How to Complete the Paper CMS-855B Enrollment Application for an ASC

Provider Outreach and Education

Published June 2012
119961

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

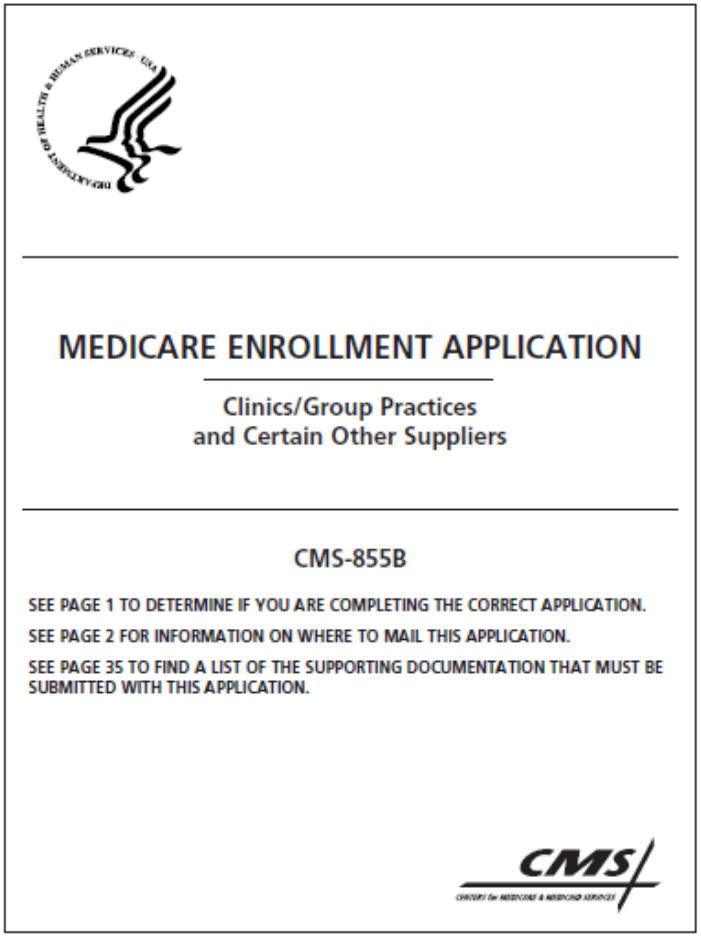
Important

The information contained in this presentation was current as of May 2012. Provider enrollment information can be found on the TrailBlazer Provider Enrollment Web page at:

http://www.trailblazerhealth.com/Provider Enrollment

CMS-855B Enrollment Application

This presentation was developed by the Provider Outreach and Education department, along with the Provider Enrollment department, to assist new Ambulatory Surgery Center (ASC) providers with correctly completing the CMS-855B enrollment application.



MEDICARE ENROLLMENT APPLICATION

Clinics/Group Practices
and Certain Other Suppliers

CMS-855B

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

SEE PAGE 2 FOR INFORMATION ON WHERE TO MAIL THIS APPLICATION.

SEE PAGE 35 TO FIND A LIST OF THE SUPPORTING DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION.

CMS

ASC Required Enrollment Forms

ASC facilities enroll with a federal tax ID. If a physician or non-physician practitioner wishes to reassign his benefits to an ASC, both the individual and the ASC must sign Form CMS-855R. The forms needed for new enrollment are:

- CMS-855B (Organization Enrollment form).
- CMS-855R if applicable (Reassignment of Benefits).
- CMS-855I if applicable (Provider Enrollment form).
- CMS-588 (Electronic Funds Transfer (EFT) form).
- CMS-460 if applicable (Participating Provider Agreement form).

ASC – Additional Documents Required for Enrollment

- Licenses, certifications and registrations required by Medicare or state law.
- Federal, state and/or local business licenses, certifications and/or registrations to operate a health care facility.
- Written confirmation from the Internal Revenue Service (IRS) confirming your Tax Identification Number (TIN) with the legal business name (e.g., IRS CP575 form).

ASC – Additional Documents Required for Enrollment (If Applicable)

- Copy of IRS Determination Letter (if registered with the IRS as non-profit).
- Written confirmation from IRS confirming the Limited Liability Company (LLC) is automatically classified as a disregarded entity (Form 8832).
- Statement in writing from the bank (if bank loan agreement states bank has waived right of offset for Medicare receivables).
- Copies of all adverse action documentation (notifications, resolutions and reinstatement letters).
- Copy of an attestation for government entities and tribal organizations.

Obtaining the CMS-855B Application

The current version of the 855B application should be used. The application will be used as a guide throughout this job aid. Please take a moment to print the application.

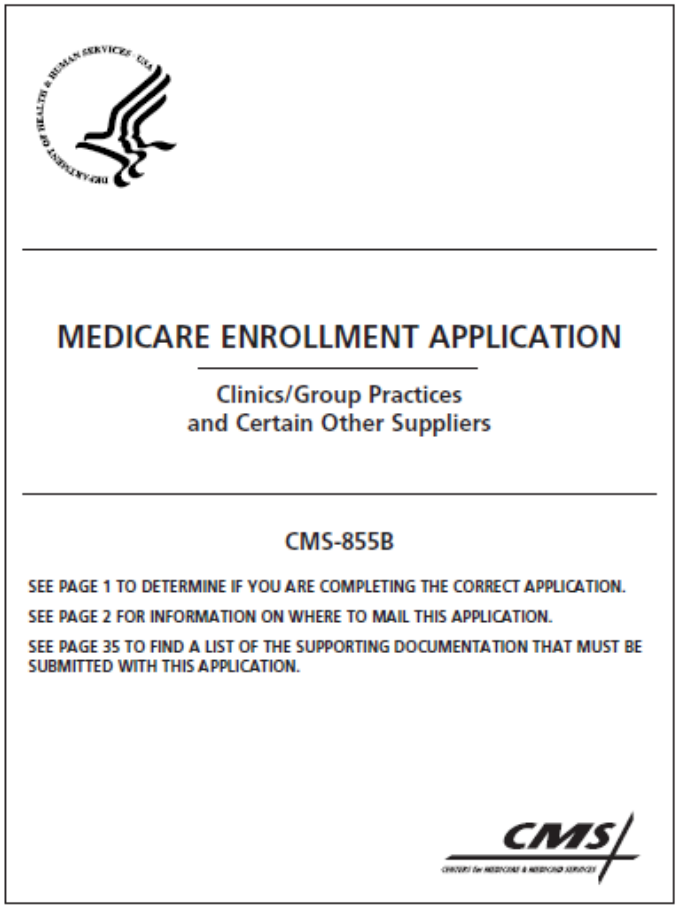
The current version of this form can be obtained from the CMS Web site at:

http://www.cms.gov/CMSforms/downloads/cms855b.pdf.

It can also be found on the TrailBlazer Web site at:

http://www.trailblazerhealth.com/ProviderEnrollment/PartBGettingStarted.aspx.

Note: The current version has "(07/11)" in the footer of the form.



MEDICARE ENROLLMENT APPLICATION

Clinics/Group Practices
and Certain Other Suppliers

CMS-855B

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

SEE PAGE 2 FOR INFORMATION ON WHERE TO MAIL THIS APPLICATION.

SEE PAGE 35 TO FIND A LIST OF THE SUPPORTING DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION.

CMS

Effective January 1, 2012, only the 07/11 version of the CMS-855B application will be accepted.

Internet-Based PECOS

When enrolling, providers have the option of using:

- Internet-based Provider Enrollment, Chain and Ownership System (PECOS).
  Or,
- Standard 855 paper enrollment.

Using Internet-based PECOS is easy!

Internet-based PECOS allows physicians and non-physicians to enroll, make changes in their enrollment or view their Medicare enrollment information. Internet-based PECOS has the following benefits:

- Faster than paper-based enrollment.
- Scenario-driven application process.
- Built-in help screens.

Additional information about Internet-based PECOS can be located at:

http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp

Enrollment Application Fee

CMS implemented an enrollment application fee for providers and suppliers who are initially enrolling in Medicare, adding a practice location or revalidating their enrollment information.

- Effective for applications received on or after March 25, 2011.
- The fee must be submitted with the application.

  And/or,

- A request for a hardship exception to the fee may be submitted with the application.

Additional information relating to the application fee can be found in the CMS MLN Matters® article MM7350 at:

http://www.cms.gov/MLNMattersArticles/downloads/MM7350.pdf

Enrollment Application Fee (Cont.)

- The application fee does not apply to:
  - Physicians.
  - Non-physician practitioners.
  - Physician organizations.
  - Non-physician organizations.
- All institutional providers of medical or other items of services or suppliers must pay the application fee.
- The fee can vary from year to year based on adjustments to the Consumer Price Index for Urban Areas (CPI-U).
- Medicare and CMS will consider the financial hardship waiver/exception on a case-by-case basis. Providers must request hardship consideration along with the application.

Enrollment Application Fee (Cont.)

- The application fee can be paid in one of two ways:
  - US Department of Treasury (all providers other than Indian Health Service (IHS)). https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do
  - Intra-Governmental Payment and Collection System (IPAC) (IHS providers will use). http://www.fms.treas.gov/ipac/index.html
- Providers are encouraged to make a copy of the receipt confirmation screen, retain a copy for the office documentation, and submit a copy to Medicare along with the certification statement and other appropriate supporting documentation.
- CMS has provided a tool to determine if the application fee applies. This tool can be viewed on the CMS Web site at:

  http://www.cms.gov/MedicareProviderSupEnroll/Downloads/ApplicationFeeRequirementMatrix.pdf.

Instructions for Completing and Submitting an 855B Application

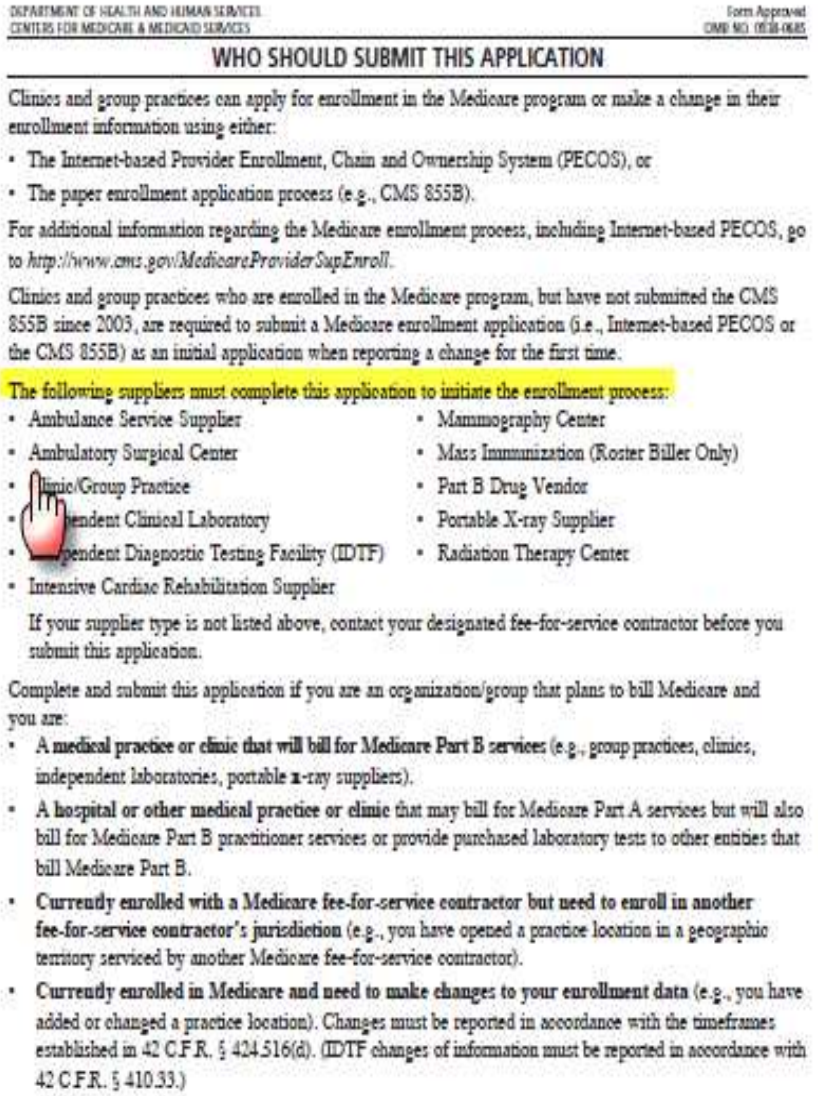
- Type or print all information so it is legible.
- Do not use pencil.
- Report additional information within a section by copying and completing that section for each individual entry.
- Attach all required supporting documentation.
- Keep a copy of your completed Medicare enrollment package for your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

The following slides will denote the page number from the 855 application.

Who Should Submit This Application

This section assists in determining whether the 855B is the correct application for the type of provider.

ASC providers will complete the 855B.



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

Form Approved
OMB NO. 0938-0685

WHO SHOULD SUBMIT THIS APPLICATION

Clinics and group practices can apply for enrollment in the Medicare program or make a change in their enrollment information using either:

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

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

Clinics and group practices who are enrolled in the Medicare program, but have not submitted the CMS 855B since 2003, are required to submit a Medicare enrollment application (i.e., Internet-based PECOS or the CMS 855B) as an initial application when reporting a change for the first time.

The following suppliers must complete this application to initiate the enrollment process:

- Ambulance Service Supplier
- Ambulatory Surgical Center
- Clinic/Group Practice
- Independent Clinical Laboratory
- Independent Diagnostic Testing Facility (IDTF)
- Intensive Cardiac Rehabilitation Supplier
- Mammography Center
- Mass Immunization (Roster Biller Only)
- Part B Drug Vendor
- Portable X-ray Supplier
- Radiation Therapy Center

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

Complete and submit this application if you are an organization/group that plans to bill Medicare and you are:

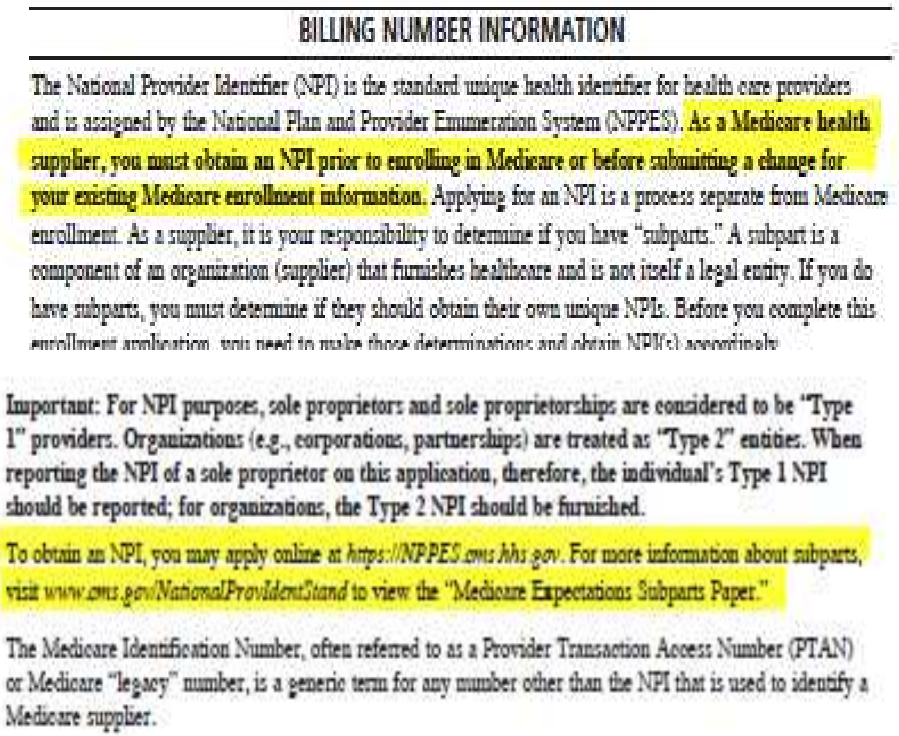
- **A medical practice or clinic that will bill for Medicare Part B services** (e.g., group practices, clinics, independent laboratories, portable x-ray suppliers).
- **A hospital or other medical practice or clinic** that may bill for Medicare Part A services but will also bill for Medicare Part B practitioner services or provide purchased laboratory tests to other entities that bill Medicare Part B.
- **Currently enrolled with a Medicare fee-for-service contractor but need to enroll in another fee-for-service contractor's jurisdiction** (e.g., you have opened a practice location in a geographic territory serviced by another Medicare fee-for-service contractor).
- **Currently enrolled in Medicare and need to make changes to your enrollment data** (e.g., you have added or changed a practice location). Changes must be reported in accordance with the timeframes established in 42 C.F.R. § 424.516(d). (IDTF changes of information must be reported in accordance with 42 C.F.R. § 410.33.)

Billing Number Information

Providers must first obtain a National Provider Identifier (NPI) before enrolling in Medicare.

An NPI number can be obtained from the CMS Web site at: https://nppes.cms.hhs.gov/.

The NPI number is required for enrollment.



BILLING NUMBER INFORMATION

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

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

To obtain an NPI, you may apply online at *https://NPPES.cms.hhs.gov*. For more information about subparts, visit *www.cms.gov/NationalProvIdentStand* to view the "Medicare Expectations Subparts Paper."

The Medicare Identification Number, often referred to as a Provider Transaction Access Number (PTAN) or Medicare "legacy" number, is a generic term for any number other than the NPI that is used to identify a Medicare supplier.

Pages 1 & 2

Section 1: Basic Information

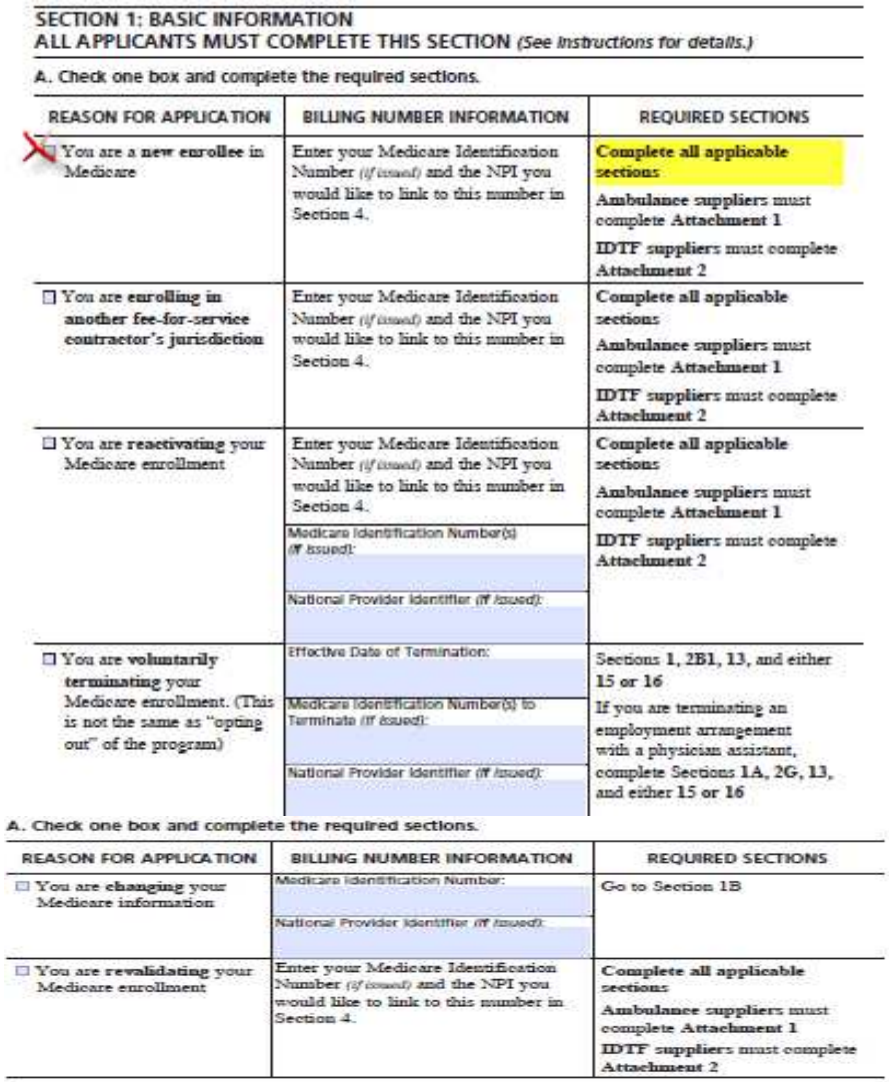
Complete the form in **blue** or **black** ink. **Do not use pencil.**

Section 1A

This section captures information about why the application is being completed.

Select “new enrollee” to indicate a **new** ASC provider enrolling in Medicare.

Complete **all** applicable application sections.



SECTION 1: BASIC INFORMATION
ALL APPLICANTS MUST COMPLETE THIS SECTION *(See instructions for details.)*

A. Check one box and complete the required sections.

REASON FOR APPLICATION	BILLING NUMBER INFORMATION	REQUIRED SECTIONS
☒ You are a **new enrollee** in Medicare	Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4.	**Complete all applicable sections** **Ambulance suppliers** must complete **Attachment 1** **IDTF suppliers** must complete **Attachment 2**
☐ You are **enrolling in another fee-for-service contractor's jurisdiction**	Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4.	**Complete all applicable sections** **Ambulance suppliers** must complete **Attachment 1** **IDTF suppliers** must complete **Attachment 2**
☐ You are **reactivating** your Medicare enrollment	Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4. Medicare Identification Number(s) *(If issued)*: National Provider Identifier *(If issued)*:	**Complete all applicable sections** **Ambulance suppliers** must complete **Attachment 1** **IDTF suppliers** must complete **Attachment 2**
☐ You are **voluntarily terminating** your Medicare enrollment. (This is not the same as "opting out" of the program)	Effective Date of Termination: Medicare Identification Number(s) to Terminate *(If issued)*: National Provider Identifier *(If issued)*:	Sections **1, 2B1, 13,** and either **15** or **16** If you are terminating an employment arrangement with a physician assistant, complete Sections **1A, 2G, 13,** and either **15** or **16**

A. Check one box and complete the required sections.

REASON FOR APPLICATION	BILLING NUMBER INFORMATION	REQUIRED SECTIONS
☐ You are **changing** your Medicare information	Medicare Identification Number: National Provider Identifier *(If issued)*:	Go to Section 1B
☐ You are **revalidating** your Medicare enrollment	Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4.	**Complete all applicable sections** **Ambulance suppliers** must complete **Attachment 1** **IDTF suppliers** must complete **Attachment 2**

Pages 4 & 5

Section 1: Basic Information (Cont.)

Section 1B

Section 1B of the application should not be completed for new ASC enrollees.

Section 1B, Attachments 1 and 2 should not be completed for new ASC enrollees.

These sections are for ambulance and Independent Diagnostic Testing Facilities (IDTFs) only.

Pages 6 & 7

SECTION 1: BASIC INFORMATION *(Continued)*

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

	REQUIRED SECTIONS
☐ Identifying Information	**1**, 2 (complete only those sections that are changing), **3**, **13**, and either **15** (if you are an authorized official) or **16** (if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier
☐ Final Adverse Actions/Convictions	**1**, **2B1**, **3**, **13**, and either **15** (if you are an authorized official) or **16** (if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier
☐ Practice Location Information, Payment Address & Medical Record Storage Information	**1**, **2B1**, **3**, **4** (complete only those sections that are changing), **13**, and either **15** (if you are an authorized official) or **16** (if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier
☐ Change of Ownership (Hospitals, Portable X-Ray Suppliers & Ambulatory Surgical Centers Only)	**Complete all sections and provide a copy of the sales agreement**
☐ Ownership Interest and/or Managing Control Information (Organizations)	**1**, **2B1**, **3**, **5**, **13**, and either **15** (if you are an authorized official) or **16** (if you are a delegated official), and **6** for the signer if that authorized or delegated official
☐ Ownership Interest and/or Managing Control Information (Individuals)	**1**,
☐ Billing Agency Information	**1**,
☐ Authorized Official(s)	**1**,
☐ Delegated Official(s) (Optional)	**1**,

ATTACHMENT 1: AMBULANCE SERVICE SUPPLIERS (ONLY)	REQUIRED SECTIONS
☐ Geographic Area	**1**, **2B1**, **3**, **13**, and **15** if you are the authorized official or **16** if you are the delegated official **Attachment 1(A)**
☐ State License Information	**1**, **2B1**, **3**, **13**, and **15** if you are the authorized official or **16** if you are the delegated official **Attachment 1(B)**
☐ Paramedic Intercept Services Information	**1**, **2B1**, **3**, **13**, and **15** if you are the authorized official or **16** if you are the delegated official **Attachment 1(C)**
☐ Vehicle Information	**1**, **2B1**, **3**, **13**, and **15** if you are the authorized official or **16** if you are the delegated official **Attachment 1(D)**

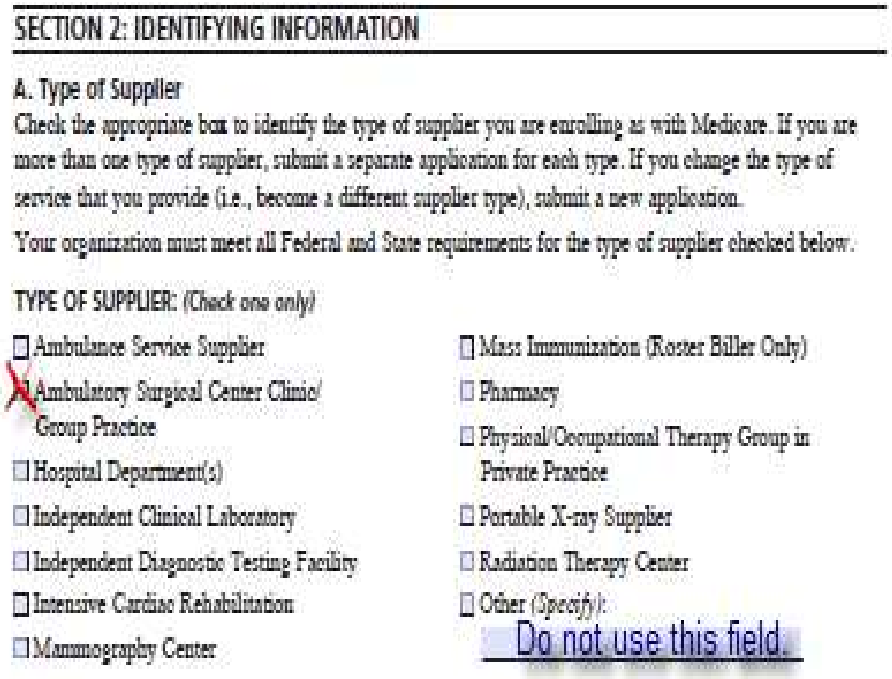
ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (ONLY)	REQUIRED SECTIONS
☐ CPT-4 and HCPCS Codes	**1**, **2B1**, **3**, **13**, and **15** if you are the authorized official or **16** if you are the delegated official **Attachment 2(B)**
☐ Interpreting Physician Information	**1**, **2B1**, **3**, **13**, and **15** if you are the authorized official or **16** if you are the delegated official **Attachment 2(C)**
☐ Personnel (Technicians) Who Perform Tests	**1**, **2B1**, **3**, **13**, and **15** if you are the authorized official or **16** if you are the delegated official **Attachment 2(D)**
☐ Supervising Physician(s)	**1**, **2B1**, **3**, **13**, and **15** if you are the authorized official or **16** if you are the delegated official **Attachment 2(E)**
☐ Liability Insurance Information	**1**, **2B1**, **3**, **13**, and **15** if you are the authorized official or **16** if you are the delegated official **Attachment 2(F)**

Section 2: Identifying Information

Section 2A

This section specifies the type of provider. ASC providers should only check “ASC.”

“Other (Specify):” should not be used.



SECTION 2: IDENTIFYING INFORMATION

A. Type of Supplier

Check the appropriate box to identify the type of supplier you are enrolling as with Medicare. If you are more than one type of supplier, submit a separate application for each type. If you change the type of service that you provide (i.e., become a different supplier type), submit a new application.

Your organization must meet all Federal and State requirements for the type of supplier checked below.

TYPE OF SUPPLIER: *(Check one only)*

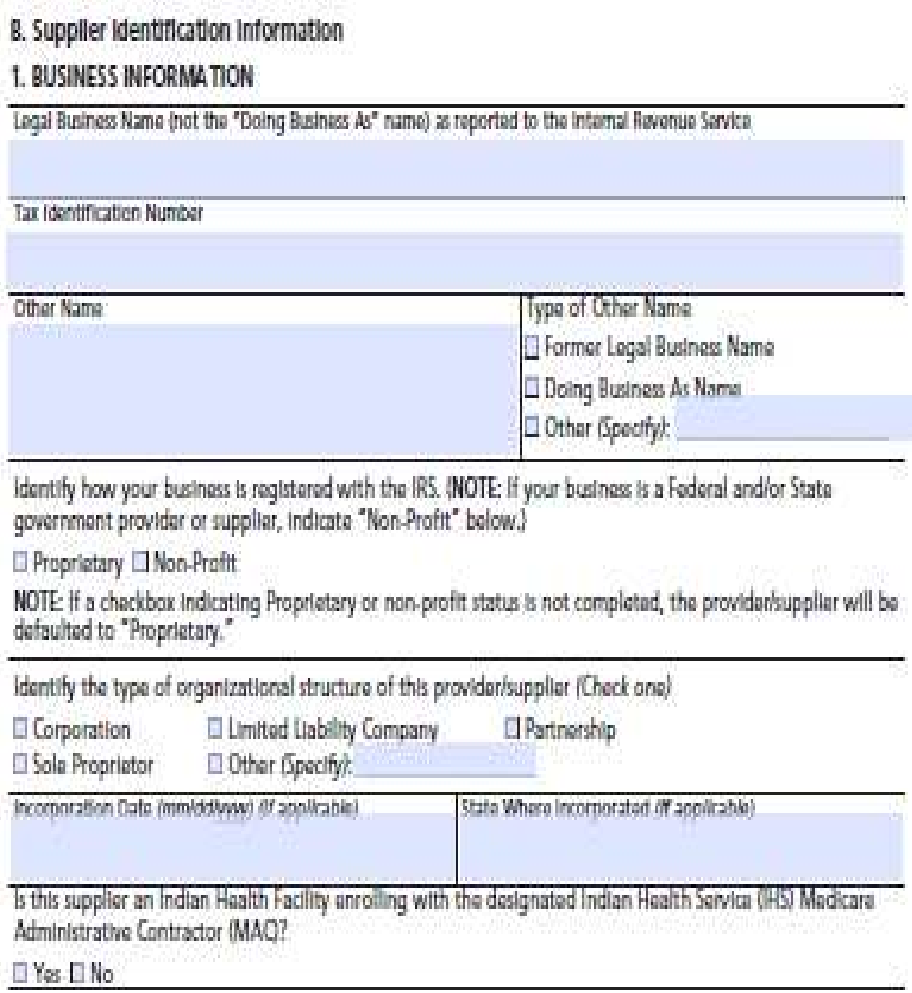
- ☐ Ambulance Service Supplier
- ☒ Ambulatory Surgical Center Clinic/ Group Practice
- ☐ Hospital Department(s)
- ☐ Independent Clinical Laboratory
- ☐ Independent Diagnostic Testing Facility
- ☐ Intensive Cardiac Rehabilitation
- ☐ Mammography Center
- ☐ Mass Immunization (Roster Biller Only)
- ☐ Pharmacy
- ☐ Physical/Occupational Therapy Group in Private Practice
- ☐ Portable X-ray Supplier
- ☐ Radiation Therapy Center
- ☐ Other *(Specify)*: Do not use this field.

Section 2: Identifying Information (Cont.)

Section 2B.1

Business Information – This section should reflect:

- The legal business name (must match the IRS tax document).
- TIN.
- Indicate how the business is registered with the IRS: proprietary or non-profit.
- If “corporation” is marked, include the incorporated date and the state.
- American Indian and/or Alaska Native facilities should check the “other” boxes in Section 2B. Specify either IHS or tribal facility.
- A new field asks whether this supplier is an Indian Health facility enrolling with the Medicare Administrative Contractor (MAC). “Yes” or “No” is required.



B. Supplier Identification Information

1. BUSINESS INFORMATION

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

Tax Identification Number

Other Name

Type of Other Name

☐ Former Legal Business Name

☐ Doing Business As Name

☐ Other (Specify):

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

☐ Proprietary ☐ Non-Profit

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

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

☐ Corporation ☐ Limited Liability Company ☐ Partnership

☐ Sole Proprietor ☐ Other (Specify):

Incorporation Date (mm/dd/yyyy) (If applicable)

State Where Incorporated (If applicable)

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

☐ Yes ☐ No

Section 2: Identifying Information (Cont.)

Section 2B.2

State License Information/ Certification Information –

- Identifies any state license or certification required to operate as the provider type for which you are enrolling.
- Remember to indicate if a state license/certification is “not applicable” for the type of provider enrolling.

2. STATE LICENSE INFORMATION/CERTIFICATION INFORMATION

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

☐ State License Not Applicable

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

Certification Information

☐ Certification Not Applicable

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

Section 2: Identifying Information (Cont.)

Section 2B.3

Correspondence Address – This section should reflect the correspondence address for the entity that was listed in Section 2B.1.

Only one correspondence address will be populated in PECOS for each tax ID.

This address cannot be a billing agency.

3. CORRESPONDENCE ADDRESS

Provide contact information for the entity or person listed in Question 1 of this section. Once enrolled, the information provided below will be used by the fee-for-service contractor if it needs to contact you directly. This address cannot be a billing agency's address.

Mailing Address Line 1 (Street Name and Number)		
Mailing Address Line 2 (Suite, Room, etc.)		
City/Town	State	ZIP Code + 4
Telephone Number	Fax Number (If applicable)	E-mail Address (If applicable)

Section 2: Identifying Information (Cont.)

Section 2C

This section is only for hospitals needing a Medicare Part B billing number for a specific department.

ASC facilities do not meet the criteria; skip to Section 2D.

C. Hospitals Only

This section should only be completed by hospitals that are currently enrolled or enrolling with a fee-fo service contractor (the Part A Medicare contractor), and will be billing a fee-for-service contractor for Medicare Part B services, as follows:

- Hospitals that need departmental billing numbers to bill for Part B practitioner services.
- Hospitals requiring a Part B billing number to provide pathology services.
- Hospitals requiring a Medicare Part B billing number to provide purchased tests to other Medicare Part B billers.
- If the hospital requires more than one departmental Part B billing number, list each department needing a number.

If your organization is not a hospital, and believes it will need a Part B billing number, contact the designated fee-for-service contractor to determine if this form should be submitted.

C. Hospitals Only *(Continued)*

NOTE: If your hospital is enrolling a clinic that is not provider-based, do not complete this section.

Check ☐ "Clinic/Group Practice" in Section 2A and complete this entire application for the clinic.

1. Are you going to:
   ☐ bill for the entire hospital with one billing number? (If yes, continue to Section 2D.)
   ☐ separately bill for each hospital department? (If yes, answer Question 2.)
2. List the hospital departments for which you plan to bill separately:

DEPARTMENT	MEDICARE IDENTIFICATION NUMBER	NPI

Pages 9 & 10

Section 2: Identifying Information (Cont.)

Section 2D

In this section, include any comments that will help explain information provided in Section 2.

Section 2E

This section is not required for ASC organizations.

D. Comments/Special Circumstances

Explain any unique circumstances concerning your practice location, the method by which you render health care services, etc.

An example might be: Indian Health clinic with no assigned street address.

The clinic is located one mile east of County Road XXX and Highway XXX.

E. Physical Therapy (PT) and Occupational Therapy (OT) Groups Only

1. Are all of the group's PT/OT services rendered in patients' homes or in the group's private office space?	☐ YES	☐ NO
2. Does this group maintain private office space?	☐ YES	☐ NO
3. Does this group own, lease, or rent its private office space?	☐ YES	☐ NO
4. Is this private office space used exclusively for the group's private practice?	☐ YES	☐ NO
5. Does this group provide PT/OT services outside of its office and/or patients' homes?	☐ YES	☐ NO

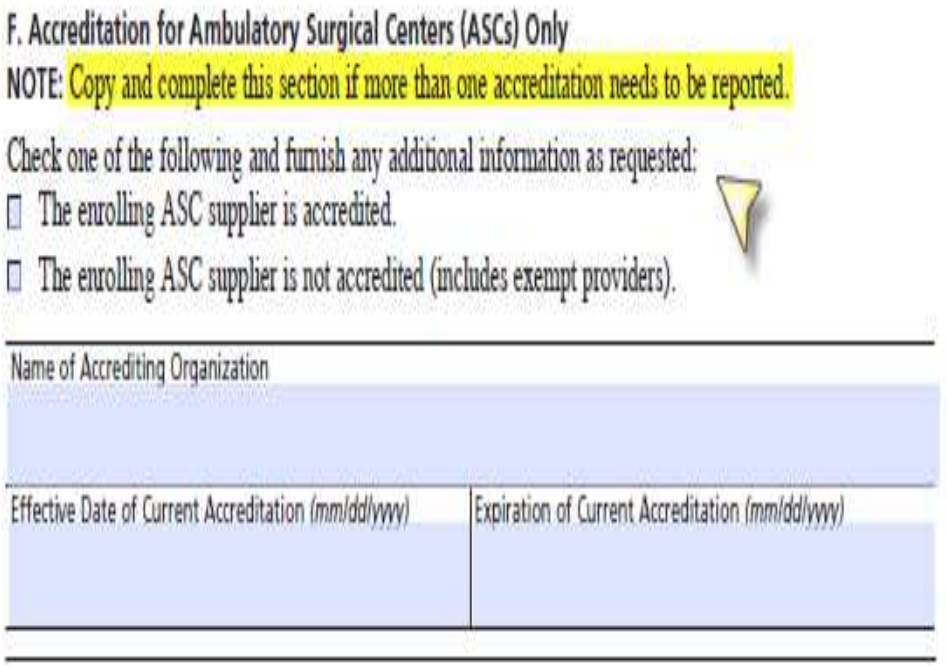
If you responded YES to any of the questions 2–5 above, submit a copy of the lease agreement that gives the group exclusive use of the facilities for PT/OT services.

Section 2: Identifying Information (Cont.)

Section 2F

Select to indicate whether or not the ASC is accredited.

If the ASC is accredited, list the name of the accrediting organization, the effective date of accreditation and the expiration date (if applicable).



F. Accreditation for Ambulatory Surgical Centers (ASCs) Only

NOTE: Copy and complete this section if more than one accreditation needs to be reported.

Check one of the following and furnish any additional information as requested:

☐ The enrolling ASC supplier is accredited.

☐ The enrolling ASC supplier is not accredited (includes exempt providers).

Name of Accrediting Organization	
Effective Date of Current Accreditation *(mm/dd/yyyy)*	Expiration of Current Accreditation *(mm/dd/yyyy)*

Section 2: Identifying Information (Cont.)

Section 2G

This section is for physician assistants and is not required for new ASC enrollees.

Section 2H

This section is for IDTFs and is not required for new ASC enrollees.

G. Termination of Physician Assistants *(Only)*

Complete this section to delete employed physician assistants from your group or clinic.

EFFECTIVE DATE OF DEPARTURE	PHYSICIAN ASSISTANT'S NAME	PHYSICIAN ASSISTANT'S MEDICARE IDENTIFICATION NUMBER	PHYSICIAN ASSISTANT'S NPI

H. Advanced Diagnostic Imaging (ADI) Suppliers Only

This section must be completed by all suppliers that also furnish and will bill Medicare for ADI services. All suppliers furnishing ADI services MUST be accredited in each ADI Modality checked below to qualify to bill Medicare for those services.

Check each ADI modality this supplier will furnish and the name of the Accrediting Organization that accredited that ADI Modality for this supplier.

☐ **Magnetic Resonance Imaging (MRI)**

Name of Accrediting Organization for MRI

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

☐ **Computed Tomography (CT)**

Name of Accrediting Organization for CT

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

☐ **Nuclear Medicine (NM)**

Name of Accrediting Organization for NM

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

☐ **Positron Emission Tomography (PET)**

Name of Accrediting Organization for PET

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

Section 3: Adverse Actions/Convictions

Section 3

This section is used to report all past or present legal convictions, exclusions, revocations and suspensions, **regardless** of whether the record has been expunged or an appeal is pending within the last 10 years.

Page 12 provides a list of reportable actions.

SECTION 3: FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS

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

Convictions

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

Exclusions, Revocations, or Suspensions

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

Section 3: Adverse Actions/Convictions (Cont.)

Section 3 (Cont.)

Providers **must** answer question 1.

If the answer is “Yes” for question 1, proceed to question 2.

Question 2 should reflect the adverse legal action, date, taken by and the resolution.

Failure to supply this information could result in a Medicare provider number(s) not being issued to new providers.

FINAL ADVERSE HISTORY

1. Has your organization, under any current or former name or business identity, ever had any of the final adverse actions listed on page 13 of this application imposed against it?

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

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

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

FINAL ADVERSE ACTION	DATE	TAKEN BY	RESOLUTION

Page 12 of the 855B provides a list of reportable actions.

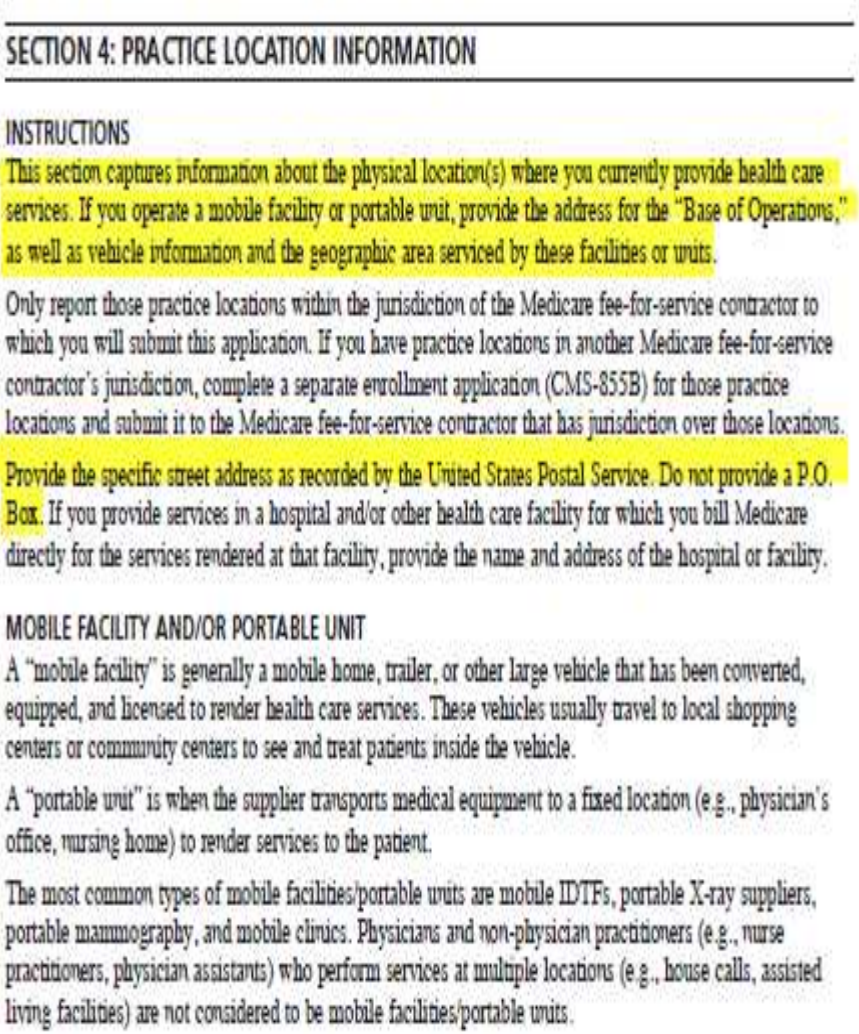
Section 4: Practice Location Information

Section 4

This section must include information about where the group or organization provides health care services. Provide the specific street address as recorded by the U.S. Postal Service. **Do not provide a P.O. box in this section.**

Section 4 will identify where the medical records are stored and the address for remittance notices and special payments.

All providers are required to complete this section.



SECTION 4: PRACTICE LOCATION INFORMATION

INSTRUCTIONS

This section captures information about the physical location(s) where you currently provide health care services. If you operate a mobile facility or portable unit, provide the address for the "Base of Operations," as well as vehicle information and the geographic area serviced by these facilities or units.

Only report those practice locations within the jurisdiction of the Medicare fee-for-service contractor to which you will submit this application. If you have practice locations in another Medicare fee-for-service contractor's jurisdiction, complete a separate enrollment application (CMS-855B) for those practice locations and submit it to the Medicare fee-for-service contractor that has jurisdiction over those locations.

Provide the specific street address as recorded by the United States Postal Service. Do not provide a P.O. Box. If you provide services in a hospital and/or other health care facility for which you bill Medicare directly for the services rendered at that facility, provide the name and address of the hospital or facility.

MOBILE FACILITY AND/OR PORTABLE UNIT

A "mobile facility" is generally a mobile home, trailer, or other large vehicle that has been converted, equipped, and licensed to render health care services. These vehicles usually travel to local shopping centers or community centers to see and treat patients inside the vehicle.

A "portable unit" is when the supplier transports medical equipment to a fixed location (e.g., physician's office, nursing home) to render services to the patient.

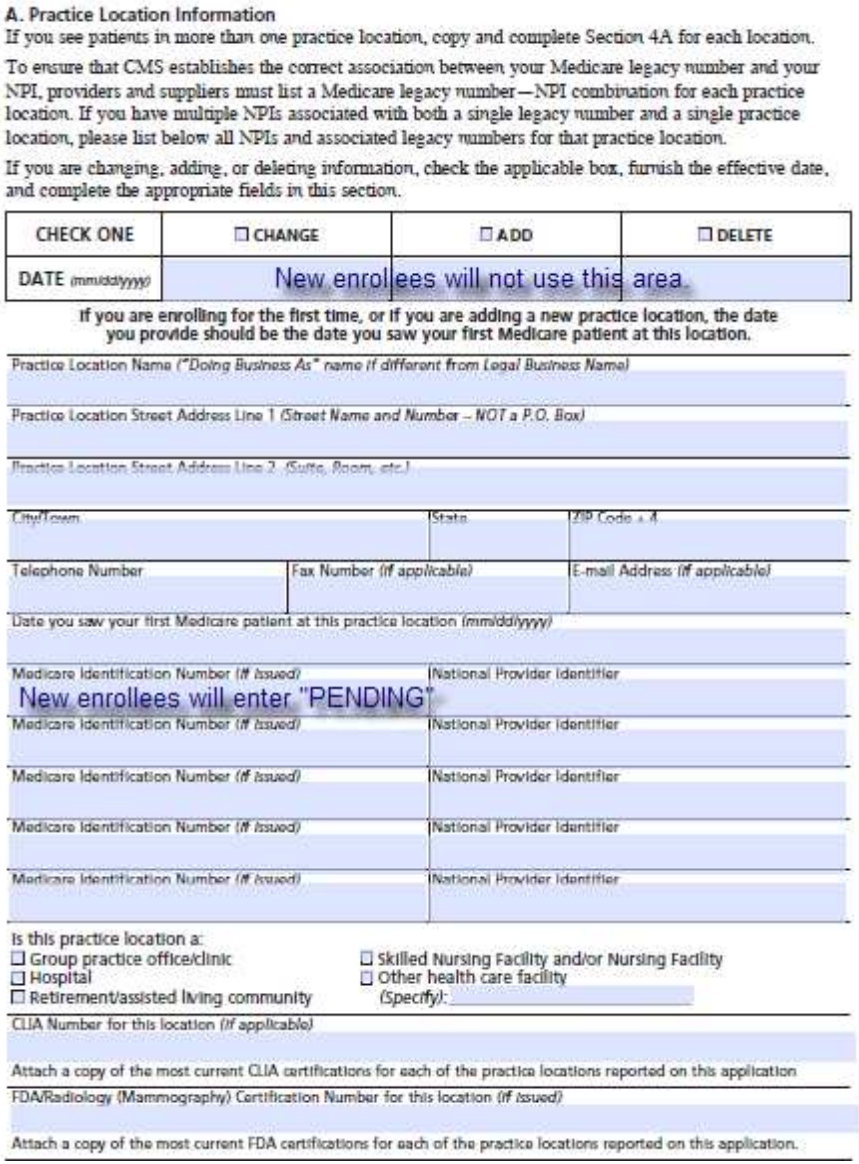
The most common types of mobile facilities/portable units are mobile IDTFs, portable X-ray suppliers, portable mammography, and mobile clinics. Physicians and non-physician practitioners (e.g., nurse practitioners, physician assistants) who perform services at multiple locations (e.g., house calls, assisted living facilities) are not considered to be mobile facilities/portable units.

Section 4: Practice Location Information (Cont.)

Section 4A

- Provide the practice location name used in everyday operations in Section 4A.
- Enter the full street number, city, state and nine-digit ZIP code. **Do not list P.O. boxes.**
- List the telephone number for the physical location. A fax number or e-mail address is not required, but welcomed.
- American Indian and/or Alaska Native clinics with no street address should list "General Delivery" or "Main Street" as the address.

Note: If the building/facility is new, you are encouraged to submit proof of the address such as: a copy of a utility bill, the lease agreement or even a postmarked envelope received at your location.



A. Practice Location Information

If you see patients in more than one practice location, copy and complete Section 4A for each location.

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

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

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)	New enrollees will not use this area.		

If you are enrolling for the first time, or if you are adding a new practice location, the date you provide should be the date you saw your first Medicare patient at this location.

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

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

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

City/Town | State | ZIP Code + 4

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

Date you saw your first Medicare patient at this practice location *(mm/dd/yyyy)*

Medicare Identification Number *(If issued)* | National Provider Identifier

New enrollees will enter "PENDING"

Medicare Identification Number *(If issued)* | National Provider Identifier

Medicare Identification Number *(If issued)* | National Provider Identifier

Medicare Identification Number *(If issued)* | National Provider Identifier

Medicare Identification Number *(If issued)* | National Provider Identifier

Is this practice location a:

☐ Group practice office/clinic
☐ Hospital
☐ Retirement/assisted living community
☐ Skilled Nursing Facility and/or Nursing Facility
☐ Other health care facility
(Specify):

CLIA Number for this location *(If applicable)*

Attach a copy of the most current CLIA certifications for each of the practice locations reported on this application

FDA/Radiology (Mammography) Certification Number for this location *(If issued)*

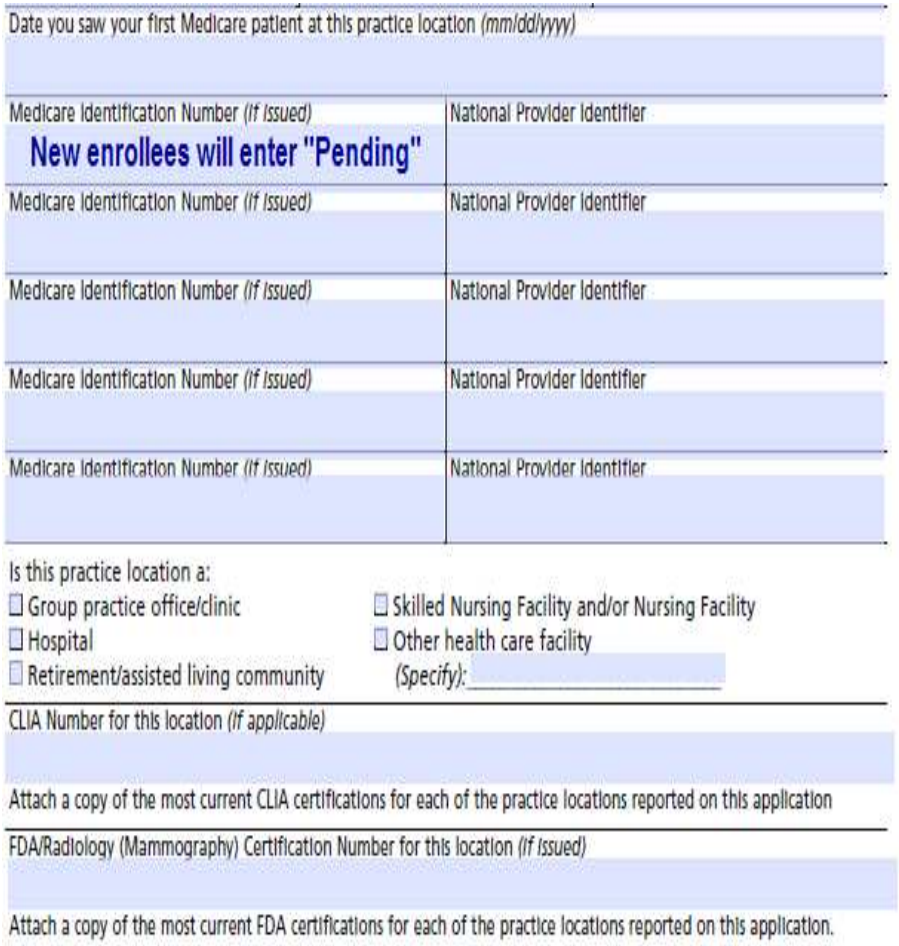
Attach a copy of the most current FDA certifications for each of the practice locations reported on this application.

Section 4: Practice Location Information (Cont.)

Section 4A (Cont.)

- Enter the first date a Medicare patient was seen at this location. This does not have to be the date the location opened for business.

  Note: This date cannot be more than 60 days in advance of the receipt date of the application.
- New enrollees should enter the word “pending” for the Medicare identification number.
- List the NPI for the ASC facility.
- Select the option that best fits this practice location. If the facility has a Clinical Laboratory Improvement Amendments (CLIA) number or Food and Drug Administration (FDA) certification, enter the numbers and attach a copy of the certification upon submission of the application.



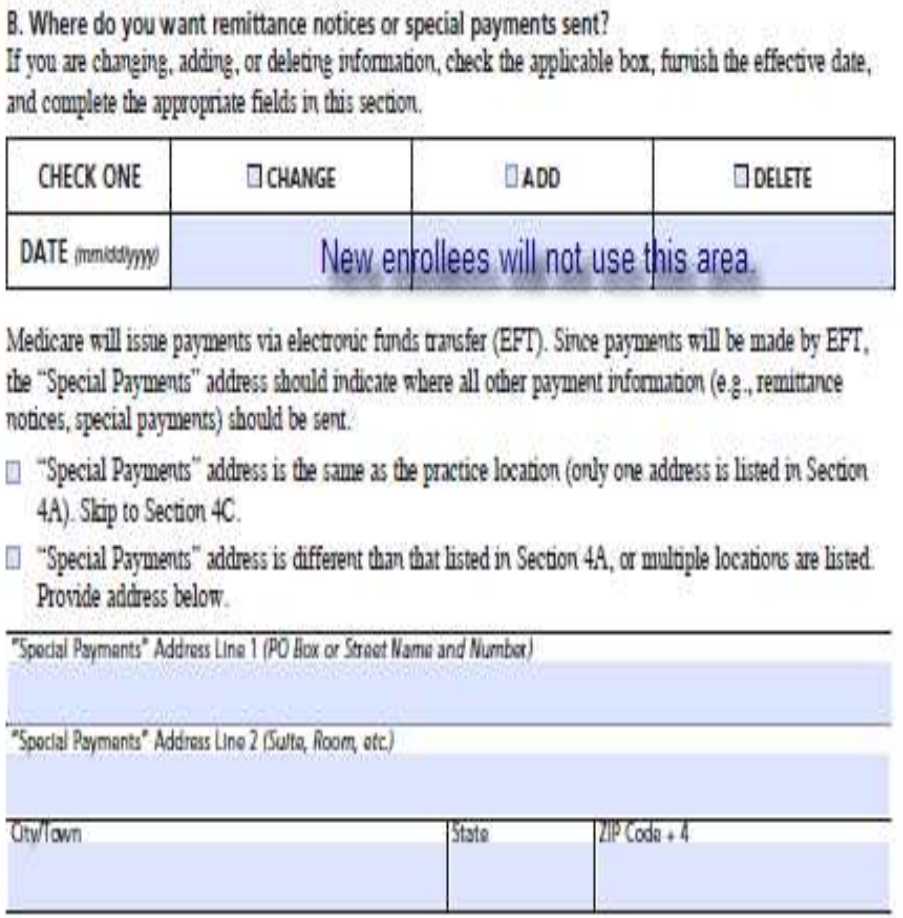
Section 4: Practice Location Information (Cont.)

Section 4B

This section contains information about where the group's remittance notices will be sent. This address will also be used to send any special Medicare payments that are not sent electronically.

Medicare will issue payments via EFT. The "special payments" address should indicate where all other payment information should be sent.

Ask yourself, "If a paper check were printed, where would we want it sent?" This address should reflect the billing or pay-to address.



B. Where do you want remittance notices or special payments sent?
If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)	New enrollees will not use this area.		

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

☐ "Special Payments" address is the same as the practice location (only one address is listed in Section 4A). Skip to Section 4C.

☐ "Special Payments" address is different than that listed in Section 4A, or multiple locations are listed. Provide address below.

"Special Payments" Address Line 1 (PO Box or Street Name and Number)

"Special Payments" Address Line 2 (Suite, Room, etc.)

City/Town	State	ZIP Code + 4

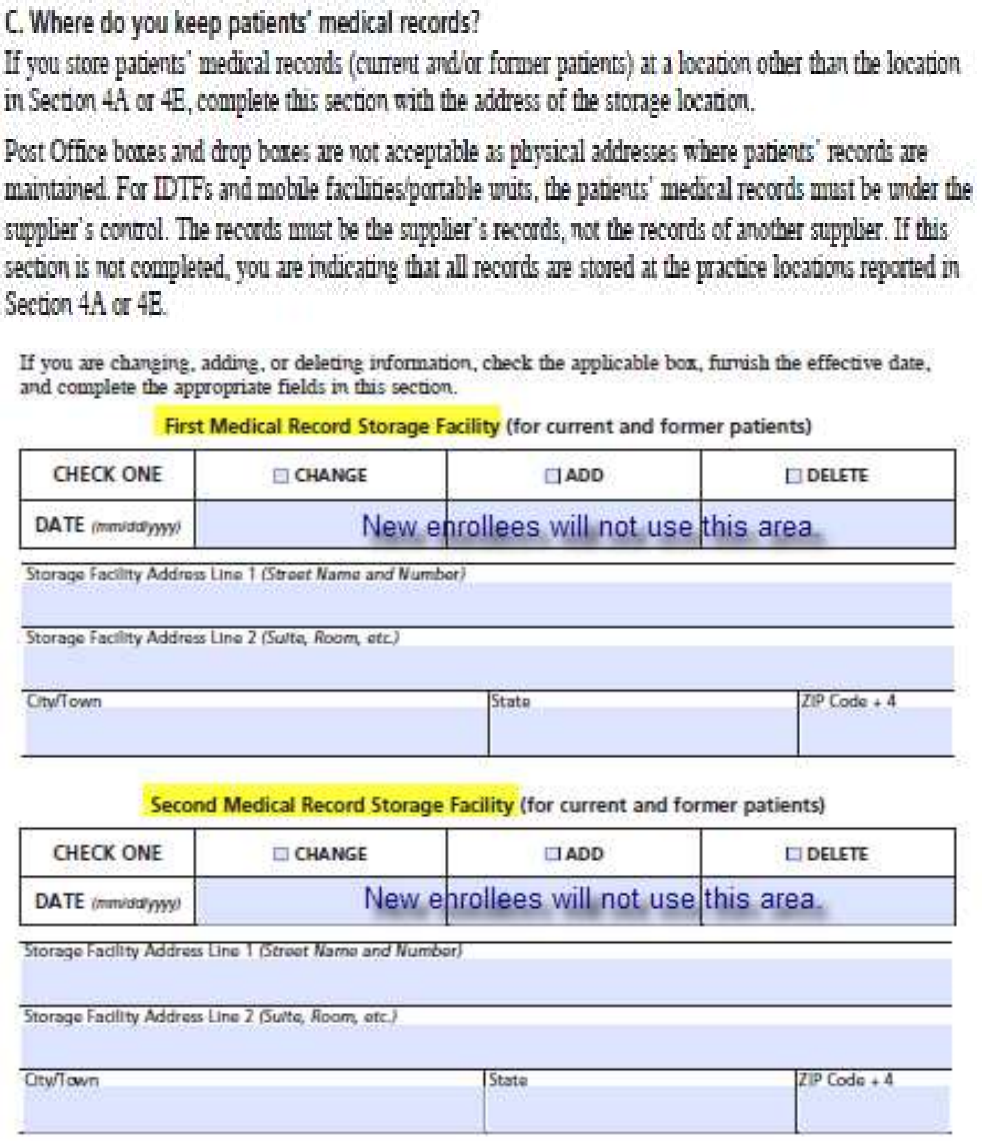
Section 4: Practice Location Information (Cont.)

Section 4C

Section 4C is used to indicate where medical records are stored if at a location other than the one reported in Sections 4A or 4E.

If this section is not completed, it indicates that all records are stored at the practice location(s) reported in Sections 4A or 4B.

This page can be copied and completed for as many different storage locations that a group may have.



C. Where do you keep patients' medical records?

If you store patients' medical records (current and/or former patients) at a location other than the location in Section 4A or 4E, complete this section with the address of the storage location.

Post Office boxes and drop boxes are not acceptable as physical addresses where patients' records are maintained. For IDTFs and mobile facilities/portable units, the patients' medical records must be under the supplier's control. The records must be the supplier's records, not the records of another supplier. If this section is not completed, you are indicating that all records are stored at the practice locations reported in Section 4A or 4E.

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

First Medical Record Storage Facility (for current and former patients)

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)	New enrollees will not use this area.		

Storage Facility Address Line 1 (Street Name and Number)

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

City/Town	State	ZIP Code + 4

Second Medical Record Storage Facility (for current and former patients)

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)	New enrollees will not use this area.		

Storage Facility Address Line 1 (Street Name and Number)

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

City/Town	State	ZIP Code + 4

Pages 16 & 17

Section 4: Practice Location Information (Cont.)

Section 4D

This section is not required for ASC facilities.

D. Rendering Services in Patients' Homes

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

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

Furnish the city/town, State and ZIP code for all locations where health care services are rendered in patients' homes. If you provide health care services in more than one State and those States are serviced by different Medicare fee-for-service contractors, complete a separate CMS-855B enrollment application for each Medicare fee-for-service contractor's jurisdiction.

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

☐ Entire State of _____

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

CITY/TOWN	STATE	ZIP CODE

Section 4: Practice Location Information (Cont.)

Sections 4E and 4F

These sections are not required for ASC facilities.

E. Base of Operations Address for Mobile or Portable Suppliers (Location of Business Office or Dispatcher/Scheduler)
The base of operations is the location from where personnel are dispatched, where mobile/portable equipment is stored, and when applicable, where vehicles are parked when not in use.

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

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

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

Street Address Line 1 (Street Name and Number)		
Street Address Line 2 (Suite, Room, etc.)		
City/Town	State	ZIP Code + 4
Telephone Number	Fax Number (If applicable)	E-mail Address (If applicable)

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

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

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

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

Section 4: Practice Location Information (Cont.)

Section 4G

This section is not required for ASC facilities.

G. Geographic Location for Mobile Or Portable Suppliers Where the Base of Operations and/or Vehicle Renders Services

Provide the city/town, State, and ZIP Code for all locations where mobile and/or portable services are rendered.

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

INITIAL REPORTING AND/OR ADDITIONS

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

☐ Entire State of _____

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

CITY/TOWN	STATE	ZIP CODE

DELETIONS

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

☐ Entire State of _____

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

CITY/TOWN	STATE	ZIP CODE

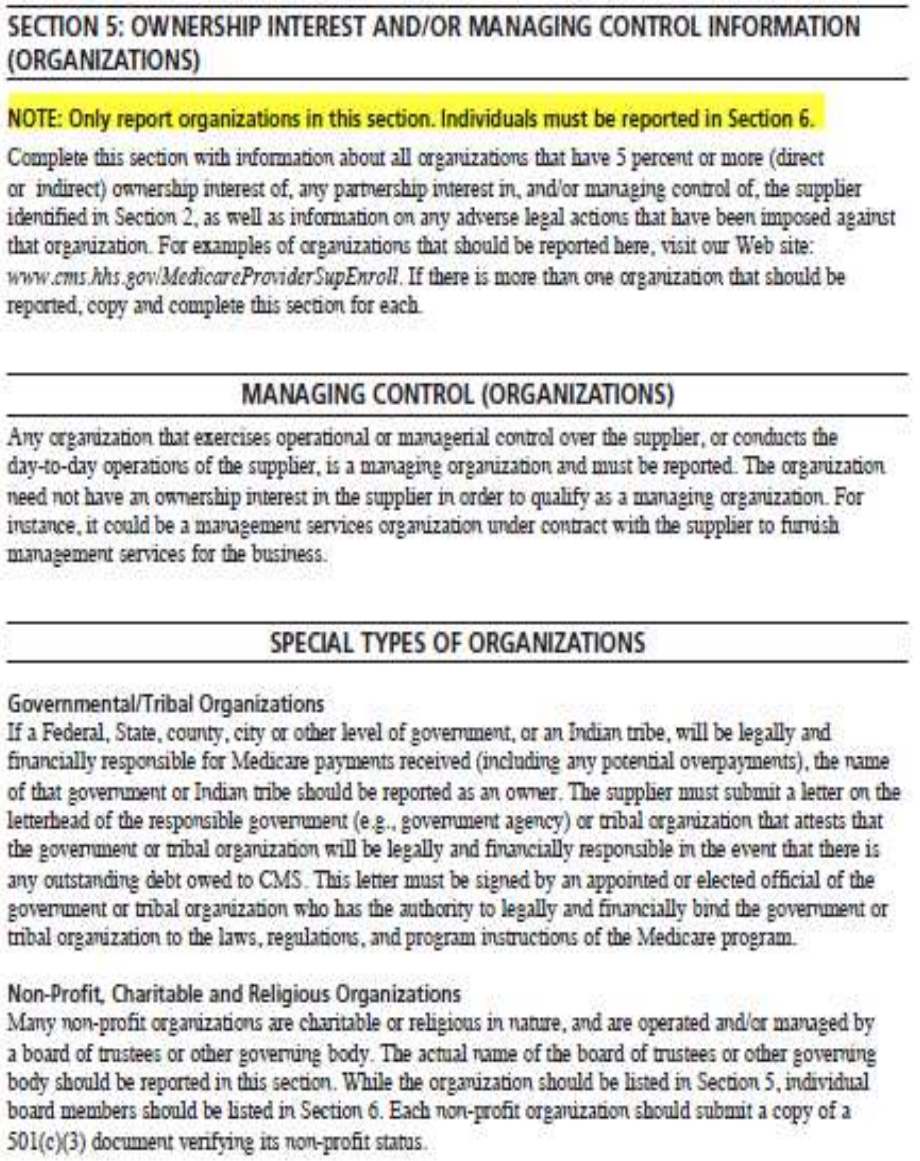
Section 5: Ownership Interest (Organizations)

Section 5

This section is used for any organization that owns 5 percent or more of the provider facility completing the application.

Organizations that have managing control or partnership interests must also be listed.

American Indian and/or Alaska Native organizations must list the name of the government (i.e., IHS) or tribal organization that will be legally and financially responsible.



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

NOTE: Only report organizations in this section. Individuals must be reported in Section 6.

Complete this section with information about all organizations that have 5 percent or more (direct or indirect) ownership interest of, any partnership interest in, and/or managing control of, the supplier identified in Section 2, as well as information on any adverse legal actions that have been imposed against that organization. For examples of organizations that should be reported here, visit our Web site: *www.cms.hhs.gov/MedicareProviderSupEnroll*. If there is more than one organization that should be reported, copy and complete this section for each.

MANAGING CONTROL (ORGANIZATIONS)

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

SPECIAL TYPES OF ORGANIZATIONS

Governmental/Tribal Organizations

If a Federal, State, county, city or other level of government, or an Indian tribe, will be legally and financially responsible for Medicare payments received (including any potential overpayments), the name of that government or Indian tribe should be reported as an owner. The supplier must submit a letter on the letterhead of the responsible government (e.g., government agency) or tribal organization that attests that the government or tribal organization will be legally and financially responsible in the event that there is any outstanding debt owed to CMS. This letter must be signed by an appointed or elected official of the government or tribal organization who has the authority to legally and financially bind the government or tribal organization to the laws, regulations, and program instructions of the Medicare program.

Non-Profit, Charitable and Religious Organizations

Many non-profit organizations are charitable or religious in nature, and are operated and/or managed by a board of trustees or other governing body. The actual name of the board of trustees or other governing body should be reported in this section. While the organization should be listed in Section 5, individual board members should be listed in Section 6. Each non-profit organization should submit a copy of a 501(c)(3) document verifying its non-profit status.

Section 5: Ownership Interest (Organizations) (Cont.)

Section 5A

This section should only be completed if:

- Five percent or more ownership of the supplier.
- Managing control of the supplier.

  Or,
- A partnership interest in the supplier.

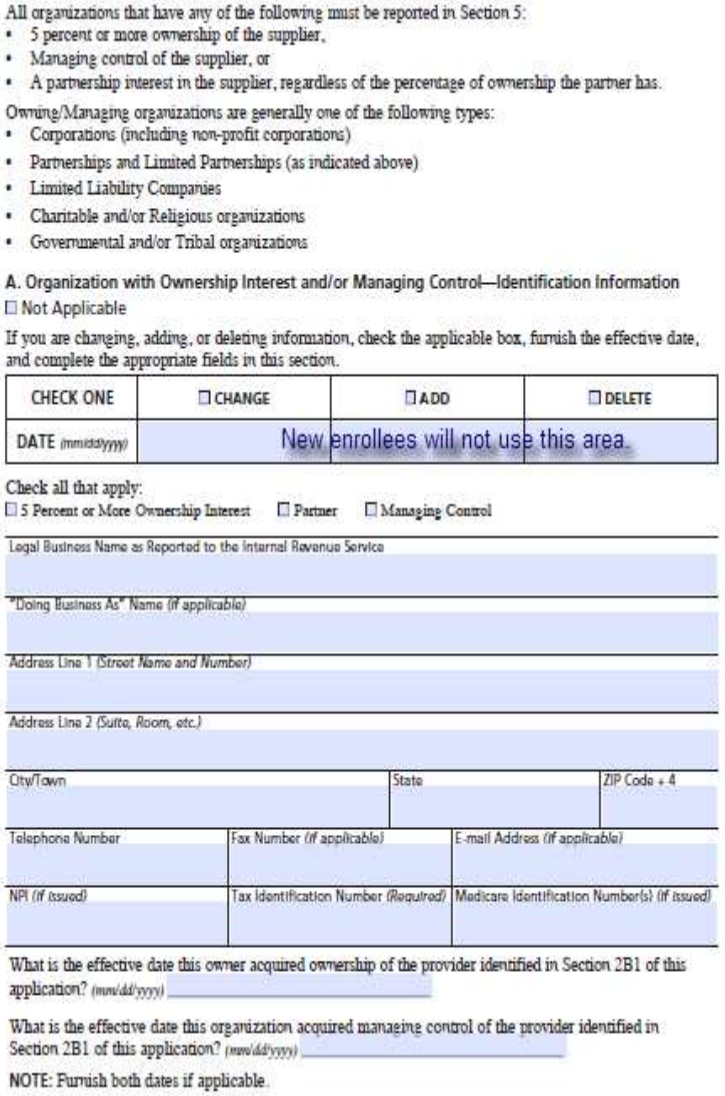
Owning/managing organizations are usually:

- Corporations.
- Partnerships and limited partnerships.
- Limited liability companies.
- Charitable and/or religious organizations.
- Governmental and/or tribal organizations.

Indicate the effective date the owner acquired ownership. Indicate the effective date the organization acquired managing control.

Note: The legal business name must be exactly the same as the one reported to the IRS.

If this section does not apply, mark as “Not Applicable.”



All organizations that have any of the following must be reported in Section 5:

- 5 percent or more ownership of the supplier,
- Managing control of the supplier, or
- A partnership interest in the supplier, regardless of the percentage of ownership the partner has.

Owning/Managing organizations are generally one of the following types:

- Corporations (including non-profit corporations)
- Partnerships and Limited Partnerships (as indicated above)
- Limited Liability Companies
- Charitable and/or Religious organizations
- Governmental and/or Tribal organizations

A. Organization with Ownership Interest and/or Managing Control—Identification Information

☐ Not Applicable

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

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)	New enrollees will not use this area.		

Check all that apply:

☐ 5 Percent or More Ownership Interest ☐ Partner ☐ Managing Control

Legal Business Name as Reported to the Internal Revenue Service

"Doing Business As" Name (if applicable)

Address Line 1 (Street Name and Number)

Address Line 2 (Suite, Room, etc.)

City/Town	State	ZIP Code + 4

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

NPI (if issued)	Tax Identification Number (Required)	Medicare Identification Number(s) (if issued)

What is the effective date this owner acquired ownership of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) _____

What is the effective date this organization acquired managing control of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) _____

NOTE: Furnish both dates if applicable.

Section 5: Ownership Interest (Organizations) (Cont.)

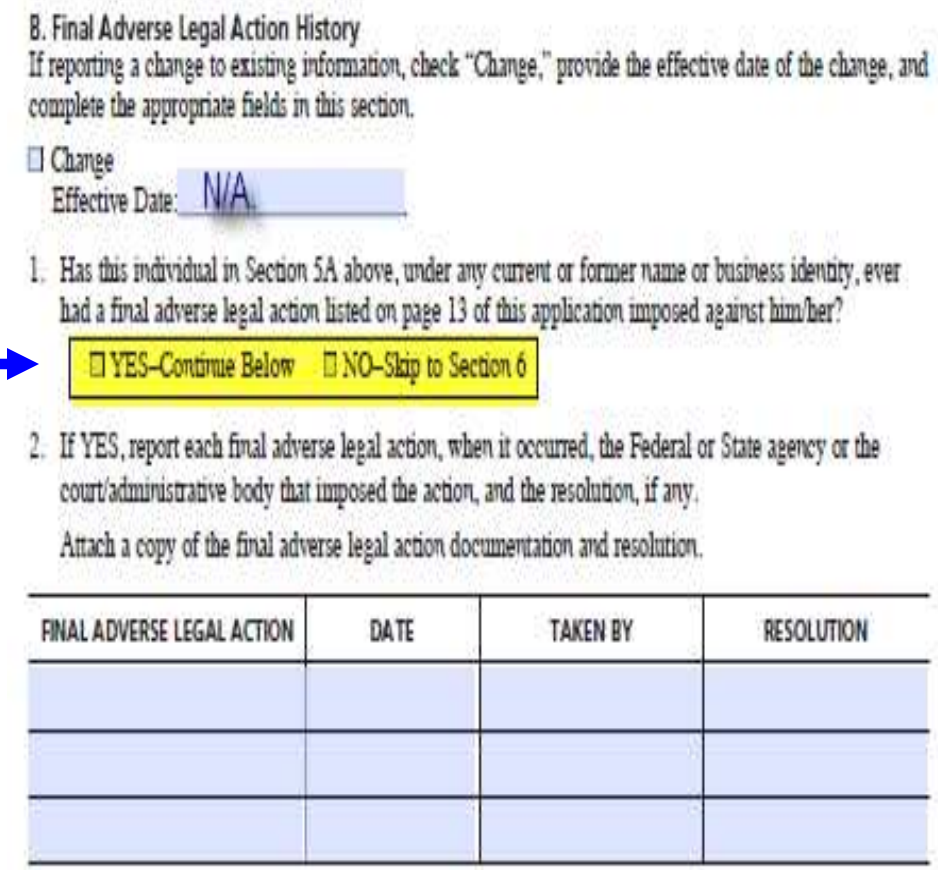
Section 5B

Report any adverse legal history of the controlling organization in Section 5B.

You must answer question 1, “Yes” or “No.”

If you answered “Yes” to question 1, then proceed to question 2.

Failure to supply this information could result in a Medicare provider number(s) not being issued to new providers.



8. Final Adverse Legal Action History

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

☐ Change
Effective Date: N/A

1. Has this individual in Section 5A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES–Continue Below ☐ NO–Skip to Section 6

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

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

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

Page 12 of the 855B provides a list of reportable actions.

Section 6: Ownership Interest and/or Managing Control

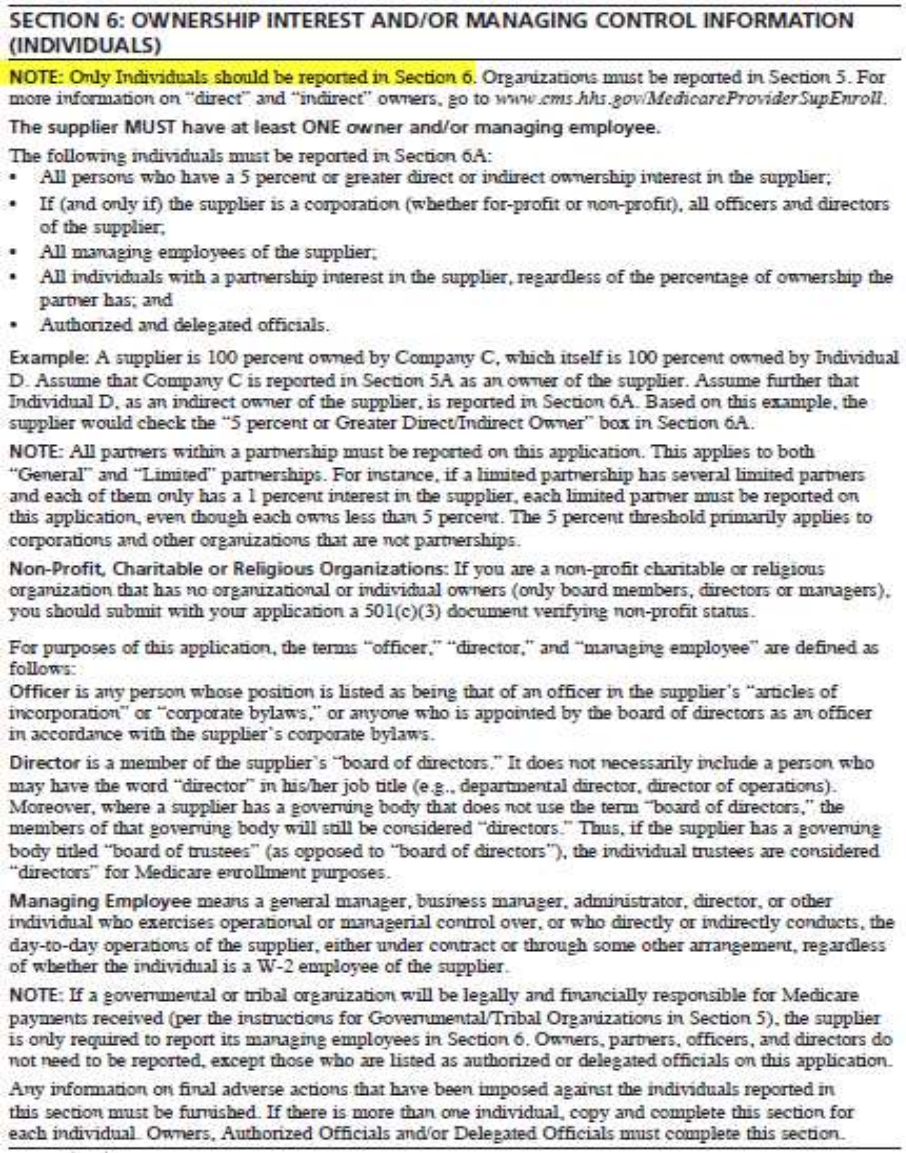
Section 6

The information in this section is for individuals having ownership of 5 percent or more of the group.

If the provider listed in Section 2 is a corporation, list all officers and directors.

List all individuals with partnership interests regardless of percentage of ownership.

List all authorized and delegated officials in this section.



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

NOTE: Only Individuals should be reported in Section 6. Organizations must be reported in Section 5. For more information on "direct" and "indirect" owners, go to *www.cms.hhs.gov/MedicareProviderSupEnroll*.

The supplier MUST have at least ONE owner and/or managing employee.

The following individuals must be reported in Section 6A:

- All persons who have a 5 percent or greater direct or indirect ownership interest in the supplier;
- If (and only if) the supplier is a corporation (whether for-profit or non-profit), all officers and directors of the supplier;
- All managing employees of the supplier;
- All individuals with a partnership interest in the supplier, regardless of the percentage of ownership the partner has; and
- Authorized and delegated officials.

Example: A supplier is 100 percent owned by Company C, which itself is 100 percent owned by Individual D. Assume that Company C is reported in Section 5A as an owner of the supplier. Assume further that Individual D, as an indirect owner of the supplier, is reported in Section 6A. Based on this example, the supplier would check the "5 percent or Greater Direct/Indirect Owner" box in Section 6A.

NOTE: All partners within a partnership must be reported on this application. This applies to both "General" and "Limited" partnerships. For instance, if a limited partnership has several limited partners and each of them only has a 1 percent interest in the supplier, each limited partner must be reported on this application, even though each owns less than 5 percent. The 5 percent threshold primarily applies to corporations and other organizations that are not partnerships.

Non-Profit, Charitable or Religious Organizations: If you are a non-profit charitable or religious organization that has no organizational or individual owners (only board members, directors or managers), you should submit with your application a 501(c)(3) document verifying non-profit status.

For purposes of this application, the terms "officer," "director," and "managing employee" are defined as follows:

Officer is any person whose position is listed as being that of an officer in the supplier's "articles of incorporation" or "corporate bylaws," or anyone who is appointed by the board of directors as an officer in accordance with the supplier's corporate bylaws.

Director is a member of the supplier's "board of directors." It does not necessarily include a person who may have the word "director" in his/her job title (e.g., departmental director, director of operations). Moreover, where a supplier has a governing body that does not use the term "board of directors," the members of that governing body will still be considered "directors." Thus, if the supplier has a governing body titled "board of trustees" (as opposed to "board of directors"), the individual trustees are considered "directors" for Medicare enrollment purposes.

Managing Employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operations of the supplier, either under contract or through some other arrangement, regardless of whether the individual is a W-2 employee of the supplier.

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

Any information on final adverse actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each individual. Owners, Authorized Officials and/or Delegated Officials must complete this section.

Section 6: Ownership Interest and/or Managing Control (Cont.)

Section 6A

If there is more than one individual who needs to be reported, copy and complete this section for each individual.

Select the individual's relationship with the supplier from Section 2B.1. You may select all that apply.

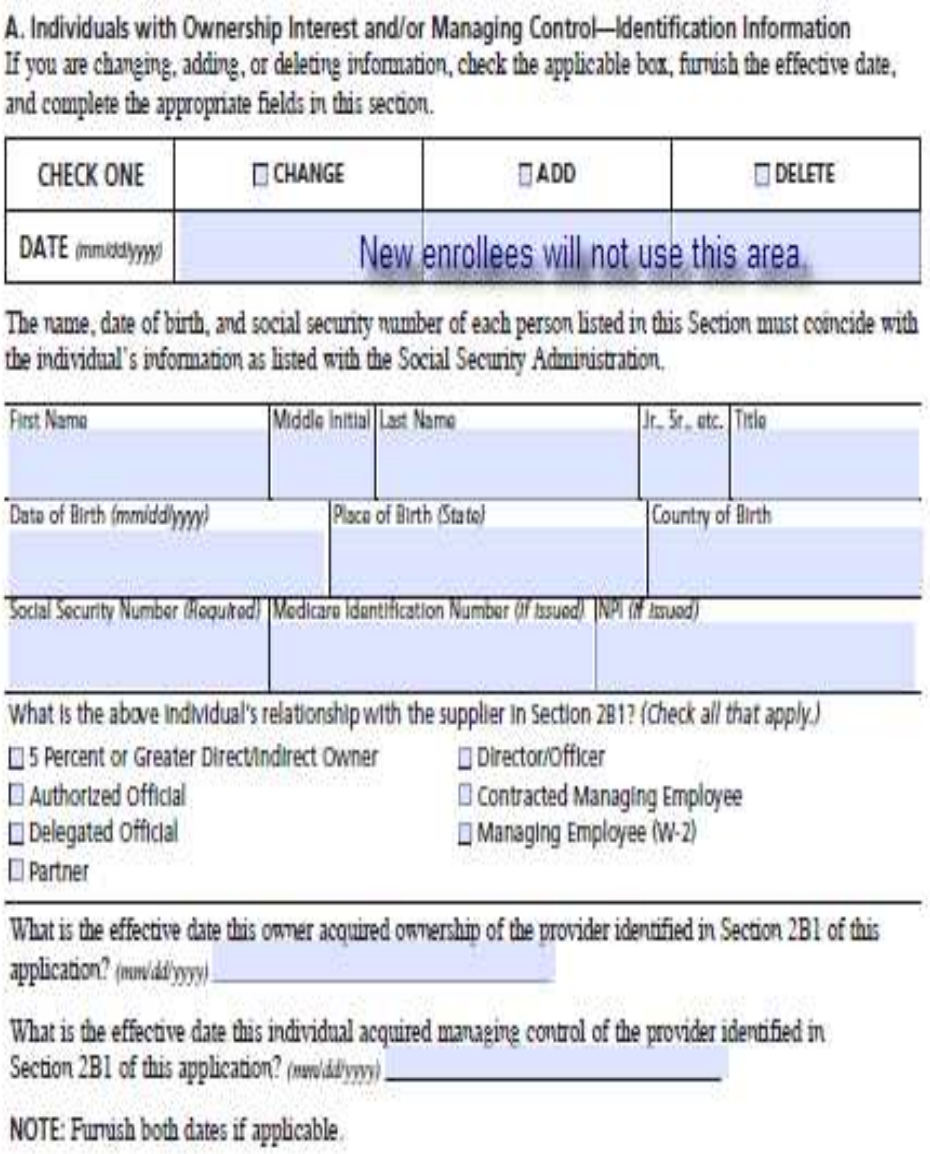
American Indian and/or Alaska Native groups should report their managing employees in Section 6.

Note: "Other" should not be used.

Reminder: Contracted managing employees cannot be authorized or delegated officials.

Note: There must be at least two individuals in Section 6 – at least one owner and one managing employee.

For example: If there are two owners, one of those managing partners must be listed also as a managing employee.



A. Individuals with Ownership Interest and/or Managing Control—Identification Information

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

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)	New enrollees will not use this area.		

The name, date of birth, and social security number of each person listed in this Section must coincide with the individual's information as listed with the Social Security Administration.

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

Date of Birth (mm/dd/yyyy)	Place of Birth (State)	Country of Birth

Social Security Number (Required)	Medicare Identification Number (If Issued)	NPI (If Issued)

What is the above individual's relationship with the supplier in Section 2B1? (Check all that apply.)

☐ 5 Percent or Greater Direct/Indirect Owner
☐ Authorized Official
☐ Delegated Official
☐ Partner
☐ Director/Officer
☐ Contracted Managing Employee
☐ Managing Employee (W-2)

What is the effective date this owner acquired ownership of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) _____

What is the effective date this individual acquired managing control of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) _____

NOTE: Furnish both dates if applicable.

Section 6: Ownership Interest and/or Managing Control (Cont.)

Section 6B

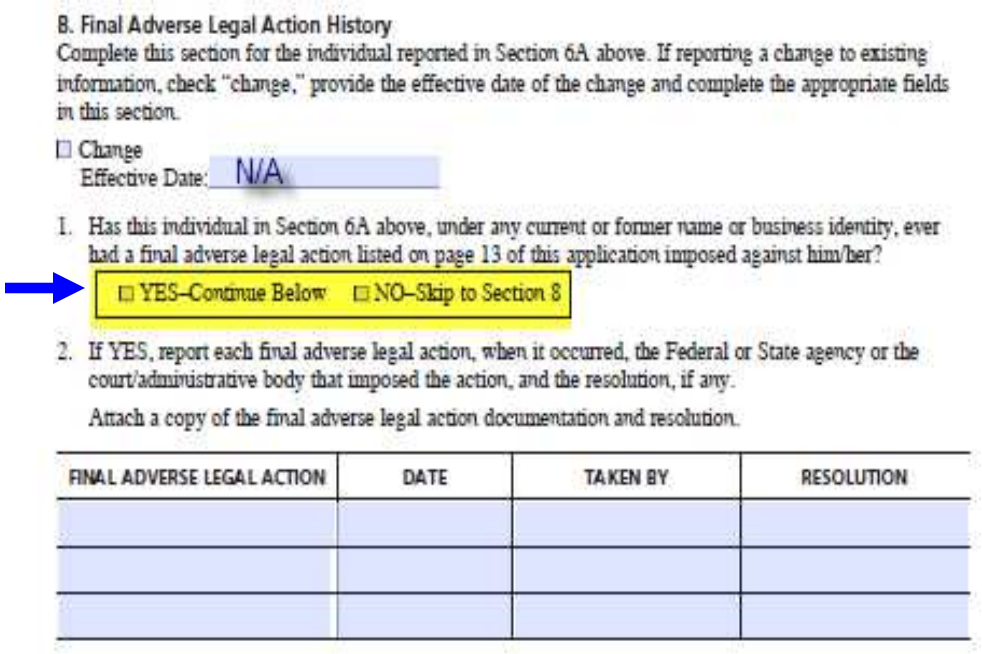
Adverse legal actions must be completed for each individual reported.

If Section 6A is copied for additional individuals, this section must be copied and completed as well.

You must answer question 1, “yes” or “no.”

If you answered “yes” to question 1, then proceed to question 2.

American Indian and/or Alaska Native groups report their managing employees in Section 6.



8. Final Adverse Legal Action History

Complete this section for the individual reported in Section 6A above. If reporting a change to existing information, check "change," provide the effective date of the change and complete the appropriate fields in this section.

☐ Change
Effective Date: N/A

1. Has this individual in Section 6A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 13 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, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

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

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

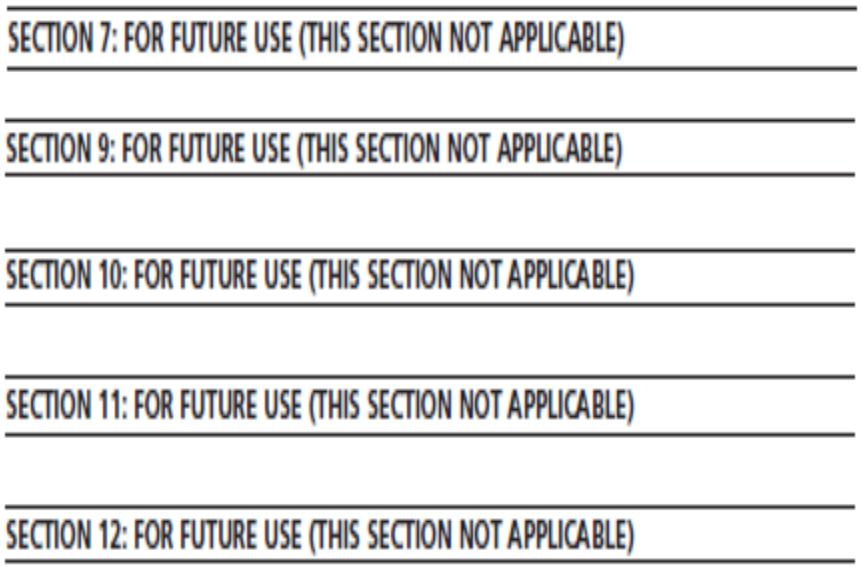
Page 12 of the 855B provides a list of reportable actions.

Failure to supply this information could result in a Medicare provider number(s) not being issued to new providers.

Sections Not Used At This Time

The following sections of the 855B are currently not used:

- Section 7.
- Section 9.
- Section 10.
- Section 11.
- Section 12.



Section 8: Billing Agency Information

Section 8

This section should reflect any individual or entity with whom you have contracted to prepare and submit claims for the business.

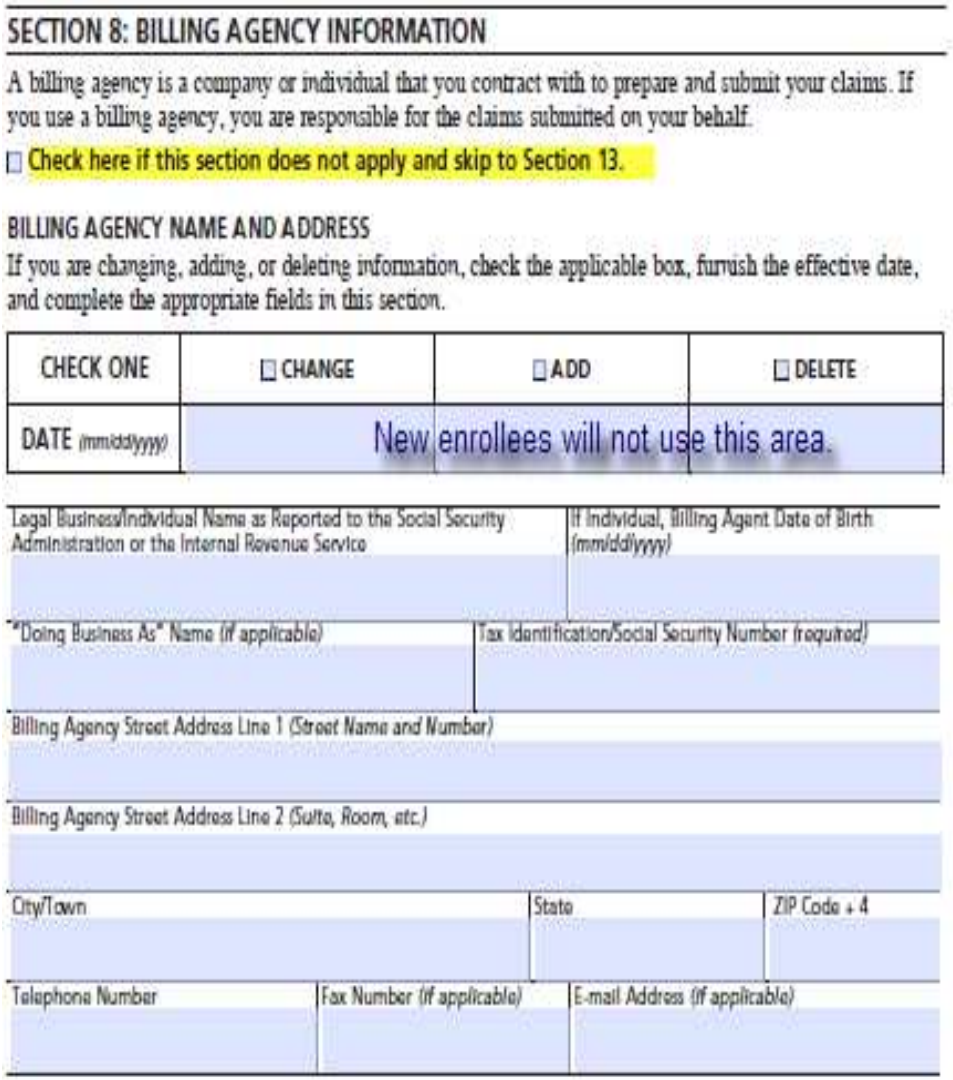
A billing agency may perform other services for provider groups, but claims completion and/or submission is included in the contract.

If a provider does not use a billing agency, indicate by checking the first box.

The legal business name must be the same one reported to the IRS.

The tax ID/Social Security number is required in this section.

The address listed in this section must be a physical street address. Do not use P.O. box information here.



SECTION 8: BILLING AGENCY INFORMATION

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

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

BILLING AGENCY NAME AND ADDRESS

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

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)	New enrollees will not use this area.		

Legal Business/Individual Name as Reported to the Social Security Administration or the Internal Revenue Service	If Individual, Billing Agent Date of Birth (mm/dd/yyyy)
"Doing Business As" Name (if applicable)	Tax Identification/Social Security Number (required)
Billing Agency Street Address Line 1 (Street Name and Number)	
Billing Agency Street Address Line 2 (Suite, Room, etc.)	

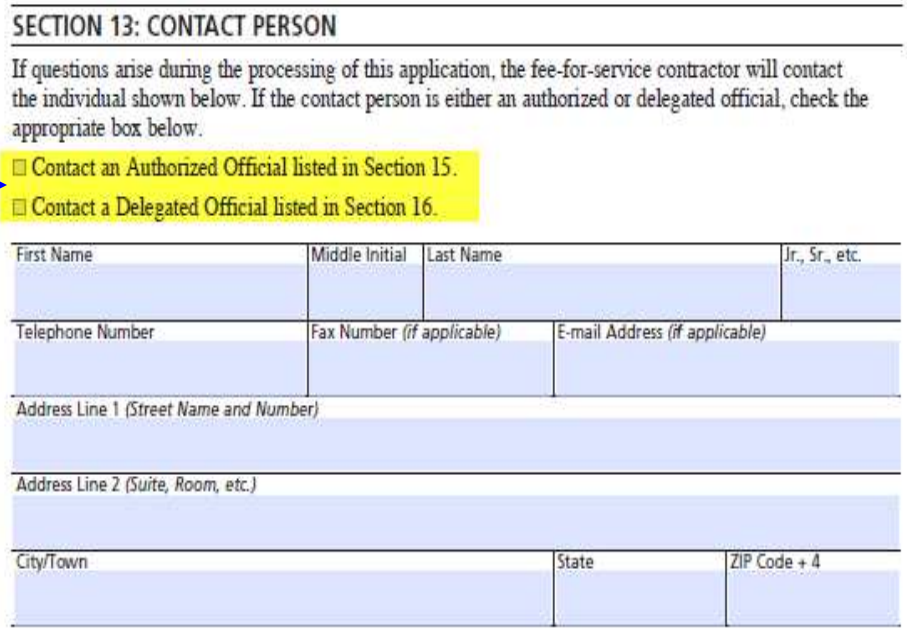
City/Town	State	ZIP Code + 4
Telephone Number	Fax Number (if applicable)	E-mail Address (if applicable)

Section 13: Contact Person

Section 13

The contact person should be someone who can answer questions about the information on the application.

- If development information is needed:
  1. The e-mail address is the **first** form of contact.
  2. The fax number is the **second** form of contact.
  3. The U.S. Postal Service is the **third** form of contact.
- Medicare will not list the contact person on the Medicare provider's record.
- If the contact person will be either the authorized or delegated official, check the appropriate box and skip to the indicated section.
- The Confirmation Letters (CLRs) will be sent to the contact person identified in this section.
- There can be more than one contact person. Copy and complete this page for each contact.



SECTION 13: CONTACT PERSON

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

☐ Contact an Authorized Official listed in Section 15.
☐ Contact a Delegated Official listed in Section 16.

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

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

Address Line 1 *(Street Name and Number)*

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

City/Town	State	ZIP Code + 4

Note: The fax number or e-mail address is not required, but welcomed. E-mail addresses or fax numbers allow for quicker contact with the provider for missing/incomplete applications.

Section 14: Penalties for Falsifying Information

Section 14

This section outlines the penalties for falsifying information and should be read by the authorized and delegated officials legally responsible for the provider listed in Section 2.

This section does not have an area to be completed.

Pages 28 & 29

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION

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

1. 18 U.S.C. § 1001 authorizes criminal penalties against an individual who, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry.

   Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000 (18 U.S.C. § 3571). Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authoriz

2. Section 1128B(a)(1) of the Soci who, "knowingly and willfully," a material fact in any applicatio

   The offender is subject to fines

3. The Civil False Claims Act, 31
   a) knowingly presents, or ca States Government a false
   b) knowingly makes, uses, o or fraudulent claim paid o
   c) conspires to defraud the C

   The Act imposes a civil penalty damages sustained by the Gover

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 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.

Section 15: Certification Statement

Section 15

This section provides descriptions of authorized and delegated officials.

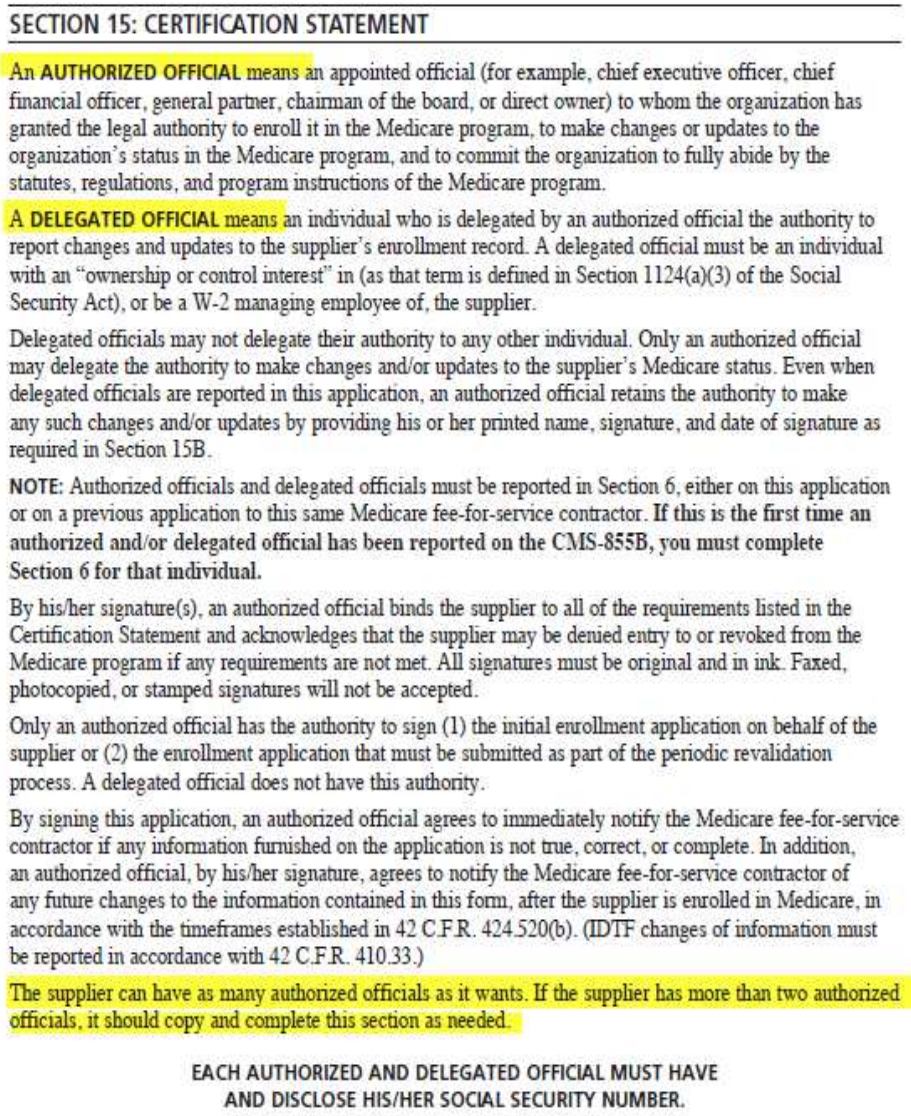
Authorized officials and delegated officials must be reported in Section 6 of this application.

An authorized official is required for all initial enrollment applications.

Examples of an authorized official are chief executive officer, chief financial officer, general partner, chairman of the board or direct owner.

Only an authorized official has the authority to sign the initial enrollment application. A delegated official does not have this authority.

The officials must read and understand pages 30 and 31.



SECTION 15: CERTIFICATION STATEMENT

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

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

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

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

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

Only an authorized official has the authority to sign (1) the initial enrollment application on behalf of the supplier or (2) the enrollment application that must be submitted as part of the periodic revalidation process. A delegated official does not have this authority.

By signing this application, an authorized official agrees to immediately notify the Medicare fee-for-service contractor if any information furnished on the application is not true, correct, or complete. In addition, an authorized official, by his/her signature, agrees to notify the Medicare fee-for-service contractor of any future changes to the information contained in this form, after the supplier is enrolled in Medicare, in accordance with the timeframes established in 42 C.F.R. 424.520(b). (IDTF changes of information must be reported in accordance with 42 C.F.R. 410.33.)

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

EACH AUTHORIZED AND DELEGATED OFFICIAL MUST HAVE AND DISCLOSE HIS/HER SOCIAL SECURITY NUMBER.

Section 15: Certification Statement (Cont.)

Items 1–7 are **very** important to read and understand when signing the certification statement in Section 15.

A. Additional Requirements for Medicare Enrollment

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

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

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

Sections 15B and 15C: Certification Statement

Sections 15B and 15C

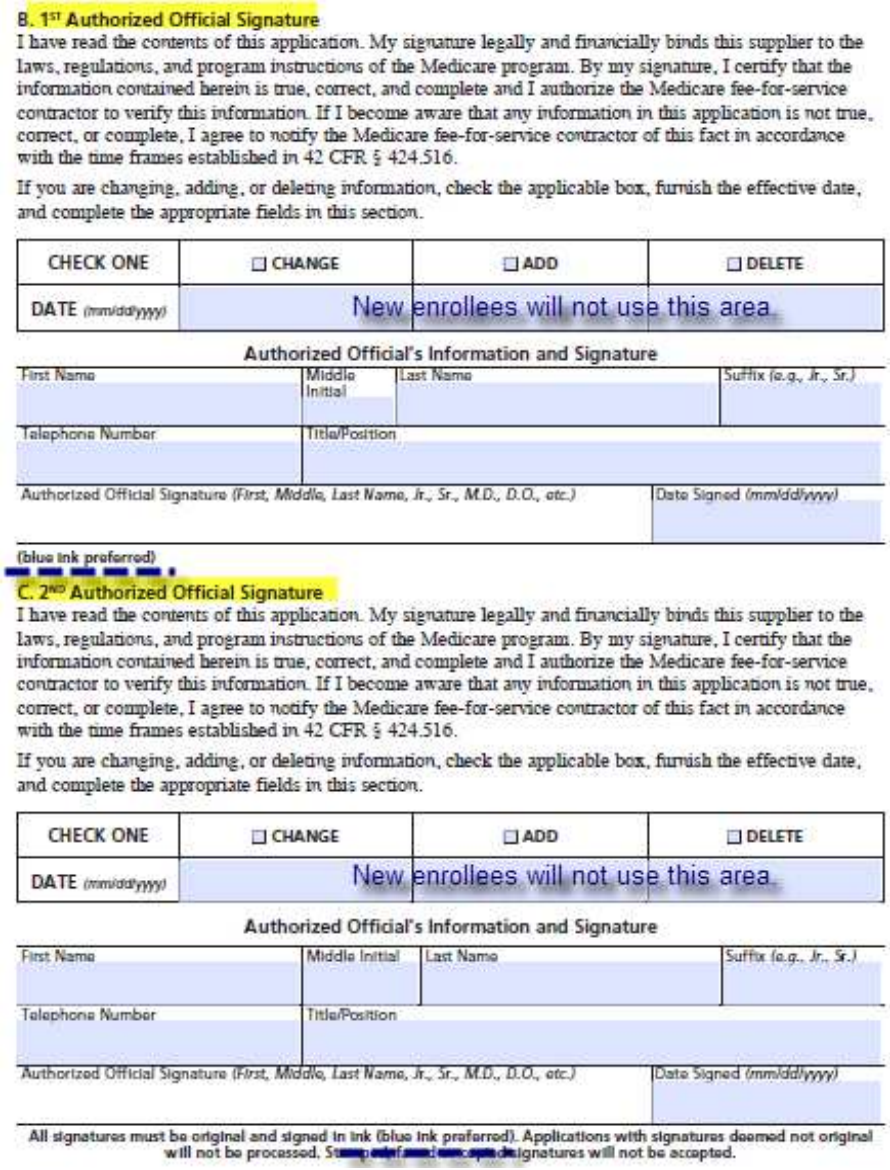
Used for authorized officials only.

Authorized officials must also be listed in Section 6 of this application.

Authorized officials must sign and date this page. Blue ink is preferred, which will indicate an original signature and not a copy.

Applications with signatures deemed not original and/or not dated will not be processed. Stamped, faxed or copied signatures will not be accepted. Applications that are not dated will also not be accepted.

There can be more than one authorized official. Copy and complete this page as needed.



8. 1ST Authorized Official Signature

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

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

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)	New enrollees will not use this area		

Authorized Official's Information and Signature

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

Telephone Number	Title/Position

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

(blue ink preferred)

C. 2ND Authorized Official Signature

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

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

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)	New enrollees will not use this area		

Authorized Official's Information and Signature

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

Telephone Number	Title/Position

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

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

Section 16: Delegated Official

Section 16

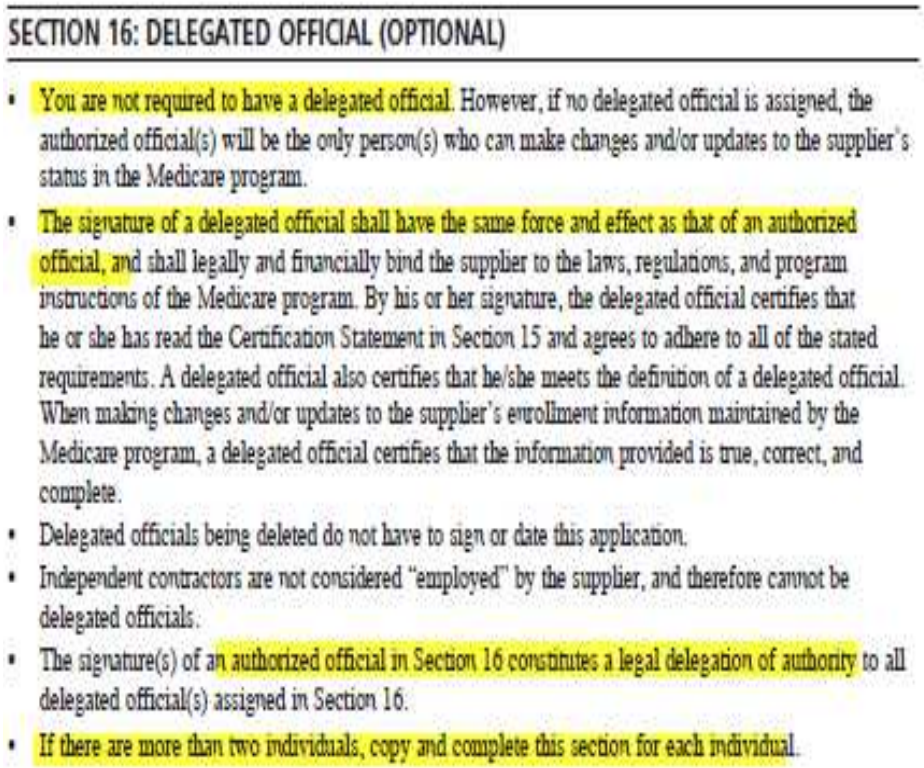
This section is optional.

If no delegated official is appointed, the authorized official will be responsible for all changes and updates made to the provider's record.

Authorized officials and delegated officials **must be** reported in Section 6 of this application.

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

Note: Delegated officials can make changes to existing enrollment profiles on behalf of the authorized official.



SECTION 16: DELEGATED OFFICIAL (OPTIONAL)

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

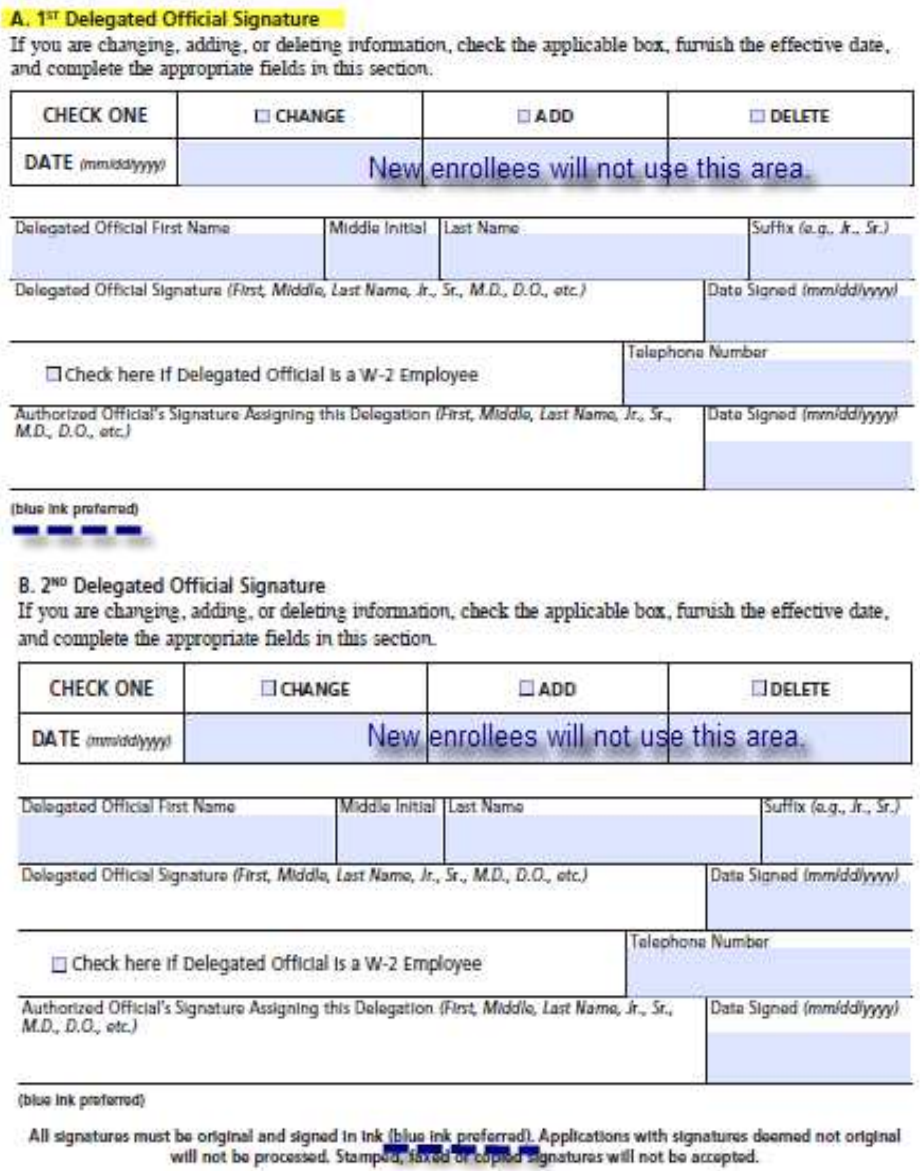
Section 16: Delegated Official (Cont.)

16A: First delegated official information.

16B: Second delegated official information.

Reminders:

- Blue ink is preferred.
- The initial appointment of a delegated official by an authorized official must be signed and dated by the authorized official.



A. 1ST Delegated Official Signature

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

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)	New enrollees will not use this area.		

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

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

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

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

(blue ink preferred)

B. 2ND Delegated Official Signature

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

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)	New enrollees will not use this area.		

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

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

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

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

(blue ink preferred)

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

Pages 33 & 34

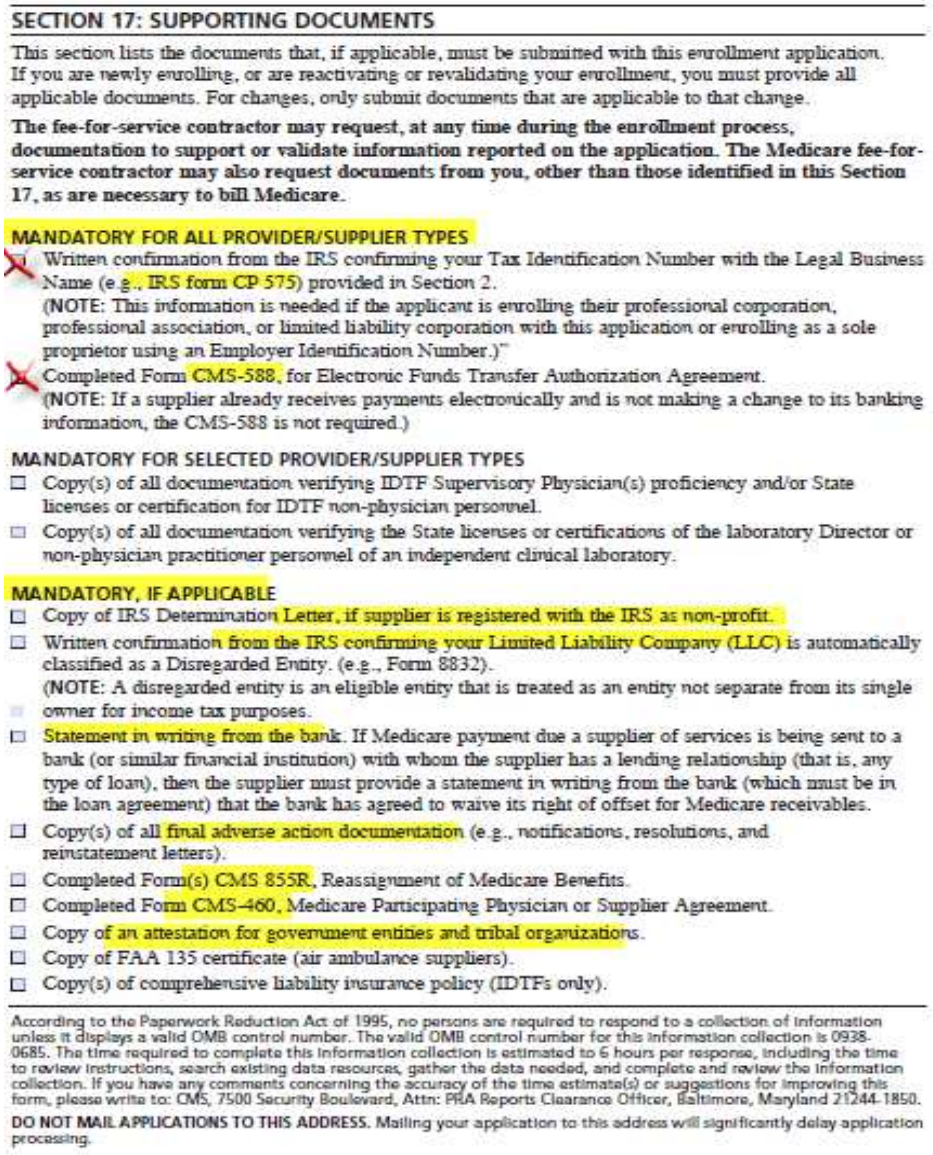
Section 17: Supporting Documents

Section 17

Indicate what is attached to the application.

Check the corresponding boxes for all information being attached to the application. Don't forget:

- Tax documents (e.g., IRS CP575, 147c, 941 coupon).
- CMS-588 (EFT authorization).
- If applicable, copies of CLIA, FDA and/or diabetes program certifications.
- Copy of attestation for government and tribal organizations.



SECTION 17: SUPPORTING DOCUMENTS

This section lists the documents that, if applicable, must be submitted with this enrollment application. If you are newly enrolling, or are reactivating or revalidating your enrollment, you must provide all applicable documents. For changes, only submit documents that are applicable to that change.

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

MANDATORY FOR ALL PROVIDER/SUPPLIER TYPES

☒ Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name (e.g., IRS form CP 575) provided in Section 2.
(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.)"

☒ Completed Form CMS-588, for Electronic Funds Transfer Authorization Agreement.
(NOTE: If a supplier already receives payments electronically and is not making a change to its banking information, the CMS-588 is not required.)

MANDATORY FOR SELECTED PROVIDER/SUPPLIER TYPES

☐ Copy(s) of all documentation verifying IDTF Supervisory Physician(s) proficiency and/or State licenses or certification for IDTF non-physician personnel.

☐ Copy(s) of all documentation verifying the State licenses or certifications of the laboratory Director or non-physician practitioner personnel of an independent clinical laboratory.

MANDATORY, IF APPLICABLE

☐ Copy of IRS Determination Letter, if supplier is registered with the IRS as non-profit.

☐ Written confirmation from the IRS confirming your Limited Liability Company (LLC) is automatically classified as a Disregarded Entity. (e.g., Form 8832).
(NOTE: A disregarded entity is an eligible entity that is treated as an entity not separate from its single owner for income tax purposes.

☐ Statement in writing from the bank. If Medicare payment due a supplier of services is being sent to a bank (or similar financial institution) with whom the supplier has a lending relationship (that is, any type of loan), then the supplier must provide a statement in writing from the bank (which must be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.

☐ Copy(s) of all final adverse action documentation (e.g., notifications, resolutions, and reinstatement letters).

☐ Completed Form(s) CMS 855R, Reassignment of Medicare Benefits.

☐ Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement.

☐ Copy of an attestation for government entities and tribal organizations.

☐ Copy of FAA 135 certificate (air ambulance suppliers).

☐ Copy(s) of comprehensive liability insurance policy (IDTFs only).

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 0938-0685. The time required to complete this information collection is estimated to 6 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 any 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, Baltimore, Maryland 21244-1850.

DO NOT MAIL APPLICATIONS TO THIS ADDRESS. Mailing your application to this address will significantly delay application processing.

Attachments 1 and 2

Attachments 1 and 2

These attachments are for ambulance providers and IDTFs and are not required for ASC provider groups.

ATTACHMENT 1: AMBULANCE SERVICE SUPPLIERS

All ambulance service suppliers enrolling in the Medicare program must complete this attachment.

A. Geographic Area

This section is to be completed with information about the geographic area in which this company provides ambulance services. If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

Provide the city/town, State, and ZIP code for all locations where this ambulance company renders services.

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

NOTE: If the ambulance company has vehicles garaged within a different Medicare contractor's jurisdiction, a separate CMS-855B enrollment application must be submitted to that fee-for-service contractor.

1. INITIAL REPORTING AND/OR ADDITIONS

If services are provided in selected cities/towns, provide the locations below. List ZIP codes only if they are not within the entire city/town.

CITY/TOWN	STATE	ZIP CODE

2. DELETIONS

If services are no longer provided in selected cities/t
if they are not within the entire city/town.

CITY/TOWN	ST

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES

INDEPENDENT DIAGNOSTIC TESTING FACILITY (IDTF) PERFORMANCE STANDARDS

Below is a list of the performance standards that an IDTF must meet in order to obtain or maintain their Medicare billing privileges. These standards, in their entirety, can be found in 42 C.F.R. section 410.33(g).

1. Operate its business in compliance with all applicable Federal and State licensure and regulatory requirements for the health and safety of patients.
2. Provides complete and accurate information on its enrollment application. Changes in ownership, changes of location, changes in general supervision, and adverse legal actions must be reported to the Medicare fee-for-service contractor on the Medicare enrollment application within 30 calendar days of the change. All other changes to the enrollment application must be reported within 90 calendar days.
3. Maintain a physical facility on an appropriate site. For the purposes of this standard, a post office box, commercial mail box, hotel or motel is not considered an appropriate site.
   (i) The physical facility, including mobile units, must contain space for equipment appropriate to the services designated on the enrollment application, facilities for hand washing, adequate patient privacy accommodations, and the storage of both business records and current medical records within the office setting of the IDTF, or IDTF home office, not within the actual mobile unit.
   (ii) IDTF suppliers that provide services remotely and do not see beneficiaries at their practice location are exempt from providing hand washing and adequate patient privacy accommodations.
4. Have all applicable diagnostic testing equipment available at the physical site excluding portable diagnostic testing equipment. A catalog of portable diagnostic equipment, including diagnostic testing equipment serial numbers, must be maintained at the physical site. In addition, portable diagnostic testing equipment must be available for inspection within two business days of a CMS inspection request. The IDTF must maintain a current inventory of the diagnostic testing equipment, including serial and registration numbers, provide this information to the designated fee-for-service contractor upon request, and notify the contractor of any changes in equipment within 90 days.
5. Maintain a primary business phone under the name of the designated business. The primary business phone must be located at the designated site of the business, or within the home office of the mobile IDTF units. The telephone number or toll free numbers must be available in a local directory and through directory assistance.
6. Have a comprehensive liability insurance policy of at least $300,000 per location that covers both the place of business and all customers and employees of the IDTF. The policy must be carried by a non-relative owned company. Failure to maintain required insurance at all times will result in revocation of the IDTF's billing privileges retroactive to the date the insurance lapsed. IDTF suppliers are responsible for providing the contact information for the issuing insurance agent and the underwriter. In addition, the IDTF must:
   (i) Ensure that the insurance policy must remain in force at all times and provide coverage of at least $300,000 per incident; and
   (ii) Notify the CMS designated contractor in writing of any policy changes or cancellations.
7. Agree not to directly solicit patients, which include, but is not limited to, a prohibition on telephone, computer, or in-person contacts. The IDTF must accept only those patients referred for diagnostic testing by an attending physician, who is furnishing a consultation or treating a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Nonphysician practitioners may order tests as set forth in §410.32(a)(3).

Pages 36–47

Medicare Supplier Enrollment Application Privacy Act Statement

The Privacy Act Statement includes important information relating to Medicare's authorization, use and disclosure of specific provider information.

MEDICARE SUPPLIER ENROLLMENT APPLICATION PRIVACY ACT STATEMENT

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

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

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

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

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

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

Protection of Proprietary Information

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

Protection of Confidential Commercial and/or Sensitive Personal Information

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

CMS-588 Electronic Funds Transfer

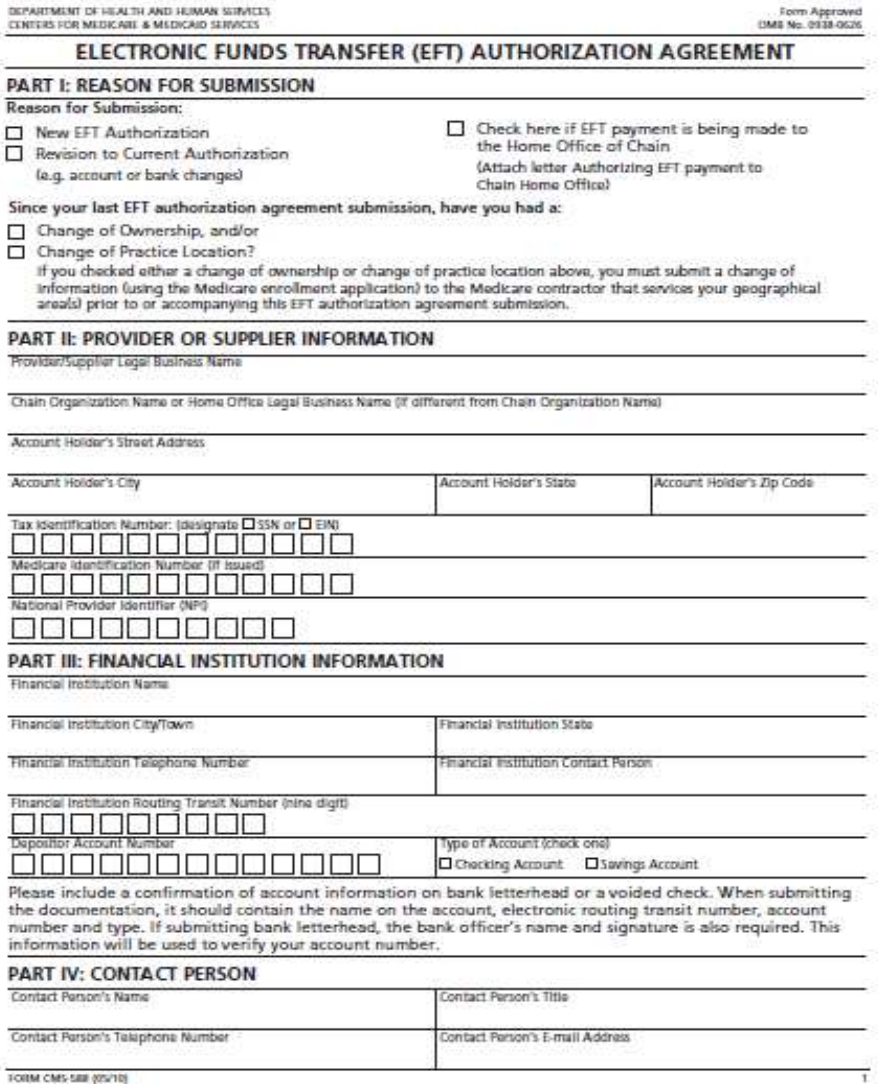
CMS mandates that all providers filing a CMS-855 form receive all Medicare reimbursement electronically. This is a way for Medicare to pay providers with a money transfer directly to a bank account.

The EFT Authorization Agreement (CMS-588) must be included with the enrollment form. The CMS-588 is located at:

http://www.cms.gov/cmsforms/downloads/CMS588.pdf

EFT eliminates the need for a provider to wait for a check to be mailed.

Include a copy of confirmation of account information on bank letterhead or a voided check. (The documentation should contain the name on the account, electronic routing transit number, account number and type. If submitting on bank letterhead, the bank officer's name and signature is also required.)



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

Form Approved
OMB No. 0938-0626

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

PART I: REASON FOR SUBMISSION

Reason for Submission:

- ☐ New EFT Authorization
- ☐ Revision to Current Authorization (e.g. account or bank changes)
- ☐ Check here if EFT payment is being made to the Home Office of Chain (Attach letter Authorizing EFT payment to Chain Home Office)

Since your last EFT authorization agreement submission, have you had a:

- ☐ Change of Ownership, and/or
- ☐ Change of Practice Location?

If you checked either a change of ownership or change of practice location above, you must submit a change of information (using the Medicare enrollment application) to the Medicare contractor that services your geographical area(s) prior to or accompanying this EFT authorization agreement submission.

PART II: PROVIDER OR SUPPLIER INFORMATION

Provider/Supplier Legal Business Name

Chain Organization Name or Home Office Legal Business Name (if different from Chain Organization Name)

Account Holder's Street Address

Account Holder's City | Account Holder's State | Account Holder's Zip Code

Tax Identification Number: (designate ☐ SSN or ☐ EIN)

Medicare Identification Number (if issued)

National Provider Identifier (NPI)

PART III: FINANCIAL INSTITUTION INFORMATION

Financial Institution Name

Financial Institution City/Town | Financial Institution State

Financial Institution Telephone Number | Financial Institution Contact Person

Financial Institution Routing Transit Number (nine digit)

Depositor Account Number | Type of Account (check one) ☐ Checking Account ☐ Savings Account

Please include a confirmation of account information on bank letterhead or a voided check. When submitting the documentation, it should contain the name on the account, electronic routing transit number, account number and type. If submitting bank letterhead, the bank officer's name and signature is also required. This information will be used to verify your account number.

PART IV: CONTACT PERSON

Contact Person's Name | Contact Person's Title

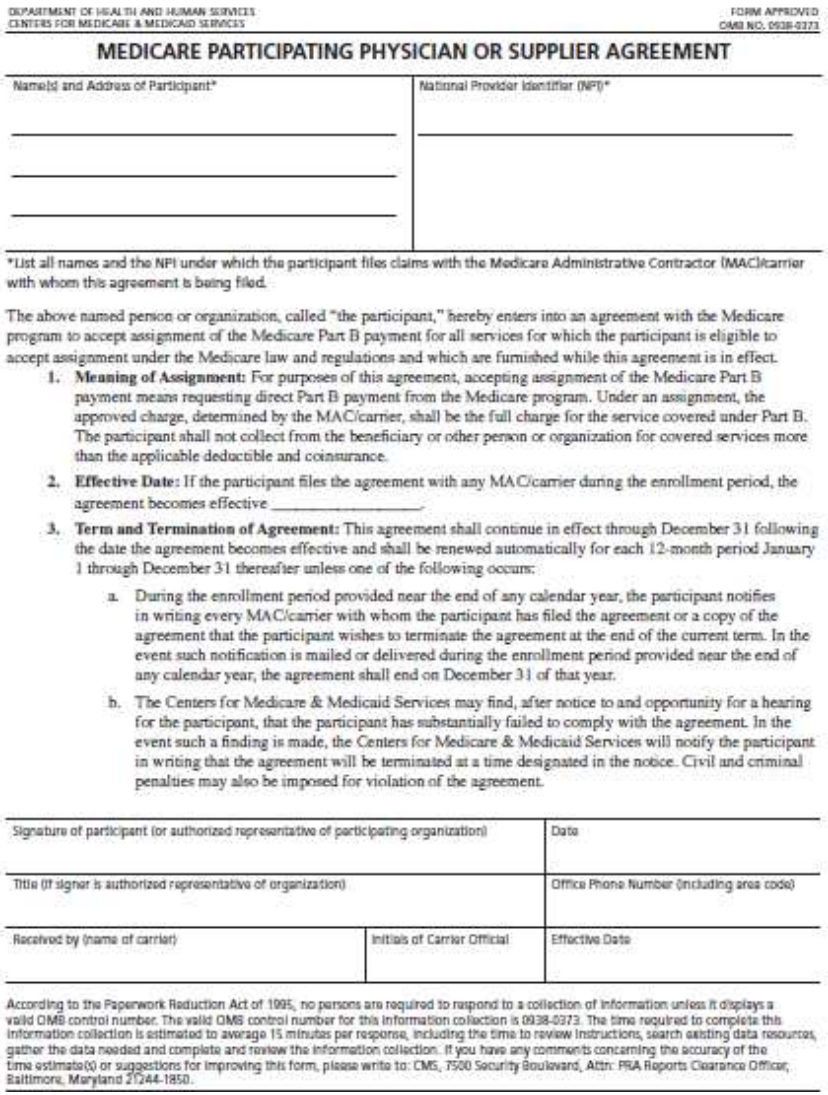
Contact Person's Telephone Number | Contact Person's E-mail Address

FORM CMS-588 (05/10) 1

CMS-460 Participating Provider/Supplier Agreement

Medicare fee schedule amounts for physicians' professional services, services and supplies provided "incident to" physicians' professional services, outpatient physical and occupational therapy services, diagnostic tests or radiology services are 5 percent higher if you participate. Also, providers receive direct and timely reimbursement from Medicare.

http://www.cms.gov/cmsforms/downloads/cms460.pdf



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

FORM APPROVED
OMB NO. 0938-0373

MEDICARE PARTICIPATING PHYSICIAN OR SUPPLIER AGREEMENT

Name(s) and Address of Participant*	National Provider Identifier (NPI)*

*List all names and the NPI under which the participant files claims with the Medicare Administrative Contractor (MAC)/carrier with whom this agreement is being filed.

The above named person or organization, called "the participant," hereby enters into an agreement with the Medicare program to accept assignment of the Medicare Part B payment for all services for which the participant is eligible to accept assignment under the Medicare law and regulations and which are furnished while this agreement is in effect.

1. **Meaning of Assignment:** For purposes of this agreement, accepting assignment of the Medicare Part B payment means requesting direct Part B payment from the Medicare program. Under an assignment, the approved charge, determined by the MAC/carrier, shall be the full charge for the service covered under Part B. The participant shall not collect from the beneficiary or other person or organization for covered services more than the applicable deductible and coinsurance.
2. **Effective Date:** If the participant files the agreement with any MAC/carrier during the enrollment period, the agreement becomes effective _____.
3. **Term and Termination of Agreement:** This agreement shall continue in effect through December 31 following the date the agreement becomes effective and shall be renewed automatically for each 12-month period January 1 through December 31 thereafter unless one of the following occurs:
   a. During the enrollment period provided near the end of any calendar year, the participant notifies in writing every MAC/carrier with whom the participant has filed the agreement or a copy of the agreement that the participant wishes to terminate the agreement at the end of the current term. In the event such notification is mailed or delivered during the enrollment period provided near the end of any calendar year, the agreement shall end on December 31 of that year.
   b. The Centers for Medicare & Medicaid Services may find, after notice to and opportunity for a hearing for the participant, that the participant has substantially failed to comply with the agreement. In the event such a finding is made, the Centers for Medicare & Medicaid Services will notify the participant in writing that the agreement will be terminated at a time designated in the notice. Civil and criminal penalties may also be imposed for violation of the agreement.

Signature of participant (or authorized representative of participating organization)		Date
Title (if signer is authorized representative of organization)		Office Phone Number (including area code)
Received by (name of carrier)	Initials of Carrier Official	Effective Date

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 0938-0373. The time required to complete this information collection is estimated to average 15 minutes 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 any 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, Baltimore, Maryland 21244-1850.

CMS-855R and CMS-855I

CMS-855R:

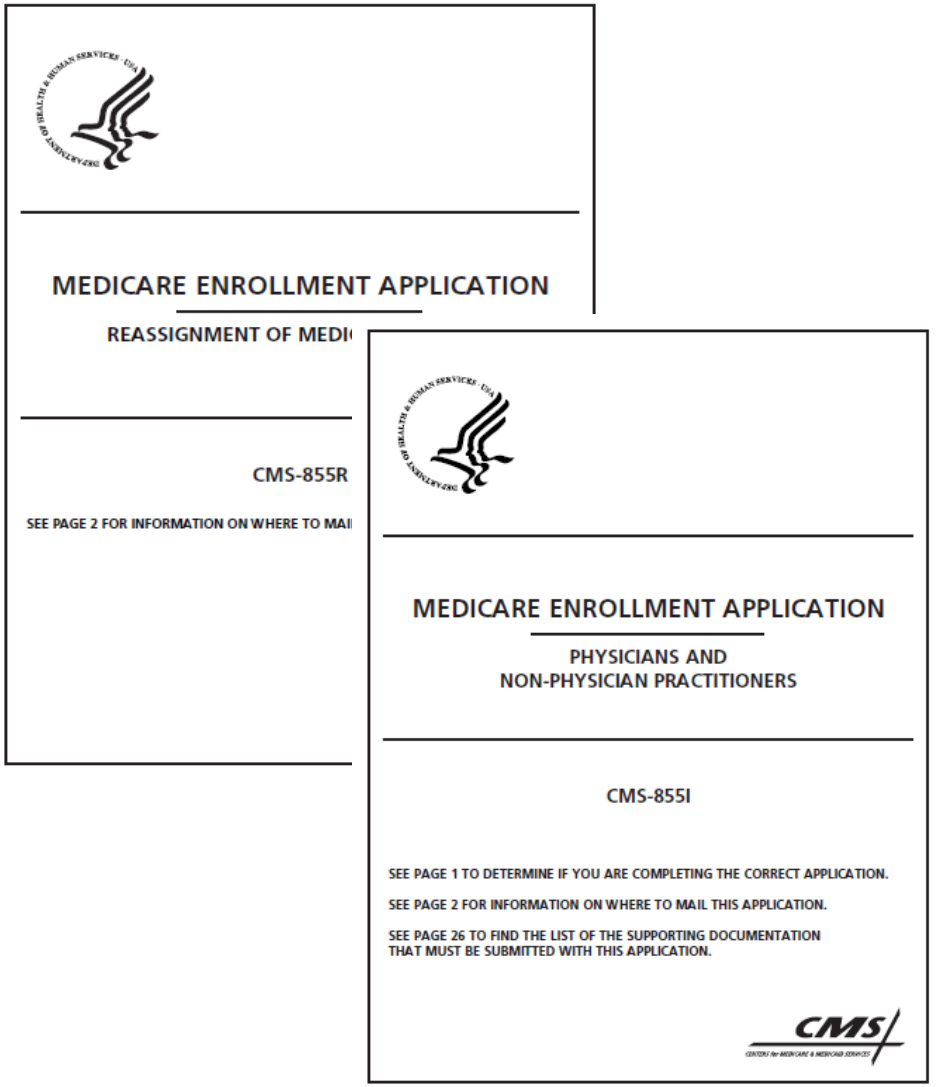
This application is used for reassigning the provider's right to bill the Medicare program and receive Medicare payments or for terminating a reassignment of benefits:

http://www.cms.gov/cmsforms/downloads/cms855r.pdf

CMS-855I:

This application is used for physicians as well as all non-physician practitioners and must be completed to initiate the enrollment process:

http://www.cms.gov/cmsforms/downloads/cms855i.pdf

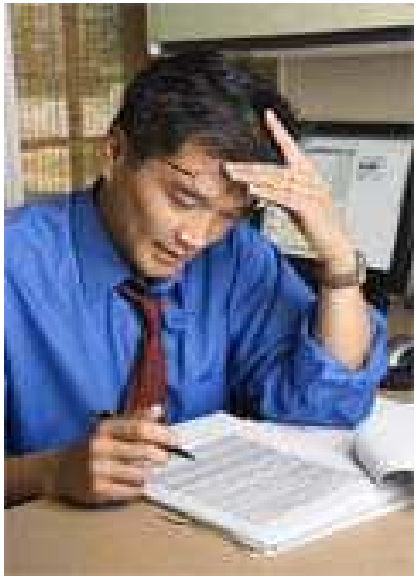


Prescreening

All enrollment applications are prescreened to ensure providers submit a complete enrollment application and all required supporting documentation.

Did you know?

The online PECOS application is scenario-driven and screens the application during entry. This process helps to ensure the online application is complete!



Prescreening (Cont.)

Applications that do not meet the screening requirements will be returned or rejected.

- Returned applications:
  - TrailBlazer will notify the provider (via mail or e-mail) that the application is being returned, the reason for return and how to reapply.
- Rejected applications:
  - TrailBlazer will send a letter to the provider (via mail, e-mail or fax) that documents and requests the missing information.
  - TrailBlazer is not required to make any additional requests for the missing data elements or documentation after the initial letter.

Note: For more detailed information on returns and rejections, see Internet-Only Manual (IOM) Pub. 100-08, Chapter 15, Section 15.8.

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c15.pdf

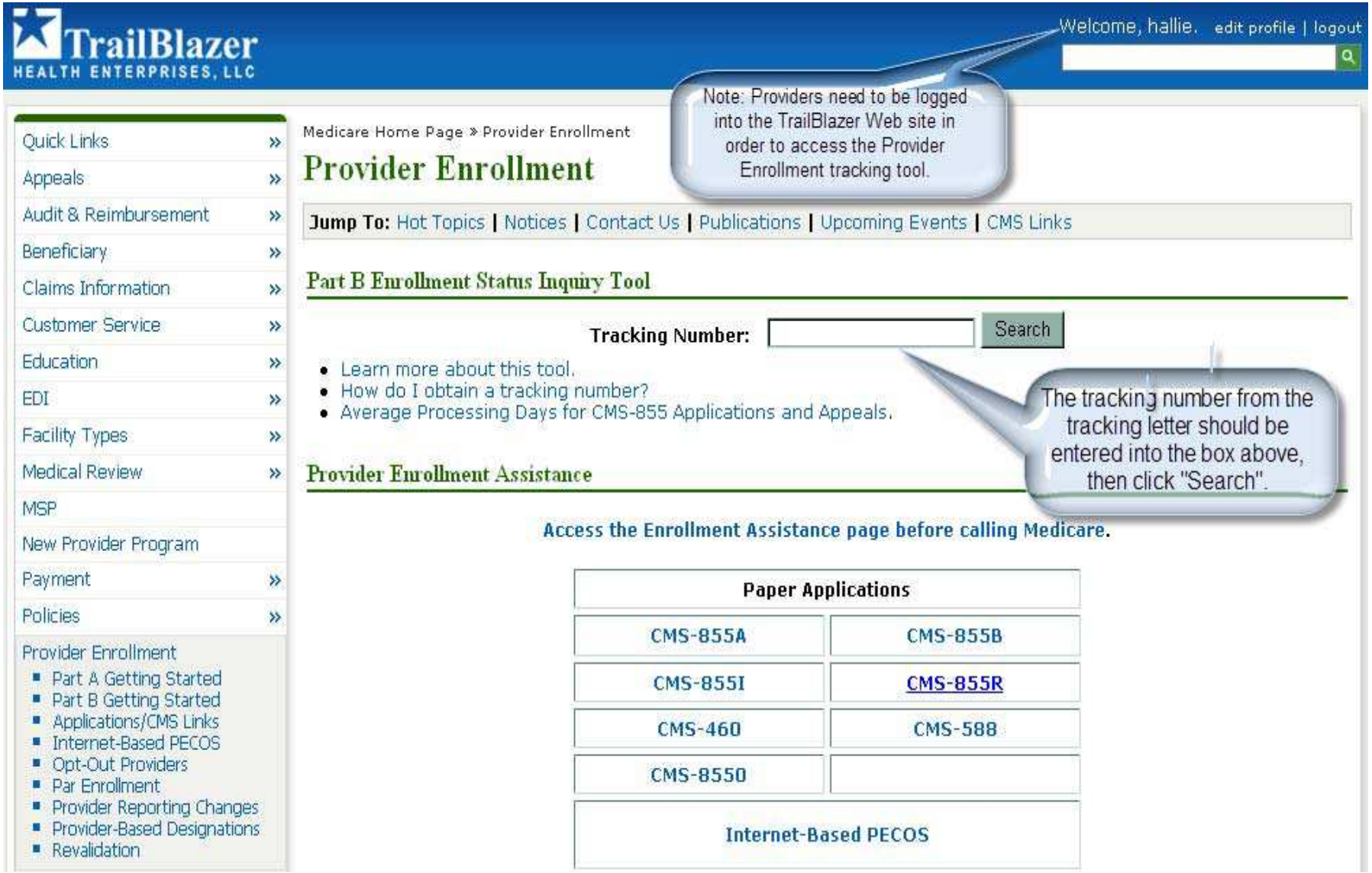
Prescreening (Cont.)

Applications that meet all screening requirements will begin the enrollment process.

- TrailBlazer will send the provider an acknowledgment letter that includes a tracking number to allow the provider to track the various phases of the application.

Note: Providers are encouraged to periodically monitor the progress of the pending application and act accordingly if there are any requests for additional information during the processing phases.

Enrollment Status Inquiry Tool



ASC Enrollment/State Validation

Part of the ASC enrollment process requires state validation.

Once Medicare has verified the ASC enrollment application, the ASC enrollment information is forwarded to the appropriate state for validation and site survey scheduling.

The state will contact the ASC, set up the inspection and then report the results to the CMS Regional Office. CMS will notify TrailBlazer of the effective date for billing privileges.

The application will remain in pending status until the state notifies CMS/Medicare of the “tie-in notice” to finalize and may issue a new ASC provider number.

Questions concerning the state validation process should be directed to the appropriate state agency or regional CMS office for the ASC survey and certification process.

Reminders

1. **Request and obtain an NPI before enrolling or making a change.**
2. **Be sure the CMS-855B application is complete.** A CMS-855B application must be completed by all individuals who will be billing Medicare carriers for medical services furnished to Medicare beneficiaries and by individuals who are already enrolled in Medicare but have a new tax ID. If you are reporting a change to your tax ID, you must complete a new application.
3. **Include the CP575, if needed**. A CP575 must be submitted with the CMS-855I and the CMS-855B application any time a tax ID number is used. The CP575 is the official letter from the IRS confirming the tax ID number with the legal business name. If the CP575 is not available, we will also accept a copy of the quarterly tax payment coupon or any official letter from the IRS that lists the legal business name and tax ID number.

Reminders (Cont.)

4. **Include all necessary supporting documentation.** This supporting documentation includes the CP575 and the CMS-588 authorization form for EFT, bank documentation, and CMS-460 if participating.
5. **Identify a contact person.** Once your application has passed CMS prescreening guidelines, a Provider Enrollment analyst will conduct research and validation of the enrollment application. Identifying a contact person who is familiar with the application and who has access to the physician, practitioner or administrator will help TrailBlazer obtain the necessary information and/or documentation in a timely manner.
6. **Sign and date the application.** In accordance with CMS regulations, any unsigned CMS-855 applications will be returned to the applicant. Any changes requested must include the effective date of the change.
7. **Submit the completed CMS-855B application.**

Mailing Address

Mail the provider enrollment form to:

TrailBlazer Health Enterprises, LLC Medicare Part B Provider Enrollment			
Colorado	**New Mexico**	**Oklahoma**	**Texas/IHS**
P.O. Box 650710 Dallas, TX 75265-0710	P.O. Box 650709 Dallas, TX 75265-0709	P.O. Box 650711 Dallas, TX 75265-0711	P.O. Box 650544 Dallas, TX 75265-0544

Physical address:

TrailBlazer Health Enterprises, LLC
Medicare Part B Provider Enrollment
Executive Center III
8330 LBJ Freeway
Dallas, TX 75243-1756

Provider Enrollment Hotline

If you have any questions, contact the Provider Enrollment department:

(866) 539-5596

Completion

Congratulations! This completes the CMS-855B application for ASCs.

Prior to mailing the form, review the information to ensure all items are completed, if appropriate, and copies of all attachments are included.

How to Complete the Paper CMS-855B Enrollment Application for an ASC

Thank you for participating.