MEDICARE ENROLLMENT APPLICATION

Medicare Diabetes Prevention Program (MDPP) Suppliers

CMS-20134

SEE PAGE 3 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION. SEE PAGE 4 FOR INFORMATION ON WHERE TO MAIL THIS APPLICATION.

SEE PAGE 31 TO FIND A LIST OF THE SUPPORTING DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION.

MDPP SUPPLIER STANDARDS

Below is an abbreviated summary of the standards every MDPP supplier must meet in order to obtain and retain their billing privileges. These requirements, in their entirety, are listed in 42 C.F.R. section 424.205(d).

1. An MDPP supplier must have and Maintain MDPP preliminary recognition or full Center for Disease Prevention and Control (CDC) Diabetes Prevention Recognition Program (DPRP) recognition.

2. An MDPP supplier must not currently have its billing privileges terminated for cause or be excluded by a state Medicaid agency.

3. The MDPP supplier must not permit MDPP services to be furnished by an ineligible coach or include on its roster any an ineligible coach. For coach eligibility criteria, see 42 C.F.R. 424.205(e).

4. An MDPP supplier must maintain at least one administrative location. All administrative locations must be located at an appropriate site, must be reported on this application. For details on the characteristics of an appropriate site, see 42 C.F.R. 424.205(d)(4).

5. An MDPP supplier must report any changes to this enrollment application within 30 days for any changes of ownership, changes to the coach roster, and final adverse legal action history and must report all other changes within 90 days.

6. An MDPP supplier must maintain a primary business telephone that is operating at administrative locations or directly where services are furnished if services are furnished in community settings. The associated telephone number must be listed with the name of the business in public view.

7. The MDPP supplier must not knowingly sell to or allow another individual or entity to use its supplier billing number.

8. An MDPP supplier must not deny an MDPP beneficiary access to MDPP services during the MDPP benefit period described in see 42 C.F.R. 410.79(c)(2), including conditioning access to MDPP services on the basis of an MDPP beneficiary's weight, health status, or achievement of performance goals, with certain exemptions detailed in 42 C.F.R. 424.05(d)(8).

9. The MDPP supplier and other individuals or entities performing functions or services on the MDPP supplier's behalf must not unduly coerce an MDPP beneficiary's decision to change or not to change to a different MDPP supplier, including through the use of pressure, intimidation, or bribery.

10. Except as allowed under 42 C.F.R 424.205(d)(8), the MDPP supplier must offer an MDPP beneficiary all services for which they are eligible. For detailed information see 42 C.F.R 424.205(d)(10).

11. Before the initial core session is furnished, the supplier must disclose detailed information about the set of MDPP services to each MDPP beneficiary to whom it wishes to begin furnishing MDPP services, including eligibility requirements, the once-per-lifetime nature of MDPP services, minimum coverage requirements, and the MDPP supplier standards..

12. The MDPP supplier must answer MDPP beneficiaries' questions about MDPP services and respond to MDPP related complaints within a reasonable timeframe. An MDPP supplier must implement a complaint resolution protocol and maintain documentation of all beneficiary contact regarding such complaints, including the name and Medicare Beneficiary Identifier of the beneficiary, a summary of the complaint, related correspondences, notes of actions taken, and the names and/or NPIs of individuals who took such action on behalf of the MDPP supplier. This information must be kept at each administrative location and made available to CMS or its contractors upon request.

13. The MDPP supplier must maintain a crosswalk file which indicates how participant identifications for the purposes of CDC performance data correspond to corresponding beneficiary health insurance claims numbers or Medicare Beneficiary Identifiers for each MDPP beneficiary. The MDPP supplier must submit the crosswalk file to CMS or its contractor, in a manner and form as directed by CMS.

14. MDPP suppliers must submit performance data for MDPP beneficiaries who attend ongoing maintenance sessions with data elements consistent with the CDC's DPRP Standards for data elements required for the core services period, in a manner and form as directly by CMS.

15. The MDPP supplier must allow CMS or its agents to conduct onsite inspections or recordkeeping reviews in order to ascertain the MDPP supplier's compliance with these standards, and must adhere to MDPP documentation requirements outlined in 42 C.F.R 424.205(g).

WHO SHOULD SUBMIT THIS APPLICATION

Organizations, including those with existing enrollments, can apply for enrollment in the Medicare program or make a change in their enrollment information using either:

- The Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or
- The paper enrollment application process (e.g., CMS-20134).

For additional information regarding the Medicare enrollment process, including Internet-based PECOS, go to *http://www.cms.gov/MedicareProviderSupEnroll*.

Any organization wishing to furnish MDPP services is required to submit a Medicare enrollment application (i.e., Internet-based PECOS or the CMS-20134) to become an MDPP supplier, including those who have an existing enrollment into Medicare.

The following suppliers must complete this application to initiate the enrollment process:

- Medicare Diabetes Prevention Program (MDPP) Supplier - In-person expanded model test

  If your supplier type is not listed above, contact your designated fee-for-service contractor before you submit this application.

Complete and submit this application if you are an organization/group that plans to bill Medicare and you are:

- **An organization with CMS MDPP preliminary recognition or full CDC Diabetes Prevention Recognition Program (DPRP) Recognition.**
- **Currently enrolled as an MDPP supplier with a Medicare fee-for-service contractor but need to enroll in another fee-for-service contractor's jurisdiction** (e.g., you have opened a administrative location in a geographic territory serviced by another Medicare fee-for-service contractor).
- **Currently enrolled in Medicare as an MDPP supplier and need to make changes to your enrollment data** (e.g., you have added a community setting or coach). Changes must be reported in accordance with the time frames established in 42 C.F.R. § 424.205(d)(5).

BILLING NUMBER INFORMATION

The National Provider Identifier (NPI) is the standard unique health identifier for health care providers and is assigned by the National Plan and Provider Enumeration System (NPPES). **As a Medicare health supplier, you must obtain an NPI prior to enrolling in Medicare or before submitting a change for your existing Medicare enrollment information.** Applying for an NPI is a process separate from Medicare enrollment. As a supplier, it is your responsibility to determine if you have "subparts." A subpart is a component of an organization (supplier) that furnishes healthcare and is not itself a legal entity. If you do have subparts, you must determine if they should obtain their own unique NPIs. Before you complete this enrollment application, you need to make those determinations and obtain NPI(s) accordingly.

Important: For NPI purposes, sole proprietors and sole proprietorships are considered to be "Type 1" providers. Organizations (e.g., corporations, partnerships) are treated as "Type 2" entities. When reporting the NPI of a sole proprietor on this application, therefore, the individual's Type 1 NPI should be reported; for organizations, the Type 2 NPI should be furnished.

To obtain an NPI, you may apply online at *https://NPPES.cms.hhs.gov*. For more information about subparts, visit *www.cms.gov/NationalProvidentStand* to view the "Medicare Expectations Subparts Paper." All MDPP coaches are required to obtain an NPI. For more information, see section 7 of this enrollment application.

The Medicare Identification Number, often referred to as a Provider Transaction Access Number (PTAN) or Medicare "legacy" number, is a generic term for any number other than the NPI that is assigned by the Medicare Administrative Contractor (MAC) at the point of enrollment to identify a Medicare supplier.

INSTRUCTIONS FOR COMPLETING AND SUBMITTING THIS APPLICATION

- Type or print all information so that it is legible. Do not use pencil.
- Report additional information within a section by copying and completing that section for each additional entry.
- Attach all required supporting documentation.
- Keep a copy of your completed Medicare enrollment package for your records.
- Send the completed application with original signatures and all required documentation to the appropriate Medicare fee-for-service contractor.

AVOID DELAYS IN YOUR ENROLLMENT

To avoid delays in the enrollment process, you should:

- Complete all required sections.
- Ensure that the legal business name shown in Section 2 matches the name on the tax documents.
- Ensure that the correspondence address shown in Section 2 is the supplier's address.
- Enter your NPI in the applicable sections.
- Enter all applicable dates.
- Ensure that the correct person signs the application.
- Send your application and all supporting documentation to the designated fee-for-service contractor.
- Promptly respond to any fingerprint solicitation(s) as a result of this enrollment application

ADDITIONAL INFORMATION

For additional information regarding the Medicare enrollment process, visit *www.cms.gov/MedicareProviderSupEnroll*.

The Medicare fee-for-service contractor may request, at any time during the enrollment process, additional documentation to support and validate information reported on the application. You are responsible for providing this documentation within 30 days of the request.

Certain information you provide on this application is considered to be protected under 5 U.S.C. Section 552(b)(4) and/or (b)(6), respectively. For more information, see the last page of this application for the Privacy Act Statement.

PROCESS FOR OBTAINING MEDICARE APPROVAL

The standard process for becoming an MDPP supplier is as follows:

1. The MDPP supplier and its coaches obtain the required National Provider Identification Number (NPI), PRIOR to completing and submitting this application to the appropriate Medicare fee-for-service contractor.
2. The supplier pays the required application fee (via www.pay.gov) upon initial enrollment, the addition of a new administrative location that results in a new PTAN, revalidation and, if requested, reactivation PRIOR to completing and submitting this application to the Medicare fee-for-service contractor.
3. The supplier completes and submits this enrollment application (CMS-20134) and all supporting documentation to the Medicare fee-for-service contractor .
4. If requested by the Medicare fee-for-service contractor, the supplier submits a fingerprint background check.

NOTE: Contact Accurate Biometrics for fingerprinting procedures, to find a fingerprint collection site, and to ensure the fingerprint results are accurately submitted to the Federal Bureau of Investigation (FBI) and properly returned to CMS. Accurate Biometrics can be contacted at 866-361-9944 or visit their website at *www.cmsfingerprinting.com*.

The Medicare fee-for-service contractor reviews the application, including verifying that all coaches are eligible, and conducts a site visit to verify compliance with the supplier standards found at 42 C.F.R. sections 424.205(d). After completing its review, the Medicare fee-for-service contractor notifies the supplier in writing about its enrollment decision.

SECTION 1: BASIC INFORMATION

NEW ENROLLEES AND THOSE WITH A NEW TAX ID NUMBER

If you are:

- Enrolling in the Medicare program for the first time with this Medicare fee-for-service contractor under this tax identification number.
- Already enrolled with a Medicare fee-for-service contractor but are establishing a practice location in another fee-for-service contractor's jurisdiction.
- Enrolled with a Medicare fee-for-service contractor but have a new tax identification number. If you are reporting a change to your tax identification number, you must complete a new application.

The following actions apply to Medicare suppliers already enrolled in the program as an MDPP supplier.

ENROLLED MEDICARE SUPPLIERS

Reactivation

To reactivate your Medicare billing privileges, submit this enrollment application. In addition, prior to being reactivated, you must be able to submit a valid claim and meet all current requirements for your supplier type before reactivation may occur.

Voluntary termination

A supplier should voluntarily terminate its Medicare enrollment when it:

- Will no longer be rendering MDPP services to Medicare beneficiaries, or
- Is planning to cease (or has ceased) MDPP-related operations.

Change of ownership

If an MDPP supplier is undergoing a change of ownership (CHOW) in accordance with the principles outlined in 42 C.F.R. 489.18, the entity must submit a new application for the new ownership.

Change of information

- A change of information should be submitted if you are changing, adding or deleting information under your current tax identification number.

Changes in your existing enrollment data must be reported to the Medicare fee-for-service contractor in accordance with 42 C.F.R. § 424.205(d)(5).

If you are already enrolled in Medicare and are not receiving Medicare payments via electronic funds transfer (EFT), any change to your enrollment information will require you to submit a CMS-588 form. All future payments will then be made via EFT.

Revalidation

CMS may require you to submit or update your enrollment information. The Medicare fee-for-service contractor will notify you when it is time for you to revalidate your enrollment information. Do not submit a revalidation application until you have been contacted the Medicare fee-for-service contractor. MDPP suppliers revalidate every five years.

ALL MDPP SUPPLIER APPLICANTS MUST COMPLETE THIS SECTION

(See instructions for details.)

A. Reason for submitting this application *(Check one box and complete the required sections)*.

REASON FOR APPLICATION	BILLING NUMBER INFORMATION	REQUIRED SECTIONS
☐ You are a **new enrollee** in Medicare	Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4.	**Complete all applicable sections**
☐ You are **reactivating** your Medicare enrollment	Enter your Medicare Identification Number and the NPI you would like to link to this number in Section 4.	**Complete all applicable sections**
	Medicare Identification Number(s)	
	National Provider Identifier	
☐ You are **voluntarily terminating** your Medicare enrollment.	Effective Date of Termination:	**Sections 1, 2B1, 13, and either 15 or 16**
	Medicare Identification Number(s) *:*	
	National Provider Identifier *(if issued):*	
☐ You are **changing** your Medicare information.	Medicare Identification Number(s) *:*	Go to Section 1B to see applicable sections.
	National Provider Identifier	
☐ You are **revalidating** your Medicare enrollment.	Enter your Medicare Identification Number and the NPI you would like to link to this number in Section 4.	**Complete all applicable sections**

SECTION 1: BASIC INFORMATION *(Continued)*

B. Check all that apply and complete the required sections:

	REQUIRED SECTIONS
☐ Identifying Information	**1, 2** (complete only those sections that are changing)**, 3, 13,** and either **15 (**if you are an authorized official) **or 16 (**if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier
☐ Recognition Status	**1, 2B1, 2B2** and either **15 (**if you are an authorized official) **or 16 (**if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier.
☐ Final Adverse Actions/ Convictions	**1, 2B1, 3, 13,** and either **15 (**if you are an authorized official) **or 16 (**if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier.
☐ MDPP Location Information - Administrative Location(s), Community Setting(s), Payment Address, or Medical Record Storage Information	**1, 2B1, 4** (complete only those sections that are changing), **13,** and either **15 (**if you are an authorized official) **or 16 (**if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier
☐ Ownership Interest and/or Managing Control Information (Organizations)	**1, 2B1, 3, 5, 13,** and either **15 (**if you are an authorized official) **or 16 (**if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier
☐ Ownership Interest and/or Managing Control Information (Individuals)	**1, 2B1, 3, 6, 13,** and either **15 (**if you are an authorized official) **or 16 (**if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier
☐ Coach(es)	1, 2B1, 7 and either **15 (**if you are an authorized official) **or 16 (**if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier
☐ Billing Agency Information	**1, 2B1, 3, 8** (complete only those sections that are changing), **13,** and either **15 (**if you are an authorized official) **or 16 (**if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier
☐ Authorized Official(s)	**1, 2B1, 3, 13, 15 or 16 (**if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier
☐ Delegated Official(s) (Optional)	**1, 2B1, 3, 13, 15, 16,** and **6** for the signer if that delegated official has not been established for this supplier.

SECTION 2: IDENTIFYING INFORMATION

A. Type of Supplier

Check the appropriate box to identify the type of supplier you are enrolling as with Medicare. If you are more than one type of supplier, submit a separate application for each type. If you change the type of service that you provide (i.e., become a different supplier type), submit a new application.

Your organization must meet all Federal and State requirements for the type of supplier checked below.

TYPE OF SUPPLIER:

☐ In-Person MDPP Supplier

B. Supplier Identification Information

1. BUSINESS INFORMATION

Legal Business Name (not the "Doing Business As" name) as reported to the Internal Revenue Service

Tax Identification Number

Other Name

Type of Other Name

☐ Former Legal Business Name ☐ Doing Business As Name ☐ Name corresponding with CDC recognition

Identify how your business is registered with the IRS. (**NOTE:** If your business is a Federal and/or State government provider or supplier, indicate "Non-Profit" below.)

☐ Proprietary ☐ Non-Profit

NOTE: If a checkbox indicating Proprietary or non-profit status is not completed, the provider/supplier will be defaulted to "Proprietary."

Identify the type of organizational structure of this provider/supplier *(Check one)*

☐ Corporation ☐ Limited Liability Company ☐ Partnership Sole Proprietor
☐ Government Owned ☐ Sole Owner of a Limited Liability Company ☐ Disregarded Entity
☐ Other: _____

Incorporation Date *(mm/dd/yyyy) (if applicable)*	State Where Incorporated *(if applicable)*

2. RECOGNITION STATUS

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			

Organizational Code	Recognition Status
Effective Date (mm/dd/yyyy)	Expiration/Renewal Date (mm/dd/yyyy)

Does this organizational code correspond with:
In-person MDPP ☐ YES ☐ NO

SECTION 2: IDENTIFYING INFORMATION *(continued)*

3. CORRESPONDENCE ADDRESS

Provide contact information for the entity listed in Question 1 of this section. Once enrolled, the information provided below will be used by the fee-for-service contractor if it needs to contact you directly. This address cannot be a billing agency's address.

Mailing Address Line 1 (Street Name and Number)			
Mailing Address Line 2 (Suite, Room, etc.)			
City/Town		State	ZIP Code + 4
Telephone Number	Fax Number (if applicable)	E-mail Address (if applicable)	

SECTION 3: FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Convictions

1. The supplier or any owner of the supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include:

   Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicare program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Act.
2. Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
5. Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation or suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any current Medicare payment suspension under any Medicare billing number.
5. Any Medicare revocation of any Medicare billing number.

Final Adverse History

1. Has your organization, under any current or former name or business identity, ever had any of the final adverse actions listed on page 11 of this application imposed against it?

   ☐ YES–Continue Below ☐ NO–Skip to Section 4
2. If yes, report each final adverse action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

   Attach a copy of the final adverse action documentation and resolution.

SECTION 3: FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS *(continued)*

Final Adverse Action	Date	Taken By	Resolution

SECTION 4: MDPP LOCATION INFORMATION

Instructions

This section captures information about the physical location(s) associated with the supplier, as well as locations where and from where you currently provide MDPP services. Provide the specific street address as recorded by the United States Postal Service. Do not provide a P.O. Box.

Administrative location

An "administrative location" means a physical location associated with the MDPP supplier's operations where they are the primary operator in the space, from where coaches are dispatched or based, and where MDPP services may or may not be furnished.

Community setting

A "community setting" means a location where the MDPP supplier furnishes MDPP services outside of their administrative locations. A community setting is a location open to the public and not primarily associated with the supplier. Community settings may include, for example, church basements or multipurpose rooms in recreation centers.

When determining whether a location is considered an administrative location or community setting, consider whether the organizational entity is the primary user of the space and whether coaches are based or dispatched from this location. If so, than the location would be considered an administrative location, even if this location dually serves as a community setting.

A. MDPP location information

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ **CHANGE**	☐ **ADD**	☐ **DELETE**
DATE (mm/dd/yyyy)			

If you have not yet furnished MDPP services at this location or are enrolling for the first time, the date you provide should be the date you submit your enrollment application. If you are adding a location where you have already begun furnishing MDPP services, the date you provide should be the date you furnished MDPP services to your first Medicare beneficiary at this location.

Location Name *("Doing Business As" name if different from Legal Business Name)*

Location Street Address Line 1 *(Street Name and Number – NOT a P.O. Box)*	Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

CDC organizational code associated with this location

SECTION 4: MDPP LOCATION INFORMATION *(continued)*

For MDPP services, this location is a:

☐ Administrative location ☐ Community setting

This location also serves as a (Administrative locations only)

☐ Group practice office/clinic
☐ Hospital
☐ Skilled Nursing Facility and/or Nursing Facility
☐ Other health care facility *(Specify):*

_____

☐ Solely MDPP supplier
☐ Operations other than health care (e.g., gym)
☐ Indian Health Services

B. Where do you want remittance notices or special payments sent?

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			

Medicare will issue payments via electronic funds transfer (EFT). Since payments will be made by EFT, the "Special Payments" address should indicate where all other payment information (e.g., remittance notices, special payments) should be sent.

☐ "Special Payments" address is the same as the administrative location (only one address is listed in Section 4A). Skip to Section 4C.

☐ "Special Payments" address is different than that listed in Section 4A, or multiple locations are listed. Provide address below.

"Special Payments" Address Line 1 (PO Box or Street Name and Number)

"Special Payments" Address Line 1 (Suite, Room, etc.))

City/Town	State	ZIP Code + 4

C. Where do you keep beneficiaries' medical records?

If you store beneficiary's medical records (current and/or former MDPP beneficiaries) at a location other than the administrative location(s) listed in Section 4A, complete this section with the address of the storage location.

Post Office boxes and drop boxes are not acceptable as physical addresses where beneficiaries' records are maintained. The records must be the supplier's records, not the records of another supplier. If this section is not completed, you are indicating that all records are stored at the administrative location(s) reported in Section 4A.

SECTION 4: MDPP LOCATION INFORMATION *(continued)*

First Medical Record Storage Facility

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			

Storage Facility Address Line 1 (Street Name and Number)

Storage Facility Address Line 2 (Suite, Room, etc.)

City/Town	State	ZIP Code + 4

Second Medical Storage Facility

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			

Storage Facility Address Line 1 (Street Name and Number)

Storage Facility Address Line 2 (Suite, Room, etc.)

City/Town	State	ZIP Code + 4

Electronic Storage

Do you store your patient records electronically? ☐ Yes ☐ No

If yes, identify where/how these records are stored below. This can be a website, URL, in-house software program, online service, vendor, etc. this must be a site that can be accessed by the CMS or its contractors AC if necessary.

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

Note: only report organizations in this section. Individuals must be reported in Section 6.

Complete this section with information about all organizations that have 5 percent or more (direct or indirect) ownership interest of, any partnership interest in, and/or managing control of, the supplier identified in Section 2, as well as information on any adverse legal actions that have been imposed against that organization. For examples of organizations that should be reported here, visit our Web site: *www.cms.hhs.gov/MedicareProviderSupEnroll*. If there is more than one organization that should be reported, copy and complete this section for each.

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. For instance, it could be a management services organization under contract with the supplier to furnish management services for the business.

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 that 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 appointed or elected 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 the Medicare program.

Non-Profit, 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. While the organization should be listed in Section 5, individual board members should be listed in Section 6. Each non-profit organization should submit a copy of a 501(c)(3) document verifying its non-profit status.

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

- 5 percent 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.

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

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

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

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

☐ Not Applicable

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ **CHANGE**	☐ **ADD**	☐ **DELETE**
DATE (mm/dd/yyyy)			

Check all that apply:

☐ 5 Percent or More Ownership Interest ☐ Partner ☐ Managing Control

Legal Business Name as Reported to the Internal Revenue Service

"Doing Business As" Name *(if applicable)*

Address Line 1 *(Street Name and Number)*

Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

NPI *(if issued)*	Tax Identification Number *(Required)*	Medicare Identification Number(s) *(if issued)*

What is the effective date this owner acquired ownership of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) _____

What is the effective date this organization acquired managing control of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) _____

NOTE: Furnish both dates if applicable.

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

B. Final Adverse Legal Action History

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

☐ Change

Effective Date:_____

1. Has this individual in Section 5A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 11 of this application imposed against him/her?

   ☐ YES–Continue Below ☐ NO–Skip to Section 6

2. If YES, report each final adverse legal action, when it occurred, the Federal or State agency or the court/ administrative body that imposed the action, and the resolution, if any.

   Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

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

NOTE: Only Individuals should be reported in Section 6. Organizations must be reported in Section 5. For more information on "direct" and "indirect" owners, go to *www.cms.hhs.gov/MedicareProviderSupEnroll.*

The supplier must have at least one owner and/or managing employee.

The following individuals must be reported in Section 6A:

- All persons who have a 5 percent or greater direct or indirect 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;
- All individuals with a partnership interest in the supplier, regardless of the percentage of ownership the partner has; and
- Authorized and delegated officials.

Example: A supplier is 100 percent owned by Company C, which itself is 100 percent owned by Individual D. Assume that Company C is reported in Section 5A as an owner of the supplier. Assume further that Individual D, as an indirect owner of the supplier, is reported in Section 6A. Based on this example, the supplier would check the "5 percent or Greater Direct/Indirect Owner" box in Section 6A.

Note: All partners within a partnership must be reported on 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 percent interest in the supplier, each limited partner must be reported on this application, even though each owns less than 5 percent. The 5 percent threshold primarily applies to corporations and other organizations that are not partnerships.

Non-Profit, Charitable or religious organizations: If you are a non-profit charitable or religious organization that has no organizational or individual owners (only board members, directors or managers), you should submit with your application a 501(c)(3) document verifying non-profit status.

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

Officer is 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.

Director is a member of the supplier's "board of directors." It does not necessarily include a person who may have the word "director" in his/her job title (e.g., departmental director, director of operations).

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.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operations of the supplier, either under contract or through some other arrangement, regardless of whether the individual is a W-2 employee of the supplier.

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

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, except those who are listed as authorized or delegated officials on this application.

Any information on final adverse actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each individual. Owners, Authorized Officials and/or Delegated Officials must complete this section.

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

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ **CHANGE**	☐ **ADD**	☐ **DELETE**
DATE **(mm/dd/yyyy)**			

The name, date of birth, and Social Security Number of each person listed in this Section must coincide with the individual's information as listed with the Social Security Administration.

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

Date of Birth *(mm/dd/yyyy)*	Place of Birth *(State)*	Country of Birth

Social Security Number *(Required)*	Medicare Identification Number *(if issued)*	NPI *(if issued)*

What is the above individual's relationship with the supplier in Section 2B1? *(Check all that apply.)*

☐ 5 Percent or Greater Direct/Indirect Owner
☐ Authorized Official
☐ Delegated Official
☐ Partner
☐ Director/Officer
☐ Contracted Managing Employee
☐ Managing Employee (W-2)

What is the effective date this owner acquired ownership of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) _____

What is the effective date this individual acquired managing control of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) _____

NOTE: Furnish both dates if applicable.

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

B. Final Adverse Legal Action History

Complete this section for the individual reported in Section 6A above. If reporting a change to existing information, check "change," provide the effective date of the change and complete the appropriate fields in this section.

☐ Change

Effective Date:_____

1. Has this individual in Section 6A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 11 of this application imposed against him/her?

   ☐ YES–Continue Below ☐ NO–Skip to Section 8

2. If YES, report each final adverse legal action, when it occurred, the Federal or State agency or the court/ administrative body that imposed the action, and the resolution, if any.

   Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

SECTION 7: COACH ROSTER

Per MDPP Supplier Standards in 42 CFR 424.205(d)(3) and coach eligibility criteria at 42 CFR 424.205(e), an MDPP supplier must not include on the roster of coaches, nor permit MDPP services to be furnished by any individual coach who meets any of ineligibility criteria outlined below. To furnish MDPP services to a beneficiary, an MDPP coach must not:

- Currently have Medicare billing privileges revoked and be currently subject to the reenrollment bar.
- Currently have its Medicaid billing privileges terminated for-cause or be excluded by a State Medicaid agency.
- Currently be excluded from any other Federal health care program, as defined in 42 CFR 1001.2, in accordance with section 1128, 1128A, 1156, 1842, 1862, 1867 or 1892 of the Act.
- Currently be debarred, suspended, or otherwise excluded from participating in any other Federal procurement or nonprocurement program or activity in accordance with the Federal Acquisition Streamlining Act implementing regulations and the Department of Health and Human Services nonprocurement common rule at 45 CFR part 76.
- Have, in the previous 10 years, one of the following State or Federal felony convictions:
  - Crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, as defined under 42 CFR 1001.2, had a guilty plea or adjudicated pretrial diversion.
  - Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, as defined under 42 CFR 1001.2, had a guilty plea or adjudicated pretrial diversion.
  - Any felony that placed the Medicare or its beneficiaries at immediate risk, such as a malpractice suit that results in the individual being convicted, as defined under 42 CFR 1001.2, had a guilty plea or adjudicated pretrial diversion of criminal neglect or misconduct.
  - Any felonies for which the individual was convicted, as defined under 42 CFR 1001.2, had a guilty plea or adjudicated pretrial diversion that would result in mandatory exclusion under section 1128(a) of the Act.

Including coaches with this background is a violation of MDPP supplier standards and may result in an enrollment denial from Medicare under 42 CFR 424.530 (a)(1) or revocation under 42 CFR 424.535 (a)(1).

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ **CHANGE**	☐ **ADD**	☐ **DELETE**
DATE (mm/dd/yyyy)			

First Name *(Required)*	Middle Initial	Last Name *(Required)*	Suffix *(e.g., Jr., Sr.)*
Social Security Number *(Required)*		Date of Birth *(mm/dd/yyyy) (Required)*	
NPI *(Required)*			

NOTE: If you are adding a coach, the date should represent the date the coach began furnishing MDPP services (for a coach that is subsequently deemed eligible, this will become their coach eligibility start date). If the coach has not yet began furnishing services, simply include the date the change is being reported. **If you are making a change to an existing coach**, indicate the date the change occurred or is being reported. **If you are deleting a coach**, please indicate the date the coach ceased furnishing MDPP services (this will become their coach eligibity end date).

SECTION 8: BILLING AGENCY INFORMATION

A billing agency is a company or individual that you contract with to prepare and submit your claims. If you use a billing agency, you are responsible for the claims submitted on your behalf.

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

BILLING AGENCY NAME AND ADDRESS

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			

Legal Business/Individual Name as Reported to the Social Security Administration or the Internal Revenue Service	If Individual, Billing Agent Date of Birth *(mm/dd/yyyy)*

"Doing Business As" Name *(if applicable)*	Tax Identification/Social Security Number *(required)*

Billing Agency Street Address Line 1 *(Street Name and Number)*

Billing Agency Street Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

SECTION 9: FOR FUTURE USE (THIS SECTION IS NOT APPLICABLE)

SECTION 10: FOR FUTURE USE (THIS SECTION IS NOT APPLICABLE)

SECTION 11: FOR FUTURE USE (THIS SECTION IS NOT APPLICABLE)

SECTION 12: FOR FUTURE USE (THIS SECTION IS NOT APPLICABLE)

SECTION 13: CONTACT PERSON

If questions arise during the processing of this application, the fee-for-service contractor will contact the individual shown below. If the contact person is either an authorized or delegated official, check the appropriate box below.

☐ Contact an Authorized Official listed in Section 15.

☐ Contact a Delegated Official listed in Section 16.

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

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

Address Line 1 *(Street Name and Number)*

Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION

This section explains the penalties for deliberately falsifying information in this application to gain or maintain enrollment in the Medicare program.

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

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

2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against any individual who, "knowingly and willfully," makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program. The offender is subject to fines of up to $25,000 and/or imprisonment for up to five years.

3. The Civil False Claims Act, 31 U.S.C. § 3729, imposes civil liability, in part, on any person who, with actual knowledge, deliberate ignorance or reckless disregard of truth or falsity

   a. presents or causes to be presented to the United States Government or its contractor or agent a false or fraudulent claim for payment or approval;

   b. (uses or causes to be used a false record or statement material either to a false or fraudulent claim or to an obligation to pay the Government;

   c. conceals or improperly avoids or decreases an obligation to pay or transmit money or property to the Government; or

   d. conspires to violate any provision of the False Claims Act.

   The False Claims Act imposes a civil penalty of between $5,000 and $10,000 per violation, as adjusted for inflation by the Federal Civil Penalties Inflation Adjustment Act, 28 U.S.C. 2461, plus three times the amount of damages sustained by the Government.

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

   a) was not provided as claimed; and/or

   b) the claim is false or fraudulent.

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

5. 18 U.S.C. 1035 authorizes criminal penalties against individuals in any matter involving a health care benefit program who knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact; or makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items or services. The individual shall be fined or imprisoned up to 5 years or both.

SECTION 15: CERTIFICATION STATEMENT

6. 18 U.S.C. 1347 authorizes criminal penalties against individuals who knowing and willfully execute, or attempt, to executive a scheme or artifice to defraud any health care benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by or under the control of any, health care benefit program in connection with the delivery of or payment for health care benefits, items, or services. Individuals shall be fined or imprisoned up to 10 years or both. If the violation results in serious bodily injury, an individual will be fined or imprisoned up to 20 years, or both. If the violation results in death, the individual shall be fined or imprisoned for any term of years or for life, or both.
7. The government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment."

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

An **AUTHORIZED OFFICIAL** means an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program.

A **DELEGATED OFFICIAL** means an individual who is delegated by an authorized official the authority to report changes and updates to the supplier's enrollment record. A delegated official must be an individual with an "ownership or control interest" in (as that term is defined in Section 1124(a)(3) of the Social Security Act), or be a W-2 managing employee of, the supplier.

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.

NOTE: Authorized officials and delegated officials must be reported in Section 6, either on this application or on a previous application to this same Medicare fee-for-service contractor. **If this is the first time an authorized and/or delegated official has been reported on the CMS-20134, you must complete Section 6 for that individual.**

By his/her signature(s), an 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 and in ink. Faxed, photocopied, or stamped signatures will not be accepted.

Only an authorized official has the authority to sign (1) the initial enrollment application on behalf of the supplier or (2) the enrollment application that must be submitted as part of the periodic revalidation process. A delegated official does not have this authority.

By signing this application, an authorized official agrees to immediately notify the Medicare fee-for-service contractor if any information furnished on the application is not true, correct, or complete. In addition, an authorized official, by his/her signature, agrees to notify the Medicare fee-for-service contractor of any future changes to the information contained in this form, after the supplier is enrolled in Medicare, in accordance with the timeframes established in 42 C.F.R. 424.205(d)(5). (IDTF changes of information must be reported in accordance with 42 C.F.R. 410.33.)

SECTION 15: CERTIFICATION STATEMENT *(continued)*

The supplier can have as many authorized officials as it wants. If the supplier has more than two authorized officials, it should copy and complete this section as needed.

EACH AUTHORIZED AND DELEGATED OFFICIAL MUST HAVE AND DISCLOSE HIS/HER SOCIAL SECURITY NUMBER.

A. Additional Requirements for Medicare Enrollment

These are additional requirements that the supplier must meet and maintain in order to bill the Medicare program. Read these requirements carefully. By signing, the supplier is attesting to having read the requirements and understanding them.

By his/her signature(s), the authorized official(s) 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 authorize the Medicare contractor to verify the information contained herein. I agree to notify the Medicare contractor of any future changes to the information contained in this application in accordance with the timeframes established in 42 C.F.R. § 424.205(d)(5). I understand that any change in the business structure of this supplier may require the submission of a new application.
2. I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare billing privileges, and/or the imposition of fines, civil damages, and/or imprisonment.
3. I agree to abide by the Medicare laws, regulations and program instructions that apply to this supplier including the MDPP supplier standards at 42 C.F.R. § 424.205(d) and beneficiary engagement incentives at 42 C.F.R. § 424.210.The Medicare laws, regulations, and program instructions are available through the Medicare contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal Anti-Kickback Statute, 42 U.S.C. section 1320a-7b(b) (Section 1128B(b) of the Social Security Act) and the Physician Self-Referral Law (Stark Law), 42 U.S.C. section 1395nn (section 1877 of the Social Security Act)).
4. Neither this supplier, nor any five percent or greater owner, partner, officer, director, managing employee, authorized official, or delegated official thereof is currently sanctioned, suspended, debarred, or excluded by the Medicare or State Health Care Program, e.g., Medicaid program, or any other Federal program, or is otherwise prohibited from supplying services to Medicare or other Federal program beneficiaries.
5. I agree that any existing or future overpayment 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 I will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.
7. I authorize any national body whose standards are recognized by the Secretary as meeting the Medicare program participation requirements, to release to any authorized representative, employee, or agent of the Centers for Medicare & Medicaid Services (CMS) a copy of my most recent performance, performance data, or recognition, together with any information related to the recognition that CMS may require (including corrective action plans).

SECTION 15: CERTIFICATION STATEMENT *(continued)*

B. 1ST Authorized Official Signature

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 and I authorize the Medicare fee-for-service 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 fee-for-service contractor of this fact in accordance with the time frames established in 42 CFR § 424.205(d)(5).

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ **CHANGE**	☐ **ADD**	☐ **DELETE**
DATE *(mm/dd/yyyy)*			

Authorized Official's Information and Signature

First Name	Middle Initial	Last Name	Suffix *(e.g., Jr., Sr.)*
Telephone Number	Title/Position		
Authorized Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*			Date Signed *(mm/dd/yyyy)*

(blue ink preferred)

C. 2ND Authorized Official Signature

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 and I authorize the Medicare fee-for-service 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 fee-for-service contractor of this fact in accordance with the time frames established in 42 CFR § 424.205(d)(5).

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ **CHANGE**	☐ **ADD**	☐ **DELETE**
DATE *(mm/dd/yyyy)*			

Authorized Official's Information and Signature

First Name	Middle Initial	Last Name	Suffix *(e.g., Jr., Sr.)*
Telephone Number	Title/Position		
Authorized Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*			Date Signed *(mm/dd/yyyy)*

All signatures must be original and signed in ink (blue ink preferred). Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

SECTION 16: DELEGATED OFFICIAL (OPTIONAL)

- You are not required to have a delegated official. However, if no delegated official is assigned, the authorized official(s) will be the only person(s) who can make changes and/or updates to the supplier's status in the Medicare program.
- The signature of a delegated official shall have the same force and effect as that of an 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. A 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, a delegated official certifies that the information provided is true, correct, and complete.
- Delegated officials being deleted do not have to sign or date this application.
- Independent contractors are not considered "employed" by the supplier, and therefore cannot be delegated officials.
- The signature(s) of an authorized official in Section 16 constitutes a legal delegation of authority to all delegated official(s) assigned in Section 16.
- If there are more than two individuals, copy and complete this section for each individual.

A. 1ST Delegated Official Signature

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ **CHANGE**	☐ **ADD**	☐ **DELETE**
DATE (mm/dd/yyyy)			

Delegated Official First Name	Middle Initial	Last Name	Suffix *(e.g., Jr., Sr.)*

Delegated Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

☐ Check here if Delegated Official is a W-2 Employee	Telephone Number

Authorized Official's Signature Assigning this Delegation *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

SECTION 16: DELEGATED OFFICIAL (OPTIONAL) *(continued)*

B. 2ND Delegated Official Signature

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			

Delegated Official First Name	Middle Initial	Last Name	Suffix *(e.g., Jr., Sr.)*

Delegated Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

☐ Check here if Delegated Official is a W-2 Employee	Telephone Number

Authorized Official's Signature Assigning this Delegation *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

All signatures must be original and signed in ink (blue ink preferred). Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

SECTION 17: SUPPORTING DOCUMENTS

This section lists the documents that, if applicable, must be submitted with this enrollment application. If you are newly enrolling, or are reactivating or revalidating your enrollment, you must provide all applicable documents. For changes, only submit documents that are applicable to that change.

The fee-for-service contractor may request, at any time during the enrollment process, documentation to support or validate information reported on the application. The Medicare fee-for-service contractor may also request documents from you, other than those identified in this Section 17, as are necessary to bill Medicare.

MANDATORY FOR ALL PROVIDER/SUPPLIER TYPES

- ☐ Copy of Certificate or Determination Letter demonstrating MDPP Preliminary or Full DPRP Recognition status.
- ☐ Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name (e.g., IRS form CP 575) provided in Section 2.
  (**NOTE:** This information is needed if the applicant is enrolling their professional corporation, professional association, or limited liability corporation with this application or enrolling as a sole proprietor using an Employer Identification Number.)"
- ☐ Completed Form CMS-588, for Electronic Funds Transfer Authorization Agreement.
  (**NOTE:** If a supplier already receives payments electronically and is not making a change to its banking information, the CMS-588 is not required.)

MANDATORY, IF APPLICABLE

- ☐ Copy of IRS Determination Letter, if supplier is registered with the IRS as non-profit.
- ☐ Written confirmation from the IRS confirming your Limited Liability Company (LLC) is automatically classified as a Disregarded Entity. (e.g., Form 8832).
  (**NOTE:** A disregarded entity is an eligible entity that is treated as an entity not separate from its single owner for income tax purposes.
- ☐ Statement in writing from the bank. If Medicare payment due a supplier of services is being sent to a bank (or similar financial institution) with whom the supplier has a lending relationship (that is, any type of loan), then the supplier must provide a statement in writing from the bank (which must be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.
- ☐ Copy(s) of all final adverse action documentation (e.g., notifications, resolutions, and reinstatement letters).
- ☐ Copy of an attestation for government entities and tribal organizations.

MEDICARE SUPPLIER ENROLLMENT APPLICATION PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) is authorized to collect the information requested on this form and to maintain the system that stores this information under provisions of sections 1102(a) (Title 42 U.S.C. 1302(a)), 1128 (42 U.S.C. 1320a–7), 1814(a)) (42 U.S.C. 1395f(a)(1), 1815(a) (42 U.S.C. 1395g(a)), 1833(e) (42 U.S.C. 1395I(3)), 1871 (42 U.S.C. 1395hh), and 1886(d)(5)(F), (42 U.S.C. 1395ww(d)(5)(F)), 1115A(c) [42 U.S.C. 1315a(c)] of the Social Security Act; 1842(r) (42 U.S.C. 1395u(r)); section 1124(a)(1) (42 U.S.C. 1320a–3(a)(1), and 1124A (42 U.S.C. 1320a–3a), section 4313, as amended, of the BBA of 1997; and section 31001(i) (31 U.S.C. 7701) of the DCIA (Pub. L. 104–134), as amended. 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 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 suppliers who are excluded from participation in the Medicare program or who utilize ineligible coaches to deliver services to Medicare beneficiaries. While submitting this information (including social security numbers (SSN)) is voluntary, all information on this form, with the exception of those sections marked as "optional" on the form, is required to enroll in Medicare as an MDPP supplier. Without this information, the ability to make payments will be delayed or denied.

The information collected on this enrollment application will be entered into the Provider Enrollment, Chain and Ownership System (PECOS).

PECOS will collect information provided by an applicant related to identity, qualifications, administrative locations, community settings, ownership, billing agency information, electronic funds transfer, the NPI and related organizations. PECOS will also maintain information on business owners, chain home offices and provider/chain associations, managing/ directing employees, partners, authorized and delegated officials, and Medicare Diabetes Prevention Program (MDPP) coaches. This system of records will contain the names, SSN, date of birth (DOB), and tax identification numbers (TIN) and National Provider Identifiers (NPI) for each disclosing entity, owners with 5 percent or more ownership or control interest, managing/ directing employees, as well as MDPP coaches. Managing/directing employees include general manager, business managers, administrators, directors, and other individuals who exercise operational or managerial control over the provider/ supplier. The system will also contain Medicare identification numbers (i.e., CCN, PTAN and the NPI), demographic data, professional data, past and present history as well as information regarding any adverse legal actions such as exclusions, sanctions, and felonious behavior.

The Privacy Act permits CMS to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. Any such disclosure of data is known as a "routine use." The CMS will only release PECOS information that can be associated with an individual as provided for under Section III "Proposed Routine Use Disclosures of Data in the System." Both identifiable and non-identifiable data may be disclosed under a routine use. CMS will only collect the minimum personal data necessary to achieve the purpose of PECOS. Below is an abbreviated summary of the six routine uses. To view the routine uses in their entirety go to: *https://www.cms.gov/Research-Statistics-Data-and-Systems/ Computer-Data-and-Systems/Privacy/Downloads/0532-PECOS.pdf.*

MEDICARE SUPPLIER ENROLLMENT APPLICATION PRIVACY ACT STATEMENT *(continued)*

1. To support CMS contractors, consultants, or grantees, who have been engaged by CMS to assist in the performance of a service related to this collection and who need to have access to the records in order to perform the activity.
2. To assist another Federal or state agency, agency of a state government or its fiscal agent to:
   a. Contribute to the accuracy of CMS's proper payment of Medicare benefits,
   b. Enable such agency to administer a Federal health benefits program that implements a health benefits program funded in whole or in part with federal funds, and/or
   c. Evaluate and monitor the quality of services and contribute to the accuracy of health insurance operations.
3. To assist an individual or organization for research, evaluation or epidemiological projects related to the prevention of disease or disability, or the restoration or maintenance of health, and for payment related projects.
4. To support the Department of Justice (DOJ), court or adjudicatory body when:
   a. The agency or any component thereof, or
   b. Any employee of the agency in his or her official capacity, or
   c. Any employee of the agency in his or her individual capacity where the DOJ has agreed to represent the employee, or
   d. The United States Government, is a party to litigation and that the use of such records by the DOJ, court or adjudicatory body is compatible with the purpose for which CMS collected the records.
5. To assist a CMS contractor that assists in the administration of a CMS administered health benefits program, or to combat fraud, waste, or abuse in such program.
6. To assist another Federal agency to investigate potential fraud, waste, or abuse in, a health benefits program funded in whole or in part by Federal funds.

The applicant 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. section 552a, to permit the government to verify information through computer matching.

This statement provides the notice required by the Privacy Act of 1974 (5 U.S.C. § 552a(e)(3)).