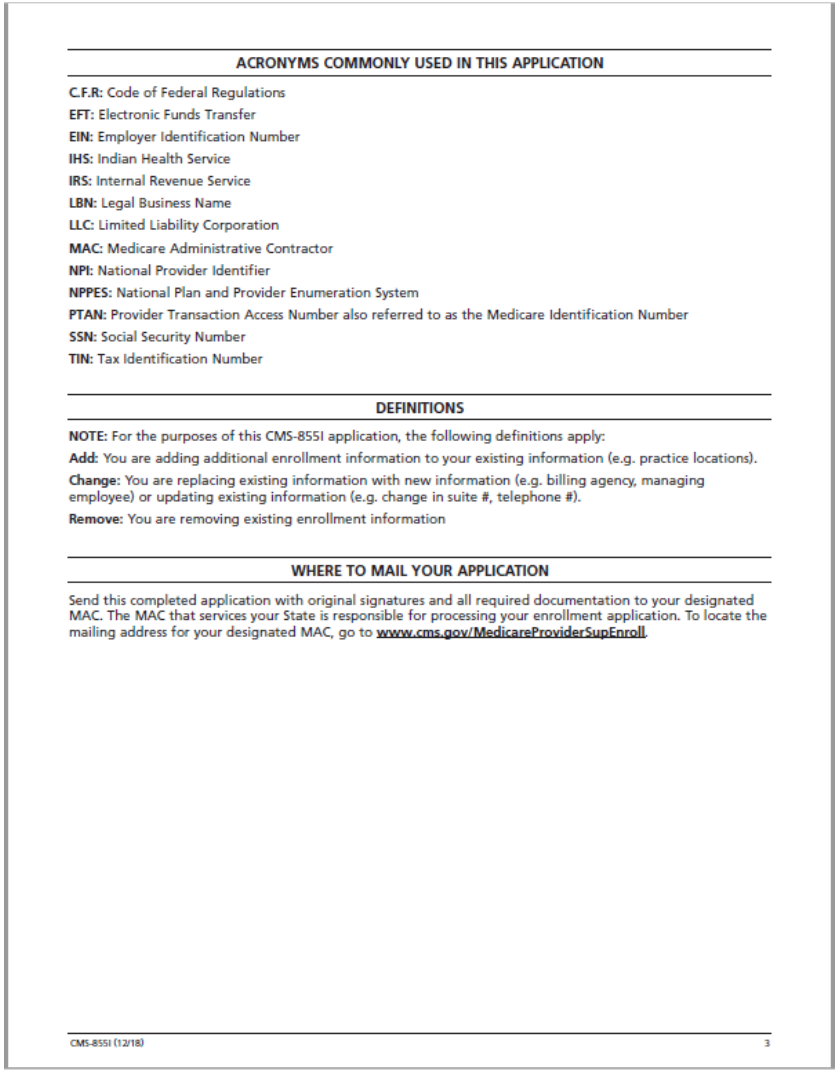
- Tips to avoid delay
- Links to PECOS and CMS 855 paper forms

Additional Information



ACRONYMS COMMONLY USED IN THIS APPLICATION

C.F.R: Code of Federal Regulations
EFT: Electronic Funds Transfer
EIN: Employer Identification Number
IHS: Indian Health Service
IRS: Internal Revenue Service
LBN: Legal Business Name
LLC: Limited Liability Corporation
MAC: Medicare Administrative Contractor
NPI: National Provider Identifier
NPPES: National Plan and Provider Enumeration System
PTAN: Provider Transaction Access Number also referred to as the Medicare Identification Number
SSN: Social Security Number
TIN: Tax Identification Number

DEFINITIONS

NOTE: For the purposes of this CMS-855I application, the following definitions apply:

Add: You are adding additional enrollment information to your existing information (e.g. practice locations).

Change: You are replacing existing information with new information (e.g. billing agency, managing employee) or updating existing information (e.g. change in suite #, telephone #).

Remove: You are removing existing enrollment information

WHERE TO MAIL YOUR APPLICATION

Send this completed application with original signatures and all required documentation to your designated MAC. The MAC that services your State is responsible for processing your enrollment application. To locate the mailing address for your designated MAC, go to www.cms.gov/MedicareProviderSupEnroll.

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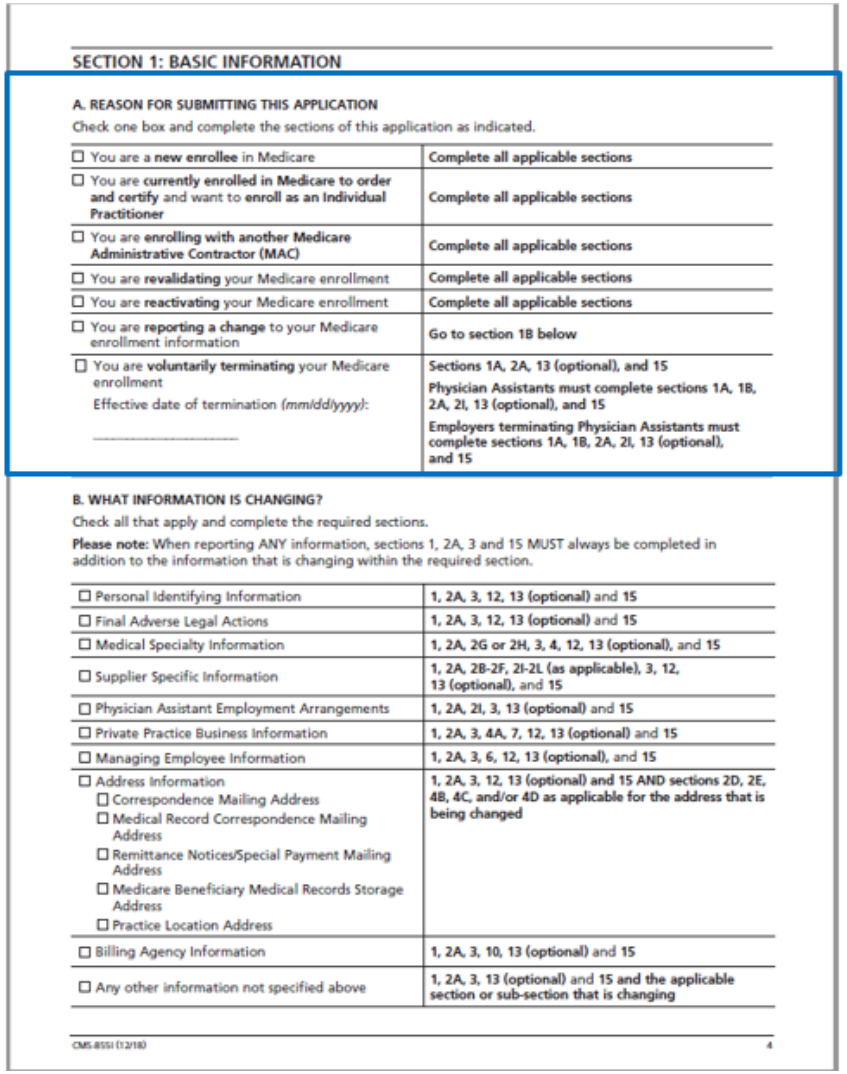
- Acronyms Commonly Used in this Application
- Definitions
- Where to Mail Your Application

Section 1: Basic Information



SECTION 1: BASIC INFORMATION

A. REASON FOR SUBMITTING THIS APPLICATION

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

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

B. WHAT INFORMATION IS CHANGING?

Check all that apply and complete the required sections.

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

☐ Personal Identifying Information	**1, 2A, 3, 12, 13 (optional)** and **15**
☐ Final Adverse Legal Actions	**1, 2A, 3, 12, 13 (optional)** and **15**
☐ Medical Specialty Information	**1, 2A, 2G or 2H, 3, 4, 12, 13 (optional)**, and **15**
☐ Supplier Specific Information	**1, 2A, 2B-2F, 2I-2L (as applicable), 3, 12, 13 (optional)**, and **15**
☐ Physician Assistant Employment Arrangements	**1, 2A, 2I, 3, 13 (optional)** and **15**
☐ Private Practice Business Information	**1, 2A, 3, 4A, 7, 12, 13 (optional)** and **15**
☐ Managing Employee Information	**1, 2A, 3, 6, 12, 13 (optional)**, and **15**
☐ Address Information ☐ Correspondence Mailing Address ☐ Medical Record Correspondence Mailing Address ☐ Remittance Notices/Special Payment Mailing Address ☐ Medicare Beneficiary Medical Records Storage Address ☐ Practice Location Address	**1, 2A, 3, 12, 13 (optional) and 15 AND sections 2D, 2E, 4B, 4C, and/or 4D as applicable for the address that is being changed**
☐ Billing Agency Information	**1, 2A, 3, 10, 13 (optional)** and **15**
☐ Any other information not specified above	**1, 2A, 3, 13 (optional)** and **15 and the applicable section or sub-section that is changing**

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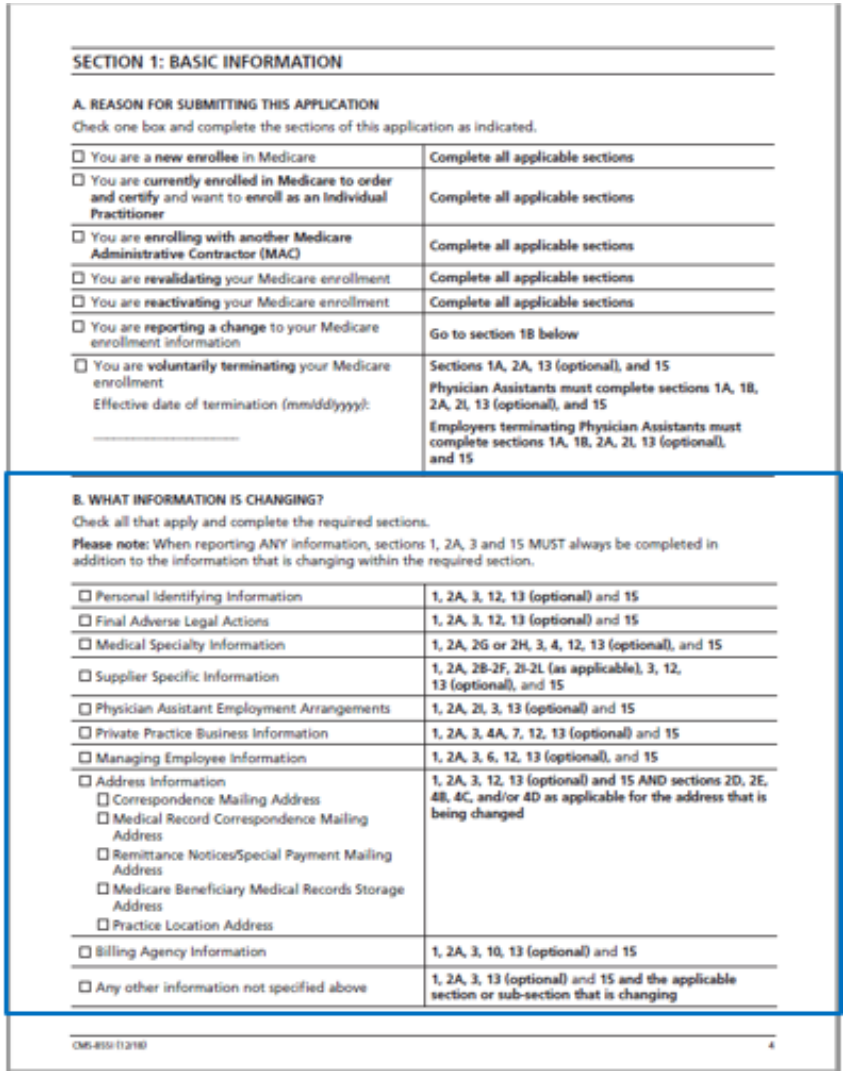
- A: Reason for Submitting this Application
  - Select “You are **revalidating** your Medicare Enrollment”

Section 1: Basic Information



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☐ You are **currently enrolled in Medicare to order and certify** and want to **enroll as an Individual Practitioner**	**Complete all applicable sections**
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☐ Any other information not specified above	**1, 2A, 3, 13 (optional)** and **15 and the applicable section or sub-section that is changing**

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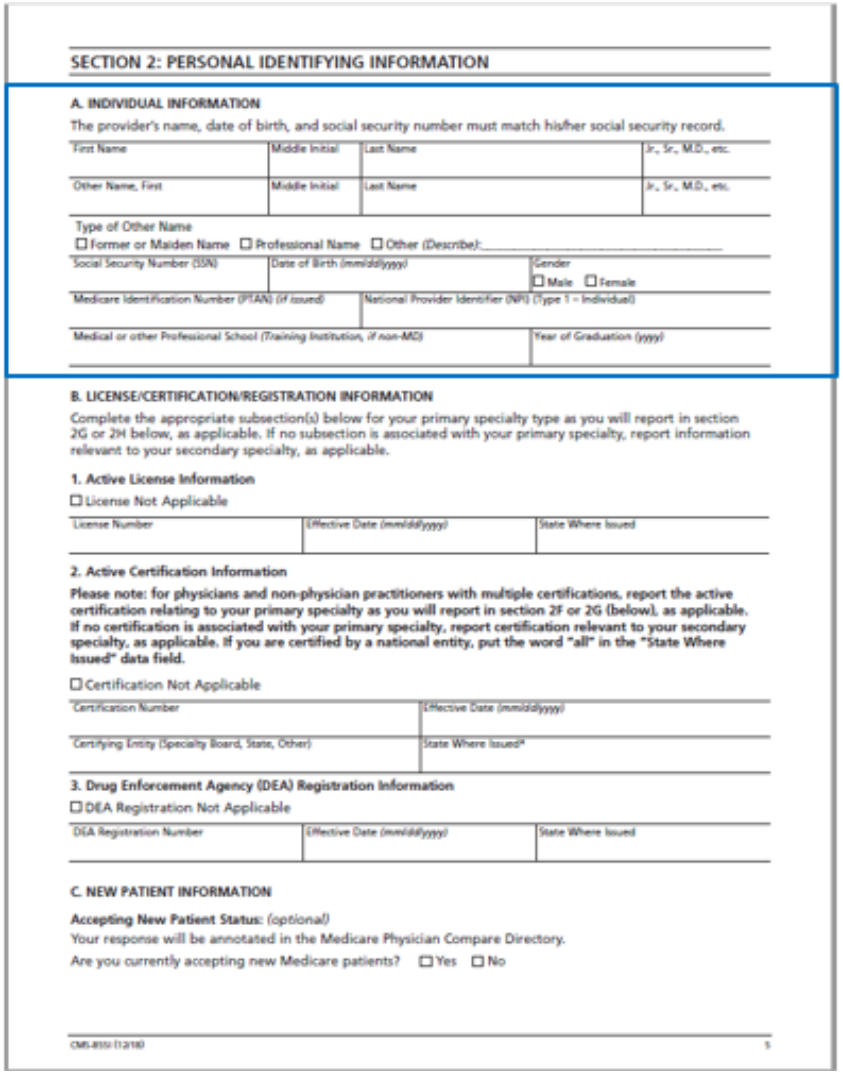
- B: What information is changing?
  - Optional during revalidation
  - Check all that apply

Section 2: Personal Identifying Information



SECTION 2: PERSONAL IDENTIFYING INFORMATION

A. INDIVIDUAL INFORMATION

The provider's name, date of birth, and social security number must match his/her social security record.

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

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

Social Security Number (SSN)	Date of Birth (mm/dd/yyyy)	Gender ☐ Male ☐ Female
Medicare Identification Number (PTAN) (if issued)	National Provider Identifier (NPI) (Type 1 – Individual)	
Medical or other Professional School (Training Institution, if non-MD)		Year of Graduation (yyyy)

B. LICENSE/CERTIFICATION/REGISTRATION INFORMATION

Complete the appropriate subsection(s) below for your primary specialty type as you will report in section 2G or 2H below, as applicable. If no subsection is associated with your primary specialty, report information relevant to your secondary specialty, as applicable.

1. Active License Information

☐ License Not Applicable

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

2. Active Certification Information

Please note: for physicians and non-physician practitioners with multiple certifications, report the active certification relating to your primary specialty as you will report in section 2F or 2G (below), as applicable. If no certification is associated with your primary specialty, report certification relevant to your secondary specialty, as applicable. If you are certified by a national entity, put the word "all" in the "State Where Issued" data field.

☐ Certification Not Applicable

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

3. Drug Enforcement Agency (DEA) Registration Information

☐ DEA Registration Not Applicable

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

C. NEW PATIENT INFORMATION

Accepting New Patient Status: *(optional)*
Your response will be annotated in the Medicare Physician Compare Directory.
Are you currently accepting new Medicare patients? ☐ Yes ☐ No

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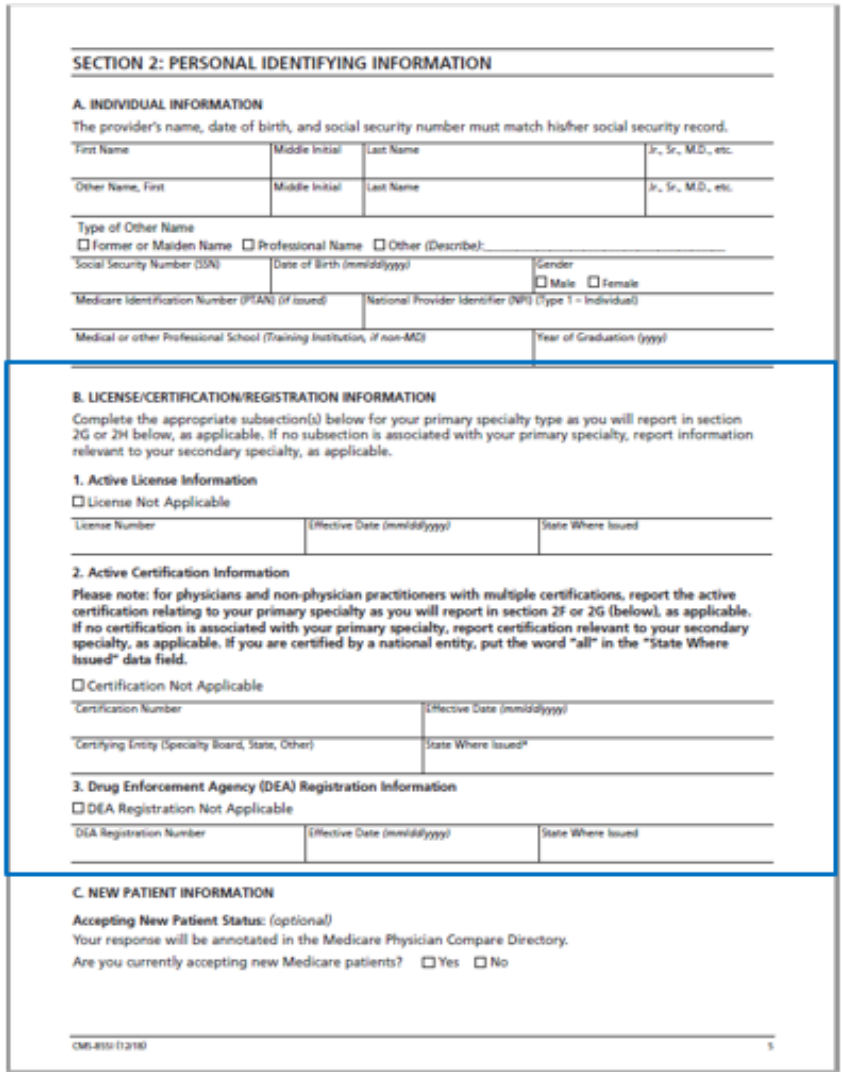
- A: Individual Information
  - Indicate legal name as it appears with the Social Security Administration Office and must be the same name used to apply for Type 1 NPI
  - Indicate other name, date of birth and Social Security Number

Section 2: Personal Identifying Information



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

Type of Other Name
☐ Former or Maiden Name ☐ Professional Name ☐ Other (Describe):

Social Security Number (SSN)	Date of Birth (mm/dd/yyyy)	Gender ☐ Male ☐ Female
Medicare Identification Number (PTAN) (if issued)	National Provider Identifier (NPI) (Type 1 – Individual)	
Medical or other Professional School (Training Institution, if non-MD)		Year of Graduation (yyyy)

B. LICENSE/CERTIFICATION/REGISTRATION INFORMATION

Complete the appropriate subsection(s) below for your primary specialty type as you will report in section 2G or 2H below, as applicable. If no subsection is associated with your primary specialty, report information relevant to your secondary specialty, as applicable.

1. Active License Information

☐ License Not Applicable

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

2. Active Certification Information

Please note: for physicians and non-physician practitioners with multiple certifications, report the active certification relating to your primary specialty as you will report in section 2F or 2G (below), as applicable. If no certification is associated with your primary specialty, report certification relevant to your secondary specialty, as applicable. If you are certified by a national entity, put the word "all" in the "State Where Issued" data field.

☐ Certification Not Applicable

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

3. Drug Enforcement Agency (DEA) Registration Information

☐ DEA Registration Not Applicable

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

C. NEW PATIENT INFORMATION

Accepting New Patient Status: *(optional)*
Your response will be annotated in the Medicare Physician Compare Directory.
Are you currently accepting new Medicare patients? ☐ Yes ☐ No

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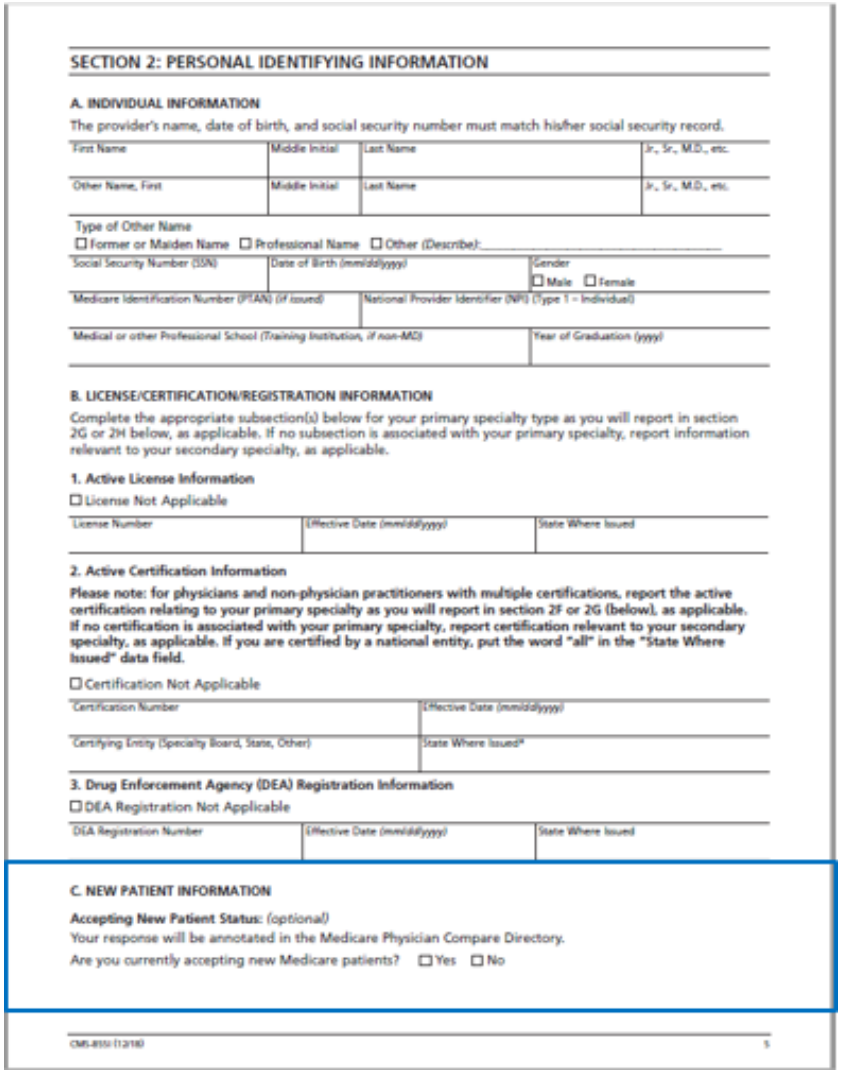
- B: License/Certification /Registration Information
  - Check box if section does not apply, otherwise furnish information
  - National Certifications, indicate “all” in the box “State Where Issued”

Section 2: Personal Identifying Information



SECTION 2: PERSONAL IDENTIFYING INFORMATION

A. INDIVIDUAL INFORMATION

The provider's name, date of birth, and social security number must match his/her social security record.

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

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

Social Security Number (SSN)	Date of Birth (mm/dd/yyyy)	Gender ☐ Male ☐ Female
Medicare Identification Number (PTAN) (if issued)	National Provider Identifier (NPI) (Type 1 – Individual)	
Medical or other Professional School (Training Institution, if non-MD)	Year of Graduation (yyyy)	

B. LICENSE/CERTIFICATION/REGISTRATION INFORMATION

Complete the appropriate subsection(s) below for your primary specialty type as you will report in section 2G or 2H below, as applicable. If no subsection is associated with your primary specialty, report information relevant to your secondary specialty, as applicable.

1. Active License Information

☐ License Not Applicable

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

2. Active Certification Information

Please note: for physicians and non-physician practitioners with multiple certifications, report the active certification relating to your primary specialty as you will report in section 2F or 2G (below), as applicable. If no certification is associated with your primary specialty, report certification relevant to your secondary specialty, as applicable. If you are certified by a national entity, put the word "all" in the "State Where Issued" data field.

☐ Certification Not Applicable

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

3. Drug Enforcement Agency (DEA) Registration Information

☐ DEA Registration Not Applicable

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

C. NEW PATIENT INFORMATION

Accepting New Patient Status: *(optional)*
Your response will be annotated in the Medicare Physician Compare Directory.
Are you currently accepting new Medicare patients? ☐ Yes ☐ No

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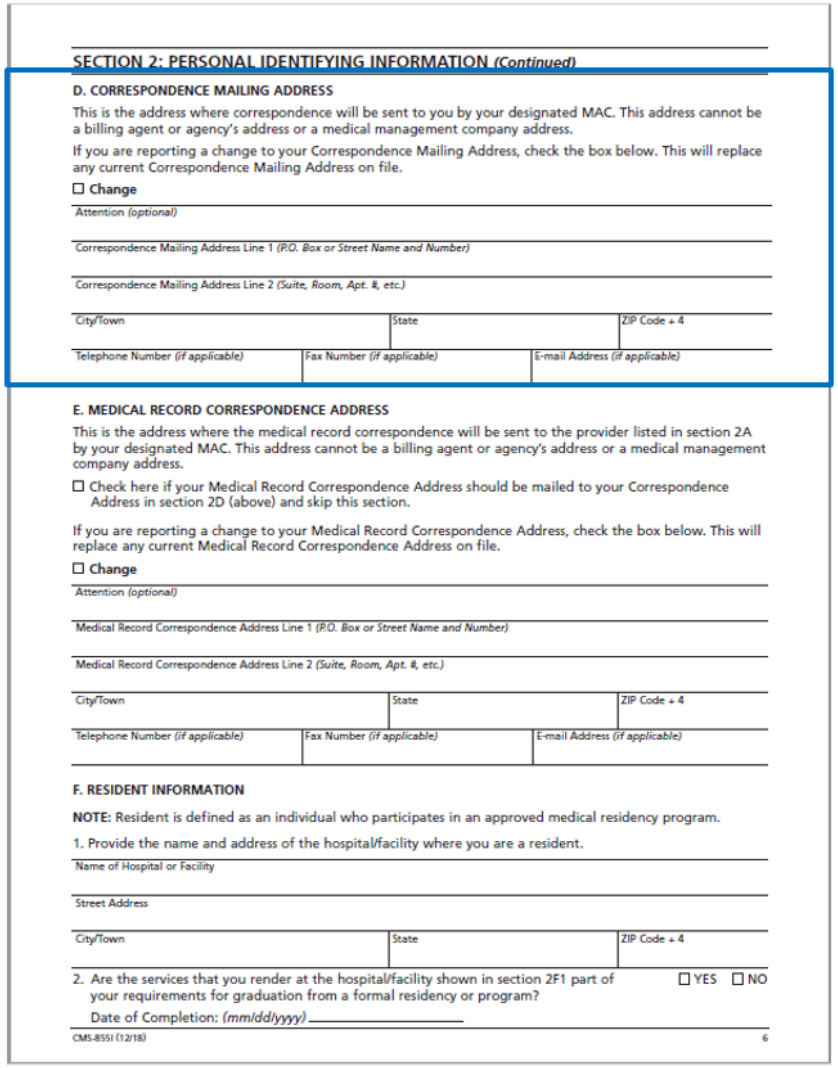
- C: New Patient Information
  - Mark "yes" or "no" (optional)

Section 2: Personal Identifying Information



SECTION 2: PERSONAL IDENTIFYING INFORMATION *(Continued)*

D. CORRESPONDENCE MAILING ADDRESS

This is the address where correspondence will be sent to you by your designated MAC. This address cannot be a billing agent or agency's address or a medical management company address.

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

☐ **Change**

Attention *(optional)*

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

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

City/Town | State | ZIP Code + 4

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

E. MEDICAL RECORD CORRESPONDENCE ADDRESS

This is the address where the medical record correspondence will be sent to the provider listed in section 2A by your designated MAC. This address cannot be a billing agent or agency's address or a medical management company address.

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

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

☐ **Change**

Attention *(optional)*

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

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

City/Town | State | ZIP Code + 4

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

F. RESIDENT INFORMATION

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

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

Name of Hospital or Facility

Street Address

City/Town | State | ZIP Code + 4

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

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

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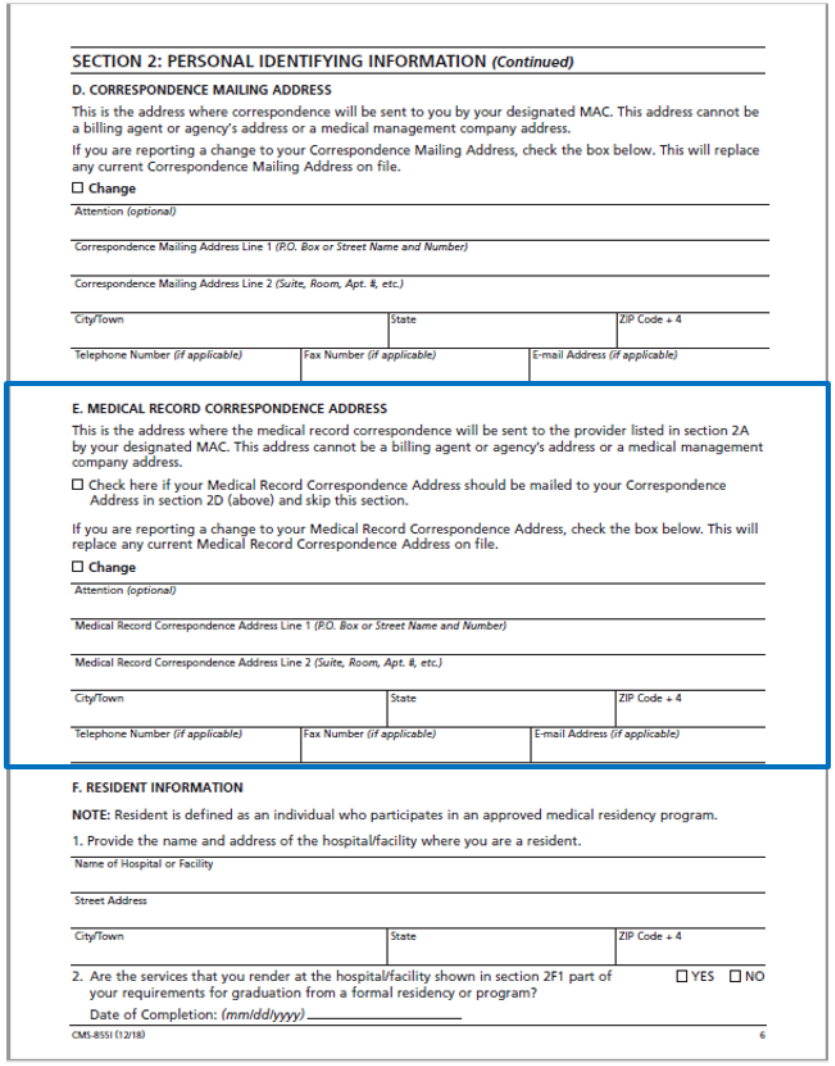
- D: Correspondence Mailing Address
  - Provide correspondence address to **directly contact** applicant
  - Cannot be a billing agency or a medical management company address
  - If reporting a change, select the “change” box

Section 2: Personal Identifying Information



SECTION 2: PERSONAL IDENTIFYING INFORMATION *(Continued)*

D. CORRESPONDENCE MAILING ADDRESS

This is the address where correspondence will be sent to you by your designated MAC. This address cannot be a billing agent or agency's address or a medical management company address.

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

☐ Change

Attention *(optional)*

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

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

City/Town | State | ZIP Code + 4

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

E. MEDICAL RECORD CORRESPONDENCE ADDRESS

This is the address where the medical record correspondence will be sent to the provider listed in section 2A by your designated MAC. This address cannot be a billing agent or agency's address or a medical management company address.

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

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

☐ Change

Attention *(optional)*

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

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

City/Town | State | ZIP Code + 4

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

F. RESIDENT INFORMATION

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

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

Name of Hospital or Facility

Street Address

City/Town | State | ZIP Code + 4

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

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

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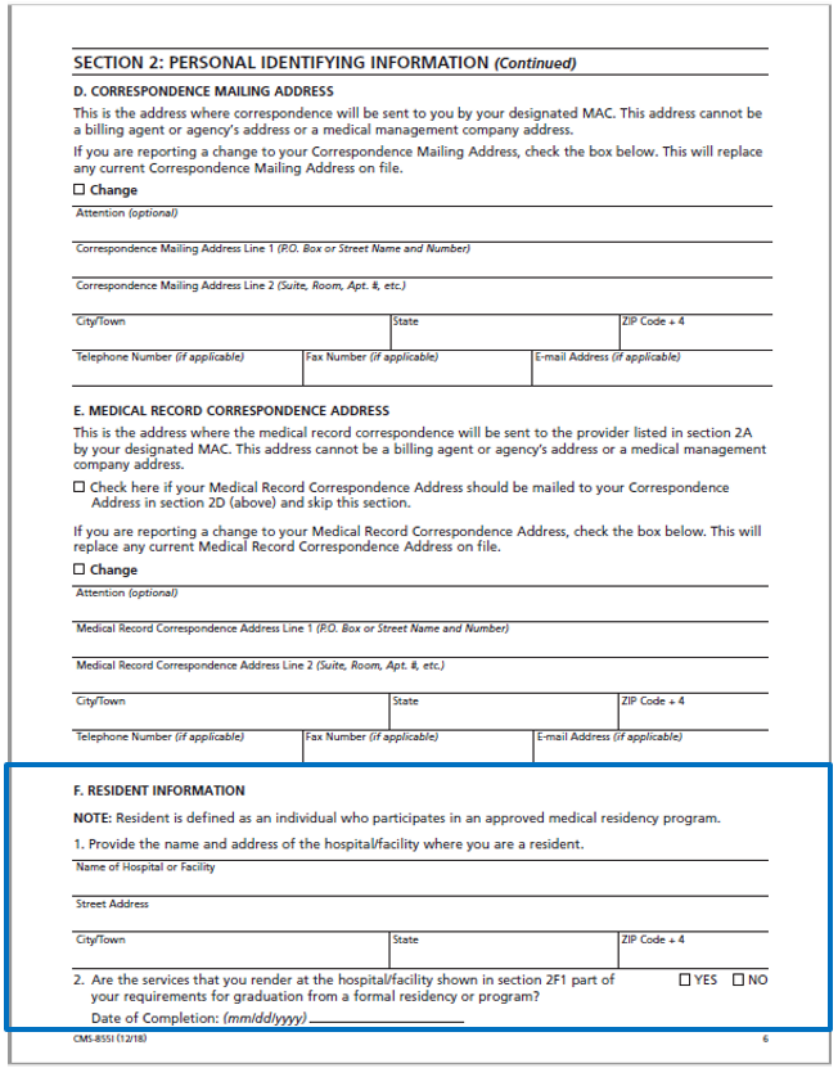
- E: Medical Record Correspondence Address
  - Check box if same as correspondence address
  - Provide medical records correspondence address to **directly contact** applicant
    - Cannot be a billing agency or a medical management company address

Section 2: Personal Identifying Information



SECTION 2: PERSONAL IDENTIFYING INFORMATION *(Continued)*

D. CORRESPONDENCE MAILING ADDRESS

This is the address where correspondence will be sent to you by your designated MAC. This address cannot be a billing agent or agency's address or a medical management company address.

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

☐ **Change**

Attention *(optional)*

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

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

City/Town | State | ZIP Code + 4

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

E. MEDICAL RECORD CORRESPONDENCE ADDRESS

This is the address where the medical record correspondence will be sent to the provider listed in section 2A by your designated MAC. This address cannot be a billing agent or agency's address or a medical management company address.

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

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

☐ **Change**

Attention *(optional)*

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

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

City/Town | State | ZIP Code + 4

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

F. RESIDENT INFORMATION

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

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

Name of Hospital or Facility

Street Address

City/Town | State | ZIP Code + 4

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

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

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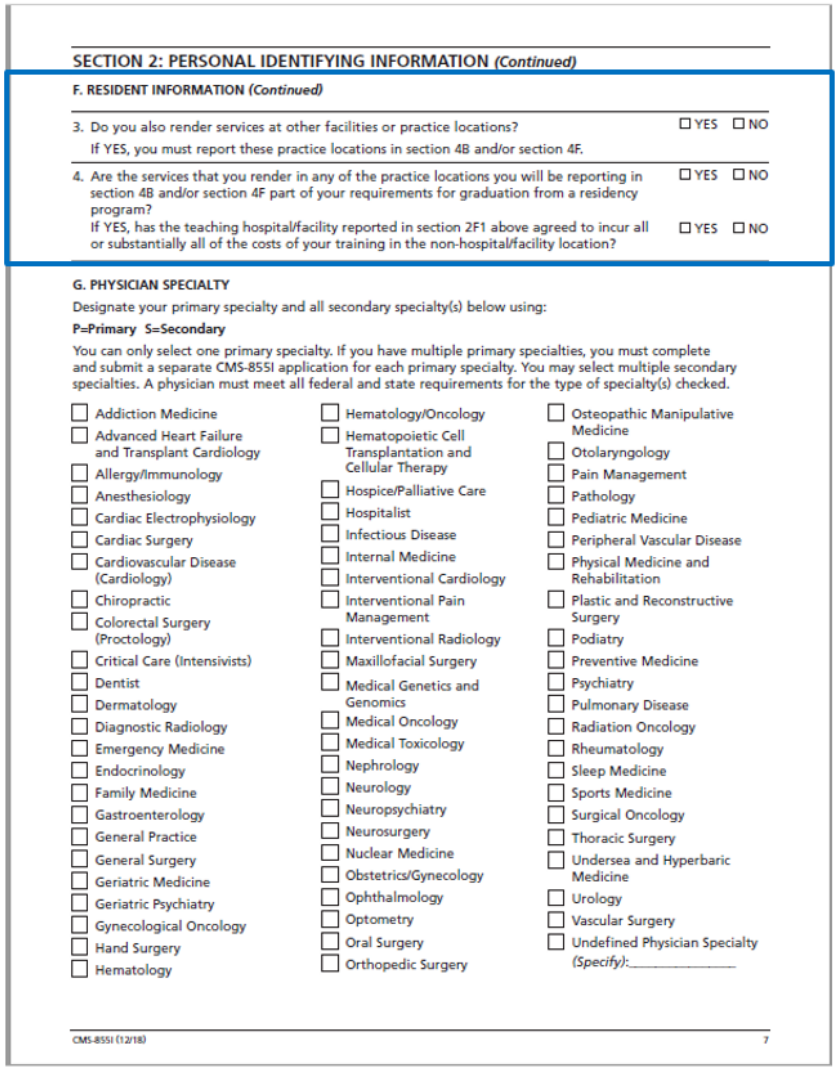
- F: Resident Information
  - Section should not apply during revalidation

Section 2: Personal Identifying Information



SECTION 2: PERSONAL IDENTIFYING INFORMATION *(Continued)*

F. RESIDENT INFORMATION *(Continued)*

3. Do you also render services at other facilities or practice locations? ☐ YES ☐ NO
   If YES, you must report these practice locations in section 4B and/or section 4F.

4. Are the services that you render in any of the practice locations you will be reporting in section 4B and/or section 4F part of your requirements for graduation from a residency program? ☐ YES ☐ NO
   If YES, has the teaching hospital/facility reported in section 2F1 above agreed to incur all or substantially all of the costs of your training in the non-hospital/facility location? ☐ YES ☐ NO

G. PHYSICIAN SPECIALTY

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

P=Primary S=Secondary

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

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

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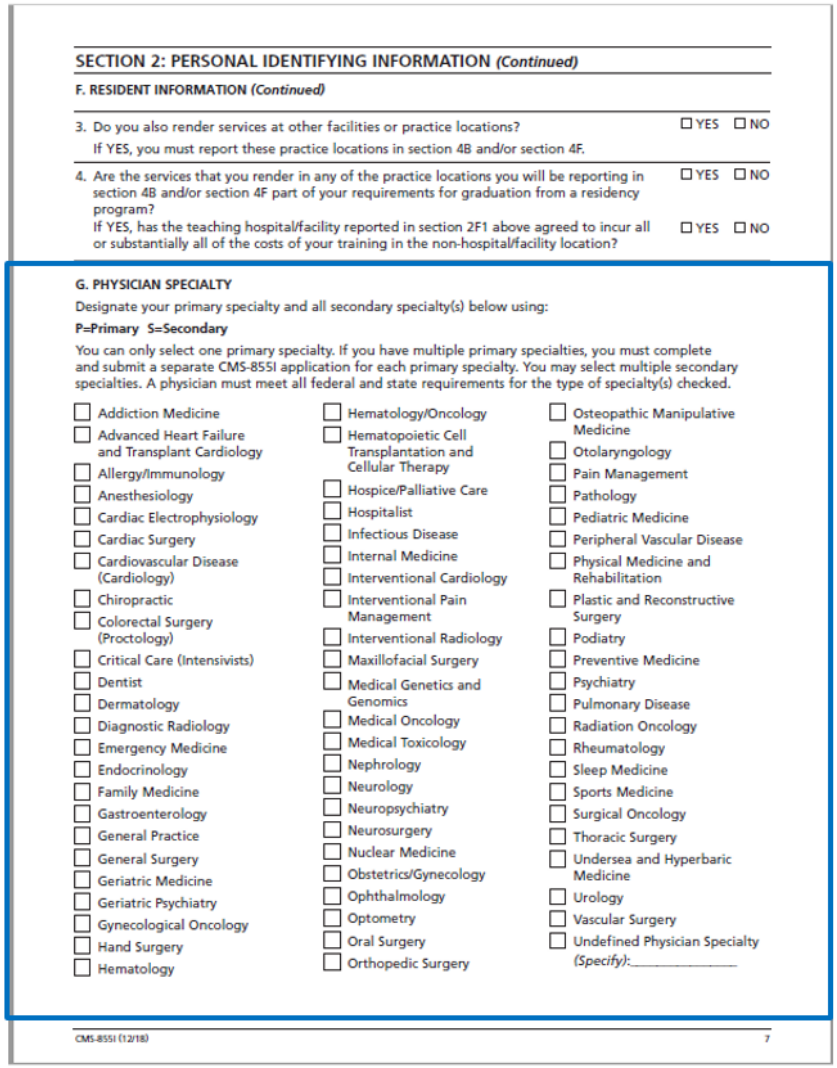
- F: Resident Information (continues)
  - Section should not apply during revalidation

Section 2: Personal Identifying Information



SECTION 2: PERSONAL IDENTIFYING INFORMATION *(Continued)*

F. RESIDENT INFORMATION *(Continued)*

3. Do you also render services at other facilities or practice locations? ☐ YES ☐ NO
   If YES, you must report these practice locations in section 4B and/or section 4F.

4. Are the services that you render in any of the practice locations you will be reporting in section 4B and/or section 4F part of your requirements for graduation from a residency program? ☐ YES ☐ NO
   If YES, has the teaching hospital/facility reported in section 2F1 above agreed to incur all or substantially all of the costs of your training in the non-hospital/facility location? ☐ YES ☐ NO

G. PHYSICIAN SPECIALTY

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

P=Primary S=Secondary

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

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

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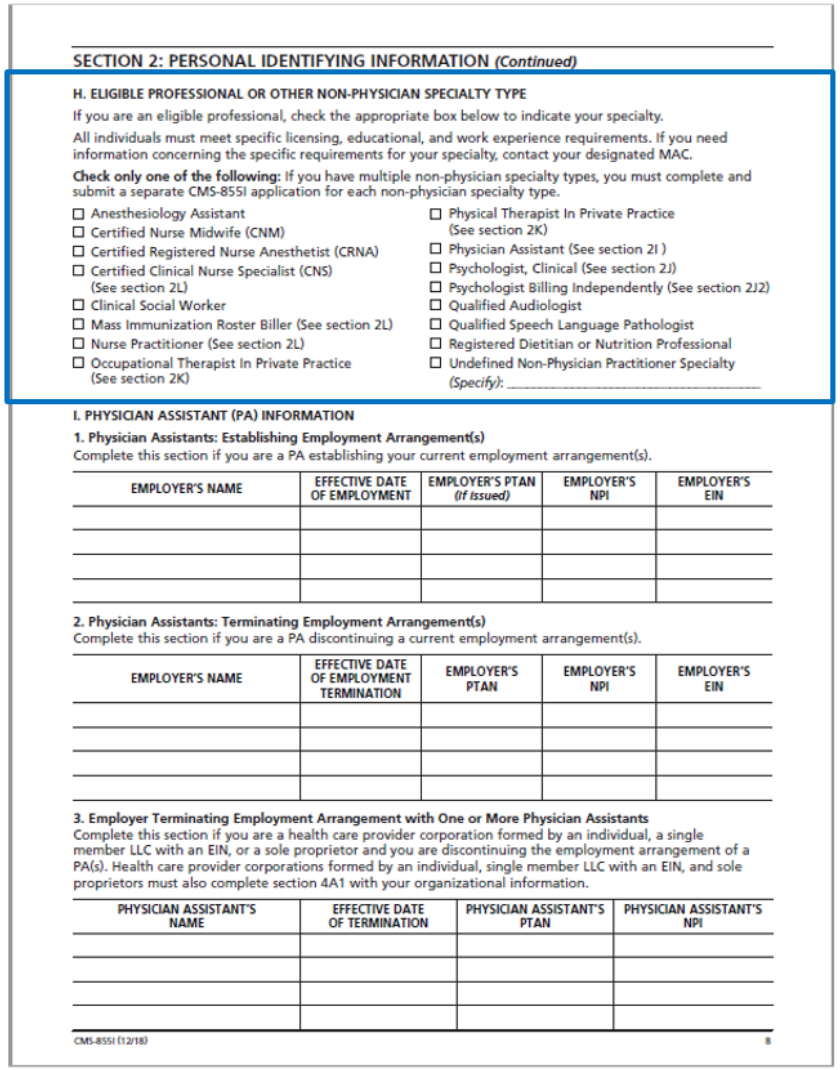
- G: Physician Specialty
  - Select a primary specialty (designated with a “P”)
    - you may select multiple secondary specialties (designated with “S”)
  - Must meet all federal and state requirements for specialty selected

Section 2: Personal Identifying Information



SECTION 2: PERSONAL IDENTIFYING INFORMATION *(Continued)*

H. ELIGIBLE PROFESSIONAL OR OTHER NON-PHYSICIAN SPECIALTY TYPE

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

All individuals must meet specific licensing, educational, and work experience requirements. If you need information concerning the specific requirements for your specialty, contact your designated MAC.

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

- ☐ Anesthesiology Assistant
- ☐ Certified Nurse Midwife (CNM)
- ☐ Certified Registered Nurse Anesthetist (CRNA)
- ☐ Certified Clinical Nurse Specialist (CNS) (See section 2L)
- ☐ Clinical Social Worker
- ☐ Mass Immunization Roster Biller (See section 2L)
- ☐ Nurse Practitioner (See section 2L)
- ☐ Occupational Therapist In Private Practice (See section 2K)
- ☐ Physical Therapist In Private Practice (See section 2K)
- ☐ Physician Assistant (See section 2I)
- ☐ Psychologist, Clinical (See section 2J)
- ☐ Psychologist Billing Independently (See section 2J2)
- ☐ Qualified Audiologist
- ☐ Qualified Speech Language Pathologist
- ☐ Registered Dietitian or Nutrition Professional
- ☐ Undefined Non-Physician Practitioner Specialty *(Specify):* _____

I. PHYSICIAN ASSISTANT (PA) INFORMATION

1. Physician Assistants: Establishing Employment Arrangement(s)

Complete this section if you are a PA establishing your current employment arrangement(s).

EMPLOYER'S NAME	EFFECTIVE DATE OF EMPLOYMENT	EMPLOYER'S PTAN *(If issued)*	EMPLOYER'S NPI	EMPLOYER'S EIN

2. Physician Assistants: Terminating Employment Arrangement(s)

Complete this section if you are a PA discontinuing a current employment arrangement(s).

EMPLOYER'S NAME	EFFECTIVE DATE OF EMPLOYMENT TERMINATION	EMPLOYER'S PTAN	EMPLOYER'S NPI	EMPLOYER'S EIN

3. Employer Terminating Employment Arrangement with One or More Physician Assistants

Complete this section if you are a health care provider corporation formed by an individual, a single member LLC with an EIN, or a sole proprietor and you are discontinuing the employment arrangement of a PA(s). Health care provider corporations formed by an individual, single member LLC with an EIN, and sole proprietors must also complete section 4A1 with your organizational information.

PHYSICIAN ASSISTANT'S NAME	EFFECTIVE DATE OF TERMINATION	PHYSICIAN ASSISTANT'S PTAN	PHYSICIAN ASSISTANT'S NPI

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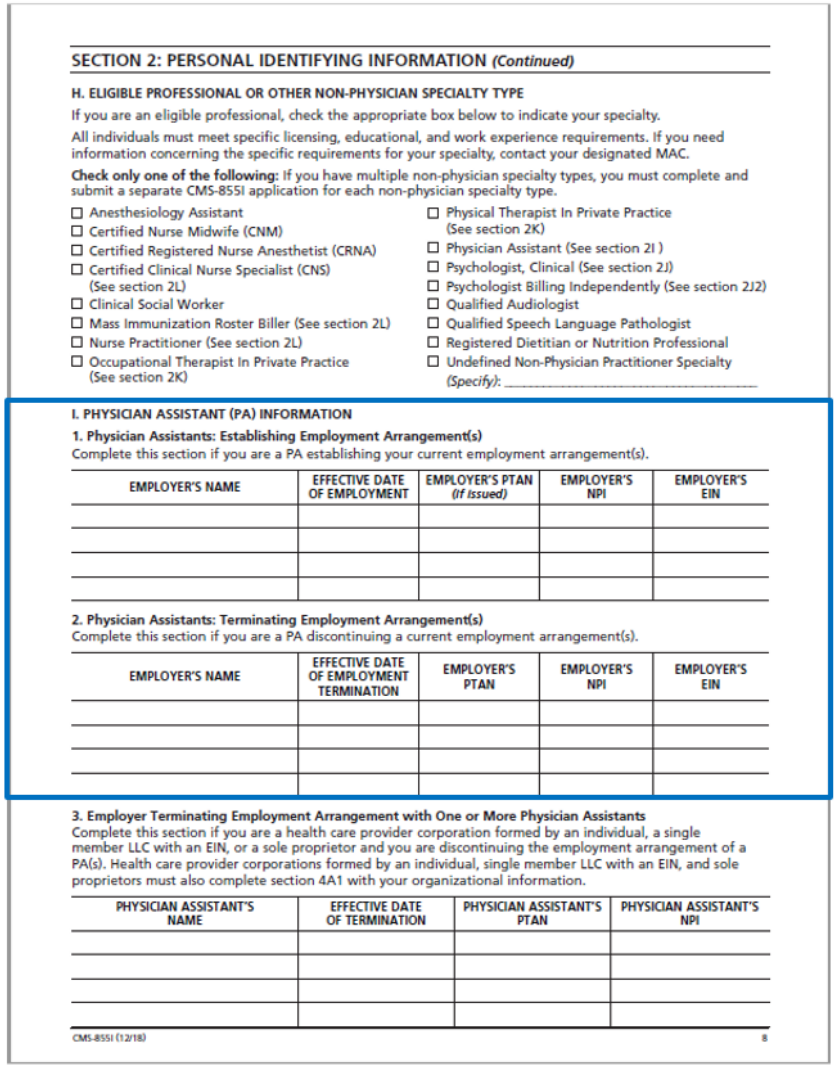
- H: Eligible Professional or Other Nonphysician Specialty Type
  - Select one specialty
  - Must meet the licensing, educational, and work experience requirements

Section 2: Personal Identifying Information



SECTION 2: PERSONAL IDENTIFYING INFORMATION *(Continued)*

H. ELIGIBLE PROFESSIONAL OR OTHER NON-PHYSICIAN SPECIALTY TYPE

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

All individuals must meet specific licensing, educational, and work experience requirements. If you need information concerning the specific requirements for your specialty, contact your designated MAC.

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

- ☐ Anesthesiology Assistant
- ☐ Certified Nurse Midwife (CNM)
- ☐ Certified Registered Nurse Anesthetist (CRNA)
- ☐ Certified Clinical Nurse Specialist (CNS) (See section 2L)
- ☐ Clinical Social Worker
- ☐ Mass Immunization Roster Biller (See section 2L)
- ☐ Nurse Practitioner (See section 2L)
- ☐ Occupational Therapist In Private Practice (See section 2K)
- ☐ Physical Therapist In Private Practice (See section 2K)
- ☐ Physician Assistant (See section 2I)
- ☐ Psychologist, Clinical (See section 2J)
- ☐ Psychologist Billing Independently (See section 2J2)
- ☐ Qualified Audiologist
- ☐ Qualified Speech Language Pathologist
- ☐ Registered Dietitian or Nutrition Professional
- ☐ Undefined Non-Physician Practitioner Specialty *(Specify)*: _____

I. PHYSICIAN ASSISTANT (PA) INFORMATION

1. Physician Assistants: Establishing Employment Arrangement(s)

Complete this section if you are a PA establishing your current employment arrangement(s).

EMPLOYER'S NAME	EFFECTIVE DATE OF EMPLOYMENT	EMPLOYER'S PTAN *(If Issued)*	EMPLOYER'S NPI	EMPLOYER'S EIN

2. Physician Assistants: Terminating Employment Arrangement(s)

Complete this section if you are a PA discontinuing a current employment arrangement(s).

EMPLOYER'S NAME	EFFECTIVE DATE OF EMPLOYMENT TERMINATION	EMPLOYER'S PTAN	EMPLOYER'S NPI	EMPLOYER'S EIN

3. Employer Terminating Employment Arrangement with One or More Physician Assistants

Complete this section if you are a health care provider corporation formed by an individual, a single member LLC with an EIN, or a sole proprietor and you are discontinuing the employment arrangement of a PA(s). Health care provider corporations formed by an individual, single member LLC with an EIN, and sole proprietors must also complete section 4A1 with your organizational information.

PHYSICIAN ASSISTANT'S NAME	EFFECTIVE DATE OF TERMINATION	PHYSICIAN ASSISTANT'S PTAN	PHYSICIAN ASSISTANT'S NPI

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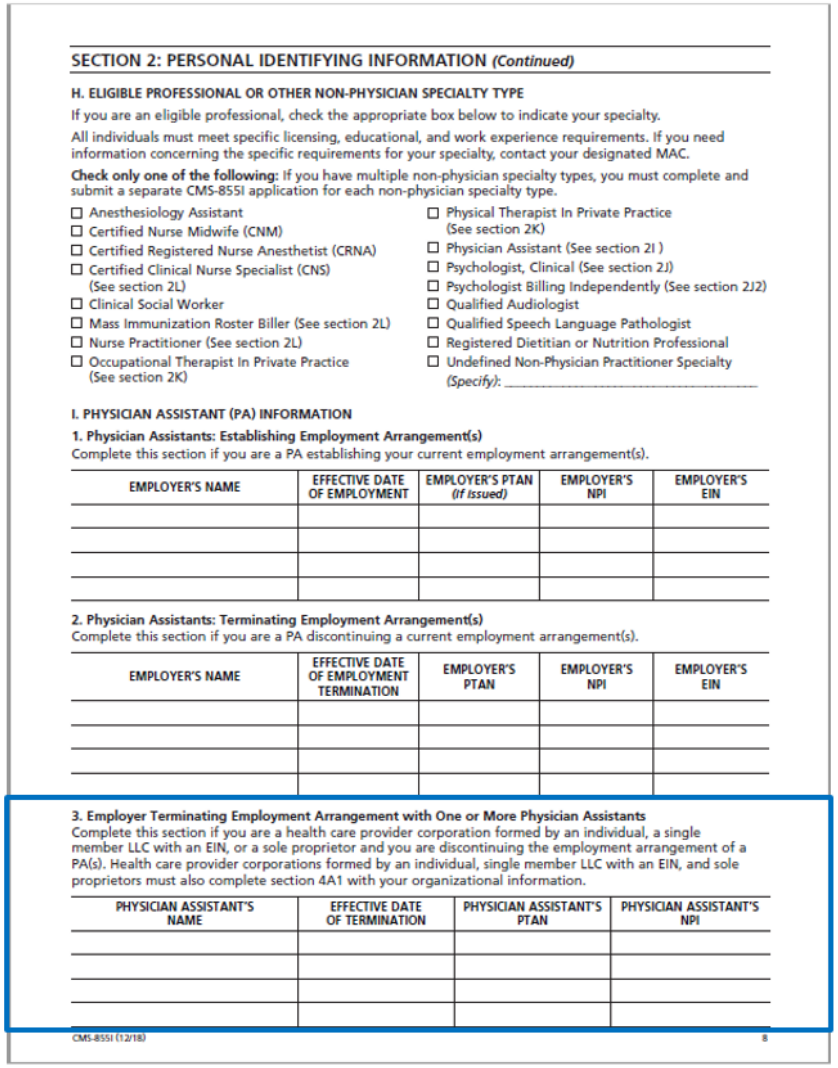
- I: Physician Assistant (PA) Information
  - PAs can identify all current employment arrangements and terminate past arrangements

Section 2: Personal Identifying Information



SECTION 2: PERSONAL IDENTIFYING INFORMATION *(Continued)*

H. ELIGIBLE PROFESSIONAL OR OTHER NON-PHYSICIAN SPECIALTY TYPE

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

All individuals must meet specific licensing, educational, and work experience requirements. If you need information concerning the specific requirements for your specialty, contact your designated MAC.

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

- ☐ Anesthesiology Assistant
- ☐ Certified Nurse Midwife (CNM)
- ☐ Certified Registered Nurse Anesthetist (CRNA)
- ☐ Certified Clinical Nurse Specialist (CNS) (See section 2L)
- ☐ Clinical Social Worker
- ☐ Mass Immunization Roster Biller (See section 2L)
- ☐ Nurse Practitioner (See section 2L)
- ☐ Occupational Therapist In Private Practice (See section 2K)
- ☐ Physical Therapist In Private Practice (See section 2K)
- ☐ Physician Assistant (See section 2I)
- ☐ Psychologist, Clinical (See section 2J)
- ☐ Psychologist Billing Independently (See section 2J2)
- ☐ Qualified Audiologist
- ☐ Qualified Speech Language Pathologist
- ☐ Registered Dietitian or Nutrition Professional
- ☐ Undefined Non-Physician Practitioner Specialty *(Specify)*: _____

I. PHYSICIAN ASSISTANT (PA) INFORMATION

1. Physician Assistants: Establishing Employment Arrangement(s)

Complete this section if you are a PA establishing your current employment arrangement(s).

EMPLOYER'S NAME	EFFECTIVE DATE OF EMPLOYMENT	EMPLOYER'S PTAN *(If issued)*	EMPLOYER'S NPI	EMPLOYER'S EIN

2. Physician Assistants: Terminating Employment Arrangement(s)

Complete this section if you are a PA discontinuing a current employment arrangement(s).

EMPLOYER'S NAME	EFFECTIVE DATE OF EMPLOYMENT TERMINATION	EMPLOYER'S PTAN	EMPLOYER'S NPI	EMPLOYER'S EIN

3. Employer Terminating Employment Arrangement with One or More Physician Assistants

Complete this section if you are a health care provider corporation formed by an individual, a single member LLC with an EIN, or a sole proprietor and you are discontinuing the employment arrangement of a PA(s). Health care provider corporations formed by an individual, single member LLC with an EIN, and sole proprietors must also complete section 4A1 with your organizational information.

PHYSICIAN ASSISTANT'S NAME	EFFECTIVE DATE OF TERMINATION	PHYSICIAN ASSISTANT'S PTAN	PHYSICIAN ASSISTANT'S NPI

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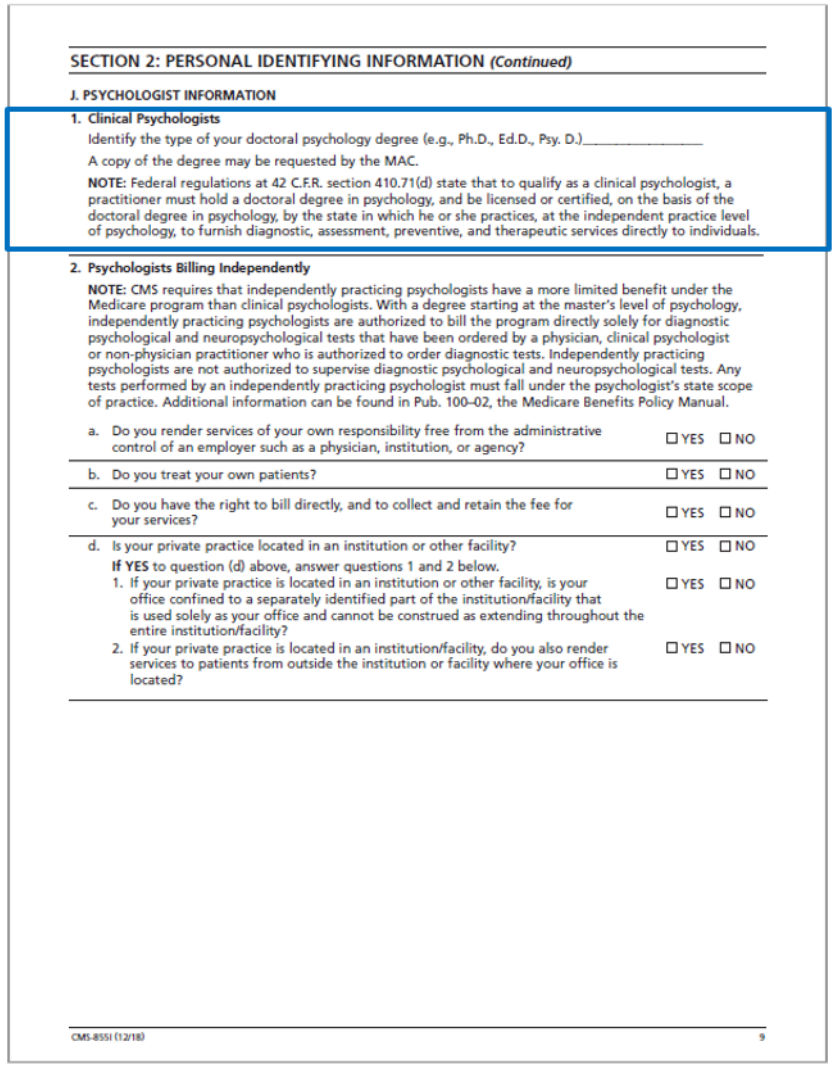
- I: Physician Assistant (PA) Information
  - Sole Owner/Sole Proprietor can terminate employment arrangement with PAs

Private Practice

Section 2: Personal Identifying Information



SECTION 2: PERSONAL IDENTIFYING INFORMATION *(Continued)*

J. PSYCHOLOGIST INFORMATION

1. Clinical Psychologists

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

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

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

2. Psychologists Billing Independently

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

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

b. Do you treat your own patients? ☐ YES ☐ NO

c. Do you have the right to bill directly, and to collect and retain the fee for your services? ☐ YES ☐ NO

d. Is your private practice located in an institution or other facility? ☐ YES ☐ NO

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

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

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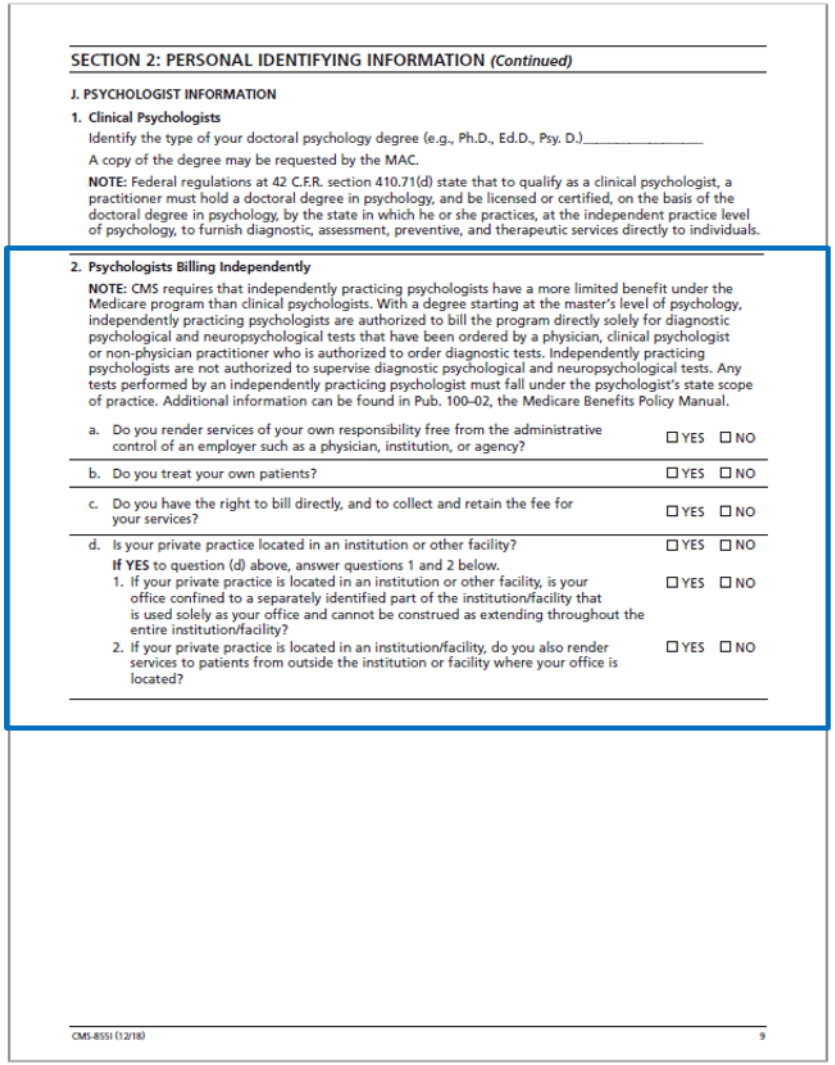
- J: Psychologist Information
  - Identify the doctoral degree in psychology

Section 2: Personal Identifying Information



SECTION 2: PERSONAL IDENTIFYING INFORMATION *(Continued)*

J. PSYCHOLOGIST INFORMATION

1. Clinical Psychologists

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

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

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

2. Psychologists Billing Independently

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

a.	Do you render services of your own responsibility free from the administrative control of an employer such as a physician, institution, or agency?	☐ YES ☐ NO
b.	Do you treat your own patients?	☐ YES ☐ NO
c.	Do you have the right to bill directly, and to collect and retain the fee for your services?	☐ YES ☐ NO
d.	Is your private practice located in an institution or other facility?	☐ YES ☐ NO
	If YES to question (d) above, answer questions 1 and 2 below.	
	1. If your private practice is located in an institution or other facility, is your office confined to a separately identified part of the institution/facility that is used solely as your office and cannot be construed as extending throughout the entire institution/facility?	☐ YES ☐ NO
	2. If your private practice is located in an institution/facility, do you also render services to patients from outside the institution or facility where your office is located?	☐ YES ☐ NO

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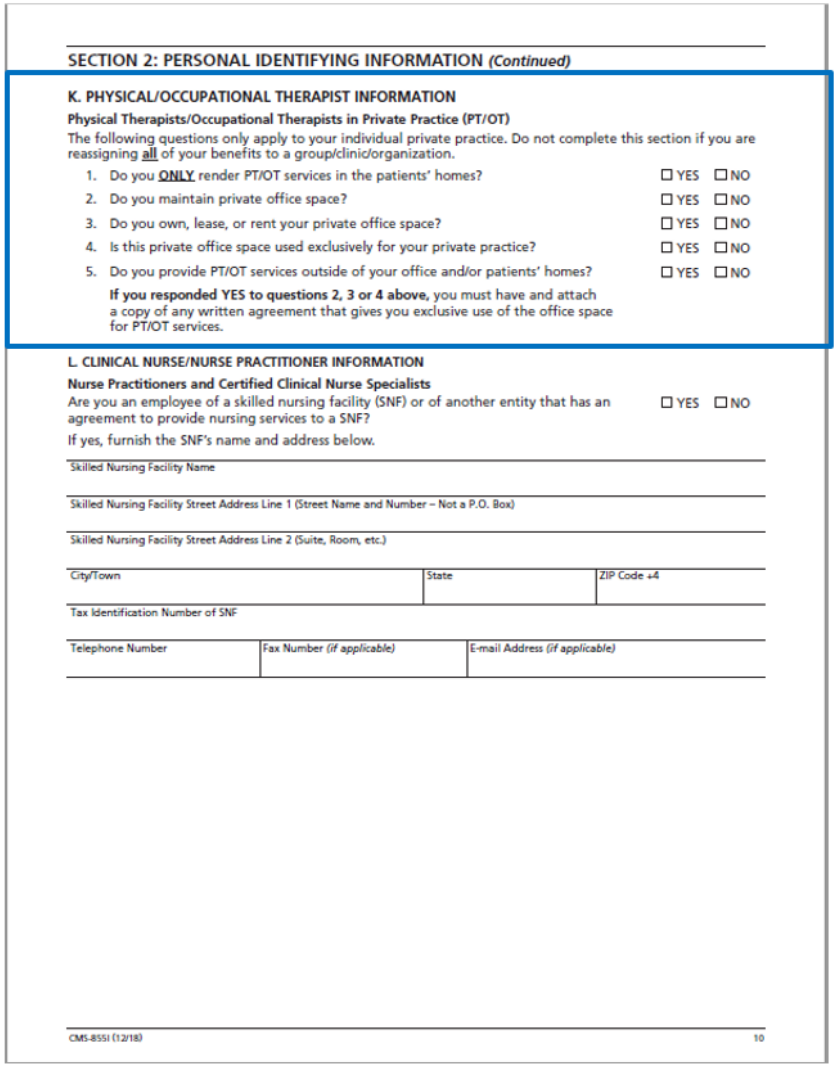
- J: Psychologist Information
  - Complete all questions for psychologists billing independently
  - This section does not apply if reassigning all benefits

Private Practice

Section 2: Personal Identifying Information



SECTION 2: PERSONAL IDENTIFYING INFORMATION *(Continued)*

K. PHYSICAL/OCCUPATIONAL THERAPIST INFORMATION

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

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

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

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

L. CLINICAL NURSE/NURSE PRACTITIONER INFORMATION

Nurse Practitioners and Certified Clinical Nurse Specialists

Are you an employee of a skilled nursing facility (SNF) or of another entity that has an agreement to provide nursing services to a SNF? ☐ YES ☐ NO

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

Skilled Nursing Facility Name

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

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

City/Town	State	ZIP Code +4

Tax Identification Number of SNF

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

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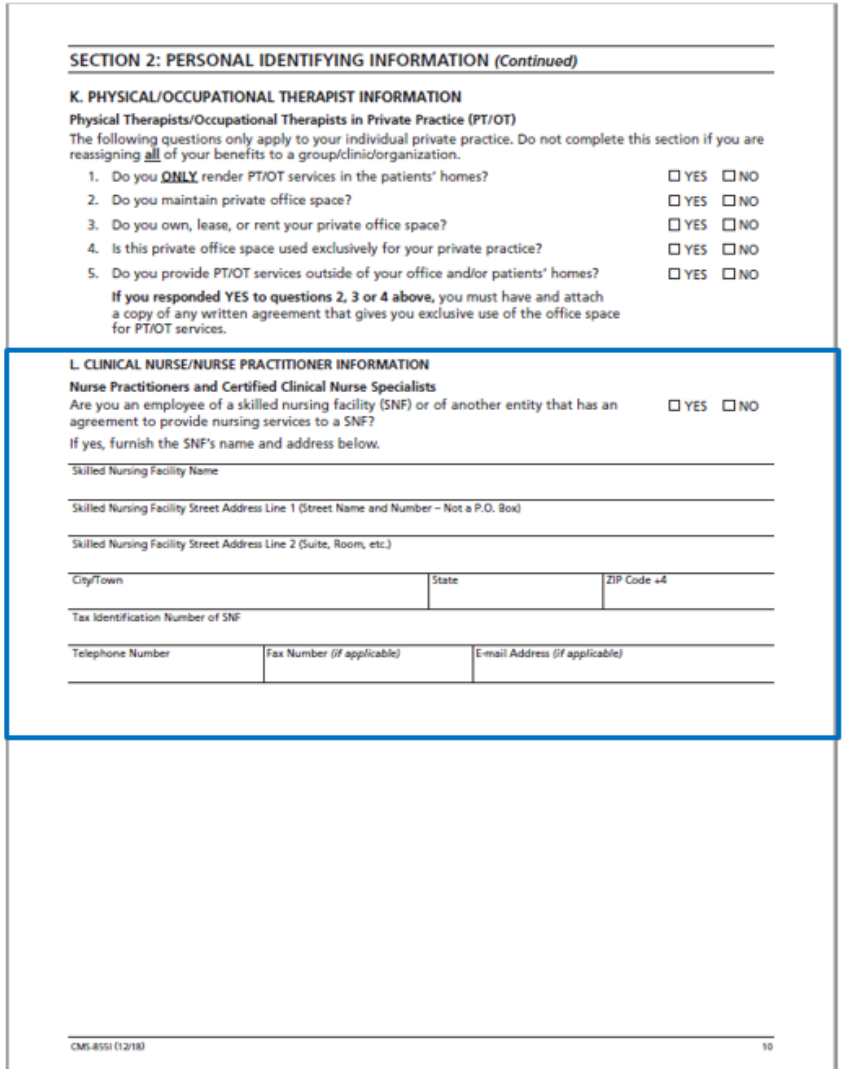
- K: Physical /Occupational Therapist Information
  - Complete all questions for physical/occupational therapists in private practice
  - This section does not apply if reassigning all benefits

Private Practice

Section 2: Personal Identifying Information



SECTION 2: PERSONAL IDENTIFYING INFORMATION *(Continued)*

K. PHYSICAL/OCCUPATIONAL THERAPIST INFORMATION

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

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

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

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

L. CLINICAL NURSE/NURSE PRACTITIONER INFORMATION

Nurse Practitioners and Certified Clinical Nurse Specialists

Are you an employee of a skilled nursing facility (SNF) or of another entity that has an agreement to provide nursing services to a SNF? ☐ YES ☐ NO

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

Skilled Nursing Facility Name

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

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

City/Town | State | ZIP Code +4

Tax Identification Number of SNF

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

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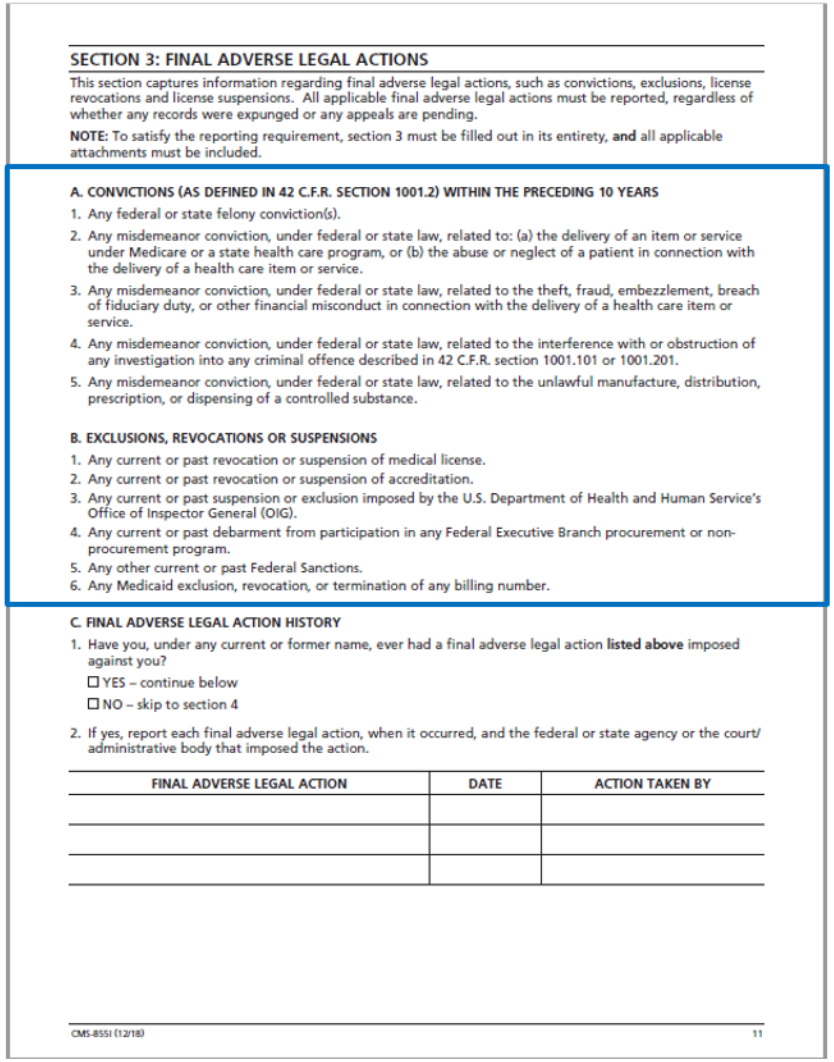
- L: Clinical Nurse /Nurse Practitioner Information
  - Select "yes" or "no"
    - If yes, furnish the facility information

Section 3: Final Adverse Legal Actions



SECTION 3: FINAL ADVERSE LEGAL ACTIONS

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

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

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

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

B. EXCLUSIONS, REVOCATIONS OR SUSPENSIONS

1. Any current or past revocation or suspension of medical license.
2. Any current or past revocation or suspension of accreditation.
3. Any current or past suspension or exclusion imposed by the U.S. Department of Health and Human Service's Office of Inspector General (OIG).
4. Any current or past debarment from participation in any Federal Executive Branch procurement or non-procurement program.
5. Any other current or past Federal Sanctions.
6. Any Medicaid exclusion, revocation, or termination of any billing number.

C. FINAL ADVERSE LEGAL ACTION HISTORY

1. Have you, under any current or former name, ever had a final adverse legal action **listed above** imposed against you?
   - ☐ YES – continue below
   - ☐ NO – skip to section 4
2. If yes, report each final adverse legal action, when it occurred, and the federal or state agency or the court/ administrative body that imposed the action.

FINAL ADVERSE LEGAL ACTION	DATE	ACTION TAKEN BY

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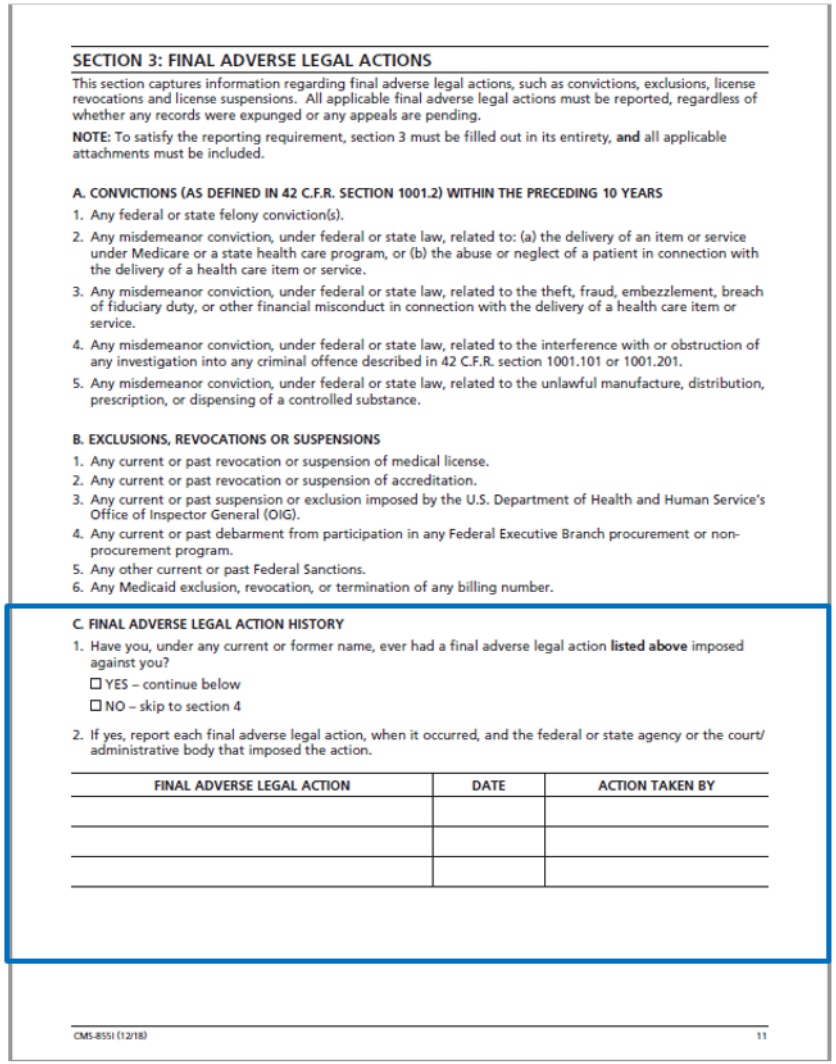
- A: Convictions
  - Within preceding 10 years
- B: Exclusions, Revocations and Suspensions
  - Current or past

Section 3: Final Adverse Legal Actions



SECTION 3: FINAL ADVERSE LEGAL ACTIONS

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

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

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

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

B. EXCLUSIONS, REVOCATIONS OR SUSPENSIONS

1. Any current or past revocation or suspension of medical license.
2. Any current or past revocation or suspension of accreditation.
3. Any current or past suspension or exclusion imposed by the U.S. Department of Health and Human Service's Office of Inspector General (OIG).
4. Any current or past debarment from participation in any Federal Executive Branch procurement or non-procurement program.
5. Any other current or past Federal Sanctions.
6. Any Medicaid exclusion, revocation, or termination of any billing number.

C. FINAL ADVERSE LEGAL ACTION HISTORY

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

☐ YES – continue below

☐ NO – skip to section 4

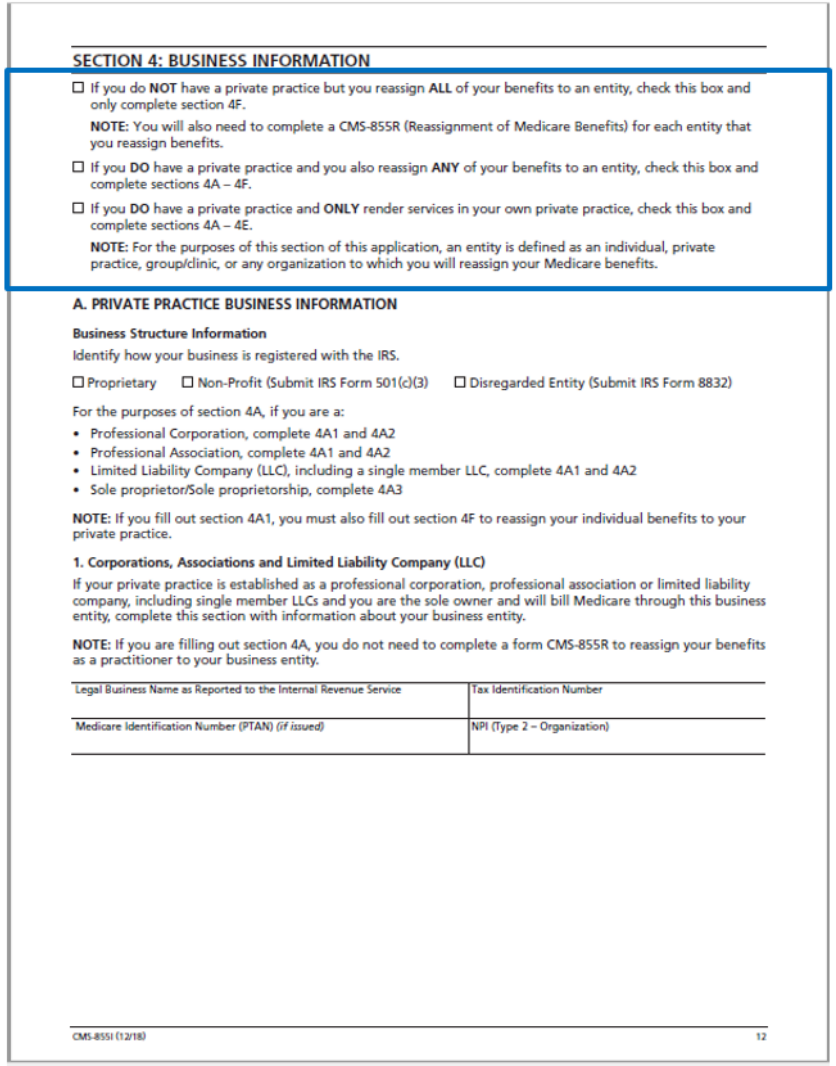
2. If yes, report each final adverse legal action, when it occurred, and the federal or state agency or the court/ administrative body that imposed the action.

FINAL ADVERSE LEGAL ACTION	DATE	ACTION TAKEN BY

CMS-855I (12/18) 11

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

Section 4: Business Information



SECTION 4: BUSINESS INFORMATION

☐ If you do **NOT** have a private practice but you reassign **ALL** of your benefits to an entity, check this box and only complete section 4F.

NOTE: You will also need to complete a CMS-855R (Reassignment of Medicare Benefits) for each entity that you reassign benefits.

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

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

NOTE: For the purposes of this section of this application, an entity is defined as an individual, private practice, group/clinic, or any organization to which you will reassign your Medicare benefits.

A. PRIVATE PRACTICE BUSINESS INFORMATION

Business Structure Information

Identify how your business is registered with the IRS.

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

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

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

NOTE: If you fill out section 4A1, you must also fill out section 4F to reassign your individual benefits to your private practice.

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

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

NOTE: If you are filling out section 4A, you do not need to complete a form CMS-855R to reassign your benefits as a practitioner to your business entity.

Legal Business Name as Reported to the Internal Revenue Service	Tax Identification Number
Medicare Identification Number (PTAN) *(if issued)*	NPI (Type 2 – Organization)

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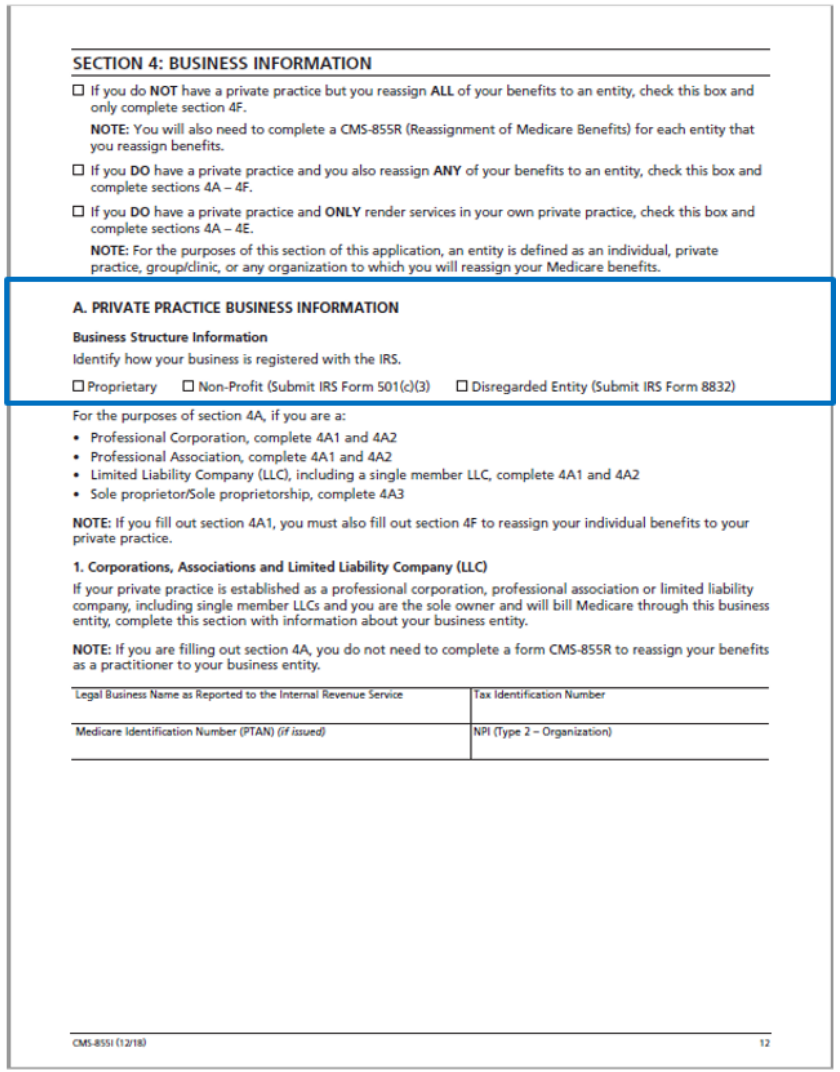
- Check applicable box for additional instructions
  - Individual reassigning all benefits, 4F only
  - Sole Owner reassigning benefits, 4A – 4F
  - Sole Proprietor with private practice, not reassigning benefits, 4A – 4E

Section 4: Business Information



SECTION 4: BUSINESS INFORMATION

☐ If you do **NOT** have a private practice but you reassign **ALL** of your benefits to an entity, check this box and only complete section 4F.

NOTE: You will also need to complete a CMS-855R (Reassignment of Medicare Benefits) for each entity that you reassign benefits.

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

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

NOTE: For the purposes of this section of this application, an entity is defined as an individual, private practice, group/clinic, or any organization to which you will reassign your Medicare benefits.

A. PRIVATE PRACTICE BUSINESS INFORMATION

Business Structure Information

Identify how your business is registered with the IRS.

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

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

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

NOTE: If you fill out section 4A1, you must also fill out section 4F to reassign your individual benefits to your private practice.

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

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

NOTE: If you are filling out section 4A, you do not need to complete a form CMS-855R to reassign your benefits as a practitioner to your business entity.

Legal Business Name as Reported to the Internal Revenue Service	Tax Identification Number
Medicare Identification Number (PTAN) *(if issued)*	NPI (Type 2 – Organization)

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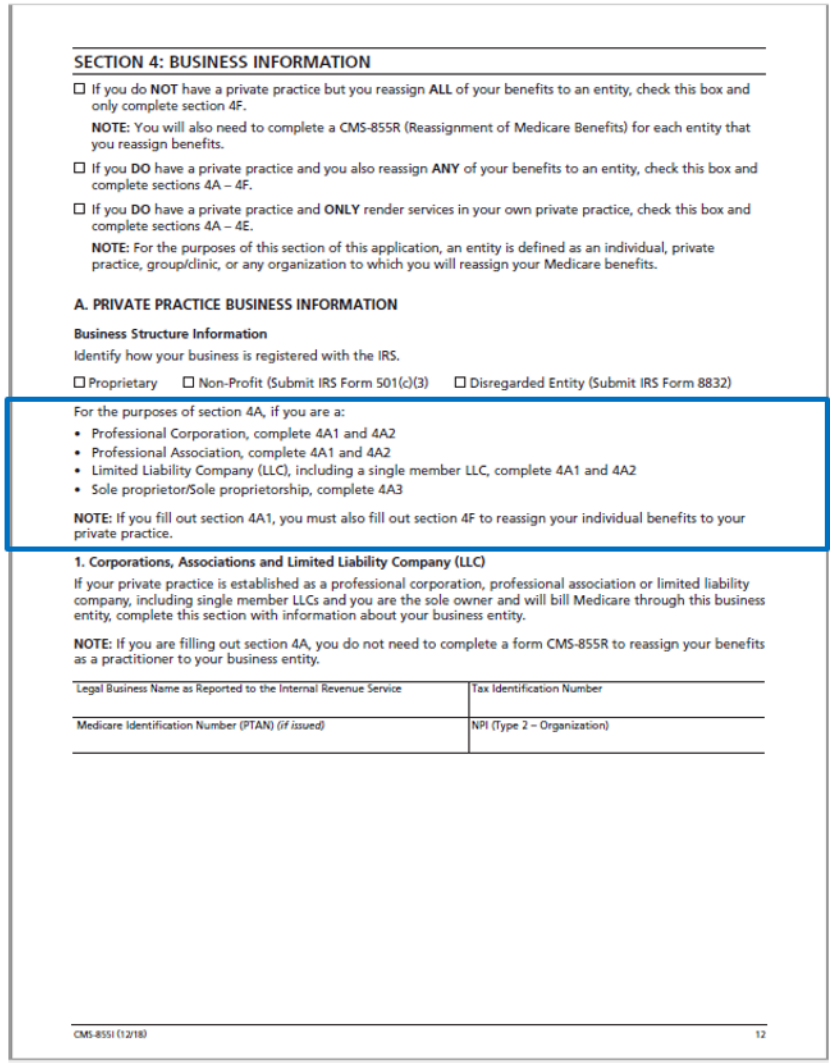
- A: Private Practice Business Information
  - Identify business structure

Private Practice

Section 4: Business Information



SECTION 4: BUSINESS INFORMATION

☐ If you do **NOT** have a private practice but you reassign **ALL** of your benefits to an entity, check this box and only complete section 4F.

NOTE: You will also need to complete a CMS-855R (Reassignment of Medicare Benefits) for each entity that you reassign benefits.

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

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

NOTE: For the purposes of this section of this application, an entity is defined as an individual, private practice, group/clinic, or any organization to which you will reassign your Medicare benefits.

A. PRIVATE PRACTICE BUSINESS INFORMATION

Business Structure Information

Identify how your business is registered with the IRS.

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

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

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

NOTE: If you fill out section 4A1, you must also fill out section 4F to reassign your individual benefits to your private practice.

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

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

NOTE: If you are filling out section 4A, you do not need to complete a form CMS-855R to reassign your benefits as a practitioner to your business entity.

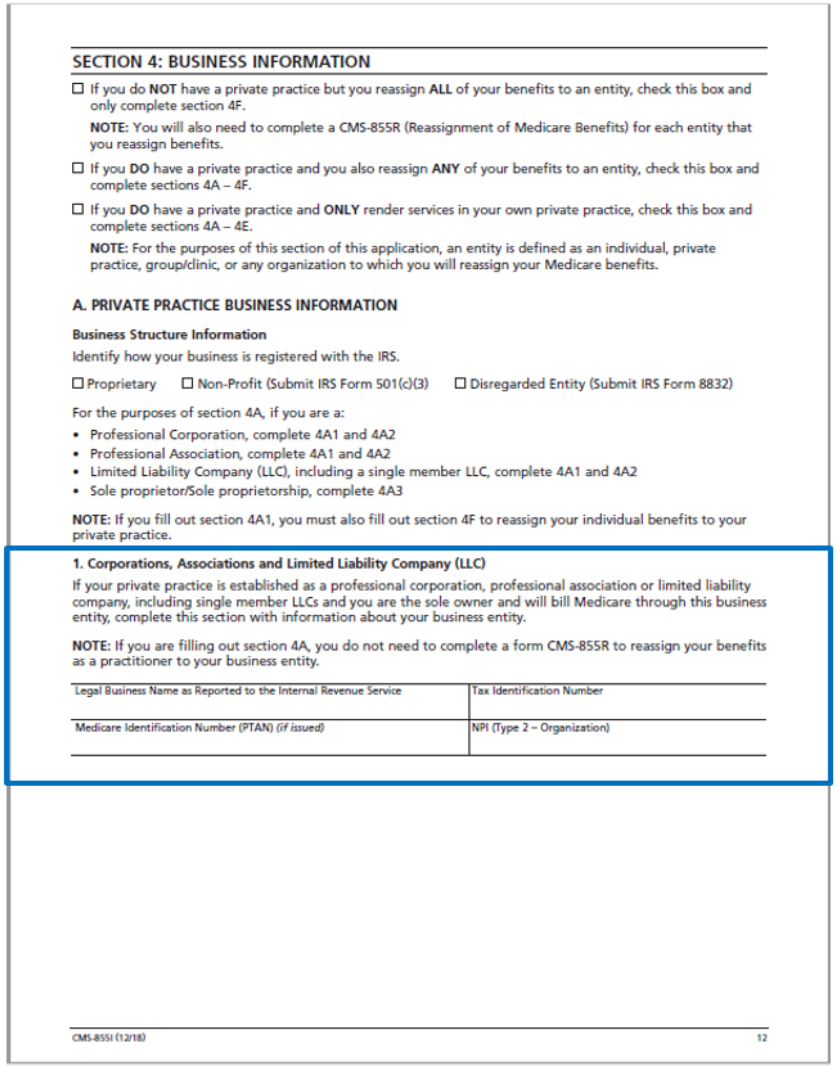
Legal Business Name as Reported to the Internal Revenue Service	Tax Identification Number
Medicare Identification Number (PTAN) *(if issued)*	NPI (Type 2 – Organization)

CMS-855I (12/18) 12

- A: Private Practice Business Information
  - Sole Owner: PC, PA or LLC complete sections 4A1 and 4A2 (4F)
  - Sole Proprietor complete section 4A3

Private Practice

Section 4: Business Information



SECTION 4: BUSINESS INFORMATION

☐ If you do **NOT** have a private practice but you reassign **ALL** of your benefits to an entity, check this box and only complete section 4F.

NOTE: You will also need to complete a CMS-855R (Reassignment of Medicare Benefits) for each entity that you reassign benefits.

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

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

NOTE: For the purposes of this section of this application, an entity is defined as an individual, private practice, group/clinic, or any organization to which you will reassign your Medicare benefits.

A. PRIVATE PRACTICE BUSINESS INFORMATION

Business Structure Information

Identify how your business is registered with the IRS.

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

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

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

NOTE: If you fill out section 4A1, you must also fill out section 4F to reassign your individual benefits to your private practice.

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

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

NOTE: If you are filling out section 4A, you do not need to complete a form CMS-855R to reassign your benefits as a practitioner to your business entity.

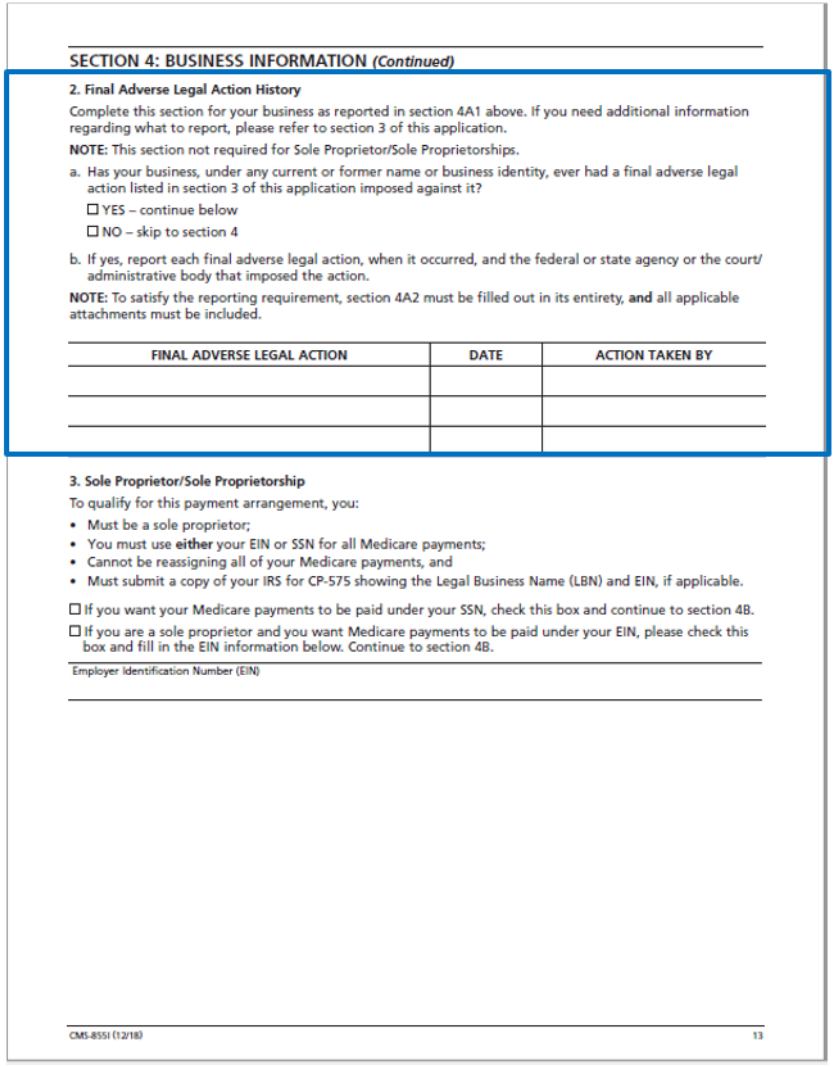
Legal Business Name as Reported to the Internal Revenue Service	Tax Identification Number
Medicare Identification Number (PTAN) *(if issued)*	NPI (Type 2 – Organization)

CMS-855I (12/18) 12

- A: Private Practice Business Information
  - 1. Corporations, Associations and Limited Liability Company (LLC)
    - Sole Owner
    - Indicate Type 2 NPI
    - Indicate legal business name and TIN as it appears on the IRS document

Private Practice

Section 4: Business Information



SECTION 4: BUSINESS INFORMATION *(Continued)*

2. Final Adverse Legal Action History

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

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

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

☐ YES – continue below

☐ NO – skip to section 4

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

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

FINAL ADVERSE LEGAL ACTION	DATE	ACTION TAKEN BY

3. Sole Proprietor/Sole Proprietorship

To qualify for this payment arrangement, you:

- Must be a sole proprietor;
- You must use **either** your EIN or SSN for all Medicare payments;
- Cannot be reassigning all of your Medicare payments, and
- Must submit a copy of your IRS for CP-575 showing the Legal Business Name (LBN) and EIN, if applicable.

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

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

Employer Identification Number (EIN)

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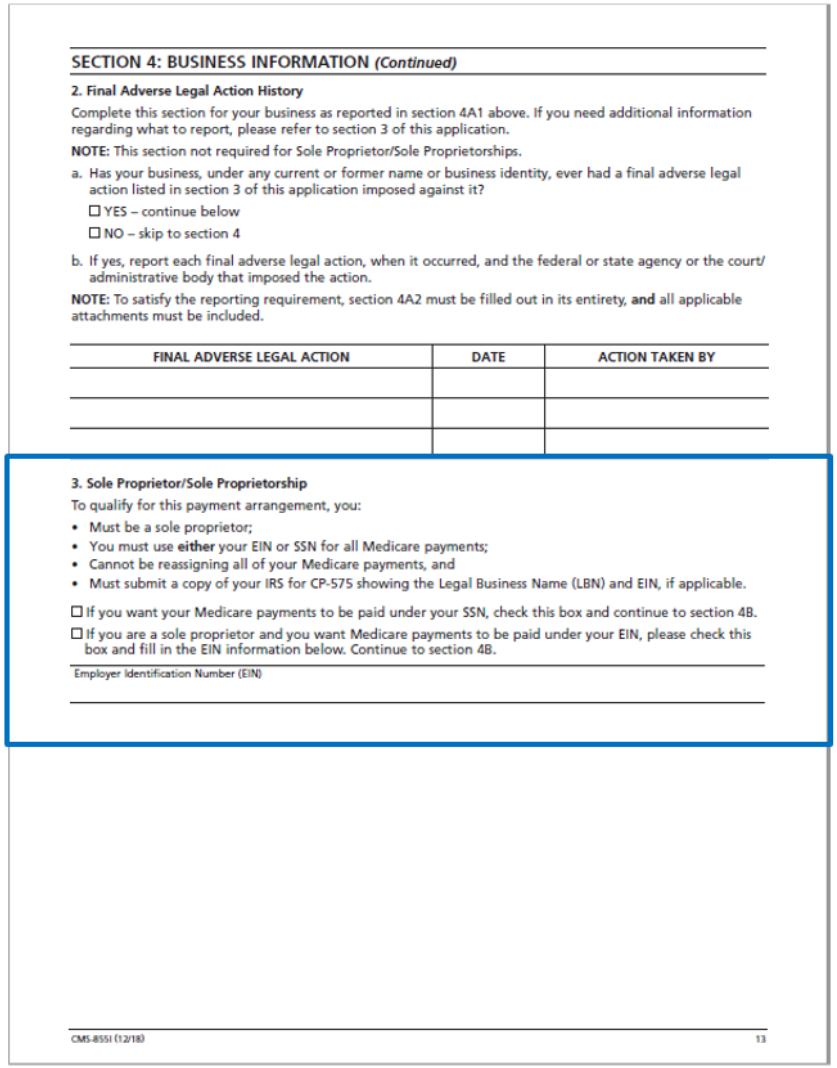
- A: Private Practice Business Information
  - 2. Final Adverse Legal Action History
    - Indicate any final adverse legal action history on the entity identified in this section
    - If no adverse legal action, check “No”
    - If any, check “Yes”, then list details in section C2 and attach final adverse legal action documentation and/or resolutions

Private Practice

Section 4: Business Information



SECTION 4: BUSINESS INFORMATION *(Continued)*

2. Final Adverse Legal Action History

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

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

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

☐ YES – continue below

☐ NO – skip to section 4

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

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

FINAL ADVERSE LEGAL ACTION	DATE	ACTION TAKEN BY

3. Sole Proprietor/Sole Proprietorship

To qualify for this payment arrangement, you:

- Must be a sole proprietor;
- You must use **either** your EIN or SSN for all Medicare payments;
- Cannot be reassigning all of your Medicare payments, and
- Must submit a copy of your IRS for CP-575 showing the Legal Business Name (LBN) and EIN, if applicable.

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

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

Employer Identification Number (EIN)

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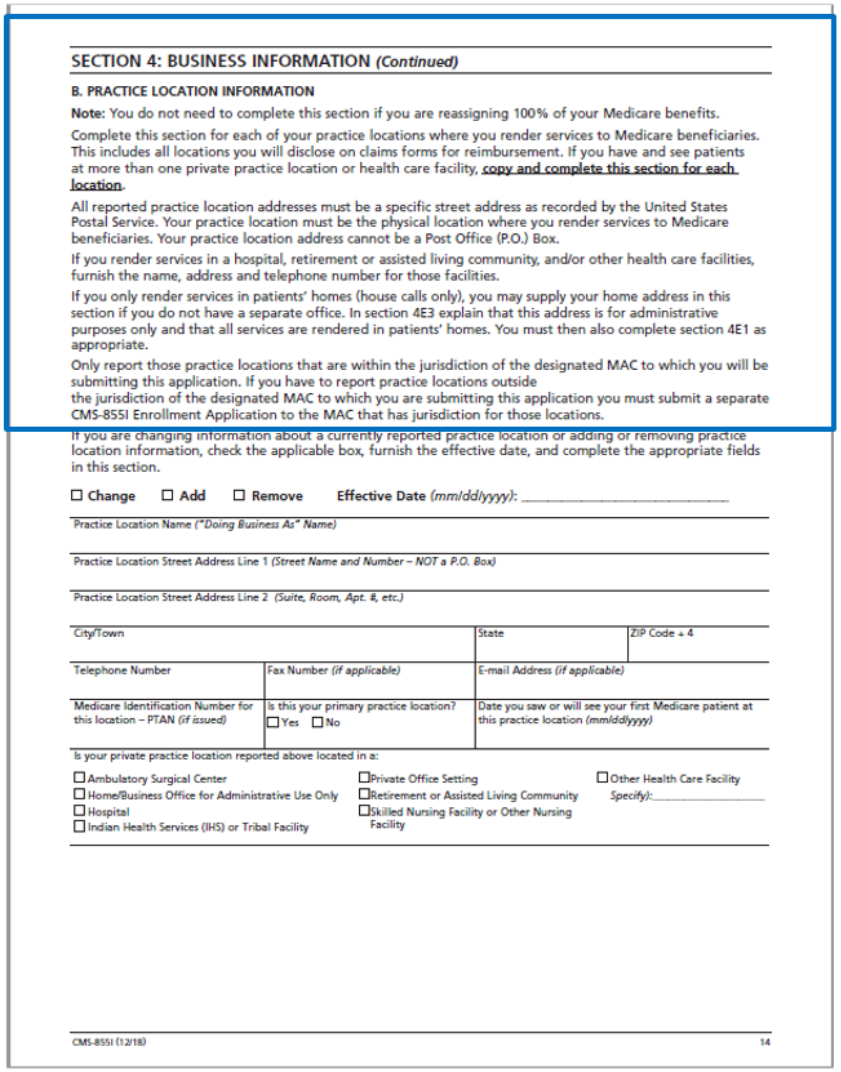
- A: Private Practice Business Information
  - 3.Sole Proprietor /Sole Proprietorship
    - Select if payments are to be reported via SSN or EIN
      - If EIN, identify number

Private Practice

Section 4: Business Information



SECTION 4: BUSINESS INFORMATION *(Continued)*

B. PRACTICE LOCATION INFORMATION

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

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

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

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

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

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

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

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

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

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

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

City/Town		State	ZIP Code + 4
Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*	
Medicare Identification Number for this location – PTAN *(if issued)*	Is this your primary practice location? ☐ Yes ☐ No	Date you saw or will see your first Medicare patient at this practice location *(mm/dd/yyyy)*	

Is your private practice location reported above located in a:

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

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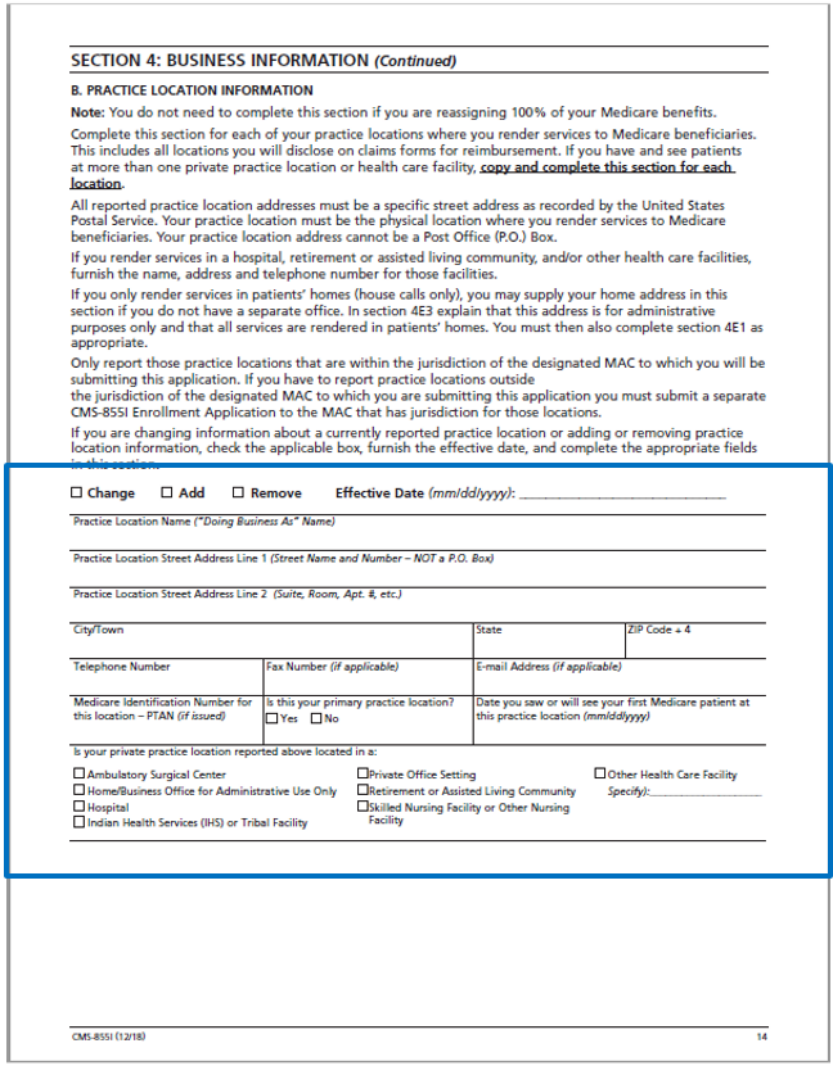
- 4B Practice Location Information
  - Instructions on how and who should complete this section
    - Report all practice locations including:
      - Ambulatory Surgical Centers
      - Hospital
      - Retirement or Assisted Living Community
      - Skilled Nursing Facility or Other Nursing Facility
      - Other health care facilities
      - Administrative Office when performing house calls, which could be home address

Private Practice

Section 4: Business Information



SECTION 4: BUSINESS INFORMATION *(Continued)*

B. PRACTICE LOCATION INFORMATION

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

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

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

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

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

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

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

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

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

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

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

City/Town	State	ZIP Code + 4

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*
Medicare Identification Number for this location – PTAN *(if issued)*	Is this your primary practice location? ☐ Yes ☐ No	Date you saw or will see your first Medicare patient at this practice location *(mm/dd/yyyy)*

Is your private practice location reported above located in a:

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

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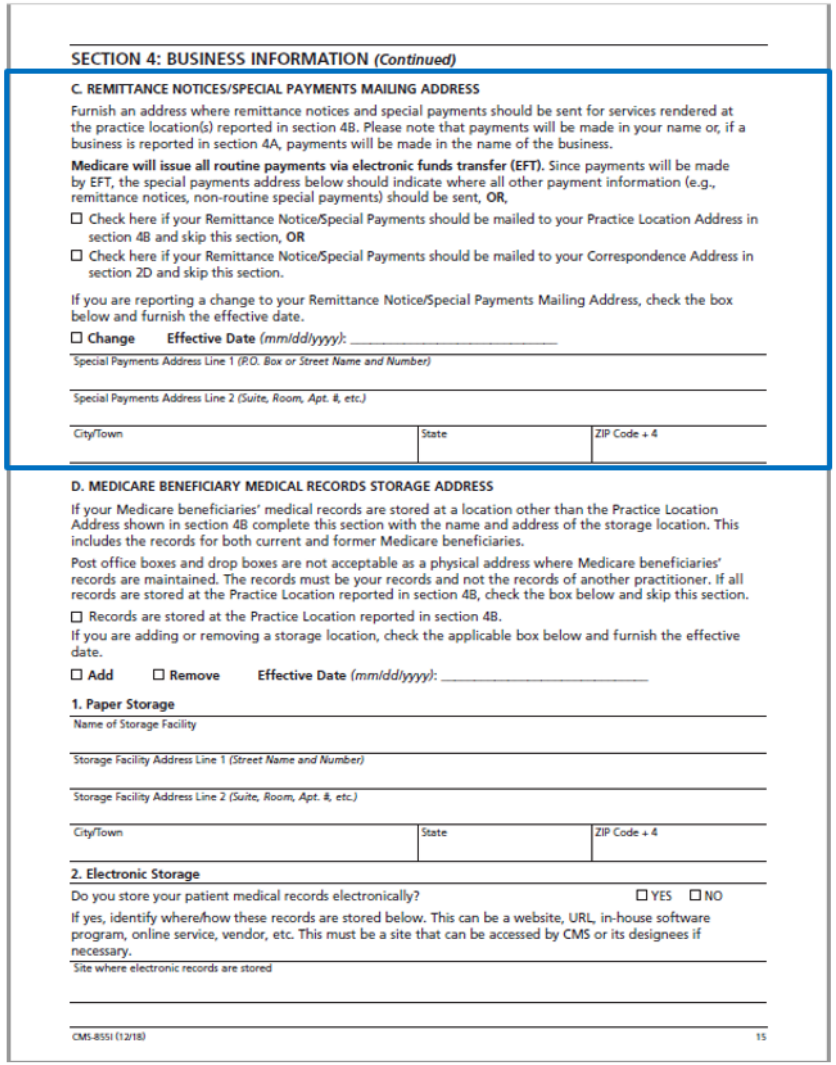
- B: Practice Location Information
  - Copy and complete section for each practice location where services are rendered
  - List all NPIs and PTANs associated
  - Indicate if primary practice location
  - If change, add or remove, furnish effective date
  - Add new location, supply date first saw Medicare patient

Private Practice

Section 4: Business Information



SECTION 4: BUSINESS INFORMATION *(Continued)*

C. REMITTANCE NOTICES/SPECIAL PAYMENTS MAILING ADDRESS

Furnish an address where remittance notices and special payments should be sent for services rendered at the practice location(s) reported in section 4B. Please note that payments will be made in your name or, if a business is reported in section 4A, payments will be made in the name of the business.

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

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

☐ Check here if your Remittance Notice/Special Payments should be mailed to your Correspondence Address in section 2D and skip this section.

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

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

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

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

City/Town | State | ZIP Code + 4

D. MEDICARE BENEFICIARY MEDICAL RECORDS STORAGE ADDRESS

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

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

☐ Records are stored at the Practice Location reported in section 4B.

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

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

1. Paper Storage

Name of Storage Facility

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

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

City/Town | State | ZIP Code + 4

2. Electronic Storage

Do you store your patient medical records electronically? ☐ YES ☐ NO

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

Site where electronic records are stored

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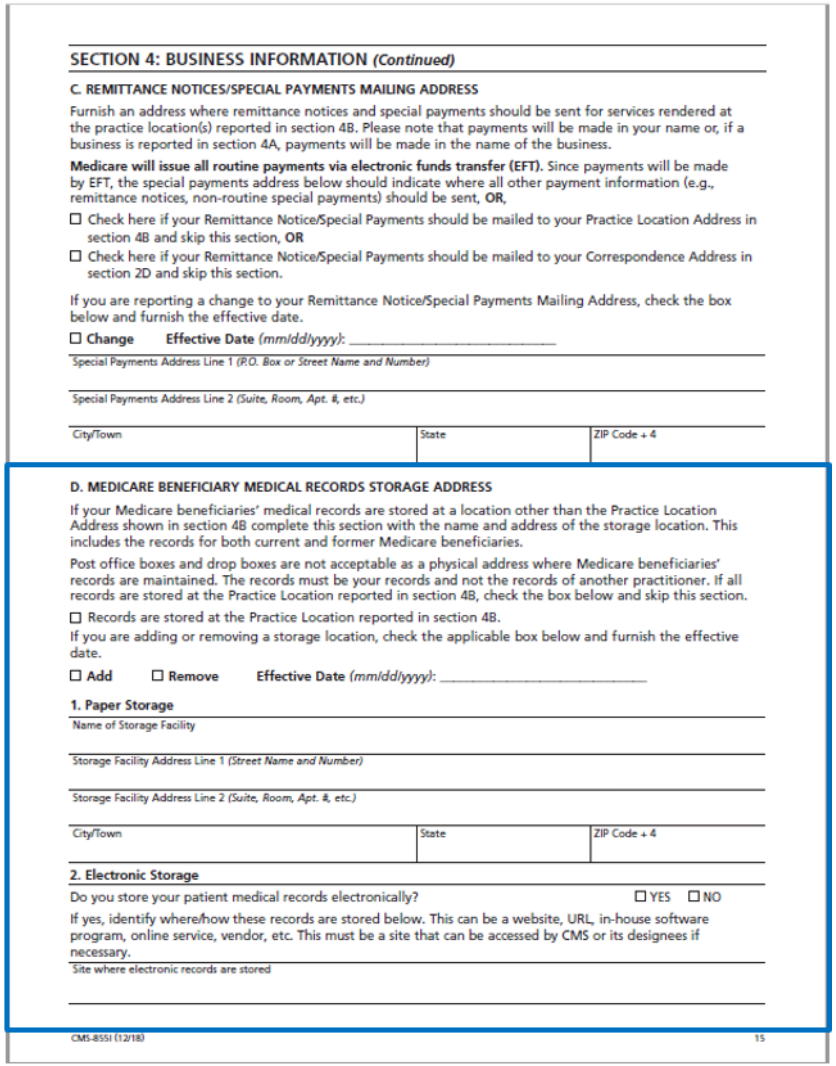
- C: Remittance Notices / Special Payments Mailing Address
  - Check the appropriate "special payments" box and follow instructions
  - If change, furnish effective date and special payment address

Private Practice

Section 4: Business Information



SECTION 4: BUSINESS INFORMATION *(Continued)*

C. REMITTANCE NOTICES/SPECIAL PAYMENTS MAILING ADDRESS

Furnish an address where remittance notices and special payments should be sent for services rendered at the practice location(s) reported in section 4B. Please note that payments will be made in your name or, if a business is reported in section 4A, payments will be made in the name of the business.

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

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

☐ Check here if your Remittance Notice/Special Payments should be mailed to your Correspondence Address in section 2D and skip this section.

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

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

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

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

City/Town | State | ZIP Code + 4

D. MEDICARE BENEFICIARY MEDICAL RECORDS STORAGE ADDRESS

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

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

☐ Records are stored at the Practice Location reported in section 4B.

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

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

1. Paper Storage

Name of Storage Facility

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

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

City/Town | State | ZIP Code + 4

2. Electronic Storage

Do you store your patient medical records electronically? ☐ YES ☐ NO

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

Site where electronic records are stored

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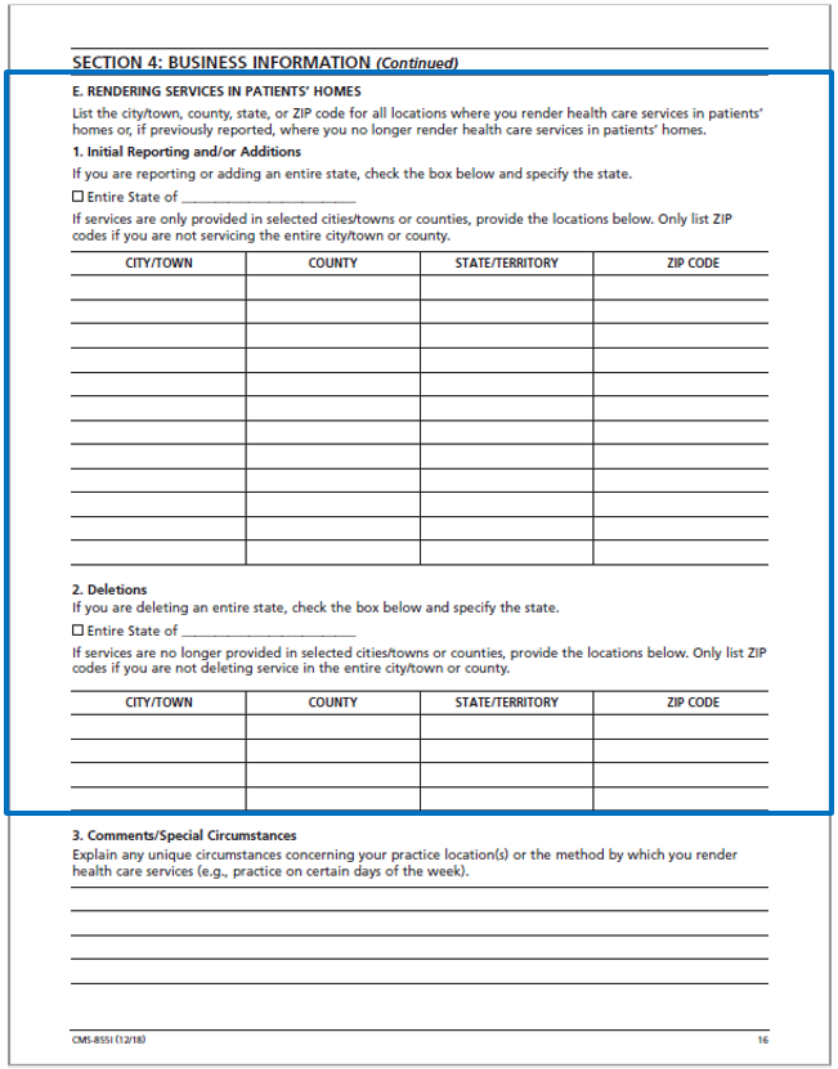
- D: Medicare Beneficiary Medical Records Storage Address
  - Check box if stored at practice location
  - Paper Storage
    - Address cannot be P.O. Box/Drop Box
  - Electronic Storage
    - Example: EPIC
  - If add or remove, furnish effective date

Private Practice

Section 4: Business Information



SECTION 4: BUSINESS INFORMATION *(Continued)*

E. RENDERING SERVICES IN PATIENTS' HOMES

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

1. Initial Reporting and/or Additions

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

☐ Entire State of _____

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

CITY/TOWN	COUNTY	STATE/TERRITORY	ZIP CODE

2. Deletions

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

☐ Entire State of _____

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

CITY/TOWN	COUNTY	STATE/TERRITORY	ZIP CODE

3. Comments/Special Circumstances

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

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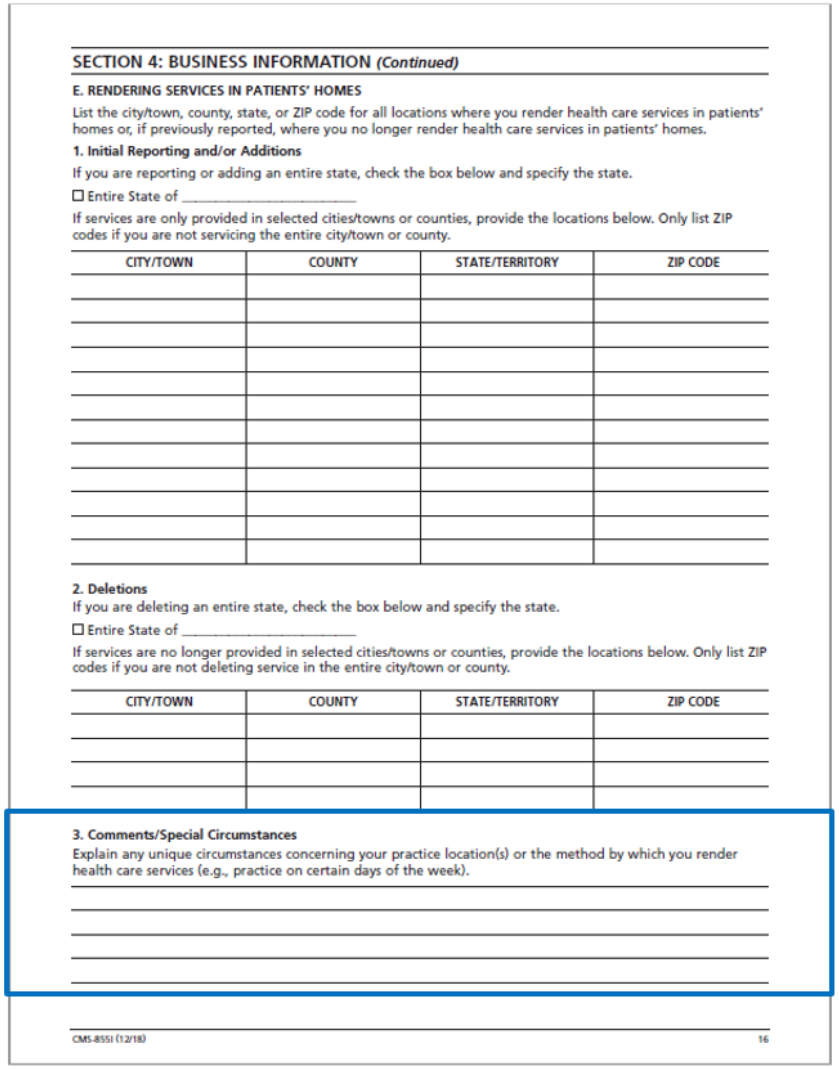
- E: Rendering Services in Patients' Homes
  - 1. Initial Reporting and/or Additions
    - Indicate entire state or city/town, county and/or zip codes
  - 2. Deletions
    - Indicate areas deleting from existing enrollment

Private Practice

Section 4: Business Information



SECTION 4: BUSINESS INFORMATION *(Continued)*

E. RENDERING SERVICES IN PATIENTS' HOMES

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

1. Initial Reporting and/or Additions

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

☐ Entire State of _____

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

CITY/TOWN	COUNTY	STATE/TERRITORY	ZIP CODE

2. Deletions

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

☐ Entire State of _____

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

CITY/TOWN	COUNTY	STATE/TERRITORY	ZIP CODE

3. Comments/Special Circumstances

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

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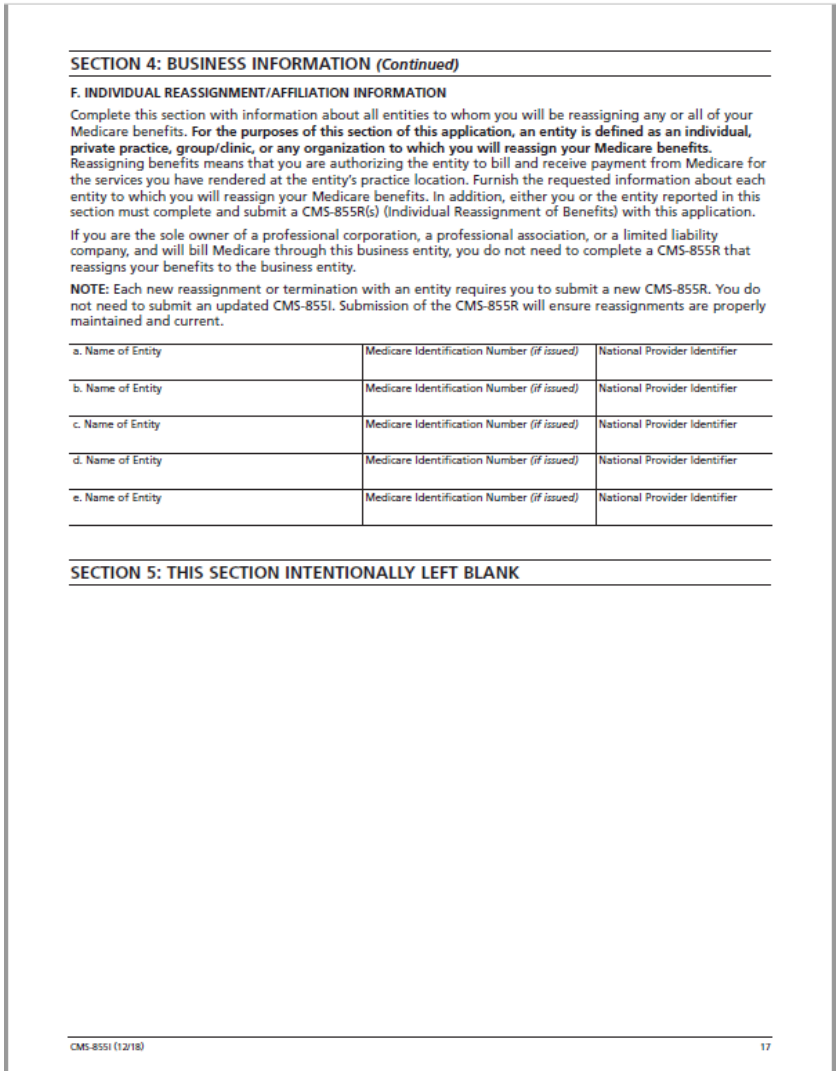
- E: Rendering Services in Patients' Homes
  - 3. Comments/Special Circumstances
    - Explain any unique circumstances concerning your practice location or the method by which you render health care services (e.g., house calls only)

Private Practice

Section 4: Business Information



SECTION 4: BUSINESS INFORMATION *(Continued)*

F. INDIVIDUAL REASSIGNMENT/AFFILIATION INFORMATION

Complete this section with information about all entities to whom you will be reassigning any or all of your Medicare benefits. **For the purposes of this section of this application, an entity is defined as an individual, private practice, group/clinic, or any organization to which you will reassign your Medicare benefits.** Reassigning benefits means that you are authorizing the entity to bill and receive payment from Medicare for the services you have rendered at the entity's practice location. Furnish the requested information about each entity to which you will reassign your Medicare benefits. In addition, either you or the entity reported in this section must complete and submit a CMS-855R(s) (Individual Reassignment of Benefits) with this application.

If you are the sole owner of a professional corporation, a professional association, or a limited liability company, and will bill Medicare through this business entity, you do not need to complete a CMS-855R that reassigns your benefits to the business entity.

NOTE: Each new reassignment or termination with an entity requires you to submit a new CMS-855R. You do not need to submit an updated CMS-855I. Submission of the CMS-855R will ensure reassignments are properly maintained and current.

a. Name of Entity	Medicare Identification Number *(if issued)*	National Provider Identifier
b. Name of Entity	Medicare Identification Number *(if issued)*	National Provider Identifier
c. Name of Entity	Medicare Identification Number *(if issued)*	National Provider Identifier
d. Name of Entity	Medicare Identification Number *(if issued)*	National Provider Identifier
e. Name of Entity	Medicare Identification Number *(if issued)*	National Provider Identifier

SECTION 5: THIS SECTION INTENTIONALLY LEFT BLANK

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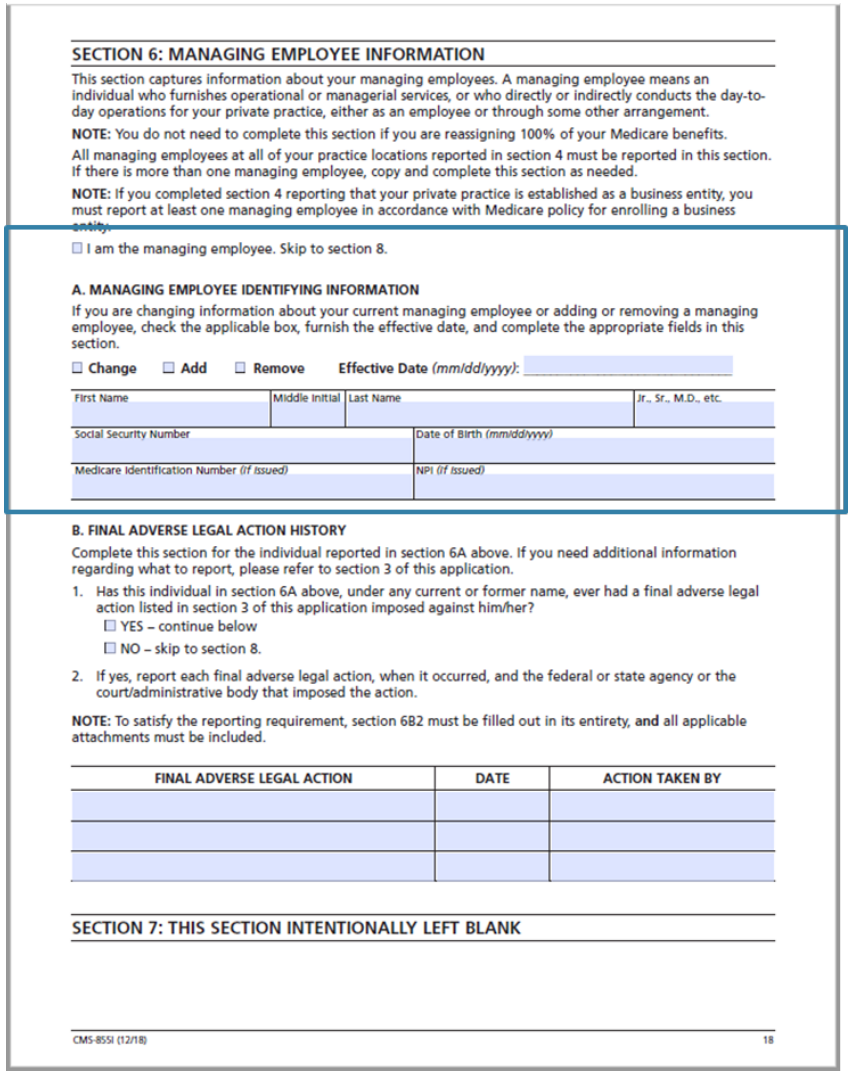
- F: Individual Reassignment/Affiliation Information
  - Complete with all entities to whom you reassign any or all of your Medicare benefits
    - If reassigning all benefits, proceed to Section 12

Section 6: Managing Employee Information



SECTION 6: MANAGING EMPLOYEE INFORMATION

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

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

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

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

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

A. MANAGING EMPLOYEE IDENTIFYING INFORMATION

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

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

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

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

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

B. FINAL ADVERSE LEGAL ACTION HISTORY

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

1. Has this individual in section 6A above, under any current or former name, ever had a final adverse legal action listed in section 3 of this application imposed against him/her?
   - ☐ YES – continue below
   - ☐ NO – skip to section 8.
2. If yes, report each final adverse legal action, when it occurred, and the federal or state agency or the court/administrative body that imposed the action.

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

FINAL ADVERSE LEGAL ACTION	DATE	ACTION TAKEN BY

SECTION 7: THIS SECTION INTENTIONALLY LEFT BLANK

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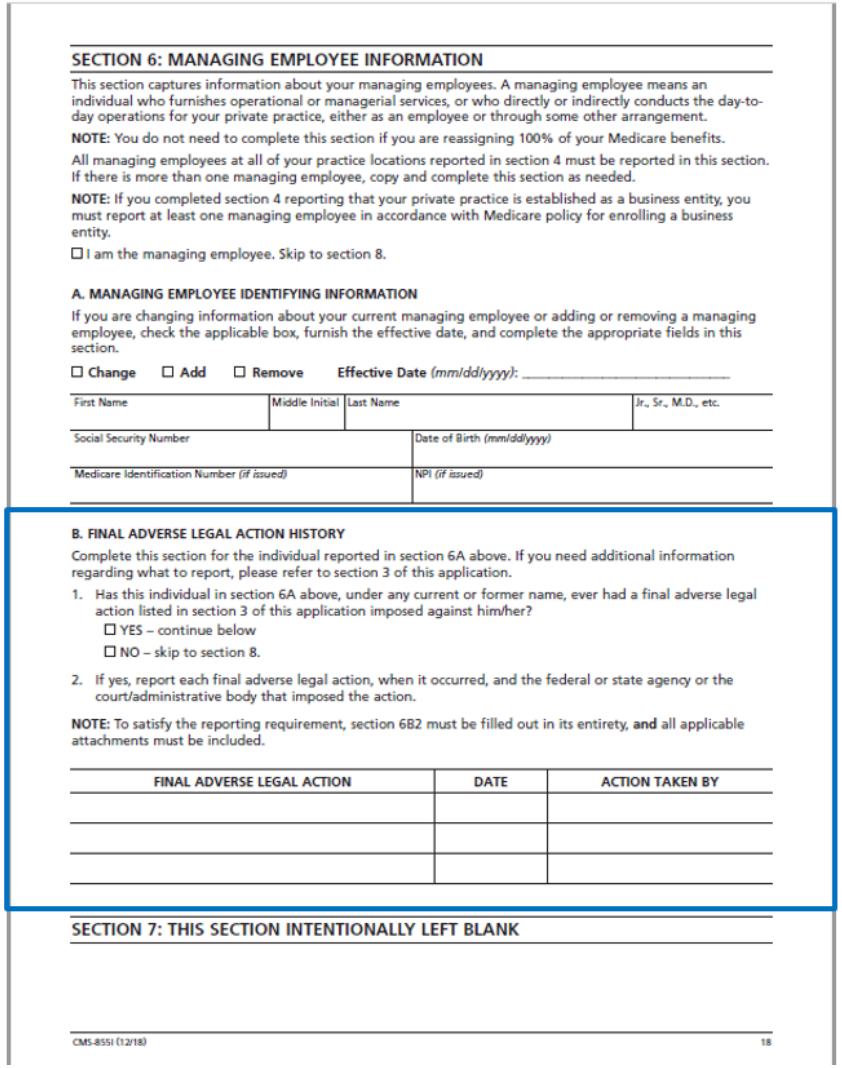
- Check the appropriate box if you are the managing employee for your Sole Owned entity or Sole Proprietorship
- A: Managing Employee Identifying Information
  - Complete for each managing employee from each of your practice locations
  - If add or remove, furnish effective date

Private Practice

Section 6: Managing Employee Information



SECTION 6: MANAGING EMPLOYEE INFORMATION

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

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

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

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

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

A. MANAGING EMPLOYEE IDENTIFYING INFORMATION

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

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

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

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

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

B. FINAL ADVERSE LEGAL ACTION HISTORY

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

1. Has this individual in section 6A above, under any current or former name, ever had a final adverse legal action listed in section 3 of this application imposed against him/her?
   - ☐ YES – continue below
   - ☐ NO – skip to section 8.
2. If yes, report each final adverse legal action, when it occurred, and the federal or state agency or the court/administrative body that imposed the action.

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

FINAL ADVERSE LEGAL ACTION	DATE	ACTION TAKEN BY

SECTION 7: THIS SECTION INTENTIONALLY LEFT BLANK

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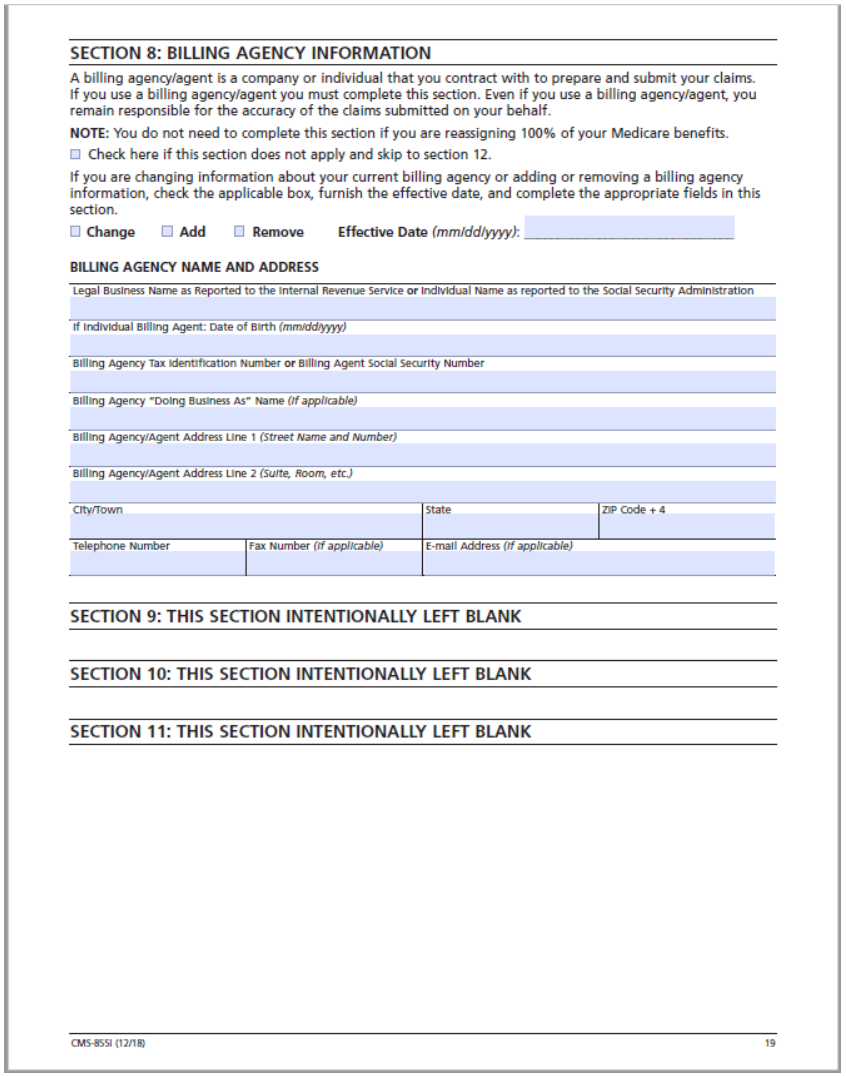
- B: Final Adverse Legal Action History
  - If no adverse legal action, check “No”
  - If any, check “Yes”, then list details in section B2 and attach final adverse legal action documentation and/or resolutions

Private Practice

Section 8: Billing Agency Information



SECTION 8: BILLING AGENCY INFORMATION

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

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

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

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

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

BILLING AGENCY NAME AND ADDRESS

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

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

Billing Agency Tax Identification Number **or** Billing Agent Social Security Number

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

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

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

City/Town	State	ZIP Code + 4

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

SECTION 9: THIS SECTION INTENTIONALLY LEFT BLANK

SECTION 10: THIS SECTION INTENTIONALLY LEFT BLANK

SECTION 11: THIS SECTION INTENTIONALLY LEFT BLANK

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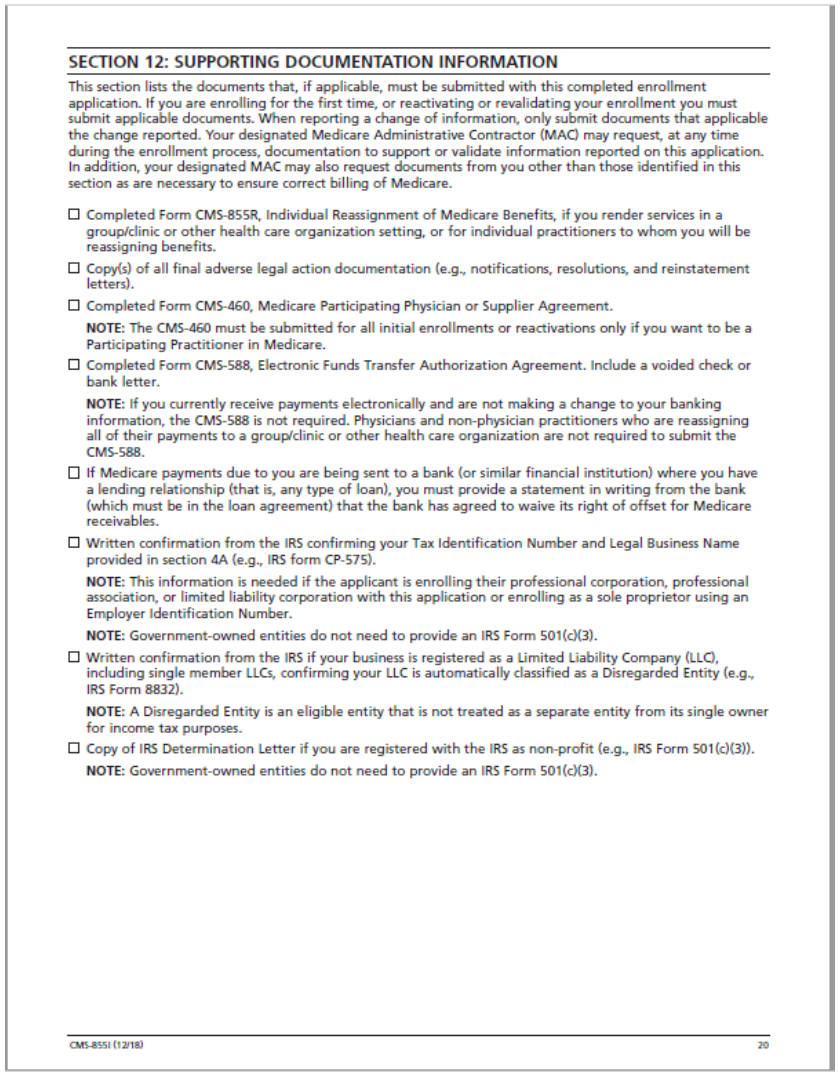
- Check box if section does not apply, otherwise furnish billing agency information
- If add or remove, furnish effective date

Note: Entities using a billing agency are responsible for claims submitted on their behalf

Private Practice

Section 12: Supporting Documentation Information



SECTION 12: SUPPORTING DOCUMENTATION INFORMATION

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

- ☐ Completed Form CMS-855R, Individual Reassignment of Medicare Benefits, if you render services in a group/clinic or other health care organization setting, or for individual practitioners to whom you will be reassigning benefits.
- ☐ Copy(s) of all final adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters).
- ☐ Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement.

  NOTE: The CMS-460 must be submitted for all initial enrollments or reactivations only if you want to be a Participating Practitioner in Medicare.
- ☐ Completed Form CMS-588, Electronic Funds Transfer Authorization Agreement. Include a voided check or bank letter.

  NOTE: If you currently receive payments electronically and are not making a change to your banking information, the CMS-588 is not required. Physicians and non-physician practitioners who are reassigning all of their payments to a group/clinic or other health care organization are not required to submit the CMS-588.
- ☐ If Medicare payments due to you are being sent to a bank (or similar financial institution) where you have a lending relationship (that is, any type of loan), you must provide a statement in writing from the bank (which must be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.
- ☐ Written confirmation from the IRS confirming your Tax Identification Number and Legal Business Name provided in section 4A (e.g., IRS form CP-575).

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

  NOTE: Government-owned entities do not need to provide an IRS Form 501(c)(3).
- ☐ Written confirmation from the IRS if your business is registered as a Limited Liability Company (LLC), including single member LLCs, confirming your LLC is automatically classified as a Disregarded Entity (e.g., IRS Form 8832).

  NOTE: A Disregarded Entity is an eligible entity that is not treated as a separate entity from its single owner for income tax purposes.
- ☐ Copy of IRS Determination Letter if you are registered with the IRS as non-profit (e.g., IRS Form 501(c)(3)).

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

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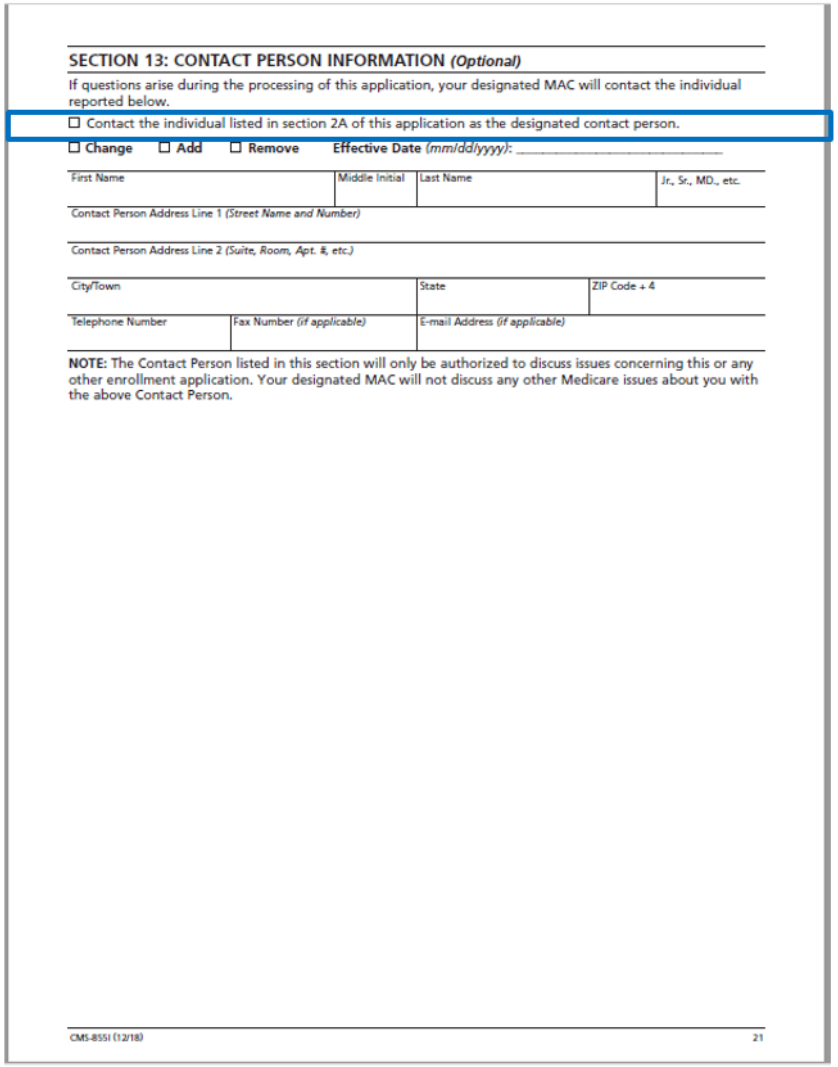
- Required documentation

Section 13: Contact Person Information



SECTION 13: CONTACT PERSON INFORMATION ***(Optional)***

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

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

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

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

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

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

City/Town	State	ZIP Code + 4

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

NOTE: The Contact Person listed in this section will only be authorized to discuss issues concerning this or any other enrollment application. Your designated MAC will not discuss any other Medicare issues about you with the above Contact Person.

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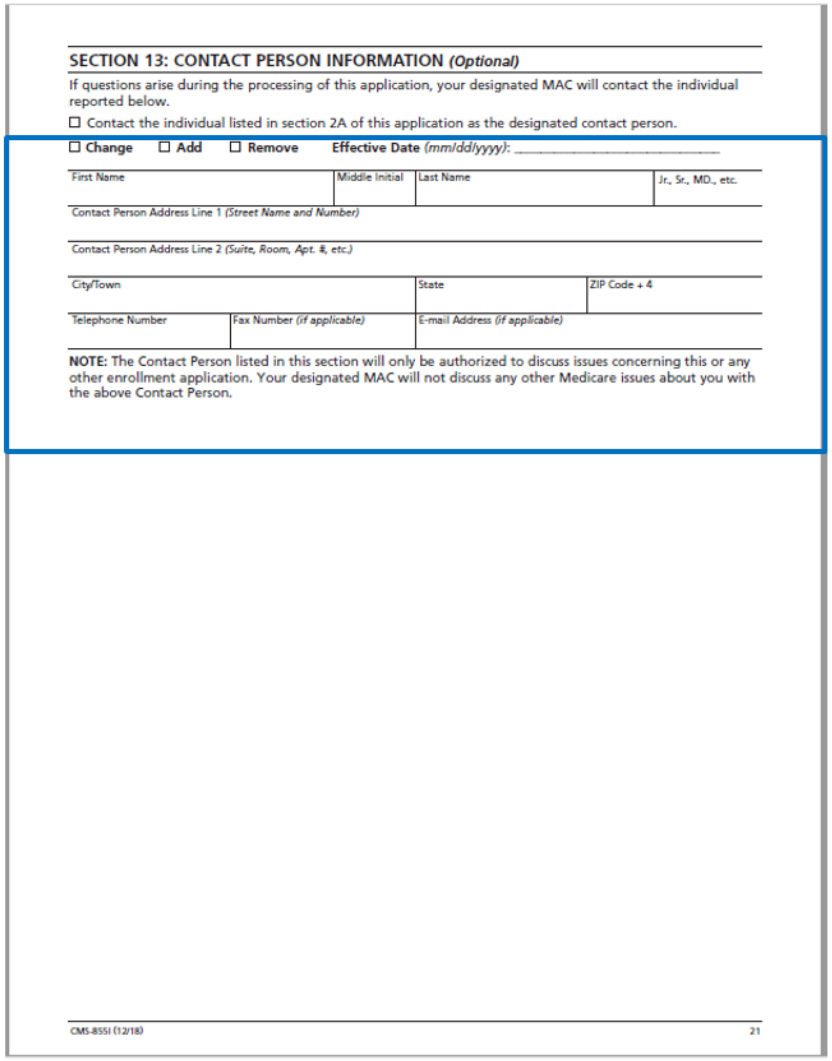
- Check the appropriate box if individual listed in section 2A is the designated contact person

Section 13: Contact Person Information



SECTION 13: CONTACT PERSON INFORMATION ***(Optional)***

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

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

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

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

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

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

City/Town	State	ZIP Code + 4

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

NOTE: The Contact Person listed in this section will only be authorized to discuss issues concerning this or any other enrollment application. Your designated MAC will not discuss any other Medicare issues about you with the above Contact Person.

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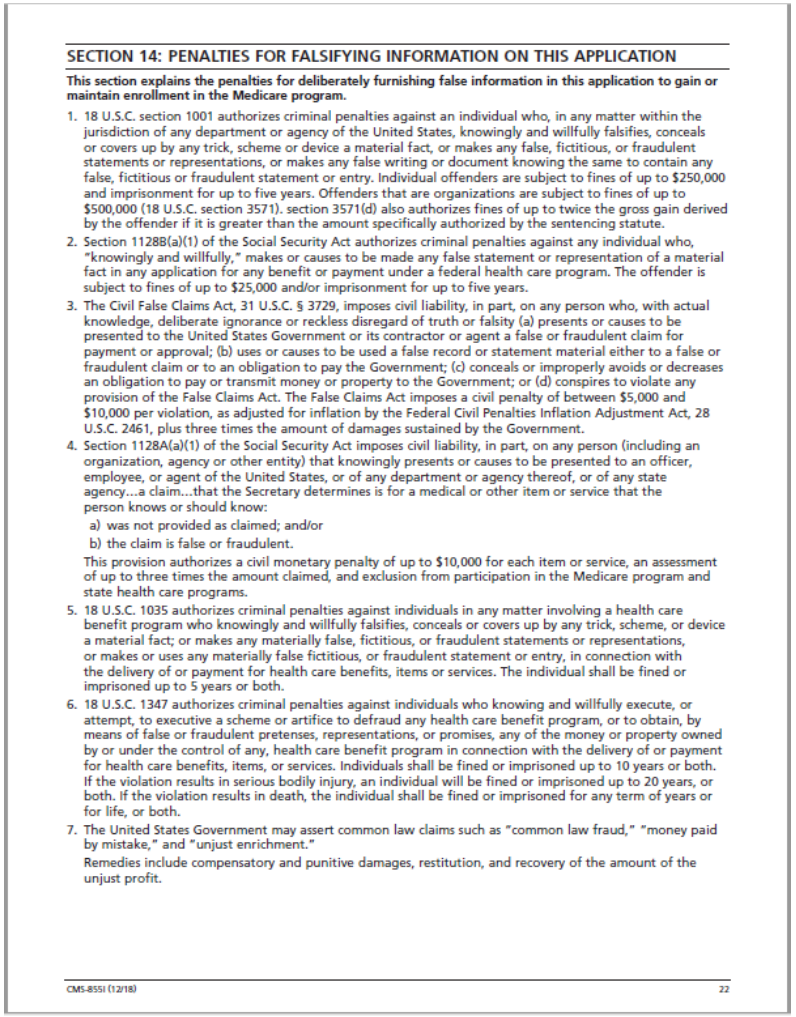
- Copy and complete section for each contact person
  - If add or remove, furnish effective date
  - Contact will be authorized to discuss issues concerning enrollment only
  - First contact person listed will receive acknowledge notice and be notified if any additional information is needed **by email**

Section 14: Penalties for Falsifying Information on this Application



SECTION 14: PENALTIES FOR FALSIFYING INFORMATION ON THIS APPLICATION

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

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

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

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

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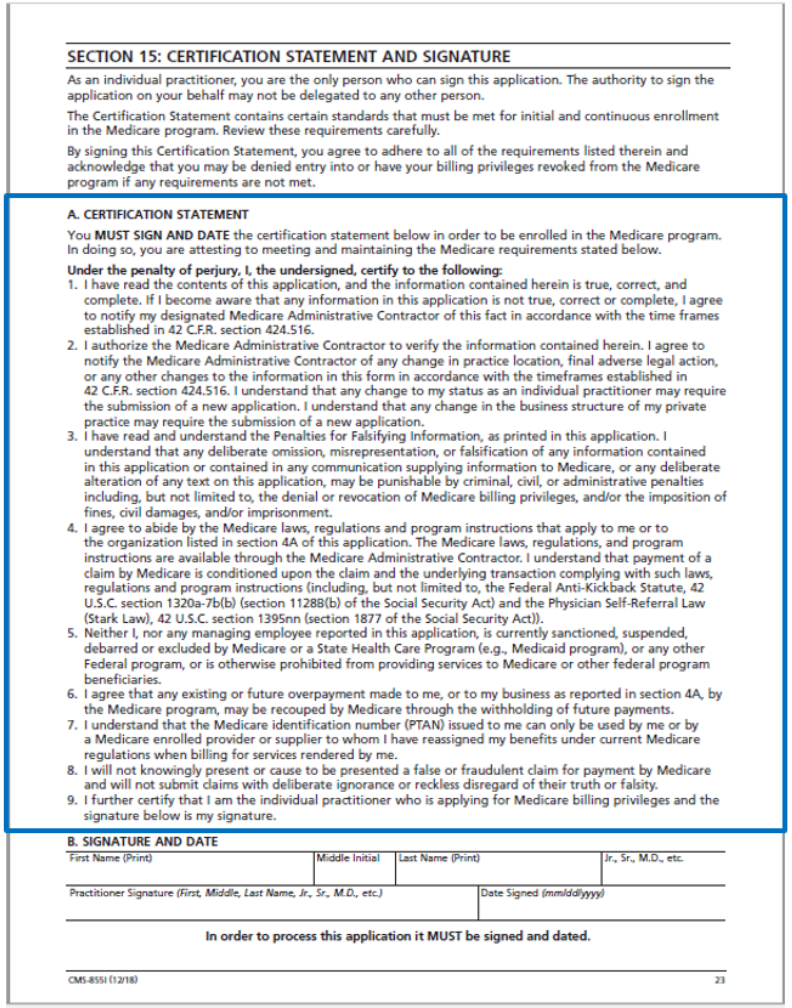
- Explains penalties for deliberately falsifying information on this application to gain or maintain enrollment in the Medicare Program

Section 15: Certification Statement and Signature



SECTION 15: CERTIFICATION STATEMENT AND SIGNATURE

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

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

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

A. CERTIFICATION STATEMENT

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

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

1. I have read the contents of this application, and the information contained herein is true, correct, and complete. If I become aware that any information in this application is not true, correct or complete, I agree to notify my designated Medicare Administrative Contractor of this fact in accordance with the time frames established in 42 C.F.R. section 424.516.
2. I authorize the Medicare Administrative Contractor to verify the information contained herein. I agree to notify the Medicare Administrative Contractor of any change in practice location, final adverse legal action, or any other changes to the information in this form in accordance with the timeframes established in 42 C.F.R. section 424.516. I understand that any change to my status as an individual practitioner may require the submission of a new application. I understand that any change in the business structure of my private practice may require the submission of a new application.
3. I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this application, may be punishable by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare billing privileges, and/or the imposition of fines, civil damages, and/or imprisonment.
4. I agree to abide by the Medicare laws, regulations and program instructions that apply to me or to the organization listed in section 4A of this application. The Medicare laws, regulations, and program instructions are available through the Medicare Administrative Contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations and program instructions (including, but not limited to, the Federal Anti-Kickback Statute, 42 U.S.C. section 1320a-7b(b) (section 1128B(b) of the Social Security Act) and the Physician Self-Referral Law (Stark Law), 42 U.S.C. section 1395nn (section 1877 of the Social Security Act)).
5. Neither I, nor any managing employee reported in this application, is currently sanctioned, suspended, debarred or excluded by Medicare or a State Health Care Program (e.g., Medicaid program), or any other Federal program, or is otherwise prohibited from providing services to Medicare or other federal program beneficiaries.
6. I agree that any existing or future overpayment made to me, or to my business as reported in section 4A, by the Medicare program, may be recouped by Medicare through the withholding of future payments.
7. I understand that the Medicare identification number (PTAN) issued to me can only be used by me or by a Medicare enrolled provider or supplier to whom I have reassigned my benefits under current Medicare regulations when billing for services rendered by me.
8. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.
9. I further certify that I am the individual practitioner who is applying for Medicare billing privileges and the signature below is my signature.

B. SIGNATURE AND DATE

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

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

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

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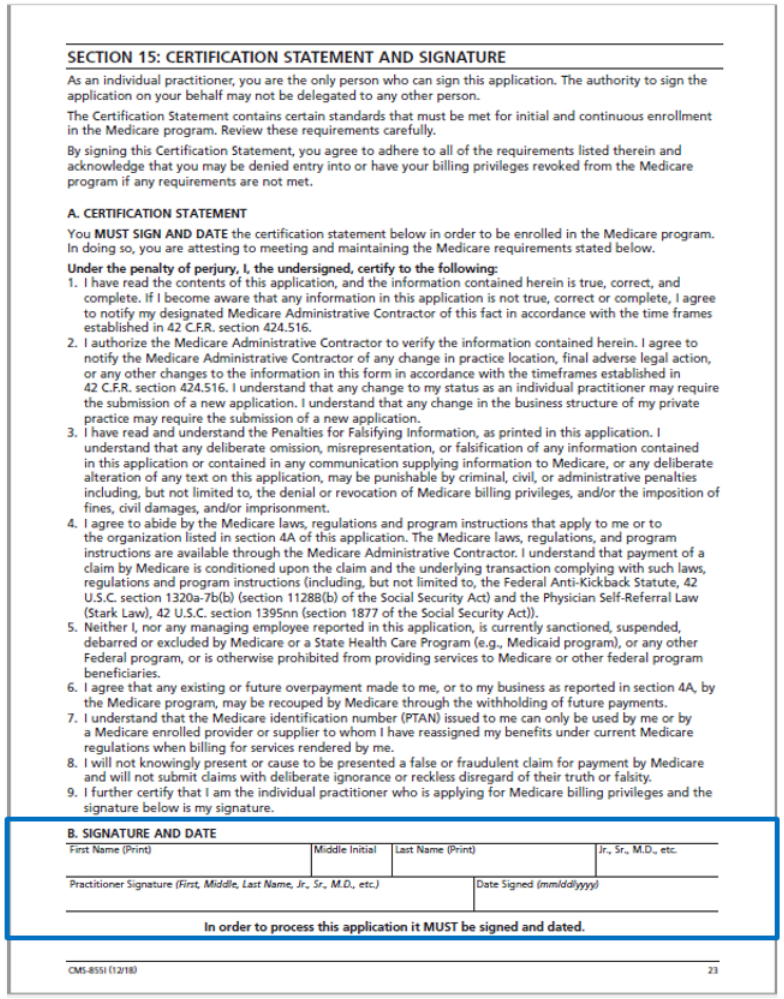
- A: Certification Statement
  - Medicare requirements providers must meet and maintain in order to bill Medicare
  - By signing the form the individual provider agrees to adhere to the requirements listed

Section 15: Certification Statement and Signature



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4. I agree to abide by the Medicare laws, regulations and program instructions that apply to me or to the organization listed in section 4A of this application. The Medicare laws, regulations, and program instructions are available through the Medicare Administrative Contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations and program instructions (including, but not limited to, the Federal Anti-Kickback Statute, 42 U.S.C. section 1320a-7b(b) (section 1128B(b) of the Social Security Act) and the Physician Self-Referral Law (Stark Law), 42 U.S.C. section 1395nn (section 1877 of the Social Security Act)).
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7. I understand that the Medicare identification number (PTAN) issued to me can only be used by me or by a Medicare enrolled provider or supplier to whom I have reassigned my benefits under current Medicare regulations when billing for services rendered by me.
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9. I further certify that I am the individual practitioner who is applying for Medicare billing privileges and the signature below is my signature.

B. SIGNATURE AND DATE

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

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

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- B: Signature and Date
  - Signed only by the Individual provider
  - Must be original signature in ink
  - Stamped signatures are not acceptable

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

MEDICARE SUPPLIER ENROLLMENT APPLICATION PRIVACY ACT STATEMENT

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

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

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

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

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

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

PRA Disclosure Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1355 (Expires 12/2021). The time required to complete this information collection is estimated to average 0.5 – 3 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to:
CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

******CMS Disclosure**** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please visit http://www.cms.gov/MedicareProviderSupEnroll.**

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Supporting Documentation

Supporting Documentation

- The following key documents are required when applicable
  - CMS-588 Electronic Funds Transfer Authorization Agreement and voided check or bank letter
  - IRS CP-575, IRS 147C or other written IRS document with legal business name and TIN or EIN confirmation
  - National certification
  - Final adverse legal action documentation and resolution

Process After Submission

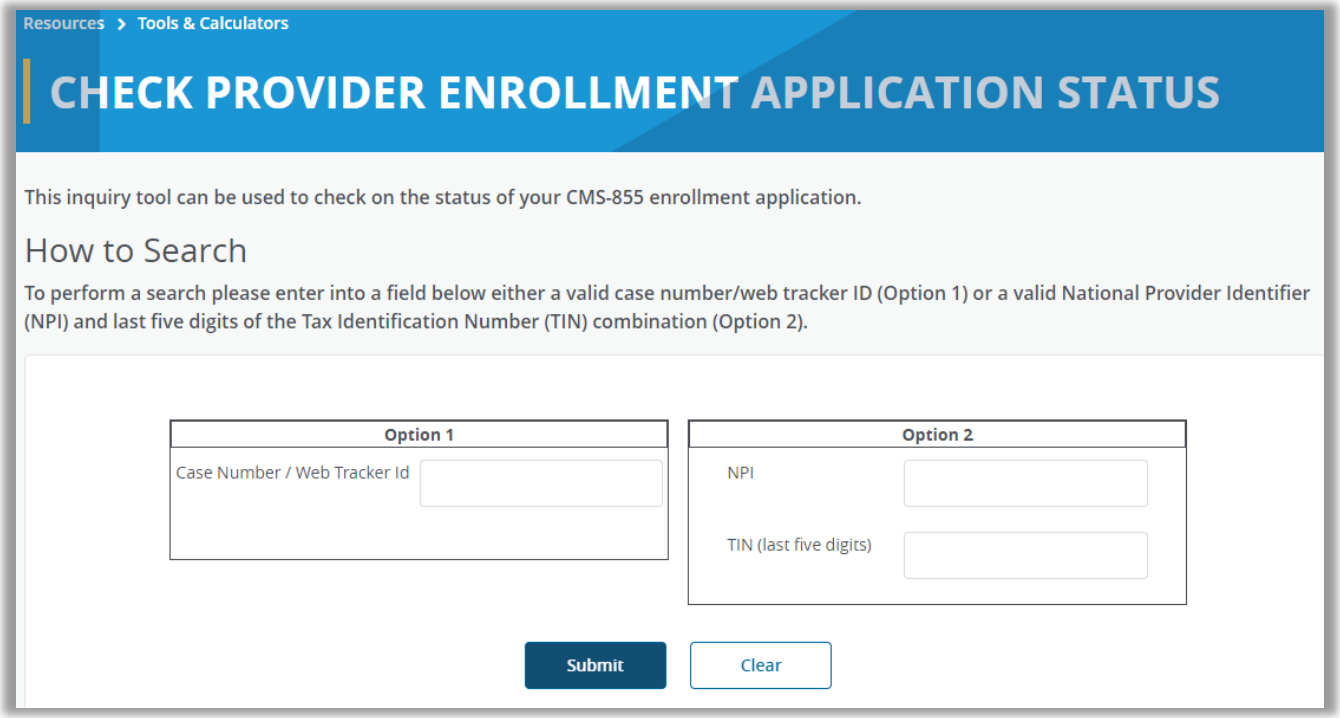
Process After Submission

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

Check Application Status

Check Application Status

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

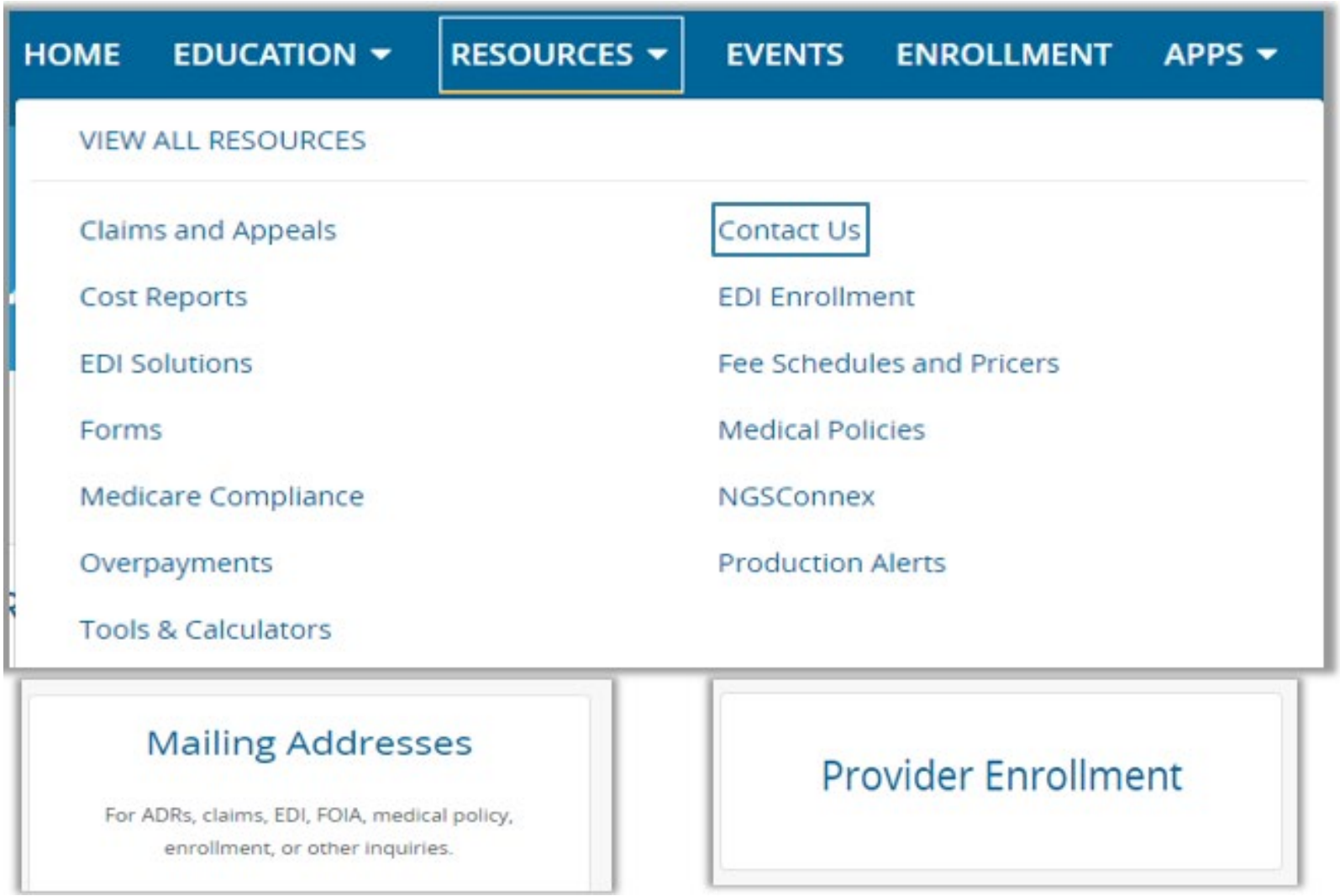


Check Application Status

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

Resources

NGSMedicare.com



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?

Follow us