OMB Approval No. 0938-0685

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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 PROVIDERS THAT WILL BILL MEDICARE FISCAL INTERMEDIARIES

Please **PRINT** or **TYPE** all information so it is legible. Do not use pencil. Failure to provide all requested information might cause the application to be returned and may delay the enrollment process. 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 the provider's completed application and supporting documents for future reference.

This application is to be completed by all health care provider organizations that provide medical services to Medicare beneficiaries and who bill fiscal intermediaries. For purposes of this application and Medicare enrollment, all such organizations will be referred to as "providers." A list of the provider types that should complete this application can be found in Section 2A. Failure to promptly submit a completed form CMS 855A to the fiscal intermediary will result in delays in obtaining enrollment and billing privileges.

To have Medicare payments sent electronically to a provider's bank account, the provider should complete the form "Medicare Authorization Agreement for Electronic Funds Transfers" (Form HCFA-588). This form should have been received in the initial enrollment package. If not, it can be obtained from the Medicare fiscal intermediary.

APPLICATION SUBMISSION AND PROCESSING

This application should be submitted directly to your intermediary of preference. See the CMS website http://www.cms.hhs.gov for a listing of fiscal intermediaries. Providers that are part of a chain, or that share fiscal data with other enrolled providers, may choose the same fiscal intermediary, even if they are not located in the area normally serviced by that fiscal intermediary. Home Health Agencies (HHA) and Hospices should submit this application to their regional home health intermediary (RHHI). However, if the HHA is provider based, it should submit this application to its parent provider's fiscal intermediary. The provider's fiscal intermediary of preference does not automatically guarantee that it will be assigned to that fiscal intermediary. Providers, who are currently enrolled in the Medicare program and are requesting to change their fiscal intermediary, must submit their request to the Medicare Regional Office prior to submission of this application. However, this is not applicable when the fiscal intermediary changes as the result of a CHOW, acquisition/merger, or a consolidation and the fiscal intermediary of preference is the fiscal intermediary currently being used by the provider who is acquiring the changing provider. The fiscal intermediary will answer any questions you have concerning completion of the CMS 855A.

The provider must immediately contact the local State Agency that handles the provider type being enrolled. The State Agency will provide you with any State-specific forms required for your provider type. They will also do preliminary planning for any required State Surveys or notice of accreditation in lieu of a survey (when this is permitted).

If the provider does not currently have a Medicare identification number, the CMS regional office will assign one upon the successful completion of enrollment. Issuance of a Medicare identification number usually requires a written agreement (usually a provider agreement) with CMS. If the fiscal intermediary should contact the provider for additional information, the provider must furnish the information immediately to ensure the timely processing of this application.

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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 provider has granted the legal authority to enroll it in the Medicare program, to make changes and/or updates to the provider's status in the Medicare program (e.g., new practice locations, change of address, etc.) and to commit the provider to fully abide by the laws, regulations, and program instructions of Medicare. The authorized official must be the provider's general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of 5% or more of the provider (see Section 5 for the definition of a "direct owner"), or must hold a position of similar status and authority within the provider's organization.
Billing Agency-A company that the enrolling provider contracts with to furnish claims processing functions for the provider.
Carrier-The Part B Medicare claims processing contractor.
Delegated Official-Any individual who has been delegated, by the provider's "Authorized Official," the authority to report changes and updates to the provider's enrollment record. A delegated official **must** be a managing employee (W-2) of the provider or have a 5% ownership interest, or any partnership interest, in the provider.
Fiscal Intermediary-The Part A Medicare claims processing contractor.
Legal Business Name-The organization 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 provider. Examples of Medicare identification numbers are Unique Physician/Practitioner Identification Number (UPIN), Online Survey Certification and Reporting number (OSCAR), National Provider Identifier (NPI), and National Supplier Clearinghouse (number) (NSC).
Mobile Facility/Portable Unit-These terms apply when a service that requires medical equipment is provided in a vehicle, or the equipment for the service is transported to multiple locations within a geographic area. The most common types of mobile facilities/portable units are mobile IDTFs, portable X-ray, portable mammography, and mobile clinics. Physical therapists and other medical practitioners (e.g., physicians, nurse practitioners, physician assistants) who perform services at multiple locations (i.e., house calls, assisted living facilities) are not considered to be mobile facilities/portable units.
Provider-A provider is a hospital, critical access hospital, skilled nursing facility, nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice, that has in effect an agreement to participate in Medicare; or a rural health clinic (RHC), Federally qualified health center (FQHC), rehabilitation agency, or public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech pathology services; or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services. A provider is not synonymous with the corporation or other legal entity that owns or operates the provider. The "provider" is the CMS recognized provider type listed above. Therefore, an owning or operating entity may own or operate many providers.
Provider Identification Number (PIN)-This number is assigned to providers, suppliers, groups and organizations in Medicare Part B. This number will identify who provided the service to the beneficiary on the Medicare claim form.
Supplier-A physician or other practitioner, or an organization other than a provider that furnishes health care services under Medicare Part B. The term supplier also includes independent laboratories, portable x-ray services, physical therapists in private practice, end stage renal disease (ESRD) facilities, and chiropractors.
Tax Identification Number (TIN)-This is a number issued by the Internal Revenue Service (IRS) that the provider 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.

To reduce the burden of furnishing some types of supporting documentation, we have designated specific types of documentation to be furnished on an "as needed" basis. However, the fiscal intermediary 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 are billing agreements, W-2 forms, pay stubs, articles of incorporation, and partnership agreements.

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SECTION 1: GENERAL APPLICATION INFORMATION

This section is to identify the reason for submittal of this application. It will also indicate whether the provider 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 provider is enrolling in the Medicare program for the first time under this tax identification number.
- For a change of ownership of an enrolled provider when the new owner will not be accepting assignment of the current provider agreement.

Revalidation:

- If the provider has been requested to revalidate its enrollment information currently on file with Medicare. Periodically (about once every three years), Medicare will require the provider to confirm and update **all** of its enrollment information. Check this box and complete this entire application unless instructed otherwise by the Medicare fiscal intermediary. 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 provider 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 provider'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 fiscal intermediary within 90 days of the effective date of the change.** If the provider organization's tax identification number has changed, a new complete CMS 855A enrollment application must be submitted as it is assumed that this provider has changed ownership. If this is not the case, please provide evidence that a change of ownership has not occurred.

NOTE: If the provider is adding a new practice location that requires a **separate** State Survey or Accreditation and a **separate** Medicare Agreement, then a **separate** CMS 855A enrollment application must be submitted for the new provider practice location. For more information concerning the addition of practice locations, contact the State Agency or CMS regional office. If a new practice location is determined **not** to be a new provider, the updated information can be submitted as a practice location change in Section 4.

Voluntary Termination of Provider Billing Number:

- If the provider will no longer be submitting claims to the Medicare program using this billing number. Voluntary termination ensures that the provider's billing number will not be fraudulently used in the event of the provider ceasing its operations. Furnish the date the provider will stop billing for Medicare covered services. In addition to completing this section, furnish the provider's Medicare identification number in Section 1 under "Change of Information" and sign the certification statement (Section 15 or 16).
- If a provider is reporting a "CHOW" and the new owner will not be accepting assignment of the assets and Medicare liabilities of the old owner. The effective date should be the date when the old owner will no longer permit use of its billing number.

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

Change of Ownership (CHOW):

- See note below and instructions for Section 1B to determine if a valid CHOW applies and needs to be reported.

Acquisitions and/or Mergers (including the CHOW):

- See note below and the instructions for Section 1C to determine if a valid acquisition/merger (and related CHOW) applies and needs to be reported.

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Consolidations (including the CHOW):

- See note below and the instructions for Section 1D to determine if a valid consolidation applies and needs to be reported.

NOTE: All sub-units of a provider with separate provider agreements that will remain in operation after a CHOW, acquisition/merger, or consolidation require completion and submission of a separate CMS 855A. All related CMS 855As should be submitted together, when administratively practical, for the providers involved. If a sub-unit will no longer be in operation upon the completion of the CHOW, acquisition/merger, or consolidation, a CMS 855A must be submitted for the sub-unit requesting a voluntary termination of its billing number.

2. Tax Identification Number (TIN) – Furnish the provider organization's taxpayer identification number (e.g., the number the provider uses to report tax information to the IRS) and attach documentation (e.g., a copy of the CP-575 form) from the IRS showing that the name matches that reported in this application. If the provider does not have an IRS CP-575, IRS Form 941, or IRS 501(c)(3) determination letter, any legal document from the IRS that shows the provider's name and TIN will be acceptable proof. Other IRS documents that may be submitted include an IRS Form 990 or a quarterly tax payment coupon. The name and TIN number on the IRS document should match those shown on this application. Upon request, the IRS will provide a Form 147C showing the provider's name and TIN.

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

If the provider cannot obtain the required IRS document, explain why in a separate attachment and provide evidence that links its legal business name with the reported TIN. If the name and TIN do not match on the submitted documents, explain why and refer to the documents which confirm the identification of the provider or owner as applicable (e.g., if the provider recently changed its name and the IRS has not sent it an updated document). The provider 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. Medicare Identification Number (MIN) - Indicate whether the provider is currently enrolled in the Medicare program. If the provider is currently enrolled in Medicare (i.e., with another fiscal intermediary) provide the name of the intermediary in this space. The provider must also furnish its Medicare identification number in the space provided. This number is issued by Medicare to identify the provider. It is also the number used on claims forms and may be referred to as a Medicare provider number, provider identification number, national provider identifier (NPI), or Online Survey Certification and Reporting (OSCAR) number. Report all currently active numbers.

NOTE: If enrolling as a provider in the Medicare program for the first time, an OSCAR number will be issued to the provider as part of the enrollment process.

4. Fiscal Intermediary Preference

   a) For new providers enrolling in Medicare for the 1st time, check the box given and furnish the name of the provider's fiscal intermediary preference in Section 1A4c, if known. Otherwise, leave blank.

   b) For providers who are currently enrolled in the Medicare program and are requesting to change their fiscal intermediary as the result of a CHOW, acquisition/merger, or a consolidation. The request to change fiscal intermediaries must be submitted to the Medicare Regional Office prior to submission of this application.

   NOTE: Currently enrolled providers who only seek to change their fiscal intermediary are not required to complete this application. Instead, they should request the change directly to their CMS regional office.

   c) For "a" or "b" above, furnish the name of the provider's fiscal intermediary preference. When submitting this application for any reason other than those given in Sections 1A4a or 1A4b above, currently enrolled providers should show their current fiscal intermediary here and skip the above check boxes.

5. Indicate if this provider would like to submit claims electronically. If the provider would like to submit claims electronically once enrolled in the Medicare program, the provider will need to complete an Electronic Data Interchange (EDI) agreement with the fiscal intermediary. Checking this box will alert the intermediary to contact their claims processing department. The claims processing department will contact the provider to process an EDI agreement once its enrollment has been completed, approved, and a Medicare billing number issued to the provider. These agreements cannot be established until the enrollment process has been completed and a Medicare billing number has been issued.

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MEDICARE FEDERAL HEALTH CARE PROVIDER/SUPPLIER ENROLLMENT APPLICATION

Application for Health Care Providers that will Bill Medicare Fiscal Intermediaries

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 providers, and that the amounts of the payments are correct. This information will also identify whether the provider is qualified to render health care services and/or furnish supplies to Medicare beneficiaries. To accomplish this, Medicare must know basic identifying and qualifying information about the health care provider that is seeking billing privileges in the Medicare program.

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

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 provider, check (√) the appropriate box in that section and skip to the next section.

1. General Application Information

A. Reason for Submittal of this Application

This section is to be completed with general information as to why this application is being submitted and whether this provider currently has a business relationship with another Federal health care program.
To ensure timely processing of this application, Numbers 1, 2 and 3 below MUST ALWAYS be completed.

1. Check one: ☐ Initial Enrollment ☐ Revalidation

☐ Change of Information (Check appropriate Section(s) Being Changed)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 10
☐ 11 ☐ 12 ☐ 13 ☐ 15 ☐ 16

☐ Voluntary Termination of Billing Number - Effective Date (MM/DD/YYYY):_____
Billing Number to be Terminated:_____

☐ Change of Ownership (CHOW) - See Instructions and Complete Section 1B

☐ Acquisition/Merger (including the CHOW) - See Instructions and Complete Section 1C

☐ Consolidation (including the CHOW) - See Instructions and Complete Section 1D

2. Tax Identification Number:_____

3. Is this provider currently enrolled in the Medicare program? ☐ YES ☐ NO
IF YES, furnish the following information about the current fiscal intermediary (FI):

Current FI Name:_____Current Medicare Identification Number or NPI:_____

4. Fiscal Intermediary Preference:

a) Check here ☐ if this provider is enrolling in the Medicare program for the first time. If known, furnish the name of the provider's fiscal intermediary preference in Section 1A4c below.

b) Check here ☐ if this provider is currently enrolled in the Medicare program and is requesting a change of its fiscal intermediary as a result of a CHOW, acquisition/merger, or a consolidation, and furnish the name of the new preferred fiscal intermediary in Section 1A4c below.

c) Name of Preferred Fiscal Intermediary:_____

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

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B. Change of Ownership Information (CHOW Only)

This section is to be completed with information that identifies the name and Medicare identification number of the currently enrolled provider (Transferor) prior to the change of ownership. This section must be completed by **both** the current owner(s) (to protect them from any future liabilities) and the new owner (to establish payment under its tax identification number) on separate CMS 855A applications. Two copies of the sales or other asset transfer agreement, in its current form, must be submitted with this application, and a copy of the final agreement must be submitted by the new owner once the sale is executed.

NOTE: If you are an individual currently enrolled as a provider and you undergo a change of ownership as a result of your incorporation, you must submit two copies of your "articles of incorporation" in lieu of a "Sales Agreement."

- The "**current**" owner (Transferor) is defined as the "old" or "selling" owner.
- The "**new**" owner is defined as the "purchasing" owner.

Any provider undergoing a "Change of Ownership" (CHOW) in accordance with the principles discussed in 42 CFR 489.18 must check the "Change of Ownership (CHOW)" box in Section 1A1. For all other ownership changes check the "Change of Information" box in Section 1A. To determine if a CHOW applies to this provider, review the principles in 42 CFR 489.18 for guidance. If further assistance is needed, contact the fiscal intermediary.

For current/selling owner(s)
A currently enrolled provider that will transfer its ownership interest to new owners in accordance with the principles discussed in 42 CFR § 489.18 should complete this section. This current owner only needs to complete the following sections of this application when reporting a CHOW: Check the Change of Ownership (CHOW) box in Section 1A1, then complete Section 1A2, 1A3, 1B, 2, 13, and sign and date the Certification Statement in Section 15.

1. Furnish the legal business name used by the current owner.
2. Furnish the "doing business as" name used by the current owner.
3. Furnish the Medicare identification number, the projected date that the current owner will no longer have ownership, and the name of the current owner's fiscal intermediary.
4. Indicate if the new owner will be accepting assignment of the current "Provider Agreement." This question does not apply to ESRD clinics.

For new/purchasing owner(s)
A prospective new owner who is participating in a Change of Ownership (CHOW) in accordance with the principles discussed in 42 CFR § 489.18 must complete this entire application. The prospective new owner should check the Change of Ownership (CHOW) box in Section 1A1. If the prospective new owner will not accept assignment of all terms and conditions of the "Provider Agreement" (including the provision concerning the responsibility for Medicare liabilities of the current owner), then the prospective new owner cannot have the current "Provider Agreement" transferred to them. The organization will then be considered a new provider to the Medicare program and must obtain approval through the normal enrollment process by submitting a CMS 855A (Initial Enrollment) prior to obtaining the right to bill Medicare.

1. Furnish the legal business name used by the current owner.
2. Furnish the "doing business as" name used by the current owner.
3. Furnish the Medicare identification number, the projected date that the current owner will no longer have ownership, and the name of the current owner's fiscal intermediary.
4. Indicate if the new owner will be accepting assignment of the current "Provider Agreement." This question does not apply to ESRD clinics.

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C. Acquisitions/Merger (including the CHOW)

Furnish the effective date of the acquisition/merger in the space provided. Two copies of the sales or other asset transfer agreement, in its current form, must be submitted with this application, and a copy of the final agreement must be submitted once the sale is executed.

This section must be completed when an acquisition results in one or more provider (OSCAR) numbers being voluntarily deactivated from the Medicare program. In general, a provider's number is deactivated if the acquisition results in **only one remaining t**ax identification number (TIN), State survey or accreditation, and Medicare agreement. If the acquisition only results in an existing provider having new owners but it will keep its current provider number, then the instructions in Section 1B above for a Change of Ownership (CHOW only) should be used.

This section should be completed on **separate** CMS 855As by **both:**

- The provider that is acquiring another provider, and
- The provider that is being acquired by another provider.

1. Provider Being Acquired - All providers being acquired should be reported in this section.

   a) Furnish the legal business name and TIN of the provider organization being acquired.

   b) Furnish the name of the fiscal intermediary and the Medicare identification number of the provider being acquired.

   c) Report all sub-units of the provider being acquired that currently have an active Medicare identification number but have not entered into separate provider agreements, and furnish the sub-unit's Medicare identification number. Do not report sub-units of the provider being acquired that have separate provider agreements. If these sub-units are also being acquired in this transaction, a separate CMS 855A must be submitted for each.

2. Acquiring Provider - This section is to be completed by both the acquired provider and the acquiring provider with information about the acquiring provider.

   a) Furnish the legal business name and the TIN of the provider that is acquiring other providers.

   b) Furnish the name of the fiscal intermediary and Medicare identification number of the acquiring provider.

NOTE: The acquiring provider should also complete Section 4 (Practice Location) to report the location of the provider it acquired as a new or additional practice location from which it will furnish services.

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1. General Application Information (Continued)

B. Change of Ownership Information (CHOW Only)

This section is to be completed with information that identifies the name and Medicare identification number of the currently enrolled provider (Transferor) prior to the change of ownership. This section must be completed by both the current owner(s) (to protect them from any future liabilities) and the new owner (to establish payment under its tax identification number). **Submit two copies of the sales or other asset transfer agreement with this application.**

1. Legal Business Name of Transferor as Reported to the IRS		
2. "Doing Business As" Name of Transferor (if applicable)		
3. Medicare Identification Number of Transferor	Projected Effective Date of Transfer (MM/DD/YYYY)	Name of Fiscal Intermediary of Transferor
4. Will the new owner be accepting assignment of the current "Provider Agreement?"	☐ YES ☐ NO	

C. Acquisitions/Merger (including the CHOW) Effective Date of Acquisition:_____

This section is to be completed when:
1) A currently enrolled provider is acquiring another currently enrolled provider(s), or
2) A currently enrolled provider is being acquired by another currently enrolled provider.
All providers involved in the acquisition must complete this section. For each provider, furnish the following information: legal business name, tax identification number, current fiscal intermediary, and Medicare identification number. For the provider being acquired, furnish the name of the sub-units of that provider and provide each sub-unit's Medicare identification number. Also indicate whether that sub-unit will remain active. If more than one provider is being acquired, copy and complete this section as needed.
NOTE: Submit two copies of the sales or other asset transfer agreement(s) with this application.

1. Provider Being Acquired

This section is to be completed with information about the currently enrolled provider that is being acquired and will no longer retain its current Medicare provider number as a result of this acquisition.

a) Legal Business Name of the "Provider Being Acquired" as Reported to the IRS	Tax Identification Number
b) Current Fiscal Intermediary	Medicare Identification Number

c) Furnish the name and Medicare identification number of all sub-units of the above provider that have separate Medicare identification numbers but have not entered into separate provider agreements, such as PPS excluded swing bed units of a hospital.

Name/Department:	Medicare Identification Number:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

2. Acquiring Provider

This section is to be completed with information about the organization acquiring the provider identified in Section 1C1.

a) Legal Business Name of the "Acquiring Provider" as Reported to the IRS	Tax Identification Number
b) Current Fiscal Intermediary	Medicare Identification Number

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D. Consolidations (including the CHOW)

Furnish the effective date of the consolidation in the space provided. Two copies of the sales or other asset transfer agreement, in its current form, must be submitted with this application, and a copy of the final agreement must be submitted once the sale is executed.

This section should be completed when a consolidation of providers will result in issuance of a **new** provider number. This usually results from the creation of a **new** provider organization, which has been issued a **new** TIN from the IRS. All applicable sections of this application should be completed for the **new** provider organization (this is similar to being an initial enrollment).

Consolidations that result in **two** or more provider (OSCAR) numbers being deactivated from the Medicare program should be reported in this section. In general, a provider number is deactivated when a TIN is removed from the IRS tax rolls. If a transaction results in an existing provider having new owners but keeping its current provider number, then the instructions in Section 1B above for a Change of Ownership (CHOW) should be used. If a transaction results in an existing provider having new owners that will be using the provider number of the acquiring provider, then the instructions in Section 1C (Acquisitions/Merger) should be used.

1. 1st Consolidating Provider

Complete this section about the 1st currently enrolled provider that, as a result of this consolidation, will no longer retain its current Medicare provider number.

a) Furnish the legal business name and TIN of the 1st provider involved in this consolidation.

b) Furnish the name of this provider's fiscal intermediary and its Medicare identification number.

c) Report all sub-units of the provider being consolidated that currently have an active Medicare identification number but have not entered into separate provider agreements, and furnish the sub-unit's Medicare identification number. Do not report sub-units of the provider being consolidated that have separate provider agreements. If these sub-units are also being consolidated in this transaction, a separate CMS 855A must be submitted for each.

2. 2nd Consolidating Provider

Complete this section about the 2nd currently enrolled provider that, as a result of this consolidation, will also no longer retain its current Medicare provider number.

a) Furnish the legal business name and TIN of the 2nd provider involved in this consolidation.

b) Furnish the name of this provider's fiscal intermediary and its Medicare identification number.

c) Report all sub-units of the provider being consolidated that currently have an active Medicare identification number but have not entered into separate provider agreements, and furnish the sub-unit's Medicare identification number. Do not report sub-units of the provider being consolidated that have separate provider agreements. If these sub-units are also being consolidated in this transaction, a separate CMS 855A must be submitted for each.

3. Newly Created Provider Identification Information

Complete this section with information about the newly created provider.

a) Furnish the legal business name and TIN of the newly created provider organization that resulted from this consolidation.

b) Furnish the new provider organization's fiscal intermediary preference.

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1. General Application Information (Continued)

D. Consolidations (including the CHOW) **Effective Date of Consolidation:**_____

All currently enrolled providers that are consolidating with other currently enrolled providers must complete this section with information about all the providers involved. This section is only to be completed when the consolidation of two or more providers results in an entirely new provider and the issuance of a new Medicare provider number. For each provider, furnish the following information: legal business name, tax identification number, current fiscal intermediary, Medicare identification number, and all sub-units of each provider. For each sub-unit, furnish the Medicare identification number and indicate which sub-units will remain active. In addition, complete Section 1D3 with identifying information about the newly created provider. If there are more than two consolidating providers, copy and complete this section as needed.

1. 1st Consolidating Provider

This section is to be completed with information about the 1st currently enrolled provider that, as a result of this consolidation, will no longer retain its current Medicare provider number.

a) Legal Business Name of the Provider Organization as Reported to the IRS	Tax Identification Number
b) Current Fiscal Intermediary	Medicare Identification Number

c) Furnish the name and Medicare identification number of all sub-units of the above provider that have separate Medicare identification numbers but have not entered into separate provider agreements, such as PPS excluded swing bed units of a hospital.

Name/Department:	Medicare Identification Number:
_____	_____
_____	_____
_____	_____
_____	_____

2. 2nd Consolidating Provider

This section is to be completed with information about the 2nd currently enrolled provider that, as a result of this consolidation, will also no longer retain its current Medicare provider number.

a) Legal Business Name of the Provider Organization as Reported to the IRS	Tax Identification Number
b) Current Fiscal Intermediary	Medicare Identification Number

c) Furnish the name and Medicare identification number of all sub-units of the above provider that have separate Medicare identification numbers but have not entered into separate provider agreements, such as PPS excluded swing bed units of a hospital.

Name/Department:	Medicare Identification Number:
_____	_____
_____	_____
_____	_____
_____	_____

3. Newly Created Provider Identification Information

Complete this section with identifying information about the newly created provider resulting from this consolidation.

a) Legal Business Name of the new Provider as Reported to the IRS	Tax Identification Number
b) Fiscal Intermediary Preference	

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SECTION 2: PROVIDER IDENTIFICATION

A. Type of Provider

1. Type of provider - Check the appropriate box to identify the type of provider for which this application is being submitted. Only **one** provider type may be checked per application. If the provider functions as two or more provider types, a separate CMS 855A must be submitted for each type. If the provider changes the type of services it provides (becomes a different provider type), a new CMS 855A must be completed and submitted (except for hospitals changing the type of hospital services provided – see #2 below).

NOTE: The only Medicare-eligible provider types are those listed. If this provider believes it meets Medicare eligibility requirements to participate in the Medicare program and its provider type is not listed, check the "Other" box and specify the type of service this provider will furnish to Medicare beneficiaries. Before checking "Other," be certain that this provider is an organizational provider type that would submit claims to a Medicare Fiscal Intermediary. Some medical organizations may own or control supplier types that are only eligible to submit claims to a Medicare carrier. These suppliers must complete the CMS 855B and submit it to their local carrier.

2. If "Hospital" was checked in Section 2A1, check all applicable types of services this hospital furnishes. If the hospital is reporting a change in the types of services it provides, check the change box and check **all** current types of provided services.
3. If "Hospital" was checked in Section 2A1:

Check the appropriate box to indicate if the hospital wants one Medicare Part B services billing number, multiple Part B services billing numbers for each department (e.g., cardiology, pathology, radiology), or if this section is not applicable. If a combination of both separate billing numbers for some departments and combined billing numbers for groups of other departments are requested, furnish all details in Section 2G. If multiple numbers are being requested, each department to be issued a Part B Medicare billing number must be reported here.

NOTE: Hospitals must complete and submit the form CMS 855B to the local Medicare carrier to obtain a Part B Medicare billing number.

4. If this hospital has a compliance plan which states that the hospital checks all managing employees against the exclusion/debarment lists of both the HHS Office of the Inspector General (OIG) and the General Services Administration (GSA), check "Yes" in the box provided. Otherwise, check "No." At any time, CMS or its Medicare contractor may request a copy of the compliance plan.

The licenses, certifications and registrations which must be submitted with this application are those required by Medicare or the State to function as the provider type for which this provider is enrolling. Local licenses/permits that are not of a medical nature are not required but any business license required to operate as a health care facility **must** be submitted. Required documents that can only be obtained after a State Survey are not required as part of the application submission but **must** be furnished within 30 days of the provider receiving them.

B. Provider 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 provider as reported to the IRS for tax purposes. This may be the same name as that of the owner of this provider.
2. Provide any "doing business as" name this provider uses. The "doing business as" name is the name the provider is generally known by to the public.
3. Check the appropriate box to indicate the organizational structure of this provider. Check "Corporation" if the provider is such, regardless of whether the provider is "for-profit" or "non-profit." "Partnership" should be checked for all "General" or "Limited" partnerships. All other providers should check "Other," and specify the type of organizational structure (e.g., limited liability company).
4. Furnish this provider's "Medicare Year-End Cost Report Date." This date will determine when cost reports and audits are due for this provider. This date may be the same as the provider's "fiscal year-end date.

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2. Provider Identification

This section is to be completed with information specifically related to the provider submitting this application. Furnish the following information about the provider: (1) provider type, (2) provider name, (3) the mailing address and telephone number where Medicare can contact the provider directly, (4) whether the provider has been accredited or Federally approved, and (5) whether the provider has any "prospective payment system" (PPS) exclusions.

A. Type of Provider

Check the appropriate boxes below. The provider must meet all Medicare requirements for the type of provider checked. Submit copies of all required licenses, certifications, and registrations with this application.

1. Type of Provider (Check one):

- ☐ Religious Non-Medical Health Care Institution (RNHCI)
- ☐ Community Mental Health Center
- ☐ Comprehensive Outpatient Rehabilitation Facility
- ☐ End-Stage Renal Disease Facility (ESRD)
- ☐ Federally Qualified Health Center (FQHC)
- ☐ Histocompatibility Laboratory
- ☐ Home Health Agency
- ☐ Home Health Agency (Sub-unit)
- ☐ Hospice
- ☐ Hospital (If checked, complete Sections 2A2 and 2A3)
- ☐ Indian Health Services Facility
- ☐ Multiple Hospital Component in a Medical Complex
- ☐ Organ Procurement Organization (OPO)
- ☐ Outpatient Physical Therapy/Occupational Therapy/ Speech Pathology Services
- ☐ Psychiatric Unit (of Hospital)
- ☐ Rehabilitation Agency (unit of a Hospital)
- ☐ Rural Health Clinic
- ☐ Skilled Nursing Facility
- ☐ Other (Specify):_____

2. If this provider is a hospital, check all applicable sub-groups listed below:

☐ Hospital ☐ Change Effective Date:_____

- ☐ Hospital—General
- ☐ Hospital—Alcohol/Drug
- ☐ Hospital—Acute Care
- ☐ Hospital—Children's (excluded from PPS)
- ☐ Hospital—Critical Access
- ☐ Hospital—Critical Access (Swing-Bed unit)
- ☐ Hospital—Long-Term (excluded from PPS)
- ☐ Hospital—Long-Term (Swing-Bed unit)
- ☐ Hospital—Psychiatric (excluded from PPS)
- ☐ Hospital—Short-Term (General and Specialty)
- ☐ Hospital—Short-Term (Swing-Bed unit)
- ☐ Hospital—Rehabilitation (excluded from PPS)
- ☐ Hospital—Rehabilitation (Swing-Bed unit)

☐ Other (Specify):

_____

3. Hospital Departments billing for Practitioner Services:
If this provider is a hospital, check the appropriate box below. See instructions before completing this section.

☐ Not Applicable

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

_____ _____ _____

_____ _____ _____

_____ _____ _____

4. Does this hospital have a compliance plan stating that all managing employees are checked against the OIG exclusion and GSA debarment lists? ☐ YES ☐ NO

B. Provider Identification Information ☐ Change Effective Date:_____

Furnish the provider's legal business name (as reported to the IRS), "doing business as" name (name provider generally known by to the public), and the various operating dates and places of formal business registration and/or incorporation. If incorporated, the provider may be required to submit a copy of its "Articles of Incorporation" for validation purposes.

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 provider (Check one):
☐ Corporation ☐ Partnership ☐ Other (Specify):_____

4. Medicare Year-End Cost Report Date (MM/DD)

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C. Correspondence Address - 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:

- **Furnish a name, address, and telephone number where Medicare or the Medicare fiscal intermediary can directly get in touch with the enrolling provider.**

This section will assist us in contacting the provider with any questions we have concerning its business relationship with the Medicare program. The provider must furnish a name, address, and telephone number where Medicare or the fiscal intermediary 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 furnish the provider with important changes or other information concerning the Medicare program that may directly affect the provider and/or its Medicare payments. This address **cannot** be that of the billing agency, management service organization, or staffing company. If we suspect that the provider's billing number is being misused, or if we have a legal question, we will contact the provider directly. This is to protect the provider as well as the Medicare program.

D. Accreditation - 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 provider is accredited by any accrediting organization that Medicare has approved for acceptance in lieu of a State Survey.
2. If "Yes," furnish the date accreditation was received, and
3. Furnish the name of the Medicare-approved accrediting body or organization.

E. Federal Approval (FQHCs and OPOs only) – This section must be completed by all Federally Qualified Health Centers and Organ Procurement Organizations. To be eligible to enroll in the Medicare program, FQHCs and OPOs must receive federal approval to operate as a health care provider.

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 if this FQHC or OPO has received federal approval. If "Yes,"
2. Furnish the date of approval and submit a copy of the approval certificate with this application.

F. Prospective Payment System Exclusions - 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 if this provider has any "Prospective Payment System Exclusions." This section is primarily for hospitals that have psychiatric units or rehabilitation agencies (units).
2. If "Yes," indicate the type of unit to be excluded by checking one or both boxes provided.

G. Comments – This section is to be used as an opportunity to explain any unique billing number requests or to clarify any other information furnished in this section (Section 2 - Provider Identification).

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2. Provider Identification (Continued)

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

This must be an address and telephone number where Medicare can contact the provider 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)

Note: Sections 2D through 2F below require a "Yes," "No," or "Pending" response. If a specific question does not apply to this provider, check "No" and continue with the next question. If the response is "Yes" or "Pending," furnish the additional information requested in that section and continue with the next question.

D. Accreditation ☐ **Change** **Effective Date:**_____

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

E. Federal Approval (FQHCs and OPOs only) ☐ **Change** **Effective Date:**_____

1. Is this provider Federally approved? ☐ YES ☐ NO ☐ PENDING
   IF YES, complete the following:
2. Date of Approval (MM/DD/YYYY):_____

F. Prospective Payment System Exclusions ☐ **Change** **Effective Date:**_____

1. Does this provider have any "Prospective Payment System" (PPS) excluded units? ☐ YES ☐ NO
   IF YES, check the type(s) of excluded unit(s) below:
2. Type of unit(s) to be excluded: ☐ Psychiatric Unit ☐ Rehabilitation Agency (unit)

G. Comments

Use this section to explain any unique billing number requests or to clarify any other information furnished in this Section.

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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 provider, 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 provider 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 provider 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 provider in violation of these Acts and subject it to possible denial of its Medicare enrollment.

1. The provider, as identified in Section 2B, must report all outstanding Medicare overpayments that it is liable for, including those paid to the provider, 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 provider's current or previous enrollment in Medicare. This includes any overpayment incurred by the provider under a different name or business identity, or in another Medicare contractor jurisdiction;

   b) CMS (or its contractors) has determined that the provider 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 provider.

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 provider's enrollment has been approved do not need to be reported unless the provider is enrolling with a different Medicare contractor.

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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 provider (see Table A below for list of adverse actions that must be reported).

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

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

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

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SECTION 4: CURRENT PRACTICE LOCATION(S)

A. Practice Location Information - Check the appropriate box to indicate whether the provider is adding a new practice location, deleting a practice location, or changing information about an existing practice location. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise, complete this section as follows:

If a reported addition or change does not require a separate OSCAR number and/or corresponding separate provider agreement (e.g., a branch or provider-based clinic), check the appropriate box and complete this section. If adding a location that requires a completely separate OSCAR number and/or corresponding separate provider agreement, a new application must be submitted for the new location as a new provider.

Home Health Agencies (HHAs) should complete this section with their administrative address and skip to Section 4E.

Community Mental Health Centers (CMHCs) must report all alternative sites where core services are provided (proposed alternative sites for initial enrollment and actual alternative sites for those CMHCs already participating in Medicare). In accordance with provisions of the Public Health Service Act, a CMHC is required to provide mental health services principally to individuals who reside in a defined geographic area (service area). Therefore, CMHCs must service a distinct and definable community. Those CMHCs operating or proposing to operate outside this specific community must have a separate provider agreement/number, submit a separate enrollment application, and individually meet the requirements to participate. CMS will determine if the alternative site is permissible or whether the site must have a separate agreement/number. CMS will consider the actual demonstrated transportation pattern of CMHC clients within the community to ensure that all core services and partial hospitalization are available from each location within the community. A CMHC patient must be able to access and receive services he/she needs at the parent CMHC site or the alternative site within the distinct and definable community served by the parent.

NOTE: Hospitals must report all practice locations where the hospital provides services. Do not report separately enrolled provider/supplier types such as SNFs, HHAs, RHCs, physician practices, clinics, etc. Practice location addresses fall into one of two categories as listed below. When furnishing the practice locations, the hospital should report the addresses in the order shown below.

- **1st** - All location addresses where the hospital performs inpatient services.
- **2nd** – All other location addresses where the hospital performs any other non-inpatient service.

NOTE: If an organization owns other providers or suppliers that are required to obtain separate provider numbers (i.e., OSCAR numbers or UPINs) do not report them as practice locations. Each of these other providers or suppliers must enroll via a separate CMS 855A or CMS 855B as appropriate.

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Practice Location Information (continued)

1. Furnish the name the provider uses at this practice location and the date the provider started rendering services at this location.
2. Furnish a complete street address, telephone number, fax number, and e-mail address (if applicable) for the provider's practice/business location.

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

3. This question is to be completed by providers that indicated that they are a hospital in Section 2A1. Indicate if the practice location shown in Section 4A is an address where inpatient services are furnished.
4. Indicate whether the provider owns/leases the practice location.
5. Report any CLIA number(s) and/or FDA/Radiology (Mammography) Certification Number(s) that have been issued to this provider for this practice location for which the provider will be billing for these types of services. Submit copies of all current valid certificates with this application.
6. This question is to be completed by providers that indicated that they are a home health agency in Section 2A1. HHA's must report all branch office locations as separate practice locations. If the branch office has been issued a Medicare identification number, furnish it in the space provided.

B. Mobile Facility and/or Portable Units

To properly pay claims, Medicare must be able to distinguish when services are provided in a mobile facility or with portable units. If the provider 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 provider transports medical equipment to a fixed location (e.g., physician's office, nursing home) to render service to the patient.

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

C. Base of Operations Address - Check the appropriate box to indicate whether the provider 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 4A1, check the box and skip to Section 4D.

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

D. Vehicle Information - Check the appropriate box to indicate whether the provider 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.

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4. Current Practice Location(s)

This section is to be completed with information about the physical location(s) where this provider currently renders health care services. If this provider operates a mobile facility or portable units, furnish the address of the "Base of Operations," as well as vehicle information and the geographic area serviced by these facilities or units. In addition, cite where this provider wants its payments sent, and where the provider maintains patients' 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. **Hospitals Only:** Is the practice location above an inpatient services practice location? ☐ YES ☐ NO

4. Does this provider: own this practice location? ☐ YES ☐ NO
lease this practice location? ☐ YES ☐ NO

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

6. **HHA's Only:** Is the above practice location a branch office in acordance with 42 CFR 484.2? ☐ YES ☐ NO
Medicare Identification Number for this Branch Office:_____

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

Does this organization 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 4E (Geographic Location).

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 in 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 - This section is to be completed by all **Home Health Agencies, Hospice Organizations**, and **Mobile** and/or **Portable** facilities with information identifying the geographic area(s) where health care services are rendered.

Check the appropriate box when the provider is using this section to add a geographic location 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 provider 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 serviced by different Medicare contractors (fiscal intermediaries), then the provider must complete a separate CMS 855A 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 provider 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 provider's fiscal intermediary. Some Medicare fiscal intermediaries do not allow multiple payment addresses. Payment will be made in the provider'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 provider 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 provider wants other financial or payment information sent.

G. Location of Patients' Medical Records - Check the appropriate box if using this section to add a new location where patients' 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 provider'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 provider'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' medical records are maintained. For IDTFs and mobile facilities/portable units, the patients' medical records must be under the provider's control. The records must be the provider's records, not the records of another provider/supplier.

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4. Practice Location (Continued)

E. Geographic Location ☐ **Add** ☐ **Delete** **Effective Date:**_____

This section is to be completed by all **Home Health Agencies, Hospice Organizations**, and **Mobile** and/or **Portable** facilities with information identifying the geographic area(s) where health care services are rendered.

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

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

1. Initial Reporting and/or Additions:

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

2. Deletions:

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

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

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

Furnish the address where payments should be sent for services rendered at the practice location in Section 4A or 4C.

"Pay To" Address (Organization or Individual Name)

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

1. Check here ☐ if **all** patients' medical records are stored at the location shown in Section 4A or 4C, and skip this section.
2. If **any** of the patients' medical records are stored in 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 provider 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 provider, 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 provider,
- Managing control of the provider, or
- A partnership interest in the provider, 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 provider, 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. 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 provider 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 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).

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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 provider must be reported in this application.

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

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

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

To calculate whether an organization or individual has financial control over the provider, 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	***Individual X*** 5%	***Individual Y*** 30%
LEVEL 2	***Company C*** 60%	***Company B*** 40%
LEVEL 1	***Company A*** 100%	

- Company A owns 100% of the Enrolling Provider
- 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 Provider. Companies B and C as well as Individuals X and Y are indirect owners of the Enrolling Provider. 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 Provider. Company A must therefore be reported in Section 5.

LEVEL 2

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

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

It is known that Company A, the LEVEL 1 (or direct) owner, owns 100% of the Enrolling Provider. 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 Provider, 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 Provider). Therefore, 1.0 multiplied by .40 equals .40, so Company B owns 40% of the Enrolling Provider, and must be reported in Section 5.

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