MEDICARE

FEDERAL HEALTH CARE
PROVIDER/SUPPLIER ENROLLMENT APPLICATION

Application for Health Care Suppliers that will Bill Medicare Carriers

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

Keep a copy of this completed package for your own records

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

OMB Approval No. 0938-0685

CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Provider/Supplier Enrollment Application

Privacy Act Statement

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

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

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

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

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

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

Protection of Proprietary Information

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

Protection of Confidential Commercial and/or Sensitive Personal Information

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

INSTRUCTIONS FOR HEALTH CARE SUPPLIERS THAT WILL BILL MEDICARE CARRIERS

Please **PRINT** or **TYPE** all information so it is legible. Do not use pencil. Failure to provide all requested information may 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 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 maintaining a photocopy of this completed application and supporting documents for future reference.

This application is to be completed by all suppliers that will bill Medicare carriers for medical services provided to Medicare beneficiaries. Failure to promptly submit a completed CMS 855B to the carrier will result in delays in obtaining enrollment and billing privileges.

This form is also used to enroll physician(s), non-physician practitioner(s) and other health care providers/suppliers who form a practice together and bill Medicare as a single supplier. This includes individuals, partnerships, groups, organizations and corporations, hereafter referred to as "organizations." An individual whose business is incorporated, has received a tax identification number for the business, and receives Medicare payment in the name of the business would qualify as an organization. Partnership agreements may be requested by the carrier on an "as needed" basis to determine if the partnership meets State requirements. If a supplier has individual practitioners, each member of the supplier must receive his or her own Unique Physician Identification Number (UPIN) and enroll as an individual (using the Application for Individual Health Care Practitioners, CMS 855I). Once the individual practitioner is enrolled, he/she can enroll as a member of an organization. When joining an organization every member of the organization must complete a copy of the CMS 855R (Individual Reassignment of Benefits).

After completing this enrollment application, the supplier may wish to submit additional forms in the following situations:

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

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

To reduce the burden of furnishing certain types of supporting documentation, we have designated specific types of documentation to be furnished on an "as needed" basis. However, the carrier may request, at any time during the enrollment process, documentation to support or validate information that is reported in this application. Some examples of documents that may be requested for validation purposes are billing agreements, IRS W-2s, pay stubs, articles of incorporation, and partnership agreements.

HOW TO MAKE CHANGES OR UPDATES TO A PREVIOUS APPLICATION

If a supplier changes its tax identification number (TIN), a new enrollment application must be completed, even if most of the data on the form remains the same unless the TIN is the only information that is changing (see "Change of Information" instructions on page 5). This change will also require that each individual in the newly enrolled supplier submit an updated CMS 855R to reassign his or her benefits to the new supplier. If an existing supplier changes its name/ownership/address, etc., and there is no change in its tax identification number, the supplier must annotate the change by checking the section where the change is going to be made, and must sign and date the certification statement. For example, if an existing supplier is only adding a practice location and has previously completed an application, the supplier completes Sections 1, 4, and 15. The supplier does not complete a full application. If the supplier is adding or deleting a member who currently is reassigning his/her benefits to the supplier, it only needs to complete a CMS 855R to make such a change. The member may also delete his/her reassignment of benefits by completing and submitting the CMS 855R.

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 organization.

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

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 supplier or have a 5% ownership interest, or any partnership interest, in the supplier.

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).

Mobile Facility/Portable Unit-These terms apply when a service that requires medical equipment is provided in a vehicle, or the equipment for the service is transported to multiple locations within a geographic area. The most common types of mobile facilities/portable units are mobile IDTFs, portable X-ray, portable mammography, and mobile clinics. Physical therapists and other medical practitioners (e.g., physicians, nurse practitioners, physician assistants) who perform services at multiple locations (i.e., house calls, assisted living facilities) are not considered to be mobile facilities/portable units.

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

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

Supplier-A physician or other practitioner, or an organization other than a provider that furnishes health care services under Medicare Part B. The term supplier also includes independent laboratories, portable x-ray services, physical therapists in private practice, end stage renal disease (ESRD) facilities, and chiropractors. For enrollment purposes, suppliers that submit claims for durable medical equipment, prosthetics, orthotics, or supplies (DMEPOS) must complete the CMS 855S. This application (CMS 855B) is not for DMEPOS suppliers.

Tax Identification Number (TIN)-This is a number issued by the Internal Revenue Service (IRS) that the supplier uses to report tax information to the IRS.

Unique Physician/Practitioner Identification Number (UPIN)-This number is assigned to physicians, non-physician practitioners, and suppliers to identify the referring or ordering physician on Medicare claims.

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. Check one of the following:

Initial Enrollment

- If the supplier is enrolling in the Medicare program for the first time with this Medicare carrier under this tax identification number.
- If the supplier is already enrolled with a carrier but needs to enroll in another carrier's jurisdiction.
- If the supplier is enrolled with this carrier but has a new tax identification number.
- When a **hospital** is enrolling with a carrier to bill for Part B services.

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

Reactivation

- If the supplier's Medicare billing number was deactivated because of non-billing. Billing privileges may be deactivated when Medicare has not received claims in a twelve-month period after the enrollment has been approved. To reactivate billing privileges, the supplier may be required to either submit an updated CMS 855B 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. It must also meet all current requirements for its supplier type, regardless of whether it was previously enrolled in the program.

Change of Information

- If the supplier is adding, deleting, or changing information under this tax identification number. Check the appropriate section where the change will be made. When providing the changed information, furnish the supplier's Medicare identification number in Section 1 and provide the new/changed information within the appropriate section. Sign and date the certification statement. **All changes must be reported to the carrier 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 in the event of the supplier ceasing its operations. Furnish the date the supplier will stop billing for Medicare covered services. In addition to completing this section, furnish the supplier's Medicare identification number in Section 1 under "Change of Information," 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.

Change of Ownership (Hospitals, Portable X-Ray Facilities, and Ambulatory Surgical Centers) - Only

- When a hospital undergoes a change of ownership (CHOW), in addition to the required submission of a CMS 855A, the hospital must also submit a new CMS 855B for the new ownership.
- When a portable x-ray facility or ambulatory surgical center undergoes a change of ownership which results in the issuance of a new tax identification number (TIN), the new owners must submit a completed CMS 855B and attach a copy of the sales agreement.

2. Tax Identification Number (TIN) - Provide the supplier's taxpayer identification number (e.g., the number the supplier uses to report tax information to the IRS) and 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 legal document 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.

3. Indicate whether the supplier is currently enrolled in the Medicare program. If the supplier is currently enrolled in Medicare (i.e., within another carrier's jurisdiction) provide the name of the carrier in this space. The supplier must also provide its Medicare identification number in the space provided. This number is issued by Medicare to identify the supplier. It is also the number used on claims forms and may be referred to as a Medicare provider number, provider identification number, or National Supplier Clearinghouse number. Report all currently active numbers.

   NOTE: Rural Health Clinics – If this supplier is a rural health clinic enrolling for a Part-B carrier billing number, check "Yes" in the box provided and furnish the rural health clinics' fiscal intermediary name and OSCAR number in the spaces provided.

If the supplier does not currently have a Medicare identification number, it will be assigned one upon the successful completion of enrollment. This number is assigned through a national registry that establishes the registration of all physicians, non-physician practitioners, group practices, and other organizations that receive Part B Medicare payments. In addition, your local carrier may assign a separate supplier identification number. The carrier will explain what number(s) has been issued and how it is to be used. If the carrier should contact the supplier for additional information, the supplier must provide the information immediately to ensure the timely processing of this application.

MEDICARE FEDERAL HEALTH CARE PROVIDER/SUPPLIER ENROLLMENT APPLICATION

Application for Health Care Suppliers that will Bill Medicare Carriers

General Instructions

The Medicare Federal Health Care Pro ider/Supplier Enrollment Application has been designed by the Centers for Medicare & Medicaid Ser ices (CMS) to assist in the administration of the Medicare program and to ensure that the Medicare program is in compliance with all regulatory requirements. The information collected in this application will be used to ensure that payments made from the Medicare trust fund are only paid to qualified health care suppliers, and that the amounts of the payments are correct. This information will also identify whether the supplier is qualified to render health care ser ices to Medicare beneficiaries. To accomplish this, Medicare must know basic identifying and qualifying information about the supplier that is seeking billing pri ileges in the Medicare program. If enrolling in the Medicare program as a supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) do not complete this application. DMEPOS suppliers should contact the National Supplier Clearinghouse (NSC) at 803-754-3951 to obtain a CMS 855S for Medicare enrollment.

Medicare needs to know: (1) the type of health care supplier enrolling, (2) what qualifies this supplier to furnish health care related ser ices, (3) where and how this supplier intends to render these ser ices, and (4) those persons or entities with an ownership interest, or managerial control, as defined in this application, o er the 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 pre iously submitted information. If a section does not apply to this supplier, check (√) the appropriate box in that section and skip to the next section. Sections 7, 11, and 12 ha e been deliberately omitted from this application because they are not applicable to the enrollment of suppliers that bill Medicare carriers.

1. General Application Information

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 Medicare or any another Federal health care program.
To ensure timely processing of this application, Numbers 1, 2 and 3 below MUST ALWAYS be completed.

A. Reason for Submittal of this Application

1. Check one:

☐ Initial Enrollment ☐ Reacti ation

☐ Change of Information (Check appropriate Section(s) below and furnish this supplier's Medicare Identification Number here):_____

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 8 ☐ 9 ☐ 10 ☐ 13 ☐ 15 ☐ 16
Attachment 1 - ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 Attachment 2 - ☐ 1 ☐ 2 ☐ 3 ☐ 4

☐ Voluntary Termination of Billing Number—Effecti e Date (MM/DD/YYYY):_____

☐ Change of Ownership (Hospitals, Portable X-Ray Facilities, and Ambulatory Surgical Centers) - **Only**

2. Tax Identification Number:_____

3. Is this supplier currently enrolled in the Medicare program? ☐ YES ☐ NO
IF YES, furnish the following information about the current carrier:

Current Carrier Name:_____ Current Medicare Identification Number:_____

SECTION 2: SUPPLIER IDENTIFICATION

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

1. Type of Supplier - Check the appropriate box to identify the type of services the supplier will provide. Only **one** supplier type may be checked per application. If the supplier functions as two or more supplier types, a separate CMS 855B must be submitted for each type. If the supplier changes the type of services it provides (becomes a different supplier type), a new CMS 855B must be completed and submitted.

Rural Health Clinics and Federally Qualified Health Centers - Rural health clinics and Federally Qualified Health Centers currently enrolled with a fiscal intermediary for Part A Medicare services, and are now enrolling with a carrier for Part B Medicare services, should check "Multi-Specialty Clinic."

If this supplier is either an **Ambulatory Surgical Center or a Portable X-Ray Facility**, it must be surveyed by the appropriate State agency prior to enrolling in the Medicare program. Therefore, immediately contact the State Agency that handles these supplier types. The State agency will provide you with any State-specific forms that are required. It will also do preliminary planning for any required State surveys.

For suppliers that are **"Medical Faculty Practice Plans,"** all Medicare requirements must be met prior to enrollment. Other documentation may be required by the Medicare carrier to verify requirements of a medical faculty practice plan (e.g., IRS approval of 501(c)(3) non-profit status, documentation that physicians are employees of the university, etc.).

Diagnostic Radiology Group Practices/Clinics: If this supplier organization performs radiological diagnostic tests, see page 55 of these instructions for important additional enrollment information and check with the local Medicare carrier to determine if enrollment as an Independent Diagnostic Testing Facility (IDTF) is required. In general, physicians who perform examinations of the patient in addition to performing the diagnostic radiological tests, portable x-ray suppliers, and FDA approved diagnostic mammography suppliers do not usually require IDTF enrollment.

Clinic/Group Practices: If this clinic/group will be billing for diagnostic tests, other than clinical laboratory or pathology tests, see page 55 of these instructions to determine if this supplier must also enroll as an Independent Diagnostic Testing Facility (IDTF).

2. PT/OT Groups Only - If the supplier is enrolling as an occupational or physical therapy group, it must answer the questions listed to determine its eligibility to bill Medicare.

3. Indicate whether the supplier will be receiving reassigned benefits from individual practitioners. This will alert the carrier that it will be receiving CMS 855R(s) to be associated with the supplier's application.

4. **Hospitals only:** Hospitals that will submit claims to a carrier must also complete and submit a CMS 855B to the local carrier. This is in addition to completing and submitting the CMS 855A to the fiscal intermediary. Check the appropriate box to indicate if the hospital wants one Medicare Part B services billing number or multiple Part B services billing numbers for each department (e.g., cardiology, pathology, radiology). If a combination of both separate billing numbers for some departments and combined billing numbers for groups of other departments are requested, furnish all details in Section 2E. If multiple numbers are being requested, each department to be issued a Part B Medicare billing number must be reported here.

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

1. Furnish the legal business name for this supplier as reported to the IRS for tax purposes, and the date the supplier's business started at this practice location.
2. Provide any "doing business as" name this supplier uses. The "doing business as" name is the name the supplier is generally known by to the public. Also furnish the county/parish where the DBA name is registered.
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" and "Limited" partnerships. All other suppliers should check "Other," and specify the type of organizational structure (e.g., limited liability company).
4. If incorporated, provide the date and State where the supplier is incorporated. The carrier may request a copy of the supplier's "articles of incorporation" if needed to validate certain information.

2. Supplier Identification

This section is to be completed with information specifically related to the supplier submitting this application. Furnish the following information about the supplier: (1) supplier type, (2) supplier name, and (3) the mailing address and telephone number where Medicare can contact the supplier directly.

A. Type of Supplier ☐ **Change** **Effective Date:**_____

The supplier must meet all Medicare requirements for the type of supplier checked below. If this supplier is a single specialty clinic/group practice, the specialty must be reported. Submit copies of all required licenses, certifications, and registrations with this application.

1. Type of Supplier (Check one):

☐ Ambulance Ser ice Supplier
☐ Ambulatory Surgical Center
☐ Diagnostic Radiology Group Practice/Clinic
☐ Hospital Department(s), Hospital Outpatient Location(s) and/or Hospital Clinic(s) (complete # 4 below)
☐ Independent Clinical Laboratory (CLIA)
☐ Independent Diagnostic Testing Facility (IDTF)
☐ Mammography Screening Center
☐ Managed Care Plan (non-Medicare +Choice)
☐ Mass Immunization Roster Biller Only
☐ Medicare +Choice Organization
☐ Medical Faculty Practice Plan:
See instructions for specific documentation requirements

☐ Multi-Specialty Clinic or Group Practice
☐ Occupational Therapy Group (complete # 2 below)
☐ Other Medical Care Group
☐ Physical Therapy Group (complete # 2 below)
☐ Physiotherapy Group
☐ Portable X-ray Facility
☐ Public Health/Welfare Agency
☐ Voluntary Health/Charitable Agency
☐ *Single-Specialty Clinic/Group Practice:
*Specify group/clinic specialty below:

_____

☐ Other (Specify):_____

2. **PT/OT Groups ONLY** - All occupational and physical therapy groups must answer the following questions:

a) Are all of the group's PT/OT ser ices only rendered in patients' homes? ☐ YES ☐ NO
b) Does this group maintain pri ate office space? ☐ YES ☐ NO
c) Does this group own, lease, or rent its pri ate office space? ☐ YES ☐ NO
d) Is this pri ate office space used exclusi ely for the group's pri ate practice? ☐ YES ☐ NO
e) Does this group furnish PT/OT ser ices outside of its office and/or patients' homes? ☐ YES ☐ NO
IF YES, pro ide a copy of the lease agreement which gi es the group exclusi e use of the facility for PT/OT ser ices.

3. Will this supplier be recei ing reassigned benefits from indi idual practitioners? ☐ YES ☐ NO
IF YES, submit a CMS 855R for each indi idual practitioner who will be reassigning benefits to this supplier.

4. **Hospitals Only** - If this supplier is a hospital applying for a billing number(s) for Part B practitioner ser ices, check the appropriate box below. See instructions before completing this section.

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

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

B. Supplier Identification Information ☐ **Change** **Effective Date:**_____

Furnish the supplier's legal business name (as reported to the IRS), "doing business as" name (name supplier generally known by to the public), and the arious operating dates and places of formal business registration and/or incorporation.

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

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

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

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

D. Accreditation (Ambulatory Surgical Centers (ASCs) ONLY) - Check the box "Change" only if reporting a change to existing information. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

1. Indicate whether this ASC is accredited by any accrediting organization that Medicare has approved for acceptance in lieu of a State Survey. If "Yes:"

2. Furnish the date accreditation was received, and

3. Furnish the name of the Medicare-approved accrediting body or organization.

E. Comments – This section is to be used as an opportunity to explain any unique or unusual circumstances concerning the supplier's practice location(s), the method by which the supplier renders health care services, or any special billing number requirements.

2. Supplier Identification (Continued)

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

This must be an address and telephone number where Medicare can contact this supplier directly.

Mailing Address Line 1		
Mailing Address Line 2		
City	State	ZIP Code + 4

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

D. Accreditation (Ambulatory Surgical Centers (ASCs) ONLY) ☐ **Change** **Effective Date:**_____

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

E. Comments

Explain any unique or unusual circumstances concerning the supplier's practice location(s), the method by which the supplier renders health care ser ices, or any special billing number requirements.

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 information is needed on how to access the data bank, call 1-800-767-6732 or visit www.npdb-hipdb.com. There is a charge for using this service.

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

B. Overpayment Information - Current laws found in the Federal Streamlining Act and the Debt Collection Improvement Act require all Federal agencies to determine whether an individual or business entity that enters into a business relationship with that agency has any outstanding debts, including overpayments under different identifiers. Failure to furnish information about overpayments will put the 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 supplier's enrollment has been approved do not have 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 ad erse legal actions and/or o erpayments that ha e been imposed or le ied against this supplier (see Table A below for list of ad erse 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, e er had any of the ad erse legal actions listed in Table A below imposed against it? ☐ YES ☐ NO

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

Ad erse Legal Action:	Date:	Law Enforcement Authority:	Resolution:

Table A

1) Any felony or misdemeanor con iction, under Federal or State law, related to: (a) the deli ery of an item or ser ice under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the deli ery of a health care item or ser ice.

2) Any felony or misdemeanor con iction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the deli ery of a health care item or ser ice.

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

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

5) Any re ocation or suspension of a license to pro ide 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 re ocation 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 Executi e 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, ha e any outstanding Medicare o erpayments? ☐ YES ☐ NO

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

Name under which the o erpayment occurred:	Account number under which the o erpayment exists:

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SECTION 4: CURRENT PRACTICE LOCATION(S)

A. Practice Location Information - Check the appropriate box if the supplier is using this section to add a new practice location, delete a practice location, or change information about an existing practice location. If the supplier is adding a new practice location, the new location **must be under the same tax identification number as the supplier's.** Provide the new information, the effective date of that change, and sign and date the certification statement. Otherwise:

1. Furnish the name of the business at this practice location and furnish the date the supplier started rendering services at this location.

NOTE: Only report those practice locations within the Medicare carrier's jurisdiction where the supplier will be submitting this application. If the supplier has practice locations in more than one Medicare carrier's jurisdiction, a separate CMS 855B must be completed for those practice locations and submitted to the Medicare carrier that has jurisdiction over those locations.

2. Provide a complete street address, telephone number, fax number, and e-mail address (if applicable) for the supplier's practice/business location.

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

3. Indicate whether the supplier owns/leases the practice location.

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

5. Report any CLIA number(s) and/or FDA/Radiology (Mammography) Certification Number(s) that have been issued to this practice location and which this supplier will be billing for these types of services.

A copy of the most current CLIA and FDA certifications for each of the practice locations reported must be submitted with this application. Do not report certificate information that was not issued under this tax identification number.

The supplier may receive more than one supplier identification number depending upon which "physician fee locality" the practice is located. The local Medicare carrier will determine whether more than one Medicare billing number will be issued.

B. Mobile Facility and/or Portable Units

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

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

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

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

1. Provide the base of operations name and the date the supplier started practicing from this location.

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

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

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

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

4. Current Practice Location(s)

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

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

1. Practice Location Name			Date Started at this Location (MM/DD/YYYY)
2. Practice Location Address Line 1			
Practice Location Address Line 2			
City	County/Parish	State	ZIP Code + 4
Telephone Number ( ) (Ext.) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)	

3. Does this supplier own/lease this practice location? ☐ YES ☐ NO

4. Is this practice location a:
- hospital? ☐ YES ☐ NO
- retirement/assisted li ing community? ☐ YES ☐ NO
- group practice office/clinic ☐ YES ☐ NO
- other health care facility? (Specify):_____ ☐ YES ☐ NO

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

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

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

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

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

1. Base of Operations Name			Date Started at this Location (MM/DD/YYYY)
2. Street Address Line 1			
Street Address Line 2			
City	County/Parish	State	ZIP Code + 4
Telephone Number ( ) (Ext.) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)	

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

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

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

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

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

1. Initial Reporting and/or Additions

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

2. Deletions

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

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

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

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

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

- If payment is being made by electronic funds transfer, the "Pay To" address should indicate where the supplier wants all other payment information to be sent (e.g., remittance notices, special payments, etc.).

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

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

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

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

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

4. Practice Location (Continued)

E. Geographic Location where the Base of Operations and/or Vehicle Renders Services

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

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

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

1. Initial Reporting and/or Additions:

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

2. Deletions:

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

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

Furnish the address where payment should be sent for ser ices rendered at the practice location(s) in Section 4A or 4C.

"Pay To" Address Line 1

"Pay To" Address Line 2

City	State	ZIP Code + 4

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

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

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

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

Name of Storage Facility/Location

Storage Facility Address Line 1

Storage Facility Address Line 2

City	State	ZIP Code + 4

H. Comments

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

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 supplier identified in Section 2B. See examples below of organizations that should be reported in this section. If individuals, and not organizations, own or manage the 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 supplier,
- Managing control of the supplier, or
- A partnership interest in the 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 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 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 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 supplier must be reported in this application. Many suppliers may be owned by only one organization, as outlined in the following examples:

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

- An ambulatory surgical center, 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 ambulance company, in that it actually owns the assets of the business. Similarly, Company X is a direct owner of the ambulatory surgical center mentioned in the second example. It has 50% actual ownership of the ambulatory surgical center.

There are occasionally more complex ownership situations. Many organizations that directly own a 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 supplier. Using our example above, if Company B owned 100% of Company A, Company B is considered to be an indirect owner of the supplier. In other words, a direct owner has an actual ownership interest in the supplier (e.g., owns stock in the business, etc.), whereas an indirect owner has an ownership interest in an organization that owns the supplier. For purposes of this application, direct and indirect owners must be reported if they own at least 5% of the 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 supplier or any of the property or assets of the supplier, **and**

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

To calculate whether an organization or individual has financial control over the 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 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 Supplier. Companies B and C as well as Individuals X and Y are indirect owners of the Enrolling 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 Supplier. Company A must therefore be reported.

LEVEL 2

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

The percentage of ownership the LEVEL 1 owner has in the Enrolling 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 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 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 Supplier). Therefore, Company B owns 40% of the Enrolling 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 Supplier, multiply:

The percentage of ownership the LEVEL 2 owner has in the Enrolling 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 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 Supplier and does not need to be reported in this application.

Repeat this process for Company B, which owns 40% of the Enrolling 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 Supplier, Individual Y must be reported on 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 Supplier, the Enrolling 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 Supplier or any of the property or assets of the Enrolling Supplier
DIVIDED BY
Dollar amount of the total property and assets of the Enrolling Supplier

***Example*:** Two years ago, a supplier obtained a $20 million loan from Entity X to add a third floor to its facility. Various assets of the supplier secure the mortgage. The total value of the 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 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 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 supplier, or conducts the day-to-day operations of the supplier, is a managing organization and must be reported. The organization need not have an ownership interest in the supplier in order to qualify as a managing organization. This could be a management services organization under contract with the 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 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 supplier. This section should not be completed for organizations that only have managing control over the 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 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 supplier is uncertain as to whether the owning organization falls within one of the adverse legal action categories, the 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.

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

This section is to be completed with information about all organizations that ha e 5% or more (direct or indirect) ownership interest of, any partnership interest in, and/or managing control of, the supplier identified in Section 2B, as well as any information on ad erse legal actions that ha e 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	Effecti e Date of Ownership (MM/DD/YYYY)
2. Legal Business Name		Effecti e Date of Control (MM/DD/YYYY)
3. "Doing Business As" Name (if applicable)		Tax Identification Number
4. Business Address Line 1		Medicare Identification Number(s) (if applicable)
Business Address Line 2		
City	State	ZIP Code + 4

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

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

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

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

Ad erse 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 supplier identified in Section 2B. In addition, all officers, directors, and managing employees of the supplier must be reported in this section. If there is more than one individual, copy and complete this section for each. **The 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 supplier;
- If (and only if) the supplier is a corporation (whether for-profit or non-profit), all officers and directors of the supplier;
- All managing employees of the supplier, and
- All individuals with a partnership interest in the 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 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 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 supplier's corporate bylaws.
- The term **"Director"** is defined as a member of the 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 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 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 supplier, or who conducts the day-to-day operations of the supplier. For Medicare enrollment purposes, "managing employee" also includes individuals who are not actual employees of the supplier but, either under contract or through some other arrangement, manage the day-to-day operations of the 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 supplier 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 Medicare carrier.

***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 supplier furnish Medicare with the individual's social security number.

2. If this individual is directly associated with the enrolling supplier (e.g., 5% direct owner, partner, officer, director, or managing employee), indicate the individual's relationship with this 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 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 supplier. Assume further that Individual D, as an indirect owner of the 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 supplier, but is considered is 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 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 supplier.

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 supplier (i.e., individuals who manage the supplier's day-to-day operations through a contractual or other arrangement but are not directly employed by the 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 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 supplier is uncertain as to whether this individual falls within one of the adverse legal action categories, the 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 indi idual that has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the supplier identified in Section 2B. All officers, directors, and managing employees of the supplier must also be reported in this section. In addition, any information on ad erse legal actions that ha e been imposed against the indi iduals reported in this section must be furnished. If there is more than one indi idual, copy and complete this section for each.

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

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

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

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

2. If the abo e indi idual is **directly** associated with the supplier in Section 2B, what is this indi idual's relationship with the supplier? (Check all that apply.)

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

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

Legal Business Name of Organization: _____

4. What is this indi idual's role with the organization reported in Section 6A3 abo e (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 indi idual in Section 6A abo e is a 5% or greater owner (direct or indirect), or has a partnership interest in, or is an actual employee of, or director/officer of, the supplier identified in Section 2B.

1. Has the indi idual in Section 6A abo e, under any current or former name or business identity, e er had any of the ad erse legal actions listed in Table A in Section 3A imposed against him or her? ☐ YES ☐ NO

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

Ad erse Legal Action:	Date:	Law Enforcement Authority:	Resolution:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SECTION 7: HAS BEEN OMITTED

SECTION 8: BILLING AGENCY

The purpose of collecting this data is to develop effective monitoring of agents/agencies that prepare and/or submit claims to bill the Medicare program on behalf of the supplier. A billing agency is a company or individual that the supplier hires or contracts with to furnish claims processing functions for its business locations. Any entity that meets this description must be reported in this section. If the 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 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 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 supplier that is enrolling is responsible for responding to the questions listed. These questions are designed to show that the 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 Medicare contractor 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 erify 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 abo e billing agency.

1. Does the supplier ha e 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 ha e 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 <u>all</u> of the following conditions included in the billing agreement?
1) The agent recei es 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 re oke at any time.
5) In recei ing 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 ser ices). ☐ YES ☐ NO
b) Does the billing agent either gi e the Medicare payment directly to this supplier or deposit the payment into this supplier's bank account? ☐ YES ☐ NO

5. Who recei es 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 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 supplier's claims electronically.

If this 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 Medicare contractor to which the 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 supplier.

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

If the 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 supplier must report the clearinghouse(s) in this section.

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

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

B. Check Box - Indicate if the supplier would like to submit claims electronically. Checking this box will alert the Medicare contractor to contact its claims processing department to process an EDI agreement once the 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 uses a "doing business as" (DBA) name with this supplier, provide that information in this space. If this clearinghouse uses more than one DBA name with this 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 supplier.

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 ser ices. 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 for this supplier MUST be submitted with this application.

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

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

C. 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)

SECTION 10: STAFFING COMPANY

The purpose of collecting this data is to develop effective internal controls to promote adherence to applicable Federal and State laws.

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

A. Check Box - If the supplier does not work for (or is not under contract with) a staffing company, check the box provided and skip to Section 13. If the supplier has been hired by (or is under contract with) a staffing company, complete the appropriate fields of this section with information about the staffing company.

B. 1st Staffing Company Name and Address - Indicate if this supplier is making a change concerning its relationship with a staffing company by checking the appropriate box "add," "delete," or "change." Provide the new information and the effective date of the change, and sign and date the certification statement. Otherwise:

1. Furnish the legal business name and tax identification number of the staffing company.

2. If applicable, furnish the staffing company's "doing business as" (DBA) name. If the reported staffing company uses more than one DBA name with this supplier, report all that apply for Medicare claims.

3. Furnish the complete mailing address, telephone number, fax number and e-mail address for the staffing company.

C. 1st Staffing Company Contract/Agreement Information - The enrolling supplier must respond to the questions listed to verify that it fully understands and comprehends its contract and that it plans to adhere to all Medicare laws, regulations, and program instructions. At any time, the carrier can request a copy of the agreement/contract signed by the supplier and the staffing company.

D-E. 2nd Staffing Company - Sections D and E are to be used to report information on a 2nd staffing company that the supplier may be working for (or under contract with) to provide medical services. See instructions for Sections B and C above.

10. Staffing Company

This section is to be completed with information about all staffing companies that use this supplier, either under written contract or by some other arrangement, to staff any other health care facilities. If this supplier is used by more than two staffing companies, copy and complete this section as needed. The supplier may be required to submit a copy of its current signed staffing company agreement/contract(s).

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

B. 1st Staffing Company using this Supplier - 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. 1st Staffing Company using this Supplier - Contract/Agreement Information

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

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

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

D. 2nd Staffing Company using this Supplier - 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. 2nd Staffing Company using this Supplier - Contract/Agreement Information

Answer the following questions about the staffing company's contract/agreement with this supplier.

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

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

SECTION 11: SURETY BOND INFORMATION

This section has been omitted.

SECTION 12: CAPITALIZATION REQUIREMENTS FOR HOME HEALTH AGENCIES

This section has been omitted.

SECTION 13: CONTACT PERSON(S)

To assist in the timely processing of the 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 supplier is not required to furnish a contact person in this section. It should be noted that if a contact person is not provided, all questions about this application will be directed to the authorized official named in Section 15B.

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

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

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

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

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION ON THIS ENROLLMENT APPLICATION

The 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.

11. Surety Bond Information — This Section Not Applicable

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 indi idual who, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals or co ers up by any trick, scheme or de ice 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.

Indi idual offenders are subject to fines of up to $250,000 and imprisonment for up to fi e 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 deri ed 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 indi idual 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 fi e years.

3. The Ci il False Claims Act, 31 U.S.C. § 3729, imposes ci il 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 Go ernment a false or fraudulent claim for payment or appro al;
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 appro ed by the Go ernment; or
c.) conspires to defraud the Go ernment by getting a false or fraudulent claim allowed or paid.

The Act imposes a ci il penalty of $5,000 to $10,000 per iolation, plus three times the amount of damages sustained by the Go ernment.

4. Section 1128A(a)(1) of the Social Security Act imposes ci il 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 ser ice that the person knows or should know:

a.) was not pro ided as claimed; and/or
b.) the claim is false or fraudulent.

This pro ision authorizes a ci il monetary penalty of up to $10,000 for each item or ser ice, 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 go ernment may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment."

Remedies include compensatory and puniti e damages, restitution, and reco ery of the amount of the unjust profit.

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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 certain individual(s) (delegated officials) for the purpose of reporting changes to the supplier's enrollment record after the supplier has been enrolled. The supplier may have no more than one currently active authorized official at any given time. See below to determine who within the 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 supplier to enroll in and bill the Medicare program. Carefully read these requirements. By signing below, the supplier will be attesting to having read these requirements and that the 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. Otherwise:

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

An authorized official is 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 definition of a "direct owner"), or must hold a position of similar status and authority within the supplier's organization.

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

By signing this form for initial enrollment in the Medicare program or for revalidation purposes, the authorized official agrees to immediately notify the 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 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 855B 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 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 Medicare contractor may request documentation verifying that the person is no longer the authorized official.

To then add a new authorized official, the 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 supplier's status in the Medicare program.

If the 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 indi idual(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 effecti e 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 ha e 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, ci il, or administrati e penalties including, but not limited to, the re ocation of Medicare billing number(s), and/or the imposition of fines, ci il damages, and/or imprisonment.
3.) I agree to abide by the Medicare laws, regulations and program instructions that apply to this supplier. The Medicare laws, regulations, and program instructions are a ailable 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 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 program, or is otherwise prohibited from supplying ser ices to Medicare or other Federal program beneficiaries.
5.) I agree that any existing or future o erpayment made to the 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. 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 supplier, or an individual with a 5% or greater direct ownership interest in, or any partnership interest in, the enrolling 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 supplier's status in the Medicare program. This individual must also be able to commit the 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 supplier. The Medicare contractor may request evidence indicating that the delegated official is an actual employee of the provider. Independent contractors are not considered "employed" by the supplier. A 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 supplier chooses not to assign any delegated officials in this application, check the box in this section. There is no requirement that the 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 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 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 Sections 15B and 16B2,
- The delegated official(s) to be added must provide the information and their signature in Section 16B, and
- The delegated official(s) to be deleted does not have to sign or date the application.

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

If the 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 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, should 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 supplier business is located **must** be included with this application.

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

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

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

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 ha e the same force and effect as that of the authorized official, and shall legally and financially bind the supplier to the laws, regulations, and program instructions of the Medicare program. By his or her signature, 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 pro ided 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 **Print** First	Middle	Last	Jr., Sr., etc.
Delegated Official **Signature** (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed
Title/Position	☐Check here only if Delegated Official is a W-2 employee*		
2. **Signature** of Authorized Official Assigning this Delegation (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed

17. Attachments

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

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

- ☐Copy(s) of all Federal, State, and/or local (city/county) professional licenses, certifications and/or registrations specifically required to operate as a health care facility
- ☐Copy(s) of all Federal, State, and/or local (city/county) business licenses, certifications and/or registrations specifically required to operate as a health care facility
- ☐Copy(s) of all professional school degrees or certificates, or e idence of qualifying course work
- ☐Copy(s) of all documentation erifying IDTF Super isory Physician(s) proficiency
- ☐Copy(s) of all CLIA Certificates, FDA Mammography Certificates, and Diabetes Education Certificates
- ☐Copy(s) of all State Pharmacy licenses
- ☐Copy(s) of all ad erse 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 partnership agreements
- ☐Copy(s) of all articles of incorporation and/or corporate charters
- ☐Completed Form HCFA-588 - Authorization Agreement for Electronic Funds Transfer
- ☐Completed Form(s) CMS 855R - Indi idual Reassignment of Benefits
- ☐IRS documents confirming the tax identification number and legal business name (e.g., CP 575)
- ☐Any additional documentation or letters of explanation as needed

Attachment 1 AMBULANCE SERVICE SUPPLIERS

All ambulance service suppliers enrolling in the Medicare program must complete this attachment. For further information concerning Medicare requirements for ambulance service suppliers, review 42 CFR 410.40 and 410.41.

SECTION 1: STATE LICENSE INFORMATION

This section is to be completed with information about the geographic area in which this company furnishes ambulance services. When applicable, State license information, as well as a copy of the license itself, must be submitted with this application.

A. Geographic Service Area - Check the appropriate box when the ambulance company is using this section to add or delete a geographic location. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

1. Initial Reporting and/or Additions - For initial enrollment, report all geographic areas where services are provided. Furnish the county/parish, city, State and ZIP Code for all geographic locations.

NOTE: If the ambulance company renders services in more than one State, and those States are serviced by different Medicare contractors (carriers), the supplier must complete a separate CMS 855B enrollment application for each Medicare contractor jurisdiction.

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

B. State License Information - Check the appropriate box to indicate whether the ambulance company is using this section to add, delete, or change information about the supplier's State license. Provide the effective date of that change, complete the appropriate information, and sign and date the certification statement. Otherwise:

1. Indicate whether the ambulance company has been licensed in the State where services are rendered.

2. If the enrolling ambulance company is not licensed by the State, explain why in the space provided.

3. If the answer is "Yes," provide all requested licensing information and attach a copy of the license. The effective date and expiration date must be stated on the license. Claims will be paid based on these dates. The enrolling supplier must provide the Medicare contractor with a copy of the license each time it is renewed in order to receive payment after the expiration date of the current license.

ATTACHMENT 1

Ambulance Service Suppliers

This attachment is to be completed by all ambulance ser ice suppliers enrolling in the Medicare program.

1. State License Information

This section is to be completed with information about the geographic area in which this company furnishes ambulance ser ices. When applicable, State license information must be pro ided. In addition, a copy of the current State license must be submitted with this application.

A. Geographic Service Area ☐ **Add** ☐ **Delete** **Effective Date:**_____

Furnish the county/parish, city, State and ZIP Code for all locations where this ambulance company renders ser ice.

Note: If this ambulance company renders services in more than one State, and those States are serviced by different Medicare contractors, a separate CMS 855B enrollment application must be completed for each Medicare contractor jurisdiction.

1. Initial Reporting and/or Additions:

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

2. Deletions:

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

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

1. Is this ambulance company licensed in the State where ser ices are rendered and billed for? ☐ YES ☐ NO

2. **IF NO**, explain why:_____

3. **IF YES**, furnish the license information for the State where this ambulance ser ice supplier will be rendering ser ices and billing Medicare. Attach a copy of the current State license.

License Number	Issuing State (if applicable)	Issuing County/Parish (if applicable)
Effecti e Date (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	

SECTION 2: DESCRIPTION OF VEHICLE

A. 1st Vehicle Information - Check the appropriate box to indicate whether the ambulance company is using this section to add or delete a vehicle currently on file. Provide the effective date of that change, complete the appropriate information, and sign and date the certification statement. Otherwise:

1. The supplier must identify the type (e.g., automobile, aircraft, boat), year, make, model, and vehicle identification number of each vehicle.

2. Indicate what medical equipment each vehicle possesses. The vehicle(s) must be specifically designed to respond to medical emergencies or to provide acute medical care to transport the sick and injured. It must have customary patient care equipment including, but not limited to, a stretcher, clean linens, emergency medical supplies and oxygen equipment, and it must have all other safety and lifesaving equipment as required by State and local authorities.

3. If the ambulance will supply Advance Life Support (ALS) services, please provide documentation of certification from the authorized licensing and regulation agency for the area of operation.

Vehicles must be regularly inspected and re-certified according to applicable State and local licensing laws. Evidence of re-certification must be submitted to the Medicare contractor on an ongoing basis as required by State and local laws.

IMPORTANT INSTRUCTIONS FOR AIR AMBULANCE

To qualify as an air ambulance supplier, the following is required:

1. A written statement, signed by the President, Chief Executive Officer or Chief Operating Officer of the airport from where the aircraft is hangered that gives the name and address of the facility, and

2. Proof that the enrolling ambulance company, or the company leasing the air ambulance vehicle to the enrolling ambulance company, possesses a valid charter flight license (FAA 135 Certificate) for the aircraft being used as an air ambulance. If the enrolling ambulance company owns the aircraft, the owner's name on the FAA 135 Certificate must be the same as the enrolling ambulance company's name (or the ambulance company owner as reported in Sections 5 or 6) in this application. If the enrolling ambulance company leases the aircraft from another company, a copy of the lease agreement must accompany this enrollment application.

B. 2nd Vehicle Information – This section is provided to report a second vehicle. See instructions above for Section 2A.

2. Description of Vehicle

This section is to be completed with information about the ehicles used by this ambulance company, the equipment they carry, and the ser ices they pro ide. If there are more than two ehicles, copy and complete this section as needed.
A copy of each vehicle's registration MUST be submitted. For air ambulance suppliers, attach a copy of FAA 135.

A. 1st Vehicle Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Type (automobile, aircraft, boat, etc.)		Vehicle Identification Number
Make	Model	Year (YYYY)

2. Does this ehicle ha e the following:

first aid supplies?	☐ YES ☐ NO	other safety/life-sa ing equipment?	☐ YES ☐ NO
oxygen equipment?	☐ YES ☐ NO	two-way telecommunications radio?	☐ YES ☐ NO
emergency warning lights?	☐ YES ☐ NO	mobile communication/wireless telephone?	☐ YES ☐ NO
sirens?	☐ YES ☐ NO	stretcher?	☐ YES ☐ NO
		clean linens?	☐ YES ☐ NO

Report other medical equipment this ehicle carries:

_____ _____ _____

3. Does this ehicle pro ide:

basic life support (BLS)?	☐ YES ☐ NO	land ambulance?	☐ YES ☐ NO
ad anced life support (ALS)?	☐ YES ☐ NO	air ambulance?	☐ YES ☐ NO
emergency runs?	☐ YES ☐ NO	marine ambulance?	☐ YES ☐ NO
non-emergency runs?	☐ YES ☐ NO		

How many crewmembers accompany this ehicle on runs?_____

B. 2nd Vehicle Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Type (automobile, aircraft, boat, etc.)		Vehicle Identification Number
Make	Model	Year (YYYY)

2. Does this ehicle ha e the following:

first aid supplies?	☐ YES ☐ NO	other safety/life-sa ing equipment?	☐ YES ☐ NO
oxygen equipment?	☐ YES ☐ NO	two-way telecommunications radio?	☐ YES ☐ NO
emergency warning lights?	☐ YES ☐ NO	mobile communication/wireless telephone?	☐ YES ☐ NO
sirens?	☐ YES ☐ NO	stretcher?	☐ YES ☐ NO
		clean linens?	☐ YES ☐ NO

Report other medical equipment this ehicle carries:

_____ _____ _____

3. Does this ehicle pro ide:

basic life support (BLS)?	☐ YES ☐ NO	land ambulance?	☐ YES ☐ NO
ad anced life support (ALS)?	☐ YES ☐ NO	air ambulance?	☐ YES ☐ NO
emergency runs?	☐ YES ☐ NO	marine ambulance?	☐ YES ☐ NO
non-emergency runs?	☐ YES ☐ NO		

How many crewmembers accompany this ehicle on runs?_____

SECTION 3: QUALIFICATION OF CREW

A. 1st Crewmember Information - Check the appropriate box to indicate whether this ambulance company is using this section to add or delete a crewmember currently on file. Provide the effective date of that change, complete the appropriate information, and sign and date the certification statement. Otherwise:

1. Furnish the name, social security number, and date of birth of each crewmember.

2. Report all training completed by each crewmember.

- For Basic Life Support (BLS) vehicle crews,
  - At least one crewmember must be certified as an emergency medical technician (EMT) by the State or local authority where the services are furnished, and
  - Must be legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle.

- For Advanced Life Support (ALS) vehicle crews,
  - At least one crewmember must meet both of the above requirements for BLS crewmembers, and
  - Must be certified as a paramedic or EMT by the State or local authority where the services are furnished to perform one or more ALS services.

All certificates verifying that the crewmembers have successfully completed the requisite training must be submitted with this application. Crewmembers must continue to pursue and complete continuing education requirements in accordance with State and local licensing laws. Evidence of re-certification must be submitted to the Medicare contractor on an ongoing basis, as required by State and local law.

B. 2nd Crewmember Information - This section is provided to report additional crewmembers. See instructions above for Section 3A.

C. 3rd Crewmember Information - This section is provided to report additional crewmembers. See instructions above for Section 3A.

D. 4th Crewmember Information - This section is provided to report additional crewmembers. See instructions above for Section 3A.

E. 5th Crewmember Information - This section is provided to report additional crewmembers. See instructions above for Section 3A.

3. Qualification of Crew

This section is to be completed with information about all crewmembers. In addition to the identifying information, all health care related training courses completed by the crewmember must be reported (see CFR 410.40 and CFR 410.41). If there are more than fi e crewmembers, copy and complete this section as needed.

A. 1st Crewmember Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

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

2. List training completed by this crewmember (i.e., First Aid, CPR, ACLS, etc.) and attach copy(s) of training certificate(s).

B. 2nd Crewmember Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

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

2. List training completed by this crewmember (i.e., First Aid, CPR, ACLS, etc.) and attach copy(s) of training certificate(s).

C. 3rd Crewmember Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

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

2. List training completed by this crewmember (i.e., First Aid, CPR, ACLS, etc.) and attach copy(s) of training certificate(s).

D. 4th Crewmember Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

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

2. List training completed by this crewmember (i.e., First Aid, CPR, ACLS, etc.) and attach copy(s) of training certificate(s).

E. 5th Crewmember Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

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

2. List training completed by this crewmember (i.e., First Aid, CPR, ACLS, etc.) and attach copy(s) of training certificate(s).

SECTION 4: CERTIFIED BASIC LIFE SUPPORT (BLS)

This section is to be completed by ambulance companies that **only** provide Basic Life Support (BLS) services.

A. Check Box—Check this box if this section does not apply and skip to Section 5.

B. Paramedic Intercept Services Information - Check the appropriate box to indicate a change from the information currently on file. Provide the effective date of that change, complete the appropriate information, and sign and date the certification statement. Otherwise:

- Answer "Yes" or "No" to the question about paramedic intercept services.

Paramedic Intercept Services involve an arrangement between a BLS ambulance company and an ALS ambulance company whereby the latter provides the ALS services and the BLS ambulance company provides the transportation component. If such an arrangement exists between the enrolling ambulance company and another ambulance company, the enrolling ambulance company must attach a copy of the signed contract(s).

SECTION 5: CERTIFIED ADVANCED LIFE SUPPORT (ALS)

This section is to be completed by ambulance suppliers that provide Advanced Life Support (ALS) services.

A. Check Box - If this section does not apply, check this box and proceed to Section 6.

B. Certified Advance Life Support Questionnaire - Check the appropriate box to indicate a change to information currently on file. Provide the effective date of that change, complete the appropriate information, and sign and date the certification statement. Otherwise:

1. Please check whether this company is certified to perform defibrillation. If "Yes," attach a copy of the certification.

2. Answer "Yes" or "No" to the question about paramedic intercept services.

Paramedic Intercept Services involve an arrangement between a BLS ambulance company and an ALS ambulance company whereby the latter provides the ALS services and the BLS ambulance company provides the transportation component. If such an arrangement exists between the enrolling ambulance company and another ambulance company, the enrolling ambulance company must attach a copy of the signed contract(s).

SECTION 6: MEDICAL DIRECTOR INFORMATION

Check the appropriate box to indicate whether this section is being used to add, delete, or change information about the medical director currently on file. Provide the effective date of that change, complete the appropriate information, and sign and date the certification statement. Otherwise:

A. Check Box - If a Medical Director is not required by the State where this ambulance company will render services, check this box and skip this section.

B. Medical Director Identification - Provide the name, social security number, date of birth, and Medicare identification number of the Medical Director.

4. Certified Basic Life Support (BLS)

This section is to be completed with specific information about the ambulance ser ice supplier if it only furnishes Certified Basic Life Support (BLS) ser ices.

A. Check here ☐ if this section does not apply and skip to Section 5.

B. Paramedic Intercept Services Information ☐ **Change** **Effective Date:**_____

Does this company ha e a contract with a paramedic or Emergency Medical Technician (EMT) organization or other Ad anced Life Support (ALS) ambulance supplier whereby the Paramedic/EMT organization or other ALS supplier furnishes Paramedic Intercept Ser ices? ☐ YES ☐ NO

IF YES, submit a copy of the signed contractual agreement(s).

5. Certified Advanced Life Support (ALS)

This section is to be completed with specific information about the ambulance ser ice supplier if the company furnishes Certified Ad ance Life Support (ALS) ser ices.

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

B. Certified Advanced Life Support Questionnaire ☐ **Change** **Effective Date:**_____

1. Is this company certified to perform defibrillation? ☐ YES ☐ NO
IF YES, attach a copy of the certification.

2. Does this company ha e a contract with a Basic Life Support Ser ice, such as a olunteer ambulance company, whereby the ALS supplier furnishes Paramedic Intercept Ser ices? ☐ YES ☐ NO

IF YES, submit a copy(s) of the signed contractual agreement(s).

6. Medical Director Information

This section is to be completed with information about all Medical Directors associated with this ambulance ser ice supplier. Some States require ambulance companies to ha e a Medical Director on staff as a requirement for State licensing. If your State has such a requirement, this section must be completed. If this ambulance company has more than one Medical director, copy and complete this section for each.

A. Check here ☐ if a Medical Director is not required by the State where this ambulance company renders services and skip this section.

B. Medical Director Identification ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

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

Social Security Number	Date of Birth (MM/DD/YYYY)	Medicare Identification Number

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Attachment 2 INDEPENDENT DIAGNOSTIC TESTING FACILITIES (IDTFs)

All suppliers that perform diagnostic tests, other than clinical laboratory or pathology tests, and are required to enroll as an IDTF must complete this attachment. CMS requires the information in this attachment to determine whether the enrolling supplier meets all IDTF standards. Not all suppliers that perform diagnostic tests are required to enroll as an IDTF. Generally, an entity can bill for the technical component of the diagnostic tests without an IDTF enrollment if it has the following characteristics:

- A physician practice that is owned, directly or indirectly, by one or more physicians or by a hospital;
- A facility that primarily bills for physician services (e.g., evaluation and management (E&M codes)) and not for diagnostic tests;
- A facility that furnishes diagnostic tests primarily to patients whose medical conditions are being treated or managed on an ongoing basis by one or more physicians in the practice;
- The diagnostic tests are performed and interpreted at the same location where the practice physicians also treat patients for their medical conditions.

However, if a substantial portion of the facility's business involves the performance of diagnostic tests, the diagnostic testing services may be a sufficiently separate business to require enrollment as an IDTF. In that case, the physician or physician group practice can continue to be enrolled as a physician or physician group practice but are also required to enroll as an IDTF. The physician or group practice can bill for professional fees and the diagnostic tests they perform on their patients using their billing number. Therefore, the practice must bill as an IDTF for diagnostic tests furnished to Medicare beneficiaries who are not regular patients of the physician or group practice.

Applicants who are unsure if they require IDTF enrollment should contact their Medicare carrier for a determination.

Diagnostic Radiology – Many diagnostic tests are radiological procedures that require the professional services of a radiologist. We recognize that a radiologist's practice is generally different from those of other physicians because radiologists usually do not bill E&M codes or treat a patient's medical condition on an ongoing basis. A radiologist or group practice of radiologists is not necessarily required to enroll as an IDTF. A radiologist or group of radiologists are not required to enroll as an IDTF if all of the following conditions are met:

- The practice is owned by radiologists, a hospital, or both;
- The owning radiologist(s) and any employed or contracted radiologist(s) regularly perform physician services (e.g., test interpretations) at the location where the diagnostic tests are performed;
- The billing patterns of the enrolled facility indicate that the facility is not primarily a testing facility and that it was organized to provide the professional services of radiologists (e.g., (1) the enrolled facility should not be billing for a significant number of purchased interpretations, (2) the facility should rarely bill for the technical component of a diagnostic test, (3) the facility should bill for a substantial percentage of all interpretations of the diagnostic tests performed by the practice), and
- A substantial majority of the radiological interpretations are performed at the practice location where the diagnostic tests are performed.

If enrolling as a diagnostic radiology group practice or clinic, and will be billing for the technical component (tc) of diagnostic radiological tests without enrolling as an IDTF, the facility should be prepared to prove that it meets the exceptions shown above.

A mobile IDTF that provides X-ray services is not classified as a portable X-ray supplier. Therefore, they cannot bill for transportation and setup. If they desire to bill for these services, they must also enroll as a portable X-ray supplier and bill in accordance with the portable X-ray supplier billing rules.

Before completing this attachment, all providers/suppliers considering enrolling as an IDTF should carefully review 42 CFR 410.33, titled "Independent Diagnostic Testing Facility." This reference is available on the Internet through the National Archives and Records Administration web site, or at many libraries or legal reference services.

Ambulatory Surgical Centers (ASCs) - An ASC cannot bill for separate diagnostic tests they perform during the ASC's scheduled hours of operation (see 42 CFR 416.2). When a provider or supplier that owns an ASC performs diagnostic tests in the same physical facility as the ASC, but during a time period when the ASC is not in operation, it must submit claims for those diagnostic tests and bill Medicare as an IDTF. Therefore, in this situation, a separate enrollment application is required by the provider or supplier to bill Medicare as an IDTF.

SECTION 1: SERVICE PERFORMANCE

A. Standards Qualifications - All IDTFs must meet current CMS standards as an IDTF prior to enrollment. The enrolling IDTF must furnish the date it met all current IDTF standards. This date may be used as the effective date for claims payment if the enrolling IDTF can provide evidence (e.g., personnel and equipment records) that they met the standards on that date.

B. CPT - 4 and HCPCS Codes - For initial enrollment, check the "Add" box and report all CPT-4 and HCPCS codes this IDTF will bill Medicare for. Otherwise:

- Indicate whether you are adding or deleting a code and provide the effective date of the addition or deletion. Provided that this is the only change the IDTF is reporting, complete the appropriate section and sign and date the certification statement. Otherwise:
  - Furnish the CPT – 4 or HCPCS code for which this IDTF intends to bill Medicare,
  - The name and type of equipment used to perform the reported procedure, and
  - The model number of the reported equipment.

  The IDTF should report all Current Procedural Technology, Version 4 (CPT-4) codes, HCFA Common Procedural Coding System Codes (HCPCS), and types of equipment (including the model number), for which it will perform tests, supervise, interpret, and/or bill. All codes reported must be for diagnostic tests that an IDTF is allowed to perform. Specifically, diagnostic tests that are clearly surgical in nature, which must be performed in a hospital or ambulatory surgical center, should not be reported.

ATTACHMENT 2

Independent Diagnostic Testing Facility (IDTF)

This attachment is to be completed by all Independent Diagnostic Testing Facilities enrolling in the Medicare program. See instructions to determine if this supplier needs to complete this Attachment to enroll in Medicare as an IDTF.

1. Service Performance

This section is to be completed with information about this IDTF's compliance with current CMS IDTF standards, the types of tests performed by this IDTF, and the equipment used by this IDTF.

A. Standards Qualifications

Does this Independent Diagnostic Testing Facility meet all current CMS standards for IDTFs? ☐ YES ☐ NO
IF YES, furnish the date that all standards were met:_____

B. CPT - 4 and HCPCS Codes ☐ **Add** ☐ **Delete** **Effective Date:**_____

Furnish all Current Procedural Terminology, Version 4 (CPT-4) codes or HCFA Common Procedure Coding System codes (HCPCS) for which this IDTF intends to bill Medicare. In addition, report all equipment this IDTF will be using and the model number of each piece of equipment.

	CPT - 4 or HCPCS Code	Equipment	Model Number
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

SECTION 2: INTERPRETING PHYSICIAN INFORMATION

This section is to be completed with identifying information on all physicians who interpret the test performed by the enrolling IDTF and for which the IDTF will bill Medicare.

A. Check Box - Check the box indicating that this section does not apply if the IDTF will not bill Medicare for interpretations of diagnostic tests performed by the IDTF and skip to Section 3. Otherwise:

B. 1st Interpreting Physician Information - Check the appropriate box to indicate whether completing this section to add, delete, or change information about a previously reported physician. Provide the effective date, complete the appropriate information, and sign and date the certification statement. Otherwise:

- Furnish the full name, social security number, date of birth, and Medicare identification number for each physician.

NOTE: All interpreting physicians must be currently enrolled in the Medicare Program.

NOTE: All interpreting physicians must complete and submit an Individual Reassignment of Benefi 0 1 5D6MS 855R) if

2. Interpreting Physician Information

This section is to be completed with identifying information about all physicians whose interpretations will be billed by this IDTF. If there are more than eight physicians, copy and complete this section as needed.

A. Check here ☐ if this section does not apply and skip to Section 3 of this Attachment.

B. 1st Interpreting Physician Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:_____**

Name First	Middle	Last	Jr., Sr., etc.
Social Security Number	Date of Birth (MM/DD/YYYY)	Medicare Identification Number	

C. 2nd Interpreting Physician Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:_____**

Name First	Middle	Last	Jr., Sr., etc.
Social Security Number	Date of Birth (MM/DD/YYYY)	Medicare Identification Number	

D. 3rd Interpreting Physician Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:_____**

Name First	Middle	Last	Jr., Sr., etc.
Social Security Number	Date of Birth (MM/DD/YYYY)	Medicare Identification Number	

E. 4th Interpreting Physician Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:_____**

Name First	Middle	Last	Jr., Sr., etc.
Social Security Number	Date of Birth (MM/DD/YYYY)	Medicare Identification Number	

F. 5th Interpreting Physician Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:_____**

Name First	Middle	Last	Jr., Sr., etc.
Social Security Number	Date of Birth (MM/DD/YYYY)	Medicare Identification Number	

G. 6th Interpreting Physician Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:_____**

Name First	Middle	Last	Jr., Sr., etc.
Social Security Number	Date of Birth (MM/DD/YYYY)	Medicare Identification Number	

H. 7th Interpreting Physician Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:_____**

Name First	Middle	Last	Jr., Sr., etc.
Social Security Number	Date of Birth (MM/DD/YYYY)	Medicare Identification Number	

I. 8th Interpreting Physician Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:_____**

Name First	Middle	Last	Jr., Sr., etc.
Social Security Number	Date of Birth (MM/DD/YYYY)	Medicare Identification Number	

Note: All interpeting physicians must be currently enrolled in the Medicare Program.

SECTION 3: NON-PHYSICIAN PERSONNEL (TECHNICIANS) WHO PERFORM TESTS

This section is to be completed with identifying and qualification information about all non-physician personnel who perform the tests furnished by the IDTF. These persons are often referred to as technicians.

A. 1st Non-Physician Personnel Information - Check the appropriate box to indicate whether this section is being completed to add, delete, or change information about a previously reported technician. Provide the effective date, complete the appropriate information, and sign and date the certification statement. Otherwise:

1. Furnish the full name, social security number, and date of birth for each technician.

2. If the technician is State licensed or certified, the applicable license and/or certification must be reported.

NOTE: Not all states have licensing requirements for all diagnostic tests. If a reported technician does not have either a State license or certification, or certification from a national credentialling body, he/she cannot perform the IDTF diagnostic tests and should not be reported. Notarized or certified true copies of the State license or certificate should be attached. The only exception to this is when a Medicare payable diagnostic test is not subject to State license or certification requirements, and no generally accepted national credentialling body exists. When this situation occurs, the technician performing the test must be reported. The IDTF should submit as an attachment any educational/credentialling and/or experience that the person has, and must fully justify why the individual should be considered qualified to perform the test(s) reported.

3. If a national credentialling body has certified the technician, furnish the name of the credentialling organization and the type of credentials issued to the technician. Notarized or certified true copies from the national credentialling body must be attached.

4. If the technician is also employed by, or working for, a hospital as well as an IDTF, this must be reported in this section. Furnish the name of the hospital where the technician is working or employed.

B. 2nd Non-Physician Personnel Information - This section is provided to report additional technicians. See instructions above for Section 3A.

C. 3rd Non-Physician Personnel Information - This section is provided to report additional technicians. See instructions above for Section 3A.

D. 4th Non-Physician Personnel Information - This section is provided to report additional technicians. See instructions above for Section 3A.

E. 5th Non-Physician Personnel Information - This section is provided to report additional technicians. See instructions above for Section 3A.

F. 6th Non-Physician Personnel Information - This section is provided to report additional technicians. See instructions above for Section 3A.

3. Non-Physician Personnel (Technicians) who Perform Tests

This section is to be completed with information about all non-physician personnel who perform tests for this IDTF.
If there are more than six technicians, copy and complete this section as needed.

A. 1st Non-Physician Personnel Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.
Social Security Number		Date of Birth (MM/DD/YYYY)	
2. Is this technician State licensed or State certified? ☐ YES ☐ NO			
License/Certification Number (if applicable)		License/Certification Issue Date (if applicable) (MM/DD/YYYY)	
State of Issuance (if applicable)		Type of License/Certification (if applicable)	
3. Is this technician certified by a national credentialling organization? ☐ YES ☐ NO			
Name of credentialling organization (if applicable)		Type of Credentials (if applicable)	
4. Is this technician employed by a hospital? ☐ YES ☐ NO **IF YES**, furnish the name of the hospital here:_____			

B. 2nd Non-Physician Personnel Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.
Social Security Number		Date of Birth (MM/DD/YYYY)	
2. Is this technician State licensed or State certified? ☐ YES ☐ NO			
License/Certification Number (if applicable)		License/Certification Issue Date (if applicable) (MM/DD/YYYY)	
State of Issuance (if applicable)		Type of License/Certification (if applicable)	
3. Is this technician certified by a national credentialling organization? ☐ YES ☐ NO			
Name of credentialling organization (if applicable)		Type of Credentials (if applicable)	
4. Is this technician employed by a hospital? ☐ YES ☐ NO **IF YES**, furnish the name of the hospital here:_____			

C. 3rd Non-Physician Personnel Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.
Social Security Number		Date of Birth (MM/DD/YYYY)	
2. Is this technician State licensed or State certified? ☐ YES ☐ NO			
License/Certification Number (if applicable)		License/Certification Issue Date (if applicable) (MM/DD/YYYY)	
State of Issuance (if applicable)		Type of License/Certification (if applicable)	
3. Is this technician certified by a national credentialling organization? ☐ YES ☐ NO			
Name of credentialling organization (if applicable)		Type of Credentials (if applicable)	
4. Is this technician employed by a hospital? ☐ YES ☐ NO **IF YES**, furnish the name of the hospital here:_____			

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3. Non-Physician Personnel (Technicians) who Perform Tests (Continued)

D. 4th Non-Physician Personnel Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

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

2. Is this technician State licensed or State certified? ☐ YES ☐ NO

License/Certification Number (if applicable)	License/Certification Issue Date (if applicable) (MM/DD/YYYY)
State of Issuance (if applicable)	Type of License/Certification (if applicable)

3. Is this technician certified by a national credentialling organization? ☐ YES ☐ NO

Name of credentialling organization (if applicable)	Type of Credentials (if applicable)

4. Is this technician employed by a hospital? ☐ YES ☐ NO
IF YES, furnish the name of the hospital here:_____

E. 5th Non-Physician Personnel Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

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

2. Is this technician State licensed or State certified? ☐ YES ☐ NO

License/Certification Number (if applicable)	License/Certification Issue Date (if applicable) (MM/DD/YYYY)
State of Issuance (if applicable)	Type of License/Certification (if applicable)

3. Is this technician certified by a national credentialling organization? ☐ YES ☐ NO

Name of credentialling organization (if applicable)	Type of Credentials (if applicable)

4. Is this technician employed by a hospital? ☐ YES ☐ NO
IF YES, furnish the name of the hospital here:_____

F. 6th Non-Physician Personnel Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

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

2. Is this technician State licensed or State certified? ☐ YES ☐ NO

License/Certification Number (if applicable)	License/Certification Issue Date (if applicable) (MM/DD/YYYY)
State of Issuance (if applicable)	Type of License/Certification (if applicable)

3. Is this technician certified by a national credentialling organization? ☐ YES ☐ NO

Name of credentialling organization (if applicable)	Type of Credentials (if applicable)

4. Is this technician employed by a hospital? ☐ YES ☐ NO
IF YES, furnish the name of the hospital here:_____

SECTION 4: SUPERVISING PHYSICIAN(S)

This section is to be completed with identifying information about the physician(s) who supervise the operation of the IDTF and who furnish the personal, direct, or general supervision per 42 CFR 410.32(b)(3). The supervising physician must also attest to his/her supervising responsibilities for the enrolling IDTF.

A. Supervising Physician Information - Check the appropriate box to indicate whether this section is being completed to add, delete, or change information about an existing supervising physician. Provide the effective date of the change, complete the appropriate information, and sign and date the certification statement. Otherwise:

1. Provide the full name, social security number, date of birth, Medicare identification number, telephone and fax numbers, and e-mail address for each supervisory physician.

2. General Supervision

- Check the appropriate boxes in this section to indicate the responsibilities assumed by the physician(s) reported in Section 4A1 furnishing General Supervision.

For each physician performing General Supervision, at least one of the three functions listed here must be checked. However, to meet the General Supervision requirement the enrolling IDTF must have at least one supervisory physician for **each** of the three functions. An example is where two physicians are responsible for function 1, a third physician is responsible for function 2, and a fourth physician is responsible for function 3. All four supervisory physicians must complete and sign the supervisory physician section of this application. They should **only** check the function(s) they actually perform.

3. Indicate the type of supervision provided by this physician for the tests performed by this IDTF.

Information concerning the type of supervision (personal, direct, or general) required for performance of specific IDTF tests can be obtained from the Medicare carrier. All IDTFs must report at least one supervisory physician, and at least one supervising physician must perform the supervision requirements stated in 42 CFR 410.32(b)(3). All supervisory physician(s) must be currently enrolled with Medicare. However, they can be enrolled with a Medicare contractor other than the one to which this application is being submitted. The physician's Medicare identification number must be reported.

The type of supervision being performed by each physician who signs the attestation in Section 4B should be indicated in Section 4A3. Definitions of the types of supervision are as follows:

Personal Supervision means a physician must be in attendance in the room during the performance of the procedure.

Direct Supervision in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and provide direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.

General Supervision means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. The qualifications and training of the non-physician personnel who actually perform the diagnostic procedure and the proper operation, maintenance, and calibration of the necessary equipment and supplies are the continuing responsibility of the physician. See the notes in this section of the application for guidance concerning: "Personal," "Direct," and "General" supervision.

B. Attestation Statement for Supervising Physicians – This section must be signed and dated by all Supervising Physician(s) rendering supervisory services for this IDTF.

1) Complete the name of the enrolling IDTF.

2) Report all CPT and HCPCS codes the IDTF performs that this supervising physician **will not** be supervising.

3) Furnish the dated signature of the supervising physician.

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

4. Supervising Physician(s)

This section is to be completed with information about all super ising physicians. If there is more than one super ising physician, copy and complete this section for each.

A. Supervising Physician Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.
Social Security Number	Date of Birth (MM/DD/YYYY)	Medicare Identification Number (if applicable)	
Telephone Number (Ext.) ( ) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)	

2. General Super ision

For o erall IDTF operation in accordance with 42 CFR 410.33(b), check all that apply for the Super ising Physician reported in Section 4A1 abo e:

- ☐ Assumes responsibility for the o erall direction and control of the quality of testing performed.
- ☐ Assumes responsibility for assuring that the non-physician personnel who actually perform the diagnostic procedures are properly trained and meet required qualifications.
- ☐ Assumes responsibility for the proper maintenance and calibration of the equipment and supplies necessary to perform the diagnostic procedures.

3. Type of Super ision Pro ided

Check the applicable box below indicating the type of super ising pro ided by the physician reported in Section 4A1 abo e for the tests performed by the IDTF in accordance with 42 CFR 410.32 (b)(3) (Definitions).

(Check applicable box) ☐ Personal Super ision ☐ Direct Super ision ☐ General Super ision

Note: Personal / Direct: If this Super ising Physician performs Personal or Direct Super ision, he/she must be currently enrolled in Medicare with the Medicare carrier to which this application is being submitted.

Note: General: If this Super ising Physician performs General Super ision, he/she must be licensed in all States where he/she will be performing the General Super ision. If this Super ising Physician is not enrolled with the Medicare carrier to which this application is being submitted, he/she must submit a copy of his/her current State license for the state in which this application is being submitted.

B. Attestation Statement for Supervising Physicians

1) ***I hereby acknowledge that I have agreed to provide (IDTF Name)_____ with the Supervisory Physician services checked above for all CPT-4 and HCPCS codes reported in Section 1B of this Attachment*** (See number 2 below if all reported CPT-4 and HCPCS codes do not apply)***. I also hereby certify that I have the required proficiency in the performance and interpretation of each type of diagnostic procedure, as reported by CPT-4 or HCPCS code in Section 1B of this Attachment (except for those CPT-4 or HCPCS codes identified in number 2 below). I have read and understand the Penalties for Falsifying Information on this Enrollment Application, as stated in Section 14 of this application. I am aware that falsifying information may result in fines and/or imprisonment. If I cease providing the stated Supervisory Physician services, I shall immediately notify the Medicare program.***

2) ***I am not acting as a Supervising Physician for the following CPT-4 and/or HCPCS codes reported in Section 1B of this Attachment.***

CPT-4 or HCPCS Code	CPT-4 or HCPCS Code	CPT-4 or HCPCS Code
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3) **Signature** of Super ising Physician:	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)	Date (MM/DD/YYYY) Signed