

## Electronic Signature How To Guide

Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) now allows providers and suppliers to *electronically sign Medicare enrollment applications*. Utilizing the electronic signature process will ensure faster application submission, resulting in an earlier effective date. *This feature does not change who is required to sign the application.*

In Internet-based PECOS, all *Individual Provider applications* that do not include new reassignments may e-sign the application as part of the submission process. This applies to Physicians and Non-Physician Practitioners, including those enrolling just to order and refer.

Any Individual Provider application (855-I) containing new reassignments (855-R) can be electronically signed as part of the submission process; however, you must select the AO/DO for the Organization that is accepting the reassignment and enter that official's email address. The official will then be required to electronically sign the application by following the instruction in an email generated by PECOS.

If an individual provider or AO/DO does not want to use the e-signature process, they simply follow the current process of printing and signing the certification statement and mailing the signed statement to their Medicare Administrative Contractor.

### Key Terms and Definitions:

- **Individual Provider** = Individual Provider or Supplier who enrolls in Medicare.
- **Authorized Official (AO)** = Person who is authorized to legally bind a company.
- **E-Signature** = Act of recording a user's: identity, intent, and acceptance or confirmation.

### Individual Enrolling and Reassigning Benefits Workflow:

**Step 1: Provider Logs into PECOS at <https://pecos.cms.hhs.gov/pecos/login.do>.**

**Medicare Enrollment**  
for Providers and Suppliers

Welcome to the Medicare Provider Enrollment, Chain, and Ownership System (PECOS)

(\*) Red asterisk indicates a required field.

PECOS supports the Medicare Provider and Supplier enrollment process by allowing registered users to securely and electronically submit and manage Medicare enrollment information.

**USER LOGIN**

You may use your NPPES or PECOS username and password to login.

\* User ID  
\* Password

**LOG IN**

[Forgot Password?](#)

[Manage/Update User Profile](#)

If you are having issues with your User ID/Password and are unable to log in, please contact the External User Services (EUS) at 1-866-484-8049/TTY 1-866-523-4759.

**BECOME A REGISTERED USER**

You may register for a user account if you are: an Individual Practitioner, Authorized or Delegated Official for a Provider or Supplier Organization, or an individual who works on behalf of Providers or Suppliers.

[Register for a user account](#)

**Note:** If you are a Medical Provider or Supplier, you must [register for an NPI](#) before enrolling with Medicare.

**PECOS is accessed with the same User ID and password used for NPPES.**

**Step 2: Provider selects My Enrollments.**

Welcome John Provider

**System Notifications**

**Note:** JavaScript must be enabled in your internet browser for PECOS to work properly. If JavaScript is currently disabled in your browser, refer to the Accessibility section in PECOS Help for instructions on enabling JavaScript.

From	To	Details
There are no notifications at this time.		

**Manage Medicare and Account Information**

**MY ENROLLMENTS** ⓘ

- Enroll in Medicare for the first time
- View and update existing Medicare information
- Continue working on saved applications

**ACCOUNT MANAGEMENT** ⓘ

- Update your user account information, request or remove access to organizations
- Manage access to Medicare enrollments

**Step 3: Provider selects View Enrollments.**

**My Enrollments**

**New Application**

**! IMPORTANT:**  
If you are responding to a **request for Revalidation**, please **do not** select the "New Application" button. Instead, **select one of your current enrollment records.**

If your organization is currently enrolled in Medicare, but you do not see your current enrollment information, please complete and submit a Security Consent Form. To submit your Security Consent Form select the Account Management button on the Home Page and then choose the Security Consent Form option.

Before you get started, please review the following checklists of information necessary to complete an enrollment via Internet-based PECOS:

- [Checklist for Sole Proprietor or Solely Owned Organizations \(eg. LLC, PC\) using PECOS](#) ⓘ
- [Checklist for Individual Physician and Non-Physician Practitioners using PECOS](#) ⓘ
- [Checklist for Provider or Supplier Organization using PECOS](#) ⓘ

To enroll in the Medicare program for the first time or to create a new enrollment, please click the "New Application" button below.

**NEW APPLICATION** ⓘ

**Existing Associates**

In order to view Medicare applications and enrollments for an associate, please click on the "View Enrollments" button next to an associate listed below.

**Individuals**

Name: JOHN PROVIDER    NPI: 1073893996

**VIEW ENROLLMENTS** ⓘ

**Step 4: From the My Enrollments page the provider scrolls to the enrollment they would like to e-sign and selects More Options.**

**Existing Enrollments**

Contractor: FIRST COAST SERVICE OPTIONS, INC.  
Enrollment Type: 855I  
Type/Specialty: FAMILY PRACTICE  
Medicare ID: PROV1234  
[View Medicare ID Report](#)  
State: FLORIDA  
Status: APPROVED [View Approved Enrollment Record](#)

Current ADI Accreditation?: No

Type of Update	Status	Tracking ID	Action
Change of Information	EDIT <a href="#">View Edit Application</a>	T071620130000000	<a href="#">VIEW</a> <a href="#">MORE OPTIONS</a>

**New Enrollments**

Enrollment Type: 855I  
Type/Specialty: FAMILY PRACTICE  
State: NEW JERSEY  
Status: NEW [View New Application](#)  
Tracking ID: T071620130000001

[VIEW](#)  
[MORE OPTIONS](#)

**Step 5: Provider chooses the option to continue working on application.**

Home > [My Enrollments](#) > Application Questionnaire

**Application Questionnaire** (\*) Red asterisk indicates a required field.

Approved Existing Provider Enrollment

\* What type of action is the applicant trying to perform?

Continue Working on Application

Delete Application

[NEXT PAGE](#)

[RETURN TO MY ENROLLMENTS](#)

**Step 6: Provider completes online Enrollment Application (Topic View or Fast Track View).**

**Topic View** Fast Track View Error/Warning Check 5

Enrollment ID: I20130529000017  
PacID: 3577700301120130529000017  
Web Tracking ID: T071620130000000  
Individual Provider NPI: 1073893996

**Reason for Application**  
Enrolled Practitioner is Updating their Enrollment by Adding, Deleting, and/or Changing Information  
[EDIT REASON](#)

**Medicare ID Report**  
Select the hyperlink to view the Medicare ID Report:  
[View Medicare ID Report](#)

**Topics**  
The data required for this enrollment application is grouped into topics. In order to electronically submit this enrollment application, you must complete all of the following topics.  
You may view and print this enrollment application at any time during the enrollment process by clicking the View and Print button below.  
This application is collecting the following topics:

Completed	Topics
—	<a href="#">Personal Information</a> more information about Personal Information
✓	<a href="#">Practitioner Specialty</a> more information about Practitioner Specialty
✓	<a href="#">PAR Status Information</a> more information about PAR Status Information

**Topic View**

Topic View **Fast Track View** Error/Warning Check 4

Enrollment ID: I20130529000017  
PacID: 3577700301120130529000017  
Web Tracking ID: T071620130000000  
Individual Provider NPI: 1073893996

**Reason for Application**  
Enrolled Practitioner is Updating their Enrollment by Adding, Deleting, and/or Changing Information  
[EDIT REASON](#)

**Topics**  
**Personal Information**  
JOHN PROVIDER  
Date of Birth: 07/12/XXXX  
Social Security Number: XXX-XX-XXXX  
Gender: Male  
IRS Proprietary/Non-Profit Status:  
Accepting New Patients: Yes  
Country of Birth:  
Medical School or other Professional School: BAYLOR COLLEGE OF DENTISTRY/TEXAS A AND M UNIVERSITY  
Year of Graduation: 1998  
[GO TO TOPIC](#)

**Fast Track View**

**Step 7: Once all topics have been completed and all errors corrected, if applicable, the provider selects begin submission.**

Completed	Topics
✓	<a href="#">Personal Information</a> more information about Personal Information
✓	<a href="#">Practitioner Specialty</a> more information about Practitioner Specialty
✓	<a href="#">Reassignment</a> more information about Reassignment
✓	<a href="#">Resident/Fellow Status</a> more information about Resident/Fellow Status
✓	<a href="#">Correspondence Address</a> more information about Correspondence Address
✓	<a href="#">License and Certification Information</a> more information about License and Certification Information
✓	<a href="#">Final Adverse Actions</a> more information about Final Adverse Actions
✓	<a href="#">Organization Control</a> more information about Organization Control
✓	<a href="#">Contact Person</a> more information about Contact Person
✓	<a href="#">Required and/or Supporting Documentation</a> more information about Required and/or Supporting Documentation

Note:

- Once you have completed all the topics and no errors are present, the 'Begin Submission' button will be enabled. You may review errors at any time by clicking the 'Error Check' tab. Clicking 'Begin Submission' will initiate the Submission Process.

**BEGIN SUBMISSION**

**Step 8: Provider identifies the Authorized Official (AO) for the entity receiving the reassigned benefits.**

Home > [My Enrollments](#) > [Initial Enrollment](#) > Submission Process

**Select Signatories**

(\*) Red asterisk indicates a required field.

**Signatories for accepting a Reassignment(s)**

You must identify the Authorized Signer for the party receiving reassigned benefits. An email will be sent to the authorized signer(s) notifying them that their signature is required for Reassignment.

NEW JERSEY ASSOCIATES IN MEDICINE, PA

Please select the Authorized Signer:

**-Please select authorized signer Org**

**NEXT PAGE**

**Step 9: Provider selects a signature method for each identified signer.**

**Manage Signatures**

Name: John Provider      TIN: XXX-XX-XXXX  
Web Tracking ID: T071620130000001      NPI: 1073893996

Please select a signature method for each signer:

Name: JACK ORGANIZATION SSN: XXX-XX-XXXX * Signature Method: <input checked="" type="radio"/> Electronic or <input type="radio"/> Paper * Email Address * Confirm Email Address	Role: AUTHORIZED OFFICIAL Document: AUTHORIZATION STATEMENT FOR ORGANIZATIONS Status: Pending
Name: John Provider [You] SSN: XXX-XX-XXXX * Signature Method: <input checked="" type="radio"/> Electronic or <input type="radio"/> Paper	Role: PRACTITIONER Document: AUTHORIZATION STATEMENT FOR INDIVIDUAL PRACTITIONERS Status: Pending
Sign Now <input checked="" type="checkbox"/>	Role: PRACTITIONER Document: CERTIFICATION STATEMENT FOR INDIVIDUAL PRACTITIONERS Status: Pending

The provider selects the Electronic method for the AO, and enters an email address to notify the AO that an enrollment application is pending their signature.

The provider chooses the electronic option.

**Step 10: Provider reviews and agrees to the Terms and Conditions.**

**E-Signature Submission**

(\*) Red asterisk indicates a required field.

**E-Signature Instructions**

To e-sign the enrollment application, follow the steps below:

1. Review all documentation prior to e-signing.
2. Review all applicable terms and conditions.
3. Accepting all applicable terms and conditions is a requirement to e-sign.

**Certification Statement Terms and Conditions**

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

By signing the Certification Statement, you agree to adhere to the following requirements listed therein and acknowledge that you may be denied entry to or revoked from the Medicare program if any requirements are not met.  
You must sign the Certification Statement below in order to be enrolled in the Medicare program.

\* Do you accept the Terms and Conditions?  
 Yes, I agree to the certification statement terms and conditions. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my traditional handwritten signature.

**Authorization Statement Terms and Conditions**

**AUTHORIZATION STATEMENT (855R)**

The signatures below authorize the reassignment of benefits to a supplier or the termination of a reassignment of benefits to a supplier, as indicated in Section 1. Title XVIII of the Social Security Act prohibits payment for services provided by an individual practitioner to be paid to another individual or supplier unless the individual practitioner who provided the services specifically authorizes another individual or supplier (employer,

\* Do you accept the Terms and Conditions?  
 Yes, I agree to the Authorization statement terms and conditions. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my traditional handwritten signature.

PREVIOUS PAGE      NEXT PAGE

Provider must agree to the terms and conditions by checking both boxes. By accepting the terms and conditions the provider's e-signature is complete.

**Step 11: Provider selects their fee-for-service contractor from the drop down box and clicks Apply.**

**Submission Page** (\*) Red asterisk indicates a required field.

**Contact and Processing**

The Medicare Contractor(s) listed here would be responsible for processing your electronic and printed application materials. If more than one contractor is listed, you must mail copies of print documents to each contractor listed. **You must mail all required print documents within 15 days of submitting the electronic part of your application.**

**Note:** It is recommended that the applicant select the Medicare Contractor of the Chain Home Office.

\* Fee-For-Service Contractor  
NOVITAS SOLUTIONS, INC.

**Reason(s) for submission:**

- A Medicare Part B practitioner is enrolling in the Medicare program for the first time to bill for Part B services. A reassignment of benefits may exist.

**Required and Supporting Documents**

The following are Required and Supporting Documents that must be mailed in or uploaded as part of your submission. Some documents may not be applicable for digital upload. Please view the notes below.

**Notes:**

- The following CMS Forms **should not** be uploaded to your submission and may result in delays in application processing: Form CMS-855A, Form CMS-855B, Form CMS-855I, Form CMS-855R, Form CMS-855S, Form CMS-855O, Form CMS-588, or any certification statement(s) and authorization statement(s).

**Step 12: The Submission Page is displayed with a list of all required and supporting documentation that must be completed and mailed to the fee-for-service contractor if not digitally uploaded. Once reviewed the provider clicks the Complete Submission button.**

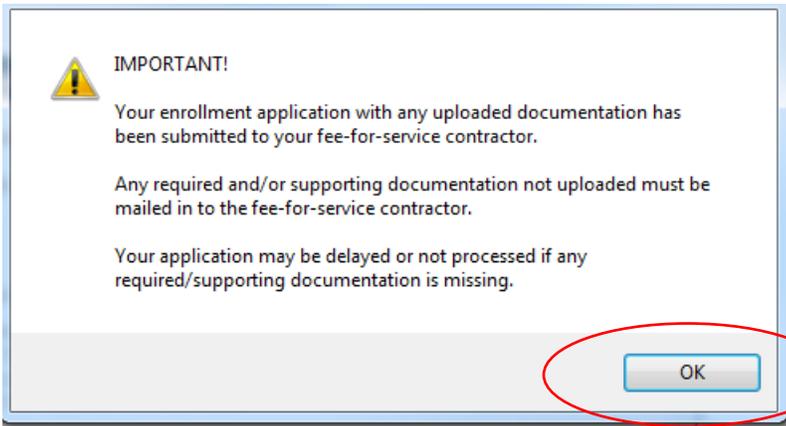
**Required/Supporting Documents:**

- Copy of Business Licenses, Certifications and/or Registrations
- IRS Confirmation Letter for Disregarded Entity
- IRS Confirmation Letter for Tax Identification Number
- Copy of IRS Determination Letter - Non Profit
- CMS-588 Form - Electronic Funds Transfer Authorization Agreement
- Copy of current CLIA and FDA certification
- CMS-855R Form - Individual Reassignment of Medicare Benefits

**Note:**

- Expand  for document details.
- Documents in PDF format require the [Adobe Acrobat Reader®](#). If you experience problems with PDF documents, please [download the latest version of the Reader®](#).

**Step 13:** A pop up message will appear prompting the provider to print, complete and mail, to the fee-for-service contractor, any required or supporting documentation. The provider clicks *Ok*.



**Step 14:** The Complete Submission confirmation page displays. Print the Provider Submission Confirmation Page for your records. Mail a copy of this page and all supporting documentation, if not digitally uploaded, to your Fee-For-Service contractor.

**Submission Confirmation - Print Your Receipt**

**Submission Complete**

You have successfully submitted your application!

**Remember to:**

- Make sure all required and supporting documents that require a signature are signed.
- Mail all required and supporting documents that has not been uploaded to your Medicare Contractor within 15 days of submitting the electronic part of your application. Your application is not complete until the Medicare Contractor(s) receives the signed required documentation of your application in the mail.
- Any required and/or supporting documentation not uploaded must be mailed in to the fee-for-service contractor.
- Your application may be delayed or not processed if any required/supporting documentation is missing.
- If you are submitting an application with Electronic Funds Transfer (EFT) Information, please include confirmation of account information on bank letterhead or a voided check.
- Print this page for your records. **Note:** You can print and/or save copies of the application and required documents for your records by visiting the "My Enrollments" page.
- You will receive e-mails about your application status. Make sure to add "customerservice-donotreply@cms.hhs.gov" to your safe sender list.

**You have successfully submitted your application!**

An e-mail containing the PIN and Web Tracking ID have been sent to the Authorized Signer(s) to complete the E-Signature process for documents pertaining to this enrollment application.

**Remember to:**

- Include the Tracking ID or a copy of this page if you are mailing supporting documentation to your Medicare Contractor
- Mail all other supporting documents to your Medicare Contractor within 15 days of submitting the electronic part of your application. Your application is not complete until the Medicare Contractor receives all required fully signed documentation for your application.
- If you are submitting an application with Electronic Funds Transfer (EFT) Information, please include confirmation of account information on bank letterhead or a voided check.
- Print this page for your records. **Note:** You can print and/or save copies of the application and required documents for your records by also visiting the "My Enrollments" page.
- You will receive e-mail about your application status. Make sure to add "customerservice-donotreply@cms.hhs.gov" to your safe sender list.

**Enrollment Tracking Information**

**Applicant Name:** John Provider

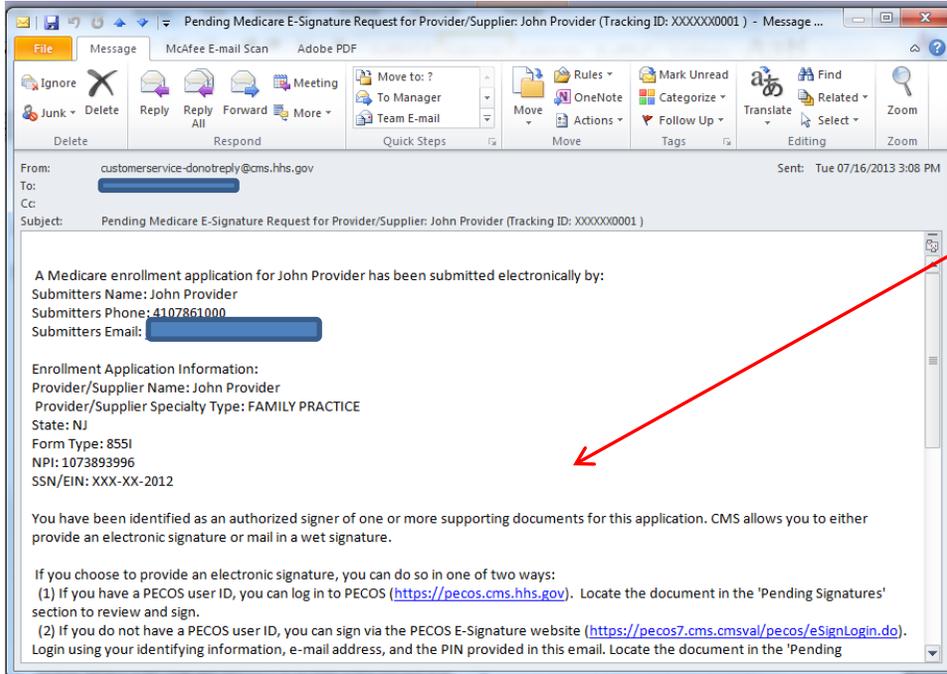
**Tracking ID:** T071620130000001

**Submitted Date:** 16 - JULY - 2013

**Submitted By:** John Provider

**Step 15: The AO of the organization receiving reassigned benefits (from Step 9) will receive a PECOS-generated email containing information about the enrollment application requiring his/her signature and a unique personal identification number (PIN) required to e-sign the document.**

*Note: The PIN received by email will expire after 72 hours. The Individual provider has the ability to resend the E-Signature email, which will reset the PIN, if needed.*

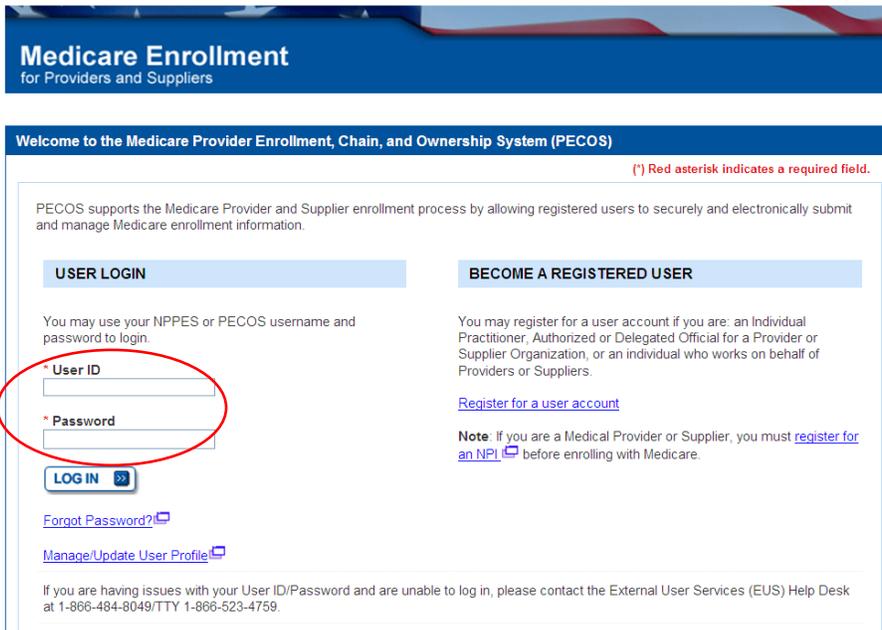


**The email will provide 2 options for e-signing the application:**

- 1. Log into Internet-based PECOS using your existing PECOS Id and password (Workflow outlined in Step 16), or**
- 2. E-sign via the PECOS E-signature website if you don't have an existing PECOS Id and password (Workflow outlined in Step 17).**

**Step 16: Option 1 - E-signing using existing PECOS Id and password**

**The AO logs into PECOS at <https://pecos.cms.hhs.gov/pecos/login.do>.**



**Step 16a: The Manage Signature section displays all applications pending the AO's signature. The AO identifies the application they wish to e-sign and clicks the View and Sign button.**

Welcome JACK ORGANIZATION

**System Notifications**

**Note:** JavaScript must be enabled in your internet browser for PECOS to work properly. If JavaScript is currently disabled in your browser, refer to the Accessibility section in PECOS Help for instructions on enabling JavaScript.

From	To	Details
There are no notifications at this time.		

**Manage Medicare and Account Information**

**MY ENROLLMENTS** 00

- Enroll in Medicare for the first time
- View and update existing Medicare information
- Continue working on saved applications

**ACCOUNT MANAGEMENT** 00

- Update your user account information, request or remove access to organizations
- Manage access to Medicare enrollments

**Manage Signatures**

**Applications Requiring Signatures**

**Applicant Name:** JOHN PROVIDER  
**TIN:** xxx-xx-2012  
**Web Tracking ID:** xxxxxx0001  
**Form Type:** 855R

**Role:** AUTHORIZED OFFICIAL  
**Document:** AUTHORIZED OFFICIAL CERTIFICATION STATEMENT FOR CLINICS AND GROUP PRACTICES

**VIEW AND SIGN** 00

**Step 16b: The AO reviews and agrees to the Terms and Conditions.**

**Review And Sign Your Certification Statement** (\*) Red asterisk indicates a required field.

**E-Signature Instructions**

To complete your E-Signature follow the steps below:

1. [Click here if you wish to review the application](#)
2. View and read the terms and conditions for the applicable document(s) that you wish to e-sign.
3. Check the box if you agree with the terms and conditions
4. Click the Submit button to complete your E-Signature

**Terms and Conditions**

**PENALTIES FOR FALSIFYING INFORMATION**

This section explains the penalties for deliberately furnishing false 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

**AUTHORIZED OFFICIAL CERTIFICATION STATEMENT FOR CLINICS AND GROUP PRACTICES (855B)**

These are additional requirements that the provider must meet and maintain to bill the Medicare program. By signing, the provider is attesting to have read the requirements and understanding them.

By his/her signature(s), the authorized official named below agrees to adhere to the following requirements stated in this Certification Statement.

\* Do you accept the Terms and Conditions?

Yes, I agree to the certification statement terms and conditions. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my traditional handwritten signature.

**SUBMIT**

The AO must agree to the terms and conditions by checking the box. By accepting the terms and conditions and submitting the provider's e-signature is complete.

**Step 16c: The AO receives confirmation that their e-signature has been accepted.**

**E-Signature Confirmation**

**Your E-Signature Has Been Accepted**

You have successfully e-signed the following document(s):

**Web tracking ID:** T071620130000001

[View Submitted Application](#)

**Provider/Supplier Name:** NEW JERSEY ASSOCIATES IN MEDICINE, PA

**Signer Name:** JACK CAPPITELLI

**Role:** AUTHORIZED OFFICIAL

**Document:** AUTHORIZATION STATEMENT FOR ORGANIZATIONS

**Signed Date:** Wed Jul 17 11:45:36 EDT 2013

**HOME**

**Step 17: Option 2 - E-sign via the PECOS E-signature website**

The AO accesses the PECOS e-signature website at <https://pecos.cms.hhs.gov/pecos/eSignLogin.do>, contained within the email.

Welcome to PECOS E-Signature Application

Remote Authentication Page (\* Red asterisk indicates a required field.)

You have been directed to this site in order to electronically sign certain required documents related to Medicare enrollment application recently submitted on your behalf.

**WARNING:** If you believe you have been directed to this site by mistake, please close this page immediately. Only authorized users have the right to access this site. By accessing and using this system you expressly consent to system monitoring. Any misuse will be documented as evidence of possible criminal activity and reported to the appropriate law enforcement officials.

Verify Your Identity and Validate Your Application Record

Enter the required Identity information:

\* First Name  
\* Last Name  
\* Date of Birth  
mm/dd/yyyy  
\* SSN  
XXX-XX-XXXX

Enter the email address and PIN you received in the PECOS emails:

\* Email Address  
\* PIN

LOG IN >>

If your PIN is lost or expired, [click here to generate a new one.](#)

The AO enters their required identity information, their email address and the PIN contained within the PECOS generated emails..

**Step 17a: The Signatures section displays all applications pending the AO's signature. The AO identifies the application they wish to e-sign and clicks the View and Sign button.**

Medicare Enrollment  
for Providers and Suppliers

Welcome JACK ORGANIZATION

Signatures

Applications Requiring Signatures

Applicant Name: John Provider  
TIN: 135747920  
Web Tracking ID: T071620130000001  
Form Type: 855R

Role: AUTHORIZED OFFICIAL  
Document: AUTHORIZATION STATEMENT FOR ORGANIZATIONS  
Application Submitted: 07/16/2013

VIEW AND SIGN >>

**Step 17b: The AO reviews and agrees to the Terms and Conditions.**

**Review And Sign Your Certification Statement**

(\*) Red asterisk indicates a required field.

**E-Signature Instructions**

To complete your E-Signature follow the steps below:

1. [Click here if you wish to review the application](#)
2. View and read the terms and conditions for the applicable document(s) that you wish to e-sign.
3. Check the box if you agree with the terms and conditions
4. Click the Submit button to complete your E-Signature

**Terms and Conditions**

**PENALTIES FOR FALSIFYING INFORMATION**

This section explains the penalties for deliberately furnishing false 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

**AUTHORIZED OFFICIAL CERTIFICATION STATEMENT FOR CLINICS AND GROUP PRACTICES (855B)**

These are additional requirements that the provider must meet and maintain to bill the Medicare program. By signing, the provider is attesting to have read the requirements and understanding them.

His/her signature(s), the authorized official named below agrees to adhere to the following requirements stated in this Certification Statement:

\* Do you accept the Terms and Conditions?

Yes, I agree to the certification statement terms and conditions. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my traditional handwritten signature.

**SUBMIT**

The AO must agree to the terms and conditions by checking the box. By accepting the terms and conditions and submitting the provider's e-signature is complete.

**Step 17c: The AO receives confirmation that their e-signature has been accepted.**

**E-Signature Confirmation**

**Your E-Signature Has Been Accepted**

You have successfully e-signed the following document(s):

**Web tracking ID:** T071620130000001

[View Submitted Application](#)

**Provider/Supplier Name:** NEW JERSEY ASSOCIATES IN MEDICINE, PA

**Signer Name:** JACK CAPPITELLI

**Role:** AUTHORIZED OFFICIAL

**Document:** AUTHORIZATION STATEMENT FOR ORGANIZATIONS

**Signed Date:** Wed Jul 17 11:45:36 EDT 2013

**HOME**

Learn more about PECOS at <https://PECOS.CMS.hhs.gov>, and be on the look-out for more enhancements in the coming months! Questions concerning a system issue regarding PECOS should be referred to the CMS EUS Help Desk at 866-484-8049 or [EUSupport@cgi.com](mailto:EUSupport@cgi.com), Monday – Friday, 7am – 7pm EST.