# MEDICARE

## FEDERAL HEALTH CARE
## PROVIDER/SUPPLIER ENROLLMENT APPLICATION


# Application for Individual Health Care Practitioners

**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**CMS 855I (11/2001)**
**(Formerly HCFA 855)**

Keep a copy of this completed package for your records

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

OMB Approval No. 0938-0685

# CENTERS FOR MEDICARE & MEDICAID SERVICES

# Medicare Provider/Supplier Enrollment Application

## Privacy Act Statement

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

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

The information collected will be entered into the Provider Enrollment, Chain and Ownership System (PECOS), and either system number 09-70-0525 titled Unique Physician/Practitioner Identification Number (UPIN) System (published in Vol. 61 of the Federal Register at page 20,528 (May 7, 1996)), or the National Provider Identifier (NPI) System, Office of Management and Budget (OMB) approval 0938-0684 (R-187). The information in this application will be disclosed according to the routine uses described below.

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

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

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

## Protection of Proprietary Information

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

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

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

# INDIVIDUAL HEALTH CARE PRACTITIONER INSTRUCTIONS

Please be sure to **PRINT** or **TYPE** all information so it is legible. Do not use pencil. Failure to provide all requested information might cause your application to be returned and may delay your enrollment. Certain sections of the application have been omitted because they do not apply to individual practitioners. 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 you need to report additional information within a section, copy and complete that section for each additional entry. We strongly suggest that you keep a photocopy of your completed application and all supporting documents for future reference.

All physicians and non-physician practitioners who render medical services to Medicare beneficiaries and submit claims for the services rendered must complete this application. This form (CMS 855I for Individual Health Care Practitioners) is to report your personal information. If you plan to provide services as part of an organization to which you will reassign your benefits, you must also complete and submit a CMS 855R (Application for the Reassignment of Medicare Benefits) with this application. For each organization you join, you must complete and submit a separate CMS 855R to officially reassign your benefits to that organization. If you are terminating your association with an organization, use the CMS 855R to indicate that change. If you plan to render all of your services in a group setting, you will complete up to Section 4 of this application and then skip to Section 14.

After completing this enrollment application (CMS 855I), you may wish to complete and submit additional forms in the following situations:

- To accept assignment of the Medicare Part B payment for your services, complete the form "Medicare Participating Physician or Supplier Agreement" (Form HCFA-460).
- To have Medicare payments sent electronically to your bank account, complete the form "Medicare Authorization Agreement for Electronic Funds Transfers" (Form HCFA-588).
- To submit claims electronically, complete the Electronic Data Interchange (EDI) agreement.

If you plan to do any of the above, submit the appropriate form(s)/agreement(s) with your application. The forms should have been received with this initial enrollment package. If you did not receive them, you can obtain the forms from the Medicare carrier.

## DEFINITIONS OF MEDICARE ENROLLMENT TERMINOLOGY

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

**Billing Agency**-A Company that you contract with to furnish claims processing functions for your practice.
**Carrier**-The Part B Medicare claims processing contractor.
**Fiscal Intermediary**-The Part A Medicare claims processing contractor.
**Legal Business Name**-The name you use when reporting to the Internal Revenue Service (IRS) for tax purposes.
**Medicare Identification Number**-This is a generic term for any number that uniquely identifies the enrolling practitioner. 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).
**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.
**Tax Identification Number (TIN)**-This is the number issued by the Internal Revenue Service (IRS) that the individual practitioner uses to report tax information to the IRS.
**Unique Physician/Practitioner Identification Number (UPIN)**-This number is assigned to physicians and non-physician practitioners 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 carrier 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, IRS W-2s, pay stubs, and staffing company contracts.

## SECTION 1: GENERAL APPLICATION INFORMATION

This section is to identify the reason for submittal of this application. It will also indicate whether you currently have 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 you are enrolling in the Medicare program for the first time with this Medicare carrier under this tax identification number.
- If you are already enrolled with a carrier but need to enroll in another carrier's jurisdiction.

**NOTE:** You must be able to submit a valid claim within twelve months of enrolling or risk deactivation of your billing number once you have enrolled.

**Reactivation:**

- If your Medicare billing number was deactivated because of non-billing. Billing privileges may be deactivated when no claims are submitted in a twelve-month period. To reactivate billing privileges, you will be required to either submit an updated CMS 855I, or certify to the accuracy of your enrollment information currently on file with CMS. In addition, prior to being reactivated, you must be able to submit a valid claim. You must also meet all current requirements for your supplier type, regardless of whether you were previously enrolled in the program unless otherwise stated in regulation.

**Change of Information:**

- If you are adding, deleting, or changing information under this tax identification number. Check the appropriate section where the change is being reported. When providing the changed information, provide your Medicare identification number in Section 1, and provide the new/changed information in the applicable section. If you would like to provide a contact person to discuss these changes, please do so in Section 13. You must sign and date the certification statement in Section 15. **All changes must be reported to the carrier within 90 days of the effective date of the change.** Anytime you add a practice location that is located in a different state than where you are currently enrolled, you must provide a copy of your State license with that change.

**Voluntary Deactivation of Billing Number:**

- If you know you will no longer be submitting claims to the Medicare program using this billing number. Voluntary deactivation ensures that your billing number will not be fraudulently used in the event of your retirement, leaving a group practice, etc. Provide the date you stopped practicing or the date on which you will stop billing for Medicare covered services. In addition, please complete Section 1 to identify yourself, and sign and date the certification statement in Section 15.

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

2. Social Security Number - For identification purposes, you must furnish your social security number. Sections 1124(a)(1) and 1124A of the Social Security Act require that you disclose your social security number to receive payment.

3. If you are currently enrolled in another carrier's jurisdiction, report the name of the carrier and your Medicare identification number in the spaces provided. For individual practitioners who are enrolled, this number will be your UPIN, PIN, and/or your National Supplier Clearinghouse (NSC) billing number. Report all currently active numbers.

**NOTE:** If you do not have a Medicare identification number, you will be assigned one upon the successful completion of your enrollment. This number is assigned through a national registry that establishes the registration of all physicians and non-physician practitioners that receive Part B Medicare payments. In addition, a separate Provider Identification Number (PIN) may be assigned to you by the local carrier. The carrier will explain what number(s) has been issued and how it is to be used. Your application should be processed (from the receipt date at the carrier) within 60 days from the date you submitted it provided you have furnished all the requested information. If the carrier should contact you for additional information, you must provide it immediately to ensure the timely processing of your application.

# MEDICARE FEDERAL HEALTH CARE PRACTITIONER ENROLLMENT APPLICATION

## Application for Individual Health Care Practitioners

## General Instructions

The Medicare Federal Health Care Practitioner 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 practitioners and that the amounts of the payments are correct. This information will also identify whether you are qualified to render health care services and/or supplies to Medicare beneficiaries. To accomplish this, Medicare must know basic identifying and qualifying information about you in order for you to be granted billing privileges in the Medicare program.

When completing this application to enroll and bill the Medicare program as an individual practitioner, you need to tell Medicare (1) who you are, (2) what qualifies you to render health care related services and/or supplies to Medicare beneficiaries, (3) where or how you intend to render these services and/or supplies, and (4) any individuals or organizations that manage your practice.

This application **MUST** be completed in its entirety, unless otherwise stated in these instructions, **or** 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 you, check (√) the appropriate box in that section. Sections 7, 11, 12, and 16, have been deliberately omitted from this application because they are not applicable to the enrollment of individual health care practitioners.

## 1. General Application Information

This section is to be completed with general information as to why you are submitting this application and whether you currently have a business relationship with another Federal health care program.
**To ensure timely processing of this application, Numbers 1, 2, and 3 below MUST ALWAYS be completed.**

**A. Reason for Submittal of this Application**

**1.** Check one: ☐ Initial Enrollment ☐ Reactivation

☐ Change of Information (Check appropriate Section(s) below and furnish your Medicare Identification Number here_____):

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 8 ☐ 9 ☐ 10 ☐ 13

☐ Voluntary Deactivation of Billing Number—Effective Date (MM/DD/YYYY):_____

**2.** Social Security Number:_____

**3.** Are you currently enrolled in the Medicare program? ☐ YES ☐ NO
**IF YES,** furnish the following information about your current carrier:

Current Carrier Name:_____ Current Medicare Identification Number:_____

## SECTION 2: PRACTITIONER IDENTIFICATION

**A. Personal Information** – The information furnished in this section will allow us to uniquely identify you in the Medicare program. Check the box "Change" only if you are reporting a change to existing information in this section. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

1. Provide your full name.
2. If you previously used another name(s), including a maiden name, supply that under "Other Name."
3. Provide your date, State, and country of birth.
4. Indicate your gender.
5. Furnish your year of graduation and the school you attended for your Physician or Non-Physician Medical Specialty.

**B. Correspondence Address** - This section will assist us in contacting you with any questions we have concerning your business relationship with the Medicare program.

Check the box "Change" only if you are reporting a change to existing information in this section. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

- **You must provide an address and telephone number where we can <u>contact you directly</u> to resolve any issues that may arise as a result of your enrollment in the Medicare program**. It also may be necessary to send you important changes/information concerning the Medicare program that directly impacts you and/or your Medicare payments. Therefore, this address cannot be that of your billing agency, management service organization, or staffing company. You may furnish your home address and telephone number if you choose.

**C. Residency Status** - Your responses to the questions in this section will assist us in determining your eligibility to bill Medicare for the services you render to Medicare patients.

Check the box "Change" only if you are reporting a change to existing information in this section. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

1. Check to identify if you are currently a resident, intern, or fellow at a health care facility.
- If "Yes," provide the name of the facility where you serve as a resident/intern/fellow.
- If "No," skip to Section 2D (Business Information).
2. State whether the services you render in the facility shown in Question 1 are part of your requirements for graduation from a formal residency program.
3. Indicate if you also render services at other facilities or practice locations.
   If "Yes," you **<u>must</u>** report these other practice locations in Section 4 (Practice Locations).
4. Indicate if any services that you render, at any practice location you report in Section 4, are required for graduation from a formal residency program.
- If "Yes," indicate if the teaching hospital has agreed to incur all or substantially all costs of the training in the other facility or practice location.

**D. Business Information (if applicable)** - Complete this section if you operate your practice as a business under a name different from your individual name. This information is needed to correctly report to the Internal Revenue Service (IRS) all Medicare payments you receive and the tax identification number under which these payments are made.

Check the box "Change" only if you are reporting a change to existing information in this section. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

1. If this section does not apply to you, check the box provided and skip to Section 2E (Medical Speciality(s)).
2. Provide the legal business name you use when reporting tax information to the IRS. Supply your tax identification number as issued by the IRS.
3. Indicate whether your business is incorporated.

**<u>NOTE</u>:** If you answer "Yes" to number 3 above, you will need to complete two applications. One application will be to establish you with the Medicare program and the other application will be required to enroll your business. Once you complete the application identifying yourself, you must also enroll the business by completing the application for suppliers billing Medicare carriers (CMS 855B). You must also complete a CMS 855R to reassign benefits payable to you as an individual practitioner to your business, which will be submitting claims for the services you have rendered. In addition, any other practitioners who render services for your business, who will be reassigning their benefits to the business, must also complete a CMS 855R.

## 2. Practitioner Identification

This section is to be completed with information about yourself; where Medicare can contact you directly; whether you are rendering services in a health care facility as a resident or an intern; and whether you have established your practice as a separate business entity. You must also designate your medical specialty.

**A. Personal Information** ☐ **Change** **Effective Date:**_____

| | | | | | |
|---|---|---|---|---|---|
| **1.** Name | First | Middle | Last | Jr., Sr., etc. | M.D., D.O., etc. |
| **2.** Other Name (including Maiden) | First | Middle | Last | Jr., Sr., etc. | M.D., D.O., etc. |

| | | |
|---|---|---|
| **3.** Date of Birth (MM/DD/YYYY) | State of Birth | Country of Birth |

**4.** Gender ☐ Male ☐ Female

| | |
|---|---|
| **5.** Year of Graduation (YYYY) | Medical School |

**B. Correspondence Address** ☐ **Change** **Effective Date:**_____

**You must furnish an address and telephone number where Medicare can contact you 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) |

**C. Residency Status** ☐ **Change** **Effective Date:**_____

**1.** Are you currently:
- a resident? ☐ YES ☐ NO
- an intern? ☐ YES ☐ NO
- in a fellowship program? ☐ YES ☐ NO

**IF YES** to any of the above questions, provide the name of the facility where you are a resident, intern, or fellow on the line below:

_____

**IF NO,** skip to Section 2D (Business Information) below.

**2.** Are the services that you render at the facility shown in Question 1 part of your requirements for graduation from a formal residency program? ☐ YES ☐ NO

**3.** Do you also render services at other facilities or practice locations? ☐ YES ☐ NO

**IF YES,** you must report these practice locations in Section 4 (Practice Location).

**4.** Are the services that you render in any of the practice locations you will be reporting in Section 4 (Practice Location) part of your requirements for graduation from a formal residency program? ☐ YES ☐ NO

**IF YES,** has the teaching hospital reported in Question 1 above agreed to incur all or substantially all of the costs of training in the non-hospital facility or location? ☐ YES ☐ NO

**D. Business Information (if applicable)** ☐ **Change** **Effective Date:**_____

**1.** Check here ☐ if this section does not apply to you and skip to Section 2E. Otherwise, furnish the following information if you operate your practice as a business under a name other than your own name.

| | |
|---|---|
| **2.** Legal Business Name as Reported to the IRS | Tax Identification Number |

**3.** Is your business incorporated? ☐ YES ☐ NO
**IF YES**, see specific instructions on how to enroll your health care business in the Medicare program.

**E. Medical Specialty**

1. **Physician Specialty** - Check the box "Change" only if you are reporting a change to existing information in this section. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

If you are a physician, please enter the appropriate letter (P = primary, S = secondary) to indicate your specialty(s). If you do not see your specialty listed, check "Undefined physician type" and report your specialty in the space provided. You must also submit copies of your State physician license, medical school degree, and your Federal controlled substance registration certificate from the Drug Enforcement Agency.

****NOTE: Diagnostic Radiology –** If you checked diagnostic radiology as your specialty, and you will bill for the technical component (tc) of the diagnostic tests, you must contact the Medicare carrier prior to your enrollment to determine if you will also need to complete a CMS 855B to enroll in Medicare as an Independent Diagnostic Testing Facility (IDTF).

**NOTE: Physicians who Bill for Diagnostic Tests (**other than clinical laboratory or pathology tests**)** – As a physician, you may bill for these diagnostic tests as long as you do not provide a substantial portion of the diagnostic tests to patients who **are not** your patients. Patients are considered your own patients if:

- They have a prior relationship with you and are receiving medical treatment from you for a specific medical condition, or
- You are also billing for patient evaluation and management codes (E & M).

A separate (additional) enrollment as an IDTF may be required if, as stated above, substantial portions of your diagnostic tests (other than clinical laboratory or pathology) are provided to patients who are not your patients. Enrollment as an IDTF will not affect your enrollment as a physician. If you only furnish diagnostic tests, claims must be submitted as an IDTF. To enroll as an IDTF, you must complete and submit a CMS 855B.

2. **Non-Physician Specialty** - Check the box "Change" only if you are reporting a change to existing information in this section. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

If you are a non-physician practitioner, enter the appropriate letter (P = primary, S = secondary) to indicate your specialty(s). If you do not see your specialty listed, check "Undefined non-physician type" and report your specialty in the space provided. All non-physician practitioners must meet specific licensing, educational (including any degrees), and work experience requirements. If you need information concerning the specific requirements for your specialty, contact the Medicare carrier. Be sure to include copies of all necessary documentation to prove your eligibility to enroll in Medicare.

**F. Supervising and/or Collaborating Physician(s) -** Indicate if you are adding or deleting a supervising and/or collaborating physician. Provide the new information and the effective date of the change. Provided that this is the only change in your information, you need to sign and date the certification statement. Otherwise:

- Furnish the name, social security number, and Medicare identification number of all applicable physicians who supervise or collaborate with you.

**NOTE:** All non-physician practitioners (excluding Physician Assistants who must complete Section 2J) who require a supervising and/or collaborating physician to qualify for Medicare billing privileges (as required by Federal law) must complete this section. In addition, **all** supervising and/or collaborating physicians reported in this section **must** be currently enrolled in the Medicare program.

## 2. Practitioner Identification (Continued)

**E. Medical Specialty(s)**

Designate your specialty(s) below using: **P=Primary** **S=Secondary (if applicable)**

**1. Physician Specialty** ☐ **Change** **Effective Date:**_____

**Submit a copy of your State Physician License and Medical School Degree.**

_____Addiction medicine
_____Allergy/Immunology
_____Anesthesiology
_____Cardiac surgery
_____Cardiovascular disease (Cardiology)
_____Chiropractic
_____Colorectal surgery (Proctology)
_____Critical care (Intensivists)
_____Dermatology
_____Diagnostic radiology**(see note)
_____Emergency medicine
_____Endocrinology
_____Family practice
_____Gastroenterology
_____General practice
_____General surgery
_____Geriatric medicine
_____Gynecological/Oncology
_____Hand surgery
_____Hematology
_____Hematology/Oncology
_____Infectious disease
_____Internal medicine
_____Interventional radiology
_____Maxillofacial surgery
_____Medical oncology
_____Nephrology
_____Neurology
_____Neuropsychiatry
_____Neurosurgery
_____Nuclear medicine
_____Obstetrics/Gynecology
_____Ophthalmology
_____Optometry
_____Oral surgery (Dentist only)
_____Orthopedic surgery
_____Osteopathic manipulative treatment
_____Otolaryngology
_____Pain Management
_____Pathology
_____Pediatric medicine
_____Peripheral vascular disease
_____Physical medicine and rehabilitation
_____Plastic and reconstructive surgery
_____Podiatry
_____Preventative medicine
_____Psychiatry
_____Pulmonary disease
_____Radiation oncology
_____Rheumatology
_____Surgical oncology
_____Thoracic surgery
_____Urology
_____Vascular surgery

_____Undefined physician type (Specify):

_____

**2. Non–Physician Specialty** ☐ **Change** **Effective Date:**_____

See instructions for specific non-physician requirements that must be met to enroll in the Medicare program. You must submit documentation (e.g., copies of licenses, degrees) that confirms you have met the requirements for your specialty.

_____Audiologist
_____Certified clinical nurse specialist
_____Certified nurse midwife
_____Certified registered nurse anesthetist
_____Licensed clinical social worker
_____Mass immunization roster biller
_____Nurse practitioner
_____Occupational therapist in private practice (see Sec. I)
_____Registered Dietition or Nutrition Professional
_____Physical therapist in private practice (see Sec. I)
_____Physician assistant (see Section J)
_____Psychologist, Clinical (see Section G)
_____Psychologist billing independently (see Section H)
_____Undefined non-physician type (Specify):

_____

**F. Supervising and/or Collaborating Physician(s)** ☐ **Add** ☐ **Delete** **Effective Date:**_____

This section must be completed by all non-physicians (excluding physician assistants) who require a supervising and/or collaborating physician to qualify for Medicare billing privileges. The supervising and/or collaborating physician must be currently enrolled with Medicare.

| Physician Name | Social Security Number | Medicare Identification Number |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**G. Clinical Psychologists - Questionnaire**

**Questions 1-4:** All clinical psychologists must respond to these questions by checking "Yes" or "No" to determine your eligibility to bill Medicare.

**H. Psychologists Billing Independently - Questionnaire**

A psychologist billing independently is defined as:

- One who renders services free of the administrative and professional control of an employer such as a physician, institution, or agency, and
- Who maintains office space at his/her own expense and furnishes services only in that space or the patient's home, and
- Has the right to collect fees for the services rendered, and
- The patients treated are the psychologist's own patients.

**Questions 1-4:** All psychologists must respond to these questions by checking "Yes" or "No" to determine if you are eligible to bill Medicare as a psychologist who is independently billing.

**I. Occupational/Physical Therapist in Private Practice (OT/PT) Only - Questionnaire**

An occupational therapist/physical therapist in private practice is defined as one who maintains a private office even if services are always furnished in patients' homes. If services are furnished in private practice office space, that space must be owned, leased, or rented by the OT/PT and used for the exclusive purpose of operating the OT's /PT's practice.

**Questions 1-5:** All OTs/PTs must respond to these questions by checking "Yes" or "No." This information will determine your eligibility to bill Medicare.

**J. Physician Assistants (PA) Only -** Indicate if you are adding or deleting an employer. Provide the new information and the effective date of the addition or deletion. Provided that this is the only change in your information, you need to sign and date the certification statement. Otherwise:

1. Furnish the name, social security number and date of birth **or** the name and Medicare identification number of the physician listed on your degree or license. For States that do not require the Supervising Physician to be identified on the PA license, provide the information required in this section about the physician who qualified you for your license.

2. In order to determine who will be billing for your services, report all employers' Medicare billing numbers. This information will allow Medicare to appropriately associate you with each of your employers.

**NOTE: Physician Assistants –** When completing this application, PAs should only complete Sections 1, 2, 3, 10, 13, 15 and 17. Also, PAs should not use or submit the CMS 855R form to report employers. The CMS 855R is only used to reassign benefits that would otherwise be paid directly to the practitioner.

## 2. Practitioner Identification (Continued)

### G. Clinical Psychologists - Questionnaire

This section must be completed by all clinical psychologists in order to determine if you are eligible to bill Medicare. Please answer all questions in this section.

**1.** Do you hold a doctoral degree in psychology? ☐ YES ☐ NO
**IF YES**, furnish the field of your psychology degree:_____
**2.** Do you inform each Medicare patient of the desireability of conferring with the patient's attending or primary care physician to consider potential medical conditions contributing to the patient's condition? ☐ YES ☐ NO
**3.** Contingent upon the patient's consent, do you consult with the patient's designated attending or primary care physician in accordance with accepted professional ethical norms, taking into consideration patient confidentiality? ☐ YES ☐ NO
**4.** If the patient assents to the consultation, do you attempt to consult with the patient's physician within a reasonable time after receiving consent? ☐ YES ☐ NO

### H. Psychologists Billing Independently - Questionnaire

This section must be completed by all psychologists billing independently in order to determine if you are eligible to bill Medicare as a psychologist "independently billing." Please answer all questions in this section.

**1.** Do you render services of your own responsibility free from the administrative control of an employer such as a physician, institution, or agency? ☐ YES ☐ NO
**2.** Do you treat your own patients? ☐ YES ☐ NO
**3.** Do you have the right to bill directly, and to collect and retain the fee for your services? ☐ YES ☐ NO
**4.** Is your private practice located in an institution? ☐ YES ☐ NO
**IF YES** to question 4 above, please answer questions "a" and "b" below.
**a)** If your private practice is located in an institution, is your office confined to a separately identified part of the facility that is used solely as your office and cannot be construed as extending throughout the entire institution? ☐ YES ☐ NO
**b)** If your private practice is located in an institution, are your services also rendered to patients from outside the institution or facility where your office is located? ☐ YES ☐ NO

### I. Occupational/Physical Therapist in Private Practice (OT/PT) - Questionnaire

This section must be completed by all occupational and physical therapists in order to determine if you are eligible to bill Medicare for services rendered in your private practice. Please answer all questions in this section.

**1.** Are all of your PT/OT services only rendered in the patients' homes? ☐ YES ☐ NO
**2.** Do you maintain private office space? ☐ YES ☐ NO
**3.** Do you own, lease, or rent your private office space? ☐ YES ☐ NO
**4.** Is this private office space used exclusively for your private practice? ☐ YES ☐ NO
**5.** Do you provide PT/OT services outside of your office and/or patients' homes? ☐ YES ☐ NO
**IF YES**, provide a copy of the lease agreement that gives you exclusive use of the facility for PT/OT services.

### J. Physician Assistants Only ☐ Add ☐ Delete Effective Date:_____

This section must be completed by all physician assistants to ensure correct claims coding when billing for your services.

**1.** Provide the name, social security number and date of birth, **or** the name and Medicare Identification Number of the physician shown on your PA degree or license in the space below. See instructions if no physician is shown.

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

| Social Security Number | Date of Birth (MM/DD/YYYY) | Medicare Identification Number (if applicable) |
|---|---|---|
| | | |

**2.** Since physician assistants cannot bill the Medicare program directly, they must report the Medicare billing number for all employers that bill Medicare for their services.

| | | |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

## 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 you. 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. You must state whether, under any current or former name or business identity, you have ever had any of the adverse legal actions listed in Table A of the application form imposed against you.

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 you are uncertain as to whether you fall within one of the adverse legal action categories or whether a name reported on this application has an adverse legal action, you should query the Healthcare Integrity and Protection Data Bank. If you need information 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 you 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. You must report all outstanding Medicare overpayments that you are liable for, including those paid to you, or on your 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 your current or previous enrollment in Medicare. This includes any overpayment incurred by you under a different name or business identity, or in another Medicare contractor jurisdiction;

   b) CMS (or its contractors) has determined that you are 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 you.

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 your enrollment has been approved do not need to be reported unless you are 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 you (see Table A below for list of adverse actions that must be reported).

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

**1.** Have you, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A below imposed against you? ☐ 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 or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.

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.** Do you, 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: |
|---|---|
| | |
| | |

## SECTION 4: CURRENT PRACTICE LOCATION(S)

This section is to be completed with information about your private practice and group affiliations. If you want to make a change to existing information about your group affiliations, you must use the CMS 855R to report those changes.

### A. Group Practice Information

1. Indicate whether **ALL** of your services will be rendered as part of a group or other organization. If "Yes," this means that you do not have a private practice where you treat Medicare patients. This also means that a group(s) or organization(s) will be billing Medicare for the services you render and that you have given the group or organization the authority to bill for you. To reassign your benefits, you must complete and submit a CMS 855R for each group to which your benefits will be reassigned.

   a-c) Provide the legal name and Medicare billing number for up to three groups. If the group's application is pending, indicate "pending" on your application in the space provided for the group's Medicare number. If you belong to more than three groups, copy and complete this section as needed. After completing this section, skip to Section 14.

2. Indicate whether **SOME** of your services will be rendered in a group setting. If not, check the box "No," and continue with Section 4B below. If "Yes," this means that in addition to your private practice you will render some services as part of a group practice, and that you have given the authority to the group to bill for these services.

   a-c) Provide the legal name and Medicare billing number for up to three groups. If the group's application is pending, indicate "pending" on your application in the space provided for the group's Medicare number. If you belong to more than three groups, copy and complete this section as needed. After completing this section, continue completing this application at Section 4B with information about your private practice.

**B. Practice Location Information** - Complete this section for each of your own private practice locations where you render services to Medicare beneficiaries. **The information provided in this section will pertain to your private practice only.** Check the box to indicate if you are adding a new practice location under an existing tax identification number, deleting a practice location, or changing information about an existing practice location. Provided that this is the only change in your information, 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 name of your practice location. If you use a "doing business as" name, provide that name in this section. State the date you started practicing at this location.

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

This address must be a specific street address as recorded by the United States Postal Service. Do not report a P.O. Box. Only report those practice locations within the Medicare carrier jurisdiction where you will be submitting this application, including reporting additions, deletions or other changes to these practice locations. If you render services in a hospital and/or other health care facility that bills Medicare directly for the services you render at that facility, furnish the name and address of that hospital or facility. In addition, provide the telephone number of this practice location. Do not provide a billing agency's telephone number. The fax number and e-mail address are optional.

If you only render services in patients' homes (house calls), you may supply your home address if you do not have an office. In Section 4E, explain that this address is for administrative purposes only and that all services are rendered in patients' homes.

If you render services in a retirement or assisted living community, complete this section with the names, telephone numbers and addresses of those communities.

3. Indicate whether you own/lease the practice location.

4. Indicate whether this address is that of a private practice office setting, hospital, retirement/assisted living community or other health care facility. Please specify if it does not fall within one of these categories.

5. If you have a CLIA number(s) and/or FDA/Radiology (Mammography) Certification Number(s) for this practice location, provide that information in this section. Submit a copy of the most current CLIA and FDA certification for each of the practice locations reported.

## 4. Current Practice Location(s)

This section is to be completed with information about where you currently render medical services to Medicare patients. You must complete this entire section beginning with Section 4A1 and carefully follow all instructions in each part. If you need additional space to report additional groups/organizations or if you have more than one private practice location, copy and complete this section as needed for each.

### A. Group Practice Information

Beginning with Section 4A1, answer "**Yes**" or "**No**" to each question. When applicable, furnish the group/organization name and Medicare number for each group/organization to which you will reassign your benefits. In addition to identifying the group/organization to which you will reassign your benefits in this section, either you or each group/organization reported in this section must also complete and submit a CMS 855R (Individual Reassignment of Benefits) with this application. Reassigning benefits means that you are authorizing the group/organization to bill Medicare for the services you have rendered in the group/organization practice location.

**1.** Will **all** of your services be rendered as part of a group(s) or organization(s) to which you will reassign your benefits? ☐ YES ☐ NO
**IF YES,** furnish the name and Medicare identification number of each group or organization below and skip to Section 14 (Penalties for Falsifying Information on this Enrollment Application).
**IF NO,** proceed to Question 2 below.

| | |
|---|---|
| **a)** Name of Group/Organization | Group/Organization Medicare Number |
| **b)** Name of Group/Organization | Group/Organization Medicare Number |
| **c)** Name of Group/Organization | Group/Organization Medicare Number |

**2.** Will **any** of your services be rendered as part of a group(s) or organization(s) to which you will reassign your benefits? ☐ YES ☐ NO
**IF YES,** furnish the name and Medicare identification number of each group or organization below and continue completing the rest of this application at Section 4B.
**IF NO,** continue with Section 4B below with information about your private practice.

| | |
|---|---|
| **a)** Name of Group/Organization | Group/Organization Medicare Number |
| **b)** Name of Group/Organization | Group/Organization Medicare Number |
| **c)** Name of Group/Organization | Group/Organization Medicare Number |

### B. Practice Location Information ☐ Add ☐ Delete ☐ Change Effective Date:_____

| | | | |
|---|---|---|---|
| **1.** Practice Location Name | | | Date you started practicing at this location (MM/YYYY) |
| **2.** Practice Location Street Address Line 1 | | | |
| Practice Location Street Address Line 2 | | | |
| City | County/Parish | State | ZIP Code + 4 |
| Telephone Number ( ) | (Ext.) ( ) | Fax Number (if applicable) ( ) | E-mail Address (if applicable) |

**3.** Do you own/lease this practice location? ☐YES ☐ NO

**4.** Is this practice location a:
- private practice office setting? ☐YES ☐ NO
- hospital? ☐YES ☐ NO
- retirement/assisted living community? ☐YES ☐ NO
- other health care facility? (Specify):_____ ☐YES ☐ NO

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

**C. Medicare Payment "Pay To" Address Information** - Check the box "Change" only if you are reporting a change to existing information in this section. Provided that this is the only change in your information, furnish the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

If you are enrolling for the first time, state where you want your Medicare payments to be sent. The ability to establish more than one "Pay-To"-address will be addressed by the local Medicare carrier. Therefore, if you want to establish multiple "Pay-To"-addresses you need to contact the carrier. Some Medicare carriers do not allow multiple payment addresses.

- Provide the P.O. Box or street address, city, State and ZIP Code for your payment address.

If you would like your payments to be deposited to your bank account electronically, place a check in the box given and complete the "Medicare Authorization Agreement for Electronic Funds Transfers" (Form HCFA-588). Payment will be made in your name as shown in Section 2A1 or your legal business name as shown in Section 2D2.

- If payment is being paid by electronic funds transfer (EFT), the "Pay To" address should indicate where you want all other payment information, (e.g., remittance notices, special payments, etc.) sent.

**D. Location of Patients' Medical Records** - Check the box "Change" only if you are reporting a change to existing information in this section. Provided that this is the only change in your information, provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. If all of your patients' medical records are located at the practice location in Section 4B, check the box provided and skip this section.

2. If any of your patients' medical records are stored in a location other than the practice location in Section 4B, complete this section with the complete address of all storage locations.

Post Office boxes and drop boxes are not acceptable as physical addresses where patients' medical records are maintained.

**E. Comments** – This section is to be used as an opportunity to explain any unusual circumstances concerning your practice location, "Pay To" address, the location of your patients' medical records, or how they are maintained and/or stored.

## 4. Current Practice Location (Continued)

**C. Medicare Payment "Pay To" Address Information** ☐ **Change** **Effective Date:**_____

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

"Pay To" Address Line 1

"Pay To" Address Line 2

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

**Check here ☐ and submit a completed Form HCFA-588 with this application if you would like to have your payments electronically transferred to your bank account.**

**D. Location of Patients' Medical Records** ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

**1.** Check here ☐ if **all** of your patients' medical records are stored in the practice location(s) shown in Section 4B, and skip this section.

**2.** If **any** of your patients' medical records are stored in a location other than the practice location(s) shown in Section 4B, complete this section for each additional storage location.

Name of Storage Facility/Location

Street Address Line 1

Street Address Line 2

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

**E. Comments**

Explain any unique or unusual circumstances concerning your practice location(s) or the method by which you render health care services (e.g., you only render services in patients' homes (house calls only)).

## SECTION 5: MANAGING CONTROL INFORMATION (ORGANIZATIONS)

This section is to be completed with information about any organization that manages your practice. See explanation below of organizations that should be reported in this section. If individuals, and not organizations, manage your practice, do not complete this section. These individuals must be reported in Section 6. If there are more than three organizations, copy and complete this section as needed.

A managing organization is defined as any organization that exercises operational or managerial control over the practitioner's practice/business, or conducts the day-to-day operations of the practitioner's practice/business. This could be a management services organization, either under contract or through some other arrangement with the practitioner to furnish management services for any of his/her practice/business location(s).

In most situations when you use a management services organization, the organization would be reported in this section and the individual person from the organization who works in your office, or handles the management or administrative duties from outside your office, would be reported in Section 6.

**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. 1st Organization with Managing Control - Identification Information** – Indicate if you are adding or deleting a managing organization, or changing information about an existing managing organization. Provide the new information and the effective date of the change. Provided that this is the only change in your information, you need to sign and date the certification statement. Otherwise:

1. Provide the legal business name and effective date of managing control.

2. Provide the managing organization's "doing business as" name (if applicable) and its tax identification number.

3. Provide the managing organization's business street address and its Medicare identification number (if applicable).

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

**C.-D. 2nd and 3rd Organization with Managing Control - Identification Information** - Sections 5C and 5D may be used to provide information about additional managing organizations. Follow the instructions in Section 5B.

## 5. Managing Control Information (Organizations)

This section is to be completed with information about all organizations that manage the day-to-day operations of the enrolling practitioner's practice. See instructions for an explanation of organizations that should be reported here. If there are more than three management organizations, copy and complete this section as needed.

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

**B. 1st Organization with Managing Control—Identification Information**

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

| | | |
|---|---|---|
| **1.** Legal Business Name as Reported to the IRS | | Effective Date of Managing Control (MM/DD/YYYY) |
| **2.** "Doing Business As" Name (if applicable) | | Tax Identification Number |
| **3.** Business Address Line 1 | | Medicare Identification Number(s) (if applicable) |
| Business Address Line 2 | | |
| City | State | ZIP Code + 4 |

**C. 2nd Organization with Managing Control—Identification Information**

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

| | | |
|---|---|---|
| **1.** Legal Business Name as Reported to the IRS | | Effective Date of Managing Control (MM/DD/YYYY) |
| **2.** "Doing Business As" Name (if applicable) | | Tax Identification Number |
| **3.** Business Address Line 1 | | Medicare Identification Number(s) (if applicable) |
| Business Address Line 2 | | |
| City | State | ZIP Code + 4 |

**D. 3rd Organization with Managing Control—Identification Information**

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

| | | |
|---|---|---|
| **1.** Legal Business Name as Reported to the IRS | | Effective Date of Managing Control (MM/DD/YYYY) |
| **2.** "Doing Business As" Name (if applicable) | | Tax Identification Number |
| **3.** Business Address Line 1 | | Medicare Identification Number(s) (if applicable) |
| Business Address Line 2 | | |
| City | State | ZIP Code + 4 |

## SECTION 6: MANAGING EMPLOYEE INFORMATION

This information is necessary to ensure that any managing employees you have hired, or managing individuals working at any of your practice locations, meet all the conditions of participation in the Medicare program.

A managing employee is defined as any individual (other than yourself), including a general manager, business manager, office manager or administrator, who exercises operational or managerial control over your practice/business, or who conducts the day-to-day operations of your practice/business. For Medicare enrollment purposes, a managing employee also includes any individual that manages your day-to-day operations, either under contract or through some other arrangement, but who is not your actual employee.

All managing employees at any of your practice locations shown in Section 4B must be reported in this section. Do not report individuals employed by hospitals, health care facilities or other organizations shown in Section 4B, or managing employees of any group or organization to which you reassign your benefits. For instance, the CEO of a hospital where one of your practice locations is situated should not be reported.

If you have more than two managing employees, copy and complete this section as needed.

**A. Check Box** - If you do not have a managing employee who meets the above definition, check the box provided and skip this section. Otherwise, provide information about all managing employees.

**B. Identifying Information** - Indicate whether you are adding or deleting a managing employee, or changing information about an existing managing employee. Provide the new information and the effective date of the change. Provided that this is the only change in your information, you need to sign and date the certification statement. Otherwise:

1. Provide the full name of the managing employee.

2. Provide the managing employee's social security number as required by Sections 1124 and 1124A of the Social Security Act, and furnish his/her date of birth and Medicare identification number (if applicable).

3. Indicate if this managing employee is actually employed by you (on your payroll as a W-2 employee).

**C. Adverse Legal History**

This section must be completed for all managing employees who are actually employed by you.

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

2. If the answer to this question is "Yes," supply all requested information. Attach a 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 you are uncertain as to whether the managing employee falls within one of the adverse legal action categories, you should review the Healthcare Integrity and Protection Data Bank. If you need information on how to access the data bank, call 1-800-767-6732 or visit www.npdb-hipdb.com.

**D-E. Identifying Information/Adverse Legal History** - Section 6D and 6E are additional sections to provide information about a second managing employee. Follow the instructions in Sections 6B and 6C above.

## SECTION 7: CHAIN HOME OFFICE INFORMATION

This section has been omitted.

## 6. Managing Employee Information

This section is to be completed with personal identification information (including adverse legal history) about all managing employees. See instructions for the definition of managing employee(s) to determine who should be reported here. If there are more than two managing employees, copy and complete this section as needed.

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

**B. Identifying Information** ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

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

| **2.** Social Security Number | Date of Birth (MM/DD/YYYY) | Medicare Identification Number (if applicable) |
|---|---|---|
| | | |

**3.** Is the above individual your own employee? ☐ YES ☐ NO

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

Complete this section only if the above individual is your own employee.

**1.** Has the employee reported in Section 6B 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: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**D. Identifying Information** ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

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

| **2.** Social Security Number | Date of Birth (MM/DD/YYYY) | Medicare Identification Number (if applicable) |
|---|---|---|
| | | |

**3.** Is the above individual your own employee? ☐ YES ☐ NO

**E. Adverse Legal History** ☐ **Change** **Effective Date:**_____

Complete this section only if the above individual is your own employee.

**1.** Has the employee reported in Section 6D 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: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## 7. Chain Home Office Information — This Section Not Applicable

## 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. A billing agency is a company or individual you hired or contracted with to furnish claims processing functions for your practice. Any entity that meets this description must be reported in this section. If you have an agreement with a billing agency and that company has a subcontract with a clearinghouse for electronic claims submission, you must report the clearinghouse in Section 9, with a copy of the electronic data interchange agreement submitted with this application.

**A. Check Box -** If you do not have a billing agency, check the box and skip to Section 9.

**B. Billing Agency Name and Address -** Indicate if you are adding or deleting a billing agent and/or making a change concerning your existing relationship with your billing agency. Provide the new information and the effective date of the change. Provided that this is the only change you are making, you will need to sign and date the certification statement. Otherwise, if you use a billing agency:

1. Provide the billing agency's legal business name and tax identification number.

2. If the billing agency has a "doing business as" name, provide that information in this space.

3. Provide the street address, telephone number, fax number and e-mail address of the billing agency.

**C. Billing Agreement/Contract Information**

You are responsible for answering the questions listed. These questions are designed to show that you fully understand and comprehend your billing agreement and that you intend to adhere to all Medicare laws, regulations, and program instructions. If you do not understand a question or you need help in interpreting your agreement, contact the Medicare carrier. At any time, the carrier may request copies of all agreements/contracts associated with this billing agency.

## 8. Billing Agency

This section is to be completed if you use or contract with a billing agency to submit claims to Medicare on your behalf. If you use more than one billing agency, copy and complete this section for each. You may be required to submit a copy of your current signed billing agreement/contract if Medicare cannot verify the information furnished 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.)<br>( ) ( ) | Fax Number (optional)<br>( ) | E-mail Address (optional) |

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

Answer the following questions about your agreement/contract with the above billing agency.

**1.** Do you have unrestricted access to your Medicare remittance notices? ☐ YES ☐ NO

**2.** Does your Medicare payment go directly to you? ☐ YES ☐ NO
**IF NO**, proceed to Question 3.
**IF YES**, skip Questions 3, 4 and 5.

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

**4.** Does your Medicare payment go directly to your billing agent? ☐ YES ☐ NO
**IF NO**, proceed to Question 5.
**IF YES**, answer the following question and skip Question 5.
a) Does the billing agent cash your check? ☐ YES ☐ NO
**IF NO**, proceed to Question b.
**IF YES**, are <u>all</u> of the following conditions included in the billing agreement?
1) The agent receives payment under an agency agreement with you.
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 you may modify or revoke at any time.
5) In receiving payment, the agent acts only on your behalf (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 you or deposit the payment into your bank account? ☐ YES ☐ NO

**5.** Who receives your Medicare payment?_____

## SECTION 9: ELECTRONIC CLAIMS SUBMISSION INFORMATION

This section is to be completed with information about any clearinghouse(s) that you use for electronic claims submission services, or if your billing agency or management services organization has a subcontract with a clearinghouse to submit your claims electronically. A copy of all **EDI** agreements between the clearinghouse(s) and the carrier(s) **must** be submitted with this application.

If you would like to submit claims electronically once you are enrolled in the Medicare program, you will need to complete an Electronic Data Interchange (EDI) agreement with your local Medicare carrier. These agreements cannot be established until the enrollment process has been completed and a Medicare billing number issued to you.

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

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

**A.** **Check Box** - Indicate if you or your billing agent does not use a clearinghouse. If checked, skip to Section 10.

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

**C.** **Clearinghouse Name and Address** - Indicate if you (or your billing agent) is adding or deleting a clearinghouse and/or making a change concerning your existing relationship with a clearinghouse. 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 clearinghouse.
2. If the clearinghouse uses a "doing business as" (DBA) name with you, furnish that information in this space. If the clearinghouse has more than one DBA name with you, report all that apply for Medicare claims.
3. Furnish the complete mailing address, telephone number, fax number and e-mail address for the clearinghouse.

**NOTE:** If you use a clearinghouse and a copy of the EDI agreement has not been prepared and submitted, contact the carrier to start this process.

## 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 you have an agreement/contract with a staffing company to furnish services to Medicare beneficiaries, complete this section. At any time, the carrier can request a copy of the agreement/contract signed by you and the staffing company.

**A.** **Check Box** - If you do not work for (or do not contract with) a staffing company, check this box and skip to Section 13.

**B.** **Staffing Company Name and Address** - Indicate if you are "adding," "deleting," or "making a change," concerning your relationship with an existing staffing company by checking the appropriate box. 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 you, 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**

Respond to the questions asked in this section to indicate that you fully understand and comprehend your contract with the staffing company and that you plan to adhere to all Medicare laws, regulations, and program instructions. At any time, the carrier can request a copy of the agreement/contract signed by you and the staffing company.

## 9. Electronic Claims Submission Information

This section is to be completed with information about any company (clearinghouse) you use or contract with for electronic claims submission services. See the instructions to determine when and how this section is to be completed. If you submit (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 your electronic data interchange (EDI) agreement if one has been established or check the box in Section 9B to start the EDI agreement process. If you use more than one clearinghouse, copy and complete this section for each. **A copy of all currently established EDI agreements 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.)<br>( ) ( ) | Fax Number (optional)<br>( ) | E-mail Address (optional) |

## 10. Staffing Company

This section is to be completed if you are employed by, or under contract to render medical services with, a company that staffs health care organizations (e.g., hospital emergency rooms) with medical professionals to treat patients. If you are employed by or under contract with more than one staffing company, copy and complete this section for each. You may be required to submit a copy of your current signed staffing company agreement/contract.

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

**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.)<br>( ) ( ) | Fax Number (optional)<br>( ) | E-mail Address (optional) |

**C. Staffing Company Contract/Agreement Information**

Answer the following questions about the staffing company and your contract/agreement with it.

**1.** If you have a contract/agreement with both a billing agency and a staffing company, does the staffing company shown in Section 10B **and** the billing agency identified in Section 8B have a common owner(s)? ☐ Not applicable ☐ YES ☐ NO

**2.** If you have a contract/agreement with both a billing agency and a staffing company (even if the billing agency and staffing company are the same), are there any provisions in your staffing company contract/agreement that supersede or contradict your billing agreement? ☐ Not applicable ☐ YES ☐ NO

## SECTION 11 SURETY BOND INFORMATION

This section has been omitted.

## SECTION 12 CAPITALIZATION REQUIREMENTS FOR HOME HEALTH AGENCIES

This section has been omitted.

## SECTION 13: CONTACT PERSON(S) - OPTIONAL

To assist in the timely processing of your application, you may want to provide the full name and telephone number of one or two individuals who can be reached to answer questions regarding the information furnished in this application. You are 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 you.

**A. Check Box -** If you do not have a contact person, check this box and skip to Section 14.

**B. 1st Contact Name and Telephone Number -** Indicate if you are completing this section to add or delete a contact person(s) currently on file. State the effective date for the change. If you are changing existing information, check the applicable box and provide the effective date of the change, and sign and date the certification statement. Otherwise:

- Furnish 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

This section explains the penalties for deliberately furnishing false information to acquire or maintain enrollment in the Medicare program. You should review this section to ensure that you understand those penalties that can be applied against you for deliberately furnishing false information in this Medicare enrollment application.

## 11. Surety Bond Information — This Section Not Applicable

## 12. Capitalization Requirements for Home Health Agencies — This Section Not Applicable

## 13. Contact Person(s)

This section is to be completed with the name(s) and telephone number(s) of a person(s), other than yourself, who can answer questions about the information furnished in this application. You do not need to furnish any names if you want all questions directed to you.

**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.

## SECTION 15: CERTIFICATION STATEMENT

As an individual practitioner, you are the only person who can sign this application. This applies not only to initial enrollment and revalidation, but also to any changes and/or updates (e.g., new practice locations, change in specialties, address changes, etc.) to your status in the Medicare program. The authority to sign the application on your behalf may not be delegated to any other person.

The Certification Statement contains certain standards that must be met for initial and continuous enrollment in the Medicare program. Review these requirements carefully.

By signing the Certification Statement, you agree to adhere to all of the requirements listed therein and acknowledge that you may be denied entry to or revoked from the Medicare program if any requirements are not met. **Your signature must be an original.** Faxed, photocopied, or stamped signatures will not be accepted.

## SECTION 16: DELEGATED OFFICIAL

This section has been omitted.

## 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:** Any licenses (business and professional) that are required by the State where your practice is located **must** be included with this application.

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

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

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

## 15. Certification Statement

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

**I, the undersigned, certify to the following:**

1.) I have read the contents of this application, and the information contained herein is true, correct, and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare program contractor of this fact immediately.

2.) I authorize the Medicare contractor to verify the information contained herein. I agree to notify the Medicare contractor of any future changes to the information contained in this form within 90 days of the effective date of the change. I understand that any change in my status as an individual practitioner may require the submission of a new application.

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

4.) I agree to abide by the Medicare laws, regulations and program instructions that apply to me. 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 my compliance with any applicable conditions of participation in Medicare.

5.) Neither I, nor any W-2 managing employee, 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.

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

7.) I understand that the Medicare billing number issued to me can only be used by me or by a provider or supplier to whom I have reassigned my benefits under current Medicare regulations, when billing for services rendered by me.

8.) 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.

9.) I further certify that I am the individual practitioner who is applying for Medicare billing privileges.

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

## 16. Delegated Official — This Section Not Applicable

## 17. Attachments

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

Place a check next to each document (as applicable or required) that you are including 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 professional school degrees or certificates or evidence of qualifying course work
- ☐ Copy(s) of all CLIA Certificates, FDA Mammography Certificates, and Diabetes Education Certificates
- ☐ Copy(s) of all controlled substance registration certificates from the Federal Drug Enforcement Agency
- ☐ Copy(s) of all adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters)
- ☐ Copy(s) of all current electronic data interchange (EDI) agreements
- ☐ Completed Form HCFA-460 – Medicare Participating Physician or Supplier Agreement
- ☐ Completed Form HCFA-588 - Authorization Agreement for Electronic Funds Transfer
- ☐ Completed Form CMS 855R – Individual Reassignment of Benefits
- ☐ IRS documentation confirming the Tax Identification Number with the Legal Business Name (e.g., CP 575)
- ☐ Any additional documentation or letters of explanation as needed