MEDICARE

FEDERAL HEALTH CARE
REASSIGNMENT OF BENEFITS APPLICATION

Application for Individual Health Care Practitioners to Reassign Medicare Benefits

CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS 855R (11/2001)
(Formerly HCFA 855R)

Keep a copy of this completed package for your own records.

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

OMB Approval No. 0938-0685

CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Provider/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 providers/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 or suppliers 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), and either system number 09-70-0525 titled Unique Physician/Practitioner Identification Number (UPIN) System (published in Vol. 61 of the Federal Register at page 20,528 (May 7, 1996)), or the National Provider Identifier (NPI) System, Office of Management and Budget (OMB) approval 0938-0684 (R-187). 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 Unique Physician Identification Number Registry 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 provider's/supplier's health care claims.

The enrolling provider or 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.

INDIVIDUAL REASSIGNMENT OF MEDICARE BENEFITS INSTRUCTIONS

Please **PRINT** or **TYPE** all information so it is legible. Do not use pencil. Failure to provide all requested information may cause this form to be returned and delay the processing of your reassignment. This application is to be completed for any **individual practitioner** who will be reassigning his or her benefits to an eligible provider or supplier. See inside front cover for mailing instructions. Electronic copies of all CMS Medicare enrollment forms can be found at the Medicare web-site at (http://www.hcfa.gov/medicare/enrollment/forms/). These electronic forms may be downloaded to your computer, completed on screen, printed, signed, and mailed to the appropriate Medicare contractor.

SECTION 1: GENERAL APPLICATION INFORMATION

Check the applicable box indicating the reason for the submittal of this application.

Add a New Reassignment – Check this box when an individual practitioner who is enrolling or is currently enrolled in the Medicare program will be reassigning his/her benefits to this provider/supplier for the 1st time. The provider/supplier must be enrolled or currently enrolling in Medicare. When adding a reassignment, complete Sections 1, 2, 3, 4, 6, and 7.

Terminate a Current Reassignment – Check this box and furnish the effective date when an individual practitioner who has reassigned his/her benefits to this provider/supplier is terminating that reassignment. No reassigned claims will be paid to the provider/supplier for services rendered after the effective date of deletion. When deleting a reassignment, complete Sections 1, 2, and 3, as well as Sections 5 and/or 7.

Add a New Practice Location(s) for a Current Reassignment – Check this box when reporting that an individual practitioner who has a current reassignment with this provider/supplier will begin rendering services at an additional practice location(s) of the provider/supplier. When adding a practice location to a current reassignment, complete Sections 1, 2, 3, 4, 6 and 7.

Delete a Practice Location(s) from a Current Reassignment – Check this box when reporting that an individual practitioner will no longer be rendering services at a previously reported practice location for this provider/supplier. When deleting a practice location from a current reassignment, complete Sections 1, 2, 3, 4, and 7.

Change Income Reporting Status – Check this box and furnish the effective date when reporting a change in the type of income tax withholding (e.g., if a practitioner changes his/her work status from "Employee" to "Independent Contractor") reported to the IRS for the individual practitioner who has reassigned his/her benefits to this provider/supplier. When changing the practitioner's income reporting status, complete Sections 1, 2, 3, 6, and 7.

NOTE: All changes must be reported to the carrier within 90 days of the effective date of the change.

SECTION 2: PROVIDER/SUPPLIER IDENTIFICATION

This section is to be completed with information about the provider/supplier to which the individual practitioner's benefits will be reassigned or have already been reassigned.

NOTE: Prior to the reassignment of benefits to this provider/supplier, both the individual **AND** the provider/supplier must be enrolled (or concurrently enrolling) in the Medicare program. If the provider/supplier's application is being submitted concurrently with this reassignment application, write **"pending"** in the Medicare identification number block.

Furnish the provider/supplier's name and tax identification number as reported to the IRS, and the supplier's Medicare identification number.

NOTE: The provider/supplier's name as reported to the IRS must be the same as reported on the CMS 855B when it enrolled.

MEDICARE FEDERAL HEALTH CARE BENEFIT REASSIGNMENT APPLICATION

Application for the Reassignment of Medicare Benefits

General Instructions

The Medicare Federal Health Care Benefit Reassignment Application has been designed by the Centers for Medicare & Medicaid Services (CMS) to assist in the administration of the Medicare program and to ensure that the Medicare program is in compliance with all regulatory requirements. The information collected in this application will be used to ensure that payments made from the Medicare trust fund are only paid to qualified health care providers or suppliers with whom an individual practitioner has a valid reassignment of benefits on file with Medicare, and that the amount of the payments are correct. To accomplish this, Medicare must know basic identifying information about the individual practitioner and the provider/supplier who the individual practitioner is authorizing to receive payment on his or her behalf for services rendered to Medicare beneficiaries.

When completing this application, Medicare must know the name, social security number, and Medicare identification number of the individual practitioner reassigning his or her benefits and the name, tax identification number, Medicare identification number, and practice locations of the supplier receiving the individual practitioner's reassigned benefits.

This application must be completed any time an individual practitioner reassigns his or her benefits to an eligible provider/supplier. Both the individual practitioner and the eligible provider/supplier must be currently enrolled (or concurrently enrolling) in the Medicare program. Generally, this application will be completed by the provider/supplier, signed by the individual practitioner, and submitted by the provider/supplier. When deleting a current reassignment, it is the individual practitioner's responsibility to submit this application with the appropriate sections completed.

1. General Application Information

This section is to be completed with information as to why this reassignment of benefits application is being submitted.

Reason for Submittal of this Application

Check one:

- ☐ Add a New Reassignment
- ☐ Terminate a Current Reassignment – Effective Date:_____
- ☐ Add a New Practice Location(s) for a Current Reassignment
- ☐ Delete a Practice Location(s) from a Current Reassignment
- ☐ Change Income Reporting Status - Effective Date (MM/DD/YYYY):_____

2. Provider/Supplier Identification

This section is to be completed with identifying information about the provider/supplier to which the individual practitioner is reassigning his or her benefits.

Legal Business Name of Provider/Supplier as Reported to IRS	
Tax Identification Number	Medicare Identification Number

3. Individual Practitioner Identification

This section is to be completed with identifying information about the individual practitioner who will be reassigning (or terminating the reassignment of) his or her benefits to the provider/supplier shown in Section 2 above.

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

Social Security Number	Medicare Identification Number

What income reporting form does the individual practitioner receive from the supplier at the end of the calendar year based on his or her relationship with the provider/supplier shown in Section 2?

Check all that apply: ☐ **W-2** ☐ **1099** ☐ **1065-K1** **Other:**_____

SECTION 3: INDIVIDUAL PRACTITIONER IDENTIFICATION

This section is to be completed for each individual practitioner who is reassigning (or terminating reassignment) of his or her Medicare benefits to the provider/supplier shown in Section 2 of this form.

- Furnish the individual's name, social security number, and Medicare identification number.

- Indicate what income reporting form the individual receives from the provider/supplier based on his/her employment with the provider/supplier.

Payroll Agent - If the provider/supplier utilizes an IRS approved Payroll Agent to pay the salaries of W-2 employees reassigning their benefits, the provider/supplier must submit copies of the completed IRS Form 2678 (Employer Appointment of Agent), and the letter (IRS Form 1997C) authorizing the appointment of a payroll agent signed by the IRS Service Center Director. These IRS forms will be used as documentation to establish the employer-employee relationship required under § 3060.1 of the Medicare Carriers Manual.

If the individual practitioner receives a form other than those listed in this section, check "Other" and identify the form.

In situations where a provider/supplier contracts with an organization (e.g., a physician group practice) for physician/practitioner services and there is no direct payment to the physician/practitioner from the provider/supplier, the "Other" block for income reporting should be used and the description should indicate **indirect contractual arrangement (ICA)**.

SECTION 4: PRACTICE LOCATION

This section is to be completed with all practice locations of the provider/supplier identified in Section 2 indicating where the individual practitioner identified in Section 3 will be rendering services on a regular basis.

NOTE: All provider/supplier practice locations reported in this section must have been (or currently are being) reported to the Medicare carrier on the CMS 855B. If a practice location reported in this section has not been previously or currently reported, the reassignment of benefits will be denied.

A. 1st Practice Location 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 attestation statement. Otherwise:

1. Provide the name of the practice location. If a "doing business as" name is used, provide that name in this section. State the date the individual practitioner began (or will begin) to render services at this location.

2. Furnish the complete street address for this practice location.

B.-D. 2nd through 4th Practice Locations – These sections are to be used to report additional practice locations where the individual practitioner will render services for the supplier.

NOTE: To reduce the burden of furnishing some types of supporting documentation, we have designated specific types of documentation to be furnished on an "as needed" basis. However, the carrier may request, at any time, documentation to support or validate information that is reported in this application. Some examples of documents that may be requested for validation are IRS W-2s, pay stubs, or employment contracts.

4. Practice Location

This section is to be completed with all practice locations of the provider/supplier identified in Section 2 indicating where the individual practitioner identified in Section 3 will be rendering services on a regular basis. If more than four locations need to be reported, copy and complete this page as needed.

A. 1st Practice Location Information ☐ **Add** ☐ **Delete** **Effective Date:**_____

1. Practice Location Name			Date practitioner began/will start rendering services at this location (MM/DD/YYYY)
2. Practice Location Street Address Line 1			
Practice Location Street Address Line 2			
City	County/Parish	State	ZIP Code + 4
Telephone Number ( )	(Ext.) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

B. 2nd Practice Location Information ☐ **Add** ☐ **Delete** **Effective Date:**_____

1. Practice Location Name			Date practitioner began/will start rendering services at this location (MM/DD/YYYY)
2. Practice Location Street Address Line 1			
Practice Location Street Address Line 2			
City	County/Parish	State	ZIP Code + 4
Telephone Number ( )	(Ext.) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

C. 3rd Practice Location Information ☐ **Add** ☐ **Delete** **Effective Date:**_____

1. Practice Location Name			Date practitioner began/will start rendering services at this location (MM/DD/YYYY)
2. Practice Location Street Address Line 1			
Practice Location Street Address Line 2			
City	County/Parish	State	ZIP Code + 4
Telephone Number ( )	(Ext.) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

D. 4th Practice Location Information ☐ **Add** ☐ **Delete** **Effective Date:**_____

1. Practice Location Name			Date practitioner began/will start rendering services at this location (MM/DD/YYYY)
2. Practice Location Street Address Line 1			
Practice Location Street Address Line 2			
City	County/Parish	State	ZIP Code + 4
Telephone Number ( )	(Ext.) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

SECTION 5: STATEMENT OF TERMINATION

This section is to be completed only if you are terminating your reassignment of benefits to the provider/supplier.

- Furnish the provider/supplier's name as reported to the IRS (the name must be the same as reported in Section 2).
- Complete, sign, and date the "Statement of Termination."

NOTE: All signatures must be original. Faxed, photocopied, or stamped signatures are not acceptable.

By his or her signature, the individual practitioner terminates the authority of the provider/supplier to claim or receive any fees or charges for the practitioner's services, and attests to the accuracy of the information provided on this form.

SECTION 6: REASSIGNMENT OF BENEFITS STATEMENT

The individual practitioner who will be reassigning benefits to the eligible provider/supplier must complete, sign, and date this Reassignment of Benefits Statement. Failure to do so will delay the processing of this application, thus limiting CMS's ability to make payments.

- Furnish the provider/supplier's name as reported to the IRS (the name must be the same as reported in Section 2).
- Type or print the individual practitioner's full name.
- The individual practitioner must sign and date this section.

NOTE: All signatures must be original. Faxed, photocopied, or stamped signatures are not acceptable.

SECTION 7: ATTESTATION STATEMENT

Either the authorized official or a delegated official who has been identified on the provider/supplier's CMS 855B application must sign and date this Attestation Statement. By his or her signature, the authorized or delegated official attests to the accuracy of the information provided and certifies that the provider/supplier applying to receive payments is in fact eligible to receive reassigned benefits.

NOTE: All signatures must be original. Faxed, photocopied, or stamped signatures are not acceptable.

For further information on the requirements regarding the reassignment of benefits, contact the Medicare carrier.

5. Statement of Termination

This section is to be completed by the individual practitioner when terminating a previously authorized reassignment of benefits.

By my signature, I hereby terminate the authority of _____ to claim or receive any fees or charges for my services. (Name of Individual or Provider/Supplier as Reported to the IRS)

I certify that I have examined the above information and that it is true, accurate and complete to the best of my knowledge. I understand that any deliberate misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws.

Individual Practitioner Name **Print** First	Middle	Last	Jr., Sr., etc.

Individual Practitioner Signature (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)	Date (MM/DD/YYYY) Signed

6. Reassignment of Benefits Statement

This section **MUST** be signed and dated by the individual practitioner shown in Section 3 to authorize the reassignment of his or her benefits to the provider/supplier shown in Section 2.

Medicare law prohibits payment for services provided by an individual practitioner to be paid to another individual or provider/supplier unless the individual practitioner who provided the services specifically authorizes another individual or provider/supplier (employer, facility, or health care delivery system) to receive said payments in accordance with 42 CFR 424.73 and 42 CFR 424.80. By signing this Reassignment of Benefits Statement, you are authorizing the individual or provider/supplier identified in Section 2 to receive Medicare payments on your behalf.

Your employment or contract with this individual or provider/supplier must be in compliance with CMS regulations. All individual practitioners who allow another individual or provider/supplier (employer, facility, or health care delivery system) to receive payment for their services must sign the Reassignment of Benefits Statement.

I acknowledge that, under the terms of my employment or contract,_____ is entitled to claim or receive any fees or charges for my services. (Name of Individual or Provider/Supplier as Reported to the IRS)

Individual Practitioner Name **Print** First	Middle	Last	Jr., Sr., etc.

Individual Practitioner **Signature** (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)	Date (MM/DD/YYYY) Signed

7. Attestation Statement

This section requires the signature of an authorized or delegated official of the provider/supplier shown in Section 2. The authorized or delegated official must currently be on file with Medicare for this application to be processed.

I certify that I have examined the above information and that it is true, accurate and complete to the best of my knowledge. I understand that any deliberate misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws. I certify that the provider/supplier requesting to receive payments is legally eligible to receive reassigned benefits per CMS regulations.

Authorized/Delegated Official Name **Print** First	Middle	Last	Jr., Sr., etc.

Authorized/Delegated Official **Signature** (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)	Date (MM/DD/YYYY) Signed