## SECTION 1: BASIC INFORMATION

**A. Provide the two-letter State Code (e.g., TX for Texas) where your business is located**

☐☐

**B. Check one box and provide the necessary information where requested**

DMEPOS suppliers must furnish their Medicare Identification Number, often referred to as a supplier number, and their NPI below. Note: Unless enrolling as a sole proprietorship with multiple locations, each enrolled supplier of DMEPOS must obtain an NPI for each practice location.

However, if the applicant is the sole owner of more than one incorporated DMEPOS supplier location (i.e., a sole proprietor with multiple locations) only one NPI will be issued.

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

| | |
|---|---|
| ☐ You are a **new enrollee** in Medicare or are enrolling a new location with a tax identification number not previously enrolled with the NSC | **Complete all applicable sections** |
| ☐ You are **adding a new business location** using a tax identification number already enrolled with the NSC | **1A, 1B, 2, 4, 6 (for managing/directing employee only), 12, 13, 15, 16 (if applicable)** |
| ☐ You are **reactivating** your Medicare Supplier Billing Number | **Complete all applicable sections** |
| ☐ You are **revalidating** your Medicare enrollment | **Complete all applicable sections** |
| ☐ You are **voluntarily terminating your Medicare enrollment.**<br><br>Effective date of termination: _____ | **1B, 4A (page 15 only), 13, and either 15** or **16** |
| ☐ You are **changing your Medicare information** | **Go to Section 1C** |

## SECTION 1: BASIC INFORMATION *(Continued)*

**C. Check the item(s) listed that is changing and complete the applicable sections**

| MARK ALL THAT APPLY | REQUIRED SECTIONS |
|---|---|
| ☐ Supplier Type (submit licensure if applicable)<br>☐ Products and Services (submit accreditation if applicable) | **1C, 2** (complete **2A1** and those data elements that are changing), **3, 13,** and either **15** (if you are the authorized official) or **16** (if you are the delegated official), and **6** for the signer if that authorized or delegated official has not been established for this DMEPOS supplier. |
| ☐ Accreditation Information | **1C, 2A1, 2G, 3, 13,** and either **15** (if you are the authorized official), or **16** (if you are the delegated official), and **6** for the signer if that authorized or delegated official has not been established for this DMEPOS supplier. |
| ☐ Surety Bond Information | **1C, 2A1, 3, 12, 13,** and either **15** (if you are the authorized official), or **16** (if you are the delegated official), and **6** for the signer if that authorized or delegated official has not been established for this DMEPOS supplier. |
| ☐ Final Adverse Actions/Convictions | **1C, 2A1, 3, 13,** and either **15** (if you are the authorized official) or **16** (if you are the delegated official), and **6** for the signer if that authorized or delegated official has not been established for this DMEPOS supplier. |
| ☐ Current Business Location | **1C, 2A1, 3, 4, 12, 13**, and either **15** (if you are the authorized official) or **16** (if you are the delegated official), and **6** for the signer if that authorized or delegated official has not been established for this DMEPOS supplier. |
| ☐ Ownership and/or Managing Control Information (Organizations) | **1C, 2A1, 3, 5, 13,** and either **15** (if you are the authorized official) or **16** (if you are the delegated official), and **6** for the signer if that authorized or delegated official has not been established for this DMEPOS supplier. |
| ☐ Ownership and/or Managing Control Information (Individuals) | **1C, 2A1, 3, 6, 13,** and either **15** (if you are the authorized official) or **16** (if you are the delegated official), and **6** for the signer if that authorized or delegated official has not been established for this DMEPOS supplier. |
| ☐ Billing Agency Information | **1, 2A1, 3, 8** (complete only those data elements that are changing), **13,** and either **15** (if you are the authorized official) or **16** (if you are the delegated official), and **6** for the signer if that authorized or delegated official has not been established for this DMEPOS supplier. |
| ☐ Authorized Official | **1C, 2A1, 3, 6, 13** and **15** |
| ☐ Delegated Official | **1C, 2A1, 3, 6, 13, 15** and **16** |

## SECTION 2: IDENTIFYING INFORMATION

## SECTION 2A1 INSTRUCTIONS

### A. SUPPLIER IDENTIFICATION

**All applicants new to Medicare or suppliers that are making changes to their Medicare information must complete this section. DO NOT PROVIDE BILLING AGENT INFORMATION HERE.**

**1. Where should we mail your 1099?**

**Organizational Suppliers (e.g., Corporations, Partnerships, LLCs, Sub-Chapter S)**
If you are an organizational supplier, furnish the supplier's legal name (as reported to the IRS) and TIN. Furnish 1099 mailing address information where indicated. A copy of the IRS CP-575 or other correspondence issued by the IRS showing the TIN for this business MUST be submitted. Complete only item A on this page.

**Sole Proprietors**
If you are a sole proprietor (only owner of a business that is not incorporated) list your Social Security Number (SSN) and the full legal name associated with the SSN as reported to the IRS in the appropriate fields. If you want your Medicare payments reported under your Employer Identification Number (EIN) furnish it in the appropriate space below. Furnish 1099 mailing address information where indicated. Complete only item B on this page.

**NOTE: Sole Proprietors:** If you furnish an EIN in Section B, payment will be made to your EIN. If you do not furnish an EIN in Section B, payment will be made to your SSN. You can not use both an SSN and EIN. You can only use one number to bill Medicare. If furnishing an EIN, a copy of the IRS CP-575 or other correspondence issued by the IRS showing the EIN for this business MUST be submitted.

**A. Organizational Suppliers (e.g., Corporations, Partnerships, LLCs, Sub-Chapter S)**

Legal Name as Reported to the IRS

Tax Identification Number

1099 Mailing Address Line 1 *(Street Name and Number)*

Former Tax Identification Number *(if changed)*

1099 Mailing Address Line 2 *(Suite, Room, etc.)*

Medicaid Number *(if applicable)*

1099 Mailing Address City

1099 Mailing Address State

1099 Mailing Address ZIP Code + 4

**B. Sole Proprietors**

Social Security Number

Full Legal Name Associated with this Social Security Number

Employer Identification Number

1099 Mailing Address Line 1 *(Street Name and Number)*

Former Tax Identification Number *(if changed)*

1099 Mailing Address Line 2 *(Suite, Room, etc.)*

Medicaid Number *(if applicable)*

1099 Mailing Address City

1099 Mailing Address State

1099 Mailing Address ZIP Code + 4

## SECTION 2: IDENTIFYING INFORMATION *(Continued)*

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

☐ Proprietary ☐ Non-Profit

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

**2. Where should correspondence be mailed?**

This is the address to which correspondence will be sent to you by the NSC and/or the DME MAC.

| Business Location Name *(NOT your billing agent, staffing company, or managing organization)* | | |
|---|---|---|
| Mailing Address Line 1 *(Street Name and Number)* | | |
| Mailing Address Line 2 *(Suite, Room, etc.)* | | |
| City/Town | State | ZIP Code + 4 |
| Telephone Number | Fax Number *(if applicable)* | E-mail Address *(if applicable)* |

**3. Where should we mail your revalidation request package if different from Section 2A2 (correspondence address) above?**

This is the address to which the NSC will send your reenrollment request package.

| Business Location Name *(NOT your billing agent, staffing company, or managing organization)* | | |
|---|---|---|
| Mailing Address Line 1 *(Street Name and Number)* | | |
| Mailing Address Line 2 *(Suite, Room, etc.)* | | |
| City/Town | State | ZIP Code + 4 |
| Telephone Number | Fax Number *(if applicable)* | E-mail Address *(if applicable)* |

**4. Is this supplier currently enrolled in the Medicare program other than as a DMEPOS supplier?**

☐ YES ☐ NO

If yes, please provide the following for each enrolled supplier:

| Medicare Contractor Name | Provider/Supplier Type | NPI |
|---|---|---|

**5. Is this supplier an Indian Health Facility?**

☐ YES ☐ NO

## SECTION 2: IDENTIFYING INFORMATION *(Continued)*

### B. TYPE OF SUPPLIER

The supplier must meet all Medicare requirements for the DMEPOS supplier type checked. Any specialty personnel including, but not limited to, Respiratory Therapists, and Orthotics/Prosthetics personnel, must have current licensure as applicable to the specialty supplier type checked as well as for products and services checked in section 2D.

**Check all that apply:**

- ☐ Ambulatory Surgical Center
- ☐ Department Store
- ☐ Grocery Store
- ☐ Home Health Agency
- ☐ Hospital
- ☐ Indian Health Service
- ☐ Intermediate Care Nursing Facility
- ☐ Medical Supply Company
- ☐ Medical Supply Company with Orthotics Personnel
- ☐ Medical Supply Company with Pedorthic Personnel
- ☐ Medical Supply Company with Prosthetics Personnel
- ☐ Medical Supply Company with Prosthetic and Orthotic Personnel
- ☐ Medical Supply Company with Registered Pharmacist
- ☐ Medical Supply Company with Respiratory Therapist
- ☐ Nursing Facility (other)
- ☐ Occularists
- ☐ Occupational Therapist
- ☐ Optician
- ☐ Orthotics Personnel
- ☐ Oxygen and/or Oxygen Related Equipment Supplier
- ☐ Pedorthic Personnel
- ☐ Pharmacy
- ☐ Physical Therapist
- ☐ Physician/Dentist
- ☐ Physician, other than Optometrist or Dentist
- ☐ Physician/Optometrist
- ☐ Prosthetics Personnel
- ☐ Prosthetic and Orthotic Personnel
- ☐ Rehabilitation Agency
- ☐ Skilled Nursing Facility
- ☐ Other_____

### C. NON-ACCREDITED PRODUCTS

**Check all that apply.**

- ☐ Epoetin
- ☐ Immunosuppressive Drugs
- ☐ Infusion Drugs
- ☐ Nebulizer Drugs
- ☐ Oral Anticancer Drugs
- ☐ Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)
- ☐ Check here if the supplier does not furnish any of the products and/or services listed in Section 2D and provides one or more of the products shown below. If checked, skip Section 2D and continue to Section 2E (Liability Insurance Information).

If you are adding/changing any supplies for which you plan to bill, you must notify the NSC. Consistent with 42 CFR § 424.57 (c)(2), a supplier has not made or caused to be made, any false statement or misrepresentation of a material fact on its application for billing privileges. (The supplier must provide complete and accurate information in response to questions on its application for billing privileges. The supplier must report to CMS any changes in information supplied on the application within 30 days of the change.) Failure to do so could result in revocation and/or overpayment collection.

## D. PRODUCTS AND SERVICES TO BE FURNISHED BY THIS SUPPLIER

Check all that apply. If you are adding/changing any supplies for which you plan to bill, you must notify the NSC. Consistent with 42 CFR § 424.57 (c)(2), a supplier has not made or caused to be made, any false statement or misrepresentation of a material fact on its application for billing privileges. (The supplier must provide complete and accurate information in response to questions on its application for billing privileges. The supplier must report to CMS any changes in information supplied on the application within 30 days of the change.) Failure to do so could result in revocation and/or overpayment collection.

If you are unsure of the licensure and/or certification and/or accreditation requirements for your product(s), services(s), and/or State, check the NSC website at *www.palmettogba.com/nsc*. Failure to attach applicable licensure and/or certification could result in denial or revocation of your Medicare billing number and/or overpayment collection.

- ☐ Automatic External Defibrillators (AEDs) and/or Supplies
- ☐ Blood Glucose Monitors and/or Supplies (mail order)
- ☐ Blood Glucose Monitors and/or Supplies (non-mail order)
- ☐ Breast Prostheses and/or Accessories
- ☐ Canes and/or Crutches
- ☐ Cochlear Implants
- ☐ Commodes/Urinals/Bedpans
- ☐ Continuous Passive Motion (CPM) Devices
- ☐ Continuous Positive Airway Pressure (CPAP) Devices and/or Supplies
- ☐ Contracture Treatment Devices: Dynamic Splint
- ☐ Diabetic Shoes/Inserts
- ☐ Diabetic Shoes/Inserts—Custom
- ☐ Enteral Nutrients
- ☐ Enteral Equipment and/or Supplies
- ☐ External Infusion Pumps and/or Supplies
- ☐ Facial Prostheses
- ☐ Gastric Suction Pumps
- ☐ Heat & Cold Applications
- ☐ Hemodialysis Equipment and/or Supplies
- ☐ High Frequency Chest Wall Oscillation (HFCWO) Devices and/or Supplies
- ☐ Home Dialysis Equipment and/or Supplies
- ☐ Hospital Beds—Electric
- ☐ Hospital Beds—Manual
- ☐ Implanted Infusion Pumps and/or Supplies
- ☐ Infrared Heating Pad Systems and/or Supplies
- ☐ Insulin Infusion Pumps and/or Supplies
- ☐ Intermittent Positive Pressure Breathing (IPPB) Devices
- ☐ Intrapulmonary Percussive Ventilation Devices
- ☐ Invasive Mechanical Ventilation Devices
- ☐ Limb Prostheses
- ☐ Mechanical In-Exsufflation Devices
- ☐ Nebulizer Equipment and/or Supplies
- ☐ Negative Pressure Wound Therapy Pumps and/or Supplies
- ☐ Neuromuscular Electrical Stimulators (NMES) and/or Supplies
- ☐ Neurostimulators and/or Supplies
- ☐ Ocular Prostheses
- ☐ Orthoses: Custom Fabricated
- ☐ Orthoses: Prefabricated (non-custom fabricated)
- ☐ Orthoses: Off-the-Shelf
- ☐ Osteogenesis Stimulators
- ☐ Ostomy Supplies
- ☐ Oxygen Equipment and/or Supplies
- ☐ Parenteral Nutrients
- ☐ Parenteral Equipment and/or Supplies
- ☐ Patient Lifts
- ☐ Penile Pumps
- ☐ Pneumatic Compression Devices and/or Supplies
- ☐ Power Operated Vehicles (Scooters)
- ☐ Prosthetic Lenses: Conventional Contact Lenses
- ☐ Prosthetic Lenses: Conventional Eyeglasses
- ☐ Prosthetic Lenses: Prosthetic Cataract Lenses
- ☐ Respiratory Assist Devices
- ☐ Respiratory Suction Pumps
- ☐ Seat Lift Mechanisms
- ☐ Somatic Prostheses
- ☐ Speech Generating Devices
- ☐ Support Surfaces: Pressure Reducing Beds/Mattresses/Overlays/Pads
- ☐ Surgical Dressings
- ☐ Tracheostomy Supplies
- ☐ Traction Equipment
- ☐ Transcutaneous Electrical Nerve Stimulators (TENS) and/or Supplies
- ☐ Ultraviolet Light Devices and/or Supplies
- ☐ Urological Supplies
- ☐ Ventilators Accessories and/or Supplies
- ☐ Voice Prosthetics
- ☐ Walkers
- ☐ Wheelchair Seating/Cushions
- ☐ Wheelchairs—Complex Rehabilitative Manual Wheelchairs
- ☐ Wheelchairs—Complex Rehabilitative Manual Wheelchair Related Accessories
- ☐ Wheelchairs—Complex Rehabilitative Power Wheelchairs
- ☐ Wheelchairs—Complex Rehabilitative Power Wheelchair Related Accessories
- ☐ Wheelchairs—Standard Manual
- ☐ Wheelchairs—Standard Manual Related Accessories
- ☐ Wheelchairs—Standard Power
- ☐ Wheelchairs—Standard Power Related Accessories

## E. COMPREHENSIVE LIABILITY INSURANCE INFORMATION

Consistent with DMEPOS supplier standards found in 42 CFR § 424.57(c)(10), all DMEPOS suppliers enrolling in Medicare must have a comprehensive liability insurance policy in the amount of at least $300,000. The NSC must be listed on the policy as a Certificate Holder. The insurance policy must remain in force at all times and provide coverage of at least $300,000 per incident. Failure to maintain the required insurance at all times will result in revocation of the Medicare supplier billing number, retroactive to the date the insurance lapsed.

Malpractice insurance policies do not demonstrate compliance with this requirement.

All DMEPOS suppliers must have comprehensive liability insurance and must submit a complete copy of their liability insurance policy or evidence of self-insurance with this application. You must provide the name and telephone number for both your insurance agent and your underwriter. The underwriter is with the company providing your insurance coverage. This contact information is necessary for the NSC to verify your policy. We will not verify this information with your insurance agent.

Name of Insurance Company

| | | | |
|---|---|---|---|
| Insurance Policy Number | Date Policy Issued *(mm/dd/yyyy)* | | Expiration Date of Policy *(mm/dd/yyyy)* |
| Insurance Agent's First Name | Middle Initial | Last Name | Jr., Sr., etc. |
| Agent's Telephone Number | Agent's Fax Number *(if applicable)* | | Agent's E-mail Address *(if applicable)* |
| Underwriter's Agent's First Name | Middle Initial | Last Name | Jr., Sr., etc. |
| Underwriter's Telephone Number | Underwriter's Fax Number *(if applicable)* | | Underwriter's E-mail Address *(if applicable)* |

Is the insurance agent also the underwriter for this policy?

☐ Yes (Submit written proof from the insurance company attesting the agent is also the underwriter.)

☐ No

## F. ORGANIZATIONAL STRUCTURE

Identify the type of organizational structure for this supplier (Check one):

☐ Not Publically Traded Corporation (regardless of whether supplier is "for-profit" or "non-profit")

☐ Publically Traded Corporation (regardless of whether supplier is "for-profit" or "non-profit")

☐ Partnership ("general" or "limited")

☐ Sole Proprietor/Sole Proprietorship

☐ Other (Specify) _____

## G. ACCREDITATION INFORMATION

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

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

☐ The enrolling supplier is accredited.

☐ The enrolling supplier is exempt from accreditation requirements.

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

## SECTION 3: FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS *(Continued)*

### FINAL ADVERSE LEGAL ACTION HISTORY

1. Have you or your organization, under any current or former name or business identity, ever had a final adverse legal action listed on page 13 of this application imposed against you/it?

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

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

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

| FINAL ADVERSE LEGAL ACTION | DATE | TAKEN BY | RESOLUTION |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## SECTION 4: CURRENT BUSINESS LOCATION

### A. BUSINESS LOCATION INFORMATION

This section captures information regarding your business location.

- A separate application must be submitted for each physical business location that intends to bill Medicare for items sold to Medicare beneficiaries from that location. Locations that serve only as warehouses or repair facilities should not be reported.
- The address must be a specific street address as recorded by the United States Postal Service. Do not furnish a P.O. Box. If you are in a hospital and/or other health care facility and you provide services to patients at that facility, furnish the name and address of the hospital or facility.
- A change to the business location address requires submission of professional and business licenses for the new address, and proof of insurance covering the new address.

**NOTE: You must separately enroll each Medicare DMEPOS supplier business location.**

**If you are making a change in this section, please check the box and list effective date below.**

| ☐ CHANGE | DATE *(mm/dd/yyyy)* _____ |
|---|---|

Business Location Name/Doing Business As Name *(NOT your billing agent, staffing company, or managing organization)*

Business Location Address Line 1 *(Street Name and Number)*

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

| City/Town | State | ZIP Code + 4 |
|---|---|---|
| | | |

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

| Date this Business Started at this Location *(mm/dd/yyyy)* | Date this Business Terminated at this Location *(if applicable) (mm/dd/yyyy)* |
|---|---|
| | |

**List your posted hours of operation as shown at your business location.**

| MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY | TOTAL HOURS Available to the Public |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

## SECTION 4: CURRENT BUSINESS LOCATION *(Continued)*

Select the State(s)/Territory(ies) where the majority of claims for this location will be submitted. Claims submissions are based on where the Medicare beneficiary resides.

**Jurisdiction A:**

- ☐ Connecticut
- ☐ Delaware
- ☐ District of Columbia
- ☐ Maine
- ☐ Maryland
- ☐ Massachusetts
- ☐ New Hampshire
- ☐ New Jersey
- ☐ New York
- ☐ Pennsylvania
- ☐ Rhode Island
- ☐ Vermont

**Jurisdiction B:**

- ☐ Illinois
- ☐ Indiana
- ☐ Kentucky
- ☐ Michigan
- ☐ Minnesota
- ☐ Ohio
- ☐ Wisconsin

**Jurisdiction C:**

- ☐ Alabama
- ☐ Arkansas
- ☐ Colorado
- ☐ Florida
- ☐ Georgia
- ☐ Louisiana
- ☐ Mississippi
- ☐ New Mexico
- ☐ North Carolina
- ☐ Oklahoma
- ☐ Puerto Rico
- ☐ South Carolina
- ☐ Tennessee
- ☐ Texas
- ☐ Virgin Islands
- ☐ Virginia
- ☐ West Virginia

**Jurisdiction D:**

- ☐ Alaska
- ☐ Arizona
- ☐ California
- ☐ Guam
- ☐ Hawaii
- ☐ Idaho
- ☐ Iowa
- ☐ Kansas
- ☐ Missouri
- ☐ Montana
- ☐ Nebraska
- ☐ Nevada
- ☐ North Dakota
- ☐ Oregon
- ☐ South Dakota
- ☐ Utah
- ☐ Washington
- ☐ Wyoming
- ☐ Northern Mariana Islands
- ☐ American Samoa

## SECTION 4: CURRENT BUSINESS LOCATION *(Continued)*

### B. WHERE DO YOU WANT REMITTANCE NOTICES OR SPECIAL PAYMENTS SENT?

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

**NOTE:** If you are a new enrollee or are adding a new business location, you must submit an EFT Authorization Agreement (CMS-588) with this application.

If you are reenrolling and/or making changes to your current EFT Authorization Agreement (CMS-588), contact your DME MAC. DME MAC contact information can be found at *www.palmettogba.com/nsc*.

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

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

☐ "Special Payments" address is the same as the business location in Section 4A. Skip to Section 4C.

☐ "Special Payments" address is different than that listed in Section 4A. Provide address below.

**NOTE:** Payment will be made in the supplier's "legal business name" shown in Section 2A1.

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

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

| City/Town | State | ZIP Code + 4 |
|---|---|---|
| | | |

## SECTION 4: CURRENT BUSINESS LOCATION *(Continued)*

### C. WHERE DO YOU KEEP MEDICARE BENEFICIARY MEDICAL RECORDS?

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

Post office boxes and drop boxes are not acceptable as physical addresses where Medicare beneficiaries' records are maintained. The records must be the supplier's records, not the records of another supplier. If all records are stored at the business location reported in Section 4A, please indicate below.

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

**First Medical Record Storage Facility (for current and former Medicare beneficiaries)**

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

☐ Records are stored at the business location reported in Section 4A.

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

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

| City/Town | State | ZIP Code + 4 |
|---|---|---|
| | | |

**Second Medical Record Storage Facility (for current and former Medicare beneficiaries)**

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

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

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

| City/Town | State | ZIP Code + 4 |
|---|---|---|
| | | |

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

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

Complete this section with information about all organizations that have 5 percent or more (direct or indirect) ownership interest of, any partnership interest in, and/or managing control of, the supplier identified in Section 4A, as well as any information on final adverse actions that have been imposed against that organization. For examples of organizations that should be reported in this section, you should visit the following Web site: *www.cms.gov/MedicareProviderSupEnroll*. If there is more than one organization, copy and complete this section for each.

## MANAGING CONTROL (ORGANIZATIONS)

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

## SPECIAL TYPES OF ORGANIZATIONS

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

**Indian Health Service Facilities:**
Special rules concerning insurance and licenses apply. Contact the NSC concerning these rules.

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

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

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

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

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

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

If there is more than one organization, copy and complete this section for each.

### A. ORGANIZATION WITH OWNERSHIP INTEREST AND/OR MANAGING CONTROL—IDENTIFICATION INFORMATION

☐ Not Applicable

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

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

Check all that apply:
☐ 5 Percent or More Ownership Interest ☐ Partner ☐ Managing Control

Legal Business Name as Reported to the Internal Revenue Service

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

Business Address Line 1 *(Street Name and Number)*

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

| City/Town | State | ZIP Code + 4 |
|---|---|---|
| | | |

Tax Identification Number *(Required)*

| Medicare Identification Number(s) *(if issued)* | NPI *(if issued)* |
|---|---|
| | |

What is the effective date this owner acquired ownership of the supplier identified in Section 2A1 of this application? *(mm/dd/yyyy)* _____

What is the effective date this organization acquired managing control of the supplier identified in Section 2A1 of this application? *(mm/dd/yyyy)* _____

**NOTE:** Furnish both dates if applicable.

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

### B. FINAL ADVERSE LEGAL ACTION HISTORY

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

☐ Change ☐ Effective Date:_____

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

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

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

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

| FINAL ADVERSE LEGAL ACTION | DATE | TAKEN BY | RESOLUTION |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

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

### A. INDIVIDUALS WITH OWNERSHIP INTEREST AND/OR MANAGING CONTROL—IDENTIFICATION INFORMATION

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

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

| 1. First Name | Middle Initial | Last Name | Jr., Sr., etc. | Title |
|---|---|---|---|---|
| | | | | |

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

| Social Security Number *(Required)* | Medicare Identification Number *(if issued)* | NPI *(if issued)* |
|---|---|---|
| | | |

2. What is the above individual's relationship with the supplier in Section 2A1? *(Check all that apply.)*

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

What is the effective date this owner acquired ownership of the supplier identified in Section 2A1 of this application? *(mm/dd/yyyy)* _____

What is the effective date this individual acquired managing control of the supplier identified in Section 2A1 of this application? *(mm/dd/yyyy)* _____

**NOTE:** Furnish both dates if applicable.

### B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for the individual reported in Section 6A above.

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

☐ Change ☐ Effective Date:_____

1. Has this individual listed in Section 6A, under any current or former name or business entity, ever had a final adverse legal action listed on page 13 of this application imposed against it?

   ☐ YES–Continue Below ☐ NO–Skip to Section 8

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

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

| FINAL ADVERSE LEGAL ACTION | DATE | TAKEN BY | RESOLUTION |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## SECTION 7: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

## SECTION 8: BILLING AGENCY INFORMATION

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

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

**BILLING AGENCY NAME AND ADDRESS**

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

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

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

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

Tax Identification Number or Social Security Number *(required)*

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

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

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

| City/Town | | State | ZIP Code + 4 |
|---|---|---|---|
| Telephone Number | Fax Number *(if applicable)* | E-mail Address *(if applicable)* | |
| Medicare Identification Number(s) *(if issued)* | | NPI *(if issued)* | |

## SECTION 9: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

## SECTION 10: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

## SECTION 11: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

## SECTION 12: SURETY BOND INFORMATION

This section is to be completed by DMEPOS suppliers mandated by law to obtain a surety bond in order to enroll in and bill the Medicare program. Furnish all requested information about the supplier's insurance agent, surety company, and the surety bond. The surety bond must be a continuous bond. A copy of the original surety bond must be submitted with this application.

### A. CHECK BOX:

Check the box if this DMEPOS supplier believes it is not required to obtain a surety bond for Medicare enrollment. Information on supplier types exempt from getting a surety bond can be found at *www.palmettogba.com/nsc* or by calling the NSC customer service line at (866) 238-9652.

### B. NAME AND ADDRESS OF SURETY BOND COMPANY:

If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. Furnish the legal business name and tax identification number of the surety bond company liable for this bond.
2. Furnish the complete business address, telephone number and e-mail address of the surety bond company.

### C. SURETY BOND INFORMATION:

If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise, complete this section with specific information about the bond as follows:

1. State the dollar amount of the bond and the bond number.
2. Furnish the effective date of the bond. If reporting a new bond or new surety bond company, furnish the expiration date of the current bond.

## SECTION 12: SURETY BOND INFORMATION *(Continued)*

This section is to be completed by all DMEPOS suppliers required by regulation (see 424.57 (c)(26) and 42 C.F.R. § 424.57 (d)) to obtain a surety bond in order to enroll and maintain Medicare billing privileges. Furnish all requested information about the supplier's insurance agent, surety company, and the surety bond.

**A. Check here ☐ if this supplier is not required to obtain a surety bond for Medicare enrollment and skip to Section 13.** See instructions for surety bond requirements.

| **B. Name and Address of Surety Bond Company** | ☐ **Change** | **Effective Date:** _____ |
|---|---|---|
| Legal Business Name of Surety Bond Company as Reported to the IRS | Tax Identification Number | |
| Business Address Line 1 *(Street Name and Number)* | | |
| Business Address Line 2 *(Suite, Room, etc.)* | | |
| City/Town | State | ZIP Code + 4 |
| Telephone Number *(Ext.)* | Fax Number *(if applicable)* | E-mail Address *(if applicable)* |

| **C. Surety Bond Information** | ☐ **Change** | **Effective Date:** _____ |
|---|---|---|
| Amount of Surety Bond<br>**$** | Surety Bond Number | |
| Effective Date of Surety Bond *(mm/dd/yyyy)* | If reporting a new bond, give cancellation date of the current bond *(mm/dd/yyyy)* | |

## SECTION 13: CONTACT PERSON

If questions arise during the processing of this application, the NSC will contact the individual shown below. If no one is listed below, we will contact you directly.

☐ Contact the Authorized Official listed in Section 15.

☐ Contact the Delegated Official listed in Section 16.

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

Address Line 1 *(Street Name and Number)*

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

| City/Town | State | ZIP Code + 4 |
|---|---|---|
| | | |

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

## SECTION 14: PENALTIES FOR FALSIFYING INFORMATION ON THIS ENROLLMENT APPLICATION

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

1. 18 U.S.C. § 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 any individual who, "knowingly and willfully," makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program. The offender is subject to fines of up to $25,000 and/or imprisonment for up to five years.

3. The Civil False Claims Act, 31 U.S.C. § 3729, imposes civil liability, in part, on any person who:
   a) knowingly presents, or causes to be presented, to an officer or any 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 three times the amount of damages sustained by the Government

4. Section 1128A(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency…a claim…that the Secretary determines is for a medical or other item or service that the person knows or should know:
   a) was not provided as claimed; and/or
   b) the claim is false or fraudulent.

   This provision authorizes a civil monetary penalty of up to $10,000 for each item or service, an assessment of up to three times the amount claimed, and exclusion from participation in the Medicare program and State health care programs.

5. 18 U.S.C. 1035 authorizes criminal penalties against individuals in any matter involving a health care benefit program who knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact; or makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items or services. The individual shall be fined or imprisoned up to 5 years or both.

## SECTION 14: PENALTIES FOR FALSIFYING INFORMATION ON THIS ENROLLMENT APPLICATION *(Continued)*

6. 18 U.S.C. 1347 authorizes criminal penalties against individuals who knowing and willfully execute, or attempt, to executive a scheme or artifice to defraud any health care benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by or under the control of any, health care benefit program in connection with the delivery of or payment for health care benefits, items, or services. Individuals shall be fined or imprisoned up to 10 years or both. If the violation results in serious bodily injury, an individual will be fined or imprisoned up to 20 years, or both. If the violation results in death, the individual shall be fined or imprisoned for any term of years or for life, or both.

7. The government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment."

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

## SECTION 15: CERTIFICATION STATEMENT

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

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

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

**NOTE:** Authorized officials and delegated officials **must** be reported in Section 6 on this application.

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

During the reenrollment process, either an authorized official or delegated official can sign the certification statement.

By signing this application, an authorized official agrees to immediately notify the NSC if any information in this application is not true, correct, or complete. In addition, an authorized official, by his/her signature, agrees to notify the NSC of any future changes to the information contained in this application, after the supplier is enrolled in Medicare, within 30 days of the effective date of the change.

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

**Each authorized and delegated official must have and disclose his/her Social Security Number.**

## SECTION 15: CERTIFICATION STATEMENT *(Continued)*

### A. ADDITIONAL REQUIREMENTS FOR MEDICARE ENROLLMENT

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

By your signature(s), the authorized official(s) named below and the delegated official(s) named in Section 16 agree to adhere to all of the requirements listed therein and acknowledge that you may be denied entry to or revoked from the Medicare program if any requirements are not met.

#### Certification Statement

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

1. I have read the contents of this application, and the information contained herein is true, correct and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the NSC of this fact in accordance with the time frames established in 42 CFR § 424.57.
2. I agree to notify the NSC of any future changes to the information contained in this application in accordance with the time frames established in 42 CFR § 424.57. I understand that any change in the business structure of this supplier may require the submission of a new application.
3. I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare identification number(s), and/or the imposition of fines, civil damages, and/or imprisonment.
4. I agree to abide by the Medicare laws, regulations and program instructions that apply to this supplier. The Medicare laws, regulations, and program instructions are available through the Medicare contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the supplier's compliance with all applicable conditions of participation in Medicare.
5. Neither this supplier, nor any five percent or greater owner, partner, officer, director, managing employee, authorized official, or delegated official thereof is currently sanctioned, suspended, debarred, or excluded by the Medicare or State Health Care Program, e.g., Medicaid program, or any other Federal program, or is otherwise prohibited from supplying services to Medicare or other Federal program beneficiaries.
6. I agree that any existing or future overpayment made to the supplier by the Medicare program may be recouped by Medicare through the withholding of future payments.
7. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.
8. I authorize any national accrediting body whose standards are recognized by the Secretary as meeting the Medicare program participation requirements, to release to any authorized representative, employee, or agent of the Centers for Medicare & Medicaid Services (CMS) a copy of my most recent accreditation survey, together with any information related to the survey that CMS may require (including corrective action plans).

## SECTION 15: CERTIFICATION STATEMENT *(Continued)*

### B. 1ST AUTHORIZED OFFICIAL SIGNATURE

I have read the contents of this application and the certification statement in section 15 of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize the NSC to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the NSC of this fact in accordance with the time frames established in 42 CFR § 424.57.

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

**NOTE:** Authorized officials must be reported in Section 6 of this application.

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

**Authorized Official's Information and Signature**

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

| Telephone Number | E-mail Address | Title/Position |
|---|---|---|
| | | |

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

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

### C. 2ND AUTHORIZED OFFICIAL SIGNATURE

I have read the contents of this application and the certification statement in section 15 of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize the NSC to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the NSC of this fact in accordance with the time frames established in 42 CFR § 424.57.

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

**NOTE:** Authorized officials must be reported in Section 6 of this application.

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

**Authorized Official's Information and Signature**

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

| Telephone Number | E-mail Address | Title/Position |
|---|---|---|
| | | |

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

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

## SECTION 16: DELEGATED OFFICIAL(S) *(Optional)*

- You are not required to have a delegated official. However, if no delegated official is assigned, the authorized official(s) will be the only person(s) who can make changes and/or updates to the supplier's status in the Medicare program.
- The signature of a delegated official shall have the same force and effect as that of an authorized official, and shall legally and financially bind the supplier to the laws, regulations, and program instructions of the Medicare program. By his or her signature, a delegated official certifies that he or she has read the Certification Statement in Section 15 and agrees to adhere to all of the stated requirements. The delegated official also certifies that he/she meets the definition of a delegated official. When making changes and/or updates to the supplier's enrollment information maintained by the Medicare program, the delegated official certifies that the information provided is true, correct, and complete.
- A delegated official who is being deleted does not have to sign or date this application.
- Independent contractors are not considered "employed" by the supplier. Therefore, an independent contractor cannot be a delegated official.
- The signature of an authorized official in Section 16 constitutes a legal delegation of authority to all delegated official(s) assigned in Section 16.
- If there are more than two individuals, copy and complete this section for each individual.
- Delegated officials must be reported in section 6 of this application.

### A. 1ST DELEGATED OFFICIAL SIGNATURE

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

**NOTE:** Delegated officials must be reported in Section 6 of this application.

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

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

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

| Telephone Number | E-mail Address |
|---|---|
| | |

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

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

## SECTION 16: DELEGATED OFFICIAL(S) *(Optional)*

### B. 2ND DELEGATED OFFICIAL SIGNATURE

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

**NOTE:** Delegated officials must be reported in Section 6 of this application.

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

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

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

| Telephone Number | E-mail Address |
|---|---|
| | |

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

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

## SECTION 17: SUPPORTING DOCUMENTS

This section lists the documents that, if applicable, must be submitted with this completed enrollment application. If you are newly enrolling, adding a new location, reactivating or reenrolling, you must provide all applicable documents. For changes, only submit documents that are applicable to the change requested. All enrolling DMEPOS suppliers are required to furnish information on all Federal, State, and local professional and business licenses, certifications, and/or registrations required to practice as a DMEPOS supplier in the DMEPOS supplier's State of business location as reported in Section 4A. Check the NSC website for further guidance on supplier requirements. You are responsible for supplying and adhering to all required licensure/ certification, requirements, etc. for the supplies/services you provide.

The enrolling DMEPOS supplier may submit a notarized Certificate of Good Standing from the DMEPOS supplier's business location's State licensing/certification board or other medical associations, in lieu of copies of the requested documents. This certification cannot be more than 30 days old.

If the enrolling DMEPOS supplier has had a previously revoked or suspended license, certification, or registration reinstated, attach a copy of the reinstatement notice with this application.

### MANDATORY

- ☐ Copy(s) of all Federal, State, and/or local (city/county) professional licenses, certifications and/or registrations, including licensure, certifications and/or registrations for applicable specialty supplier types, products and services.
- ☐ Copy(s) of all Federal, State, and/or local (city/county) business licenses, certifications and/or registrations.
- ☐ Copy(s) of all liability insurance policies.
- ☐ Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name (e.g., IRS form CP 575) provided in Section 2.
  (Note: This information is needed if the applicant is enrolling their professional corporation, professional association, or limited liability corporation with this application or enrolling as a sole proprietor using an Employer Identification Number.)
- ☐ Completed Form CMS-588, Electronic Funds Transfer Authorization Agreement.
  (Note: If a supplier already receives payments electronically and is not making a change to its banking information, the CMS-588 is not required.)

### MANDATORY, IF APPLICABLE

- ☐ Copy of IRS Determination Letter, if supplier is registered with the IRS as non-profit.
- ☐ Written confirmation from the IRS confirming your Limited Liability Company (LLC) is automatically classified as a Disregarded Entity, (e.g., Form 8832).
  (NOTE: A disregarded entity is an eligible entity that is treated as an entity not separate from its single owner for income tax purposes.
- ☐ Copy(s) of all final adverse action documentation (e.g., notifications, resolutions, and reinstatement letters).
- ☐ Copy(s) of all State pharmacy licenses
- ☐ Statement in writing from the bank. If Medicare payment due a supplier is being sent to a bank (or similar financial institution) where the supplier has a lending relationship (that is, any type of loan), then the supplier must provide a statement in writing from the bank (which must be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.
- ☐ Copy of delegated official's W-2 if one has been designated.
- ☐ Copy of your bill of sale if you purchased an existing DMEPOS supplier with an active Medicare supplier billing number.
- ☐ Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement.
- ☐ Copy of Surety Bond.

## CMS MEDICARE DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS) SUPPLIER STANDARDS

A complete list of the DMEPOS supplier standards, including the surety bond provisions, can be found at *http://www.cms.gov/MedicareProviderSupEnroll/10_DMEPOSSupplierStandards.asp#TopOfPage*. An abbreviated list of the Supplier Standards can be viewed and downloaded from the National Supplier Clearinghouse Medicare Administrative Contractor (NSC-MAC) at *http://www.palmettogba.com/nsc*.

# MEDICARE SUPPLIER ENROLLMENT APPLICATION PRIVACY ACT STATEMENT

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

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

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

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

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

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

### Protection of Proprietary Information

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

### Protection of Confidential Commercial and/or Sensitive Personal Information

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