MEDICARE

FEDERAL HEALTH CARE
PROVIDER/SUPPLIER ENROLLMENT APPLICATION

Application for Health Care
Providers that will Bill
Medicare Fiscal Intermediaries

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

OMB Approval No. 0938-0685

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

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S ERVICES

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/supplier 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/suppliers of medical services/supplies 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.

INSTRUCTIONS FOR HEALTH CARE PROVIDERS THAT WILL BILL MEDICARE FISCAL INTERMEDIARIES

Please **PRINT** or **TYPE** all information so it is legible. Do not use pencil. Failure to provide all requested information might cause the application to be returned and may delay the enrollment process. 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.

Whenever additional information needs to be reported within a section, copy and complete that section for each additional entry. We strongly suggest maintaining a photocopy of the provider's completed application and supporting documents for future reference.

This application is to be completed by all health care provider organizations that provide medical services to Medicare beneficiaries and who bill fiscal intermediaries. For purposes of this application and Medicare enrollment, all such organizations will be referred to as "providers." A list of the provider types that should complete this application can be found in Section 2A. Failure to promptly submit a completed CMS 855A to the fiscal intermediary will result in delays in obtaining enrollment and billing privileges.

After completing the enrollment application, the provider may wish to complete and submit additional forms in the following situations:

- To have Medicare payments sent electronically to a provider's bank account, the provider should complete the form "Medicare Authorization Agreement for Electronic Funds Transfers" (Form HCFA-588).
- To submit claims electronically, the provider will need to complete the Electronic Data Interchange (EDI) agreement.

If the provider plans to do any of the above, submit the appropriate form(s)/agreement with this application. The forms should have been received in the initial enrollment package. If not, they can be obtained from the Medicare fiscal intermediary.

APPLICATION SUBMISSION AND PROCESSING

This application should be submitted directly to your intermediary of preference. See the CMS web-site (http://www.hcfa.gov/medicare/enrollment) for a listing of fiscal intermediaries. Providers that are part of a chain, or that share fiscal data with other enrolled providers, may choose the same fiscal intermediary, even if they are not located in the area normally serviced by that fiscal intermediary. Home Health Agencies (HHA) and Hospices should submit this application to their regional home health intermediary (RHHI). However, if the HHA is provider based, it should submit this application to its parent provider's fiscal intermediary. The provider's fiscal intermediary of preference does not automatically guarantee that it will be assigned to that fiscal intermediary. Providers, who are currently enrolled in the Medicare program and are requesting to change their fiscal intermediary, must submit their request to the Medicare Regional Office prior to submission of this application. However, this is not applicable when the fiscal intermediary changes as the result of a CHOW, acquisition/merger, or a consolidation and the fiscal intermediary of preference is the fiscal intermediary currently being used by the provider who is acquiring the changing provider. The fiscal intermediary will answer any questions you have concerning completion of the CMS 855A.

The provider must immediately contact the local State Agency that handles the provider type being enrolled. The State Agency will provide you with any State-specific forms required for your provider type. They will also do preliminary planning for any required State Surveys or notice of accreditation in lieu of a survey (when this is permitted).

If the provider does not currently have a Medicare identification number, the CMS regional office will assign one upon the successful completion of enrollment. Issuance of a Medicare identification number usually requires a written agreement (usually a provider agreement) with CMS. If the fiscal intermediary should contact the provider for additional information, the provider must furnish the information immediately to ensure the timely processing of this application.

DEFINITIONS OF MEDICARE ENROLLMENT TERMINOLOGY

To help you understand certain terms used throughout the application, we have included the following definitions.

Authorized Official-An appointed official to whom the provider has granted the legal authority to enroll it in the Medicare program, to make changes and/or updates to the provider's status in the Medicare program (e.g., new practice locations, change of address, etc.) and to commit the provider to fully abide by the laws, regulations, and program instructions of Medicare. The authorized official must be the provider's general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of 5% or more of the provider (see Section 5 for the definition of a "direct owner"), or must hold a position of similar status and authority within the provider's organization.
Billing Agency-A Company that the enrolling provider contracts with to furnish claims processing functions for the provider.
Carrier-The Part B Medicare claims processing contractor.
Delegated Official-Any individual who has been delegated, by the provider's "Authorized Official," the authority to report changes and updates to the provider's enrollment record. A delegated official **must** be a managing employee (W-2) of the provider or have a 5% ownership interest, or any partnership interest, in the provider.
Fiscal Intermediary-The Part A Medicare claims processing contractor.
Legal Business Name-The name that is reported to the Internal Revenue Service (IRS) for tax reporting purposes.
Medicare Identification Number-This is a generic term for any number that uniquely identifies the enrolling provider. Examples of Medicare identification numbers are Unique Physician/Practitioner Identification Number (UPIN), Online Survey Certification and Reporting number (OSCAR), and National Supplier Clearinghouse (number) (NSC).
Mobile Facility/Portable Unit-These terms apply when a service that requires medical equipment is provided in a vehicle, or the equipment for the service is transported to multiple locations within a geographic area. The most common types of mobile facilities/portable units are mobile IDTFs, portable X-ray, portable mammography, and mobile clinics. Physical therapists and other medical practitioners (e.g., physicians, nurse practitioners, physician assistants) who perform services at multiple locations (i.e., house calls, assisted living facilities) are not considered to be mobile facilities/portable units.
Provider-A provider is a hospital, critical access hospital, skilled nursing facility, nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice, that has in effect an agreement to participate in Medicare; or a rural health clinic (RHC), Federally qualified health center (FQHC), rehabilitation agency, or public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech pathology services; or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services. A provider is not synonymous with the corporation or other legal entity that owns or operates the provider. The "provider" is the CMS recognized provider type listed above. Therefore, an owning or operating entity may own or operate many providers.
Provider Identification Number (PIN)-This number is assigned to providers, suppliers, groups and organizations in Medicare Part B. This number will identify who provided the service to the beneficiary on the Medicare claim form.
Supplier-A physician or other practitioner, or an organization other than a provider that furnishes health care services under Medicare Part B. The term supplier also includes independent laboratories, portable x-ray services, physical therapists in private practice, end stage renal disease (ESRD) facilities, and chiropractors.
Tax Identification Number (TIN)-This is a number issued by the Internal Revenue Service (IRS) that the provider uses to report tax information to the IRS.
Unique Physician/Practitioner Identification Number (UPIN)-This number is assigned to physicians, non-physician practitioners, and suppliers to identify the referring or ordering physician on Medicare claims.

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 fiscal intermediary may request, at any time during the enrollment process, documentation to support or validate information that is reported in this application. Some examples of documents that may be requested for validation are billing agreements, W-2s, pay stubs, articles of incorporation, and partnership agreements.

HOW TO MAKE CHANGES OR UPDATES TO A PREVIOUS APPLICATION

If a provider organization has a change in its tax identification number (TIN), a new enrollment application must be completed, even if most of the data on the form remains the same unless the TIN is the only information that is changing (see "Change of Information" instructions on page 5). If an existing provider and/or the provider's organization changes its name, address, etc., and there is no change in its tax identification number, the provider must annotate the change by checking the section where the change is going to be made and sign and date the certification statement. For example, if an existing provider is only changing a practice location and has previously completed an application, the provider completes Sections 1, 4, and 15. The provider does not complete a full application.

SECTION 1: GENERAL APPLICATION INFORMATION

This section is to identify the reason for submittal of this application. It will also indicate whether the provider currently has a business relationship with Medicare or another Federal health care program.

A. Reason for Submittal of this Application - This section identifies the reason this application is being submitted.

1. Check one of the following:

Initial Enrollment

- If the provider is enrolling in the Medicare program for the first time under this tax identification number.
- For a change of ownership of an enrolled provider when the new owner will not be accepting assignment of the current provider agreement.

NOTE: The provider must be able to submit a valid claim within twelve months of enrolling or risk deactivation of its billing number once it has enrolled.

Reactivation

- If the provider's Medicare billing number was deactivated because of non-billing. Billing privileges may be deactivated when Medicare has not received claims in a twelve-month period after the effective date of the provider agreement. To reactivate billing privileges, the provider may be required to either submit an updated CMS 855A or certify to the accuracy of its enrollment information currently on file with CMS. In addition, prior to being reactivated, the provider must be able to submit a valid claim. It must also meet all current requirements for its provider type, regardless of whether it was previously enrolled in the program.

Change of Information

- If the provider is adding, deleting, or changing information under this tax identification number. Check the appropriate section where the change will be made. When providing the changed information, furnish the provider's Medicare identification number in Section 1 and provide the new/changed information within the appropriate section. Sign and date the certification statement. **All changes must be reported to the fiscal intermediary within 90 days of the effective date of the change.** If the provider organization's tax identification number has changed, a new complete CMS 855A enrollment application must be submitted as it is assumed that this provider has changed ownership. If this is not the case, please provide evidence that a change of ownership has not occurred.

NOTE: If the provider is adding a new practice location that requires a **separate** State Survey or Accreditation and a **separate** Medicare Agreement, then a **separate** CMS 855A enrollment application must be submitted for the new provider practice location. For more information concerning the addition of practice locations, contact the State Agency or CMS regional office. If a new practice location is determined **not** to be a new provider, the updated information can be submitted as a practice location change in Section 4.

Voluntary Termination of Provider Billing Number

- If the provider will no longer be submitting claims to the Medicare program using this billing number. Voluntary termination ensures that the provider's billing number will not be fraudulently used in the event of the provider ceasing its operations. Furnish the date the provider will stop billing for Medicare covered services. In addition to completing this section, furnish the provider's Medicare identification number in Section 1 under "Change of Information" and sign the certification statement (Section 15).
- If a provider is reporting a "CHOW" and the new owner will not be accepting assignment of the assets and Medicare liabilities of the old owner. The effective date should be the date when the old owner will no longer permit use of its billing number.

NOTE: "Voluntary Termination" **cannot** be used to circumvent any corrective action plan or any pending/ongoing investigation.

Change of Ownership (CHOW)

- See note below and instructions for Section 1B to determine if a valid CHOW applies and needs to be reported.

Acquisitions and/or Mergers (including the CHOW)

- See note below and the instructions for Section 1C to determine if a valid acquisition/merger (and related CHOW) applies and needs to be reported.

Consolidations (including the CHOW)

- See note below and the instructions for Section 1D to determine if a valid consolidation applies and needs to be reported.

NOTE: All sub-units of a provider with separate provider agreements that will remain in operation after a CHOW, acquisition/merger, or consolidation require completion and submission of a separate CMS 855A. All related CMS 855As should be submitted together, when administratively practical, for the providers involved. If a sub-unit will no longer be in operation upon the completion of the CHOW, acquisition/merger, or consolidation, a CMS 855A must be submitted for the sub-unit requesting a voluntary termination of its billing number.

2. Tax Identification Number (TIN) – Furnish the provider organization's taxpayer identification number (e.g., the number the provider uses to report tax information to the IRS) and attach documentation (e.g., a copy of the CP-575 form) from the IRS showing that the name matches that reported in this application. If the provider does not have an IRS CP-575, IRS Form 941, or IRS 501(c)(3) determination letter, any legal document from the IRS that shows the provider's name and TIN will be acceptable proof. Other IRS documents that may be submitted include an IRS Form 990 or a quarterly tax payment coupon. The name and TIN number on the IRS document should match those shown on this application.

If the provider cannot obtain the required IRS document, explain why in a separate attachment and provide evidence that links its legal business name with the reported TIN. If the name and TIN do not match on the submitted documents, explain why and refer to the documents which confirm the identification of the provider or owner as applicable (e.g., if the provider recently changed its name and the IRS has not sent it an updated document). The provider may then submit the old IRS document with the old name, as well as a copy of documentation filed with the IRS and State concerning the name change.

3. Medicare Identification Number (MIN) - If this provider is currently enrolled in Medicare, furnish its Medicare identification number in the space provided. This number is issued by Medicare to identify the provider. It is also the number used on claims forms and may be referred to as a Medicare provider number, Online Survey Certification and Reporting (OSCAR) number, or provider identification number. Report all currently active numbers.

NOTE: If enrolling as a provider in the Medicare program for the first time, an OSCAR number will be issued to the provider as part of the enrollment process.

4. Fiscal Intermediary Preference

   a) For new providers enrolling in Medicare for the 1st time, check the box given and furnish the name of the provider's fiscal intermediary preference in Section 1A4c, if known. Otherwise, leave blank.

   b) For providers who are currently enrolled in the Medicare program and are requesting to change their fiscal intermediary as the result of a CHOW, acquisition/merger, or a consolidation. The request to change fiscal intermediaries must be submitted to the Medicare Regional Office prior to submission of this application.

   NOTE: Currently enrolled providers who only seek to change their fiscal intermediary are not required to complete this application. Instead, they should request the change directly to their CMS regional office.

   c) For "a" or "b" above, furnish the name of the provider's fiscal intermediary preference. When submitting this application for any reason other than those given in Sections 1A4a or 1A4b above, currently enrolled providers should show their current fiscal intermediary here and skip the above check boxes.

MEDICARE FEDERAL HEALTH CARE PROVIDER/SUPPLIER ENROLLMENT APPLICATION

Application for Health Care Providers that will Bill Medicare Fiscal Intermediaries

General Instructions

The Medicare Federal Health Care Provider/Supplier Enrollment 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, and that the amounts of the payments are correct. This information will also identify whether the provider is qualified to render health care services and/or furnish supplies to Medicare beneficiaries. To accomplish this, Medicare must know basic identifying and qualifying information about the health care provider that is seeking billing privileges in the Medicare program.

Medicare needs to know: (1) the type of health care provider enrolling, (2) what qualifies this provider as a health care related provider of services and/or supplies, (3) where this provider intends to render these services and/or furnish supplies, and (4) those persons or entities with an ownership interest, or managerial control, as defined in this application, over the provider.

This application **MUST** be completed in its entirety, unless the appropriate box is checked to indicate the section does not apply or when reporting a change to previously submitted information. If a section does not apply to this provider, check (√) the appropriate box in that section and skip to the next section.

1. General Application Information

A. Reason for Submittal of this Application

This section is to be completed with general information as to why this application is being submitted and whether this provider currently has a business relationship with another Federal health care program.
To ensure timely processing of this application, Numbers 1 and 2 below MUST ALWAYS be completed.

1. Check one:

- ☐ Initial Enrollment ☐ Reactivation
- ☐ Change of Information (Check appropriate Section(s))
  ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9
  ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 15 ☐ 16
- ☐ Voluntary Termination of Billing Number - Effective Date (MM/DD/YYYY):_________________
- ☐ Change of Ownership (CHOW) - See Instructions and Complete Section 1B
- ☐ Acquisition/Merger (including the CHOW) - See Instructions and Complete Section 1C
- ☐ Consolidation (including the CHOW) - See Instructions and Complete Section 1D

2. Tax Identification Number:____________________________

3. Medicare Identification Number:________________________

4. Fiscal Intermediary Preference:

a) Check here ☐ if this provider is enrolling in the Medicare program for the first time. If known, furnish the name of the provider's fiscal intermediary preference in Section 1A4c below.

b) Check here ☐ if this provider is currently enrolled in the Medicare program and is requesting a change of its fiscal intermediary as a result of a CHOW, acquisition/merger, or a consolidation, and furnish the name of the new preferred fiscal intermediary in Section 1A4c below.

c) Name of Preferred Fiscal Intermediary:____

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B. Change of Ownership Information (CHOW Only)

This section is to be completed with information that identifies the name and Medicare identification number of the currently enrolled provider (Transferor) prior to the change of ownership. This section must be completed by **both** the current owner(s) (to protect them from any future liabilities) and the new owner (to establish payment under its tax identification number) on separate CMS 855A applications. Two copies of the sales or other asset transfer agreement, in its current form, must be submitted with this application, and a copy of the final agreement must be submitted once the sale is executed.

NOTE: If you are an individual currently enrolled as a provider and you undergo a change of ownership as a result of your incorporation, you must submit two copies of your "articles of incorporation" in lieu of a "Sales Agreement."

- The "**current"** owner (Transferor) is defined as the "old" or "selling" owner.
- The "**new"** owner is defined as the "purchasing" owner.

Any provider undergoing a "Change of Ownership" (CHOW) in accordance with the principles discussed in 42 CFR 489.18 must check the "Change of Ownership (CHOW)" box in Section 1A1. For all other ownership changes check the "Change of Information" box in Section 1A. To determine if a CHOW applies to this provider, review the principles in 42 CFR 489.18 for guidance. If further assistance is needed, contact the fiscal intermediary.

For current/selling owner(s)

A currently enrolled provider that will transfer its ownership interest to new owners in accordance with the principles discussed in 42 CFR § 489.18 should complete this section. This current owner only needs to complete the following sections of this application when reporting a CHOW: Check the Change of Ownership (CHOW) box in Section 1A1, then complete Section 1A2, 1A3, and Section 1B, and sign and date the Certification Statement in Section 15.

1. Furnish the legal business name used by the current owner.

2. Furnish the "doing business as" name used by the current owner.

3. Furnish the Medicare identification number, the projected date that the current owner will no longer have ownership, and the name of the current owner's fiscal intermediary.

4. Indicate if the new owner will be accepting assignment of the current "Provider Agreement."

For new/purchasing owner(s)

A prospective new owner who is participating in a Change of Ownership (CHOW) in accordance with the principles discussed in 42 CFR § 489.18 must complete this entire application. The prospective new owner should check the Change of Ownership (CHOW) box in Section 1A1. If the prospective new owner will not accept assignment of all terms and conditions of the "Provider Agreement" (including the provision concerning the responsibility for Medicare liabilities of the current owner), then the prospective new owner cannot have the current "Provider Agreement" transferred to them. The organization will then be considered a new provider to the Medicare program and must obtain approval through the normal enrollment process by submitting a CMS 855A (Initial Enrollment) prior to obtaining the right to bill Medicare.

1. Furnish the legal business name used by the current owner.

2. Furnish the "doing business as" name used by the current owner.

3. Furnish the Medicare identification number, the projected date that the current owner will no longer have ownership, and the name of the current owner's fiscal intermediary.

4. Indicate if the new owner will be accepting assignment of the current "Provider Agreement."

C. Acquisitions/Merger (including the CHOW)

Furnish the effective date of the acquisition/merger in the space provided. Two copies of the sales or other asset transfer agreement, in its current form, must be submitted with this application, and a copy of the final agreement must be submitted once the sale is executed.

This section must be completed when an acquisition results in one or more provider (OSCAR) numbers being voluntarily deactivated from the Medicare program. In general, a provider's number is deactivated if the acquisition results in **only one remaining t**ax identification number (TIN), State survey or accreditation, and Medicare agreement. If the acquisition only results in an existing provider having new owners but it will keep its current provider number, then the instructions in Section 1B above for a Change of Ownership (CHOW only) should be used.

This section should be completed on **separate** CMS 855As by **both:**

- The provider that is acquiring another provider, and
- The provider that is being acquired by another provider.

1. Provider Being Acquired - All providers being acquired should be reported in this section.
   a) Furnish the legal business name and TIN of the provider organization being acquired.
   b) Furnish the name of the fiscal intermediary and the Medicare identification number of the provider being acquired.
   c) Report all sub-units of the provider being acquired that currently have an active Medicare identification number but have not entered into separate provider agreements, and furnish the sub-unit's Medicare identification number. Do not report sub-units of the provider being acquired that have separate provider agreements. If these sub-units are also being acquired in this transaction, a separate CMS 855A must be submitted for each.
2. Acquiring Provider - This section is to be completed by both the acquired provider and the acquiring provider with information about the acquiring provider.
   a) Furnish the legal business name and the TIN of the provider that is acquiring other providers.
   b) Furnish the name of the fiscal intermediary and Medicare identification number of the acquiring provider.

NOTE: The acquiring provider should also complete Section 4 (Practice Location) to report the location of the provider it acquired as a new or additional practice location from which it will furnish services.

1. General Application Information (Continued)

B. Change of Ownership Information (CHOW Only)

This section is to be completed with information that identifies the name and Medicare identification number of the currently enrolled provider (Transferor) prior to the change of ownership. This section must be completed by both the current owner(s) (to protect them from any future liabilities) and the new owner (to establish payment under its tax identification number). **Submit two copies of the sales or other asset transfer agreement with this application.**

1. Legal Business Name of Transferor as Reported to the IRS		
2. "Doing Business As" Name of Transferor (if applicable)		
3. Medicare Identification Number of Transferor	Projected Effective Date of Transfer (MM/DD/YYYY)	Name of Fiscal Intermediary of Transferor
4. Will the new owner be accepting assignment of the current "Provider Agreement?"		☐ YES ☐ NO

C. Acquisitions/Merger (including the CHOW) **Effective Date of Acquisition:____________________**

This section is to be completed when:

1) A currently enrolled provider is acquiring another currently enrolled provider(s), or
2) A currently enrolled provider is being acquired by another currently enrolled provider.

All providers involved in the acquisition must complete this section. For each provider, furnish the following information: legal business name, tax identification number, current fiscal intermediary, and Medicare identification number. For the provider being acquired, furnish the name of the sub-units of that provider and provide each sub-unit's Medicare identification number. Also indicate whether that sub-unit will remain active. If more than one provider is being acquired, copy and complete this section as needed.

NOTE: Submit two copies of the sales or other asset transfer agreement(s) with this application.

1. Provider Being Acquired

This section is to be completed with information about the currently enrolled provider that is being acquired and will no longer retain its current Medicare provider number as a result of this acquisition.

a) Legal Business Name of the "Provider Being Acquired" as Reported to the IRS	Tax Identification Number
b) Current Fiscal Intermediary	Medicare Identification Number

c) Furnish the name and Medicare identification number of all sub-units of the above provider that have separate Medicare identification numbers but have not entered into separate provider agreements, such as PPS excluded swing bed units of a hospital.

Name/Department:	Medicare Identification Number:
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

2. Acquiring Provider

This section is to be completed with information about the organization acquiring the provider identified in Section 1C1.

a) Legal Business Name of the "Acquiring Provider" as Reported to the IRS	Tax Identification Number
b) Current Fiscal Intermediary	Medicare Identification Number

D. Consolidations (including the CHOW)

Furnish the effective date of the consolidation in the space provided. Two copies of the sales or other asset transfer agreement, in its current form, must be submitted with this application, and a copy of the final agreement must be submitted once the sale is executed.

This section should be completed when a consolidation of providers will result in issuance of a **new** provider number. This usually results from the creation of a **new** provider organization, which has been issued a **new** TIN from the IRS. All applicable sections of this application should be completed for the **new** provider organization (this is similar to being an initial enrollment).

Consolidations that result in **two** or more provider (OSCAR) numbers being deactivated from the Medicare program should be reported in this section. In general, a provider number is deactivated when a TIN is removed from the IRS tax rolls. If a transaction results in an existing provider having new owners but keeping its current provider number, then the instructions in Section 1B above for a Change of Ownership (CHOW) should be used. If a transaction results in an existing provider having new owners that will be using the provider number of the acquiring provider, then the instructions in Section 1C (Acquisitions/Merger) should be used.

1. 1st Consolidating Provider

Complete this section about the 1st currently enrolled provider that, as a result of this consolidation, will no longer retain its current Medicare provider number.

a) Furnish the legal business name and TIN of the 1st provider involved in this consolidation.

b) Furnish the name of this provider's fiscal intermediary and its Medicare identification number.

c) Report all sub-units of the provider being consolidated that currently have an active Medicare identification number but have not entered into separate provider agreements, and furnish the sub-unit's Medicare identification number. Do not report sub-units of the provider being consolidated that have separate provider agreements. If these sub-units are also being consolidated in this transaction, a separate CMS 855A must be submitted for each.

2. 2nd Consolidating Provider

Complete this section about the 2nd currently enrolled provider that, as a result of this consolidation, will also no longer retain its current Medicare provider number.

a) Furnish the legal business name and TIN of the 2nd provider involved in this consolidation.

b) Furnish the name of this provider's fiscal intermediary and its Medicare identification number.

c) Report all sub-units of the provider being consolidated that currently have an active Medicare identification number but have not entered into separate provider agreements, and furnish the sub-unit's Medicare identification number. Do not report sub-units of the provider being consolidated that have separate provider agreements. If these sub-units are also being consolidated in this transaction, a separate CMS 855A must be submitted for each.

3. Newly Created Provider Identification Information

Complete this section with information about the newly created provider.

a) Furnish the legal business name and TIN of the newly created provider organization that resulted from this consolidation.

b) Furnish the new provider organization's fiscal intermediary preference.

1. General Application Information (Continued)

D. Consolidations (including the CHOW) **Effective Date of Consolidation:**________________________

All currently enrolled providers that are consolidating with other currently enrolled providers must complete this section with information about all the providers involved. This section is only to be completed when the consolidation of two or more providers results in an entirely new provider and the issuance of a new Medicare provider number. For each provider, furnish the following information: legal business name, tax identification number, current fiscal intermediary, Medicare identification number, and all sub-units of each provider. For each sub-unit, furnish the Medicare identification number and indicate which sub-units will remain active. In addition, complete Section 1D3 with identifying information about the newly created provider. If there are more than two consolidating providers, copy and complete this section as needed.

1. 1st Consolidating Provider

This section is to be completed with information about the 1st currently enrolled provider that, as a result of this consolidation, will no longer retain its current Medicare provider number.

a) Legal Business Name of the Provider Organization as Reported to the IRS	Tax Identification Number
b) Current Fiscal Intermediary	Medicare Identification Number

c) Furnish the name and Medicare identification number of all sub-units of the above provider that have separate Medicare identification numbers but have not entered into separate provider agreements, such as PPS excluded swing bed units of a hospital.

Name/Department:	Medicare Identification Number:
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

2. 2nd Consolidating Provider

This section is to be completed with information about the 2nd currently enrolled provider that, as a result of this consolidation, will also no longer retain its current Medicare provider number.

a) Legal Business Name of the Provider Organization as Reported to the IRS	Tax Identification Number
b) Current Fiscal Intermediary	Medicare Identification Number

c) Furnish the name and Medicare identification number of all sub-units of the above provider that have separate Medicare identification numbers but have not entered into separate provider agreements, such as PPS excluded swing bed units of a hospital.

Name/Department:	Medicare Identification Number:
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

3. Newly Created Provider Identification Information

Complete this section with identifying information about the newly created provider resulting from this consolidation.

a) Legal Business Name of the new Provider as Reported to the IRS	Tax Identification Number
b) Fiscal Intermediary Preference	

SECTION 2: PROVIDER IDENTIFICATION

A. Type of Provider

1. Type of provider - Check the appropriate box to identify the type of provider for which this application is being submitted. Only **one** provider type may be checked per application. If the provider functions as two or more provider types, a separate CMS 855A must be submitted for each type. If the provider changes the type of services it provides (becomes a different provider type), a new CMS 855A must be completed and submitted (except for hospitals changing the type of hospital services provided – see #2 below).

NOTE: The only Medicare-eligible provider types are those listed. If this provider believes it meets Medicare eligibility requirements to participate in the Medicare program and its provider type is not listed, check the "Other" box and specify the type of service this provider will furnish to Medicare beneficiaries. Before checking "Other," be certain that this provider is an organizational provider type that would submit claims to a Medicare Fiscal Intermediary. Some medical organizations may own or control supplier types that are only eligible to submit claims to a Medicare carrier. These suppliers must complete the CMS 855B and submit it to their local carrier.

2. If "Hospital" was checked in Section 2A1, check all applicable types of services this hospital furnishes. If the hospital is reporting a change in the types of services it provides, check the change box and check **all** current types of provided services.
3. If "Hospital" was checked in Section 2A1,

a) Check the appropriate box to indicate if the hospital wants one Medicare Part B services billing number, multiple Part B services billing numbers for each department (e.g., cardiology, pathology, radiology), or if this section is not applicable. If a combination of both separate billing numbers for some departments and combined billing numbers for groups of other departments are requested, furnish all details in Section 2G. If multiple numbers are being requested, each department to be issued a Part B Medicare billing number must be reported here.

NOTE: Hospitals must complete and submit the form CMS 855B to the local Medicare carrier to obtain a Part B Medicare billing number.

b) If this hospital has a compliance plan which states that the hospital checks all managing employees against the exclusion/debarment lists of both the HHS Office of the Inspector General (OIG) and the General Services Administration (GSA), check "Yes" in the box provided. Otherwise, check "No." At any time, CMS or its Medicare contractor may request a copy of the compliance plan.

The licenses, certifications and registrations which must be submitted with this application are those required by Medicare or the State to function as the provider type for which this provider is enrolling. Local licenses/permits that are not of a medical nature are not required but any business license required to operate as a health care facility **must** be submitted. Required documents that can only be obtained after a State Survey are not required as part of the application submission but **must** be furnished within 30 days of the provider receiving them.

B. Provider Identification Information

Provider Identification Information - Check the box "Change" only if reporting a change to existing information. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

1. Furnish the legal business name for this provider as reported to the IRS for tax purposes. This may be the same name as that of the owner of this provider.
2. Provide any "doing business as" name this provider uses. The "doing business as" name is the name the provider is generally known by to the public. Also provide the county/parish where the DBA name is registered, if applicable.
3. Check the appropriate box to indicate the organizational structure of this provider. Check "Corporation" if the provider is such, regardless of whether the provider is "for-profit" or "non-profit." "Partnership" should be checked for all "General" or "Limited" partnerships. All other providers should check "Other," and specify the type of organizational structure (e.g., limited liability company).
4. Furnish this provider's "Medicare Year-End Cost Report Date." This date will determine when cost reports and audits are due for this provider. This date may be the same as the provider's "fiscal year-end date. Also furnish the date the enrolling provider started rendering services at this practice location.
5. If incorporated, provide the date and State where the provider is incorporated. Otherwise, enter "not applicable" (N/A). The fiscal intermediary may request a copy of the provider's articles of incorporation to verify information reported in this application.

2. Provider Identification

This section is to be completed with information specifically related to the provider submitting this application. Furnish the following information about the provider: (1) provider type, (2) provider name, (3) the mailing address and telephone number where Medicare can contact the provider directly, (4) whether the provider has been accredited or Federally approved, and (5) whether the provider has any "prospective payment system" (PPS) exclusions.

A. Type of Provider

Check the appropriate boxes below. The provider must meet all Medicare requirements for the type of provider checked. Submit copies of all required licenses, certifications, and registrations with this application.

1. Type of Provider (Check one):

- ☐ Religious Non-Medical Health Care Institution (RNHCI)
- ☐ Community Mental Health Center
- ☐ Comprehensive Outpatient Rehabilitation Facility
- ☐ End-Stage Renal Disease Facility (ESRD)
- ☐ Federally Qualified Health Center (FQHC)
- ☐ Histocompatibility Laboratory
- ☐ Home Health Agency
- ☐ Home Health Agency (Sub-unit)
- ☐ Hospice
- ☐ Hospital (If checked, complete Sections 2A2 and 2A3)
- ☐ Indian Health Services Facility
- ☐ Multiple Hospital Component in a Medical Complex
- ☐ Organ Procurement Organization (OPO)
- ☐ Outpatient Physical Therapy/Occupational Therapy/ Speech Pathology Services
- ☐ Psychiatric Unit (of Hospital)
- ☐ Rehabilitation Agency (unit of a Hospital)
- ☐ Rural Health Clinic
- ☐ Skilled Nursing Facility
- ☐ Other (Specify):________________________________

2. If this provider is a hospital, check all applicable sub-groups listed below:

☐ Hospital ☐ Change Effective Date:________

- ☐ Hospital—General
- ☐ Hospital—Alcohol/Drug
- ☐ Hospital—Acute Care
- ☐ Hospital—Children's (excluded from PPS)
- ☐ Hospital—Critical Access
- ☐ Hospital—Critical Access (Swing-Bed unit)
- ☐ Hospital—Long-Term (excluded from PPS)
- ☐ Hospital—Long-Term (Swing-Bed unit)
- ☐ Hospital—Psychiatric (excluded from PPS)
- ☐ Hospital—Short-Term (General and Specialty)
- ☐ Hospital—Short-Term (Swing-Bed unit)
- ☐ Hospital—Rehabilitation (excluded from PPS)
- ☐ Hospital—Rehabilitation (Swing-Bed unit)

☐ Other (Specify):

____

3. Hospital Departments billing for Practitioner Services:

a) If this provider is a hospital, check the appropriate box below. See instructions before completing this section.

☐ Not Applicable

☐ Single billing number for all departments ☐ Separate billing number for each department listed below

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

b) Does this hospital have a compliance plan stating that all managing employees are checked against the OIG exclusion and GSA debarment lists? ☐ YES ☐ NO

B. Provider Identification Information ☐ Change Effective Date:____________________

Furnish the provider's legal business name (as reported to the IRS), "doing business as" name (name provider generally known by to the public), and the various operating dates and places of formal business registration and/or incorporation. If incorporated, the provider may be required to submit a copy of its "Articles of Incorporation" for validation purposes.

1. Legal Business Name as Reported to the IRS	
2. "Doing Business As" (DBA) Name (if applicable)	County/Parish where DBA Name Registered (if applicable)
3. Identify the type of organizational structure for this provider (Check one): ☐ Corporation ☐ Partnership ☐ Other (Specify):____________________	
4. Medicare Year-End Cost Report Date (MM/DD)	Date Business Started (MM/DD/YYYY)
5. Incorporation Date (if applicable) (MM/DD/YYYY)	State where Incorporated (if applicable)

C. Correspondence Address - Check the box “Change” only if reporting a change to existing information. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

- **Furnish an address and telephone number where Medicare or the Medicare fiscal intermediary can directly get in touch with the enrolling provider.**

This section will assist us in contacting the provider with any questions we have concerning its business relationship with the Medicare program. The provider must furnish an address and telephone number where Medicare or the fiscal intermediary can directly contact it to resolve any personal or business issues that arise as a result of its enrollment in the Medicare program. This data will also be used to furnish the provider with important changes or other information concerning the Medicare program that may directly affect the provider and/or its Medicare payments. This address **cannot** be that of the billing agency, management service organization, or staffing company. If we suspect that the provider’s billing number is being misused, or if we have a legal question, we will contact the provider directly. This is to protect the provider as well as the Medicare program.

D. Accreditation - Check the box “Change” only if reporting a change to existing information. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

1. Indicate whether this provider is accredited by any accrediting organization that Medicare has approved for acceptance in lieu of a State Survey.
2. If “Yes,” furnish the date accreditation was received, and
3. Furnish the name of the Medicare-approved accrediting body or organization.

E. Federal Approval (FQHCs and OPOs only) – This section must be completed by all Federally Qualified Health Centers and Organ Procurement Organizations. To be eligible to enroll in the Medicare program, FQHCs and OPOs must receive federal approval to operate as a health care provider.

Check the box “Change” only if reporting a change to existing information. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

1. Indicate if this FQHC or OPO has received federal approval. If “Yes,”
2. Furnish the date of approval and submit a copy of the approval certificate with this application.

F. Prospective Payment System Exclusions - Check the box “Change” only if reporting a change to existing information. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

1. Indicate if this provider has any “Prospective Payment System Exclusions.” This section is primarily for hospitals that have psychiatric units or rehabilitation agencies (units).
2. If “Yes,” indicate the type of unit to be excluded by checking one or both boxes provided.

G. Comments – This section is to be used as an opportunity to explain any unique billing number requests or to clarify any other information furnished in this section (Section 2 - Provider Identification).

2. Provider Identification (Continued)

C. Correspondence Address ☐ **Change** **Effective Date:**__________________

This must be an address and telephone number where Medicare can contact the provider directly.

Mailing Address Line 1		
Mailing Address Line 2		
City	State	ZIP Code + 4
Telephone Number ( ) (Ext.) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

Note: Sections 2D through 2F below require a "Yes," "No," or "Pending" response. If a specific question does not apply to this provider, check "No" and continue with the next question. If the response is "Yes" or "Pending," furnish the additional information requested in that section and continue with the next question.

D. Accreditation ☐ **Change** **Effective Date:**__________________

1. Is this provider accredited? ☐ YES ☐ NO ☐ PENDING
IF YES, complete the following:
2. Date of Accreditation (MM/DD/YYYY):____________________________
3. Name of Accrediting Body:____

E. Federal Approval (FQHCs and OPOs only) ☐ **Change** **Effective Date:**__________________

1. Is this provider Federally approved? ☐ YES ☐ NO ☐ PENDING
IF YES, complete the following:
2. Date of Approval (MM/DD/YYYY):__________________________

F. Prospective Payment System Exclusions ☐ **Change** **Effective Date:**__________________

1. Does this provider have any "Prospective Payment System" (PPS) excluded units? ☐ YES ☐ NO
IF YES, check the type(s) of excluded unit(s) below:
2. Type of unit(s) to be excluded: ☐ Psychiatric Unit ☐ Rehabilitation Agency (unit)

G. Comments

Use this section to explain any unique billing number requests or to clarify any other information furnished in this Section.

SECTION 3: ADVERSE LEGAL ACTIONS AND OVERPAYMENTS

A. Adverse Legal History - This section is to be completed with information concerning any adverse legal actions that have been imposed or levied against this provider. See Table A on the application form for a list of adverse actions that must be reported.

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. The provider must state whether, under any current or former name or business identity, it has ever had any of the adverse legal actions listed in Table A of the application form imposed against it.

2. If the answer to this question is "Yes," supply all requested information. Attach copies of official documentation related to the adverse legal action. Such documentation includes adverse legal action notifications (e.g., notification of disciplinary action; criminal court documentation that verifies the conviction of a crime) and documents that evidence how the adverse legal action was finally resolved (e.g., reinstatement notices, etc.).

If the provider is uncertain as to whether it falls within one of the adverse legal action categories or whether a name reported on this application has an adverse legal action, query the Healthcare Integrity and Protection Data Bank. If information is needed on how to access the data bank, call 1-800-767-6732 or visit www.npdb-hipdb.com. There is a charge for using this service.

Table A--This is the list of adverse legal actions that must be reported.

B. Overpayment Information - Current laws found in the Federal Streamlining Act and the Debt Collection Improvement Act require all Federal agencies to determine whether an individual or business entity that enters into a business relationship with that agency has any outstanding debts, including overpayments under different identifiers. Failure to furnish information about overpayments will put the provider in violation of these Acts and subject it to possible denial of its Medicare enrollment.

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. The provider must report all outstanding Medicare overpayments that it is liable for, including those paid to the provider, or on its behalf under a different name. For purposes of this section, the term "outstanding Medicare overpayment" is defined as a debt that meets **all** of the conditions listed below:

   a) The overpayment arose out of the provider's current or previous enrollment in Medicare. This includes any overpayment incurred by the provider under a different name or business identity, or in another Medicare contractor jurisdiction;

   b) CMS (or its contractors) has determined that the provider is liable for the overpayment; and

   c) The overpayment is not or has not been included as part of a repayment plan approved by CMS (or its contractors), nor is the overpayment amount being repaid through the withholding of Medicare payments to the provider.

Any overpayment not meeting all of these conditions should not be reported.

2. Furnish the name or business identity under which the overpayment occurred and the account number under which the overpayment exists.

NOTE: Overpayments that occur after the providers' enrollment has been approved do not need to be reported unless the provider is enrolling with a different Medicare contractor.

3. Adverse Legal Actions and Overpayments

This section is to be completed with information concerning any adverse legal actions and/or overpayments that have been imposed or levied against this provider (see Table A below for list of adverse actions that must be reported).

A. Adverse Legal History ☐ **Change** **Effective Date:**____________________

1. Has this provider, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A below imposed against it? ☐ YES ☐ NO
2. **IF YES**, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:

Table A

1) Any felony or misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.

2) Any felony or misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.

3) Any felony misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.

4) Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

5) Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.

6) Any revocation or suspension of accreditation.

7) Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.

8) Any current Medicare payment suspension under any Medicare billing number.

Note: All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

B. Overpayment Information ☐ **Change** **Effective Date:**____________________

1. Does this provider, under any current or former name or business identity, have any outstanding Medicare overpayments? ☐ YES ☐ NO
2. **IF YES**, furnish the name and account number under which the overpayment(s) exists.

Name under which the overpayment occurred:	Account number under which the overpayment exists:

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SECTION 4: CURRENT PRACTICE LOCATION(S)

A. Practice Location Information - Check the appropriate box to indicate whether the provider is adding a new practice location, deleting a practice location, or changing information about an existing practice location. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise, complete this section as follows:

If a reported addition or change does not require a separate OSCAR number and/or corresponding separate provider agreement (e.g., a branch or provider-based clinic), check the appropriate box and complete this section. If adding a location that requires a completely separate OSCAR number and/or corresponding separate provider agreement, a new application must be submitted for the new location as a new provider.

Home Health Agencies (HHAs) should complete this section with their administrative address and skip to Section 4E.

Community Mental Health Centers (CMHCs) must report all alternative sites where core services are provided (proposed alternative sites for initial enrollment and actual alternative sites for those CMHCs already participating in Medicare). In accordance with provisions of the Public Health Service Act, a CMHC is required to provide mental health services principally to individuals who reside in a defined geographic area (service area). Therefore, CMHCs must service a distinct and definable community. Those CMHCs operating or proposing to operate outside this specific community must have a separate provider agreement/number, submit a separate enrollment application, and individually meet the requirements to participate. CMS will determine if the alternative site is permissible or whether the site must have a separate agreement/number. CMS will consider the actual demonstrated transportation pattern of CMHC clients within the community to ensure that all core services and partial hospitalization are available from each location within the community. A CMHC patient must be able to access and receive services he/she needs at the parent CMHC site or the alternative site within the distinct and definable community served by the parent.

NOTE: Hospitals must report all practice locations where the hospital provides services. Do not report separately enrolled provider/supplier types such as SNFs, HHAs, RHCs, physician practices, clinics, etc. Practice location addresses fall into one of two categories as listed below. When furnishing the practice locations, the hospital should report the addresses in the order shown below.

- **1st** - All location addresses where the hospital performs inpatient services.
- **2nd** – All other location addresses where the hospital performs any other non-inpatient service.

NOTE: If an organization owns other providers or suppliers that are required to obtain separate provider numbers (i.e., OSCAR numbers or UPINs) do not report them as practice locations. Each of these other providers or suppliers must enroll via a separate CMS 855A or CMS 855B as appropriate.

Practice Location Information (continued)

1. Furnish the name the provider uses at this practice location and the date the provider started rendering services at this location.
2. Furnish a complete street address, telephone number, fax number, and e-mail address (if applicable) for the provider's practice/business location.

The address must be a specific street address as recorded by the United States Postal Service. Do not report a P.O. Box. If the provider renders services in a hospital and/or other health care facility for which it bills Medicare directly for the services furnished at that facility, furnish the name and address of that hospital or facility. Do not furnish the provider's billing agency information anywhere in this section. The fax number and e-mail addresses are optional.

3. This question is to be completed by providers that indicated that they are a hospital in Section 2A1. Indicate if the practice location shown in Section 4A is an address where inpatient services are furnished.
4. Indicate whether the provider owns/leases the practice location.
5. Report any CLIA number(s) and/or FDA/Radiology (Mammography) Certification Number(s) that have been issued to this provider for this practice location for which the provider will be billing for these types of services. Submit copies of all current valid certificates with this application.

B. Mobile Facility and/or Portable Units

To properly pay claims, Medicare must be able to distinguish when services are provided in a mobile facility or with portable units. If the provider has a mobile facility or portable unit, provide this information in this section. A "mobile facility" is generally a mobile home, trailer, or other large vehicle that has been converted, equipped, and licensed to render health care services. These vehicles usually travel to local shopping centers or community centers to see and treat patients **inside** the vehicle. A "portable unit" is when the provider transports medical equipment to a fixed location (e.g., physician's office, nursing home) to render service to the patient.

- State whether or not this provider furnishes services in or from a mobile facility or portable unit. If "Yes," use Sections 4C through 4E to furnish information about the mobile/portable services.

C. Base of Operations Address - Check the appropriate box to indicate whether the provider is using this section to add a new mobile/portable practice location, delete a mobile/portable practice location, or change information about an existing mobile/portable practice location. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

- If the base of operations address is the same as the practice location reported above in Section 4A1, check the box and skip to Section 4D.

1. Provide the base of operations name and the date the provider started practicing from this location.
2. Provide the address from where personnel are dispatched, where mobile/portable equipment is stored and, when applicable, where vehicles are parked when not in use. Provide the telephone number, fax number and e-mail address (if applicable) for this base of operations location.

D. Vehicle Information - Check the appropriate box to indicate whether the provider is using this section to add a vehicle, delete a vehicle, or change information about a vehicle. Provide the effective date of the change, and sign and date the certification statement. Otherwise:

1.-3. Furnish the type of vehicle and the vehicle identification number. A copy of all health care related permit(s), license(s), and registration(s) must be submitted for each vehicle reported.

This section is to provide us with information about the mobile unit when the services are rendered **in or from** the vehicle. Do not furnish information about the vehicle(s) that are used only to transport medical equipment (e.g., when the equipment is transported in a van but is used in a fixed setting, such as a doctor's office) or ambulance vehicles.

4. Current Practice Location(s)

This section is to be completed with information about the physical location(s) where this provider currently renders health care services. If this provider operates a mobile facility or portable units, furnish the address of the "Base of Operations," as well as vehicle information and the geographic area serviced by these facilities or units. In addition, cite where this provider wants its payments sent, and where the provider maintains patients' records. If there is more than one practice location, copy and complete this section for each.

A. Practice Location Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**______________

1. Practice Location Name	Date Started at this Location (MM/DD/YYYY)
2. Practice Location Address Line 1	
Practice Location Address Line 2	

City	County/Parish	State	ZIP Code + 4

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

3. **Hospitals Only:** Is the practice location above an inpatient services practice location? ☐ YES ☐ NO

4. Does this provider own/lease this practice location? ☐ YES ☐ NO

5. CLIA Number for this location (if applicable)	FDA/Radiology (Mammography) Certification Number(s) for this location (if applicable)

B. Mobile Facility and/or Portable Units ☐ **Change** **Effective Date:**____________________

Does this organization furnish health care services from a mobile facility or portable unit? ☐ YES ☐ NO
IF YES, use Sections 4C through 4E to furnish information about the mobile/portable services.
IF NO, proceed to Section 4F (Medicare Payment "Pay To" Address).

C. Base of Operations Address ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**______________

The base of operations is the location from where personnel are dispatched, where mobile/portable equipment is stored and, when applicable, where vehicles are parked when not in use. See instructions for further examples.
Check here ☐ and skip to Section 4D if the "Base of Operations" address is the same as the "Practice Location."

1. Base of Operations Name	Date Started at this Location (MM/DD/YYYY)
2. Street Address Line 1	
Street Address Line 2	

City	County/Parish	State	ZIP Code + 4

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

D. Vehicle Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**______________

If the mobile health care services are rendered in a vehicle, such as a mobile home or trailer, furnish the following vehicle information. See the instructions for a full explanation of the types of vehicles that need to be reported. If more than three vehicles are used, copy and complete this section as needed.

Type of Vehicle	Vehicle Identification Number
1. Type of Vehicle (van, mobile home, trailer, etc.)	Vehicle Identification Number
2. Type of Vehicle (van, mobile home, trailer, etc.)	Vehicle Identification Number
3. Type of Vehicle (van, mobile home, trailer, etc.)	Vehicle Identification Number

Note: For each vehicle, a copy of all health care related permits/licenses/registrations MUST be submitted.

E. Geographic Location where the Base of Operations and/or Vehicle Renders Services - Check the appropriate box when the provider is using this section to add a geographic location or delete a geographic location. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

1. Initial Reporting and/or Additions

- The provider should furnish the county/parish, city, State and ZIP Code for all locations at which it will render services to Medicare beneficiaries in or from its mobile facility or portable unit. For those mobile facilities or portable units that travel across State lines, and when those States are serviced by different Medicare contractors (fiscal intermediaries), then the provider must complete a separate CMS 855A enrollment application for each Medicare contractor jurisdiction.

2. Deletions

- If deleting a location where mobile or portable services were provided, indicate the county/parish, city, State, and ZIP Code of the location being deleted.

F. Medicare Payment "Pay To" Address - The provider must indicate where it wants its Medicare payments to be sent. Check the box "Change" only if reporting a change to existing information. Provide the date of that change, and sign and date the certification statement. Otherwise:

- Provide the street or P.O. Box address, city, State and ZIP Code for the address where payments are to be sent.

The ability to establish more then one "pay to" address will be addressed by the provider's fiscal intermediary. Some Medicare fiscal intermediaries do not allow multiple payment addresses. Payment will be made in the provider's "legal business name" as shown in Section 2B1.

- If the provider would like payments to be deposited in its bank account electronically, place a check in the box given and complete the form "Medicare Authorization Agreement for Electronic Funds Transfers (Form HCFA-588).

- If payment is being made by electronic funds transfer, the "Pay To" address should indicate where the provider wants other financial or payment information sent.

G. Location of Patients' Medical Records - Check the appropriate box if using this section to add a new location where patients' records are kept, delete a location, or change information about an existing location. Provide the effective date of that change, complete the appropriate information, and sign and date the certification statement. Otherwise:

1. If all of the provider's patients' medical records are stored at the practice location shown in Section 4A or the base of operations shown in Section 4C, check the box provided and skip this section.

2. If any of the provider's patients' medical records are stored at a location other the practice location shown in Section 4A or the base of operations shown in Section 4C, this section must be completed with a complete address of the storage location.

Post Office Boxes and drop boxes are not acceptable as physical addresses where patients' medical records are maintained. For IDTFs and mobile facilities/portable units, the patients' medical records must be under the provider's control. The records must be the provider's records, not the records of another provider/supplier.

H. Comments - This section is to be used to explain any unusual situations concerning the provider's practice location, including its "pay to" address, information concerning mobile facilities/portable units, or storage of patient records.

4. Practice Location (Continued)

E. Geographic Location ☐ **Add** ☐ **Delete** **Effective Date:**____________________

This section is to be completed with information identifying the geographic area(s) where health care services are rendered by all **Home Health Agencies**, and **Mobile** and/or **Portable** facilities.

Furnish the county/parish, city, State and ZIP Code for all locations where mobile and/or portable services are rendered.

Note: If this provider renders mobile health care services in more than one State, and those States are served by different Medicare contractors, then a separate CMS 855A enrollment application must be completed for each Medicare contractor jurisdiction.

1. Initial Reporting and/or Additions:

County/Parish:	City:	State:	ZIP Code(s):

2. Deletions:

County/Parish:	City:	State:	ZIP Code(s):

F. Medicare Payment "Pay To" Address ☐ **Change** **Effective Date:**____________________

Furnish the address where payments should be sent for services rendered at the practice location in Section 4A or 4C.

"Pay To" Address Line 1

"Pay To" Address Line 2

City	State	ZIP Code + 4

Check here ☐ and complete and submit Form HCFA-588 with this application if the provider would like its payments electronically transferred to its bank account.

G. Location of Patients' Medical Records ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_______

1. Check here ☐ if **all** patients' medical records are stored at the location shown in Section 4A or 4C, and skip this section.

2. If **any** of the patients' medical records are stored in a location other than the location shown in Section 4A or 4C, complete this section with the name and address of the storage location.

Name of Storage Facility/Location

Storage Facility Address Line 1

Storage Facility Address Line 2

City	State	ZIP Code + 4

H. Comments

Explain any unique or unusual circumstances concerning the provider's practice location(s) or the method by which the provider renders health care services.

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

This section is to be completed with information about any organization that has 5% or more (direct or indirect) ownership of, any partnership interest in, and/or managing control of the provider identified in Section 2B. See examples below of organizations that should be reported in this section. If individuals, and not organizations, own or manage the provider, do not complete this section. These individuals must be reported in Section 6. If there is more than one organization, copy and complete this section for each.

A. Check Box - Check the box if there are no organizations to be reported in this section. If this box is checked, proceed to Section 6.

B. Organization with Ownership Interest and/or Managing Control - Identification Information - If adding, deleting, or changing information on an existing owner, partner, or managing organization, check the appropriate box, indicate the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. If not reporting a change, do not check any box, and complete this section for the following:

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

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

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

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

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

***IMPORTANT* – Only report organizations in this section. Any organization previously reported in Section 2 does not need to be repeated in this section. Individuals must be reported in Section 6.**

1. Check all boxes that apply to indicate the relationship between the provider and the owning or managing organization. Provide the effective date of such ownership or control. If the organization reported in this section has a partnership interest in the provider, furnish the effective date of ownership.

2. Provide the legal business name and tax identification number of the owning or managing organization.

3. If applicable, provide the owning or managing organization's "doing business as" name and its Medicare identification number.

4. Provide the organization's business street address.

The following contains an explanation of the terms "direct ownership," "indirect ownership," and "managing control," as well as instructions concerning organizations that must be reported in this application.

EXAMPLES OF 5% OR MORE "DIRECT" OWNERSHIP

All organizations that own 5% or more of the provider must be reported in this application. Many providers may be owned by only one organization, as outlined in the following examples:

- The provider is a skilled nursing facility that is wholly (100%) owned by Company A. As such, the provider would have to report Company A in this section.
- A hospice, operating as a corporation, wants to enroll in Medicare. Company X owns 50% of the corporation's stock. Since Company X obviously owns more than 5% of the business, it must be reported in this application.

In the first example, Company A is considered a direct owner of the skilled nursing facility, in that it actually owns the assets of the business. Similarly, Company X is a direct owner of the hospice mentioned in the second example. It has 50% actual ownership of the hospice.

There are occasionally more complex ownership situations. Many organizations that directly own a provider are themselves wholly or partly owned by other organizations (or even individuals). This is often the result of the use of holding companies and parent/subsidiary relationships. Such organizations and individuals are considered to be "indirect" owners of the provider. Using our example above, if Company B owned 100% of Company A, Company B is considered to be an indirect owner of the provider. In other words, a direct owner has an actual ownership interest in the provider (e.g., owns stock in the business, etc.), whereas an indirect owner has an ownership interest in an organization that owns the provider. For purposes of this application, direct and indirect owners must be reported if they own at least 5% of the provider. To calculate whether these indirect owners meet the 5% ownership level, review the formula outlined in Example 1 in this section.

For purposes of this application, ownership also includes "financial control." Financial control exists when:

(1) An organization or individual is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the provider or any of the property or assets of the provider, **and**

(2) The interest is equal to or exceeds 5% of the total property and assets of the provider.

To calculate whether an organization or individual has financial control over the provider, use the formula outlined in Example 2 of the instructions for this section.

EXAMPLES OF "INDIRECT" OWNERSHIP FOR ENROLLMENT PURPOSES

Example 1 (Ownership)

LEVEL 3	***Individual X*** 5%	***Individual Y*** 30%
LEVEL 2	***Company C*** 60%	***Company B*** 40%
LEVEL 1	***Company A*** 100%	

- Company A owns 100% of the Enrolling Provider
- Company B owns 40% of Company A
- Company C owns 60% of Company A
- Individual X owns 5% of Company C
- Individual Y owns 30% of Company B

In this example, Company A (Level 1) is the direct owner of the Enrolling Provider. Companies B and C as well as Individuals X and Y are indirect owners of the Enrolling Provider. To calculate ownership shares using the above-cited example, utilize the following steps:

LEVEL 1

The diagram above indicates that Company A owns 100% of the Enrolling Provider. Company A must therefore be reported.

LEVEL 2

To calculate the percentage of ownership held by Company C of the Enrolling Provider, multiply:

The percentage of ownership the LEVEL 1 owner has in the Enrolling Provider
MULTIPLIED BY
The percentage of ownership the LEVEL 2 owner has in that LEVEL 1 owner

It is known that Company A, the LEVEL 1 (or direct) owner, owns 100% of the Enrolling Provider. The diagram also indicates that Company C, a LEVEL 2 owner, owns 60% of Company A. As such, multiply 100% (or 1.0) by 60% (.60). The result is .60. Therefore, Company C indirectly owns 60% of the Enrolling Provider, and must be reported.

Repeat the same procedure for Company B, the other LEVEL 2 owner. Because Company B owns 40% of Company A, multiply this figure by 100% (again, the ownership stake Company A has in the Enrolling Provider). Therefore, Company B owns 40% of the Enrolling Provider, and must be reported.

This process is continued until all LEVEL 2 owners have been accounted for.

LEVEL 3

To calculate the percentage of ownership that Individual X has in the Enrolling Provider, multiply:

The percentage of ownership the LEVEL 2 owner has in the Enrolling Provider
MULTIPLIED BY
The percentage of ownership the LEVEL 3 owner has in that LEVEL 2 owner

It has already been established that Company C owns 60% of the Enrolling Provider. According to the example above, Individual X (Level 3) owns 5% of Company C. Therefore, multiply 60% (.60) by 5% (.05), resulting in .03. This means that Individual X owns 3% of the Enrolling Provider and does not need to be reported in this application.

Repeat this process for Company B, which owns 40% of the Enrolling Provider. The diagram states that Individual Y (Level 3) owns 30% of Company B. We thus multiply 40% (.40) by 30% (.30). The result is .12, or 12%. Because Individual Y owns 12% of the Enrolling Provider, Individual Y must be reported in this application (in Section 6 - Individuals).

This process is continued until all owners in LEVEL 3 have been accounted for. Should there be entities at LEVEL 4 and above that have at least a 5% ownership interest in the Enrolling Provider, the Enrolling Provider may submit an organizational chart identifying these entities and/or individuals. The chart should contain the names, business addresses and TINs of these entities, and/or the names and social security numbers of these individuals.

Example 2 (Financial Control)

The percentage of financial control can be calculated by using the following formula:

Dollar amount of the mortgage, deed of trust, or other obligation secured by
the Enrolling Provider or any of the property or assets of the Enrolling Provider
DIVIDED BY
Dollar amount of the total property and assets of the Enrolling Provider

***Example*:** Two years ago, a provider obtained a $20 million loan from Entity X to add a third floor to its facility. Various assets of the provider secure the mortgage. The total value of the provider's property and assets is $100 million.

Using the formula described above, divide $20 million (the dollar amount of the secured mortgage) by $100 million (the total property and assets of the Enrolling Provider). This results in .20, or 20%. Because Entity X's interest represents at least 5% of the total property and assets of the Enrolling Provider, financial control exists and Entity X must be reported in this section.

MANAGING CONTROL (ORGANIZATIONS)

Any organization that exercises operational or managerial control over the provider, or conducts the day-to-day operations of the provider, is a managing organization and must be reported. The organization need not have an ownership interest in the provider in order to qualify as a managing organization. This could be a management services organization under contract with the provider 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 provider must submit a letter on the letterhead of the responsible government (e.g., government agency) or tribal organization, which 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 "authorized 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. See Section 15 for further information on "authorized officials."

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.

C. Adverse Legal History - This section is to be completed with information concerning any adverse legal actions that have been imposed or levied against the organization(s) reported in this section **if** the organization has a 5% or greater ownership interest in, or any partnership interest in, the provider. This section should not be completed for organizations that only have managing control over the provider. See Table A in Section 3 of the application form for a list of adverse actions that must be reported.

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. The provider must state whether the organization reported in Section 5B, under any current or former name or business identity, has ever had any of the adverse legal actions listed in Section 3 (Table A) of this form imposed against it.

2. If the answer to this question is "Yes," supply all requested information. Attach copies of official documentation related to the adverse legal action. Such documentation includes adverse legal action notifications (e.g., notification of disciplinary action; criminal court documentation that verifies the conviction of a crime) and documents that evidence how the adverse legal action was finally resolved (e.g., reinstatement notices, etc.).

If the provider is uncertain as to whether the owning organization falls within one of the adverse legal action categories, the provider should query the Healthcare Integrity and Protection Data Bank. If the provider needs information on how to access the data bank, call 1-800-767-6732 or visit www.npdb-hipdb.com.

5. Ownership Interest and/or Managing Control Information (Organizations)

This section is to be completed with information about all organizations that have 5% or more (direct or indirect) ownership interest of, any partnership interest in, and/or managing control of, the provider identified in Section 2B, as well as any information on adverse legal actions that have been imposed against that organization. See instructions for examples of organizations that should be reported here. If there is more than one organization, copy and complete this section for each.

A. Check here ☐ if this section does not apply and skip to Section 6.

B. Organization with Ownership Interest and/or Managing Control - Identification Information

☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**____________

1. Check all that apply: ☐ 5% or more Ownership Interest ☐ Managing Control ☐ Partner	Effective Date of Ownership (MM/DD/YYYY)
2. Legal Business Name as Reported to the IRS	Effective Date of Control (MM/DD/YYYY)
3. "Doing Business As" Name (if applicable)	Tax Identification Number
4. Business Address Line 1	Medicare Identification Number(s) (if applicable)
Business Address Line 2	

City	State	ZIP Code + 4

C. Adverse Legal History ☐ **Change** **Effective Date:**____________

This section is to be completed only if the organization in Section 5B above is a 5% or greater owner (direct or indirect) of the provider identified in Section 2B, or has a partnership interest in the provider identified in Section 2B.

1. Has the organization in Section 5B above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against it? ☐ YES ☐ NO

2. **IF YES**, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:

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

This section is to be completed with information about any individual that has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the provider identified in Section 2B. In addition, all officers, directors, and managing employees of the provider must be reported in this section. If there is more than one individual, copy and complete this section for each. **The provider MUST have at least ONE managing employee**.

NOTE: Hospitals Only: Hospitals that have checked "Yes" to having a compliance plan in accordance with Medicare requirements in Section 2.A.3.b. are not required to report their managing employees in this application. However, this section **must** be completed for the Authorized Official reported in Section 15 and all Delegated Officials reported in Section 16.

A. Individual with Ownership Interest and/or Managing Control - Identification Information - If adding, deleting, or changing information on an existing 5% or greater owner, partner, officer, director, or managing employee, check the appropriate box, indicate the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. If not reporting a change, complete this section for the following:

The following individuals **must** be reported in Section 6A:

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

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

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

- The term **"Officer"** is defined as any person whose position is listed as being that of an officer in the provider's **"Articles of Incorporation"** or **"Corporate Bylaws," OR** anyone who is appointed by the board of directors as an officer in accordance with the provider's corporate bylaws.
- The term **"Director"** is defined as a member of the provider's **"Board of Directors."** It does not include a person who may have the word "Director" in his/her job title (e.g., Departmental Director, Director of Operations). See note below.

NOTE: A person who has the word "Director" in his/her job title may be a "managing employee," as defined below. Moreover, where a provider has a governing body that does not use the term "Board of Directors," the members of that governing body will still be considered "Directors." Thus, if the provider has a governing body titled "Board of Trustees" (as opposed to "Board of Directors"), the individual trustees are considered "Directors" for Medicare enrollment purposes.

- The term **"Managing Employee"** is defined as any individual, including a general manager, business manager, or administrator, who exercises operational or managerial control over the provider, or who conducts the day-to-day operations of the provider. For Medicare enrollment purposes, "managing employee" also includes individuals who are not actual employees of the provider but, either under contract or through some other arrangement, manage the day-to-day operations of the provider.

NOTE: If a governmental or tribal organization will be legally and financially responsible for Medicare payments received (per the instructions for Governmental/Tribal Organizations in Section 5), the provider is only required to report its managing employees in Section 6. Owners, partners, officers, and directors do not need to be reported.

Refer to the instructions and examples in Section 5 for further clarification of what is meant by the terms "direct owner" and "indirect owner." If further assistance is needed in completing this section, contact the fiscal intermediary.

***IMPORTANT* – Only Individuals should be reported in Section 6. Organizations must be reported in Section 5.**

1. Furnish the individual's name, social security number, date of birth, Medicare identification number (if applicable), and effective date of ownership and/or control. All 5% owners and partners must furnish the effective date of ownership. All officers, directors, and managing employees must furnish the effective date of control.

NOTE: Sections 1124 and 1124A of the Social Security Act require that the provider furnish Medicare with the individual's social security number.

2. If this individual is directly associated with the enrolling provider (e.g., 5% direct owner, partner, officer, director, or managing employee), indicate the individual's relationship with this provider.

3. If this individual is directly associated with an organization reported in Section 5, indicate the name of that organization, and

4. Indicate the individual's role with the organization reported in Section 6A3. If this individual has a title other than those listed in this section, check the "Other" box and specify the title used by this individual.

Example: A provider is 100% owned by Company C, which itself is 100% owned by Individual D. Assume that Company C is reported in Section 5 as an owner of the provider. Assume further that Individual D, as an indirect owner of the provider, is reported in Section 6A1. Based on this example:

- Section 6A2 would not be completed for Individual D. This is because Individual D is not directly associated with the provider, but is considered an indirect owner.

- In Section 6A3, Company C would be reported since Individual D is a direct owner of Company C and Company C was reported in Section 5.

- In Section 6A4, the provider would check the "5% or Greater Owner" box. This is because the percentage of Individual D's ownership of the organization reported in Section 6A3, which in this example is Company C, makes him an indirect 5% or greater owner of the provider.

B. Adverse Legal History - This section is to be completed with information concerning any adverse legal actions that have been imposed or levied against certain individuals reported in Section 6A. See note below concerning which individuals should or should not be reported in this section. See Table A in Section 3 of the application form for a list of adverse actions that must be reported.

NOTE: Do not report adverse legal actions for those individuals who meet the definition of "managing employee" but are not actual employees of the provider (i.e., individuals who manage the provider's day-to-day operations through a contractual or other arrangement but are not directly employed by the provider). Complete this section for all other individuals reported in Section 6A.

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. The provider must state whether the individual reported in Section 6A, under any current or former name or business identity, has ever had any of the adverse legal actions listed in Section 3 (Table A) of this form imposed against him or her.

2. If the answer to this question is "Yes," supply all requested information. Attach copy(s) of official documentation related to the adverse legal action. Such documentation includes adverse legal action notifications (e.g., notification of disciplinary action; criminal court documentation that verifies the conviction of a crime) and documents that evidence how the adverse legal action was finally resolved (e.g., reinstatement notices, etc.).

If the provider is uncertain as to whether this individual falls within one of the adverse legal action categories, the provider should query the Healthcare Integrity and Protection Data Bank. If the provider needs information on how to access the data bank, call 1-800-767-6732 or visit www.npdb-hipdb.com.

6. Ownership Interest and/or Managing Control Information (Individuals)

This section is to be completed with information about any individual that has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the provider identified in Section 2B. All officers, directors, and managing employees of the provider must also be reported in this section. In addition, any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each.

A. Individual with Ownership Interest and/or Managing Control - Identification Information

☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**____________________

1. Name First	Middle	Last	Jr., Sr., etc.
Social Security Number		Date of Birth (MM/DD/YYYY)	Credentials (M.D., O.D., etc.)

Medicare Identification Number (if applicable)	Effective Date of Ownership (MM/DD/YYYY)	Effective Date of Control (MM/DD/YYYY)

2. If the above individual is **directly** associated with the provider in Section 2B, what is this individual's relationship with the provider? (Check all that apply.)

☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☐ Director/Officer ☐ Other (Specify): ________________________________

3. If the above individual is **directly** associated with an organization identified in Section 5B, furnish the name of that organization in the space below:

Legal Business Name of Organization: ____

4. What is this individual's role with the organization reported in Section 6A3 above? (Check all that apply.)

☐ 5% or Greater Owner ☐ Partner ☐ Managing Employee
☐ Director/Officer ☐ Other (Specify):________________________________

B. Adverse Legal History ☐ **Change** **Effective Date:**____________________

Please read the applicable instructions before completing this section. This section is to be completed only if the individual in Section 6A above is a 5% or greater owner (direct or indirect) of, has a partnership interest in, is an actual employee of, or director/officer of, the provider identified in Section 2B.

1. Has the individual in Section 6A above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against him or her? ☐ YES ☐ NO

2. **IF YES**, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
____________________	______________	____________________	____________________
____________________	______________	____________________	____________________
____________________	______________	____________________	____________________

SECTION 7: CHAIN HOME OFFICE INFORMATION

All providers that are currently part of a chain organization or who are joining a chain organization must complete this section with information about the chain home office. This information will be used to ensure proper reimbursement when the provider year-end cost report is filed with the Medicare fiscal intermediary. It is important to furnish the information in this section to avoid overpayments and/or other administrative actions or penalties.

Chain organizations are generally defined as multiple providers owned, leased, or through any other devise, controlled by a single organization. The controlling organization is known as the chain "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, and
- Maintains and centrally controls individual provider cost reports and fiscal records. In addition, a major portion of the Medicare audit for each provider in the chain can be performed centrally at the chain "home office."

A few of the most common provider types that would typically be in a chain organization are Comprehensive Outpatient Rehabilitation Facilities (CORFs), Skilled Nursing Facilities (SNFs), and Home Health Agencies (HHAs).

A. Check Box - If this section does not apply to this provider, check the box provided and skip to Section 8.

B. Type of Action this Provider is Reporting - If this section is being completed to report a change to the information previously reported about the chain home office, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

- Check the appropriate box to indicate the type of action this provider is reporting about its relationship to the chain organization. Check the:
  - 1st box if this provider is enrolling in Medicare for the 1st time, or is undergoing a change of ownership. If this box is checked, complete this entire section.
  - 2nd box if the provider is no longer associated with the chain organization previously reported. Furnish the effective date of this action, and identify the old chain home office in Section 7D.
  - 3rd box if the provider has changed from one chain to another. Furnish the effective date of this action, and complete Section 7D with information about the NEW chain home office.
  - 4th box if only the name of the chain home office is changing and all other information remains the same. Furnish the effective date of this action, and furnish the new chain home office name in Section 7D1.

C. Chain Home Office Administrator Information - If this section is being completed to report a change to the information previously reported about the chain home office administrator, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

- Furnish the name of the chain home office administrator, and his/her title, social security number, and date of birth.

D. Chain Home Office Information - If this section is being completed to report a change to the information previously reported about the chain home office, 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 chain home office as reported to the IRS.
2. Furnish the street address, telephone number, fax number, and e-mail address of the home office corporate headquarters. Do not give a P.O. Box or Drop Box address.
3. Furnish the home office chain number, the name of the home office fiscal intermediary, and the home office "cost report" year-end date.

E. Type of Business Structure of the Chain Home Office - If this section is being completed to report a change to the information previously reported about the chain home office's business structure, check "Change," provide the effective date of the change, check the appropriate box in this section, and sign and date the certification statement. Otherwise:

- Check one of the choices given that best describes the home office business structure.

F. Provider's Affiliation to the Chain Home Office - If this section is being completed to report a change to the information previously reported about the provider's affiliation to the chain home office, check "Change," provide the effective date of the change, check the appropriate box, and sign and date the certification statement. Otherwise:

- Check the appropriate box to indicate how this provider is affiliated with the home office.

7. Chain Home Office Information

This section is to be completed with information about the "Home Office" for those providers that are members of, or are joining, a chain organization.

A. Check here ☐ if this section does not apply and skip to Section 8.

B. Type of Action this Provider is Reporting ☐ **Change** **Effective Date:**____________________

Check one:

☐ Provider in chain for first time (Initial Enrollment or Change of Ownership)
☐ Provider dropped out of current chain Effective date:______________________
☐ Provider in a different chain since last report Effective date:______________________
☐ Provider in same chain under new chain name Effective date:______________________

C. Chain Home Office Administrator Information ☐ **Change** **Effective Date:**____________________

Name of Home Office Administrator or CEO First	Middle	Last	Jr., Sr., etc.
Title of Home Office Administrator	Social Security Number	Date of Birth (MM/DD/YYYY)	

D. Chain Home Office Information ☐ **Change** **Effective Date:**____________________

1. Name of Home Office as Reported to the IRS		Tax Identification Number
2. Home Office Business Street Address Line 1		
Home Office Business Street Address Line 2		
City	State	ZIP Code + 4
Telephone Number ( ) (Ext.) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)
3. Chain Number	Home Office Intermediary	Home Office Cost Report Year-End Date (MM/DD)

E. Type of Business Structure of the Chain Home Office ☐ **Change** **Effective Date:**____________________

Check one:

Voluntary:
☐ Non-Profit – Religious Organization
☐ Non-Profit – Other (Specify):____________________

Proprietary:
☐ Individual
☐ Corporation
☐ Partnership
☐ Other (Specify):________________________________

Government:
☐ Federal
☐ State
☐ City
☐ County
☐ City-County
☐ Hospital District
☐ Other (Specify below):
____

F. Provider's Affiliation to the Chain Home Office ☐ **Change** **Effective Date:**____________________

Check one:

☐ Joint Venture/Partnership ☐ Managed/Related ☐ Leased
☐ Operated/Related ☐ Wholly Owned ☐ Other (Specify):___________

SECTION 8: BILLING AGENCY

The purpose of collecting this data is to develop effective monitoring of agents/agencies that prepare and/or submit claims to bill the Medicare program on behalf of the provider. A billing agency is a company or individual that the provider hires or contracts with to furnish claims processing functions for its business locations. Any entity that meets this description must be reported in this section. If the provider has an agreement with a billing agency and that company has a subcontract with a clearinghouse for electronic claims submission, the clearinghouse must be reported in Section 9 and a copy of the electronic data interchange agreement submitted with this application.

A. Check Box - If this provider does not use a billing agency, check the box and skip to Section 9.

B. Billing Agency Name and Address - 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 name and tax identification number of the billing agency.

2. Furnish the "doing business as" name of the billing agency.

3. Furnish the complete address and telephone number of the billing agency.

If the provider has an agreement with a billing agency or management service organization and that company has a subcontract with a clearinghouse, this information must be reported in Section 9 (Electronic Claims Submission Information) of this application. A copy of the electronic data interchange (EDI) agreement must be submitted with this application.

C. Billing Agreement/Contract 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.

The provider that is enrolling is responsible for responding to the questions listed. These questions are designed to show that the provider fully understands and comprehends its billing agreement and that it intends to adhere to all Medicare laws, regulations, and program instructions. At any time, the fiscal intermediary or CMS may request copies of all agreements/contracts associated with this billing agency.

8. Billing Agency

This section is to be completed with information about all billing agencies this provider uses or contracts with that submit claims to Medicare on the provider's behalf. If more than one billing agency is used, copy and complete this section for each. The provider may be required to submit a copy of its current signed billing agreement/contract if Medicare cannot verify the information in this section.

A. Check here ☐ if this section does not apply and skip to Section 9.

B. Billing Agency Name and Address ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:_______**

1. Legal Business Name as Reported to the IRS		Tax Identification Number
2. "Doing Business As" Name (if applicable)		
3. Business Street Address Line 1		
Business Street Address Line 2		
City	State	ZIP Code + 4
Telephone Number (Ext.) ( ) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

C. Billing Agreement/Contract Information ☐ **Change** **Effective Date:_____________**

Answer the following questions about the provider's agreement/contract with the above billing agency.

1. Does the provider have unrestricted access to its Medicare remittance notices? ☐ YES ☐ NO

2. Does the provider's Medicare payment go directly to the provider? ☐ YES ☐ NO
IF NO, proceed to Question 3.
IF YES, skip Questions 3, 4 and 5.

3. Does the provider's Medicare payment go directly to a bank? ☐ YES ☐ NO
IF NO, proceed to Question 5.
IF YES, answer the following questions and skip Questions 4 and 5.
a) Is the bank account only in the name of the provider? ☐ YES ☐ NO
b) Does the provider have unrestricted access to the bank account and statements? ☐ YES ☐ NO
c) Does the bank only answer to the provider regarding what the provider wants from the bank (e.g., sweep account instructions, bank statements, closing account, etc.)? ☐ YES ☐ NO

4. Does the provider's Medicare payment go directly to the billing agent? ☐ YES ☐ NO
IF NO, proceed to Question 5.
IF YES, answer the following question and skip Question 4.
a) Does the billing agent cash the provider's check? ☐ YES ☐ NO
IF NO, proceed to Question b.
IF YES, are all of the following conditions included in the billing agreement?
1) The agent receives payment under an agency agreement with the provider.
2) The agent's compensation is not related in any way to the dollar amounts billed or collected.
3) The agent's compensation is not dependent upon the actual collection of payment.
4) The agent acts under payment disposition instructions that the provider may modify or revoke at any time.
5) In receiving payment, the agent acts only on behalf of the provider (except insofar as the agent uses part of that payment as compensation for the agent's billing and collection services). ☐ YES ☐ NO

b) Does the billing agent either give the Medicare payment directly to this provider or deposit the payment into this provider's bank account? ☐ YES ☐ NO

5. Who receives the provider's Medicare payment?___________________________________

SECTION 9: ELECTRONIC CLAIMS SUBMISSION INFORMATION

This section is to be completed with information about any clearinghouse(s) used by the provider for electronic claims submission services, including its billing agency if the billing agency furnishes this service, or if its billing agency or management services organization has a subcontract with a clearinghouse to submit the provider's claims electronically.

If this provider would like to submit claims electronically once it is enrolled in the Medicare program, it will need to complete an Electronic Data Interchange (EDI) agreement with each Medicare contractor to which the provider will be submitting claims. These agreements cannot be established until the enrollment process has been completed and a Medicare billing number has been issued to the provider.

At the time of initial enrollment, if the provider knows it will be submitting its claims electronically through the use of a clearinghouse(s), and the provider knows the clearinghouse(s) it will use, report the clearinghouse(s) in this section.

If the provider is already enrolled in Medicare and is submitting this form to report that it (or its billing agency or management services organization) will begin to submit claims electronically through a clearinghouse, the provider must report the clearinghouse(s) in this section.

A copy of all **EDI** agreements between the clearinghouse(s) and the Medicare contractor for the provider completing this application **must** be submitted with this application.

A. **Check Box** - Indicate if the provider or its billing agent or management services organization does not use a clearinghouse. If checked, skip to Section 10.

B. **Check Box** - Indicate if the provider would like to submit claims electronically. Checking this box will alert the Medicare contractor to contact its claims processing department to process an EDI agreement once the provider's enrollment has been completed and approved and a Medicare billing number issued.

C. **Clearinghouse Name and Address** - 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. Provide the clearinghouse's legal business name and tax identification number.
2. If the clearinghouse uses a "doing business as" (DBA) name with this provider, provide that information in this space. If this clearinghouse uses more than one DBA name with this provider, report all that apply.
3. Provide the street address, telephone number, fax number and e-mail address.

SECTION 10: STAFFING COMPANY

A staffing company is an organization that contracts with health care professionals to furnish health care at medical facilities (such as hospital emergency rooms) where it is also under contract (or some similar agreement) to furnish such. A staffing company cannot bill Medicare in the staffing company's name for medical services or supplies furnished under this arrangement. If the provider has an agreement/contract with a staffing company to furnish services to Medicare beneficiaries, complete this section. At any time, the fiscal intermediary may request a copy of the agreement/contract signed by the provider and the staffing company.

A. **Check Box** - If the provider does not use a staffing company, check the box provided and skip to Section 11.

B. **Staffing Company Name and Address** - Indicate if this provider is making a change concerning its relationship with a staffing company by checking the appropriate box "add," "delete," or "change." Provide the new information and the effective date of the change, and sign and date the certification statement. Otherwise:

1. Furnish the legal business name and tax identification number of the staffing company.
2. If applicable, furnish the staffing company's "doing business as" (DBA) name. If the reported staffing company uses more than one DBA name with this provider, report all that apply for Medicare claims.
3. Furnish the complete mailing address, telephone number, fax number and e-mail address for the staffing company.

C. **Staffing Company Contract/Agreement Information** - The enrolling provider must respond to the questions listed to verify that it fully understands and comprehends its contract and that it plans to adhere to all Medicare laws, regulations, and program instructions. At any time, the fiscal intermediary or carrier can request a copy of the agreement/contract signed by the provider and the staffing company.

9. Electronic Claims Submission Information

This section is to be completed with information about any company (clearinghouse) this provider uses or contracts with for electronic claims submission services. See the instructions to determine when and how this section is to be completed. If this provider submits (or will be submitting) claims electronically without the use of a 3rd party company (clearinghouse), check the box in Section 9A and submit a copy of the provider's electronic data interchange (EDI) agreement if one has been established or check the box in Section 9B to start the EDI agreement process. If more than one clearinghouse is used, copy and complete this section for each.

A copy of all currently established EDI agreements for this provider MUST be submitted with this application.

A. Check here ☐ if this section does not apply and skip to Section 10.

B. Check here ☐ if enrolling in Medicare for the first time and would like to submit claims electronically.

C. Clearinghouse Name and Address ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:_______**

1. Legal Business Name as Reported to the IRS		Tax Identification Number
2. "Doing Business As" Name (if applicable)		
3. Business Street Address Line 1		
Business Street Address Line 2		
City	State	ZIP Code + 4
Telephone Number (Ext.) ( ) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

10. Staffing Company

This section is to be completed with information about all staffing companies that this provider uses, either under written contract or by an unwritten agreement. If this provider uses more than one staffing company, copy and complete this section for each. The provider may be required to submit a copy of its current signed staffing company agreement/contract.

A. Check here ☐ if this section does not apply and skip to Section 11.

B. Staffing Company Name and Address ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:_______**

1. Legal Business Name as Reported to the IRS		Tax Identification Number
2. "Doing Business As" Name (if applicable)		
3. Business Street Address Line 1		
Business Street Address Line 2		
City	State	ZIP Code + 4
Telephone Number (Ext.) ( ) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

C. Staffing Company Contract/Agreement Information

Answer the following questions about the staffing company and the provider's contract/agreement with them.

1. Does the staffing company shown in Section 10B above **and** the billing agency identified in Section 8B have a common owner(s)? ☐ YES ☐ NO

2. If applicable, are there any provisions in the staffing company contract/agreement that supersede or contradict the enrolling provider's billing agreement? ☐ Not applicable ☐ YES ☐ NO

3. What department(s) of this provider does this company staff?____________________ ____________________

SECTION 11: SURETY BOND INFORMATION

This section is to be completed by those provider types mandated by law to obtain a surety bond in order to enroll in and bill the Medicare program. Furnish all requested information about the provider's insurance agent, surety company, and the surety bond. To determine which provider types currently require a surety bond, check the CMS web-site, or contact the local State Agency or provider group association. Provider types that may be required to obtain a surety bond are home health agencies, comprehensive outpatient rehabilitation facilities, and rehabilitation agencies.

The surety bond must be an annual bond, continuous bond, or a government security in lieu of a bond (i.e., a Treasury note, United States bond, or other Federal public debt obligation). Annual surety bond renewals must be reported to the fiscal intermediary on a timely basis to ensure continuance of claims payments. The original surety bond must be submitted with this application. Failure to submit the surety bond will prevent the processing of this application. If an insurance agent or an insurance broker issues the bond, the provider must supply a certified copy of the agent's Power of Attorney with this application.

A. Check Box – Check the box if this provider is not required to obtain a surety bond for Medicare enrollment.

B. Check Box - Check the box if this provider qualifies for an exemption as a government entity.

If this provider believes it is government-operated and entitled to an exemption to the surety bond requirement, the provider must furnish a letter signed by a government official of the Federal, State, local or Tribal Government (on official government letterhead), asserting that the government agency/tribe will back the debts owed by this provider in full faith and credit of the government/tribe. This letter can be the same letter that is referred to in Section 5 of these instructions. Otherwise, a surety bond **must** be obtained prior to participating in the Medicare program.

C. 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 mailing address, telephone number and e-mail address of the surety bond company.

D. Name and Address of Insurance Agency/Broker - 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. Provide the legal business name of the agency that issued the bond.
2. Provide the name of the individual agent who issued the bond for the bond agency.
3. Furnish the complete mailing address, telephone number and e-mail address of the agency.

E. 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.
3. Indicate if the bond is renewed annually or if it is continuous.
4. Indicate if this is a "Dual Obligee Bond." A dual obligee bond is issued when a provider bills both the Medicare and Medicaid programs.

F. Government Security - 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 government security as follows:

1. State the amount of the bond, the effective date, and the Federal Reserve Account number.
2. Check the appropriate box indicating the duration for which the government security will be effective.

11. Surety Bond Information

This section is to be completed by providers mandated by law to obtain a surety bond in order to enroll in and bill the Medicare program. See instructions to determine whether this provider is required to obtain a surety bond. Furnish all requested information about the provider's insurance agent, surety company, and the surety bond.

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

B. Check here ☐ if this provider qualifies for a waiver of the bond requirement based on its operation as a government entity. See instructions for specific documentation requirements and skip to Section 12.

C. Name and Address of Surety Bond Company ☐ **Change** **Effective Date:____________________**

1. Legal Business Name of Surety Bond Company as Reported to the IRS		Tax Identification Number
2. Mailing Address Line 1		
Mailing Address Line 2		
City	State	ZIP Code + 4
Telephone Number (Ext.) ( ) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

D. Name and Address of Insurance Agency/Broker

☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:____________________**

1. Legal Business Name of Agency/Broker as Reported to the IRS		
2. Name of Individual Agent		
3. Mailing Address Line 1		
Mailing Address Line 2		
City	State	ZIP Code + 4
Telephone Number (Ext.) ( ) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

E. Surety Bond Information ☐ **Change** **Effective Date:____________________**

1. Amount of Surety Bond $	Surety Bond Number
2. Effective Date of Surety Bond (MM/DD/YYYY)	If reporting a new bond, give cancellation date of the current bond (MM/DD/YYYY)

3. Is the surety bond: ☐ Annual? (or) ☐ Continuous?

4. Check here ☐ if this is a Medicare/Medicaid "Dual Obligee Surety Bond."

F. Government Security ☐ **Change** **Effective Date:____________________**

If a government security has been purchased, furnish the following information.

1. Amount $	Effective Date (MM/DD/YYYY)	Federal Reserve Bank Account Number

2. Check the appropriate box below:

a) Is the Treasury Bill: ☐ 3 months? ☐ 6 months? ☐ 1 year?

b) Is the Treasury Note: ☐ 2 years? ☐ 5 years? ☐ 10 years?

c) Is the government security a 30-year Treasury Bond? ☐ YES ☐ NO

Note: If the government security is less than one year in duration, the provider must submit proof of the renewable government security at least 14 days prior to the expiration date.

SECTION 12: CAPITALIZATION REQUIREMENTS FOR HOME HEALTH AGENCIES (HHAs)

All HHAs and HHA sub-units enrolling in the Medicare program must complete this section. HHAs and HHA sub-units initially enrolling in Medicare, Medicaid, or both programs on or after January 1, 1998 are required to provide documentation supporting that they have sufficient initial reserve operating funds (capitalization) to operate for the first three months of operation in the Medicare and/or Medicaid program(s). The capitalization requirement applies to all HHAs and HHA sub-units that are enrolling in the Medicare program, including HHAs or HHA sub-units currently participating in the Medicare program that, as a result of a change of ownership, will be issued a new provider number. The capitalization requirement does not apply to a branch of an HHA. Regulations found at 42 CFR 489.28 require that an intermediary determine the required amount of reserve operating funds needed for the enrolling HHA or HHA sub-unit by comparing the enrolling HHA or HHA sub-unit to at least three other new HHAs that it serves which are comparable to the enrolling HHA or HHA sub-unit. Factors to be considered are geographic location, number of visits, type of HHA or HHA sub-unit and business structure of the HHA or HHA sub-unit. The fiscal intermediary then verifies that the enrolling HHA or HHA sub-unit has the required funds. To assist the fiscal intermediary in determining the amount of funds necessary, the enrolling HHA or HHA sub-unit should complete this section. For additional information on capitalization requirements, see Volume 63, Number 2 of the Federal Register published on January 5, 1998, beginning at page 292.

A. Check Box - Check the box provided if this section does not apply and skip to Section 13.

B. Type of Home Health Agency - Check the appropriate box to indicate if this HHA is operated as a non-profit agency, or a proprietary (for-profit) agency.

C. Projected Number of Visits by this Home Health Agency - Furnish the number of visits this HHA projects it will make during the first (next) three months of operations and the first (next) 12 months of operations. If this is an established HHA that is currently providing services, furnish the projected number of visits for the next three and twelve months, beginning with next month.

D. Financial Documentation - Although not required with this application, in order to expedite the enrollment process the HHA may attach a copy of its most current savings, checking or other financial statement(s) that verifies the initial reserve operating funds.

1. These documents should be submitted with:

   a) An attestation from an officer of the bank or other financial institution stating that the funds are in the account(s) and are immediately available for the HHA's use, and

   b) Certification from the HHA regarding any borrowed funds.

2. Indicate whether or not the HHA will be submitting the required documentation (financial statements and attestations) with this application.

NOTE: If the HHA chooses not to submit the above documents with this application, the HHA will be requested to do so prior to being issued a Medicare billing number.

E. Additional Information

Use this space to explain or justify any unique financial situations of this HHA that may be helpful in determining the HHA's compliance with the capitalization requirements.

12. Capitalization Requirements for Home Health Agencies (HHAs)

This section is to be completed by Home Health Agencies with information about capitalization. As of January 1, 1998 all HHAs are required to provide documentation verifying that they have sufficient initial reserve operating funds (capitalization) to operate for the first three months of operation in the Medicare program. See instructions for further details on capitalization requirements.

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

B. Type of Home Health Agency

Check one: ☐ Non-profit Agency ☐ Proprietary Agency

C. Projected Number of Visits by this Home Health Agency

How many visits does this HHA project it will make in the first:
three months of operation?___________
twelve months of operation?__________

D. Financial Documentation

1. Although not required to be submitted concurrently with this application, in order to expedite the enrollment process the HHA may attach a copy of its most current savings, checking or other financial statement(s) that verifies the initial reserve operating funds, accompanied by:
a) An attestation from an officer of the bank or other financial institution stating that the funds are in the account(s) and are immediately available for the HHA's use, and
b) Certification from the HHA attesting that at least 50% of the reserve operating funds are non-borrowed funds.

2. Will the HHA be submitting the above documentation with this application? ☐ YES ☐ NO

NOTE: The Fiscal Intermediary may require a subsequent attestation that the funds are still available. If the Fiscal Intermediary determines that the HHA requires funds in addition to those indicated on the originally submitted account statement(s), it will require verification of the additional amount as well as a new attestation statement.

E. Additional Information

Provide any additional information, either in the space below or through documentation, necessary to assist the fiscal intermediary or State agency in properly comparing this HHA with other comparable HHAs.

SECTION 13: CONTACT PERSON(S)

To assist in the timely processing of the provider's application, provide the name and telephone number of an individual who can be reached to answer questions regarding the information furnished in this application. The supplier is not required to furnish a contact person in this section. It should be noted that if a contact person is not provided, all questions about this application will be directed to the authorized official named in Section 15B.

A. **Check Box** - If this section does not apply, check the box and skip to Section 14.

B. **1st Contact Name and Telephone Number** – 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:

- Provide the name, e-mail address, and telephone number of an individual who can answer questions about the information furnished in this application.

C. **2nd Contact Name and Telephone Number** – Same as "B" above.

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION ON THIS ENROLLMENT APPLICATION

The provider should review this section to understand those penalties that can be applied against it for deliberately furnishing false information to enroll or maintain enrollment in the Medicare program.

13. Contact Person(s)

Furnish the name(s) and telephone number(s) of a person(s) who can answer questions about the information furnished in this application. If a contact person is not reported in this section, all questions will be directed to the authorized official named in Section 15B.

A. Check here ☐ if this section does not apply and skip to Section 14.

B. 1st Contact Name and Telephone Number ☐ Add ☐ Delete ☐ Change Effective Date:_______

Name First	Last	E-mail Address (if applicable)	Telephone Number (Ext.)
			( ) ( )

C. 2nd Contact Name and Telephone Number ☐ Add ☐ Delete ☐ Change Effective Date:_______

Name First	Last	E-mail Address (if applicable)	Telephone Number (Ext.)
			( ) ( )

14. Penalties for Falsifying Information on this Enrollment Application

This section explains the penalties for deliberately furnishing false information to gain 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. 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.

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SECTION 15: CERTIFICATION STATEMENT

This section is used to officially notify the provider of additional requirements that must be met and maintained in order for the provider to be enrolled in the Medicare program. This section also requires the signature and date thereof of an authorized official who can legally and financially bind the provider to the laws, regulations, and program instructions of the Medicare program. Section 16 permits the authorized official to delegate signature authority to certain individual(s) (delegated officials) for the purpose of reporting changes to the provider's enrollment record after the provider has been enrolled. The provider may have no more than one currently active authorized official at any given time. <u>See 15B below to determine who within the provider organization qualifies as an authorized official.</u>

A. Additional Requirements for Medicare Enrollment – These are the additional requirements that must be met and maintained by the provider to enroll in and bill the Medicare program. Carefully read these requirements. By signing below, the provider will be attesting to having read these requirements and that the provider understands them.

B. Authorized Official Signature - If adding, deleting, or changing information on an existing authorized official, check the appropriate box and indicate the effective date of that change.

<u>NOTE</u>: The authorized official must also be reported in Section 6.

- The authorized official must sign and date this application.

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

An authorized official is an appointed official to whom the provider has granted the legal authority to enroll it in the Medicare program, to make changes and/or updates to the provider's status in the Medicare program (e.g., new practice locations, change of address, etc.), and to commit the provider to fully abide by the laws, regulations, and program instructions of Medicare. The authorized official must be the provider's general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of 5% or more of the provider (see Section 5 for definition of a "direct owner"), or must hold a position of similar status and authority within the provider's organization.

Only the authorized official has the authority to sign (1) the initial CMS 855A enrollment application on behalf of the provider and (2) the CMS 855A enrollment application that must be submitted as part of the periodic revalidation process. The delegated official has no such authority.

By signing this form for initial enrollment in the Medicare program or for revalidation purposes, the authorized official agrees to immediately notify the fiscal intermediary if any information in the application is not true, correct, or complete. In addition, the authorized official, by his/her signature, agrees to notify the fiscal intermediary of any changes to the information contained in this form, after the provider is enrolled in Medicare, within 90 days of the effective date of the change.

<u>Governmental/Tribal Organizations</u>

As stated in the instructions for Governmental/Tribal Organizations in Section 5, the authorized official signing the CMS 855A in Section 15 must be the same person submitting the letter attesting that the governmental or tribal organization will be legally and financially responsible for any outstanding debts owed to CMS. For instance, the head of a County Department of Health and Human Services would ordinarily qualify as an authorized official of the governmental entity.

SPECIAL REPORTING REQUIREMENTS

To change authorized officials, the provider must:

- Check the "Delete" box in Section 15B,
- Provide the effective date of the deletion, and
- Have the authorized official being deleted provide his/her printed name, signature, and date of signature.

NOTE: If the current authorized official's signature is unattainable (e.g., person has left the company), the Medicare contractor may request documentation verifying that the person is no longer the authorized official.

To then add a new authorized official, the provider must:

- Copy the page containing the Certification Statement,
- Check the "Add" box in Section 15B and provide the effective date of the addition,
- Have the new authorized official provide the information requested in 15B, and
- Have the new authorized official provide his/her signature and date of signature.

By signing his or her name, the new authorized official assumes from the prior authorized official all of the powers (e.g., the power to delegate authority to a delegated official, etc.) previously held by the latter, and also agrees to adhere to all Medicare requirements, including those outlined in Sections 15A and 15B of the Certification Statement. However, a change of the authorized official has no bearing on the authority of existing delegated officials to make changes and/or updates to the provider's status in the Medicare program.

If the provider is reporting a change of information about the current authorized official (e.g., change in job title), this section should be completed as follows:

- Check the box to indicate a change and furnish the effective date,
- Provide the new information, and
- Have the authorized official sign and date this section.

15. Certification Statement

This section is used to officially notify the provider of additional requirements that must be met and maintained in order for the provider to be enrolled in the Medicare program. This section also requires the signature and date thereof of an "Authorized Official" who can legally and financially bind the provider to the laws, regulations, and program instructions of the Medicare program. Section 16 permits the "Authorized Official" to delegate signature authority to other individual(s) (Delegated Officials) employed by the provider for the purpose of reporting future changes to the provider's enrollment record. See instructions to determine who within the provider qualifies as an Authorized Official and a Delegated Official.

A. Additional Requirements for Medicare Enrollment

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

1.) I agree to notify the Medicare contractor of any future changes to the information contained in this form within 90 days of the effective date of the change. I understand that any change in the business structure of this provider may require the submission of a new application.

2.) I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the revocation of Medicare billing number(s), and/or the imposition of fines, civil damages, and/or imprisonment.

3.) I agree to abide by the Medicare laws, regulations, and program instructions that apply to this provider. 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 provider's compliance with all applicable conditions of participation in Medicare.

4.) Neither this provider, nor any 5% or greater owner, partner, officer, director, W-2 managing employee, authorized official, or delegated official thereof is currently sanctioned, suspended, debarred, or excluded by the Medicare or Medicaid program, or any other Federal program, or is otherwise prohibited from providing services to Medicare or other Federal program beneficiaries.

5.) I agree that any existing or future overpayment made to the provider by the Medicare program may be recouped by Medicare through the withholding of future payments.

6.) I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

B. Authorized Official Signature ☐ Add ☐ Delete ☐ Change Effective Date:______________

I have read the contents of this application. My signature legally and financially binds this provider 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, to the best of my knowledge, and I authorize the Medicare program contractor to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare program contractor of this fact immediately.

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

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

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SECTION 16: DELEGATED OFFICIAL (OPTIONAL)

A delegated official must be a W-2 managing employee of the provider, or an individual with a 5% or greater direct ownership interest in, or any partnership interest in, the enrolling provider. Delegated officials are persons who are delegated the legal authority by the authorized official reported in Section 15B to make changes and/or updates to the provider's status in the Medicare program. This individual must also be able to commit the provider to fully abide by the laws, regulations, and program instructions of Medicare. For purposes of this section only, if the individual being assigned as a delegated official is a managing employee, that individual **must** be an actual W-2 employee of the enrolling provider. The Medicare contractor may request evidence indicating that the delegated official is an actual employee of the provider. Independent contractors are not considered "employed" by the provider. A provider can have no more than three delegated officials at any given time.

The signature of the authorized official in Section 16B2 constitutes a legal delegation of authority to any and all delegated official(s) assigned in Section 16.

A. Check Box - If the provider chooses not to assign any delegated officials in this application, check the box in this section. There is no requirement that the provider have a delegated official. However, if no delegated officials are assigned, the authorized official will be the only person who can make changes and/or updates to the provider's status in the Medicare program. All delegated officials must meet the following requirements:

NOTE: Section 6 **MUST** be completed for **all** delegated officials. This requirement also includes delegated officials of a hospital that indicated that it has a compliance plan and did not report any managing individuals in Section 6.

- The delegated official must sign and date this application.
- The delegated official must furnish his/her title/position, and
- The delegated official must check the box furnished if they are a W-2 employee. *Only check if W-2 employee.

B. Delegated Official Signature - If the provider chooses to add delegated officials or to delete existing ones, this section should be completed as follows:

- Check the appropriate box indicating if the delegated official is being added or deleted and furnish the effective date,
- The authorized official must provide his or her signature and date of signature in Sections 15B and 16B2,
- The delegated official(s) to be added must provide the information and their signature in Section 16B, and
- The delegated official(s) to be deleted does not have to sign or date the application.

NOTE: All signatures must be original. Faxed, photocopied, or stamped signatures will not be accepted.

If the provider is reporting a change of information about an existing delegated official (e.g., change in job title), this section should be completed as follows:

- Check the box marked "Change" and furnish the effective date,
- Provide the new information, and
- The authorized official must sign and date Section 15B.

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 provider'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.

In addition, the delegated official, by his/her signature, agrees to notify the Medicare contractor of any changes to the information contained in this application within 90 days of the effective date of the change.

SECTION 17: ATTACHMENTS

This section contains a list of documents that, if applicable, must be submitted with this enrollment application. Failure to provide the required documents will delay the enrollment process.

- Check the appropriate boxes indicating which documents are being submitted with this application.

NOTE: The licenses, certifications and registrations which must be submitted with this application are those required by Medicare and the State to function as the provider type for which this provider is enrolling. Local licenses/permits that are not of a medical nature are not required but any business license required to operate as a health care facility **must** be included with this application. Required documents that can only be obtained after a State Survey are not required as part of the application submission but **must** be furnished within 30 days of the provider receiving them. The Medicare contractor will furnish specific licensing requirements for your provider type upon request.

All enrolling providers are required to furnish information on all Federal, State and local (city/county) professional and business licenses, certifications and/or registrations as required in the provider's State to operate as a health care facility (e.g., CLIA and FDA mammography certificates, hazardous waste disposal license, etc.). The Medicare contractor will supply specific licensing requirements for this provider type upon request.

In lieu of copies of the above-requested documents, the enrolling provider may submit a notarized Certificate of Good Standing from the provider's State licensing/certification board or other medical associations. This certification cannot be more than 30 days old.

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0685. The time required to complete this information collection is estimated at 5-8 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

16. Delegated Official (Optional)

The signature of the authorized official below constitutes a legal delegation of authority to the official(s) named in this section to make changes and/or updates to this provider's enrollment information. The signature(s) of the delegated official(s) shall have the same force and effect as that of the authorized official, and shall legally and financially bind the provider to all the laws, regulations, and program instructions of the Medicare program. By his or her signature, the delegated official certifies that he or she has read the Certification Statement in Section 15 and agrees to adhere to all of the stated requirements. The delegated official also certifies that he/she meets the definition of a delegated official. When making changes and/or updates to the provider's enrollment information maintained by the Medicare program, the delegated official certifies that the information provided is true, correct, and complete. If assigning more than one delegated official (maximum of three), copy and complete this section as needed.

A. Check here ☐ if this provider will not be assigning any delegated official(s) and skip to Section 17.

B. Delegated Official Signature ☐ Add ☐ Delete ☐ Change Effective Date:______________

1. Delegated Official Name **Print** First	Middle	Last	Jr., Sr., etc.
Delegated Official **Signature** (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed
Title/Position	☐ Check here only if Delegated Official is a W-2 employee*		
2. **Signature** of Authorized Official Assigning this Delegation (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed

17. Attachments

This section is a list of documents that, if applicable, should be submitted with this completed enrollment application.

Place a check next to each document (as applicable or required) from the list below that is being included with this completed application.

- ☐ Copy(s) of all Federal, State, and/or local (city/county) professional licenses, certifications and/or registrations specifically required to operate as a health care facility
- ☐ Copy(s) of all Federal, State, and/or local (city/county) business licenses, certifications and/or registrations specifically required to operate as a health care facility
- ☐ Copy(s) of all CLIA Certificates, FDA Mammography Certificates, and Diabetes Education Certificates
- ☐ Copy(s) of all State Pharmacy licenses
- ☐ Copy(s) of all adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters)
- ☐ Copy(s) of all current signed electronic data interchange (EDI) agreements
- ☐ Copy(s) of all surety bonds and/or Agent's Power of Attorney
- ☐ Copy(s) of all partnership agreements
- ☐ Copy(s) of all articles of incorporation and/or corporate charters
- ☐ Copy(s) of all sales agreements (CHOWS, Acquisitions/Mergers, and Consolidations only) (2 copies)
- ☐ Copy(s) of all documents that demonstrate meeting capitalization requirements (HHAs only)
- ☐ Completed Form HCFA-588-Authorization Agreement for Electronic Funds Transfer
- ☐ IRS documents confirming the tax identification number and legal business name (e.g., CP 575)
- ☐ Any additional documentation or letters of explanation as needed