MEDICARE

FEDERAL HEALTH CARE
PROVIDER/SUPPLIER ENROLLMENT APPLICATION

Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

Keep a copy of this complete package for your own records

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

National Supplier Clearinghouse
Post Office Box 100142
Columbia, South Carolina 29202-3142

OMB Approval No. 0938-0685

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M EDICARE & MEDICAID
S ERVICES

Medicare Provider/Supplier Enrollment Application

Privacy Act Statement

The Centers for Medicare & Medicaid Services (CMS) is authorized to collect the information requested on this form by sections 1124(a)(1), 1124A(a)(3), 1128, 1814, 1815, 1833(e), and 1842(r) of the Social Security Act [42 U.S.C. §§ 1320a-3(a)(1), 1320a-7, 1395f, 1395g, 1395l(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 (OMB) approval 0938-0684 (R-187). The information in this application will be disclosed according to the routine uses described below.

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

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

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

Protection of Proprietary Information

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

Protection of Confidential Commercial and/or Sensitive Personal Information

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

INSTRUCTIONS FOR APPLICATION FOR DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS) SUPPLIERS

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 the application to be returned and may delay the enrollment process. Certain sections of the application have been omitted because they do not apply to DMEPOS suppliers. See inside front cover for mailing instructions. Electronic copies of all CMS Medicare enrollment forms can be found at the Medicare web-site at (http://www.hcfa.gov/medicare/enrollment/forms/). These electronic forms may be downloaded to your computer, completed on screen, printed, signed, and mailed to the appropriate Medicare contractor.

Whenever additional information needs to be reported within a section, copy and complete that section for each additional entry. We strongly suggest that the DMEPOS supplier keep, for future reference, a photocopy of its completed application and supporting documents.

This application is to be completed by DMEPOS suppliers that will bill Medicare carriers for Durable Medical Equipment, Prosthetics, Orthotics, or Supplies (DMEPOS) provided to Medicare beneficiaries. Failure to promptly submit a completed CMS 855S to the National Supplier Clearinghouse will result in delays in obtaining enrollment and billing privileges.

DEFINITIONS OF MEDICARE ENROLLMENT TERMINOLOGY

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

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

Billing Agency-A Company that the enrolling supplier contracts with to furnish claims processing functions for the supplier.

Business Location-This is the physical structure from which the enrolling supplier conducts its business operations.

Carrier-The Part B Medicare claims processing contractor.

Delegated Official-Any individual who has been delegated, by the supplier's "Authorized Official," the authority to report changes and updates to the supplier's enrollment record. A delegated official **must** be a managing employee (W-2) of the DMEPOS supplier or have a 5% ownership interest, or any partnership interest, in the DMEPOS supplier.

DMEPOS-Durable Medical Equipment, Prosthetics, Orthotics, and Supplies.

DMEPOS Supplier-A business or individual that furnishes Durable Medical Equipment, Prosthetics, Orthotics, or Supplies.

Enrolling Supplier-The enrolling supplier is the business location from where DMEPOS items are furnished. All sections of this application must be completed with information related to the "Business Location" reported in Section 4A.

Fiscal Intermediary-The Part A Medicare claims processing contractor.

Legal Business Name-The name that is reported to the Internal Revenue Service (IRS) for tax reporting purposes.

Medicare Identification Number-This is a generic term for any number that uniquely identifies the enrolling supplier. 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).

National Supplier Clearinghouse (NSC)-The DMEPOS Medicare enrollment contractor.

Provider-A provider is a hospital, critical access hospital, skilled nursing facility, nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice, that has in effect an agreement to participate in Medicare; or a rural health clinic (RHC), Federally qualified health center (FQHC), rehabilitation agency, or public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech pathology services; or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services. A provider is not synonymous with the corporation or other legal entity that owns or operates the provider. The "provider" is the CMS recognized provider type listed above. Therefore, an owning or operating entity may own or operate many providers.

Provider Identification Number (PIN)-This number is assigned to providers, suppliers, groups and organizations in Medicare Part B. This number will identify who provided the service to the beneficiary on the Medicare claim form.

Supplier-A physician or other practitioner, or an organization other than a provider that furnishes health care services under Medicare Part B. The term supplier also includes independent laboratories, portable x-ray services, physical therapists in private practice, end stage renal disease (ESRD) facilities, and chiropractors. For enrollment purposes, suppliers who submit claims for durable medical equipment, prosthetics, orthotics, or supplies (DMEPOS) must complete the CMS 855S.

Tax Identification Number (TIN)-The number issued by the IRS and used to report tax information to the IRS.

SECTION 1: GENERAL APPLICATION INFORMATION

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

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

1. Select one of the following:

Initial Enrollment of a New DMEPOS Supplier:
- If the supplier is enrolling in the Medicare program for the first time as a DMEPOS supplier.

Re-enrollment:
- If the supplier is currently enrolled in the program and has been asked to verify and update the enrollment information currently on file, and to attest that it is still eligible to receive Medicare payments.

Reactivation:
- If the supplier's Medicare billing number was deactivated because of non-billing.

Billing privileges may be deactivated when no claims are submitted in a one-year period. To reactivate billing privileges, the supplier may be required to either submit an updated CMS 855S or certify to the accuracy of its enrollment information currently on file with CMS. In addition, prior to being reactivated, the supplier must be able to submit a valid claim. The supplier must also meet all current Medicare requirements as a DMEPOS supplier regardless of whether it was previously enrolled in the program.

Enrollment of a New Location for a Currently Enrolled DMEPOS Supplier:
- If the supplier is currently enrolled in the program and is applying to enroll a new business location.

Change of Information:
- If the supplier is adding, deleting, or changing existing information under this tax identification number.

If an existing supplier changes its name/owner/address, etc., the supplier must annotate the change by checking the section(s) where the change is going to be made, completing the appropriate section(s), and signing and dating the certification statement. For example, if an existing supplier is moving to a new location and has previously completed an application, the supplier completes Sections 1, 4, and 15. The supplier does not complete a full application. When reporting a change of information, always complete Section 1 to identify the supplier and provide the new/changed information in the section checked, and sign and date the certification statement (Section 15). **All changes must be reported to the NSC within 90 days of the effective date of the change.**

Voluntary Termination of Billing Number:
- If the supplier will no longer be submitting claims to the Medicare program using this billing number.

Voluntary termination ensures that the supplier's billing number will not be fraudulently used if the supplier ceases its Medicare operations. Provide the date operations ceased or the date the supplier will stop billing for Medicare covered services. In addition, complete Section 1 to identify the supplier and sign and date the certification statement (Section 15).

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

2. This section identifies the State where the supplier's business location is located. Please indicate the two-letter state code for the State where the supplier's business is located (for example, "SC" for "South Carolina").

3. Supplier numbers can be used nationally when filing claims; however, the supplier is required to indicate the region where the majority of claims for this location will be submitted. Claims are submitted based on where the Medicare beneficiary resides. See list below to determine the appropriate box(es) to check.

   - **Region A** - Delaware, Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont
   - **Region B** - District of Columbia, Illinois, Indiana, Maryland, Michigan, Minnesota, Ohio, West Virginia, Wisconsin, Virginia
   - **Region C** - Alabama, Arkansas, Colorado, Florida, Georgia, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, Virgin Islands
   - **Region D** - Alaska, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming

4. Indicate whether the supplier is currently enrolled in another part of the Medicare program (e.g., as a home health agency). If "Yes," provide the name of the Medicare contractor to which it submits claims in this space and its Medicare identification number. Report all currently active Medicare numbers. This is the number used to identify the supplier and is used on claims forms. This number may be referred to as a Medicare provider number, provider identification number, or National Supplier Clearinghouse number. Report all numbers that have been issued to this supplier.

If the supplier does not currently have a Medicare identification number, it will be assigned one upon the successful completion of its enrollment. The supplier will receive information about what number(s) has been issued and how it is to be used.

NOTE: To reduce the burden of furnishing some types of supporting documentation, we have designated specific types of documentation to be furnished on an "as needed" basis. However, the carrier may request, at any time during the enrollment or re-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, articles of incorporation, and partnership agreements.

MEDICARE FEDERAL HEALTH CARE PROVIDER/SUPPLIER ENROLLMENT APPLICATION

Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers

General Instructions

The Medicare Federal Health Care Provider/Supplier Enrollment Application has been designed by the Centers for Medicare & Medicaid Services (CMS) to assist in the administration of the Medicare program and to ensure that the Medicare program is in compliance with all regulatory requirements. The information collected in this application will be used to ensure that payments made from the Medicare trust fund are paid only to qualified DMEPOS suppliers, and that the amounts of the payments are correct. This information will also identify whether the DMEPOS supplier is qualified to furnish health care items to Medicare beneficiaries. To accomplish this, Medicare must know basic identifying and qualifying information about the DMEPOS supplier that is seeking billing privileges in the Medicare program.

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

This application **MUST** be completed in its entirety, unless the appropriate box is checked to indicate the section does not apply or when reporting a change to previously submitted information. If a section does not apply to this DMEPOS supplier, check (√) the appropriate box in that section and skip to the next section. Sections 7, 10, and 12 have been deliberately omitted from this application because they are not applicable to the enrollment of DMEPOS suppliers that bill Medicare carriers.

1. General Application Information

A. Reason for Submittal of this Application

This section is to be completed with general information as to why this application is being submitted and whether this supplier currently has 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.

1. Check one:

- ☐ Initial Enrollment of a New DMEPOS Supplier
- ☐ Re-enrollment ☐ Reactivation
- ☐ Enrollment of a New Location for a Currently Enrolled DMEPOS Supplier
- ☐ Change of Information (including Ownership) - (Check appropriate Section(s) below and furnish this supplier's Medicare NSC Identification Number here):______________________________
  ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 8 ☐ 9 ☐ 11 ☐ 13 ☐ 15 ☐ 16
- ☐ Voluntary Termination of Billing Number - Effective Date (MM/DD/YYYY):_________________

2. Please indicate the two-letter state code for the state where the enrolling business location is located for this DMEPOS supplier.

_______ ______ (Example: S C for South Carolina)

3. To which region(s) will this supplier submit the majority of claims for this location?
☐ Region A ☐ Region B ☐ Region C ☐ Region D ☐ All Regions

4. Is this supplier currently enrolled in the Medicare program other than as a DMEPOS supplier? ☐ YES ☐ NO
IF YES, furnish the following information about the current enrollment:

Medicare Contractor Name:________________________ Medicare Identification Number:____________________

SECTION 2: SUPPLIER IDENTIFICATION

A. Supplier IRS Identification Information - This section is to be completed with information specifically related to the business location of the DMEPOS supplier submitting this application.

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

1. Provide the legal business name as reported to the Internal Revenue Service (IRS), and the tax identification number (TIN) issued by the IRS to this supplier business location or the TIN used by this business location for tax reporting purposes.

Attach documentation (e.g., a copy of the IRS CP-575) from the IRS showing that the name matches that reported in this application. If the supplier does not have an IRS CP-575, any official correspondence from the IRS that shows the supplier's name and TIN will be acceptable proof.

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

2. Furnish the address where the IRS Form 1099 is to be mailed for this supplier.

B. Type of Business for this Supplier – Indicate the type of business operated by the supplier at this location.

1. Check all items that apply to the business location for which this application is being submitted.
2. Indicate the primary type of business conducted at the business location for which this application is being submitted.

NOTE: Copies of all Federal, State and local (city/county) professional and business licenses, certifications and/or registrations required to practice as a DMEPOS supplier in the enrolling supplier's State (e.g., Federal Drug Enforcement Agency (DEA) number for pharmacies, business occupancy license, local business license), must be submitted with this application.

C. Products and Services to be Furnished by this Supplier – Provide the types of DMEPOS products and services supplied from this business location.

1. If this supplier is a physician, check the box provided and skip this section.
2. Indicate all primary products and services furnished by this supplier from this business location by placing a "P" in the appropriate box **and** indicate all secondary products and services furnished by this supplier from this business location by placing a "S" in the appropriate box.

NOTE: If "Parenteral Nutrition" and/or "Drugs/Pharmaceuticals" have been checked, a copy of the supplier's State pharmacy license **must** be submitted with this application.

D. Liability Insurance Information – All DMEPOS suppliers enrolling in Medicare must have liability insurance. Furnish the requested information about the insurance company and submit a copy(s) of the supplier's current liability insurance policy with this application.

2. Supplier Identification

This section is to be completed with information specifically related to the business location of the supplier submitting this application. Furnish the following information: the supplier's legal business name and address as reported to the IRS for issuance of IRS Form 1099, the type of business this supplier operates as, the type(s) of products and services this supplier will furnish, and information about the supplier's liability insurance.

A. Supplier IRS Identification Information ☐ Change Effective Date:____________________

Furnish the supplier's legal business name (as reported to the IRS). A copy of the IRS CP-575 or other correspondence issued by the IRS showing the TIN for this business **MUST** be submitted.

1. Legal Business Name as Reported to the IRS		Tax ID Number
2. 1099 Mailing Address Line 1		Former Tax ID Number (if changed)
1099 Mailing Address Line 2		
1099 Mailing Address City	1099 Mailing Address State	1099 Mailing Address ZIP Code + 4

B. Type of Business for this Supplier

The supplier must meet all Medicare requirements for a DMEPOS supplier. Submit copies of all required licenses, certifications, and registrations with this application.

1. Type of Supplier (Check all that apply):

- ☐ Medical Supply Company
- ☐ Medical Supply Company with Registered Pharmacist
- ☐ Medical Supply Company with Respiratory Therapist
- ☐ Medical Supply Company with Orthotics Personnel
- ☐ Medical Supply Company with Prosthetics Personnel
- ☐ Orthotics Personnel
- ☐ Prosthetics Personnel
- ☐ Medicare + Choice Organization
- ☐ Other Managed Care Organization
- ☐ Optician
- ☐ Optometrist
- ☐ Home Health Agency
- ☐ Skilled Nursing Facility
- ☐ Intermediate Care Nursing Facility
- ☐ Nursing Facility (Other)
- ☐ Pharmacy
- ☐ Grocery Store
- ☐ Department Store
- ☐ Occupational Therapist/Physical Therapist
- ☐ Physician
- ☐ Hospital

2. Which of the above is the primary type of business for the business location of the enrolling supplier?

C. Products and Services to be Furnished by this Supplier

1. If this supplier is a physician, check here ☐ and skip this section.

2. Indicate all primary products and services furnished by this supplier by placing a "P" in the appropriate box **and** indicate all secondary products and services furnished by this supplier by placing a "S" in the appropriate box.

- ☐ Enteral Nutrition
- ☐ Durable Medical Equipment
- ☐ Prosthetics
- ☐ Orthotics
- ☐ Optician
- ☐ Other
- ☐ Oxygen
- ☐ Dialysis Equipment and Supplies
- ☐ Diabetic Equipment and Supplies
- ☐ Parenteral Nutrition
- ☐ Drugs/Pharmaceuticals
- ☐ Diabetic Footwear

D. Liability Insurance Information

Note: All DMEPOS suppliers must submit a copy of their liability insurance policy or evidence of self-insurance with this application.

Name of Insurance Company			
Insurance Policy Number	Date Policy Issued (MM/DD/YYYY)	Expiration Date of Policy (MM/DD/YYYY)	
Insurance Agent's Name: First	Middle	Last	Jr., Sr., etc.
Agent's Telephone Number (Ext.) ( ) ( )	Agent's Fax Number (Ext.) ( )	E-mail Address (if applicable)	

SECTION 3: ADVERSE LEGAL ACTIONS AND OVERPAYMENTS

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

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

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

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

If the supplier is uncertain as to whether it falls within one of the adverse legal action categories or whether a name reported on this application has an adverse legal action, query the Healthcare Integrity and Protection Data Bank. If the supplier needs 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 the supplier in violation of these Acts and subject it to possible denial of its Medicare enrollment.

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

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

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

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

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

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

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

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

3. Adverse Legal Actions and Overpayments

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

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

1. Has this supplier, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A below imposed against it? ☐ YES ☐ NO

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

Adverse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
________________	_____________	__________________________	____________________
________________	_____________	__________________________	____________________
________________	_____________	__________________________	____________________

Table A

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

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

3) Any felony 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. Does this supplier, under any current or former name or business identity, have any outstanding Medicare overpayments? ☐ YES ☐ NO

2. **IF YES**, furnish the name and account number under which the overpayment(s) exists.

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

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SECTION 4: CURRENT BUSINESS LOCATION ADDRESS INFORMATION

This section is to be completed with information about the business location for which this application is being submitted. The supplier must also furnish a mailing address for receiving correspondence from Medicare, an address where payments are to be sent, and an address where patients' records are stored for this location.

A. Business Location Address Information – This must be the actual address where the supplier's business is physically located. It must be the address and telephone number where patients can contact the supplier directly.

NOTE: A separate application must be submitted for each business location that conducts business with the public and intends to bill Medicare for the items sold to the public. Locations that serve only as warehouses or repair facilities should not 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. Furnish the "doing business as" (DBA) name if different from the legal business name reported in Section 2A for this business location. The "doing business as" name is the name the supplier is generally known by to the public.

2. Provide the street address and telephone number of this business location. A post office box or a drop box address is **not** acceptable as a DMEPOS supplier business location. The address must be the actual physical location of the supplier's business. The telephone number must be where customers can call to ask questions or register complaints.

3. Check the appropriate box to indicate the organizational structure of this supplier. Check "Corporation" if the supplier is such, regardless of whether the supplier is "for-profit" or "non-profit." "Partnership" should be checked for all "General" or "Limited" partnerships. All other suppliers should check "Other," and specify the type of organizational structure (e.g., limited liability company).

4. Provide the date this business location was established to furnish and bill for DMEPOS supplies. This date will assist in establishing the effective date for claims processing. Also, when applicable, furnish the date this business location stopped furnishing DMEPOS supplies.

B. "Mail To" Address – The supplier must provide an address and telephone number where it can be directly contacted by Medicare or the NSC to resolve any enrollment or billing issues. This address will also be used to send the supplier important information concerning the Medicare program that may directly affect its Medicare payments. Therefore, this address cannot be that of the billing agency, management service organization, or staffing company.

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

1. If the "Mail To" address is the same as the "Business" address reported in Section 4A, check the box provided at the top of this section and continue with Section 4C. Otherwise furnish a "Mail To" name for the supplier in Section 4A.

2. Furnish an address, telephone number, fax number and email address where Medicare can directly contact the supplier.

C. "Pay To" Address - The supplier must indicate where its Medicare payments are to be sent. This address may be a post office box or drop box location. If the supplier would like payments to be deposited to its bank account electronically, check the appropriate box to indicate direct deposit and complete and submit the form "Medicare Authorization Agreement for Electronic Funds Transfers" (Form HCFA-588).

Payment will be made in the DMEPOS supplier's "legal business name" as shown in Section 2A1.

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.

If the "Pay To" address is the same as the "Business" address reported in Section 4A, check the box provided at the top of this section and continue with Section 4D. Otherwise:

- Furnish a "Pay To" address where Medicare can send payments.
- If payment is being paid by electronic funds transfer (EFT), the "Pay To" address should indicate where the DMEPOS supplier wants all other payment information, (e.g., remittance notices, special payments, etc.) sent.

D. Location of Patients' Medical Records – All patient medical records must be accessible to Medicare for possible review. This section only needs to be completed if the supplier's patients' medical records are stored in a location other than the business location shown in Section 4A. Post office boxes and drop boxes are not acceptable addresses for the storage of patients' medical records.

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:

If the "Location of Patients' Medical Records" address is the same as the "Business" address reported in Section 4A, check the box provided at the top of this section and continue with Section 5. Otherwise:

- Furnish the address where the supplier maintains its patients' medical records.

4. Current Business Location Address Information

This section is to be completed with information about the business location for which this application is being submitted. Also furnish a mailing address for receiving correspondence from Medicare, an address where payments are to be sent, and an address where patients' records are stored for this location. A separate application must be submitted for each business location that conducts business with the public and intends to bill Medicare for the items sold to the public.

A. Business Location Address Information ☐ **Change** **Effective Date:**______________

This must be the physical address and telephone number of the business location and where patients can contact the supplier directly. The "Doing Business As" name is the name the supplier is generally known by to the public.

1. "Doing Business As" (DBA) Name (if applicable) for the supplier identified in Section 2A		
2. Business Address Line 1		
Business Address Line 2		
Business City	Business State	Business ZIP Code + 4
Telephone Number ( ) (Ext.) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

3. Identify the type of organizational structure for this supplier (Check one):
☐ Corporation ☐ Partnership ☐ Other (Specify):______________________________

4. Date this Business Started at this Location (MM/DD/YYYY)	Date this Business Terminated at this Location (if applicable) (MM/DD/YYYY)

B. "Mail To" Address ☐ **Same as Section 4A** ☐ **Change** **Effective Date:**______________

This must be an address and telephone number where Medicare can <u>contact the supplier directly</u>.

1. "Mail To" Name for the supplier identified in Section 4A above		
2. "Mail To" Address Line 1		
"Mail To" Address Line 2		
"Mail To" City	"Mail To" State	"Mail To" ZIP Code + 4
Telephone Number ( ) (Ext.) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

C. "Pay To" Address ☐ **Same as Section 4A** ☐ **Change** **Effective Date:**______________

Furnish the address where payment should be sent for supplies furnished from the business location in Section 4A above.

"Pay To" Address Line 1		
"Pay To" Address Line 2		
"Pay To" City	"Pay To" State	"Pay To" ZIP Code + 4

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

D. Location of Patients' Medical Records ☐ **Same as Section 4A** ☐ **Change** **Effective Date:**______________

If **<u>any</u>** of the patients' medical records are stored at a location other than the business location shown in Section 4A, complete this section with the name and address of the storage location.

Patient medical record storage location Name		
Patient medical record storage location Address Line 1		
Storage location Address Line 2		
Storage location City	Storage State	Storage ZIP Code + 4

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

This section is to be completed with information about any organization that has 5% or more (direct or indirect) ownership of, any partnership interest in, and/or managing control of the DMEPOS supplier identified in Section 4A. See examples below of organizations that should be reported in this section. If individuals, and not organizations, own or manage the DMEPOS supplier, do not complete this section. These individuals must be reported in Section 6. If there is more than one organization, copy and complete this section for each.

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

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

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

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

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

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

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

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

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

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

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

4. Provide the organization's business street address.

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

EXAMPLES OF 5% OR MORE "DIRECT" OWNERSHIP

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

- The DMEPOS supplier is a pharmacy that is wholly (100%) owned by Company A. As such, the DMEPOS supplier would have to report Company A in this section.

- A medical supply, company operating as a corporation, wants to enroll in Medicare. Company X owns 50% of the corporation's stock. Since Company X obviously owns more than 5% of the business, it must be reported in this application.

In the first example, Company A is considered a direct owner of the pharmacy, in that it actually owns the assets of the business. Similarly, Company X is a direct owner of the medical supply company mentioned in the second example. It has 50% actual ownership of the medical supply company.

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

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

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

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

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

EXAMPLES OF "INDIRECT" OWNERSHIP FOR ENROLLMENT PURPOSES

Example 1 (Ownership)

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

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

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

LEVEL 1

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

LEVEL 2

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

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

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

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

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

LEVEL 3

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

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

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

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

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

Example 2 (Financial Control)

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

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

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

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

MANAGING CONTROL (ORGANIZATIONS)

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

SPECIAL TYPES OF ORGANIZATIONS

Governmental/Tribal Organizations: If a Federal, State, county, city or other level of government, or an Indian tribe, will be legally and financially responsible for Medicare payments received (including any potential overpayments), the name of that government or Indian tribe should be reported as an owner. The DMEPOS supplier must submit a letter on the letterhead of the responsible government (e.g., government agency) or tribal organization, which attests that the government or tribal organization will be legally and financially responsible in the event that there is any outstanding debt owed to CMS. This letter must be signed by an "authorized official" of the government or tribal organization who has the authority to legally and financially bind the government or tribal organization to the laws, regulations, and program instructions of Medicare. See Section 15 for further information on "authorized officials."

Charitable and Religious Organizations: Many non-profit organizations are charitable or religious in nature, and are operated and/or managed by a Board of Trustees or other governing body. The actual name of the Board of Trustees or other governing body should be reported in this section.

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

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

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

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

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

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

This section is to be completed with information about all organizations that have 5% or more (direct or indirect) ownership of, any partnership interest in, and/or managing control of, the supplier identified in Section 4A, as well as any information on adverse legal actions that have been imposed against that organization. See instructions for examples of organizations that should be reported here. If there is more than one organization, copy and complete this section for each.

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

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

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

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

City	State	ZIP Code + 4

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

This section is to be completed only if the organization in Section 5B above is a 5% or greater owner (direct or indirect) of the supplier identified in Section 4A, or has a partnership interest in the supplier identified in Section 4A.

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

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

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

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

This section is to be completed with information about any individual that has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the DMEPOS supplier identified in Section 4A. In addition, all officers, directors, and managing employees of the DMEPOS supplier must be reported in this section. If there is more than one individual, copy and complete this section for each. **The DMEPOS supplier MUST have at least ONE managing employee**.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Section 6A2 would not be completed for Individual D. This is because Individual D is not directly associated with the DMEPOS supplier, but is considered an indirect owner.
- In Section 6A3, Company C would be reported since Individual D is a direct owner of Company C and Company C was reported in Section 5.
- In Section 6A4, the DMEPOS supplier would check the "5% or Greater Owner" box. This is because the percentage of Individual D's ownership of the organization reported in Section 6A3, which in this example is Company C, makes him an indirect 5% or greater owner of the provider.

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

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

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

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

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

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

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

This section is to be completed with information about any individual that has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the supplier identified in Section 4A. All officers, directors, and managing employees of the supplier must also be reported in this section. In addition, any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each.

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

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

1. Name First	Middle	Last	Jr., Sr., etc.
Social Security Number		Date of Birth (MM/DD/YYYY)	Credentials (MD., O.D., etc.)
Medicare Identification Number (if applicable)	Effective Date of Ownership (MM/DD/YYYY)	Effective Date of Control (MM/DD/YYYY)	

2. If the above individual is **directly** associated with the supplier identified in Section 4A, what is this individual's relationship with the supplier? (Check all that apply.)

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

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

Legal Business Name of Organization: ______________________________

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

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

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

Please read the applicable instructions before completing this section. This section is to be completed only if the individual in Section 6A above is a 5% or greater owner (direct or indirect) of, has a partnership interest in, or is an actual employee of, or director/officer of, the DMEPOS supplier identified in Section 4A.

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

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

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

SECTION 7: CHAIN HOME OFFICE INFORMATION

This section has been omitted.

SECTION 8: BILLING AGENCY

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

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

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

1. Furnish the name and tax identification number of the billing agency.

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

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

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

C. Billing Agreement/Contract Information

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

7. Chain Home Office Information — This Section Not Applicable

8. Billing Agency

This section is to be completed with information about all billing agencies this supplier uses or contracts with that submit claims to Medicare on behalf of the supplier. If more than one billing agency is used, copy and complete this section for each. The supplier may be required to submit a copy of its 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.) ( ) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

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

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

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

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

3. Does the supplier's 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 only in the name of the supplier? ☐ YES ☐ NO
- **b)** Does the supplier have unrestricted access to the bank account and statements? ☐ YES ☐ NO
- **c)** Does the bank only answer to the supplier regarding what the supplier wants from the bank (e.g., sweep account instructions, bank statements, closing account, etc.)? ☐ YES ☐ NO

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

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

SECTION 9: ELECTRONIC CLAIMS SUBMISSION INFORMATION

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

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

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

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

A copy of all **EDI** agreements between the clearinghouse(s) and the DMERC(s) **must** be submitted with this application.

A. **Check Box** - Indicate if the DMEPOS supplier or its billing agent or management services organization does not use a clearinghouse. If checked, skip to Section 11.

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

C. **1st Clearinghouse Name and Address -** If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

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

D.-E. **2nd and 3rd Clearinghouses** – These sections are to be used to report additional clearinghouses used by this DMEPOS supplier.

SECTION 10: STAFFING COMPANY

This section has been omitted.

9. Electronic Claims Submission Information

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

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 11.

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

C. 1st Clearinghouse Name and Address ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:_______**

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

D. 2nd Clearinghouse Name and Address ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:_______**

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

E. 3rd Clearinghouse Name and Address ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:_______**

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

10. Staffing Company — This Section Not Applicable

SECTION 11: SURETY BOND INFORMATION

This section is to be completed by DMEPOS suppliers mandated by law to obtain a surety bond in order to enroll in and bill the Medicare program. Furnish all requested information about the supplier's insurance agent, surety company, and the surety bond. Read the letter sent with this application to determine if this DMEPOS supplier is required to obtain a surety bond.

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

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

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

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

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

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

D. Name and Address of Insurance Agency/Broker - If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. Provide the legal business name of the agency that issued the bond.
2. Provide the name of the individual agent who issued the bond for the bond agency.
3. Furnish the complete mailing address, telephone number and e-mail address of the agency.

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

1. State the dollar amount of the bond and the bond number.
2. Furnish the effective date of the bond. If reporting a new bond or new surety bond company, furnish the expiration date of the current bond.
3. Indicate if the bond is renewed annually or if it is continuous.
4. Indicate if this is a "Dual Obligee Bond." A dual obligee bond is issued when a supplier bills both the Medicare and Medicaid programs.

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

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

11. Surety Bond Information

This section is to be completed by all DMEPOS suppliers mandated by regulation (see C.F.R. 424.57) to obtain a surety bond in order to enroll in and bill the Medicare program. Furnish all requested information about the supplier's insurance agent, surety company, and the surety bond.

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

B. Check here ☐ if this supplier qualifies for a waiver of the bond requirement based on its operation as a government entity. See instructions for specific documentation requirements and skip to Section 13.

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

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

D. Name and Address of Insurance Agency/Broker ☐ **Change** **Effective Date:**____________________

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

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

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

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

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

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

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

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

2. Check the appropriate box below:
- **a)** Is the Treasury Bill: ☐ 3 months? ☐ 6 months? ☐ 1 year?
- **b)** Is the Treasury Note: ☐ 2 years? ☐ 5 years? ☐ 10 years?
- **c)** Is the government security a 30-year Treasury Bond? ☐ YES ☐ NO

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

SECTION 12: CAPITALIZATION REQUIREMENTS FOR HOME HEALTH AGENCIES

This section has been omitted.

SECTION 13: CONTACT PERSON(S)

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

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

B. **1st Contact Name and Telephone Number** - If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

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

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

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION ON THIS ENROLLMENT APPLICATION

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

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

13. Contact Person(s)

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

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

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

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

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

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

14. Penalties for Falsifying Information on this Enrollment Application

This section explains the penalties for deliberately furnishing false information to gain enrollment in the Medicare program.

1. 18 U.S.C. § 1001 authorizes criminal penalties against an individual who, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry.

Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000 (18 U.S.C. § 3571). Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against any individual who, “knowingly and willfully,” makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program.

The offender is subject to fines of up to $25,000 and/or imprisonment for up to five years.

3. The Civil False Claims Act, 31 U.S.C. § 3729, imposes civil liability, in part, on any person who:

a) knowingly presents, or causes to be presented, to an officer or any employee of the United States Government a false or fraudulent claim for payment or approval;

b) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or

c) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

The Act imposes a civil penalty of $5,000 to $10,000 per violation, plus three times the amount of damages sustained by the Government.

4. Section 1128A(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency…a claim…that the Secretary determines is for a medical or other item or service that the person knows or should know:

a) was not provided as claimed; and/or

b) the claim is false or fraudulent.

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

5. The government may assert common law claims such as “common law fraud,” “money paid by mistake,” and “unjust enrichment.”

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

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SECTION 15: CERTIFICATION STATEMENT

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

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

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

NOTE: The authorized official must also be reported in Section 6.

- The authorized official must sign and date this application.

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

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

Only the authorized official has the authority to sign (1) the initial CMS 855S application on behalf of the DMEPOS supplier. The delegated official has no such authority.

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

Governmental/Tribal Organizations

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

SPECIAL REPORTING REQUIREMENTS

To change authorized officials, the DMEPOS supplier must:

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

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

To then add a new authorized official, the DMEPOS supplier must:

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

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

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

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

15. Certification Statement

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

A. Additional Requirements for Medicare Enrollment

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

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

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

3.) I agree to abide by the Medicare laws, regulations, and program instructions applicable to DMEPOS suppliers. The Medicare laws, regulations, and program instructions are available through the Medicare contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the supplier's compliance with all applicable conditions of participation in Medicare.

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

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

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

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

I have read the contents of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete to the best of my knowledge, and I authorize the Medicare program contractor to verify this information. I also certify that I have read, understand, meet, and will continue to meet all supplier standards as outlined in 42 CFR § 424.57. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare program contractor of this fact immediately.

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

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

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SECTION 16: DELEGATED OFFICIAL (OPTIONAL)

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

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

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

NOTE: The delegated official must also be reported in Section 6.

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

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

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

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

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

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

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

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

SECTION 17: ATTACHMENTS

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

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

NOTE: Any licenses that are needed to operate this business (business and professional) in the State where the enrolling DMEPOS supplier business is located **must** be included with this application.

All enrolling DMEPOS suppliers are required to furnish information on all Federal, State and local (city/county) professional and business licenses, certifications and/or registrations required to practice as a DMEPOS supplier in DMEPOS supplier's State (e.g., Federal Drug Enforcement Agency (DEA) number for pharmacies, business occupancy license, local business license, etc.). The Medicare contractor will supply specific licensing requirements for a DMEPOS supplier upon request.

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

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

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

16. Delegated Official (Optional)

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

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

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

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

17. Attachments

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

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

- ☐Copy(s) of all Federal, State, and/or local (city/county) professional licenses, certifications and/or registrations
- ☐Copy(s) of all Federal, State, and/or local (city/county) business licenses, certifications and/or registrations
- ☐Copy(s) of all adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters)
- ☐Copy(s) of all current signed electronic data interchange (EDI) agreements
- ☐Copy(s) of all State pharmacy licenses
- ☐Copy(s) of all surety bonds and/or Agent's Power of Attorney
- ☐Copy(s) of all liability insurance policies
- ☐Copy(s) of all partnership agreements
- ☐Copy(s) of all articles of incorporation and/or corporate charters
- ☐Completed Form HCFA-588 – Authorization Agreement for Electronic Funds Transfer
- ☐IRS documents confirming the tax identification number and legal business name (e.g., CP 575)
- ☐Any additional documentation or letters of explanation as needed