OMB Approval No. 0938-0685

MEDICARE AND OTHER FEDERAL HEALTH CARE PROGRAMS PROVIDER/SUPPLIER ENROLLMENT APPLICATION INSTRUCTIONS

General Application - HCFA 855

Upon completion, return this application and all necessary documentation to:

MEDICARE REGISTRATION
P O BOX 44021
JACKSONVILLE, FLORIDA 32231-4021

General

This application must be completed by all providers and suppliers of medical and other health services for enrollment in the Medicare or any other federal health care program.

Some applicants may also need to be surveyed and/or certified by the appropriate State Agency or Regional Medicare Office when required to meet Medicare conditions of enrollment. In this case, those applicants must initially contact the State Agency or Regional Medicare Office prior to completion and submission of this application.

If you need assistance or have any questions concerning the completion of this application, contact your local Medicare or other federal health care contractor.

A separate application must be submitted for each classification of provider/supplier type (e.g., physician in private practice, physician in group practice) even if the different types of services are furnished within the same organization or entity (e.g., hospitals and all affiliated units).

Each entity of an organization must submit a separate application (e.g., hospital based skilled nursing facility, hospices, outpatient clinics, etc.). Each entity of a chain organization must submit a separate application.

Providers and/or suppliers enrolling in the Medicare or any other federal health care program as a group member, partner, or individual contractor who reassigns their Medicare or other federal health care program benefits to the enrolling applicant must also complete HCFA Form 855R (Individual Reassignment of Benefits Application).

Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies must enroll in the Medicare or any other federal health care program using HCFA Form 855S (DMEPOS Supplier Enrollment Application) instead of this application.

Upon completion and approval of this application, the applicant will be issued a provider/supplier billing number. This number will be automatically deactivated if it is inactive for 12 consecutive months. A new HCFA Form 855 must be completed and approved to re-activate the billing number.

For your convenience, the application form of this package has been perforated for easy removal of individual pages. It is not necessary to return the instructions or unused attachments when returning this completed application.

Note: Any changes in the information reported in this application must be reported to the Medicare or other federal health care contractor within 30 calendar days of said change.

Definitions

Authorized Representative: The appointed official (e.g., officer, chief executive officer, general partner, etc.) who has the authority to enroll the entity in Medicare or other federal health care programs as well as to make changes and/or updates to the applicant's status, and to commit the corporation to Medicare or other federal health care program laws and regulations.

The Authorized Representative may be contacted to answer questions regarding the information furnished in this application.

Chain Organization: Multiple providers and/or suppliers (chains) are owned, leased or through any other devices, controlled by a single business entity. The chain organization must consist of two or more health care facilities. The controlling business entity is called the chain "Home Office." Each entity in the chain may have a different owner (generally chains are not owned by the "Home Office").

Typically, the chain "Home Office:"

-maintains uniform procedures in each facility for handling admissions, utilization review, preparation and processing admission notices and bills;

-maintains and controls centrally, individual provider/supplier cost reports and fiscal records and a major part of the Medicare audit for each component can be performed centrally.

Examples of provider types that would typically be chain organizations are: Certified Outpatient Rehabilitation Facilities (CORFs); Skilled Nursing Facilities (SNFs); and Home Health Agencies (HHAs).

Clinical Laboratory Improvement Amendments (CLIA) Number : This number is assigned to laboratories who are certified by the Health Care Financing Administration (HCFA) under the Clinical Laboratory Improvement Amendments.

Note: Any laboratory soliciting or accepting specimens for laboratory testing is required to hold a valid certificate issued by the Secretary of the United States Department of Health and Human Services or hold a license from a CLIA exempt State.

Consolidated Cost Report: A cost report compiled for multiple facilities joined together and filed under the parent facility's Medicare Identification Number.

Contractor: Any individual, entity, facility, organization, business, group practice, etc., receiving an Internal Revenue Service (IRS) Form 1099 for services provided to this applicant (e.g., independent contractor, subcontractor).

Distinct Part Unit [of a facility]: A separate psychiatric, rehabilitation, or skilled nursing unit that is attached to a hospital paid under the Prospective Payment System (PPS) but which is paid on a cost reimbursement or other non-PPS basis. It must be a clearly identifiable unit, such as an entire ward, wing, floor, or building, including all the beds and related services in the unit, that meets all the requirements for a type of facility other than the one in which it is located, **and** houses all the beneficiaries and recipients for whom payment is made under Medicare for services in the other type of facility.

Food and Drug Administration Number (FDA): This is the certification number assigned by the FDA for equipment used in mammography screening and diagnostic services.

Group Member: A physician or non-physician practitioner who renders services in a group practice and who reassigns benefits to the group.

Independent Diagnostic Testing Facility (IDTF) (formerly Independent Physiological Laboratories (IPL's)): An entity independent of a hospital or physician's office in which diagnostic tests are performed by licensed, certified non-physician personnel under appropriate physician supervision (e.g., free standing cardiac catherization facility, imaging center, etc.).

Legal Business Name: The legal name of the individual or entity applying for enrollment. This name should be the same name the applicant uses in reporting to the Internal Revenue Service.

Medicaid Number: This number uniquely identifies the applicant as a Medicaid provider and/or supplier in a given State.

Medicare Identification Number: This number uniquely identifies the applicant as a Medicare provider and/or supplier and is the number used on claim forms. The Medicare Identification Number is also known as Medicare Provider Number and Provider Identification Number (PIN). Examples of Medicare Identification Numbers are the UPINs, OSCAR numbers, and NSC numbers.

Note: If the applicant is enrolling in the Medicare or other federal health care programs for the first time, the applicant will receive a Medicare or other federal health care program identification number upon enrollment.

National Provider Identifier (NPI): This number is assigned using the National Provider System to identify health care providers and/or suppliers. In the future, it will replace the Medicare Identification Number.

National Supplier Clearinghouse Number (NSC): This number uniquely identifies the applicant as a supplier of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). It is the number used by DMEPOS suppliers on claim forms.

On-Line Survey Certification and Reporting System (OSCAR): National database used for maintaining and retrieving survey and certification data for certified providers and/or suppliers that are approved to participate in the Medicare, Medicaid and CLIA programs. OSCAR numbers are assigned by the Regional Medicare office.

Other Affiliated Units: Entities that are either a Provider Based Facility, a Distinct Part Unit, or file a consolidated cost report.

Provider Based Facility: Entities operating under the control of a parent organization (e.g., hospital based End Stage Renal Disease Unit, Skilled Nursing Facility, etc.).

Reassignee: An individual or organization that allows another organization to bill Medicare or other federal health care programs on their behalf for services rendered.

Unique Physician Identification Number (UPIN): This number is assigned to physicians, non-physician practitioners and groups to identify the referring or ordering physician on Medicare claims.

APPLICATION COMPLETION INSTRUCTIONS

Furnish all requested information in its entirety. If a field is not applicable, write N/A in the field. If entire section is not applicable, check the box at the beginning of the section indicating the entire section is not applicable. Any section of the application that does not have a check box at the beginning of the section indicating the entire section is not applicable must be completed by applicant.

Check Type of Business: (For administrative purposes only)

Check appropriate box indicating how applicant's business is structured. The answer to this item will not affect the amount of reimbursement or enrollment status.

Note: If applicant's business structure is a **partnership,** applicant must provide a copy of its partnership agreement signed by all parties and identifying the general partner (if any) and attest that the partnership meets all State requirements. **Partnerships** see group instruction.

Check "Applicant Enrolling As" Type: (For administrative purposes only) The answer to this item will not affect the amount of reimbursement or enrollment status.

See the instructions below that identify which sections the

applicant is responsible for completing.

Individual: An individual person enrolling as a physician, supplier or non-physician practitioner (e.g., physician, nurse, midwife, etc.).

Note: An individual who is registered as a business is considered a sole proprietor for the purpose of completing this application and should not check this box.

Individuals complete sections 1a, 1d, 2, 3, 4, 5, 6, 7, 8, 9, 12, 13, 14, 15, 17, and 18.

Sole Proprietor: An individual person registered as a business and issued a tax identification number from the IRS and rendering services under the business name.

Sole Proprietors complete sections 1a, 1b, 1d, 2, 3, 4, 5, 6, 7, 8, 9, 12, 13, 14, 15, 17 and 18.

Organization: A company, not-for-profit entity, governmental agency (Federal, State, or Local) or a qualified health care delivery system which renders medical care (e.g., pharmacy, equipment manufacturer, hospital, Public Health Clinic, laboratory, skilled nursing facility, Ambulance Service Supplier, Independent Diagnostic Testing Facility, etc.).

Organizations complete sections 1b, 1d, 2, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, and 18.

Ambulance Service Suppliers must also complete Attachment 1.

Independent Diagnostic Testing Facilities must also complete Attachment 2.

Home Health Agencies must also complete Attachment 3.

Group: Two or more physicians, non-physician practitioners or other health care providers/suppliers who form a practice together (as authorized by State law) and bill Medicare or other federal health care programs as a single unit. A group has individual practitioners. The individual members must be enumerated and enrolled in the Medicare or other federal health care program as individuals in order to enroll as members of the group.

Only those health care practitioners who are authorized to bill Medicare or other federal health care programs directly in their individual capacities are allowed to form a group. A group can only be enrolled if it can meet the conditions for reassignment (see instructions for the Reassignment of Benefits section).

The above definition of a group is to be used for Medicare or other federal health care programs' enrollment purposes only. It is not the group definition described in section 1877(h) of the Social Security Act.

Groups/Partnerships complete sections 1c, 1d, 2, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 17 and 18.

All group member/partners must complete HCFA Form 855R.

Note: PARTNERSHIPS: For purposes of this application, partnerships should check that they are "enrolling as" a group.

Note: RURAL HEALTH CLINICS: Rural Health Clinics that meet the definition of a group, should also submit HCFA Form 855R (Individual Reassignment of Benefits Application) for each member of the group. This is not applicable to those Rural Health Clinics that are provider based.

Mass Immunization Biller Only: A health care provider/supplier who roster bills Medicare or other federal health care programs solely for mass immunizations.

Mass Immunization/Roster Billers complete sections 1a, 1b, 1d, 2, 5, 6, 7, 8, 9, 12, 13, 14, 15, 17 and 18.

Note: Applicants enrolling in the Medicare or other federal health care program as mass immunization/roster billers cannot bill the Medicare or other federal health care program for any other services. The applicant agrees to accept assignment of the influenza/pneumococcus benefit as payment in full and cannot "balance bill" the beneficiary.

For those who are only applying to enroll in the Medicare or other federal health care program to roster bill for mass immunization, enter "Roster" under primary speciality in Section 1A if applicant is an individual, or enter "Roster" under type of facility in Section 1B if applicant is an organization.

Check appropriate federal health care program:

If applicant is enrolling in a federal health care program other than Medicare, check the appropriate box. Check only one box. For each federal health care program in which the applicant wishes to enroll, the applicant must complete a separate enrollment application and submit it to that federal health care program.

Check Application For:

Initial Enrollment: Applicant is enrolling in the Medicare or other federal health care programs for the first time, or re-activating a prior Medicare billing number.

Enrollment of Additional Location(s): Currently enrolled provider/supplier is applying to enroll a new practice location.

Recertification: Currently enrolled provider/supplier is completing application to comply with mandatory periodic re-survey and/or recertification through the State agency or Regional Medicare Office.

Change of Ownership (CHOW): This term applies to certain limited circumstances as defined in 42 CFR § 489.18 as described below.

A new or prospective new owner must complete this application to report new or prospective new ownership. In addition, the

applicant must also submit an Individual Reassignment of Benefits Application (HCFA Form 855R) identifying all individuals who will reassign their benefits to the applicant.

A change of ownership is defined as:

- In the case of an unincorporated sole proprietorship, transfer of title and property to another party;

- In the case of a corporation, the merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation (transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute a change of ownership); and

- In the case of leasing, the lease of all or part of a provider/supplier facility constitutes a change of ownership of the leased portion.

  Note: A currently enrolled provider/supplier who is reporting new information on the current owners (i.e., addition(s) or deletion(s) of owner(s)) which is not expected to result in a CHOW as defined above, must make the appropriate changes using the ownership information section of this application. This action is considered a change of information (see below).

Change of Information: Currently enrolled provider/supplier is completing applicable sections of the application to report a change in information other than a CHOW as defined above. Currently enrolled provider/suppliers can use HCFA Form 855C (Change of Information Form) to report changes in name, specialty, e-mail address, practice location address, billing agency address, pay to address, surety bond changes/renewals, mailing address, pricing locality, telephone number(s), fax number(s), deactivation of Medicare or other federal health care billing number(s), addition or deletion of authorized representatives, and potential termination of current ownership.

Changes not listed above must be reported using this application.

When using this application to notify the Medicare or other federal health care program that a practice location(s), owner(s), or various personnel are no longer associated with this entity, check the appropriate deletion box in the applicable section(s) and identify the practice location and/or personnel.

All changes must be reported in writing and have an original signature. For individuals, the applicant must sign and for organizations and group practices, an "Authorized Representative" must sign to confirm the requested change(s). Faxed or photocopied signatures will **not** be accepted.

Check Where Applicant Will Be Submitting Bills:

MEDICARE APPLICANTS ONLY

Fiscal Intermediary: Applicant will be enrolled to bill the fiscal intermediary only. The fiscal intermediary is generally known as the Part A Medicare Contractor. The applicant will generally be a hospital or other health care facility.

- In the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable State law;

Carrier: Applicant will be enrolled to bill the carrier only. The carrier is generally known as the Part B Medicare Contractor. The applicant will generally be a physician or non-physician practitioner.

Both: Application will automatically be forwarded to bill both the fiscal intermediary and the carrier for enrollment consideration.

Regional Home Health Intermediary: Applicant will be enrolled to bill the regional home health intermediary.

If applicant checked that they will be billing a fiscal intermediary, indicate applicant's preferred choice of fiscal intermediary from the separate list included in this package.

Check other federal health care program(s) where applicant is currently enrolled:

If applicant is currently enrolled in any other federal health care program(s), check all appropriate boxes.

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1. Applicant Identification

A. Individuals Only

Complete all items in this section if applicant plans to bill the Medicare or other federal health care program as an individual practitioner.

If an individual or sole proprietorship, complete applicant's full name (this is the name payment will be made in), date and place of birth (county and/or city). If applicant has previously practiced or operated a business under another name, including applicant's maiden name, supply that name under Other Name.

If applicable, check if applicant is a resident or intern at a hospital.

If applicant is enrolling as an individual or sole proprietor, furnish the applicant's primary speciality (e.g. general practitioner, urologist, nurse practitioner, etc.). Listing a secondary speciality is optional.

Gender and Race/Ethnicity information is optional. This data will only be used to assist HCFA in uniquely identifying the applicant.

A. Individuals Only (continued)

If applicant is employed by an entity that will receive payments for the applicant's services, applicant must complete and sign the HCFA Form 855R (Individual Reassignment of Benefits Application).

B. Organizations Only

Complete this section if applicant is a sole proprietor of the business or if applicant is a publicly or privately held business entity.

Complete all items in this section. For Legal Business Name, supply the name that the business, organization or group practice reports to the IRS (this is the name payment will be made in). For Type of Facility give the classification that designates the entity (e.g., hospital, skilled nursing facility, home health agency, ambulance company, etc.), and check whether this facility is accredited or non-accredited.

> **Note:** Clinical laboratories and independent diagnostic testing facilities should annotate this section "LABORATORY" (LAB).

All organizations must identify if they are considered a Provider Based Facility, a Distinct Part Unit, or file a consolidated cost report under another provider/supplier Medicare identification number. If an organization is a Distinct Part Unit, then the organization also falls under the broader category of Provider Based Facility.

If the organization is a:

-Provider Based Facility;
-Distinct Part Unit;
-or files a consolidated cost report,

then the organization must provide the name and Medicare identification number of their parent provider.

> **Note:** The final determination as to whether an entity is truly a Provider Based Facility will be made by HCFA prior to completion of the enrollment process.

In addition to the parent provider relationship described above, the organization must identify how many Provider Based Facilities, Distinct Part Units, Branches, or Multi-campus sites the organization is responsible for. For each of those locations identified, the Practice Location(s) section of this application must be completed.

If applicant receives payment from Medicare or any other federal health care agency for any services rendered by a contractor, when permitted by Medicare or other federal health care program requirements, the contractor must complete and sign the HCFA Form 855R (Individual Reassignment of Benefits Application).

C. Physician and Non-Physician Practitioner Groups Only

Complete all items in this section. Furnish the group's legal business name. This should be the legal name used in reporting to the IRS. Furnish the group's primary specialty (the primary specialty of the majority of the group's members). Designation of a secondary specialty is optional. All group members who the group will be billing the Medicare or other federal health care program in their behalf, must be individually enrolled in the given Medicare or other federal health care program.

> **Note:** The group's members must be enrolled within the same federal health care program as the group enrollment. Otherwise, the group member must enroll separately as an individual in the group's federal health care program prior to becoming a member of that group practice.

Each group member must complete and sign the HCFA Form 855R (Individual Reassignment of Benefits Application).

> **Note: PARTNERSHIPS**: When completing this section, provide legal business name of partnership, date partnership was incorporated, and the State where the partnership is incorporated. Place "n/a" in the specialty block.

D. All Applicants

Provide applicant's mailing address. This is where the applicant can receive correspondence and bulletins from Medicare or other federal health care program contractors. This address may be the applicant's home address or a Post Office Box. Applicant must supply fax number and e-mail address if available. If applicable, provide applicant's previously assigned Medicare Identification Number(s) and the name(s) of the Carrier and/or Fiscal Intermediary to which applicant most recently submitted bills using this number. If applicable, provide applicant's most recent Medicaid number and the State in which it was issued. Applicant must provide his/her social security number and when applicable, his/her employer identification number(s).

> **Note:** All applicants **must** provide either their social security number and/or, when applicable, their employer identification number (EIN). **If applicant uses more than one EIN, list all, starting with the EIN(s) currently used or to be used for tax reporting purposes relating to this application. Attach a copy of IRS Form CP 575 to verify the applicant's EIN.**

Applicant must answer all questions related to criminal activity. Answering "yes" to any of these questions will not automatically deny enrollment into Medicare or other federal health care programs. For purposes of these questions related to criminal activity, an "immediate family member" of the applicant is defined as:

- a husband or wife;
- the natural or adoptive parent, child or sibling;
- the stepparent, stepchild, stepbrother or stepsister;
- the father, mother, daughter, son, brother or sister;
- parent-in-law, brother-in-law or sister-in-law;
- the grandparent or grandchild; and
- the spouse of a grandparent or grandchild.

For purposes of these questions related to criminal activity, "member of household" with respect to the applicant is defined as any individual sharing a common abode as part of a single family unit with the applicant, including domestic employees and others who live together as a family unit, but not including a roomer or boarder.

Indicate whether the applicant (under the name of the applicant shown on this application or any other name) has any

outstanding overpayments with Medicare, Medicaid or any other federal program. If the applicant has an outstanding overpayment, furnish the name of the federal program where the overpayment exists. If this outstanding overpayment is in a name other than the name identified in the Applicant Identification section, furnish the other name in the space All applicants are required to furnish information on all Federal, State and local (city/county) professional and business licenses, certifications and/or registrations required to practice as applicant's provider/supplier type in applicant's (e.g. State medical license for physician, State certification and/or registration for Nurses, Federal DEA number, Business Occupancy License, local business license, etc.). The local Medicare or other federal health care contractor will supply specific credentialing requirements for applicant's provider/supplier type upon request.

Notarized or "certified true" copies of the above information are optional, but will speed the processing of this application.

> **Notarized:** A notarized copy of an original document that will have a stamp which states "Official Seal" along with the name and signature of the notary public, State, County, and the date the notary's commission expires.
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> **Certified True:** This is a copy of the original document obtained from where it originated or is stored, and it has a raised seal which identifies the State and County in which it originated or is stored.

In lieu of copies of the above requested documents, the applicant may submit a notarized or "certified true" Certificate of Good Standing from the applicant's State licensing/certification board or other medical association. This certificate cannot be more than 30 days old.

Non-physician practitioners who must meet Medicare or other federal health care program requirements for professional experience should submit evidence of practice and the dates of employment.

If applicant's enrollment requires a State survey and/or certification, the applicant is required to forward copies of State survey and/or certification documents to the Medicare or other federal health care contractor once they are received from the State agency or Regional Medicare Office.

> **Note:** Temporary licenses are acceptable submissions with this application. However, once received, a copy of the applicant's permanent license must be forwarded to the Medicare or other federal health care program contractor within 30 days of receipt.

If applicant's State licensure is dependent upon State survey and/or certification, check applicable box and furnish information on all other required licensing information.

> **Note:** A business license is required for each practice location.

If applicant had a previously revoked or suspended license, certification, or registration reinstated, attach a copy of the reinstatement notice(s) with this application, if applicable.

provided.

2. Professional and Business License, Certification, and Registration Information

3. Professional School Information (Individuals Only)

If applicable, supply information about the educational institution from which applicant received medical, professional, or related degree or training as required by applicant's State. Enclose copies of diploma, degree or evidence of qualifying course work.

Non-physician practitioners who must meet HCFA or other federal health care program requirements for education must provide documentation of courses or degrees taken that satisfy Medicare or other federal health care program requirements. Contact the local Medicare or other federal health care program representative for requirements needed for applicant's provider/supplier type.

4. Board Certification

If applicant is Board Certified, furnish requested information for each Board Certification obtained by the applicant.

5. Exclusion/Sanction Information

Supply all requested information. If applicable, attach copy(s) of any official documentation related to the adverse legal action identified, including reinstatement notices. If applicant has not had any adverse legal actions, check the "none of these" box.

6. Practice Location(s)

Provide all information requested for each location where applicant will render services to Medicare or other federal health care program beneficiaries.

Individual practitioners should include all hospitals and/or other health care facilities where they render service or have privileges to treat patients. Individual practitioners who only render services in the patient's home (house calls) should supply his/her home address in this section. If individual practitioners render services in retirement or assisted living communities, complete this section using the names and addresses of these communities.

Hospitals must list all off-site clinics, distinct part units, and provider based facilities (e.g., skilled nursing facility, rural health clinic, etc.) and multi-campus sites.

Home health agencies and hospices must list all branches.

> **Note:** Listing the facilities, clinics, units, and multi-campus sites controlled by a hospital or other entity does not automatically enroll them in the Medicare or other federal health program. The HCFA Form 855 (General Enrollment Application) must also be completed for each of these entities.

Post Office boxes and drop boxes are **not** acceptable as practice location addresses. The phone number must be a number where patients and/or customers can reach the applicant to ask questions or register complaints.

Furnish the "Pay To" address for payment of services rendered at this practice location. Payments will be made in the legal business name that the individual, organization, or group/partnership uses to report to the IRS, as reported in Section 1 of this application. In most circumstances, payment will be made in the name of the individual who furnished the service unless a valid Reassignment of Benefits Statement has been completed. The "Pay To" address may be a Post Office box.

Furnish the name and social security number of the primary managing/directing employee of this practice location.

If applicable, provide the CLIA number or FDA certification number associated with each piece of equipment at each practice location and submit a copy of the most current certification.

6. Practice Location(s) (continued)

Indicate whether patient records are kept on the premises. If not, supply the name of the storage facility/location and the physical address where the records are maintained. Post Office boxes and drop boxes are **not** acceptable as the physical address where patient records are maintained.

7. Prior Practice Information

FOR MEDICARE ENROLLMENT ONLY

If applicant has previously billed Medicare or Medicaid, supply requested information about the prior practice. Indicate whether applicant was a participating or non-participating provider/ supplier in the prior practice.

8. Ownership Information

Complete this section for all individuals and/or entities who have an ownership or control interest in the applicant's business/entity. If owner is an individual, complete owner name, social security number and employer identification number. If applicant is owned by another entity, complete legal business name and employer identification number of the owning entity as well as the name(s) and social security number of each owner of that entity. Entities with ownership interest must provide their legal business name(s).

A person or entity with an ownership or control interest is one that:

- has an ownership interest totaling 5% or more in the provider/supplier;
- has a direct, indirect, or combination of direct and indirect ownership interest equal to 5% or more in the provider/supplier, where the amount of an indirect ownership interest is determined by multiplying the percentages of ownership in each entity (for example, if A owns 10 % of the stock in a corporation that owns 80% of the provider/supplier, A's interest equates to an 8% indirect ownership interest in the provider/supplier and must be reported);
- owns an interest of 5% or more in any mortgage, deed of trust, note or other obligation secured by the provider/supplier if that interest equals at least 5% of the value of the property or assets of the provider/supplier;
- is an officer or director of a provider/supplier that is organized as a corporation; and/or
- is a partner in a provider/supplier that is organized as a partnership.

Supply all requested information about the owner's past and present billing relationships with Medicare. Furnish past history for the last 10 years. If data is not known or is incomplete, check the appropriate box.

Supply all requested adverse legal action information about the owner(s). If applicable, attach copy(s) of any official documentation related to the adverse legal action identified, including reinstatement notices. If none of the owner(s) has had any adverse legal actions, check the "none of these" box.

Attach a copy of the applicant's IRS Form CP 575 pertaining to this business. The IRS Form CP 575 will be used to verify the employer identification number (EIN).
In lieu of the IRS Form CP 575, the applicant may use any official correspondence, such as the quarterly tax payment coupon, from the IRS showing the name of the entity as shown on this application and the EIN.

9. Managing/Directing Employees

Complete this section for all managing and/or directing employees, employed by the applicant. This section should include, but is not limited to, general manager(s), business manager(s), administrator(s), director(s), or other individuals who exercise operational or managerial control over the provider/supplier, or who directly or indirectly conduct the applicant's day-to-day operations.

Note: This section **is not** to be completed with information about billing agency or management service organization employees. If applicant uses a billing agency or management service organization, complete the appropriate section of this application.

Note: Non-profit organizations should complete this section with information about the members on the Board of Directors and the managing and/or directing employees and submit a copy of the 501(C)(3) approval notification from the IRS.

Note: For large business organizations, furnish only the top 20 compensated managing and/or directing personnel. Social security numbers must be provided for all persons listed in this section.

Applicant must include all managing and/or directing

employees for each practice location. Organizations must also complete this section for all corporate officers. Include the name(s) and address(es) of all practice location(s) where this employee manages and/or directs.

Supply all requested information about the managing and/or directing employee's past and present billing relationships with Medicare or other federal health care programs.

Supply all requested information about other entities this managing and/or directing employee managed or directed that previously billed or are presently billing the Medicare or other Supply all requested adverse legal information about the managing/directing employee(s). If applicable, attach copy(s) of any official documentation related to the adverse legal action identified, including reinstatement notices. If none of the managing/directing employee(s) has had any adverse legal actions, check the "none of these" box.

10. Parent/Joint Venture or Subsidiary Information

If applicant is a subsidiary (wholly or partially owned by another organization or business), or a joint venture (equally owned by another individual(s), organization(s) or business(s)), complete all information requested in this section about the parent company or joint venture. Attach a copy of the parent company's or other owner's IRS Form CP 575 pertaining to this business.

11. Chain Organization Information

When applicable, this section to be completed by Medicare Part A Institutional provider/suppliers ONLY. This includes all institutional chain provider/suppliers that bill fiscal intermediaries (e.g., Home Health Agencies and Skilled Nursing Facilities).

If applicant is in a chain organization, check appropriate action block for this chain, then supply all information requested about the chain home office.

12. Contractor Information (Business Organizations)

This section is to be completed with information about all business organizations that the applicant contracts with that:

- provide medical or diagnostic services or medical supplies for which the cost or value is $10,000 or more in a 12 month period; OR
- will reassign benefits to the applicant, regardless of annual cost or value of medical or diagnostic services or medical supplies provided.

Provide all requested information about the contractor's past and present billing relationships with Medicare or Medicaid.

Supply all requested adverse legal action information about the contractor(s). If applicable, attach copy(s) of any official documentation related to the adverse legal action identified, including reinstatement notices. If none of the contractor(s) has had any adverse legal actions, check the "none of these" box.

If a business or group contractor will be reassigning Medicare or other federal health care program benefits to the applicant, federal health care programs. Furnish past history for the last 10 years. If data is not known or is incomplete, check the box indicating this.

Supply all requested information about other entities this managing and/or directing employee had ownership interest in that previously billed or are presently billing the Medicare or other federal health care programs. Furnish past history for the last 10 years. If data is not known or is incomplete, check the appropriate box.

an authorized representative of the business or group contractor must complete and sign the Reassignment of Benefits section of this application. See instructions below for additional reassignment of benefits information.

> **Note:** Individuals with whom the applicant contracts with to do business and who will reassign benefits to the applicant must complete the **HCFA Form 855R** (Individual Reassignment of Benefits Application).

If a currently enrolled provider/supplier is obtaining the services of a new contractor that will be reassigning its benefits, complete only the Application Identification section, the Contractor Information section and the Reassignment of Benefits Statement.

13. Reassignment of Benefits Statement

In general, Medicare and other federal health care programs make payment only to the beneficiary or the individual or entity that directly provides the service.

Reassigned benefits must be within the same federal health care program (e.g., Medicare to Medicare, CHAMPUS to CHAMPUS, etc.).

If the applicant receives payment on behalf of other business organizations for services provided, the other business organization must complete and sign the Reassignment of Benefits Statement. Failure to do so will cause a delay in processing the application and limit the Medicare or other federal health care program contractor's ability to make payment.

This section must be signed by an Authorized Representative of the entity reassigning its benefits to this applicant.

The reassignee is permitted by Federal law to reassign Medicare benefits to an employer, the facility where the service is rendered, a health care delivery system, or agent. For further information on Federal requirements on reassignment of benefits the applicant should contact the local Medicare or other federal health care program contractor before signing the application.

The Legal Business Name of the applicant must be the same as the Legal Business Name of the applicant identified in Section 1 of this application.

Individual practitioners, including individual contractors and group members, who reassign Medicare or other federal health

care program benefits to this applicant must complete the HCFA Form 855R. Individual practitioners who are contracted by the applicant, but do not reassign their benefits to the applicant do not need to complete the HCFA Form 855R.

14. Billing Agency/Management Service Organization Address

A Billing Agency is a company contracted by the applicant to furnish all claims processing functions for the applicant's practice.

A Management Service Organization is a company contracted by the applicant to furnish some or all administrative, clerical and claims processing functions of the applicant's practice.
Any change in the contract between the applicant and the billing agency and/or management service organization must be reported to the Medicare or other federal health care program contractor within 30 calendar days of said change.

15. Electronic Claims Submission Information

If applicant plans to submit bills electronically, or would like information about electronic billing, supply a contact name and phone number. The Medicare or other federal health care program contractor will be in contact with further instructions about qualifying for electronic billing submissions.

> **Note:** Electronic Funds Transfer can only be made into an account controlled exclusively by the applicant.

16. Surety Bond Information

Complete all requested information.

Annual surety bond renewals must be reported to the Medicare or other federal health care program contractor using HCFA Form 855C (Change of Information Form).

16. Surety Bond Information (continued)

An original copy of the surety bond must be submitted with this application. Failure to submit a copy of the surety bond will prevent the processing of this application. In addition, the applicant must obtain and submit a certified copy of the agent's Power of Attorney with this application, if the bond is issued by an agent.

17. Contact Person

Provide the full name and telephone number of an individual who can be reached to answer questions regarding the information furnished in this application.

18. Certification Statement

This statement includes the minimum standards to which the applicant must adhere to be enrolled in Medicare or other federal health care programs. Read these statements carefully.

By signing the Certification Statement, the applicant agrees to adhere to all the conditions listed and is aware that the applicant may be denied entry to or revoked from the program if any conditions are violated. The Certification Statement must contain an original signature. Faxed or photocopied signatures will not be accepted.

If the applicant currently uses or will be using a billing agency and/or management service organization to submit bills, complete all requested information and attach a current copy of the signed contract between the applicant and the billing agency or management service organization.

> **Note:** If applicant uses a billing agency and/ or management service organization but no written contract exists between applicant and billing agency and/or management service organization, a contract must be written and furnished with this application.

> **Note:** If applicant is applying as an individual or sole proprietor, **applicant** must sign and date the Certification Statement. If applicant is applying as an organization or as a group practice, **an authorized representative of the organization/group practice** must sign the Certification Statement. If applicant has more than one authorized representative, furnish the names and signatures of those authorized representatives who will be directly involved with the Medicare or other federal health care contractors.

Attachment 1 Ambulance Service Suppliers

This attachment is to be completed by the applicant for each ambulance service company being enrolled in the Medicare or other federal health care program.

1. State License Information

If applicant is currently State licensed and certified to operate as an ambulance service supplier, complete this section and attach copy(s) of all State licenses and documents.

A copy of applicant's current license or certificate must be attached to this form. The effective date and expiration date must be stated on the license or certificate. Claims will be paid based on these dates. The applicant must provide this office with a copy of the renewal license in order to receive payment after the expiration date.

2. Description of Vehicle(s)

Applicant must identify the type (e.g., automobile, aircraft, boat) of each vehicle, and furnish year, make, model, and vehicle identification number.

The applicant's vehicle(s) must be specially designed and equipped for transporting the sick or injured. It must have customary patient care equipment including, but not limited to, a stretcher, clean linens, first aid supplies and oxygen equipment, and it must have all other safety and lifesaving equipment as required by State and local authorities. If the ambulance will supply Advanced Life Support services, list all the necessary equipment and provide documentation of certification from the authorized licensing and regulation agency for applicant's area of operation.

Vehicles must be regularly inspected and recertified according to applicable State and local licensure laws. Evidence of recertification must be submitted to the Medicare or other federal health care program contractor on an ongoing basis, as required by State or local law.

Note: Air Ambulance

To qualify for air ambulance, the following is required:

- a written statement that gives the name and address of the facility where the aircraft is hangared signed by the President, Chief Executive Officer, or Chief Operating Officer of the airport; and
- proof that the air ambulance applicant or its leasing company possess a valid charter flight license (FAA 135 Certificate) for the aircraft being used as an air ambulance. If the air medical transportation company owns the aircraft, the owner's name on the FAA 135 Certificate must be the same as the applicant's name on this enrollment application. If the air medical transportation company leases the aircraft, a copy of the lease agreement must accompany this enrollment application. The name of the company leasing the aircraft must be the same as the applicant's name on this enrollment application.

3. Qualification of Crew

The ambulance crew must consist of at least two members. Those crew members charged with the care or handling of the patient must include one individual with adequate first aid training, (i.e., training at least equivalent to that provided by the basic and advanced Red Cross first aid courses). If the ambulance crew will provide ALS services, they must list their ALS training courses.

Training "equivalent" to the basic and advanced Red Cross first aid courses include ambulance service training and experience acquired in military service and/or successful completion by the individual of a comparable first aid course furnished by or under the sponsorship of State or local authorities, an educational institution, a fire department, a hospital, a professional organization, or other such qualified organization.

Applicant must enclose a certificate(s) showing that crew members have successfully completed the required first aid training, or give a description of the equivalent military training, where and when it was received. Crew must continue to pursue and complete continuing education requirements in accordance with State and local licensure laws. Evidence of recertification must be submitted to the Medicare or other federal health care program contractor on an ongoing basis, as required by State and local law.

4. Billing Method

FOR MEDICARE ENROLLMENT ONLY

Answer all applicable questions regarding billing methods. Supply the name of the Medical Director and the geographic area the applicant services.

Note: Paramedic Intercept Services:

- A basic life support (BLS) ambulance supplier may arrange with a paramedic/Emergency Medical Technician (EMT) organization or another advanced life support (ALS) ambulance supplier to provide the advanced life support services while it provides for the transportation component. The BLS would bill for the ALS services and make arrangement to pay the organization providing the ALS services. As an alternative, the BLS could arrange for the organization providing the ALS to be its billing agent.

- If this alternate arrangement exists, applicant must complete the Billing Agency/Management Service Organization and Reassignment of Benefits section and submit a copy of the signed contract.

Check the appropriate box indicating if applicant bills for nautical miles or statute miles.

If applicant is not enrolling in the Medicare program skip this section.

5. Exclusion/Sanction Information

Supply all requested adverse legal action information about the ambulance crew member(s). If applicable, attach copy(s) of any official documentation related to the adverse legal action identified, including reinstatement notices. If none of the ambulance crew members has had any adverse legal actions, check the "none of these" box.

Attachment 2 Independent Diagnostic Testing Facilities (IDTFs)

Formerly known as Independent Physiological Laboratories.

This attachment is to be completed by the applicant for each Independent Diagnostic Testing Facility being enrolled in the Medicare or other federal health care program.

Definition:

Independent Diagnostic Testing Facility (IDTF): An entity independent of a hospital or physician's office in which diagnostic tests are performed by licensed, certified non-physician personnel under appropriate physician supervision (e.g., free standing cardiac catherization facility, imaging center).

> **Note:** A cardiac catherization facility which is a physician's office is not an IDTF. The term "free standing" means that the cardiac catherization facility, whether office or IDTF, is independent of a hospital.

1. Identification of Practice Location

Indicate whether this practice location is operating as a mobile unit. If so, provide vehicle identification number and expiration date of vehicle license. If operating mobile units, the vehicles must be regularly inspected and recertified according to State and local licensure laws. Evidence of recertification must be submitted to the Medicare or other federal health care program contractor on an ongoing basis, as required by State and local law.

Identify practice location of IDTF for which this attachment is being completed. If this is a mobile unit, furnish the address where the vehicle is stored.

If applicable, complete all information concerning applicant's practice location.

2. Identification of Supervising/Directing Physician(s)

The information in this section is required only if applicant's State requires that a supervising physician be associated with all IDTFs. Supervising physicians must perform their duties as described by State requirements. Each supervising/directing physician is required to be enrolled as an individual practitioner in Medicare or other federal health care program for which the applicant is applying.

3. Service Performance

List all Current Procedural Terminology, Version 4 (CPT-4) and HCFA Common Procedure Coding System (HCPCS) codes this IDTF or its contractors intend to perform, supervise, interpret, or bill. Describe the setting where the service will be rendered, and identify each physician who will be performing, supervising, and/or interpreting the test results.

4. Referral Records

Explain how referral records, physician's written order and the name of the technician who rendered the service are maintained.

5. Supervising/Directing Physician Exclusion/Sanction Information

Supply all requested adverse legal action information about the supervising/directing physician(s). If applicable, attach copy(s) of any official documentation related to the adverse legal action identified, including reinstatement notices. If none of the supervising/directing physician(s) has had any adverse legal actions, check the "none of these" box.

6. Signature of Supervising/Directing Physician(s)

Each supervising/directing physician identified in Section 2 of this attachment must sign this attachment.

Attachment 3 Home Health Agencies (HHAs)

This attachment is to be completed by all Home Health Agencies for enrollment in the Medicare or other federal health care program.

This attachment must be completed with information about other related business interests in which the HHA itself has a 5% or more ownership interest in or control of the other related business.

In addition, each owner listed in the Ownership Information section **and** each managing/ directing employee listed in the Managing/ Directing Employee section who has a 5% or more ownership interest in or controls the other related businesses (as defined below) must complete this attachment.

Copy and submit a separate Attachment 3 for the HHA, each owner and each managing/ directing employee, as applicable.

Definitions:

Related to the Provider: Related to the provider (HHA) means that the provider (HHA), to a significant extent, is associated or affiliated with or has control of or is controlled by an organization furnishing services, facilities, or supplies to the provider.

Common Ownership: Common ownership exists if an individual or individuals possess significant ownership or equity in the provider (HHA) **and** the institution or organization serving the provider (HHA).

Control Interest: Control exists if an owner of the HHA has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution furnishing services, facilities, or supplies to the provider (HHA).

1. Other Related Business Interests

The HHA itself and all owners and managing/ directing employees of the enrolling Home Health Agency are required to furnish identifying information about all other related businesses in which they have a 5% or more ownership in and/ or control interest.

In general, businesses than furnish services, facilities, and supplies to the provider (HHA) that are related to the provider (HHA) by common ownership or control interest are to be listed in this attachment.

Supply all requested information about the related businesses.

For purposes of this application, the definition of related businesses as found in 42 CFR § 413.17 which concerns ownership and control, and is limited to businesses who actually do business with the HHA being enrolled will be used. These rules apply regardless of that business' relationship to Medicare, Medicaid or any other health care program, industry, or business.
Examples of related businesses:

- if an HHA, or the owner, or the managing/ directing employee owns a small retail store that has no business dealings with the HHA, the store is not considered to be a related business;

- a consulting firm owned by the HHA, one of the HHA owners, or one of the HHA managing/ directing employees, which provides management services to the HHA would be considered a related business; and

- a retail business owned by the HHA, one of the HHA owners, or one of the HHA managing/ directing employees, which provides supplies to the HHA would be considered a related business.

Identify the type of business in which the related business is engaged (e.g., durable medical equipment company, consulting firm).

Identify the relationship of the related business to the HHA (e.g., affiliate, joint venture, supplier).

DOCUMENTATION REQUIREMENTS FOR NON-PHYSICIAN PRACTITIONERS

The Health Care Financing Administration has established criteria for determining the eligibility of non-physician practitioners for enrollment and reimbursement under Part B of the Medicare program. Specific guidelines for your profession are outlined below. Medicare requires this information before a provider number may be issued to you.

Please complete the enclosed HCFA 855 application package and attach the appropriate degree, certificate or documentation.

Audiologist

- Be licensed as a audiologist in the state in which services are performed and meet at least one of the following requirements:

    - Be eligible for a certificate of clinical competence in audiology granted by the American Speech and Hearing Association under its requirements; or

    - Meet the educational requirements for certification, and is in the process of accumulating the supervised experience required for certification. (Attach a certificate of completion or a letter from the physician stating supervised experience is in process).

Certified Nurse-Midwife

- Be currently licensed as a registered professional nurse in the state in which services are performed; and

- Be legally authorized under state law or regulations to practice as a nurse-midwife and have completed a program of study and clinical experience for nurse-midwives, as specified by the state; or

- Be currently certified as a nurse-midwife by the American College of Nurse-Midwives; or

Have satisfactorily completed a formal education program (of at least one academic year) that, upon completion, qualifies the nurse to take the certification examination offered by the American College of Nurse-Midwives; or

Have satisfactorily completed a formal education program for preparing registered nurses to furnish gynecological and obstetrical care to women during pregnancy, delivery, and the postpartum period, and care to normal newborns, and practice as a nurse-midwife for a total of 12 months during any 18 month period from August 8, 1976 to July 16, 1982.

Certified Registered Nurse Anesthetist

A Certified Registered Nurse Anesthetist is a registered nurse licensed in the state in which the services are performed.

Is currently certified by the Council of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists, or

Has graduated within the past 18 months from a nurse anesthesia program that meets the standards of the Council of Accreditation of Nurse Anesthesia Educational Programs and is awaiting initial certification.

A notarized copy of the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetist card.

Clinical Nurse Specialist

Coverage is available for services performed in rural areas by clinical nurse specialists (CNSs) working in collaboration with a physician (i.e., a doctor of medicine or doctor of osteopathy (MD/DO)).

Direct payment can be made to the CNS or the employer or contractor of the CNS with the following qualifications:

Be licensed in the state in which the services are performed.

Possess a Master's degree in nursing, with an emphasis in clinical nursing.

Possess a Baccalaureate degree in nursing.

Has a minimum of two years postgraduate direct patient care in the practice discipline of the private practice for which the nurse has been prepared.

Clinical Social Worker

Must be currently licensed as a clinical social worker in the state in which services are performed.

Possess a Masters or Doctors degree in social work.

Have performed at least two years of supervised clinical social work. This may be a copy of the documentation which was sent to the state or a letter from a supervisor stating that they supervised at least two years of clinical social work.

*Independent Physical Therapist

Be licensed as a physical therapist in the state in which the services are performed and meet at least one of the following requirements:

Has graduated from a physical therapy curriculum approved by the American Physical Therapy Association or by the Council on Medical Education and Hospitals of the American Medical Association, or jointly by the Council on Medical Education of the American Medical Association and the American Physical Therapy Associations:

Prior to January 1, 1996, was admitted to membership by the American Physical Therapy Association, or was admitted to registration by the American Registry of Physical Therapists, or has graduated from a physical therapy curriculum in a four year college or university approved by a state department of education;

Has two years of appropriate experience as a physical therapist and has achieved a satisfactory grade on a proficiency examination approved by the secretary except that such determinations of proficiency do not apply with respect to persons initially licensed by a state as a physical therapist after December 31, 1977, or seeking qualifications as a physical therapist after that date;

Was licensed or registered prior to January 1, 1966, and prior to January 1, 1970, had 15 years of full-time experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending and referring physicians; or

If trained outside the United States, has graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy, meets the requirements for membership in a member organization of the World Confederation for Physical Therapy, has one year of experience under the supervision of an active member of the American Physical Therapy Association, and has successfully completed a qualifying examination as prescribed by the American Physical Therapy Association.

*Independent Occupational Therapist

Be licensed as an occupational therapist in the state in which the services are performed and meet a least one of the following requirements:

Is a graduate of an occupational therapy curriculum accredited jointly by the Council on Medical Education of the American Medical Association and the American Occupational Therapy Association;

Is eligible for certification by or for the National Registration Examination of the American Occupational Therapy Association; or

Has two years appropriate experience as an occupational therapist, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U. S. Public Health Service, except that such determinations of proficiency do not apply with respect to persons initially licensed by a state or seeking initial qualifications as an occupational therapist after December 31, 1977.

***Independent Practice Defined - Consider a qualified therapist to be in independent practice if:**

The therapist renders services free of the administrative and professional control of an employer such as a physician, institution, or agency;

The therapist maintains office space at his/her own expense and furnishes services only in that space or the patient's home;

The patients treated are the therapist's own patients; and

The therapist has the right to collect fees for the services rendered.

Nurse Practitioner

Be licensed as a registered professional nurse in the state in which the services are performed and meet at least one of the following:

Be currently certified as a primary care nurse practitioner by the American Nurses' Association or by the National Board of Pediatric Nurse Practitioners and Associates;

Have satisfactorily completed a formal education program of at least one academic year that prepares registered nurses to perform an expanded role in the delivery of primary care and that includes at least four months (in the aggregate) of classroom instruction, and that awards a degree, diploma, or certification for successful completion of the program; or

Have successfully completed a formal education program (that does not qualify under the immediately preceding requirement) that prepares registered nurses to perform an expanded role in the delivery of primary care and have been performing that expanded role for at least 12 months during the 18 month period immediately preceding February 8, 1978, the effective date for provision of the services of nurse practitioners as reflected in the conditions for certification

for rural health clinics.

Physician Assistant

- Meet the applicable state requirements governing the qualifications for Physician Assistants and at least one of the following three conditions:

- Is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians;

- Has satisfactorily completed a program for preparing Physician Assistants that:

    - Was at least one academic year in length;

    - Consisted of supervised clinical practice and at least four months (in the aggregate) of classroom instruction directed toward preparing students to deliver health care; and

    - Was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation; or

- Has satisfactorily completed a formal educational program for preparing Physician Assistants (that does not meet the requirements of the immediately preceding requirement) and was assisting primary care physicians for a total of 12 months during the 18 month period immediately preceding January 1, 1987.

Clinical Psychologist

Be currently licensed as a clinical psychologist in the state in which services are performed.

Hold a doctoral degree in psychology from a program in clinical psychology.

Possess two years of supervised clinical experience (at least one year must be post-degree).

Attestation statement (please read and signed below).

In accordance with Medicare guidelines, I, the undersigned, do attest that I meet all of the above listed requirements and, furthermore, that I will inform each Medicare patient of the desirability of conferring with the patient's primary care or attending physician to consider potential medical conditions contributing to the patient's condition; and will either:

provide written notification to the patient's designated primary care or attending physician that services are provided to the patient; or
consult directly with the physician to consider medical conditions that may be contributing to the patient's condition;

In all cases, unless the patient specifically request that such notice or consultation not be made.

_____ _____

SIGNATURE OF PROVIDER DATE

SPECIALTY CODES

01 General Practice
02 General Surgery
03Allergy/Immunology
04 Otolaryngology
05 Anesthesiology
06 Cardiology
07 Dermatology
08 Family Practice
10 Gastroenterology
11 Internal Medicine
12 Osteopathic Manipulative Therapy
13 Neurology
14 Neurosurgery
16 Obstetrics/Gynecology
18 Ophthalmology
19 Oral Surgery (Dentist only)
20 Orthopedic Surgery
22 Pathology
24 Plastic & Reconstructive. Surgery
25 Physical Medicine and Rehab.
26 Psychiatry
28 Colorectal Surgery
29 Pulmonary Disease
30 Diagnostic Radiology
33 Thoracic Surgery
34 urology
35 Chiropractic
36 Nuclear Medicine
37 Pediatric Medicine
38 Geriatric Medicine
39 Nephrology
40 Hand Surgery
41 Optometry
42 Certified Nurse Midwife
43 CRNA Anesthesia Assistant
44 Infectious Disease
45 Mammography Screening Center
46 Endocrinology
47 Independent Diagnostic Testing Facility
48 Podiatry
49 Ambulatory Surgical Center
50 Nurse Practitioner
51 Medical Supply Co. W/Cert. Orthotist
52 Medical Supply Co. W/Cert. Prosthetist
53 Medical Supply Co. W/Cert. Prosthetist-Orthotist
54 Medical Supply Co. Not included in Specialty 51-53
59 Ambulance Service (Private)
60 Public Health/Welfare Agency
63 Portable X-Ray Supplier
64 Audiologist (Billing Independently)
65 Physical Therapist (Private Practice)
66 Rheumatology
67 Occupational Therapist (Private Practice)
68 Clinical Psychologist
69 Clinical Laboratory (Billing Indep.)
70 Multi-Specialty Clinic or Group Practice
76 Peripheral Vascular Disease
77 Vascular Surgery
78 Cardiac Surgery
79 Addiction Medicine
80 Licensed Clinical Social Worker
81 Critical Care (Intensivists)
82 Hematology
83 Hematology/Oncology
84 Preventative Medicine
85 Maxillofacial Surgery
86 Neuropsychiatry
87 All Other (Drug & Dept. Store, etc.)
88 Unknown Supplier/Provider
89 Certified Clinical Nurse Specialist
90 Medical Oncology
91 Surgical Oncology
92 Radiation Oncology
93 Emergency Medicine
94 Interventional Radiology
96 Optician
97 Physician Assistant
98 Gynecological/Oncology
99 Unknown Physician Specialty

OMB Approval No. 0938-0685 066B

MEDICARE/FEDERAL HEALTH CARE PROVIDER/SUPPLIER ENROLLMENT APPLICATION

General Application

PLEASE CHECK APPLICABLE BOX

Type of Business: ☐ Individual ☐ Corporation ☐ Partnership ☐ Other (specify) _____

Applicant Enrolling As: **PLEASE CHECK APPLICABLE BOX**
☐ Individual ☐ Sole Proprietor ☐ Organization ☐ Group ☐ Mass Immunization Biller Only

Check the appropriate box listed below if applicant is completing this application for enrollment in a federal health care program other than Medicare.
(Check only one program box.)
☐ State Medicaid ☐ CHAMPUS ☐ Indian Health Service
☐ Railroad Retirement Board ☐ Public Health Service ☐ CHAMPVA ☐ Other (specify) _____

PLEASE CHECK APPLICABLE BOX

Application For: ☐ Initial Enrollment ☐ Recertification ☐ Change of Ownership (CHOW)
☐ Enrollment of Additional Location(s) ☐ Change of Information

MEDICARE APPLICANTS ONLY:
Where will applicant be submitting billings? ☐ Fiscal Intermediary ☐ Carrier ☐ Both (OR) ☐ Regional Home Health Intermediary
If fiscal intermediary is checked, furnish name of applicant's preferred fiscal intermediary. _____

Is the applicant currently enrolled in another federal health care program? ☐ **YES** ☐ **NO**
IF YES, check all the appropriate federal programs listed below.
☐ Medicare ☐ State Medicaid ☐ CHAMPUS ☐ Indian Health Service
☐ Railroad Retirement Board ☐ Public Health Service ☐ CHAMPVA ☐ Other (specify) _____

1. Applicant Identification

A. Individuals ONLY

Check here ☐ **only if this entire section does not apply to the applicant.**

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

Residency Status (if applicable) ☐ resident ☐ intern
Name of Facility Where Resident or Intern:

Are services rendered in the above setting part of the applicant's requirements for graduation from a formal residency program? ☐ YES ☐ NO

Primary Specialty (e.g. pathology, cardiology, nurse practitioner, etc.) (required)	Secondary Specialty (if applicable)

Gender (optional) ☐ male ☐ female

Race/Ethnicity (optional) ☐ Asian or Asian American or Pacific Islander ☐ Hispanic ☐ Black (not Hispanic) or African-American ☐ North American Indian or Alaska Native ☐ White (not Hispanic)

Date of Birth (MM/DD/YYYY)	County of Birth	State of Birth	Country of Birth

B. Organizations ONLY

Check here ☐ **only if this entire section does not apply to the applicant.**

1. Legal Business Name	Fiscal Year End Date (MM/DD)	Incorporation Date (if applicable) (MM/DD/YYYY)
Type of Facility (e.g., hospital, nursing home, clinical laboratory, roster biller, etc.)		☐ Accredited ☐ Non-Accredited

State Where Incorporated:	Date Business Established at This Location (MM/DD/YYYY)	All other States in which applicant does business:

2. Is this a organization a Provider Based Facility? ☐ Yes ☐ No
Is this organization a Distinct Part Unit? ☐ Yes ☐ No
Does this organization file a consolidated cost report under another Medicare provider's number? ☐ Yes ☐ No

IF YES to any of the above three questions, furnish name of parent provider.	Parent Medicare Provider Number

3. Does this organization operate other affiliated units, off-site clinics, or have multi-campus sites or branches? ☐ Yes ☐ No
If Yes, how many of each? _____ other affiliated units _____ off-site clinics _____ multi-campus sites _____ branches
Complete the Practice Location(s) section for each unit, clinic, site, and/or branch operated.

1. Applicant Identification (continued)

C. Physician and Non-Physician Practitioner Groups ONLY (For each group member, complete HCFA Form 855R.)

Check here ☐ **only if this entire section does not apply to the applicant.**

Legal Business Name	Incorporation Date (if applicable) (MM/DD/YYYY)	State Where Incorporated
Group's Primary Specialty (required)	Group's Secondary Specialty (if applicable)	

D. All Applicants

1. Mailing Address Line 1

Mailing Address Line 2

City	County	State	ZIP Code + 4
Telephone Number ( )	Fax Number ( )	E-mail Address	
Employer Identification Number (if applicable)	Social Security Number (if applicable)	Medicare Identification Number(s) (if applicable)	

2. Does applicant now have or has applicant ever had a Medicare or Medicaid provider number in this or any other State?

☐ **Yes** ☐ **No** **IF YES, supply all current and prior information requested below.**

Current Carrier Name (if applicable)	Current Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
Prior Carrier Name (if applicable)	Prior Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)

Current CLIA Number (if applicable)	Prior CLIA Number (if applicable)

3. Has applicant ever been convicted of any health care related crime? ☐ **Yes** ☐ **No**

Has applicant ever been convicted of a felony under Federal or State law? ☐ **Yes** ☐ **No**

4. Has any family and/or household member(s) of the applicant who has ownership or control interest in the enrolling business or entity ever been convicted, assessed, or excluded from the Medicare program due to fraud, obstruction of an investigation, or a controlled substance violation?

☐ **Yes** ☐ **No** **IF YES, furnish name and relationship of relative/household member(s) below.**

Name:	First	Middle	Last	Jr., Sr., etc.	Relationship

5. Does the applicant, under any name or business identity, have any outstanding overpayments with Medicare, Medicaid or any other federal program?

☐ **Yes** ☐ **No** **IF YES, under what federal program?** _____

IF YES, under what name? _____

2. Professional and Business License/Certification/Registration Information

Attach a copy(s) of each required Federal, State, and/or local city/county business and/or professional license, certification and/or registration. Notarized or "certified true" copies are optional but will speed the processing of this application.

Check here ☐ **if applicant's State licensure is pending upon completion of State survey and/or certification.**

Has applicant ever had any Federal, State, and/or local city/county business and/or professional business license, certification and/or registration revoked or suspended? ☐ **Yes** ☐ **No**

IF YES, explain below and attach copy(s) of reinstatement letter(s) if applicable.

_____

_____

3. Professional School Information (Individuals only)

Check here ☐ **only if this entire section does not apply to the applicant.**

Attach a copy of each degree or certificate. Notarized or "certified true" copies are optional but will speed the processing of this application.

School Name		Graduation Year (YYYY)
City	State	Country

4. Board Certification

Check here ☐ **only if this entire section does not apply to the applicant.**

If applicant is Board Certified in his/her primary specialty complete the following information.

If applicant is Board Certified in more than one specialty, copy this section and complete the following information for each.

Certification Board Name

Certification Number	Effective Date (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)

5. Exclusion/Sanction Information

Check if the applicant has ever had any of the following adverse legal actions imposed by the Medicare, Medicaid, or any other federal agency or program. For each box checked, include the date the adverse legal action was imposed.
Check all that apply or the "none of these" box. Attach copy of adverse legal action notification.

A.
- ☐ Administrative Sanction(s) _____
- ☐ Program exclusion(s) _____
- ☐ Suspension of payment(s) _____
- ☐ Civil monetary penalty(s) _____
- ☐ Assessment(s) _____
- ☐ Program Debarment(s) _____

B. Health Care Related:
- ☐ Criminal fine(s) _____
- ☐ Restitution order(s) _____
- ☐ Pending civil judgment(s) _____
- ☐ Pending criminal judgment(s) _____
- ☐ Judgment(s) pending under the False Claims Act _____

C. ☐ None of these

D. Does the applicant have any outstanding criminal fines? ☐ Yes ☐ No restitution orders? ☐ Yes ☐ No

6. Practice Location(s)

Check here ☐ **if deleting this practice location.**

A. How many practice locations does applicant utilize? _____ For each additional practice location, copy and complete this section.

B. "Doing Business As" name for this location	Medicare Identification Number for this location (if applicable)

Business Street Address Line 1

Business Street Address Line 2

City	County	State	ZIP Code + 4

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

Is this location an ☐ off site clinic? ☐ distinct part unit? ☐ multi-campus site? ☐ branch?
☐ a location that files a consolidated cost report? ☐ provider based facility? ☐ or none of these?

Date applicant began practicing at this location? (MM/DD/YYYY)	If applicable, date applicant ceased practicing at this location? (MM/DD/YYYY)

Check whether the applicant owns or leases this practice location? ☐ Own ☐ Lease

C. "Pay To" address for this practice location. Check here ☐ and skip to section 6D if same as practice location in section 6B.
Check here ☐ if applicant wants all practice location payments listed in this application sent to address furnished in Section 6C.

Mailing Address Line 1

Mailing Address Line 2

City	State	ZIP Code + 4	Telephone Number ( )

D. Name of managing/directing employee for this location? First	Middle	Last	Social Security Number

E. CLIA Number for this location (if applicable)	FDA Mammography Certification Number(s) for this location (if applicable)

F. Are all patient records stored at this practice location? ☐ **Yes** ☐ **No** **IF NO, supply storage location below.**

Name of Storage Facility/Location	Telephone Number ( )	Fax Number ( )

Street Address Line 1

Street Address Line 2

City	State	ZIP Code + 4

7. Prior Practice Information

Check here ☐ **only if this entire section does not apply to the applicant.**

If applicant has previously billed the Medicare or Medicaid programs, furnish requested prior practice information below.
For each additional prior practice, copy and complete this section.

Type of Practice	Status ☐ Inactive ☐ Active	IF INACTIVE, supply date of termination (MM/DD/YYYY)

Legal Business Name

Doing Business As Name

Medicare Identification Number(s)	Medicaid Number/State	Telephone Number ( )

Business Street Address Line 1

Business Street Address Line 2

City	State	ZIP Code + 4

Was applicant a ☐ participating or ☐ non-participating provider/supplier in this prior practice?

8. Ownership Information

Check here ☐ **if deleting this owner's association with this entity.**

Effective date of deletion? _____ **(MM/DD/YYYY)**

How many owners have 5 percent or more ownership interest in this entity? _____ **(maximum of 20)**

For each owner, complete this section. If more than one owner, copy and complete this section for each.

All applicants must submit a copy of the entity's IRS Form CP 575.

A. Identifying Information

Owner Name: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Other Name: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.

Date of Birth (MM/DD/YYYY)	County of Birth	State of Birth	Country of Birth

Legal Business Name

"Doing Business As" Name	Effective Date of Ownership (MM/DD/YYYY)

Social Security Number	Employer Identification Number	Medicare Identification Number (if applicable)

B. Does this owner now have or has this owner ever had a Medicare or Medicaid provider number in this or any other State?
☐ **Yes** ☐ **No** **IF YES, supply all current and prior information requested below.**

Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
Prior Carrier Name (if applicable)	**Prior Fiscal Intermediary Name (if applicable)**	**Prior Medicaid Number/State (if applicable)**

C. Has this owner ever managed or directed other organizations that have billed or are currently billing Medicare for services?
☐ **Yes** ☐ **No** **IF YES, how many?** _____

Copy and complete the following for each organization this owner managed or directed in the last 10 years.

If this list is incomplete, check here ☐ **indicating that some information for the last 10 years is missing.**

Organization's Legal Business Name

Employer Identification Number	Medicare Identification Number	Date Associated FROM ---- TO (MM/DD/YYYY)
Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
Prior Carrier Name (if applicable)	Prior Fiscal Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)

8. Ownership Information (continued)

D. Has this owner ever had ownership in other organizations that have billed or are currently billing Medicare for services?

☐ **Yes** ☐ **No** **IF YES, how many?** _____

Copy and complete the following for each organization this owner has had ownership in during the last 10 years.

If this list is incomplete, check here ☐ **indicating that some information for the last 10 years is missing.**

Organization's Legal Business Name

Employer Identification Number	Medicare Identification Number	Date Associated FROM ---- TO (MM/DD/YYYY)
Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
Prior Carrier Name (if applicable)	Prior Fiscal Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)

E. Check if this owner has ever had any of the following adverse legal actions imposed by the Medicare, Medicaid, or any other federal agency or program. For each box checked, include the date the adverse legal action was imposed. Check all that apply or the "none of these" box. Attach copy of adverse legal action notification.

1.
- ☐ Administrative Sanction(s) _____
- ☐ Program exclusion(s) _____
- ☐ Suspension of payment(s) _____
- ☐ Civil monetary penalty(s) _____
- ☐ Assessment(s) _____
- ☐ Program Debarment(s) _____

2. Health Care Related:
- ☐ Criminal fine(s) _____
- ☐ Restitution order(s) _____
- ☐ Pending civil judgment(s) _____
- ☐ Pending criminal judgment(s) _____
- ☐ Judgment(s) pending under the False Claims Act _____

3. ☐ None of these

4. Does this owner have any outstanding criminal fines? ☐ Yes ☐ No restitution orders? ☐ Yes ☐ No

F. Has this owner ever been convicted of any health care related crime? ☐ **Yes** ☐ **No**

Has this owner ever been convicted of a felony under Federal or State law? ☐ **Yes** ☐ **No**

9. Managing/Directing Employees

If applicant is the sole owner and the sole managing/directing employee, skip this section.

Check here ☐ **if deleting this managing/directing employee's association with the applicant.**

Effective date of deletion? _____ **(MM/DD/YYYY)**

What is the total number of managing/directing employees for all location(s) listed in this application? _____ **(Maximum of 20)**

For each managing/directing employee, complete this section. If more than one, copy and complete this section for each.

A. Identifying Information

Name: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.	Title/Position

Social Security Number	Employer Identification Number (if applicable)	Medicare Identification Number (if applicable)	
Date of Birth (MM/DD/YYYY)	County of Birth	State of Birth	Country of Birth

Legal Name of Business Where This Person Manages/Directs

"Doing Business As" Name Where This Person Manages/Directs

B. Has this Managing/Directing employee ever had a Medicare or Medicaid provider number in this or any other State?

☐ **Yes** ☐ **No** **IF YES, supply all current and prior information requested below.**

If additional space is needed, copy and complete this section.

Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
Prior Carrier Name (if applicable)	Prior Fiscal Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)

9. Managing/Directing Employees (continued)

C. Has this managing/directing employee ever managed or directed other organizations that have billed or are currently billing Medicare for services? ☐ **Yes** ☐ **No** **IF YES, how many?** _____

Copy and complete the following for each organization this managing/directing employee managed or directed in the last 10 years.

If this list is incomplete, check here ☐ **indicating that some information for the last 10 years is missing.**

Legal Business Name		
Medicare Identification Number	Employer Identification Number	
Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
Prior Carrier Name (if applicable)	Prior Fiscal Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)

D. Has this managing/directing employee ever had ownership interest in other organizations that have billed or are currently billing Medicare for services? ☐ **Yes** ☐ **No** **IF YES, how many?** _____

Copy and complete the following for each organization this managing/directing employee managed or directed in the last 10 years.

If this list is incomplete, check here ☐ **indicating that some information for the last 10 years is missing.**

Legal Business Name		
Medicare Identification Number	Employer Identification Number	
Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
Prior Carrier Name (if applicable)	Prior Fiscal Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)

E. Check if this managing/directing employee has ever had any of the following adverse legal actions imposed by the Medicare, Medicaid, or any other federal agency or program. For each box checked, include the date the adverse legal action was imposed. Check all that apply or the "none of these" box. Attach copy of adverse legal action notification.

1.
- ☐ Administrative Sanction(s) _____
- ☐ Program exclusion(s) _____
- ☐ Suspension of payment(s) _____
- ☐ Civil monetary penalty(s) _____
- ☐ Assessment(s) _____
- ☐ Program Debarment(s) _____

2. Health Care Related:
- ☐ Criminal fine(s) _____
- ☐ Restitution order(s) _____
- ☐ Pending civil judgment(s) _____
- ☐ Pending criminal judgment(s) _____
- ☐ Judgment(s) pending under the False Claims Act _____

3. ☐ None of these

4. Does this managing/directing employee have any outstanding criminal fines? ☐ Yes ☐ No restitution orders? ☐ Yes ☐ No

10. Parent/Joint Venture Information

Check here ☐ **only if this entire section does not apply to the applicant.**

Check if this entity is a subsidiary company or joint venture. ☐ **Subsidiary Company** ☐ **Joint Venture**

Complete the information below about the PARENT company or JOINT venture.

Attach a copy of parent company's or other owner's IRS Form CP 575 pertaining to this applicant.

Legal Business Name		
"Doing Business As" Name		Effective Date of Affiliation (MM/DD/YYYY)
Employer Identification Number	Medicare Identification Number	
Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
Prior Carrier Name (if applicable)	Prior Fiscal Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)
Business Street Address Line 1		
Business Street Address Line 2		
City	State	ZIP Code + 4
Telephone Number ( )	Fax Number ( )	E-mail Address

11. Chain Organization Information

When applicable, this section to be completed by Medicare Part A institutional provider/suppliers.

Check here ☐ **only if this entire section does not apply to the applicant.**

Does the applicant need to register a chain action? (see list below) ☐ **Yes** ☐ **No**

IF YES, check the appropriate action:
- ☐ Applicant in chain for first time
- ☐ Applicant in a different chain since last report
- ☐ Applicant dropped out of all chains
- ☐ Applicant in same chain under new chain name

Complete the following information about the chain Home Office:

Name of Home Office				Effective Date of Linkage (MM/DD/YYYY)
Name of Home Office Administrator or CEO: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.

Title of Home Office Administrator

Home Office Business Street Address Line 1

Business Street Address Line 2

City	State	ZIP Code + 4
Telephone Number ( )	Fax Number ( )	E-mail Address
Chain Number	Name of Home Office Intermediary	

Applicant's Affiliation to Chain: ☐ Joint Venture/Partnership ☐ Managed/Related ☐ Leased ☐ Operated/Related ☐ Wholly Owned ☐ Other _____

Fiscal Year End Date of this Chain (MM/DD)	Do all the providers of the chain use the same Part A fiscal intermediary? ☐ **Yes** ☐ **No**

12. Contractor Information (Business Organizations)

A. Does the applicant contract with a business organization for any medical or diagnostic services or medical supplies for which the cost or value is $10,000 or more in a 12 month period? ☐ **Yes** ☐ **No**

IF YES, how many business organizations does the applicant contract with? _____

For each of these contractors, complete this section. If more than one contractor, copy and complete this section for each.

B. Will the applicant be billing and receiving payment (reassigned benefits) for medical or diagnostic services or medical supplies rendered by any other business organization, (excluding individuals), regardless of cost or value? ☐ **Yes** ☐ **No**

IF YES, how many business organizations reassign benefits to the applicant? _____

Each business organization (excluding individuals) that reassigns benefits to the applicant must also complete the Reassignment of Benefits Statement section. If more than one reassignee, copy and complete both sections for each reassignee.

Check here ☐ **if no longer using this contractor OR here** ☐ **if no longer accepting reassigned benefits from this business.**

Legal Business Name

Doing Business As Name	Effective Date of Relationship/Reassignment (MM/DD/YYYY)

Business Street Address Line 1

Business Street Address Line 2

City	State	ZIP Code + 4
Telephone Number ( )	Fax Number ( )	E-mail Address

Employer Identification Number	Medicare Identification Number (if applicable)

12. Contractor Information (Business Organizations) (continued)

C. Does this business/contractor now have or ever had a Medicare or Medicaid provider number in this or any other State?

☐ **Yes** ☐ **No** **IF YES, supply all current and prior information requested below.**

Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
Prior Carrier Name (if applicable)	Prior Fiscal Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)

D. Check if this business/contractor has ever had any of the following adverse legal actions imposed by the Medicare, Medicaid, or any other federal agency or program. For each box checked, include the date the adverse legal action was imposed. Check all that apply or the "none of these" box. Attach copy of adverse legal action notification.

1.
- ☐ Administrative Sanction(s) _____
- ☐ Program exclusion(s) _____
- ☐ Suspension of payment(s) _____
- ☐ Civil monetary penalty(s) _____
- ☐ Assessment(s) _____
- ☐ Program Debarment(s) _____

2. Health Care Related:
- ☐ Criminal fine(s) _____
- ☐ Restitution order(s) _____
- ☐ Pending civil judgment(s) _____
- ☐ Pending criminal judgment(s) _____
- ☐ Judgment(s) pending under the False Claims Act _____

3. ☐ None of these

4. Does this business/contractor have any outstanding criminal fines? ☐ Yes ☐ No restitution orders? ☐ Yes ☐ No

13. Reassignment of Benefits Statement (Business Organizations and Groups Only)

Check here ☐ **only if this entire section does not apply to the applicant.**

Medicare law prohibits payment for services to entities other than the provider/supplier who provided the services unless the provider/supplier specifically authorizes another entity (employer, facility, health care delivery system, or agent) to bill for its services, per Federal Regulation 42 CFR 424.80. This Reassignment of Benefits Statement authorizes this applicant to receive Medicare payments on your behalf.
Your contract with the applicant must be in compliance with HCFA regulations. The Reassignment of Benefits Statement must be signed by all providers/suppliers who allow this applicant to receive payment for the provider/supplier's services.

I acknowledge that, under the terms of my contract, _____
(Legal Business Name of Applicant)

is entitled to claim or receive any fees or charges for my services.

Legal Business Name of Reassignee			Reassignee's Medicare Identification Number		
Name of Authorized Representative for the Reassignee (printed)	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Signature of Authorized Representative for the Reassignee	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)		Date (MM/DD/YYYY)		

14. Billing Agency/Management Service Organization Address

Check here ☐ **only if this entire section does not apply to the applicant.**

Check here ☐ **if deleting (no longer using) this billing agency/service management organization.**

Applicant MUST submit a copy of the applicant's current signed billing agreement or contract with this application.

Name of Billing Agency/Management Service Organization			Employer Identification Number
Agency/Organization Contact Person Name: First	Middle	Last	Jr., Sr., etc.
Business Street Address Line 1			
Business Street Address Line 2			
City	State		ZIP Code + 4
Telephone Number ( )	Fax Number ( )		E-mail Address

15. Electronic Claims Submission Information

Check here ☐ **only if this entire section does not apply to the applicant.**

Furnish the name of a contact person in this section if the applicant would like to submit claims electronically.

Contact Person Name: First	Middle	Last	Jr., Sr., etc.

Mailing Address Line 1

Mailing Address Line 2

City	State	ZIP Code + 4

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

16. Surety Bond Information

Check here ☐ **only if this entire section does not apply to the applicant.**

Name of Surety Bond Company

Agent's Name: First	Middle	Last	Jr., Sr., etc.

Telephone Number ( )	Fax Number ( )

Amount of Surety Bond $	Effective Date of Surety Bond (MM/DD/YYYY)	Annual Renewal Date of Surety Bond (MM/DD/YYYY)

17. Contact Person

Furnish the name and telephone number of a person who can answer questions about the information furnished in this application.

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

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

Penalties for Falsifying Information on the Medicare Health Care Provider/Supplier Enrollment Application.

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 authorized by the sentencing statute.

2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against an individual who "knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a program under a Federal health care program."
The offender is subject to fines of up to $25,000 and/or imprisonment for up to five years.

3. The Civil False Claims Act, 31 U.S.C. § 3729 imposes civil liability, in part, on any person who:
a.) knowingly presents, or causes to be presented, to an officer or an employee of the United States Government a false or fraudulent claim for payment or approval;
b.) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or
c.) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.
The Act imposes a civil penalty of $5,000 to $10,000 per violation, plus 3 times the amount of damages sustained by the Government.

4. Section 1128A(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency. . .
a claim. . .that the Secretary determines is for a medical or other item or service that the person knows or should know:
a.) was not provided as claimed; and/or
b.) the claim is false or fraudulent.
This provision authorizes a civil monetary penalty of up to $10,000 for each item or service, an assessment of up to 3 times the amount claimed, and exclusion from participation in the Medicare program and State health care programs.

5. 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.

18. Certification Statement

I, the undersigned, certify to the following:

1.) **I have read the contents of the application and the information contained herein is true, correct, and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare or other federal health care program contractor of this fact immediately.**
2.) **I authorize the Medicare or other federal health care program contractor to verify the information contained herein. I agree to notify the Medicare or other federal health care program contractor of any changes in this form within 30 days of the effective date of the change. I understand that a change in the incorporation of my organization or my status as an individual or group biller may require a new application.**
3.) **I have read and understand the Penalties for Falsifying Information on the Medicare Health Care Provider/Supplier Enrollment Application, as printed in this application. I am aware that falsifying information will result in fines and/or imprisonment.**
4.) **I am familiar with and agree to abide by the Medicare or other federal health care program laws and regulations that apply to my provider/supplier type. The Medicare laws and regulations are available through the Medicare Contractor.**
5.) **Neither the individual practitioner, nor the company, nor any owner, director, officer, employee of the company, or any contractor retained by the company or any of the aforementioned persons, currently is subject to sanction under the Medicare or Medicaid program or debarred, suspended, or excluded under any other Federal agency or program, or otherwise is prohibited from providing services to Medicare or other federal health care program beneficiaries.**
6.) **I agree that any existing or future overpayment to me by the Medicare or other federal health care program(s) may be recouped by Medicare or the other federal health care program(s) through withholding future payments.**
7.) **I understand that only the Medicare or other federal health care program(s) billing number for the provider/supplier who performed the service or to whom benefits were reassigned under current Medicare or other federal health care program(s) regulations may be used when billing Medicare or other federal health care program(s) for services.**
8.) **I understand that any omission, misrepresentation or falsification of any information contained in this application or contained in any communication supplying information to Medicare or other federal health care program(s) to complete or clarify this application may be punishable by criminal, civil, or other administrative actions including revocation of Medicare or other federal health care program(s) billing number(s), fines, penalties, damages, and/or imprisonment under Federal law.**
9.) **I will not knowingly and willfully present or cause to be presented a false or fraudulent claim for payment by the Medicare or other federal health care program(s).**
10.) **I further certify that I am the individual practitioner who is applying for the billing number, or in the case of a business organization, I am an officer, chief executive officer, or general partner of the business organization that is applying for the Medicare or other federal health care program(s) billing number.**

Applicant Name (printed) First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Applicant Signature (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY)	

FOR GROUPS AND ORGANIZATIONS: **(Please list all "Authorized Representatives" for this group/organization)**

Check here ☐ **if deleting this representative from this entity.**

Authorized Representative Name (printed) First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Title/Position	Social Security Number		Medicare Identification Number (if applicable)	
Authorized Representative Signature (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY)	

Check here ☐ **if deleting this representative from this entity.**

Authorized Representative Name (printed) First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Title/Position	Social Security Number		Medicare Identification Number (if applicable)	
Authorized Representative Signature (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY)	

Ambulance Service Suppliers

1. State License Information

Is applicant licensed as a Supplier of Ambulance Services by applicant's State? ☐ **Yes** ☐ **No**

IF YES, complete this section and attach a copy of the applicant's current State license.

License Number	Issuing State	Effective Date (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)

2. Description of Vehicle

Copy and complete this section as needed for additional vehicles.

For each vehicle, attach copy of the vehicle registration.

1. Type (automobile, aircraft, boat, etc.) | Vehicle Identification Number

Make	Model	Year (YYYY)

Does this vehicle have the following:

first aid supplies?	☐ Yes	☐ No	other safety/life saving equipment?	☐ Yes	☐ No
oxygen equipment?	☐ Yes	☐ No	two-way telecommunications radio?	☐ Yes	☐ No
warning lights?	☐ Yes	☐ No	mobile communication?	☐ Yes	☐ No
sirens?	☐ Yes	☐ No			

List other medical equipment this vehicle carries.

_____ _____

_____ _____

_____ _____

_____ _____

Does this vehicle provide:

basic life support (BLS)?	☐ Yes	☐ No	land ambulance?	☐ Yes	☐ No
advanced life support (ALS)?	☐ Yes	☐ No	air ambulance?	☐ Yes	☐ No
emergency runs?	☐ Yes	☐ No	marine ambulance?	☐ Yes	☐ No
non-emergency runs?	☐ Yes	☐ No			

How many crew members accompany this vehicle on runs? _____

2. Type (automobile, aircraft, boat, etc.) | Vehicle Identification Number

Make	Model	Year (YYYY)

Does this vehicle have the following:

first aid supplies?	☐ Yes	☐ No	other safety/life saving equipment?	☐ Yes	☐ No
oxygen equipment?	☐ Yes	☐ No	two-way telecommunications radio?	☐ Yes	☐ No
warning lights?	☐ Yes	☐ No	mobile communication?	☐ Yes	☐ No
sirens?	☐ Yes	☐ No			

List other medical equipment this vehicle carries.

_____ _____

_____ _____

_____ _____

_____ _____

Does this vehicle provide:

basic life support (BLS)?	☐ Yes	☐ No	land ambulance?	☐ Yes	☐ No
advanced life support (ALS)?	☐ Yes	☐ No	air ambulance?	☐ Yes	☐ No
emergency runs?	☐ Yes	☐ No	marine ambulance?	☐ Yes	☐ No
non-emergency runs?	☐ Yes	☐ No			

How many crew members accompany this vehicle on runs? _____

3. Qualification of Crew

Copy and complete this section as needed for additional crew.

1. Name: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.	Social Security Number

List training completed by this crew member (i.e., First Aid, CPR, ACLS, etc.) and attach copy(s) of training certificate(s).

2. Name: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.	Social Security Number

List training completed by this crew member (i.e., First Aid, CPR, ACLS, etc.) and attach copy(s) of training certificate(s).

3. Name: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.	Social Security Number

List training completed by this crew member (i.e., First Aid, CPR, ACLS, etc.) and attach copy(s) of training certificate(s).

4. Billing Method

A. Certified Basic Life Support (BLS) companies complete the following:

Contact the local Medicare contractor for information on the billing method that applies in the State where applicant will operate.

Does company bill Method 1 (an all-inclusive base rate)? ☐ Yes ☐ No
Does company bill Method 2 (base rate plus a separate charge for mileage)? ☐ Yes ☐ No
Does company bill Method 3 (base rate plus a separate charge for supplies)? ☐ Yes ☐ No
Does company bill Method 4 (separate charges for services, mileage, and supplies)? ☐ Yes ☐ No
Is company certified to perform defibrillation? (IF YES, attach certification.) ☐ Yes ☐ No

Does company provide Advanced Life Support (ALS) Services under contract with a paramedic or Emergency Medical Technician (EMT) organization or an Advanced Life Support (ALS) ambulance supplier? ☐ Yes ☐ No
IF YES, submit a copy(s) of the signed contractual agreement(s).

Does the company provide Paramedic Intercept Service? ☐ Yes ☐ No
If YES, does the Basic Life Support Service submit Medicare claims for the paramedic service (reassign benefits)? ☐ Yes ☐ No
If YES, complete the Reassignment of Benefits Statement section.

AIR AMBULANCE ONLY: Do you bill nautical mileage ☐ or statute mileage ☐ ?

Medical Director Name: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.

Social Security Number	Medicare Identification Number (if applicable)

What geographic area does company serve?

4. Billing Method (continued)

B. Certified Advanced Life Support (ALS) companies complete the following:

Contact the local Medicare contractor for information on the billing method that applies in the State where applicant will operate.

Does company bill Method 1 (an all-inclusive base rate)?	☐ Yes	☐ No
Does company bill Method 2 (base rate plus a separate charge for mileage)?	☐ Yes	☐ No
Does company bill Method 3 (base rate plus a separate charge for supplies)?	☐ Yes	☐ No
Does company bill Method 4 (separate charges for services, mileage, and supplies)?	☐ Yes	☐ No
Does company have a contract with any municipality?	☐ Yes	☐ No
If Yes, submit copy(s) of the signed contractual agreement(s).		
Is company certified to perform defibrillation? (IF YES, attach certification.)	☐ Yes	☐ No

AIR AMBULANCE ONLY: Do you bill nautical mileage ☐ or statute mileage ☐ ?

Medical Director Name: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.

Social Security Number	Medicare Identification Number (if applicable)

What geographic area does company serve?

5. Exclusion/Sanction Information

Check here ☐ **only if this entire section does not apply to the applicant.**

Copy and complete this section as needed for additional crew members.

If any member of the ambulance crew has ever had any of the following adverse legal actions imposed by the Medicare, Medicaid, or any other federal agency or program, furnish identifying information below and check the appropriate box(es). For each box checked, include the date the adverse legal action was imposed. Attach copy of adverse legal action notification.

Name: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.

Social Security Number	Employer Identification Number

1.
- ☐ Administrative Sanction(s) _____
- ☐ Program exclusion(s) _____
- ☐ Suspension of payment(s) _____
- ☐ Civil monetary penalty(s) _____
- ☐ Assessment(s) _____
- ☐ Program Debarment(s) _____

2. Health Care Related:
- ☐ Criminal fine(s) _____
- ☐ Restitution order(s) _____
- ☐ Pending civil judgment(s) _____
- ☐ Pending criminal judgment(s) _____
- ☐ Judgment(s) pending under the False Claims Act _____

3. Does this ambulance crew member have any outstanding criminal fines? ☐ Yes ☐ No restitution orders? ☐ Yes ☐ No

Independent Diagnostic Testing Facility (IDTFs)

This attachment must be completed for each IDTF owned and/or operated by the applicant.

1. Identification of Practice Location

A. Is this practice location a mobile unit? ☐ **YES** ☐ **NO**

IF YES, please list the vehicle(s) identification number(s) and the expiration date of the license for all mobile units and submit copies of all vehicle(s) registration(s).

Vehicle Identification Number	Expiration Date of License (MM/DD/YYYY)
1	
2	
3	

B. Identify the practice location for which this attachment is being completed.
If this practice location is a mobile unit, complete the address information below with the storage location of the mobile unit.

"Doing Business As" Name of This Practice Location

Practice Location Street Address Line 1

Practice Location Street Address Line 2

City	State	ZIP Code + 4

C. Is this practice location used for any other purpose? ☐ **YES** ☐ **NO**

IF YES, please answer the following questions:

Is this practice location used for another type of business? ☐ **YES** ☐ **NO**

IF YES, what type? _____

Is this practice location used for residential purposes? ☐ **YES** ☐ **NO**

IF YES, explain reason for dual use as residence. _____

If used for any purpose other than another business or a residence, please explain the other use below.

_____

D. Are all diagnostic tests and/or services performed at the practice location? ☐ **YES** ☐ **NO**

IF NO, furnish the additional location address information where the diagnostic tests and/or services are performed.
If more than one location, copy and complete this section for each.

Legal Business Name

"Doing Business As" Name

Street Address Line 1

Street Address Line 2

City	State	ZIP Code + 4

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

2. Identification of Supervising/Directing Physician(s)

List all supervising/directing physicians affiliated with this IDTF.
For each additional supervising/directing physician, copy and complete this section.

A. Name: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Social Security Number		Medicare Identification Number		
Current Medicaid Number/State (if applicable)		Prior Medicaid Number/State (if applicable)		
B. Name: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Social Security Number		Medicare Identification Number		
Current Medicaid Number/State (if applicable)		Prior Medicaid Number/State (if applicable)		

3. Service Performance (For each additional CPT- 4 or HCPCS code, copy and complete this section.)

A. List all Current Procedural Terminology, Version 4 (CPT-4) codes or HCFA Common Procedure Coding System codes (HCPCS), equipment, and model number of equipment which this facility or its contractors intend to perform, supervise, interpret, or bill.

	CPT-4 or HCPCS Code	Equipment	Model Number
1			
2			
3			
4			
5			

Where will these services be rendered? (Check all that apply.) ☐ Physician's Office ☐ Skilled Nursing Facility ☐ Hospital
☐ Other (Explain.) _____

Will this IDTF be billing for the professional services? ☐ **YES** ☐ **NO**
IF YES, fill out the following information for each physician who will be performing the professional services (interpretations).

1. Name: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Title	Social Security Number	Medicare Identification Number		
2. Name: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Title	Social Security Number	Medicare Identification Number		

B. Will tests be taken by employees who are licensed or approved by the State in:

X-Ray Technology ☐ **YES** ☐ **NO** Other ☐ **YES** ☐ **NO**
Nursing ☐ **YES** ☐ **NO** (IF YES to "Other", explain and give qualifications below.)

_____

IF YES to any of the above, provide the following information for each employee licensed or approved and a copy of their license or certificate of approval. If additional space is needed, copy and complete this section.

1. Name: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Social Security Number	License Number	License Issue Date (MM/DD/YYYY)		
2. Name: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Social Security Number	License Number	License Issue Date (MM/DD/YYYY)		

4. Referral Records

Does applicant maintain records of:

the name of the attending or consulting physician who ordered the test(s)?	☐ YES	☐ NO
a copy of the physician's written order(s) for the test(s)?	☐ YES	☐ NO
the name(s) of the technician(s) who rendered the service(s)?	☐ YES	☐ NO

IF YES to any of the above, explain how the referral records are maintained (e.g., electronic, paper, by patient name, by physician name).

_____

_____

_____

5. Supervising/Directing Physician Exclusion/Sanction Information

Check if this supervising/directing physician has ever had any of the following adverse legal actions imposed by the Medicare, Medicaid, or any other federal agency or program. For each box checked, include the date the adverse legal action was imposed. Check all that apply or the "none of these" box. Attach copy of adverse legal action notification.

A.		**B.** Health Care Related:		**C.**	
☐	Administrative Sanction(s) _____	☐	Criminal fine(s) _____	☐	None of these
☐	Program exclusion(s) _____	☐	Restitution order(s) _____		
☐	Suspension of payment(s) _____	☐	Pending civil judgment(s) _____		
☐	Civil monetary penalty(s) _____	☐	Pending criminal judgment(s) _____		
☐	Assessment(s) _____	☐	Judgment(s) pending under the False Claims Act _____		
☐	Program Debarment(s) _____				

D. Does this supervising/directing physician have any outstanding criminal fines? ☐ Yes ☐ No restitution orders? ☐ Yes ☐ No

6. Signature of Supervising/Directing Physician(s)

Each supervising/directing physician must sign the following statement:
For additional supervising/directing physician signatures, copy and complete this section.

I hereby acknowledge that I have agreed to provide (IDTF Name) _____ with general supervisory and/or directing responsibilities for tests performed by this facility. If I terminate my relationship with this IDTF, I will report the date of termination to the Medicare contractor within 30 days of termination.

1. Supervising/Directing Physician Name (printed): First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.	Date (MM/DD/YYYY)
Signature of Supervising/ Directing Physician	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Title/Position	

I hereby acknowledge that I have agreed to provide (IDTF Name) _____ with general supervisory and/or directing responsibilities for tests performed by this facility. If I terminate my relationship with this IDTF, I will report the date of termination to the Medicare contractor within 30 days of termination.

2. Supervising/Directing Physician Name (printed): First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.	Date (MM/DD/YYYY)
Signature of Supervising/ Directing Physician	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Title/Position	

ATTACHMENT 3

Home Health Agencies (HHAs)

1. Other Related Business Interests (Control and/or Ownership)

For each owner listed in the Ownership section, each managing/directing employee listed in the Managing/Directing Employee section, as well as the home health agency (HHA) itself, complete the following information about all other businesses that each owner, managing/directing employee, or the HHA has a 5% or greater ownership and/or control interest. Indicate the relationship to the HHA.

Check here ☐ **if this entire attachment does not apply to the HHA, any of it's owners and/or managing/directing employees.**

For each owner, managing/directing employee and/or when additional space is needed, copy and complete this attachment.

Name: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.

Is this individual an owner or managing/directing employee? ☐ owner ☐ managing/directing employee

A. Legal Business Name of Related Business		Type of Business
"Doing Business As" Name		Employer Identification Number
Business Street Address Line 1		
Business Street Address Line 2		
City	State	ZIP Code + 4
Telephone Number ( )	Fax Number ( )	E-mail Address
Relationship of This Business to the HHA (e.g., affiliate, contractor, supplier, etc.)		Effective Date of Ownership (MM/DD/YYYY)

B. Legal Business Name of Related Business		Type of Business
"Doing Business As" Name		Employer Identification Number
Business Street Address Line 1		
Business Street Address Line 2		
City	State	ZIP Code + 4
Telephone Number ( )	Fax Number ( )	E-mail Address
Relationship of This Business to the HHA (e.g., affiliate, contractor, supplier, etc.)		Effective Date of Ownership (MM/DD/YYYY)

C. Legal Business Name of Related Business		Type of Business
"Doing Business As" Name		Employer Identification Number
Business Street Address Line 1		
Business Street Address Line 2		
City	State	ZIP Code + 4
Telephone Number ( )	Fax Number ( )	E-mail Address
Relationship of This Business to the HHA (e.g., affiliate, contractor, supplier, etc.)		Effective Date of Ownership (MM/DD/YYYY)