

Keep a copy of this completed package for your own records

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



Medicare Provider/Supplier Enrollment Application

Privacy Act Statement

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

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

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

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

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

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

Protection of Proprietary Information

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

Protection of Confidential Commercial and/or Sensitive Personal Information

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

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**INSTRUCTIONS FOR HEALTH CARE SUPPLIERS
THAT WILL BILL MEDICARE CARRIERS**

Please **PRINT** or **TYPE** all information so it is legible. Do not use pencil. Failure to provide all requested information may cause the application to be returned and may delay the enrollment process. Certain sections of the application have been omitted because they do not apply to suppliers. See inside front cover for mailing instructions. Electronic copies of all CMS Medicare enrollment forms can be found at the Medicare website at <http://www.cms.hhs.gov>. These electronic forms may be downloaded to your computer, completed on screen, printed, signed, and mailed to the appropriate Medicare contractor.

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

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

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

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

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

If the supplier plans to do any of the above, submit the appropriate form(s)/agreement(s) with this application. The forms should have been received with this initial enrollment package. If not, they can be obtained from the Medicare carrier or the forms can be found at the Medicare website at <http://www.cms.hhs.gov>.

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

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DEFINITIONS OF MEDICARE ENROLLMENT TERMINOLOGY

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

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

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

Carrier-The Part B Medicare claims processing contractor.

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

Fiscal Intermediary-The Part A Medicare claims processing contractor.

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

Medicare Identification Number-This is a generic term for any number that uniquely identifies the enrolling supplier. Examples of Medicare identification numbers are Unique Physician/Practitioner Identification Number (UPIN), National Provider Identifier (NPI), Online Survey Certification and Reporting number (OSCAR), National Supplier Clearinghouse (number) (NSC), and Provider Identification number (PIN).

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

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

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

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

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

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

SECTION 1: GENERAL APPLICATION INFORMATION

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

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

1. Check one of the following:

Initial Enrollment:

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

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

Reactivation:

- If the supplier's Medicare billing number was deactivated. To reactivate billing privileges, the supplier may be required to either submit an updated CMS 855B or certify to the accuracy of its enrollment information currently on file with CMS. In addition, prior to being reactivated, the supplier must be able to submit a valid claim. It must also meet all current requirements for its supplier type, regardless of whether it was previously enrolled in the program.

Revalidation:

- If the supplier has been requested to revalidate its enrollment information currently on file with Medicare. Periodically (about once every three years), Medicare will require the supplier to confirm and update **all** of its enrollment information. Check this box and complete this entire application unless instructed otherwise by the Medicare carrier. A copy of the original application with all changes clearly indicated with a current signature and date may be submitted.

Change of Information:

- If the supplier is adding, deleting, or changing information under this tax identification number. Check the appropriate section where the change will be made. When providing the changed information, furnish the supplier's Medicare identification number in Section 1 and provide the new/changed information within the appropriate section. Sign and date the certification statement. **All changes must be reported to the carrier within 90 days of the effective date of the change.**
- **Tax Identification Number Change:** If the supplier is reporting a change to its tax identification number, a complete new CMS 855B enrollment application must be submitted as it is assumed that a change of ownership has occurred. If this is not the case, please provide evidence that a change of ownership has not occurred when reporting this change.
- If the supplier is adding or deleting a member who currently is reassigning his/her benefits to the supplier, it only needs to complete a CMS 855R to make such a change. The member may also delete his/her reassignment of benefits by completing and submitting the CMS 855R.

Voluntary Termination of Billing Number:

- If the supplier will no longer be submitting claims to the Medicare program using this billing number. Voluntary termination ensures that the supplier's billing number will not be fraudulently used in the event of the supplier ceasing its operations. Furnish the date the supplier will stop billing for Medicare covered services. In addition to completing this section, furnish the supplier's Medicare identification number in Section 1 under "Change of Information," and sign and date the certification statement (Section 15).

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

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

- When a hospital undergoes a change of ownership (CHOW), in addition to the required submission of a CMS 855A, the hospital must also submit a new CMS 855B for the new ownership.
 - When a portable x-ray facility or ambulatory surgical center undergoes a change of ownership that results in the issuance of a new tax identification number (TIN), the new owners must submit a completed CMS 855B and attach a copy of the sales agreement.
2. Tax Identification Number (TIN) - Provide the supplier's taxpayer identification number (e.g., the number the supplier uses to report tax information to the IRS) and attach documentation (e.g., a copy of the IRS CP-575) from the IRS showing that the name matches that reported in this application. If the supplier does not have an IRS CP-575, any legal document from the IRS that shows the supplier's name and TIN will be acceptable proof. Upon request, the IRS will provide a Form 147C showing the supplier's name and TIN.

NOTE: An IRS CP 575 or other documentation must be submitted for each TIN reported on this application.

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

3. Indicate whether the supplier is currently enrolled in the Medicare program. If the supplier is currently enrolled in Medicare (i.e., within another carrier's jurisdiction) provide the name of the carrier in this space. The supplier must also provide its Medicare identification number in the space provided. This number is issued by Medicare to identify the supplier. It is also the number used on claims forms and may be referred to as a Medicare provider number, provider identification number, or National Supplier Clearinghouse number. Report all currently active numbers.
4. Indicate if this supplier would like to submit claims electronically. If the supplier would like to submit claims electronically once enrolled in the Medicare program, the supplier will need to complete an Electronic Data Interchange (EDI) agreement with the local Medicare carrier. Checking this box will alert the carrier to contact their claims processing department. The claims processing department will contact the supplier to process an EDI agreement once its enrollment has been completed, approved, and a Medicare billing number issued to the supplier. These agreements cannot be established until the enrollment process has been completed and a Medicare billing number has been issued.

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

If the supplier does not currently have a Medicare identification number, it will be assigned one upon the successful completion of enrollment. Your local carrier will assign a separate supplier identification number. The carrier will explain what number(s) has been issued and how it is to be used. If the carrier should contact the supplier for additional information, the supplier must provide the information immediately to ensure the timely processing of this application.

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MEDICARE FEDERAL HEALTH CARE PROVIDER/SUPPLIER ENROLLMENT APPLICATION**Application for Health Care Suppliers that will Bill Medicare Carriers****General Instructions**

The Medicare Federal Health Care Provider/Supplier Enrollment Application has been designed by the Centers for Medicare and Medicaid Services (CMS) to assist in the administration of the Medicare program and to ensure that the Medicare program is in compliance with all regulatory requirements. The information collected in this application will be used to ensure that payments made from the Medicare trust fund are only paid to qualified health care suppliers, and that the amounts of the payments are correct. This information will also identify whether the supplier is qualified to render health care services to Medicare beneficiaries. To accomplish this, Medicare must know basic identifying and qualifying information about the supplier that is seeking billing privileges in the Medicare program. If enrolling in the Medicare program as a supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) do not complete this application. DMEPOS suppliers should contact the National Supplier Clearinghouse (NSC) at 866-238-9652 to obtain a CMS 855S for Medicare enrollment.

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

This application **MUST** be completed in its entirety, unless the appropriate box is checked to indicate the section does not apply or when reporting a change to previously submitted information. If a section does not apply to this supplier, check (✓) the appropriate box in that section and skip to the next section. Sections 7, 9, 11, and 12 have been deliberately omitted from this application because they are not applicable to the enrollment of suppliers that bill Medicare carriers.

1. General Application Information

This section is to be completed with general information as to why this application is being submitted and whether this supplier currently has a business relationship with Medicare or any another Federal health care program.

To ensure timely processing of this application, Numbers 1, 2 and 3 below MUST ALWAYS be completed.

A. Reason for Submittal of this Application

1. Check one: Initial Enrollment Reactivation Revalidation
- Change of Information (Check appropriate Section(s) below and furnish this supplier's Medicare Identification Number here): _____
- 1 2 3 4 5 6 8 10 13 15 16
Attachment 1 - 1 2 3 Attachment 2 - 1 2 3 4
- Voluntary Termination of Billing Number—Effective Date (MM/DD/YYYY): _____
Medicare Billing Number to be Terminated: _____
- Change of Ownership (Hospitals, Portable X-Ray Facilities, and Ambulatory Surgical Centers) - **Only**

2. Tax Identification Number: _____

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

Current Carrier Name: _____ Current Medicare Identification Number or NPI: _____

4. Check here if this supplier would like to submit claims electronically and is enrolling in Medicare for the first time.

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SECTION 2: SUPPLIER IDENTIFICATION

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

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

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

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

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

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

Clinic/Group Practices: If this clinic/group will be billing for diagnostic tests, other than clinical laboratory or pathology tests, see page 51 of these instructions to determine if this supplier must also enroll as an Independent Diagnostic Testing Facility (IDTF).

2. Indicate whether the supplier will be receiving reassigned benefits from individual practitioners. This will alert the carrier that it will be receiving CMS 855R(s) to be associated with the supplier's application.
3. PT/OT Groups Only - If the supplier is enrolling as an occupational or physical therapy group, it must answer the questions listed to determine its eligibility to bill Medicare.

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

1. Furnish the legal business name for this supplier as reported to the IRS for tax purposes.
2. Provide any "doing business as" name this supplier uses. The "doing business as" name is the name the supplier is generally known by to the public.
3. Check the appropriate box to indicate the organizational structure of this supplier. Check "Corporation" if the supplier is such, regardless of whether the supplier is "for-profit" or "non-profit." "Partnership" should be checked for all "General" and "Limited" partnerships. All other suppliers should check "Other," and specify the type of organizational structure (e.g., limited liability company). The carrier may request a copy of the supplier's "articles of incorporation" if needed to validate certain information.

2. Supplier Identification			
This section is to be completed with information specifically related to the supplier submitting this application. Furnish the following information about the supplier: (1) supplier type, (2) supplier name, and (3) the mailing address and telephone number where Medicare can contact the supplier directly.			
A. Type of Supplier <input type="checkbox"/> Change		Effective Date: _____	
The supplier must meet all Medicare requirements for the type of supplier checked below. If this supplier is a single specialty clinic/group practice, the specialty must be reported. Submit copies of all required licenses, certifications, and registrations with this application.			
1. Type of Supplier (Check one):			
<input type="checkbox"/> Ambulance Service Supplier <input type="checkbox"/> Ambulatory Surgical Center <input type="checkbox"/> Diagnostic Radiology Group Practice/Clinic <input type="checkbox"/> Hospital or other provider type which is also enrolled with a fiscal intermediary (complete 2E on page 11) <input type="checkbox"/> Independent Clinical Laboratory (CLIA) <input type="checkbox"/> Independent Diagnostic Testing Facility (IDTF) <input type="checkbox"/> Mammography Screening Center <input type="checkbox"/> Managed Care Plan (non-Medicare + Choice) <input type="checkbox"/> Mass Immunization Roster Biller Only <input type="checkbox"/> Medicare +Choice Organization <input type="checkbox"/> Medical Faculty Practice Plan: See instructions for specific documentation requirements <input type="checkbox"/> Multi-Specialty Clinic or Group Practice	<input type="checkbox"/> Occupational Therapy Group (complete 2A2 below) <input type="checkbox"/> Other Medical Care Group <input type="checkbox"/> Physical Therapy Group (complete 2A2 below) <input type="checkbox"/> Portable X-ray Facility <input type="checkbox"/> Public Health/Welfare Agency <input type="checkbox"/> Radiation Therapy Center <input type="checkbox"/> Slide Preparation Facility <input type="checkbox"/> Voluntary Health/Charitable Agency <input type="checkbox"/> *Single-Specialty Clinic/Group Practice: *Specify group/clinic specialty below: _____ <input type="checkbox"/> Other (Specify): _____		
2. Will this supplier be receiving reassigned benefits from individual practitioners? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, submit a CMS 855R for each individual practitioner who will be reassigning benefits to this supplier.			
3. PT/OT Groups ONLY - All occupational and physical therapy groups <u>must</u> answer the following questions:			
a) Are all of the group's PT/OT services only rendered in patients' homes? <input type="checkbox"/> YES <input type="checkbox"/> NO			
b) Does this group maintain private office space? <input type="checkbox"/> YES <input type="checkbox"/> NO			
c) Does this group own, lease, or rent its private office space? <input type="checkbox"/> YES <input type="checkbox"/> NO			
d) Is this private office space used exclusively for the group's private practice? <input type="checkbox"/> YES <input type="checkbox"/> NO			
e) Does this group furnish PT/OT services outside of its office and/or patients' homes? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, provide a copy of the lease agreement that gives the group exclusive use of the facility for PT/OT services.			
B. Supplier Identification Information <input type="checkbox"/> Change		Effective Date: _____	
Furnish the supplier's legal business name (as reported to the IRS), "doing business as" name (name supplier generally known by to the public), and organizational structure.			
1. Legal Business Name as Reported to the IRS			
2. "Doing Business As" (DBA) Name (if applicable)			
3. Identify the type of organizational structure for this supplier (Check one): <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other (Specify): _____			
C. Correspondence Address <input type="checkbox"/> Change		Effective Date: _____	
This must be an address and telephone number where Medicare can contact this supplier directly.			
Mailing Address (Organization or Individual Name)			
Mailing Address Line 1 (Street Name and Number)			
Mailing Address Line 2 (Suite, Room, etc.)			
City		State	ZIP Code + 4
Telephone Number () ()	(Ext.) () ()	Fax Number (if applicable) () ()	E-mail Address (if applicable)

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

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

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

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

1. Indicate whether this ASC is accredited by any accrediting organization that Medicare has approved for acceptance in lieu of a State Survey. If "Yes:"
2. Furnish the date accreditation was received, and
3. Furnish the name of the Medicare-approved accrediting body or organization.

E. Hospitals and Other Providers Enrolled with a Fiscal Intermediary (Only) - This section is **only** to be completed by hospitals and certain other provider organizations that are currently enrolled or enrolling with a fiscal intermediary. Generally, this applies to hospitals that need departmental billing numbers to bill for Part B practitioner services. Hospitals requiring a Part B billing number to sell pathology services should also complete this section. If the hospital requires more than one departmental Part B billing number list each department needing a number. If the provider is other than a hospital, or is also enrolled or enrolling with a fiscal intermediary, and believes it needs or will need a Part B billing number, contact the local carrier to determine if this form should be submitted. Otherwise:

- Furnish the department name(s) and/or type(s) of service this provider will render that require a Part B Medicare supplier billing number from the local Medicare carrier.

NOTE: Provider-Based Clinic - A hospital that is enrolling a clinic that is not provider-based should not complete this section. They should check "Multi-Specialty Clinic or Group Practice" in Section 2A1 on page 9 and complete this entire application for the clinic.

F. Suppliers Employing Physician Assistants (Only) - This section is to be completed by all supplier groups/clinics who need to delete physician assistants (PAs) from the practice when they are no longer employed by the practice.

- Check the delete box and provide the effective date of the deletion and the name and Medicare identification number of the PA.

NOTE: Supplier groups/clinics should not use or submit the CMS 855R form to report physician assistants. The CMS 855R is only used to reassign benefits that would otherwise be paid directly to a practitioner.

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

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SECTION 3: ADVERSE LEGAL ACTIONS AND OVERPAYMENTS

A. Adverse Legal History - This section is to be completed with information concerning any adverse legal actions that have been imposed or levied against this supplier, as identified in Section 2B. See Table A on the application form for a list of adverse actions that must be reported.

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

1. The supplier must state whether, under any current or former name or business identity, it has ever had any of the adverse legal actions listed in Table A of the application form imposed against it.
2. If the answer to this question is "Yes," supply all requested information. Attach copies of official documentation related to the adverse legal action. Such documentation includes adverse legal action notifications (e.g., notification of disciplinary action; criminal court documentation that verifies the conviction of a crime) and documents that evidence how the adverse legal action was finally resolved (e.g., reinstatement notices, etc.).

If the supplier is uncertain as to whether it falls within one of the adverse legal action categories or whether a name reported on this application has an adverse legal action, query the Healthcare Integrity and Protection Data Bank. If information is needed on how to access the data bank, call 1-800-767-6732 or visit www.npdb-hipdb.com. There is a charge for using this service.

Table A--This is the list of adverse legal actions that must be reported. All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

B. Overpayment Information - Current laws found in the Federal Streamlining Act and the Debt Collection Improvement Act require all Federal agencies to determine whether an individual or business entity that enters into a business relationship with that agency has any outstanding debts, including overpayments under different identifiers. Failure to furnish information about overpayments will put the supplier in violation of these Acts and subject it to possible denial of its Medicare enrollment.

1. The supplier, as identified in Section 2B, must report all outstanding Medicare overpayments that it is liable for, including those paid to the supplier, or on its behalf, under a different name. For purposes of this section, the term "outstanding Medicare overpayment" is defined as a debt that meets **all** of the conditions listed below:
 - a) The overpayment arose out of the supplier's current or previous enrollment in Medicare. This includes any overpayment incurred by the supplier under a different name or business identity, or in another Medicare contractor jurisdiction;
 - b) CMS (or its contractors) has determined that the supplier is liable for the overpayment; and
 - c) The overpayment is not or has not been included as part of a repayment plan approved by CMS (or its contractors), nor is the overpayment amount being repaid through the withholding of Medicare payments to the supplier.

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

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

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

3. Adverse Legal Actions and Overpayments

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

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

1. Has this supplier, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A below imposed against it? YES NO
2. **IF YES**, report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

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

Table A

- 1) Any felony conviction under Federal or State law, regardless of whether it was health care related.
- 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 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 misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.
- 6) 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.
- 7) Any revocation or suspension of accreditation.
- 8) 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.
- 9) Any current Medicare payment suspension under any Medicare billing number.

Note: All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

B. Overpayment Information

1. Does this supplier, under any current or former name or business identity, have any outstanding Medicare overpayments? YES NO
2. **IF YES**, furnish the name and account number under which the overpayment(s) exists.

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

SECTION 4: CURRENT PRACTICE LOCATION(S)

A. Practice Location Information - Check the appropriate box if the supplier is using this section to add a new practice location, delete a practice location, or change information about an existing practice location. Provide the new information, the effective date of that change, and sign and date the certification statement. Otherwise:

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

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

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

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

NOTE: Managed Care Plan – Managed care organizations (including Medicare + Choice Organizations), that have contracts with Medicare are only required to provide county/parish, State, and Zip Code.

3. Indicate whether the supplier owns or leases the practice location.
4. Indicate whether this address is that of a hospital, retirement/assisted living community, group practice office/clinic, or other health care facility. Please specify the location if it does not fall within one of these categories.
5. Report any CLIA number(s) and/or FDA/Radiology (Mammography) Certification Number(s) that have been issued to this practice location and which this supplier will be billing for these types of services.

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

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

B. Mobile Facility and/or Portable Units

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

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

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

- If the base of operations address is the same as the practice location reported above in Section 4A, check the box and skip to Section 4D.
1. Provide the base of operations name and the date the supplier started practicing from this location.
 2. Provide the address from where personnel are dispatched, where mobile/portable equipment is stored and, when applicable, where vehicles are parked when not in use. Provide the telephone number, fax number and e-mail address (if applicable) for this base of operations location.

NOTE: If this supplier does not have a physical location where equipment and/or vehicles are stored or from where personnel report on a regular basis, complete this section with information about the location of the dispatcher/scheduler and fully explain the method of operation in Section 2G. This situation may occur if the supplier operates mobile units that travel continuously from one location directly to another.

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

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

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

4. Current Practice Location(s)

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

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

1. Practice Location (Name)		Date Started at this Location (MM/DD/YYYY)	
2. Practice Location Address Line 1 (Street Name and Number)			
Practice Location Address Line 2 (Suite, Room, etc.)			
City	County/Parish	State	ZIP Code + 4
Telephone Number () ()	(Ext.) ()	Fax Number (if applicable) () ()	E-mail Address (if applicable)
3. Does this provider:		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO	
own this practice location?			
lease this practice location?			
4. Is this practice location a:		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO	
hospital?			
retirement/assisted living community?			
group practice office/clinic			
other health care facility? (Specify): _____			
5. CLIA Number for this location (if applicable)		FDA/Radiology (Mammography) Certification Number(s) for this location (if applicable)	

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

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

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

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

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

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

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

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

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

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

1. Initial Reporting and/or Additions

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

2. Deletions

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

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

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

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

- The "Pay To" address is not the same address used for Electronic Funds Transfers. If the supplier would like payments to be deposited in its bank account electronically, place a check in the box given and complete the form "Medicare Authorization Agreement for Electronic Funds Transfers (Form HCFA-588).
- If payment will be made by electronic funds transfer, the "Pay To" address should indicate where the supplier wants all other payment information to be sent (e.g., remittance notices, special payments, etc.).

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

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

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

4. Practice Location (Continued)			
E. Geographic Location where the Base of Operations and/or Vehicle Renders Services			
<input type="checkbox"/> Add		<input type="checkbox"/> Delete	
Effective Date: _____			
Furnish the county/parish, city, State and ZIP Code for all locations where mobile and/or portable services are rendered.			
Note: If this supplier renders mobile health care services in more than one State, and those States are served by different Medicare contractors, a separate CMS 855B enrollment application must be completed for each Medicare contractor jurisdiction.			
1. <u>Initial Reporting and/or Additions:</u>			
County/Parish:	City:	State:	ZIP Code(s):
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
2. <u>Deletions:</u>			
County/Parish:	City:	State:	ZIP Code(s):
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
F. Medicare Payment "Pay To" Address <input type="checkbox"/> Change Effective Date: _____			
Check here <input type="checkbox"/> and complete and submit Form HCFA-588 with this application if the supplier would like its payments electronically transferred to its bank account.			
Furnish the address where payment should be sent for services rendered at the practice location(s) in Section 4A or 4C.			
"Pay To" Address Line 1 (Street Name and Number)			
"Pay To" Address Line 2 (Suite, Room, etc.)			
City	State	ZIP Code + 4	
_____	_____	_____	
G. Location of Patients' Medical Records <input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change Effective Date: _____			
1. Check here <input type="checkbox"/> if all patients' medical records are stored at the location shown in Section 4A or 4C, and skip this section.			
2. If any of the patients' medical records are stored at a location other than the location shown in Section 4A or 4C, complete this section with the name and address of the storage location.			
Name of Storage Facility/Location			
Storage Facility Address Line 1 (Street Name and Number)			
Storage Facility Address Line 2 (Suite, Room, etc.)			
City	State	ZIP Code + 4	
_____	_____	_____	

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

This section is to be completed with information about any organization that has 5% or more (direct or indirect) ownership of, any partnership interest in, and/or managing control of the supplier identified in Section 2B. See examples below of organizations that should be reported in this section. If individuals, and not organizations, own or manage the supplier, do not complete this section. These individuals must be reported in Section 6. If there is more than one organization, copy and complete this section for each.

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

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

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

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

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

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

NOTE: All partners within a partnership must be reported in Section 6 of this application. This applies to both “General” and “Limited” partnerships. For instance, if a limited partnership has several limited partners and each of them only has a 1% interest in the supplier, each limited partner must be reported in this application, even though each owns less than 5%. The 5% threshold primarily applies to corporations or other organizations that are not partnerships.

IMPORTANT – Only report organizations in this section. **Individuals** must be reported in Section 6.

1. Check all boxes that apply to indicate the relationship between the supplier and the owning or managing organization.
2. Provide the legal business name of the owning or managing organization.
3. If applicable, provide the owning or managing organization’s “doing business as” name.
4. Provide the owning or managing organization’s complete business street address.
5. Provide the owning or managing organization’s tax identification number and, if one (or more) has been issued, its Medicare identification number(s).

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

EXAMPLES OF 5% OR MORE “DIRECT” OWNERSHIP

All organizations that own 5% or more of the supplier must be reported in this application.

Many suppliers may be owned by only one organization. For instance, suppose the supplier is an ambulance company that is wholly (100%) owned by Company A. In this case, Company A is considered to be a direct owner of the ambulance company, in that it actually owns the assets of the business. As such, the supplier would have to report Company A in this section.

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

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

- (1) An organization or individual is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the supplier or any of the property or assets of the supplier, **and**
- (2) The interest is equal to or exceeds 5% of the total property and assets of the supplier.

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

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EXAMPLES OF "INDIRECT" LEVELS OF OWNERSHIP FOR ENROLLMENT PURPOSES**Example 1 (Ownership)**

LEVEL 3	<i>Individual X</i> 5%	<i>Individual Y</i> 30%
LEVEL 2	<i>Company C</i> 60%	<i>Company B</i> 40%
LEVEL 1	<i>Company A</i> 100%	

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

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

LEVEL 1

The diagram above indicates that Company A owns 100% of the Enrolling Supplier. Company A must therefore be reported in Section 5.

LEVEL 2

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

$$\begin{array}{l} \textit{The percentage of ownership the LEVEL 1 owner has in the Enrolling Supplier} \\ \mathbf{MULTIPLIED\ BY} \\ \textit{The percentage of ownership the LEVEL 2 owner has in that LEVEL 1 owner} \end{array}$$

It is known that Company A, the LEVEL 1 (or direct) owner, owns 100% of the Enrolling Supplier. The diagram also indicates that Company C, a LEVEL 2 owner, owns 60% of Company A. As such, multiply 100% (or 1.0) by 60% (.60). The result is .60. Therefore, Company C indirectly owns 60% of the Enrolling Supplier, and must be reported in Section 5.

Repeat the same procedure for Company B, the other LEVEL 2 owner. Because Company B owns 40% of Company A, multiply this figure by 100% (again, the ownership stake Company A has in the Enrolling Supplier). Therefore, 1.0 multiplied by .40 equals .40, so Company B owns 40% of the Enrolling Supplier, and must be reported in Section 5.

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

LEVEL 3

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

$$\begin{array}{l} \textit{The percentage of ownership the LEVEL 2 owner has in the Enrolling Supplier} \\ \mathbf{MULTIPLIED\ BY} \\ \textit{The percentage of ownership the LEVEL 3 owner has in that LEVEL 2 owner} \end{array}$$

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

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

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

Example 2 (Financial Control)

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

$$\begin{array}{l} \textit{Dollar amount of the mortgage, deed of trust, or other obligation secured by} \\ \textit{the Enrolling Supplier or any of the property or assets of the Enrolling Supplier} \\ \mathbf{DIVIDED\ BY} \\ \textit{Dollar amount of the total property and assets of the Enrolling Supplier} \end{array}$$

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

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

MANAGING CONTROL (ORGANIZATIONS)

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

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SPECIAL TYPES OF ORGANIZATIONS

Governmental/Tribal Organizations: If a Federal, State, county, city or other level of government, or an Indian tribe, will be legally and financially responsible for Medicare payments received (including any potential overpayments), the name of that government or Indian tribe should be reported as an owner. The supplier must submit a letter on the letterhead of the responsible government (e.g., government agency) or tribal organization, which attests that the government or tribal organization will be legally and financially responsible in the event that there is any outstanding debt owed to CMS. This letter must be signed by an "authorized official" of the government or tribal organization who has the authority to legally and financially bind the government or tribal organization to the laws, regulations, and program instructions of Medicare. See Section 14 for further information on and a definition of "authorized officials."

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

- C. Adverse Legal History** - This section is to be completed with information concerning any adverse legal actions that have been imposed or levied against the organization(s) reported in this section. See Table A in Section 3 of the application form for a list of adverse actions that must be reported.

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

1. The supplier must state whether the organization reported in Section 5B, under any current or former name or business identity, has ever had any of the adverse legal actions listed in Section 3 (Table A) of this form imposed against it.
2. If the answer to this question is "Yes," supply all requested information. Attach copies of official documentation related to the adverse legal action. Such documentation includes adverse legal action notifications (e.g., notification of disciplinary action; criminal court documentation that verifies the conviction of a crime) and documents that evidence how the adverse legal action was finally resolved (e.g., reinstatement notices, etc.).

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

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

This section is to be completed with information about all organizations that have 5% or more (direct or indirect) ownership interest of, any partnership interest in, and/or managing control of, the supplier identified in Section 2B, as well as any information on adverse legal actions that have been imposed against that organization. See instructions for examples of organizations that should be reported here. If there is more than one organization, copy and complete this section for each.

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

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

Add Delete Change Effective Date: _____

1. Check all that apply: 5% or more Ownership Interest Partner
 Managing Control

2. Legal Business Name

3. "Doing Business As" Name (if applicable)

4. Business Address Line 1 (Street Name and Number)

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

City	State	ZIP Code + 4
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5. Tax Identification Number	Medicare Identification Number(s) (if applicable)
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C. Adverse Legal History Change Effective Date: _____

This section is to be completed for the organization reported in Section 5B above.

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

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

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

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

This section is to be completed with information about any individual who has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the supplier identified in Section 2B. In addition, all officers, directors, and managing employees of the supplier must be reported in this section. If there is more than one individual, copy and complete this section for each. **The supplier MUST have at least ONE owner and/or managing employee.** If this is a “one person” operation, then report yourself in this section as both a 5% or greater owner and a managing employee or director/officer.

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

The following individuals must be reported in Section 6A: (see below for definitions of these terms)

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

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

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

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

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

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

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

Refer to the instructions and examples in Section 5 for further clarification of what is meant by the terms “direct owner” and “indirect owner.” If further assistance is needed in completing this section, contact the Medicare carrier.