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***IMPORTANT* – Only Individuals should be reported in Section 6. Organizations must be reported in Section 5.**

1. Furnish the individual's full name, title, date of birth, social security number, and Medicare identification number or NPI (if applicable).

NOTE: Section 1124A of the Social Security Act requires that the supplier furnish Medicare with the individual's social security number.

2. Indicate the individual's relationship with the enrolling supplier identified in Section 2B. If this individual has a title other than that listed in this section, check the "Other" box and specify the title used by this individual.

Example: A supplier is 100% owned by Company C, which itself is 100% owned by Individual D. Assume that Company C is reported in Section 5B as an owner of the supplier. Assume further that Individual D, as an indirect owner of the supplier, is reported in Section 6A1. Based on this example, the supplier would check the "5% or Greater Indirect Owner" box in Section 6A2.

B. Adverse Legal History - This section is to be completed with information concerning any adverse legal actions that have been imposed or levied against individuals reported in Section 6A. See Table A in Section 3 of this application 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 individual reported in Section 6A, under any current or former name or business identity, has ever had any of the adverse legal actions listed in Section 3 (Table A) of this form imposed against him or her.

2. If the answer to this question is "Yes," supply all requested information. Attach copy(s) of official documentation related to the adverse legal action. Such documentation includes adverse legal action notifications (e.g., notification of disciplinary action; criminal court documentation that verifies the conviction of a crime) and documents that evidence how the adverse legal action was finally resolved (e.g., reinstatement notices, etc.).

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

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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. All officers, directors, and managing employees of the supplier must also be reported in this section. In addition, any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each individual.

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

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

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

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

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

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

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

This section is to be completed for the individual reported in Section 6A above.

1. Has the individual in Section 6A 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 him or her? ☐ 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:

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SECTION 7: CHAIN HOME OFFICE INFORMATION

This section has been intentionally omitted.

SECTION 8: BILLING AGENCY

The purpose of collecting this information is to develop effective monitoring of agents/agencies that prepare and/or submit claims to bill the Medicare program on behalf of the supplier. A billing agency is a company or individual that the supplier hires or contracts with to furnish claims processing functions for its business locations. Any entity that meets this description must be reported in this section.

A. Check Box - If this supplier does not use a billing agency, check the box and skip to Section 10.

B. Billing Agency Name and Address - If reporting a change to information about a previously reported billing agency, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. Furnish the name and tax identification number of the billing agency.

2. Furnish the "doing business as" name of the billing agency.

3. Furnish the complete address and telephone number of the billing agency.

C. Billing Agreement/Contract Information - If reporting a change to existing information about a previously reported billing agreement/contract, check "Change," provide the effective date of the change, complete this entire questionnaire, and sign and date the certification statement. Otherwise:

The supplier that is enrolling is responsible for responding to the questions listed.

These questions are designed to show that the supplier fully understands and comprehends its billing agreement and that it intends to adhere to all Medicare laws, regulations, and program instructions. At any time, the Medicare contractor or CMS may request copies of all agreements/contracts associated with this billing agency.

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7. Chain Home Office Information — This Section Not Applicable

8. Billing Agency

This section is to be completed with information about all billing agencies this supplier uses or contracts with that submit claims to Medicare on behalf of the supplier. If more than one billing agency is used, copy and complete this section for each. The supplier may be required to submit a copy of its current signed billing agreement/contract if Medicare cannot verify the information furnished in this section.

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

B. Billing Agency Name and Address ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Legal Business Name as Reported to the IRS		Tax Identification Number
2. "Doing Business As" Name (if applicable)		
3. Business Street Address Line 1 (Street Name and Number)		
Business Street Address Line 2 (Suite, Room, etc.)		
City	State	ZIP Code + 4
Telephone Number (Ext.) ( ) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

C. Billing Agreement/Contract Information ☐ **Change** **Effective Date:**_____

Answer the following questions about the supplier's agreement/contract with the above billing agency.

1. Does the supplier have unrestricted access to its Medicare remittance notices? ☐ YES ☐ NO
2. Does the supplier's Medicare payment go directly to the supplier? ☐ YES ☐ NO
   IF NO, proceed to Question 3.
   IF YES, skip Questions 3, 4 and 5.
3. Does the supplier's Medicare payment go directly to a bank? ☐ YES ☐ NO
   IF NO, proceed to Question 4.
   IF YES, answer the following questions and skip Questions 4 and 5.
   a) Is the bank account only in the name of the supplier? ☐ YES ☐ NO
   b) Does the supplier have unrestricted access to the bank account and statements? ☐ YES ☐ NO
   c) Does the bank only answer to the supplier regarding what the supplier wants from the bank (e.g., sweep account instructions, bank statements, closing account, etc.)? ☐ YES ☐ NO
4. Does the supplier's Medicare payment go directly to the billing agent? ☐ YES ☐ NO
   IF NO, proceed to Question 5.
   IF YES, answer the following question and skip Question 5.
   a) Does the billing agent cash the supplier's check? ☐ YES ☐ NO
      IF NO, proceed to Question b.
      IF YES, are <u>all</u> of the following conditions included in the billing agreement? ☐ YES ☐ NO
      1) The agent receives payment under an agency agreement with the supplier. ☐ YES ☐ NO
      2) The agent's compensation is not related in any way to the dollar amounts billed or collected. ☐ YES ☐ NO
      3) The agent's compensation is not dependent upon the actual collection of payment. ☐ YES ☐ NO
      4) The agent acts under payment disposition instructions that the supplier may modify or revoke at any time. ☐ YES ☐ NO
      5) In receiving payment, the agent acts only on behalf of the supplier (except insofar as the agent uses part of that payment as compensation for the agent's billing and collection services). ☐ YES ☐ NO
   b) Does the billing agent either give the Medicare payment directly to this supplier or deposit the payment into this supplier's bank account? ☐ YES ☐ NO
5. Who receives the supplier's Medicare payment?_____

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SECTION 9: FOR FUTURE USE

This section has been intentionally omitted.

SECTION 10: STAFFING COMPANY

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

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

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

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

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

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

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

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

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

SECTION 11: SURETY BOND INFORMATION

This section has been intentionally omitted.

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9. For Future Use — This Section Not Applicable

10. Staffing Company

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

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

B. 1st Staffing Company using this Supplier - Name and Address

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

1. Legal Business Name as Reported to the IRS		Tax Identification Number
2. "Doing Business As" Name (if applicable)		
3. Business Street Address Line 1 (Street Name and Number)		
Business Street Address Line 2 (Suite, Room, etc.)		
City	State	ZIP Code + 4
Telephone Number (Ext.) ( ) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

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

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

1. Does the staffing company shown in Section 9B above **and** the billing agency identified in Section 8B have a common owner(s)? ☐ YES ☐ NO
2. If applicable, are there any provisions in the staffing contract/agreement that supersede or contradict the enrolling supplier's billing agreement? ☐ Not applicable ☐ YES ☐ NO

D. 2nd Staffing Company using this Supplier - Name and Address

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

1. Legal Business Name as Reported to the IRS		Tax Identification Number
2. "Doing Business As" Name (if applicable)		
3. Business Street Address Line 1 (Street Name and Number)		
Business Street Address Line 2 (Suite, Room, etc.)		
City	State	ZIP Code + 4
Telephone Number (Ext.) ( ) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

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

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

1. Does the staffing company shown in Section 9D above **and** the billing agency identified in Section 8B have a common owner(s)? ☐ YES ☐ NO
2. If applicable, are there any provisions in the staffing contract/agreement that supersede or contradict the enrolling supplier's billing agreement? ☐ Not applicable ☐ YES ☐ NO

11. Surety Bond Information — This Section Not Applicable

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SECTION 12: CAPITALIZATION REQUIREMENTS FOR HOME HEALTH AGENCIES

This section has been intentionally omitted.

SECTION 13: CONTACT PERSON INFORMATION (OPTIONAL)

To assist in the timely processing of the supplier's application, provide the full name, e-mail address, telephone number, and mailing address of an individual who can be reached to answer questions regarding the information furnished in this application (preferably the individual who completed this application). The supplier is not required to furnish a contact person in this section. It should be noted that if a contact person is not provided, all questions about this application will be directed to the authorized official named in Section 15B.

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

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

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

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION ON THIS ENROLLMENT APPLICATION

The supplier should review this section to understand those penalties that can be applied against it for deliberately furnishing false information to enroll or maintain enrollment in the Medicare program.

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12. Capitalization Requirements for Home Health Agencies This Section Not Applicable

13. Contact Person Information (Optional)

Furnish the name, telephone number and address of a person who can answer questions about the information furnished in this application (preferably the individual who completed this application). If a contact person is not furnished in this section, all questions will be directed to the authorized official named in Section 15B.

A. Check here ☐ if this section does not apply and skip to Section 14.

B. Contact Person Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

Name: First	Last	
Address Line 1 (Street Name and Number)		
Address Line 2 (Suite, Room, etc.)		
City	State	ZIP Code + 4
E-mail Address (if applicable)	Telephone Number ( )	(Ext.) ( )

14. Penalties for Falsifying Information on this Enrollment Application

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

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

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

2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against any individual who, "knowingly and willfully," makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program.

The offender is subject to fines of up to $25,000 and/or imprisonment for up to five years.

3. The Civil False Claims Act, 31 U.S.C. § 3729, imposes civil liability, in part, on any person who:
   a.) knowingly presents, or causes to be presented, to an officer or any employee of the United States Government a false or fraudulent claim for payment or approval;
   b.) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or
   c.) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

The Act imposes a civil penalty of $5,000 to $10,000 per violation, plus three times the amount of damages sustained by the Government.

4. Section 1128A(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency...a claim...that the Secretary determines is for a medical or other item or service that the person knows or should know:
   a.) was not provided as claimed; and/or
   b.) the claim is false or fraudulent.

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

5. The government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment."

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

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SECTION 15: CERTIFICATION STATEMENT

This section is used to officially notify the supplier of additional requirements that must be met and maintained in order for the supplier to be enrolled in the Medicare program. This section also requires the signature and date signed of an authorized official who can legally and financially bind the supplier to the laws, regulations, and program instructions of the Medicare program. Section 16 permits the authorized official to delegate signature authority to certain individual(s) (delegated officials) for the purpose of reporting changes to the supplier's enrollment record after the supplier has been enrolled. The supplier may have no more than one currently active authorized official at any given time. See below to determine who within the supplier organization qualifies as an authorized official.

A. Additional Requirements for Medicare Enrollment – These are the additional requirements that must be met by the supplier to enroll in and maintained by the supplier to bill the Medicare program. Carefully read these requirements. By signing, the supplier will be attesting to having read these requirements and that the supplier understands them.

B. Authorized Official Signature - If adding a new, or deleting an existing authorized official, check the appropriate box and indicate the effective date of that change. Otherwise:

- The authorized official must sign and date this application.

NOTE: The authorized official must also be reported in Section 6.

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

C. 2nd Authorized Official Signature - This section provided to report a second (optional) authorized official for this supplier. See instructions above for Section 15B.

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

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

By signing this form for initial enrollment in the Medicare program or for revalidation purposes, the authorized official agrees to immediately notify the Medicare program contractor if any information in the application is not true, correct, or complete. In addition, the authorized official, by his/her signature, agrees to notify the Medicare contractor of any future changes to the information contained in this form, after the supplier is enrolled in Medicare, within 90 days of the effective date of the change.

Governmental/Tribal Organizations

As stated in the instructions for Governmental/Tribal Organizations in Section 5, the authorized official signing the CMS 855B in Section 15 must be the same person submitting the letter attesting that the governmental or tribal organization will be legally and financially responsible for any outstanding debts owed to CMS. For instance, the head of a County Department of Health and Human Services would ordinarily qualify as an authorized official of the governmental entity.

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SPECIAL REPORTING REQUIREMENTS

To change authorized officials, the supplier must:

- Check the "Delete" box in Section 15B,
- Provide the effective date of the deletion, and
- Have the authorized official being deleted provide his/her printed name, signature, and date of signature.

NOTE: If the current authorized official's signature is unattainable (e.g., person has left the company), the Medicare contractor may request documentation verifying that the person is no longer the authorized official.

To then add a new authorized official, the supplier must:

- Copy the page containing the Certification Statement,
- Check the "Add" box in Section 15B and provide the effective date of the addition,
- Have the new authorized official provide the information requested in 15B, and
- Have the new authorized official provide his/her signature and date of signature.

By signing his or her name, the new authorized official assumes from the prior authorized official all of the powers (e.g., the power to delegate authority to a delegated official, etc.) previously held by the latter, and also agrees to adhere to all Medicare requirements, including those outlined in Sections 15A and 15B of the Certification Statement. However, a change of the authorized official has no bearing on the authority of existing delegated officials to make changes and/or updates to the supplier's status in the Medicare program.

If the supplier is reporting a change of information about the current authorized official (e.g., change in job title), this section should be completed as follows:

- Check the box to indicate a change and furnish the effective date,
- Provide the new information, and
- Have the authorized official sign and date this section.

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15. Certification Statement

This section is used to officially notify the supplier of additional requirements that must be met and maintained in order for the supplier to be enrolled in the Medicare program. This section also requires the signature and date signed of an "Authorized Official" who can legally and financially bind the supplier to the laws, regulations, and program instructions of the Medicare program. Section 16 permits the "Authorized Official" to delegate signature authority to other individual(s) (Delegated Officials) employed by the supplier for the purpose of reporting future changes to the supplier's enrollment record. See instructions to determine who qualifies as an Authorized Official and a Delegated Official for the supplier.

A. Additional Requirements for Medicare Enrollment

By his/her signature(s), the authorized official named below and the delegated official(s) named in Section 16 agree to adhere to the following requirements stated in this Certification Statement:

1.) I agree to notify the Medicare contractor of any future changes to the information contained in this form within 90 days of the effective date of the change. I understand that any change in the business structure of this supplier may require the submission of a new application.

2.) I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare billing number(s), and/or the imposition of fines, civil damages, and/or imprisonment.

3.) I agree to abide by the Medicare laws, regulations and program instructions that apply to this supplier. The Medicare laws, regulations, and program instructions are available through the Medicare contractor.

4.) Neither this supplier, nor any 5% or greater owner, partner, officer, director, managing employee, authorized official, or delegated official thereof is currently sanctioned, suspended, debarred, or excluded by the Medicare or Medicaid program, or any other Federal program, or is otherwise prohibited from supplying services to Medicare or other Federal program beneficiaries.

5.) I agree that any existing or future overpayment made to the supplier by the Medicare program may be recouped by Medicare through the withholding of future payments.

6.) I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

7.) I authorize the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Osteopathic Association (AOA), or any other national accrediting body whose standards are recognized by the Secretary as meeting the Medicare program participation requirements, to release to any authorized representative, employee, or agent of the Centers for Medicare & Medicaid Services (CMS), a copy of my most recent accreditation survey, together with any information related to the survey that CMS may require (including corrective action plans).

B. 1st Authorized Official Signature ☐ **Add** ☐ **Delete** **Effective Date:**_____

I have read the contents of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete to the best of my knowledge, and I authorize the Medicare program contractor to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare program contractor of this fact immediately.

Authorized Official Name **Print** First	Middle	Last	Jr., Sr., etc.
Authorized Official **Signature** (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)		Title/Position	Date (MM/DD/YYYY) Signed

C. 2nd Authorized Official Signature ☐ **Add** ☐ **Delete** **Effective Date:**_____

I have read the contents of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete to the best of my knowledge, and I authorize the Medicare program contractor to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare program contractor of this fact immediately.

Authorized Official Name **Print** First	Middle	Last	Jr., Sr., etc.
Authorized Official **Signature** (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)		Title/Position	Date (MM/DD/YYYY) Signed

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SECTION 16: DELEGATED OFFICIAL (OPTIONAL)

A delegated official must be a W-2 managing employee of the supplier, or an individual with a 5% or greater direct ownership interest in, or any partnership interest in, the enrolling supplier. Delegated officials are persons who are delegated the legal authority by the authorized official reported in Section 15B to make changes and/or updates to the supplier's status in the Medicare program. This individual must also be able to commit the supplier to fully abide by the laws, regulations, and program instructions of Medicare. For purposes of this section only, if the individual being assigned as a delegated official is a managing employee, that individual **must** be an actual W-2 employee of the enrolling supplier. The Medicare contractor may request evidence indicating that the delegated official is an actual employee of the supplier. Independent contractors are not considered "employed" by the supplier. A supplier can have no more than three delegated officials at any given time.

The signature of the authorized official in Section 16B2 constitutes a legal delegation of authority to any and all delegated official(s) assigned in Section 16.

A. Check Box - If the supplier chooses not to assign any delegated officials in this application, check the box in this section. There is no requirement that the supplier have a delegated official. However, if no delegated officials are assigned, the authorized official will be the only person who can make changes and/or updates to the supplier's status in the Medicare program. All delegated officials must meet the following requirements:

- The delegated official must sign and date this application,
- The delegated official must furnish his/her title/position, and
- The delegated official must check the box furnished if they are a W-2 employee.

NOTE: The delegated official must also be reported in Section 6.

B. Delegated Official Signature

If the supplier chooses to add delegated officials or to delete existing ones, this section should be completed as follows:

- Check the appropriate box indicating if the delegated official is being added or deleted and furnish the effective date,
- The authorized official must provide his or her signature and date of signature in Sections 15B and 16B2,
- The delegated official(s) to be added must provide the information and their signature in Section 16B, and
- The delegated official(s) to be deleted does not have to sign or date the application.

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

If the supplier is reporting a change of information about an existing delegated official (e.g., change in job title, etc.), this section should be completed as follows:

- Check the box marked "Change" and furnish the effective date,
- Provide the new information, and
- The authorized official must sign and date Sections 15B and 16B2.

Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the supplier's Medicare status. Even when delegated officials are reported in this application, an authorized official retains the authority to make any such changes and/or updates by providing his or her printed name, signature, and date of signature as required in Section 15B.

In addition, the delegated official, by his/her signature, agrees to notify the Medicare contractor of any changes to the information contained in this application within 90 days of the effective date of the change.

B. 2nd Delegated Official Signature - This section provided to report a second (optional) delegated official for this provider. See instructions above for Section 15B.

C. 3rd Delegated Official Signature - This section provided to report a third (optional) delegated official for this provider. See instructions above for Section 15B.

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SECTION 17: ATTACHMENTS

This section contains a list of documents that, if applicable, should be submitted with this enrollment application. Failure to provide the required documents will delay the enrollment process.

- Check the appropriate boxes indicating which documents are being submitted with this application.

NOTE: Any licenses that are needed to operate this business (both business and professional) in the State where the enrolling supplier business is located **must** be included with this application.

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

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

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

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16. Delegated Official (Optional)

The signature of the authorized official below constitutes a legal delegation of authority to the official(s) named in this section to make changes and/or updates to this supplier's enrollment information. The signature(s) of the delegated official(s) shall have the same force and effect as that of the authorized official, and shall legally and financially bind the supplier to the laws, regulations, and program instructions of the Medicare program. By his or her signature, the delegated official certifies that he or she has read the Certification Statement in Section 15 and agrees to adhere to all of the stated requirements. The delegated official also certifies that he/she meets the definition of a delegated official. When making changes and/or updates to the supplier's enrollment information maintained by the Medicare program, the delegated official certifies that the information provided is true, correct, and complete to the best of his/her knowledge.

A. Check here ☐ if this supplier will not be assigning any delegated official(s) and skip to Section 17.

B. 1st Delegated Official Signature ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Delegated Official Name **Print** First	Middle	Last	Jr., Sr., etc.
Delegated Official **Signature** (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed
Title/Position	☐Check here only if Delegated Official is a W-2 employee		
2. **Signature** of Authorized Official Assigning this Delegation (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed

C. 2nd Delegated Official Signature ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

3. Delegated Official Name **Print** First	Middle	Last	Jr., Sr., etc.
Delegated Official **Signature** (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed
Title/Position	☐Check here only if Delegated Official is a W-2 employee		
4. **Signature** of Authorized Official Assigning this Delegation (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed

D. 3rd Delegated Official Signature ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

5. Delegated Official Name **Print** First	Middle	Last	Jr., Sr., etc.
Delegated Official **Signature** (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed
Title/Position	☐Check here only if Delegated Official is a W-2 employee		
6. **Signature** of Authorized Official Assigning this Delegation (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed

17. Attachments

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

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

- ☐Copy(s) of all Federal, State, and/or local (city/county) professional licenses, certifications and/or registrations specifically required to operate as a health care facility
- ☐Copy(s) of all Federal, State, and/or local (city/county) business licenses, certifications and/or registrations specifically required to operate as a health care facility
- ☐Copy(s) of all professional school degrees or certificates, or evidence of qualifying course work
- ☐Copy(s) of all documentation verifying IDTF Supervisory Physician(s) proficiency
- ☐Copy(s) of all CLIA Certificates, FDA Mammography Certificates, and Diabetes Education Certificates
- ☐Copy(s) of all adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters)
- ☐Completed Form HCFA-588 - Authorization Agreement for Electronic Funds Transfer
- ☐Completed Form(s) CMS 855R - Individual Reassignment of Benefits
- ☐IRS documents confirming the tax identification number and legal business name (e.g., CP 575)

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Attachment 1 — AMBULANCE SERVICE SUPPLIERS

All ambulance service suppliers enrolling in the Medicare program must complete this attachment. For further information concerning Medicare requirements for ambulance service suppliers, review 42 CFR 410.40, 410.41, and 414.605.

SECTION 1: STATE LICENSE INFORMATION

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

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

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

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

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

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

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

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

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

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

- Answer "Yes" or "No" to the question about paramedic intercept services. This question is necessary for billing purposes to correctly identify any paramedic intercept services relationships.

Paramedic Intercept Services involve an arrangement between a BLS ambulance company and an ALS ambulance company whereby the latter provides the ALS services and the BLS ambulance company provides the transportation component. If such an arrangement exists between the enrolling ambulance company and another ambulance company, the enrolling ambulance company must attach a copy of the signed contract(s). For more information, see 42 CFR 410.40.

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ATTACHMENT 1

Ambulance Service Suppliers

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

1. State License Information

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

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

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

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

1. Initial Reporting and/or Additions:

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

2. Deletions:

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

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

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

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

7. **IF YES**, furnish the license information for the State where this ambulance service supplier will be rendering services and billing Medicare. Attach a copy of the current State license.

License Number	Issuing State (if applicable)	Issuing County/Parish (if applicable)

Effective Date (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)

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

Does this ambulance company currently participate in a paramedic intercept services arrangement? ☐ YES ☐ NO

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

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SECTION 2: DESCRIPTION OF VEHICLE

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

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

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

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

Vehicles must be regularly inspected and re-certified according to applicable State and local licensing laws. Evidence of re-certification must be submitted to the Medicare contractor upon request.

IMPORTANT INSTRUCTIONS FOR AIR AMBULANCE

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

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

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

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

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2. Description of Vehicle

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

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

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

2. Does this vehicle have the following:

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

Report other medical equipment this vehicle carries:

_____ _____ _____

3. Does this vehicle provide:

advanced life support (Level 1)?	☐ YES ☐ NO	specialty care transport?	☐ YES ☐ NO
advanced life support (Level 2)?	☐ YES ☐ NO	land ambulance?	☐ YES ☐ NO
basic life support?	☐ YES ☐ NO	air ambulance – fixed wing?	☐ YES ☐ NO
emergency runs?	☐ YES ☐ NO	air ambulance – rotary wing?	☐ YES ☐ NO
non-emergency runs?	☐ YES ☐ NO	marine ambulance?	☐ YES ☐ NO

How many crewmembers accompany this vehicle on runs?_____

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

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

2. Does this vehicle have the following:

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

Report other medical equipment this vehicle carries:

_____ _____ _____

3. Does this vehicle provide:

advanced life support (Level 1)?	☐ YES ☐ NO	specialty care transport?	☐ YES ☐ NO
advanced life support (Level 2)?	☐ YES ☐ NO	land ambulance?	☐ YES ☐ NO
basic life support?	☐ YES ☐ NO	air ambulance – fixed wing?	☐ YES ☐ NO
emergency runs?	☐ YES ☐ NO	air ambulance – rotary wing?	☐ YES ☐ NO
non-emergency runs?	☐ YES ☐ NO	marine ambulance?	☐ YES ☐ NO

How many crewmembers accompany this vehicle on runs?_____

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SECTION 3: QUALIFICATION OF CREW

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

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

2. Report all training completed by each crewmember.

All certificates verifying that the crewmembers have successfully completed the requisite training must be submitted with this application. Crewmembers must continue to pursue and complete continuing education requirements in accordance with State and local licensing laws. Evidence of re-certification must be submitted to the Medicare contractor upon request.

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

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

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

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

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3. Qualification of Crew

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

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

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

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

_____

_____

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

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

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

_____

_____

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

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

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

_____

_____

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

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

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

_____

_____

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

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

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

_____

_____

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Attachment 2 — INDEPENDENT DIAGNOSTIC TESTING FACILITIES (IDTFs)

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

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

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

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

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

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

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

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

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

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

SECTION 1: SERVICE PERFORMANCE

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

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

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

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ATTACHMENT 2

Independent Diagnostic Testing Facility (IDTF)

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

1. Service Performance

This section is to be completed with information about the types of tests performed by this IDTF, and the equipment used by this IDTF.

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

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

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

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SECTION 2: INTERPRETING PHYSICIAN INFORMATION

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

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

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

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

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

NOTE: All interpreting physicians must complete and submit an Individual Reassignment of Benefits (CMS 855R) if:

- The interpreting physician is an employee of the IDTF,
- A contractor is working in a practice location that the IDTF owns or leases.

C. 2nd Interpreting Physician Information - This section is provided to report additional physicians. See instructions above for Section 2B.

D. 3rd Interpreting Physician Information - This section is provided to report additional physicians. See instructions above for Section 2B.

E. 4th Interpreting Physician Information - This section is provided to report additional physicians. See instructions above for Section 2B.

F. 5th Interpreting Physician Information - This section is provided to report additional physicians. See instructions above for Section 2B.

G. 6th Interpreting Physician Information - This section is provided to report additional physicians. See instructions above for Section 2B.

H. 7th Interpreting Physician Information - This section is provided to report additional physicians. See instructions above for Section 2B.

I. 8th Interpreting Physician Information - This section is provided to report additional physicians. See instructions above for Section 2B.

All interpreting physicians whose services will be billed for by the IDTF (commonly known as billing "globally") must be reported.

The IDTF must also report all independent contractor physicians (for which it will bill) who perform professional interpretations off the premises of the IDTF's practice location. For these interpretations to be billable by the IDTF, they must meet the conditions shown in MCM 3060.5 concerning purchased interpretations. A CMS 855R is not required for the interpreting physician in these situations.

When a mobile unit of the IDTF performs a technical component of a diagnostic test and the interpretive physician is the same physician who ordered the test, the IDTF **cannot** bill for the interpretation. Therefore, these interpreting physicians should not be reported since the interpretive physician must submit his/her own claims for these tests.

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2. Interpreting Physician Information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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