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2. Supplier Identification

This section is to be completed with information specifically related to the business location of the supplier submitting this application. Furnish the following information: the supplier's legal business name and address as reported to the IRS for issuance of IRS Form 1099, the type of business this supplier operates as, the type(s) of products and services this supplier will furnish, and information about the supplier's liability insurance.

A. Supplier IRS Identification Information ☐ **Change** **Effective Date:**_____

Furnish the supplier's legal business name (as reported to the IRS). A copy of the IRS CP-575 or other correspondence issued by the IRS showing the TIN for this business **MUST** be submitted.

1. Legal Business Name as Reported to the IRS		Tax ID Number
2. 1099 Mailing Address Line 1 (Street Name and Number)		Former Tax ID Number (if changed)
1099 Mailing Address Line 2 (Suite, Room, etc.)		
1099 Mailing Address City	1099 Mailing Address State	1099 Mailing Address ZIP Code + 4

B. Type of Business for this Supplier

The supplier must meet all Medicare requirements for a DMEPOS supplier. Submit copies of all required licenses, certifications, and registrations with this application.

1. Type of Supplier (Check all that apply):

☐ Medical Supply Company
☐ Medical Supply Company with Registered Pharmacist
☐ Medical Supply Company with Respiratory Therapist
☐ Medical Supply Company with Orthotics Personnel
☐ Medical Supply Company with Prosthetics Personnel
☐ Orthotics Personnel
☐ Prosthetics Personnel
☐ Medicare + Choice Organization
☐ Managed Care Plan (non-Medicare + Choice)
☐ Optician
☐ Optometrist
☐ Home Health Agency
☐ Skilled Nursing Facility
☐ Intermediate Care Nursing Facility
☐ Nursing Facility (Other)
☐ Pharmacy
☐ Grocery Store
☐ Department Store
☐ Occupational Therapist/Physical Therapist
☐ Physician
☐ Hospital

2. Which of the above is the primary type of business for the business location of the enrolling supplier?

C. Products and Services to be Furnished by this Supplier

1. Check here ☐ if this supplier is a physician and skip to Section D.

2. Indicate all primary **and** secondary products and services furnished by this supplier by circling the letter "P" or the letter "S" next to the appropriate product or service.

P	S	Enteral Nutrition	P	S	Optician	P	S	Oxygen
P	S	Durable Medical Equipment	P	S	Other (Specify):_____	P	S	Parenteral Nutrition
P	S	Prosthetics	P	S	Diabetic Equipment and Supplies	P	S	Drugs/Pharmaceuticals
P	S	Orthotics	P	S	Dialysis Equipment and Supplies	P	S	Diabetic Footwear

D. Liability Insurance Information

Note: All DMEPOS suppliers must submit a copy of their liability insurance policy or evidence of self-insurance with this application.

Name of Insurance Company			
Insurance Policy Number	Date Policy Issued (MM/DD/YYYY)	Expiration Date of Policy (MM/DD/YYYY)	
Insurance Agent's Name: First	Middle	Last	Jr., Sr., etc.
Agent's Telephone Number ( ) (Ext.) ( )	Agent's Fax Number (if applicable) ( )	E-mail Address (if applicable)	

E. Incorporation Information

Is this DMEPOS supplier business incorporated? ☐ YES ☐ NO

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SECTION 3: ADVERSE LEGAL ACTIONS AND OVERPAYMENTS

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

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

1. The supplier must state whether, under any current or former name or business identity, it has ever had any of the adverse legal actions listed in Table A of the application form imposed against it.

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

If the supplier is uncertain as to whether it falls within one of the adverse legal action categories or whether a name reported on this application has an adverse legal action, query the Healthcare Integrity and Protection Data Bank. If the supplier needs 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 the supplier in violation of these Acts and subject it to possible denial of its Medicare enrollment.

1. The supplier, as identified in Section 2A, must report all outstanding Medicare overpayments that it is liable for, including those paid to the supplier, or on its behalf, under a different name. For purposes of this section, the term "outstanding Medicare overpayment" is defined as a debt that meets **all** of the conditions listed below:

   a) The overpayment arose out of the supplier's current or previous enrollment in Medicare. This includes any overpayment incurred by the supplier under a different name or business identity, or in another Medicare contractor jurisdiction;

   b) CMS (or its contractors) has determined that the supplier is liable for the overpayment; and

   c) The overpayment is not or has not been included as part of a repayment plan approved by CMS (or its contractors), nor is the overpayment amount being repaid through the withholding of Medicare payments to the supplier.

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

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

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

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3. Adverse Legal Actions and Overpayments

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

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

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

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

Table A

1) Any felony conviction under Federal or State law, regardless of whether it was health care related.

2) Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.

3) Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.

4) Any misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.

5) Any misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

6) Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.

7) Any revocation or suspension of accreditation.

8) Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.

9) Any current Medicare payment suspension under any Medicare billing number.

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

B. Overpayment Information

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

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

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SECTION 4: CURRENT BUSINESS LOCATION ADDRESS INFORMATION

This section is to be completed with information about the business location for which this application is being submitted. The supplier must also furnish a mailing address for receiving correspondence from Medicare, an address where payments are to be sent, and an address where Medicare beneficiaries' records are stored for this location.

A. Business Location Address Information – This must be the actual address where the supplier's business is physically located. It must be the address and telephone number where Medicare beneficiaries can contact the supplier directly.

NOTE: A separate application must be submitted for each physical business location that conducts business with the public and intends to bill Medicare from that location for the items sold to the public. Locations that serve only as warehouses or repair facilities should not 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. Furnish the "doing business as" (DBA) name if different from the legal business name reported in Section 2A for this business location. The "doing business as" name is the name the supplier is generally known by to the public.

2. Provide the street address and telephone number of this business location. A post office box or a drop box address is **not** acceptable as a DMEPOS supplier business location. The address must be the actual physical location of the supplier's business. The telephone number must be the number where customers can call to ask questions or register complaints.

3. Check the appropriate box to indicate the organizational structure of this supplier. Check "Corporation" if the supplier is such, regardless of whether the supplier is "for-profit" or "non-profit." "Partnership" should be checked for all "General" or "Limited" partnerships. All other suppliers should check "Other," and specify the type of organizational structure (e.g., limited liability company).

4. Provide the date this business location was established to furnish and bill for DMEPOS supplies. This date will assist in establishing the effective date for claims processing. Also, when applicable, furnish the date this business location stopped furnishing DMEPOS supplies.

B. "Mail To" Address – The supplier must provide an address and telephone number where it can be directly contacted by Medicare or the NSC to resolve any enrollment or billing issues. This address will also be used to send the supplier important information concerning the Medicare program that may directly affect its Medicare payments. Therefore, this address cannot be that of the billing agency, management service organization, or staffing company. This address may be a post office box or a drop box location.

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.

If the "Mail To" address is the same as the "Business" address reported in Section 4A, check the box provided in this section and continue with Section 4C. Otherwise:

1. Furnish a "Mail To" name for the supplier in Section 4A.

2. Furnish an address, telephone number, fax number and email address where Medicare can directly contact the supplier.

3. If the DMEPOS supplier has more than one business location and the "Mail To" address is the same "Mail To" address for all of the supplier's business locations, check the box provided.

NOTE: If the "Mail To" address is a P.O. Box or Drop Box, it can not be the same as the "Business" address reported in Section 4A since a P.O. Box or Drop Box address is not acceptable as a DMEPOS supplier business address.

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C. "Pay To" Address – This address is the address the supplier must provide to indicate **where its Medicare payments are to be sent**. This address may be a post office box or drop box location.

Payment will be made in the DMEPOS supplier's "legal business name" as shown in Section 2A1.

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.

If the "Pay To" address is the same as the "Business" address reported in Section 4A, check the box provided at the top of this section and continue with Section 4D. Otherwise:

1. Furnish a "Pay To" address where Medicare can send payments.

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

2. If the DMEPOS supplier has more than one business location and the "Pay To" address is the same "Pay To" address for all of the supplier's business locations, check the box provided.

NOTE: If the "Pay To" address is a P.O. Box or Drop Box, it can not be the same as the "Business" address reported in Section 4A since a P.O. Box or Drop Box address is not acceptable as a DMEPOS supplier business address.

D. Location of Medicare Beneficiaries' Medical Records – All Medicare beneficiary medical records must be accessible to Medicare for possible review. This section only needs to be completed if the supplier's Medicare beneficiaries' medical records are stored in a location other than the business location shown in Section 4A. Post office boxes and drop boxes are not acceptable addresses for the storage of Medicare beneficiaries' medical records.

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:

If the "Location of Medicare Beneficiaries' Medical Records" address is the same as the "Business" address reported in Section 4A, check the box provided at the top of this section and continue with Section 5. Otherwise:

1. Furnish the address where the supplier maintains its Medicare Beneficiaries' medical records.

2. If the DMEPOS supplier has more than one business location and the "Storage Location" address is the same "Storage Location" address for all of the supplier's business locations, check the box provided.

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4. Current Business Location Address Information

This section is to be completed with information about the business location for which this application is being submitted. Also furnish a mailing address for receiving correspondence from Medicare, an address where payments are to be sent, and an address where Medicare beneficiaries' records are stored for this location. A separate application must be submitted for each business location that intends to bill Medicare for the items sold to the public from that location.

A. Business Location Address Information ☐ **Change** **Effective Date:**_____

This must be the physical address and telephone number of the business location and where Medicare beneficiaries can contact the supplier directly. The "Doing Business As" name is the name the supplier is generally known by to the public.

1. "Doing Business As" (DBA) Name (if applicable) for the supplier identified in Section 2A

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

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

Business City	Business State	Business ZIP Code + 4
Telephone Number (Ext.) ( ) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

3. Identify the type of organizational structure for this supplier (Check one):
☐ Corporation ☐ Partnership ☐ Other (Specify):_____

4. Date this Business Started at this Location (MM/DD/YYYY)	Date this Business Terminated at this Location (if applicable) (MM/DD/YYYY)

B. "Mail To" Address ☐ **Same as Section 4A** ☐ **Change** **Effective Date:**_____

This must be an address and telephone number where Medicare can contact the supplier directly.

1. "Mail To" Name for the supplier identified in Section 4A above

2. "Mail To" Address Line 1 (Street Name and Number or P.O. Box)

"Mail To" Address Line 2 (Suite, Room, etc.)

"Mail To" City	"Mail To" State	"Mail To" ZIP Code + 4
Telephone Number (Ext.) ( ) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

3. Check here ☐ if this "Mail To" address is to be used as the mail to address for all of the supplier's business locations.

C. "Pay To" Address ☐ **Same as Section 4A** ☐ **Change** **Effective Date:**_____

Furnish the address **where payment should be sent** for supplies furnished from the business address in Section 4A.

1. "Pay To" Address Line 1 (Street Name and Number or P.O. Box)

"Pay To" Address Line 2 (Suite, Room, etc.)

"Pay To" City	"Pay To" State	"Pay To" ZIP Code + 4

2. Check here ☐ if this "Pay To" address is to be used as the pay to address for all of the supplier's business locations.

D. Location of Medicare Beneficiaries' Medical Records ☐ **Change** **Effective Date:**_____

Check here ☐ if **all** Medicare beneficiary medical records are stored at the business location shown in Section 4A. Otherwise, complete this section with the name and address of the storage location.

1. Medicare Beneficiary Medical Record Storage Location Name

Medicare Beneficiary Medical Record Storage Location Address Line 1 (Street Name and Number)

Storage Location Address Line 2 (Suite, Room, etc.)

Storage Location City	Storage State	Storage ZIP Code + 4

2. Check here ☐ if this "Storage Location" address is to be used as the storage address for all business locations.

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

This section is to be completed with information about any organization that has 5% or more (direct or indirect) ownership of, any partnership interest in, and/or managing control of the DMEPOS supplier identified in Section 4A. See examples below of organizations that should be reported in this section. If there is more than one organization, copy and complete this section for each.

If individuals, and not organizations, own or manage the DMEPOS supplier, do not complete this section. These individuals must be reported in Section 6.

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

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

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

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

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

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

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

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

1. Check all boxes that apply to indicate the relationship between the DMEPOS supplier and the owning or managing organization.

2. Provide the legal business name of the owning or managing organization.

3. If applicable, provide the owning or managing organization's "doing business as" name.

4. Provide the owning or managing organization's complete business street address.

5. Provide the owning or managing organization's tax identification number and, if one (or more) has been issued, its Medicare identification number(s) or NPI(s).

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

EXAMPLES OF 5% OR MORE "DIRECT" OWNERSHIP

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

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

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

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

(1) An organization or individual is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the DMEPOS supplier or any of the property or assets of the DMEPOS supplier, **and**

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

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

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EXAMPLES OF "INDIRECT" LEVELS OF OWNERSHIP FOR ENROLLMENT PURPOSES

Example 1 (Ownership)

LEVEL 3	***Individual X*** 5%	***Individual Y*** 30%
LEVEL 2	***Company C*** 60%	***Company B*** 40%
LEVEL 1	***Company A*** 100%	

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

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

LEVEL 1

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

LEVEL 2

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

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

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

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

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

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LEVEL 3

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

The percentage of ownership the LEVEL 2 owner has in the Enrolling DMEPOS Supplier
MULTIPLIED BY
The percentage of ownership the LEVEL 3 owner has in that LEVEL 2 owner

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

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

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

Example 2 (Financial Control)

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

Dollar amount of the mortgage, deed of trust, or other obligation secured by the Enrolling DMEPOS Supplier or any of the property or assets of the Enrolling DMEPOS Supplier
DIVIDED BY
Dollar amount of the total property and assets of the Enrolling DMEPOS Supplier

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

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

MANAGING CONTROL (ORGANIZATIONS)

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

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SPECIAL TYPES OF ORGANIZATIONS

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

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

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

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

1. The DMEPOS supplier must state whether the organization reported in Section 5B, under any current or former name or business identity, has ever had any of the adverse legal actions listed in Section 3 (Table A) of this form imposed against it.

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

If the DMEPOS supplier is uncertain as to whether the owning or managing organization falls within one of the adverse legal action categories, the DMEPOS supplier should query the Healthcare Integrity and Protection Data Bank. If the DMEPOS 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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5. Ownership Interest and/or Managing Control Information (Organizations)

This section is to be completed with information about all organizations that have 5% or more (direct or indirect) ownership of, any partnership interest in, and/or managing control of, the supplier identified in Section 4A, as well as any information on adverse legal actions that have been imposed against that organization. See instructions for examples of organizations that should be reported here. If there is more than one organization, copy and complete this section for each.

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

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

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

1. Check all that apply:	☐ 5% or more Ownership Interest ☐ Managing Control	☐ Partner
2. Legal Business Name		
3. "Doing Business As" Name (if applicable)		
4. Business Address Line 1 (Street Name and Number)		
Business Address Line 2 (Suite, Room, etc.)		
City	State	ZIP Code + 4
5. Tax Identification Number	Medicare Identification Number(s) or NPI(s) (if applicable)	

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

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

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

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

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

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

This section is to be completed with information about any individual who has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the DMEPOS supplier identified in Section 4A. In addition, all officers, directors, and managing employees of the DMEPOS supplier must be reported in this section. If there is more than one individual, copy and complete this section for each. **The DMEPOS supplier MUST have at least ONE owner and/or managing employee.** If this is a "one person" operation, then report yourself in this section as **both** a 5% or greater owner and a managing employee or director/officer.

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

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

- All persons who have a 5% or greater ownership interest in the DMEPOS supplier reported in Section 4A;
- If (and only if) the DMEPOS supplier is a corporation (whether for-profit or non-profit), all officers and directors of the DMEPOS supplier reported in Section 4A;
- All managing employees of the DMEPOS supplier reported in Section 4A, and
- All individuals with a partnership interest in the DMEPOS supplier reported in Section 4A, regardless of the percentage of ownership the partner has.

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

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

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

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

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

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

Refer to the instructions and examples in Section 5 for further clarification of what is meant by the terms "direct owner" and "indirect owner." If further assistance is needed in completing this section, contact the National Supplier Clearinghouse.

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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, social security number, date of birth, and Medicare identification number or NPI (if applicable).

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

2. Indicate the individual's relationship with the enrolling supplier identified in Section 2A. 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 the application form for a list of adverse actions that must be reported.

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

1. The DMEPOS 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 DMEPOS supplier is uncertain as to whether this individual falls within one of the adverse legal action categories, the DMEPOS 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 that has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the supplier identified in Section 4A. 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 or NPI (if applicable)

2. What is the above individual's relationship with the supplier in Section 2A? (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 that prepare and/or submit claims to bill the Medicare program on behalf of the DMEPOS supplier. A billing agency is a company or individual that the DMEPOS supplier hires or contracts with to furnish claims processing functions for its business location. Any entity that meets this description must be reported in this section.

A. Check Box - If this DMEPOS supplier does not use a billing agency, check the box and skip to Section 11.

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

These questions are designed to show that the DMEPOS 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 NSC or CMS may request copies of all agreements/contracts associated with this billing agency.

SECTION 9: FOR FUTURE USE

This section has been intentionally omitted.

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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 11.

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?_____

9. For Future Use — This Section Not Applicable

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SECTION 10: STAFFING COMPANY - This section has been intentionally omitted.

SECTION 11: SURETY BOND INFORMATION

This section is to be completed by DMEPOS suppliers mandated by law to obtain a surety bond in order to enroll in and bill the Medicare program. Furnish all requested information about the supplier's insurance agent, surety company, and the surety bond. Read the letter sent with this application or call the NSC to determine if this DMEPOS supplier is required to obtain a surety bond. The surety bond must be an annual bond, a continuous bond, or a government security in lieu of a bond, (i.e., a Treasury note, United States bond, or other Federal public debt obligation). Annual surety bond renewals must be reported to the NSC on a timely basis to ensure continuance of claim payments. A certified true or notarized copy of the original surety bond must be submitted with this application. Failure to submit the surety bond will prevent the processing of this application. If an insurance agent or an insurance broker issues the bond, the DMEPOS supplier must also submit a certified copy of the agent's Power of Attorney with this application.

A. Check Box – Check the box if this DMEPOS supplier is not required to obtain a surety bond for Medicare enrollment.

B. Check Box - Check the box if this DMEPOS supplier qualifies for an exemption as a government entity.

If this DMEPOS supplier believes it is a government-operated DMEPOS supplier and is entitled to an exemption to the surety bond requirement, the DMEPOS supplier must furnish a letter signed by a government official of the Federal, State, local or Tribal Government (on official government letterhead), asserting that the government agency/tribe will back the debts owed by this DMEPOS supplier in full faith and credit of the government/tribe with this application. This letter can be the same letter that is referred to in Section 5 of these instructions. Otherwise, a surety bond **must** be obtained prior to participating in the Medicare program.

C. Name and Address of Surety Bond Company - 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. Furnish the legal business name and tax identification number of the surety bond company liable for this bond.
2. Furnish the complete business address, telephone number and e-mail address of the surety bond company.

D. Name and Address of Insurance Agency/Broker - 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. Provide the legal business name of the agency that issued the bond.
2. Provide the name of the individual agent who issued the bond for the bond agency.
3. Furnish the complete business address, telephone number and e-mail address of the agency.

E. Surety Bond Information – If the supplier has a Government Security check "Not Applicable" and skip to Section F below. 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, complete this section with specific information about the bond as follows:

1. State the dollar amount of the bond and the bond number.
2. Furnish the effective date of the bond. If reporting a new bond or new surety bond company, furnish the expiration date of the current bond.
3. Indicate if the bond is renewed annually or if it is continuous.
4. Indicate if this is a "Dual Obligee Bond." A dual obligee bond is issued when a supplier bills both the Medicare and Medicaid programs.

F. Government Security - If the supplier has a Surety Bond check "Not Applicable," skip this section and complete Section E above. 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, complete this section with specific information about the government security as follows:

1. State the amount of the bond, the effective date, and the Federal Reserve Account number.
2. Check the appropriate box indicating the type and duration for which the government security will be effective.

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10. Staffing Company — This Section Not Applicable

11. Surety Bond Information

This section is to be completed by all DMEPOS suppliers mandated by regulation (see C.F.R. 424.57) to obtain a surety bond in order to enroll in and bill the Medicare program. Furnish all requested information about the supplier's insurance agent, surety company, and the surety bond.

A. Check here ☐ if this supplier is not required to obtain a surety bond for Medicare enrollment and skip to Section 13. See instructions for surety bond requirements.

B. Check here ☐ if this supplier qualifies for a waiver of the bond requirement based on its operation as a government entity. See instructions for specific documentation requirements and skip to Section 13.

C. Name and Address of Surety Bond Company ☐ **Change**		**Effective Date:**_____
1. Legal Business Name of Surety Bond Company as Reported to the IRS		Tax Identification Number
2. Business Address Line 1 (Street Name and Number)		
Business Address Line 2 (Suite, Room, etc.)		
City	State	ZIP Code + 4
Telephone Number ( ) (Ext.) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

D. Name and Address of Insurance Agency/Broker ☐ **Change**		**Effective Date:**_____
1. Legal Business Name of Agency/Broker as Reported to the IRS		
2. Name of Individual Agent		
3. Business Address Line 1 (Street Name and Number)		
Business Address Line 2 (Suite, Room, etc.)		
City	State	ZIP Code + 4
Telephone Number ( ) (Ext.) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)

E. Surety Bond Information ☐ **Not Applicable** ☐ **Change**	**Effective Date:**_____
1. Amount of Surety Bond $	Surety Bond Number
2. Effective Date of Surety Bond (MM/DD/YYYY)	If reporting a new bond, give cancellation date of the current bond (MM/DD/YYYY)
3. Is the surety bond: ☐ Annual? (or) ☐ Continuous?	
4. Check here ☐ if this is a Medicare/Medicaid "Dual Obligee Surety Bond."	

F. Government Security ☐ **Not Applicable** ☐ **Change**		**Effective Date:**_____
If a government security has been purchased, furnish the following information.		
1. Amount $	Effective Date (MM/DD/YYYY)	Federal Reserve Bank Account Number

2. Check the appropriate box below:
   - a) Is the Treasury Bill: ☐ Not Applicable ☐ 3 months? ☐ 6 months? ☐ 1 year?
   - b) Is the Treasury Note: ☐ Not Applicable ☐ 2 years? ☐ 5 years? ☐ 10 years?
   - c) Is the government security a 30-year Treasury Bond? ☐ YES ☐ NO ☐ Not Applicable

Note: If the government security is less than one year in duration, the supplier must submit proof of the renewable government security to the NSC at least 14 days prior to the expiration date.

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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 DMEPOS supplier's application, provide the full name, SSN, mailing address, e-mail address, and telephone number 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 full 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 DMEPOS supplier should review this section to understand those penalties that can be applied against the supplier 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(s) and telephone number(s) of a person(s) 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 Name and Telephone Number ☐ Add ☐ Delete ☐ Change Effective Date:_____

Name: First	Last	Social Security Number
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 DMEPOS supplier of additional requirements that must be met and maintained in order for the DMEPOS 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 DMEPOS 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 DMEPOS supplier's enrollment record after the DMEPOS supplier has been enrolled. The DMEPOS supplier may have no more than two (2) currently active authorized officials at any given time. See 15B below to determine who within the DMEPOS supplier organization qualifies as an authorized official.

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

B. **1st 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.

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

- The authorized official must sign and date this application.

By his/her signature, the authorized official binds the DMEPOS supplier to all of the requirements listed in the Certification Statement and acknowledges that the DMEPOS 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 DMEPOS supplier has granted the legal authority to enroll it in the Medicare program, to make changes and/or updates to the DMEPOS supplier's status in the Medicare program (e.g., new practice locations, change of address, etc.), and to commit the DMEPOS supplier to fully abide by the laws, regulations, and program instructions of Medicare. The authorized official must be the DMEPOS supplier him/herself in sole proprietorships or the DMEPOS supplier's general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of 5% or more of the enrolling DMEPOS supplier (see Section 5 for definition of a "direct owner"), or must hold a position of similar status and authority within the DMEPOS supplier's organization.

Only the authorized official has the authority to sign the initial CMS 855S application and the re-enrollment CMS 855S application on behalf of the DMEPOS supplier. The delegated official has no such authority.

By signing this form for initial enrollment in the Medicare program or for re-enrollment 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 DMEPOS supplier is enrolled in Medicare, within 30 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 855S 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 DMEPOS 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 NSC may request documentation verifying that the person is no longer the authorized official.

To then add a new authorized official, the DMEPOS 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 DMEPOS supplier's status in the Medicare program.

If the DMEPOS 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.

NOTE: DMEPOS supplier's can have **no more than two (2)** authorized officials at any given time.

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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 30 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 applicable to DMEPOS suppliers. The Medicare laws, regulations, and program instructions are available through the Medicare contractor.

4.) Neither this DMEPOS 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 agency or program, or is otherwise prohibited from providing services to Medicare or other Federal program beneficiaries.

5.) I agree that any existing or future overpayment made to the DMEPOS 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.

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. I also certify that I have read, understand, meet, and will continue to meet all supplier standards as outlined in 42 CFR § 424.57. 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. I also certify that I have read, understand, meet, and will continue to meet all supplier standards as outlined in 42 CFR § 424.57. 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

OMB Approval No. 0938-0685

SECTION 16: DELEGATED OFFICIAL (OPTIONAL)

A delegated official must be a W-2 managing employee of the DMEPOS supplier, or an individual with a 5% or greater direct ownership interest in, or any partnership interest in, the enrolling DMEPOS supplier. Delegated officials are persons who are delegated the legal authority by the authorized official reported in Section 14B to make changes and/or updates to the DMEPOS supplier's status in the Medicare program. This individual must also be able to commit the DMEPOS 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 DMEPOS supplier. The NSC may request evidence indicating that the delegated official is an actual employee of the DMEPOS supplier. Independent contractors are not considered "employed" by the DMEPOS supplier. A DMEPOS 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 DMEPOS supplier chooses not to assign any delegated officials in this application, check the box in this section. There is no requirement that the DMEPOS 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 DMEPOS 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. 1st Delegated Official Signature

If the DMEPOS 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(s) 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 are not acceptable.

If the DMEPOS 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 DMEPOS 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 30 days of the effective date of the change.

C. 2nd Delegated Official Signature - This section provided to report a second (optional) delegated official for this supplier. See instructions above for Section 16B.

D. 3rd Delegated Official Signature - This section provided to report a second (optional) delegated official for this supplier. See instructions above for Section 16B.

OMB Approval No. 0938-0685

SECTION 17: ATTACHMENTS

This section contains a list of documents that, if applicable, must 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 (both business and professional) that are needed to operate this business in the State where the enrolling DMEPOS supplier business is located as reported in section 4A **must** be included with this application.

All enrolling DMEPOS suppliers are required to furnish information on all Federal, State and local (city/county) professional and business licenses, certifications and/or registrations required to practice as a DMEPOS supplier in DMEPOS supplier's State of business location as reported in section 4A (e.g., Federal Drug Enforcement Agency (DEA) number for pharmacies, business occupancy license, local business license, etc.). The NSC will supply specific licensing requirements for a DMEPOS supplier upon request.

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

If the enrolling DMEPOS 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 all 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.

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:**_____

2. 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		
3. **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:**_____

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

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
- ☐ Copy(s) of all Federal, State, and/or local (city/county) business licenses, certifications and/or registrations
- ☐ Copy(s) of all adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters)
- ☐ Copy(s) of all State pharmacy licenses
- ☐ Copy(s) of all surety bonds and/or Agent's Power of Attorney
- ☐ Copy(s) of all liability insurance policies
- ☐ IRS documents confirming the tax identification number and legal business name (e.g., CP 575)
- ☐ Any additional documentation or letters of explanation as needed

[FR Doc. 03–9943 Filed 4–24–03; 8:45 am]
BILLING CODE 4120–01–P

Proposed Rules

Federal Register
Vol. 68, No. 80
Friday, April 25, 2003

This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 420, 424, 489, and 498

[CMS–6002–P]

RIN 0938–AH73

Medicare Program; Requirements for Establishing and Maintaining Medicare Billing Privileges

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would require that all providers and suppliers (other than physicians who have elected to ''opt-out'' of the Medicare program) complete an enrollment form and submit specified information to us, and periodically update and certify to the accuracy of the enrollment information, to receive and maintain billing privileges in the Medicare program. The information must clearly identify the provider or supplier and its place of business, provide documentation that it is qualified to perform the services for which it is billing, ensure that it is not currently excluded from the Medicare program, and meets any other applicable Medicare requirements. If we determine the information submitted is incomplete, invalid, or insufficient to meet Medicare requirements, we would have the discretion to reject, deny, deactivate, or revoke billing privileges.

This proposed rule would implement provisions in the Medicare statute that require the Secretary to ensure that all Medicare providers and suppliers are qualified to provide the appropriate health care services. These statutory provisions include requirements meant to protect beneficiaries and the Medicare trust fund by preventing unqualified, fraudulent, or excluded providers and suppliers from providing services to Medicare beneficiaries or billing the Medicare program or its beneficiaries.

DATES: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on June 24, 2003.

ADDRESSES: In commenting, please refer to file code CMS–6002–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. Mail written comments (one original and two copies) to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–6002–P, P.O. Box 8013, Baltimore, MD 21244–8013.

Please allow sufficient time for us to receive mailed comments on time in the event of delivery delays.

If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) to one of the following addresses:

Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5–14–03, 7500 Security Boulevard, Baltimore, MD 21244–8013.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available if you wish to retain proof of filing by stamping in and retaining an extra copy of the comments being filed).

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and could be considered late.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Michael C. Collett, (410) 786–6121.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone (410) 786–7197.

Copies: To order copies of the **Federal Register** containing this document, send your request to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250–7954. Specify the date of the issue requested and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512–1800 (or toll-free at 1–888–293–6498) or by faxing to (202) 512–2250. The cost for each copy is $10. As an alternative, you can view and photocopy the **Federal Register** document at most libraries designated as Federal Depository Libraries and at many other public and academic libraries throughout the country that receive the **Federal Register**.

This **Federal Register** document is also available from the **Federal Register** online database through *GPO Access,* a service of the U.S. Government Printing Office. The Web site address is: *http://www.access.gpo.gov/nara/index.html.*

I. Background

A. General

The Medicare program, Title XVIII of the Social Security Act (the Act), is currently the principal payer for health care for 39.2 million enrolled beneficiaries. Under section 1802 of the Act, a beneficiary may obtain health services from any institution, agency, or person qualified to participate in the Medicare program. Qualifications to participate are specified in statute and in regulations. See, for example, sections 1814, 1815, 1819, 1833, 1834, 1842, 1861, 1866, and 1891 of the Act; and 42 CFR Chapter IV, Subchapter E, which concerns standards and certification requirements.

Providers and suppliers furnishing services must comply with the Medicare requirements stipulated in the Act and in our regulations. These requirements are meant to ensure compliance with applicable statutes, as well as to promote the furnishing of high quality care. We and/or State Survey and Certification Agencies inspect facilities when required, for compliance with regulatory and operational requirements before we allow them to participate in the Medicare program. Thereafter, either