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SECTION 3: PERSONNEL (TECHNICIANS) WHO PERFORM TESTS

This section is to be completed with identifying and qualification information about all personnel who perform the tests furnished by the IDTF. These persons are often referred to as technicians.

A. 1st Personnel (Technician) Information - Check the appropriate box to indicate whether this section is being completed to add, delete, or change information about a previously reported technician. Provide the effective date, complete the appropriate information, and sign and date the certification statement. Otherwise:

1. Furnish the full name, social security number, and date of birth for each technician.

2. If the technician is State licensed or certified, the applicable license and/or certification must be reported.

NOTE: Not all states have licensing requirements for all diagnostic tests. If a reported technician does not have either a State license or certification, or certification from a national credentialling body, he/she cannot perform the IDTF diagnostic tests and should not be reported. Notarized or certified true copies of the State license or certificate should be attached. The only exception to this is when a Medicare payable diagnostic test is not subject to State license or certification requirements, and no generally accepted national credentialling body exists. When this situation occurs, the technician performing the test must be reported. The IDTF should submit as an attachment any educational/credentialling and/or experience that the person has, and must fully justify why the individual should be considered qualified to perform the test(s) reported.

3. If a national credentialling body has certified the technician, furnish the name of the credentialling organization and the type of credentials issued to the technician. Notarized or certified true copies from the national credentialling body must be attached.

4. If the technician is also employed by, or working for, a hospital as well as an IDTF, this must be reported in this section. Furnish the name of the hospital where the technician is working or employed.

B. 2nd Personnel (Technician) Information - This section is provided to report additional technicians. See instructions above for Section 3A.

C. 3rd Personnel (Technician) Information - This section is provided to report additional technicians. See instructions above for Section 3A.

D. 4th Personnel (Technician) Information - This section is provided to report additional technicians. See instructions above for Section 3A.

E. 5th Personnel (Technician) Information - This section is provided to report additional technicians. See instructions above for Section 3A.

F. 6th Personnel (Technician) Information - This section is provided to report additional technicians. See instructions above for Section 3A.

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3. Personnel (Technicians) who Perform Tests

This section is to be completed with information about all non-physician personnel who perform tests for this IDTF. If there are more than six technicians, copy and complete this section as needed.

A. 1st Personnel (Technician) Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

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

2. Is this technician State licensed or State certified? ☐ YES ☐ NO

License/Certification Number (if applicable)	License/Certification Issue Date (if applicable) (MM/DD/YYYY)
State of Issuance (if applicable)	Type of License/Certification (if applicable)

3. Is this technician certified by a national credentialling organization? ☐ YES ☐ NO

Name of credentialling organization (if applicable)	Type of Credentials (if applicable)

4. Is this technician employed by a hospital? ☐ YES ☐ NO
IF YES, furnish the name of the hospital here:_____

B. 2nd Personnel (Technician) Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

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

2. Is this technician State licensed or State certified? ☐ YES ☐ NO

License/Certification Number (if applicable)	License/Certification Issue Date (if applicable) (MM/DD/YYYY)
State of Issuance (if applicable)	Type of License/Certification (if applicable)

3. Is this technician certified by a national credentialling organization? ☐ YES ☐ NO

Name of credentialling organization (if applicable)	Type of Credentials (if applicable)

4. Is this technician employed by a hospital? ☐ YES ☐ NO
IF YES, furnish the name of the hospital here:_____

C. 3rd Personnel (Technician) Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

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

2. Is this technician State licensed or State certified? ☐ YES ☐ NO

License/Certification Number (if applicable)	License/Certification Issue Date (if applicable) (MM/DD/YYYY)
State of Issuance (if applicable)	Type of License/Certification (if applicable)

3. Is this technician certified by a national credentialling organization? ☐ YES ☐ NO

Name of credentialling organization (if applicable)	Type of Credentials (if applicable)

4. Is this technician employed by a hospital? ☐ YES ☐ NO
IF YES, furnish the name of the hospital here:_____

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3. Personnel (Technicians) who Perform Tests (Continued)

D. 4th Personnel (Technician) Information ☐ Add ☐ Delete ☐ Change **Effective Date:**_____

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

2. Is this technician State licensed or State certified? ☐ YES ☐ NO

License/Certification Number (if applicable)	License/Certification Issue Date (if applicable) (MM/DD/YYYY)
State of Issuance (if applicable)	Type of License/Certification (if applicable)

3. Is this technician certified by a national credentialling organization? ☐ YES ☐ NO

Name of credentialling organization (if applicable)	Type of Credentials (if applicable)

4. Is this technician employed by a hospital? ☐ YES ☐ NO
IF YES, furnish the name of the hospital here:_____

E. 5th Personnel (Technician) Information ☐ Add ☐ Delete ☐ Change **Effective Date:**_____

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

2. Is this technician State licensed or State certified? ☐ YES ☐ NO

License/Certification Number (if applicable)	License/Certification Issue Date (if applicable) (MM/DD/YYYY)
State of Issuance (if applicable)	Type of License/Certification (if applicable)

3. Is this technician certified by a national credentialling organization? ☐ YES ☐ NO

Name of credentialling organization (if applicable)	Type of Credentials (if applicable)

4. Is this technician employed by a hospital? ☐ YES ☐ NO
IF YES, furnish the name of the hospital here:_____

F. 6th Personnel (Technician) Information ☐ Add ☐ Delete ☐ Change **Effective Date:**_____

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

2. Is this technician State licensed or State certified? ☐ YES ☐ NO

License/Certification Number (if applicable)	License/Certification Issue Date (if applicable) (MM/DD/YYYY)
State of Issuance (if applicable)	Type of License/Certification (if applicable)

3. Is this technician certified by a national credentialling organization? ☐ YES ☐ NO

Name of credentialling organization (if applicable)	Type of Credentials (if applicable)

4. Is this technician employed by a hospital? ☐ YES ☐ NO
IF YES, furnish the name of the hospital here:_____

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SECTION 4: SUPERVISING PHYSICIAN(S)

This section is to be completed with identifying information about the physician(s) who supervise the operation of the IDTF and who furnish the personal, direct, or general supervision per 42 CFR 410.32(b)(3). The supervising physician must also attest to his/her supervising responsibilities for the enrolling IDTF.

A. Supervising Physician Information - Check the appropriate box to indicate whether this section is being completed to add, delete, or change information about an existing supervising physician. Provide the effective date of the change, complete the appropriate information, and sign and date the certification statement. Otherwise:

1. Provide the full name, social security number, date of birth, Medicare identification number, telephone and fax numbers, and e-mail address for each supervisory physician.

2. General Supervision

- Check the appropriate boxes in this section to indicate the responsibilities assumed by the physician(s) reported in Section 4A1 furnishing General Supervision.

For each physician performing General Supervision, at least one of the three functions listed here must be checked. However, to meet the General Supervision requirement the enrolling IDTF must have at least one supervisory physician for **each** of the three functions. An example is where two physicians are responsible for function 1, a third physician is responsible for function 2, and a fourth physician is responsible for function 3. All four supervisory physicians must complete and sign the supervisory physician section of this application. They should **only** check the function(s) they actually perform.

3. Indicate the type of supervision provided by this physician for the tests performed by this IDTF.

Information concerning the type of supervision (personal, direct, or general) required for performance of specific IDTF tests can be obtained from the Medicare carrier. All IDTFs must report at least one supervisory physician, and at least one supervising physician must perform the supervision requirements stated in 42 CFR 410.32(b)(3). All supervisory physician(s) must be currently enrolled with Medicare. However, they can be enrolled with a Medicare contractor other than the one to which this application is being submitted. The physician's Medicare identification number must be reported.

The type of supervision being performed by each physician who signs the attestation in Section 4B should be indicated in Section 4A3. Definitions of the types of supervision are as follows:

Personal Supervision means a physician must be in attendance in the room during the performance of the procedure.

Direct Supervision in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and provide direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.

General Supervision means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. The qualifications and training of the non-physician personnel who actually perform the diagnostic procedure and the proper operation, maintenance, and calibration of the necessary equipment and supplies are the continuing responsibility of the physician. See the notes in this section of the application for guidance concerning: "Personal," "Direct," and "General" supervision.

B. Attestation Statement for Supervising Physicians – This section must be signed and dated by all Supervising Physician(s) rendering supervisory services for this IDTF.

1) Complete the name of the enrolling IDTF.

2) Report all CPT and HCPCS codes the IDTF performs that this supervising physician **will not** be supervising.

3) Furnish the dated signature of the supervising physician.

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

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4. Supervising Physician(s)

This section is to be completed with information about all supervising physicians. If there is more than one supervising physician, copy and complete this section for each.

A. Supervising Physician Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.
Social Security Number	Date of Birth (MM/DD/YYYY)	Medicare Identification Number (if applicable)	
Telephone Number (Ext.) ( ) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)	

2. General Supervision

For overall IDTF operation in accordance with 42 CFR 410.33(b), check all that apply for the Supervising Physician reported in Section 4A1 above:

- ☐ Assumes responsibility for the overall direction and control of the quality of testing performed.
- ☐ Assumes responsibility for assuring that the non-physician personnel who actually perform the diagnostic procedures are properly trained and meet required qualifications.
- ☐ Assumes responsibility for the proper maintenance and calibration of the equipment and supplies necessary to perform the diagnostic procedures.

3. Type of Supervision Provided

Check the applicable box below indicating the type of supervising provided by the physician reported in Section 4A1 above for the tests performed by the IDTF in accordance with 42 CFR 410.32 (b)(3) (Definitions).

(Check applicable box) ☐ Personal Supervision ☐ Direct Supervision ☐ General Supervision

Note: Personal / Direct: If this Supervising Physician performs Personal or Direct Supervision, he/she must be currently enrolled in Medicare with the Medicare carrier to which this application is being submitted.

Note: General: If this Supervising Physician performs General Supervision, he/she must be licensed in all States where he/she will be performing the General Supervision. If this Supervising Physician is not enrolled with the Medicare carrier to which this application is being submitted, he/she must submit a copy of his/her current State license for the state in which this application is being submitted.

B. Attestation Statement for Supervising Physicians

1) ***I hereby acknowledge that I have agreed to provide (IDTF Name)_____ with the Supervisory Physician services checked above for all CPT-4 and HCPCS codes reported in Section 1B of this Attachment*** (See number 2 below if all reported CPT-4 and HCPCS codes do not apply). ***I also hereby certify that I have the required proficiency in the performance and interpretation of each type of diagnostic procedure, as reported by CPT-4 or HCPCS code in Section 1B of this Attachment (except for those CPT-4 or HCPCS codes identified in number 2 below). I have read and understand the Penalties for Falsifying Information on this Enrollment Application, as stated in Section 14 of this application. I am aware that falsifying information may result in fines and/or imprisonment. If I cease providing the stated Supervisory Physician services, I shall immediately notify the Medicare program.***

2) ***I am not acting as a Supervising Physician for the following CPT-4 and/or HCPCS codes reported in Section 1B of this Attachment.***

CPT-4 or HCPCS Code	CPT-4 or HCPCS Code	CPT-4 or HCPCS Code
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3) **Signature** of Supervising Physician:	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)	Date (MM/DD/YYYY) Signed

MEDICARE

FEDERAL HEALTH CARE
PROVIDER/SUPPLIER ENROLLMENT APPLICATION

Application for Individual Health Care Practitioners

CENTERS FOR MEDICARE & MEDICAID SERVICES

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Keep a copy of this completed package for your records

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

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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 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 of medical services 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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INDIVIDUAL HEALTH CARE PRACTITIONER INSTRUCTIONS

Please be sure to **PRINT** or **TYPE** all information so it is legible. Do not use pencil. Failure to provide all requested information might cause your application to be returned and may delay your enrollment. Certain sections of the application have been omitted because they do not apply to individual practitioners. 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 you need to report additional information within a section, copy and complete that section for each additional entry. We strongly suggest that you keep a photocopy of your completed application and all supporting documents for future reference.

All physicians and non-physician practitioners who render medical services to Medicare beneficiaries and submit claims for the services rendered must complete this application. This form (CMS 855I for Individual Health Care Practitioners) is to report your personal information. If you plan to provide services as part of an organization to which you will reassign your benefits, you must also complete and submit a CMS 855R (Application for the Reassignment of Medicare Benefits) with this application. For each organization you join, you must complete and submit a separate CMS 855R to officially reassign your benefits to that organization. If you are terminating your association with an organization, use the CMS 855R to indicate that change. If you plan to render all of your services in a group setting, you will complete up to Section 4 of this application and then skip to Sections 13 through 17.

In addition to completing this enrollment application (CMS 855I), you may wish to complete and submit additional forms in the following situations:

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

If you plan to do any of the above, submit the appropriate form(s)/agreement(s) with your application. The forms should have been received with this initial enrollment package. If you did not receive them, you can obtain the forms from the Medicare carrier or the forms can be found at http://www.cms.hhs.gov.

DEFINITIONS OF MEDICARE ENROLLMENT TERMINOLOGY

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

Billing Agency-A company that you contract with to furnish claims processing functions for your practice.
Carrier-The Part B Medicare claims processing contractor.
Legal Business Name-The name you use when reporting to the Internal Revenue Service (IRS) for tax purposes.
Medicare Identification Number-This is a generic term for any number that uniquely identifies the enrolling practitioner. Examples of Medicare identification numbers are Unique Physician/Practitioner Identification Number (UPIN), National Provider Identifier (NPI), National Supplier Clearinghouse (NSC) number and Provider Identification number (PIN).
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.
Tax Identification Number (TIN)-This is the number issued by the Internal Revenue Service (IRS) that the individual practitioner uses to report tax information to the IRS.
Unique Physician/Practitioner Identification Number (UPIN)-This number is assigned to physicians and non-physician practitioners 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 carrier may request documentation at any time during the enrollment process, to support or validate information that is reported in this application. Some examples of documents that may be requested for validation are billing agreements, IRS W-2 forms, pay stubs, and staffing company contracts.

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SECTION 1: GENERAL INFORMATION

This section is to identify the reason for submittal of this application. It will also indicate whether you currently have 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 you are enrolling in the Medicare program for the first time with this Medicare carrier under this tax identification number.
- If you are already enrolled with a carrier but need to enroll in another carrier's jurisdiction.

NOTE: You must be able to submit a valid claim within six months of enrolling or risk deactivation of your billing number once you have enrolled.

Reactivation:

- If your Medicare billing number was deactivated because of non-billing. Billing privileges may be deactivated when no claims are submitted in a six-month period. To reactivate billing privileges, you will be required to either submit an updated CMS 855I, or certify to the accuracy of your enrollment information currently on file with CMS. In addition, prior to being reactivated, you must be able to submit a valid claim. You must also meet all current requirements for your supplier type, regardless of whether you were previously enrolled in the program unless otherwise stated in regulation.

Revalidation:

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

Change of Information:

- If you are adding, deleting, or changing information under this tax identification number. Check the appropriate section where the change is being reported. When providing the changed information, provide your Medicare identification number in Section 1, and provide the new/changed information in the applicable section. If you would like to provide a contact person to discuss these changes, please do so in Section 13. You must sign and date the certification statement in Section 15. **All changes must be reported to the carrier within 90 days of the effective date of the change.** Anytime you add a practice location that is located in a different state than where you are currently enrolled, you must provide a copy of your State license with that change.

NOTE: When submitting this application to report a change of information, only complete those sections necessary to report the change.

Voluntary Deactivation of Billing Number:

- If you know you will no longer be submitting claims to the Medicare program using this billing number. Voluntary deactivation ensures that your billing number will not be fraudulently used in the event of your retirement, leaving a group practice, etc. Provide the date you stopped practicing or the date on which you will stop billing for Medicare covered services and the billing number to be deactivated. In addition, please complete Section 1 to identify yourself, and sign and date the certification statement in Section 15.

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

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2. Social Security Number - For identification purposes, you must furnish your social security number. Section 1124A of the Social Security Act requires that you disclose your social security number to receive payment.

3. If you are currently enrolled in another carrier's jurisdiction, report the name of the carrier and your Medicare identification number or NPI in the spaces provided. For individual practitioners who are enrolled, this number will be your UPIN, PIN, NPI, and/or your National Supplier Clearinghouse (NSC) billing number. Report all currently active numbers.

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

NOTE: If you do not have a Medicare identification number, you will be assigned one upon the successful completion of your enrollment. A separate Provider Identification Number (PIN) may be assigned to you by the local carrier. The carrier will explain what number(s) has been issued and how it is to be used. Normally, your application should be processed (from the receipt date at the carrier) within 60 days from the date you submitted it provided you have furnished all the requested information. If the carrier should contact you for additional information, you must provide it immediately to ensure the timely processing of your application.

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MEDICARE FEDERAL HEALTH CARE PRACTITIONER ENROLLMENT APPLICATION

Application for Individual Health Care Practitioners

General Instructions

The Medicare Federal Health Care Practitioner 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 practitioners and that the amounts of the payments are correct. This information will also identify whether you are qualified to render health care services and/or supplies to Medicare beneficiaries. To accomplish this, Medicare must know basic identifying and qualifying information about you in order for you to be granted billing privileges in the Medicare program.

When completing this application to enroll and bill the Medicare program as an individual practitioner, you need to tell Medicare (1) who you are, (2) what qualifies you to render health care related services and/or supplies to Medicare beneficiaries, (3) where or how you intend to render these services and/or supplies, and (4) any individuals or organizations that manage your practice.

This application **MUST** be completed in its entirety, unless otherwise stated in these instructions. If a section does not apply to you, check (√) the appropriate box in that section. Sections 7, 11, 12, and 16, have been deliberately omitted from this application because they are not applicable to the enrollment of individual health care practitioners.

1. General Information

This section is to be completed with general information as to why you are submitting this application and whether you currently have a business relationship with Medicare.
To ensure timely processing of this application, Numbers 1, 2, and 3 below MUST ALWAYS be completed.

A. Reason for Submittal of this Application

1. Check one: ☐ Initial Enrollment ☐ Reactivation ☐ Revalidation

☐ Change of Information - Check appropriate Section(s) below and furnish your Medicare Identification Number here:_____

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 8 ☐ 10 ☐ 13

☐ Voluntary Deactivation of Billing Number—Effective Date (MM/DD/YYYY):_____

Medicare Identification Number to be Deactivated:_____

2. Social Security Number:_____

3. Are you currently enrolled in the Medicare program? ☐ YES ☐ NO
IF YES, furnish the following information about your current carrier:

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

4. Check here ☐ if you would like to submit claims electronically and are enrolling in Medicare for the first time.

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SECTION 2: PRACTITIONER IDENTIFICATION

A. Personal Information – The information furnished in this section will allow us to uniquely identify you in the Medicare program. Check the box "Change" only if you are reporting a change to existing information in this section. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

1. Provide your full name.
2. If you previously used another name(s), including a maiden name, supply that under "Other Name."
3. Provide your date, State, and country of birth.
4. Indicate your gender.
5. Furnish the name of the medical school or other health care training institution you attended for the Medical Specialty you will check in Section 2E1 or Section 2E2 and your year of graduation or certification.

B. Correspondence Address - This section will assist us in contacting you with any questions we have concerning your business relationship with the Medicare program.

Check the box "Change" only if you are reporting a change to existing information in this section. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

- **You must provide an address and telephone number where we can contact you directly to resolve any issues that may arise as a result of your enrollment in the Medicare program.** It also may be necessary to send you important changes/information concerning the Medicare program that directly impacts you and/or your Medicare payments. Therefore, this address cannot be that of your billing agency, management service organization, or staffing company. You may furnish your home address and telephone number if you choose.

C. Residency Status - Your responses to the questions in this section will assist us in determining your eligibility to bill Medicare for the services you render to Medicare patients.

Check the box "Change" only if you are reporting a change to existing information in this section. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

1. Check to identify if you are currently a resident, intern, or fellow at a health care facility.
   - If "Yes," provide the name of the facility where you serve as a resident/intern/fellow.
   - If "No," skip to Section 2D (Business Information).
2. State whether the services you render in the facility shown in Question 1 are part of your requirements for graduation from a formal residency program.
3. Indicate if you also render services at other facilities or practice locations.
   - If "Yes," you **must** report these other practice locations in Section 4 (Current Practice Location(s)).
4. Indicate if any services that you render, at any practice location you report in Section 4, are required for graduation from a formal residency program.
   - If "Yes," indicate if the teaching hospital has agreed to incur all or substantially all costs of the training in the other facility or practice location.

D. Business Information (if applicable) - Complete this section if you operate your practice as a business under a name different from your individual name. For instance, you must complete this section if your business is setup as a corporation. This information is needed to correctly report to the IRS all Medicare payments you receive and the tax identification number under which these payments are made.

Check the box "Change" only if you are reporting a change to existing information in this section. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

1. If this section does not apply to you, check the box provided and skip to Section 2E (Medical Specialty(s)).
2. Provide the legal business name you use when reporting tax information to the IRS. Supply your tax identification number as issued by the IRS and a copy of the IRS CP 575 or other documentation that confirms the reported TIN.

NOTE: If your business **is a corporation,** you will need to complete three applications. The 1st application (CMS 855I) is required to establish you as an individual practitioner with the Medicare program. The 2nd application (CMS 855B) is required to enroll your business. Once you complete the applications identifying yourself and your business, you must also complete a CMS 855R to reassign benefits payable to you as an individual practitioner to your business, which will be submitting claims for the services you have rendered. In addition, any other practitioners who render services for your business, who will be reassigning their benefits to the business, must also complete a CMS 855R.

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2. Practitioner Identification

This section is to be completed with information about yourself; where Medicare can contact you directly; whether you are rendering services in a health care facility as a resident or an intern; and whether you have established your practice as a separate business entity. You must also designate your medical specialty.

A. Personal Information ☐ **Change** **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
2. Other Name First (including Maiden)	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.

3. Date of Birth (MM/DD/YYYY)	State of Birth	Country of Birth

4. Gender ☐ Male ☐ Female

5. Medical School/Training Institution	Year of Graduation (YYYY)

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

You must furnish an address and telephone number where Medicare can contact you directly.

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)

C. Residency Status ☐ **Change** **Effective Date:**_____

1. Are you currently: a resident? ☐ YES ☐ NO
an intern? ☐ YES ☐ NO
in a fellowship program? ☐ YES ☐ NO

IF YES to any of the above questions, provide the name of the facility where you are a resident, intern, or fellow on the line below:

_____

IF NO, skip to Section 2D (Business Information) below.

2. Are the services that you render at the facility shown in Question 1 part of your requirements for graduation from a formal residency program? ☐ YES ☐ NO

3. Do you also render services at other facilities or practice locations? ☐ YES ☐ NO

IF YES, you must report these practice locations in Section 4 (Practice Location).

4. Are the services that you render in any of the practice locations you will be reporting in Section 4 (Practice Location) part of your requirements for graduation from a formal residency program? ☐ YES ☐ NO

IF YES, has the teaching hospital reported in Question 1 above agreed to incur all or substantially all of the costs of training in the non-hospital facility or location? ☐ YES ☐ NO

D. Business Information (if applicable) ☐ **Change** **Effective Date:**_____

1. Check here ☐ if this section does not apply to you and skip to Section 2E. Otherwise, furnish the following information if you operate your practice as a business under a name other than your own name.

2. Legal Business Name as Reported to the IRS	Tax Identification Number

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E. Medical Specialty

1. **Physician Specialty** - Check the box "Change" only if you are reporting a change to existing information in this section. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

a) If you are a physician, please enter the appropriate letter (P = primary, S = secondary) to indicate your specialty(s). You may only enter one (1) primary specialty and unlimited secondary specialties. If you do not see your specialty listed, check "Undefined physician type" and report your specialty in the space provided.

b) Submit a copy of your State physician license and furnish the license number, issue date and renewal date in the space provided.

NOTE: Diagnostic Radiology – If you checked diagnostic radiology as your specialty, and you will bill for the technical component (tc) of the diagnostic tests, you must contact the Medicare carrier prior to your enrollment to determine if you will also need to complete a CMS 855B to enroll in Medicare as an Independent Diagnostic Testing Facility (IDTF).

NOTE: Physicians who Bill for Diagnostic Tests (other than clinical laboratory or pathology tests) – As a physician, you may bill for these diagnostic tests as long as you do not provide a substantial portion of the diagnostic tests to patients who **are not** your patients. Patients are considered your own patients if:

- They have a prior relationship with you and are receiving medical treatment from you for a specific medical condition, or
- You are also billing for patient evaluation and management codes (E & M).

A separate (additional) enrollment as an IDTF may be required if, as stated above, substantial portions of your diagnostic tests (other than clinical laboratory or pathology) are provided to patients who are not your patients. Enrollment as an IDTF will not affect your enrollment as a physician. If you only furnish diagnostic tests, claims must be submitted as an IDTF. To enroll as an IDTF, you must complete and submit a CMS 855B.

2. **Non-Physician Specialty** - Check the box "Change" only if you are reporting a change to existing information in this section. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

a) If you are a non-physician practitioner, check the appropriate space to indicate your specialty. You may only check one non-physician specialty. If you want to enroll with more then one non-physician specialty you must submit a separate application for each. If you do not see your specialty listed, check "Undefined non-physician type" and report your specialty in the space provided.

b) All non-physician practitioners must meet specific licensing, educational (including any degrees and/or certificates), and work experience requirements. If you need information concerning the specific requirements for your specialty, contact the Medicare carrier. Submit copies of all necessary documentation to prove your eligibility to enroll in Medicare and furnish any license (or other) number, issue date and renewal date in the space provided.

F. Physician Assistants (PA) Only - Indicate if you are adding or deleting an employer. Provide the new information and the effective date of the addition or deletion. Provided that this is the only change in your information, you need to sign and date the certification statement. Otherwise:

- In order to determine who will be billing for your services, report all employers' names and Medicare billing numbers. This information will allow Medicare to appropriately associate you with each of your employers. All employers must be currently enrolled in the Medicare program.

NOTE: Physician Assistants – When completing this application, PAs should only complete Sections 1, 2, 3, 10, 13, 15 and 17. Also, PAs should not use or submit the CMS 855R form to report employers. The CMS 855R is only used to reassign benefits that would otherwise be paid directly to the practitioner.

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2. Practitioner Identification (Continued)

E. Medical Specialty(s)

1. Physician Specialty ☐ **Change** **Effective Date:**_____

a) Designate your primary speciality and all secondary specialty(s) below using: **P=Primary** **S=Secondary**

_____Addiction medicine	_____Hematology/Oncology	_____Otolaryngology
_____Allergy/Immunology	_____Infectious disease	_____Pathology
_____Anesthesiology	_____Internal medicine	_____Pediatric medicine
_____Cardiac surgery	_____Interventional Pain Management	_____Peripheral vascular disease
_____Cardiovascular disease (Cardiology)	_____Interventional radiology	_____Physical medicine and rehabilitation
_____Chiropractic	_____Maxillofacial surgery	_____Plastic and reconstructive surgery
_____Colorectal surgery (Proctology)	_____Medical oncology	_____Podiatry
_____Critical care (Intensivists)	_____Nephrology	_____Preventive medicine
_____Dermatology	_____Neurology	_____Psychiatry
_____Diagnostic radiology**(see note)	_____Neuropsychiatry	_____Pulmonary disease
_____Emergency medicine	_____Neurosurgery	_____Radiation oncology
_____Endocrinology	_____Nuclear medicine	_____Rheumatology
_____Family practice	_____Obstetrics/Gynecology	_____Surgical oncology
_____Gastroenterology	_____Ophthalmology	_____Thoracic surgery
_____General practice	_____Optometry	_____Urology
_____General surgery	_____Oral surgery (Dentist only)	_____Vascular surgery
_____Geriatric medicine	_____Orthopedic surgery	
_____Gynecological/Oncology	_____Osteopathic manipulative treatment	_____Undefined physician type (Specify): _____
_____Hand surgery		
_____Hematology		

b) **Submit a copy of your State Physician License** and furnish the following information:

License Number	Issue/Effective Date (MM/DD/YYYY)	Expiration/Renewal Date (MM/DD/YYYY)

2. Non–Physician Specialty ☐ **Change** **Effective Date:**_____

a) See instructions for specific non-physician requirements that must be met to enroll in the Medicare program and check the appropriate specialty below.

Check only one:

_____Anesthesiology Assistant	_____Nurse practitioner
_____Audiologist	_____Occupational therapist in private practice (see Sec. I)
_____Certified nurse midwife	_____Physical therapist in private practice (see Sec. I)
_____Certified registered nurse anesthetist	_____Physician assistant (see Sections F)
_____Clinical nurse specialist	_____Psychologist, Clinical (see Section G)
_____Clinical social worker	_____Psychologist billing independently (see Section H)
_____Mass immunization roster biller	_____Registered Dietitian or Nutrition Professional
	_____Undefined non-physician type (Specify): _____

b) Submit documentation (e.g., copies of licenses, degrees) that confirms you have met the requirements for your specialty and furnish the following information:

License (or other) Number	Issue/Effective Date (MM/DD/YYYY)	Expiration/Renewal Date (MM/DD/YYYY)

F. Physician Assistants (PA) Only ☐ **Add** ☐ **Delete** **Effective Date:**_____

This section must be completed by all physician assistants to ensure correct claims coding when billing for your services. Since physician assistants cannot bill the Medicare program directly, they must report the Medicare billing number for all employers that bill Medicare for their services. All employers must be enrolled in the Medicare program.

Employer's Name	Medicare Identification Number
_____	_____
_____	_____
_____	_____

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G. Clinical Psychologists - Questionnaire

Questions 1-4: All clinical psychologists must respond to these questions by checking "Yes" or "No" to determine your eligibility to bill Medicare.

H. Psychologists Billing Independently - Questionnaire

A psychologist billing independently is defined as:

- One who renders services free of the administrative and professional control of an employer such as a physician, institution, or agency, and
- Who maintains office space at his/her own expense and furnishes services only in that space or the patient's home, and
- Has the right to collect fees for the services rendered, and
- The patients treated are the psychologist's own patients.

Questions 1-4: All psychologists must respond to these questions by checking "Yes" or "No" to determine if you are eligible to bill Medicare as a psychologist who is independently billing.

I. Occupational/Physical Therapist in Private Practice (OT/PT) Only - Questionnaire

An occupational therapist/physical therapist in private practice is defined as one who maintains a private office even if services are always furnished in patients' homes. If services are furnished in private practice office space, that space must be owned, leased, or rented by the OT/PT practice and used for the exclusive purpose of operating the OT's /PT's practice.

Questions 1-5: All OTs/PTs must respond to these questions by checking "Yes" or "No." This information will determine your eligibility to bill Medicare.

J. Suppliers Employing Physician Assistants (Only) – This section is to be completed by all suppliers who want to delete physician assistants (PAs) within the practice.

Check if deleting the PA and provide the effective date of the deletion and the name and Medicare identification number of the PA.

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

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2. Practitioner Identification (Continued)

G. Clinical Psychologists - Questionnaire

This section must be completed by all clinical psychologists in order to determine if you are eligible to bill Medicare. Please answer all questions in this section.

1. Do you hold a doctoral degree in psychology? ☐ YES ☐ NO
   IF YES, furnish the field of your psychology degree:_____
2. Do you inform each Medicare patient of the desirability of conferring with the patient's attending or primary care physician to consider potential medical conditions contributing to the patient's condition? ☐ YES ☐ NO
3. Contingent upon the patient's consent, do you consult with the patient's designated attending or primary care physician in accordance with accepted professional ethical norms, taking into consideration patient confidentiality? ☐ YES ☐ NO
4. If the patient assents to the consultation, do you attempt to consult with the patient's physician within a reasonable time after receiving consent? ☐ YES ☐ NO

H. Psychologists Billing Independently - Questionnaire

This section must be completed by all psychologists billing independently in order to determine if you are eligible to bill Medicare as a psychologist "billing independently." Please answer all questions in this section.

1. Do you render services of your own responsibility free from the administrative control of an employer such as a physician, institution, or agency? ☐ YES ☐ NO
2. Do you treat your own patients? ☐ YES ☐ NO
3. Do you have the right to bill directly, and to collect and retain the fee for your services? ☐ YES ☐ NO
4. Is your private practice located in an institution? ☐ YES ☐ NO
   IF YES to question 4 above, please answer questions "a" and "b" below.

a) If your private practice is located in an institution, is your office confined to a separately identified part of the facility that is used solely as your office and cannot be construed as extending throughout the entire institution? ☐ YES ☐ NO

b) If your private practice is located in an institution, are your services also rendered to patients from outside the institution or facility where your office is located? ☐ YES ☐ NO

I. Occupational/Physical Therapist in Private Practice (OT/PT) - Questionnaire

This section must be completed by all occupational and physical therapists in order to determine if you are eligible to bill Medicare for services rendered in your private practice. Please answer all questions in this section.

1. Are all of your OT/PT services only rendered in the patients' homes? ☐ YES ☐ NO
2. Do you maintain private office space? ☐ YES ☐ NO
3. Do you own, lease, or rent your private office space? ☐ YES ☐ NO
4. Is this private office space used exclusively for your private practice? ☐ YES ☐ NO
5. Do you provide OT/PT services outside of your office and/or patients' homes? ☐ YES ☐ NO
   IF YES, provide a copy of the lease agreement that gives you exclusive use of the facility for OT/PT services.

J. Suppliers Employing Physician Assistants (Only)

This section is to be completed when deleting PAs from the supplier's practice.

Delete	Date	Physician Assistant Name	Medicare Identification Number
☐	_____	_____	_____
☐	_____	_____	_____
☐	_____	_____	_____
☐	_____	_____	_____
☐	_____	_____	_____
☐	_____	_____	_____
☐	_____	_____	_____

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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 you. 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. You must state whether, under any current or former name or business identity, you have ever had any of the adverse legal actions listed in Table A of the application form imposed against you.

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 you are uncertain as to whether you fall 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 you need information 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 you in violation of these Acts and subject you to possible denial of your Medicare enrollment.

1. You must report all outstanding Medicare overpayments that you are liable for, including those paid to you, or on your 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 your current or previous enrollment in Medicare. This includes any overpayment incurred by you under a different name or business identity, or in another Medicare contractor jurisdiction;

   b) CMS (or its contractors) has determined that you are 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 you.

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 your enrollment has been approved do not need to be reported unless you are 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 you (see Table A below for list of adverse actions that must be reported).

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

1. Have you, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A below imposed against you? ☐ 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. Do you, 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)

This section is to be completed with information about your private practice and group affiliations. If you want to make a change to existing information about your group affiliations, you must use the CMS 855R to report those changes.

A. Group Practice Information

1. Indicate whether **ALL** of your services will be rendered as part of a group or other organization. If "Yes," this means that you do not have a private practice where you treat Medicare patients. This also means that a group(s) or organization(s) will be billing Medicare for the services you render and that you have given the group or organization the authority to bill for you. To reassign your benefits, you must complete and submit a CMS 855R for each group to which your benefits will be reassigned.

   a-c) Provide the legal name and Medicare billing number for up to three groups. If the group's application is pending, indicate "pending" on your application in the space provided for the group's Medicare number. If you belong to more than three groups, copy and complete this section as needed. After completing this section, skip to Sections 13 through 17.

2. Indicate whether **SOME** of your services will be rendered in a group setting. If not, check the box "No," and continue with Section 4B below. If "Yes," this means that in addition to your private practice you will render some services as part of a group practice, and that you have given the authority to the group to bill for these services.

   a-c) Provide the legal name and Medicare billing number for up to three groups. If the group's application is pending, indicate "pending" on your application in the space provided for the group's Medicare number. If you belong to more than three groups, copy and complete this section as needed. After completing this section, continue completing this application at Section 4B with information about your private practice.

B. Practice Location Information - Complete this section for each of your own private practice locations where you render services to Medicare beneficiaries. **The information provided in this section will pertain to your private practice only.** Check the box to indicate if you are adding a new practice location under an existing tax identification number, deleting a practice location, or changing information about an existing practice location. Provided that this is the only change in your information, provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. Provide the name of your practice location. If you use a "doing business as" name, provide that name in this section. Furnish the date you started rendering services at this location.
2. Furnish the complete street address for your practice location.

This address must be a specific street address as recorded by the United States Postal Service. Do not report a P.O. Box. Only report those practice locations within the Medicare carrier jurisdiction where you will be submitting this application, including reporting additions, deletions or other changes to these practice locations. If you render services in a hospital and/or other health care facility that bills Medicare directly for the services you render at that facility, furnish the name and address of that hospital or facility. In addition, provide the telephone number of this practice location. Do not provide a billing agency's telephone number. The fax number and e-mail address are optional.

If you only render services in patients' homes (house calls), you may supply your home address if you do not have an office. In Section 4E, explain that this address is for administrative purposes only and that all services are rendered in patients' homes.

If you render services in a retirement or assisted living community, complete this section with the names, telephone numbers and addresses of those communities.

3. Indicate whether you own/lease the practice location.
4. Indicate whether this address is that of a private practice office setting, hospital, retirement/assisted living community or other health care facility. Please specify if it does not fall within one of these categories.
5. If you have a CLIA number(s) and/or FDA/Radiology (Mammography) Certification Number(s) for this practice location, provide that information in this section. Submit a copy of the most current CLIA and FDA certification for each of the practice locations reported.

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4. Current Practice Location(s)

This section is to be completed with information about where you currently render medical services to Medicare patients. You must complete this entire section beginning with Section 4A1 and carefully follow all instructions in each part. If you need additional space to report additional groups/organizations or if you have more than one private practice location, copy and complete this section as needed for each.

A. Group Practice Information

Beginning with Section 4A1, answer "**Yes**" or "**No**" to each question. When applicable, furnish the group/organization name and Medicare number for each group/organization to which you will reassign your benefits. In addition to identifying the group/organization to which you will reassign your benefits in this section, either you or each group/organization reported in this section must also complete and submit a CMS 855R (Individual Reassignment of Benefits) with this application. Reassigning benefits means that you are authorizing the group/organization to bill Medicare for the services you have rendered at the group/organization's practice location.

1. Will **all** of your services be rendered as part of a group(s) or organization(s) to which you will reassign your benefits? ☐ YES ☐ NO
IF YES, furnish the name and Medicare identification number of each group or organization below and skip to Sections 13 through 17.
IF NO, proceed to Question 2 below.

a) Name of Group/Organization	Group/Organization Medicare Number
b) Name of Group/Organization	Group/Organization Medicare Number
c) Name of Group/Organization	Group/Organization Medicare Number

2. Will **any** of your services be rendered as part of a group(s) or organization(s) to which you will reassign your benefits? ☐ YES ☐ NO
IF YES, furnish the name and Medicare identification number of each group or organization below and continue completing the rest of this application at Section 4B.
IF NO, continue with Section 4B below with information about your private practice.

a) Name of Group/Organization	Group/Organization Medicare Number
b) Name of Group/Organization	Group/Organization Medicare Number
c) Name of Group/Organization	Group/Organization Medicare Number

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

1. Practice Location Name			Date You Started Rendering Services at this Location (MM/DD/YYYY)
2. Practice Location Street Address Line 1 (Street Name and Number)			
Practice Location 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)

3. Do you own/lease this practice location? ☐YES ☐ NO

4. Is this practice location a:
private practice office setting? ☐YES ☐ NO
hospital? ☐YES ☐ NO
retirement/assisted living community? ☐YES ☐ NO
other health care facility? (Specify):_____ ☐YES ☐ NO

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

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C. Medicare Payment "Pay To" Address Information - Check the box "Change" only if you are reporting a change to existing information in this section. Provided that this is the only change in your information, furnish the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

If you are enrolling for the first time, state where you want your Medicare payments to be sent. The ability to establish more than one "Pay To" address will be addressed by the local Medicare carrier. Therefore, if you want to establish multiple "Pay To" addresses you need to contact the carrier. Some Medicare carriers do not allow multiple payment addresses.

- Provide the P.O. Box or street address, city, State and ZIP Code for your payment address.

If you would like your payments to be deposited to your bank account electronically, place a check in the box given and complete the "Medicare Authorization Agreement for Electronic Funds Transfers" (Form HCFA-588).

- If payment will be paid by electronic funds transfer (EFT), the "Pay To" address should indicate where you want all other payment information (e.g., remittance notices, special payments, etc.) sent.

NOTE: Payment can only be made in your name as shown in Section 2A1 or your legal business name as shown in Section 2D2.

D. Location of Patients' Medical Records - Check the box "Change" only if you are reporting a change to existing information in this section. Provided that this is the only change in your information, provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. If all of your patients' medical records are located at the practice location in Section 4B, check the box provided and skip this section.

2. If any of your patients' medical records are stored in a location other than the practice location in Section 4B, complete this section with the complete address of all storage locations.

Post Office boxes and drop boxes are not acceptable as physical addresses where patients' medical records are maintained.

E. Comments – This section is to be used as an opportunity to explain any unusual circumstances concerning your practice location, "Pay To" address, the location of your patients' medical records, or how they are maintained and/or stored.

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4. Current Practice Location (Continued)

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

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

"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

Check here ☐ and submit a completed Form HCFA-588 with this application if you would like to have your payments electronically transferred to your bank account.

D. Location of Patients' Medical Records ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Check here ☐ if **all** of your patients' medical records are stored in the practice location(s) shown in Section 4B, and skip this section.
2. If **any** of your patients' medical records are stored in a location other than the practice location(s) shown in Section 4B, complete this section for each additional storage location.

Name of Storage Facility/Location		
Street Address Line 1		
Street Address Line 2		
City	State	ZIP Code + 4

E. Comments

Explain any unique or unusual circumstances concerning your practice location(s) or the method by which you render health care services (e.g., you only render services in patients' homes (house calls only)).

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SECTION 5: MANAGING CONTROL INFORMATION (ORGANIZATIONS)

This section is to be completed with information about any organization that manages your practice. See explanation below of organizations that should be reported in this section. If individuals, and not organizations, manage your practice, 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 as needed.

A managing organization is defined as any organization that exercises operational or managerial control over the practitioner's practice/business, or conducts the day-to-day operations of the practitioner's practice/business. This could be a management services organization, either under contract or through some other arrangement with the practitioner to furnish management services for any of his/her practice/business location(s).

In most situations when you use a management services organization, the organization would be reported in this section and the individual person from the organization who works in your office, or handles the management or administrative duties from outside your office, would be reported in Section 6.

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

B. Organization with Managing Control - Identification Information – Indicate if you are adding or deleting a managing organization, or changing information about an existing managing organization. Provide the new information and the effective date of the change. Provided that this is the only change in your information, you need to sign and date the certification statement. Otherwise:

1. Provide the legal business name of the managing/controlling organization.
2. Provide the managing/controlling organization's "doing business as" name (if applicable).
3. Provide the managing/controlling organization's full business street address.
4. Provide the managing/controlling organization's tax identification number and, if one has been issued, its Medicare identification number.

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

SECTION 6: MANAGING EMPLOYEE INFORMATION (INDIVIDUALS)

This section is to be completed with information about all managing individuals (employed or otherwise) working at any of your practice locations, to ensure they meet all the conditions of participation in the Medicare program.

A managing employee is defined as any individual (other than yourself), including a general manager, business manager, office manager or administrator, who exercises operational or managerial control over your practice/business, or who conducts the day-to-day operations of your practice/business. For Medicare enrollment purposes, a managing employee also includes any individual who manages your day-to-day operations, either under contract or through some other arrangement, but who is not your actual employee.

All managing employees at any of your practice locations shown in Section 4B must be reported in this section. However, this does not include individuals employed by hospitals, health care facilities or other organizations shown in Section 4B, or managing employees of any group or organization to which you reassign your benefits. For instance, the CEO of a hospital where one of your practice locations is situated should not be reported. If you have more than three managing employees, copy and complete this section as needed.

A. Check Box - Check the box if there are no managing employees to be reported in this section and proceed to Section 7.

B. Identifying Information - Indicate whether you are adding or deleting a managing employee, or changing information about an existing managing employee. Provide the new information and the effective date of the change. Provided that this is the only change in your information, you need to sign and date the certification statement. Otherwise:

1. Provide the full name of the managing employee.
2. Provide the managing employee's title and date of birth.
3. Provide the managing employee's social security number and Medicare identification number or NPI (if applicable).

C-D. 2nd and 3rd Managing Employee - Identifying Information - Section 6C and 6D are additional sections to provide information about a second and third managing employee. Follow the instructions in Sections 6B.