NATIONAL PROVIDER ENROLLMENT CONFERENCE

57 Million Patients, 2 Million Providers, ONE Mission

CMS 855I, 855R Enrollment & Policy Overview

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Session Overview

- Learn how to initially enroll, revalidate, and submit changes of information for individual providers
- Cover all aspects of completing the CMS-855I & 855R with a walkthrough of both the paper and PECOS versions of the form
- Learn how to avoid common mistakes when submitting the 855-I&R

What are the 855I and 855R?

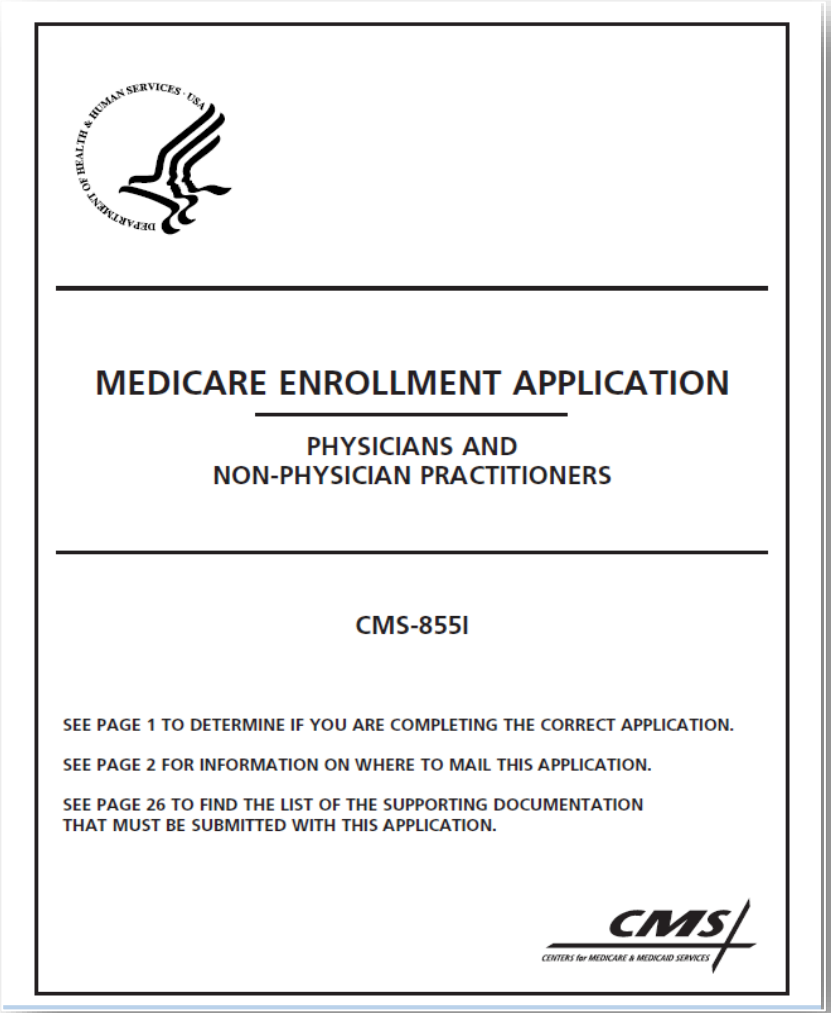
❖ **855I**

- CMS form which enrolls physicians and non-physician practitioners who render Medicare Part B services to beneficiaries
- Enrolls practitioners who are the sole owner of a professional corporation and bill Medicare through this business entity

❖ **855R**

- CMS form which establishes a reassignment of your right to bill the Medicare program and receive Medicare payments
- Reassigning your Medicare benefits means that an individual will allow an eligible Part B provider to submit claims and receive payment for Medicare services that the individual has provided

Getting Started: CMS-855I Application



MEDICARE ENROLLMENT APPLICATION

PHYSICIANS AND
NON-PHYSICIAN PRACTITIONERS

CMS-855I

SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION.

SEE PAGE 2 FOR INFORMATION ON WHERE TO MAIL THIS APPLICATION.

SEE PAGE 26 TO FIND THE LIST OF THE SUPPORTING DOCUMENTATION
THAT MUST BE SUBMITTED WITH THIS APPLICATION.

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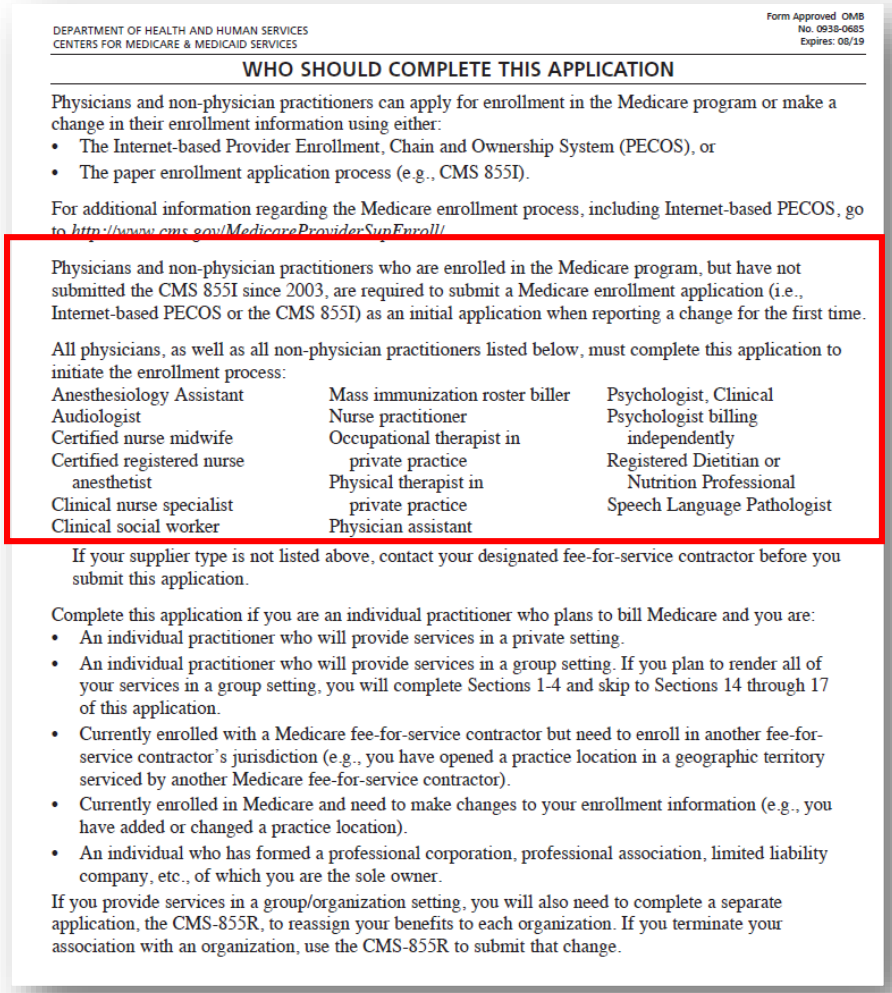
https://www.cms.gov/Medicare/CMS-Forms/CMSForms/Downloads/cms855i.pdf

Who should complete this application?



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved OMB
No. 0938-0685
Expires: 08/19

WHO SHOULD COMPLETE THIS APPLICATION

Physicians and non-physician practitioners can apply for enrollment in the Medicare program or make a change in their enrollment information using either:

- The Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or
- The paper enrollment application process (e.g., CMS 855I).

For additional information regarding the Medicare enrollment process, including Internet-based PECOS, go to *http://www.cms.gov/MedicareProviderSupEnroll/*

Physicians and non-physician practitioners who are enrolled in the Medicare program, but have not submitted the CMS 855I since 2003, are required to submit a Medicare enrollment application (i.e., Internet-based PECOS or the CMS 855I) as an initial application when reporting a change for the first time.

All physicians, as well as all non-physician practitioners listed below, must complete this application to initiate the enrollment process:

Anesthesiology Assistant	Mass immunization roster biller	Psychologist, Clinical
Audiologist	Nurse practitioner	Psychologist billing independently
Certified nurse midwife	Occupational therapist in private practice	Registered Dietitian or Nutrition Professional
Certified registered nurse anesthetist	Physical therapist in private practice	Speech Language Pathologist
Clinical nurse specialist	Physician assistant	
Clinical social worker		

If your supplier type is not listed above, contact your designated fee-for-service contractor before you submit this application.

Complete this application if you are an individual practitioner who plans to bill Medicare and you are:

- An individual practitioner who will provide services in a private setting.
- An individual practitioner who will provide services in a group setting. If you plan to render all of your services in a group setting, you will complete Sections 1-4 and skip to Sections 14 through 17 of this application.
- Currently enrolled with a Medicare fee-for-service contractor but need to enroll in another fee-for-service contractor's jurisdiction (e.g., you have opened a practice location in a geographic territory serviced by another Medicare fee-for-service contractor).
- Currently enrolled in Medicare and need to make changes to your enrollment information (e.g., you have added or changed a practice location).
- An individual who has formed a professional corporation, professional association, limited liability company, etc., of which you are the sole owner.

If you provide services in a group/organization setting, you will also need to complete a separate application, the CMS-855R, to reassign your benefits to each organization. If you terminate your association with an organization, use the CMS-855R to submit that change.

- All individuals (Physicians and NPPs) in private practice/sole owner or sole proprietorship
- All individuals (physician and NPPs) who reassign benefits

Section 1A: Basic Information

- Physician Assistant Identification
- Individual Provider Identification

SECTION 1: BASIC INFORMATION

A. Check one box and complete the required sections.

Since physician assistants do not complete Section 4, all physician assistants must furnish their Medicare Identification Number (if issued) and their NPI here:

Medicare Identification Number(s):_____ NPI:_____

If you are reassigning all of your Medicare benefits per section 4B1 of this application, furnish your Medicare Identification Number (if issued) and your individual (Type 1) NPI here:

Medicare Identification Number(s):_____ NPI:_____

Section 1A: Basic Information

REASON FOR APPLICATION	BILLING NUMBER INFORMATION	REQUIRED SECTIONS
☐ You are a **new enrollee** in Medicare	Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4.	**Complete all applicable sections**
☐ You are **enrolling with another fee-for-service contractor**	Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4.	**Complete all applicable sections**
☐ You are **reactivating** your Medicare enrollment	Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4.	**Complete all applicable sections**
☐ You are **voluntarily terminating** your Medicare enrollment	Effective Date of Termination: Medicare Identification Number(s) to Terminate *(if issued)*: National Provider Identifier *(if issued)*:	Sections **1A, 13** and **15** Physician Assistants must complete Sections **1A, 2F, 13** and **15** Employers terminating Physician Assistants must complete Sections **1A, 2G, 13** and **15**
☐ You are **changing** your Medicare information	Medicare Identification Number *(if issued)*: NPI:	Go to Section **1B**
☐ You are **revalidating** your Medicare enrollment	Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4.	**Complete all applicable sections**

- Enter the appropriate information in the Billing Number Information column
- Complete the Required Sections that correspond to the submittal reason

Section 1B: Basic Information

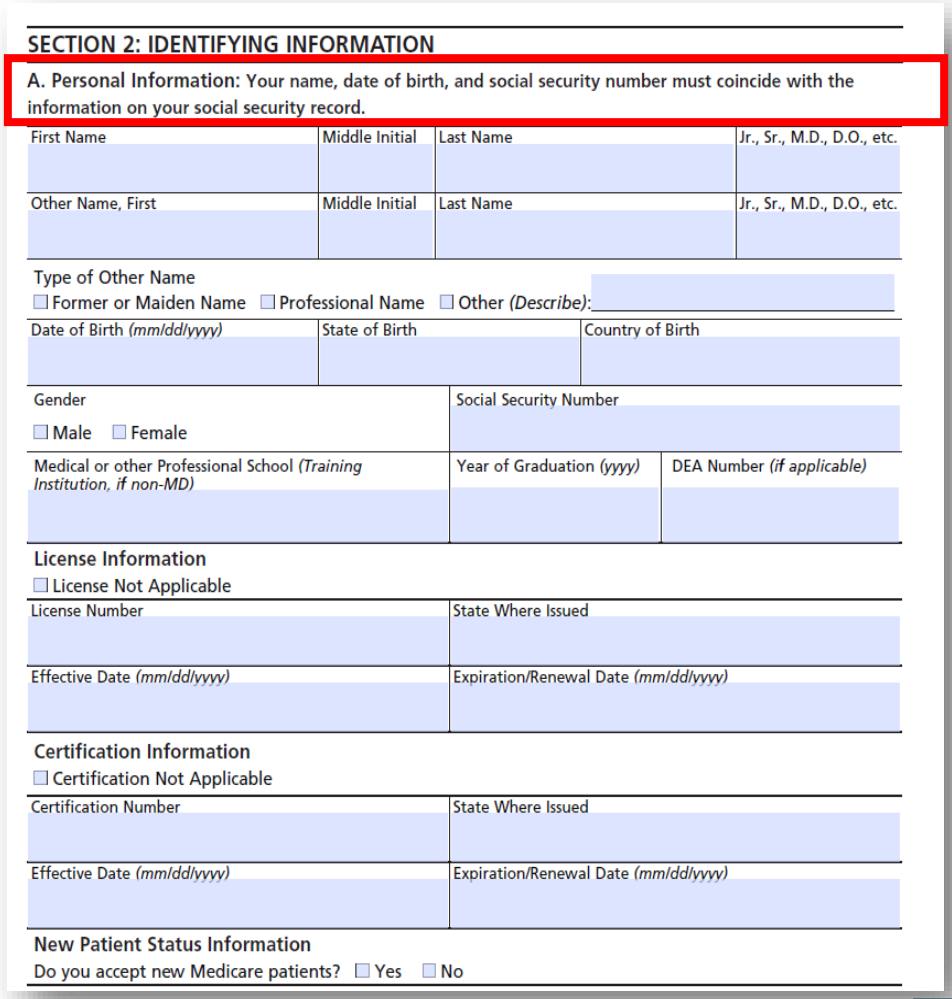
SECTION 1: BASIC INFORMATION *(Continued)*

B. Check all that apply and complete the required sections.

	REQUIRED SECTIONS
☐ Identifying Information	**1, 2** (complete only those sections that are changing), **3, 13** and **15**
☐ Final Adverse Actions/Convictions	**1, 2A, 3, 13 and 15**
☐ Practice Location Information, Payment Address and Medical Record Storage Information	**1, 2A, 3, 4** (complete only those sections that are changing), **13** and **15**
☐ Individuals Having Managing Control	**1, 2A, 3, 6, 13,** and **15**
☐ Billing Agency Information	**1, 2A, 3, 8** (complete only those sections that are changing), **13** and **15**

- Make note of Required Sections related to specific changes

Section 2: Identifying Information



SECTION 2: IDENTIFYING INFORMATION

A. Personal Information: Your name, date of birth, and social security number must coincide with the information on your social security record.

First Name	Middle Initial	Last Name	Jr., Sr., M.D., D.O., etc.
Other Name, First	**Middle Initial**	**Last Name**	**Jr., Sr., M.D., D.O., etc.**

Type of Other Name
☐ Former or Maiden Name ☐ Professional Name ☐ Other *(Describe)*:

Date of Birth *(mm/dd/yyyy)*	State of Birth	Country of Birth

Gender ☐ Male ☐ Female	Social Security Number

Medical or other Professional School *(Training Institution, if non-MD)*	Year of Graduation *(yyyy)*	DEA Number *(if applicable)*

License Information
☐ License Not Applicable

License Number	State Where Issued
Effective Date *(mm/dd/yyyy)*	**Expiration/Renewal Date *(mm/dd/yyyy)***

Certification Information
☐ Certification Not Applicable

Certification Number	State Where Issued
Effective Date *(mm/dd/yyyy)*	**Expiration/Renewal Date *(mm/dd/yyyy)***

New Patient Status Information
Do you accept new Medicare patients? ☐ Yes ☐ No

- **2A:** Personal Information
  - Indicate legal name as it appears with the Social Security Administration Office

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Section 2: Identifying Information

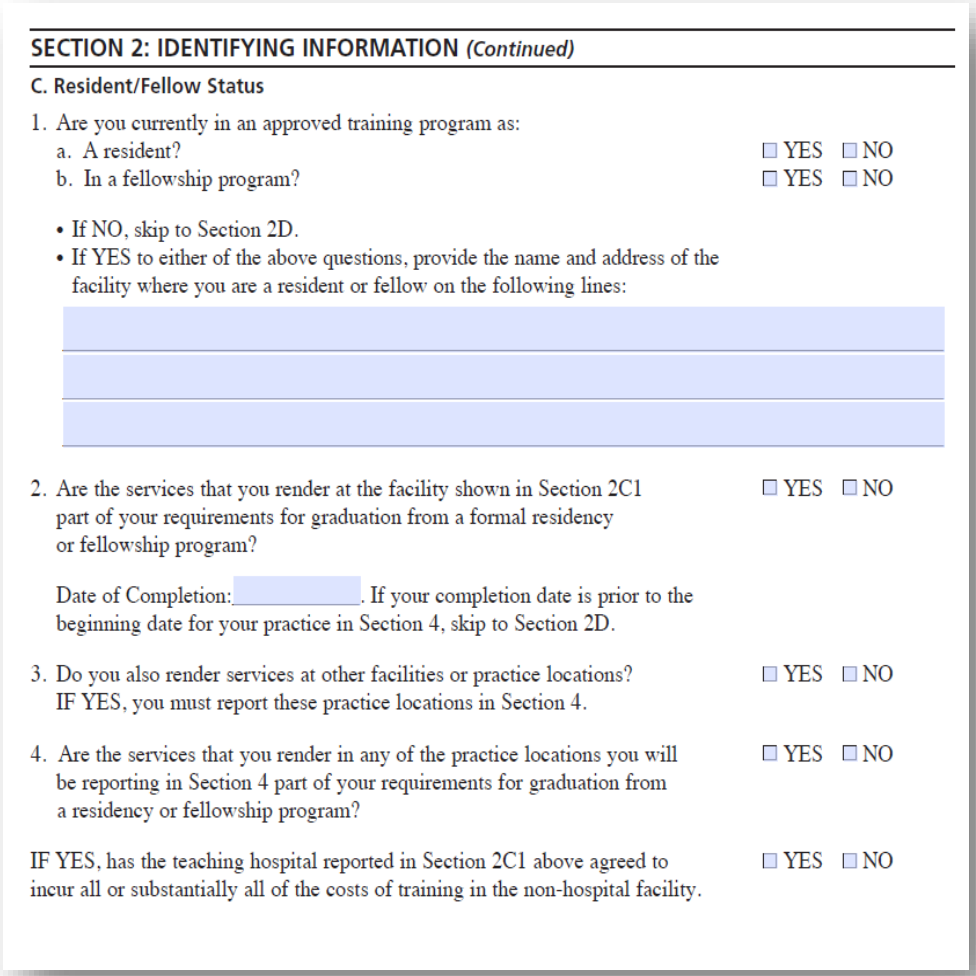
- **2B:** Correspondence Address
  - The correspondence address provided will be used to contact the provider directly
  - Cannot be a billing agency address

B. Correspondence Address

Provide contact information for the person shown in Section 2A above. Once enrolled, the information provided below will be used by the fee-for-service contractor if it needs to contact you directly. This address cannot be a billing agency's address.

Mailing Address Line 1 *(Street Name and Number)*			
Mailing Address Line 2 *(Suite, Room, etc.)*			
City/Town		State	ZIP Code + 4
Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*	

Section 2: Identifying Information



SECTION 2: IDENTIFYING INFORMATION *(Continued)*

C. Resident/Fellow Status

1. Are you currently in an approved training program as:
   a. A resident? ☐ YES ☐ NO
   b. In a fellowship program? ☐ YES ☐ NO

   • If NO, skip to Section 2D.
   • If YES to either of the above questions, provide the name and address of the facility where you are a resident or fellow on the following lines:

2. Are the services that you render at the facility shown in Section 2C1 part of your requirements for graduation from a formal residency or fellowship program? ☐ YES ☐ NO

   Date of Completion:_____. If your completion date is prior to the beginning date for your practice in Section 4, skip to Section 2D.

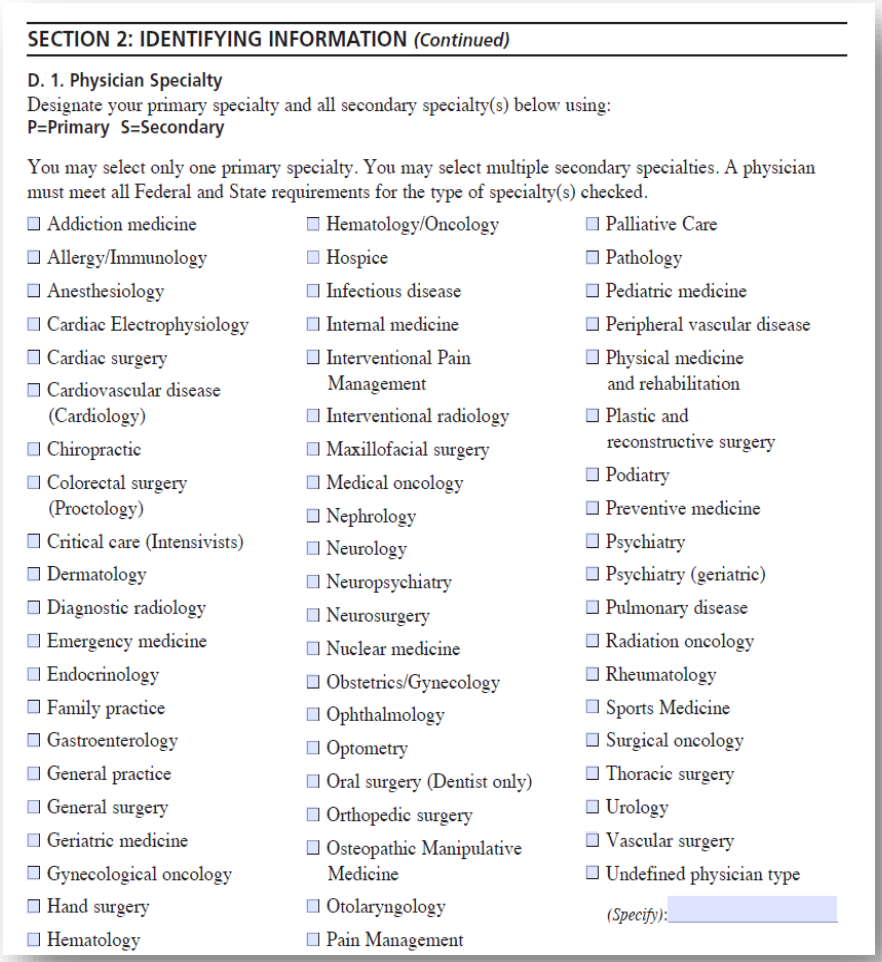
3. Do you also render services at other facilities or practice locations? ☐ YES ☐ NO
   IF YES, you must report these practice locations in Section 4.

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

IF YES, has the teaching hospital reported in Section 2C1 above agreed to incur all or substantially all of the costs of training in the non-hospital facility. ☐ YES ☐ NO

- **2C:** Resident/Fellow Status

Section 2: Identifying Information



SECTION 2: IDENTIFYING INFORMATION *(Continued)*

D. 1. Physician Specialty

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

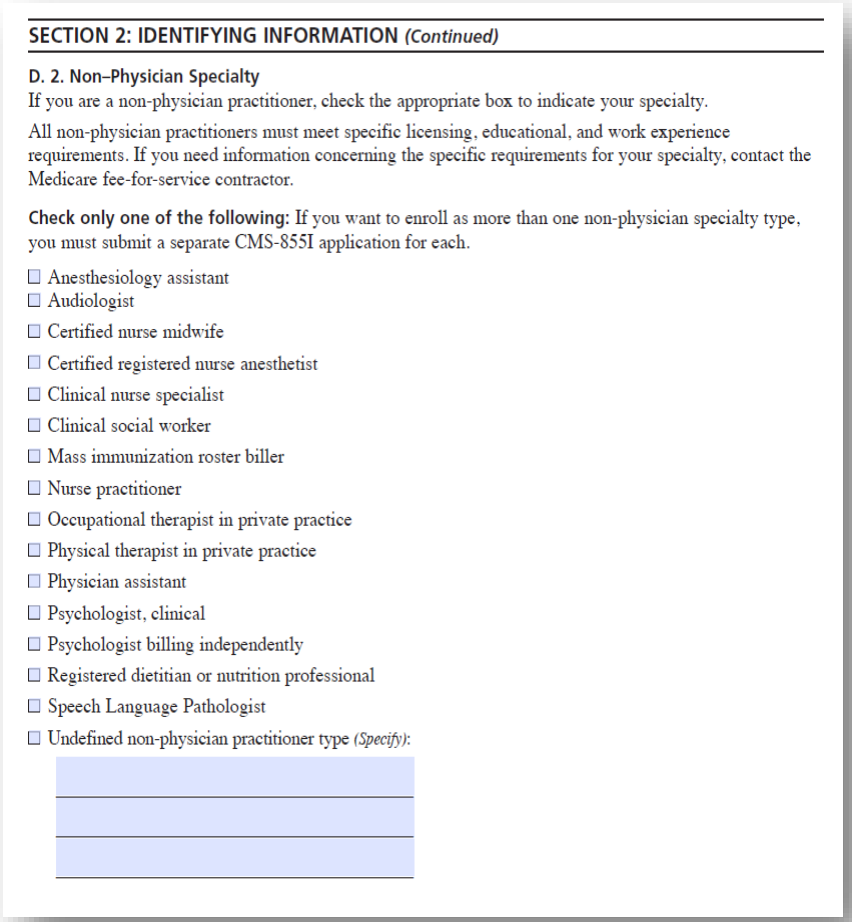
You may select only one primary specialty. You may select multiple secondary specialties. A physician must meet all Federal and State requirements for the type of specialty(s) checked.

- ☐ Addiction medicine
- ☐ Allergy/Immunology
- ☐ Anesthesiology
- ☐ Cardiac Electrophysiology
- ☐ Cardiac surgery
- ☐ Cardiovascular disease (Cardiology)
- ☐ Chiropractic
- ☐ Colorectal surgery (Proctology)
- ☐ Critical care (Intensivists)
- ☐ Dermatology
- ☐ Diagnostic radiology
- ☐ Emergency medicine
- ☐ Endocrinology
- ☐ Family practice
- ☐ Gastroenterology
- ☐ General practice
- ☐ General surgery
- ☐ Geriatric medicine
- ☐ Gynecological oncology
- ☐ Hand surgery
- ☐ Hematology
- ☐ Hematology/Oncology
- ☐ Hospice
- ☐ Infectious disease
- ☐ Internal medicine
- ☐ Interventional Pain Management
- ☐ Interventional radiology
- ☐ Maxillofacial surgery
- ☐ Medical oncology
- ☐ Nephrology
- ☐ Neurology
- ☐ Neuropsychiatry
- ☐ Neurosurgery
- ☐ Nuclear medicine
- ☐ Obstetrics/Gynecology
- ☐ Ophthalmology
- ☐ Optometry
- ☐ Oral surgery (Dentist only)
- ☐ Orthopedic surgery
- ☐ Osteopathic Manipulative Medicine
- ☐ Otolaryngology
- ☐ Pain Management
- ☐ Palliative Care
- ☐ Pathology
- ☐ Pediatric medicine
- ☐ Peripheral vascular disease
- ☐ Physical medicine and rehabilitation
- ☐ Plastic and reconstructive surgery
- ☐ Podiatry
- ☐ Preventive medicine
- ☐ Psychiatry
- ☐ Psychiatry (geriatric)
- ☐ Pulmonary disease
- ☐ Radiation oncology
- ☐ Rheumatology
- ☐ Sports Medicine
- ☐ Surgical oncology
- ☐ Thoracic surgery
- ☐ Urology
- ☐ Vascular surgery
- ☐ Undefined physician type

(Specify): _____

- **2D1:** Physician Specialty
  - Select a primary specialty (designated with a “P”)
  - May select multiple secondary specialties (designated with “S”)

Section 2: Identifying Information



SECTION 2: IDENTIFYING INFORMATION *(Continued)*

D. 2. Non–Physician Specialty

If you are a non-physician practitioner, check the appropriate box to indicate your specialty.

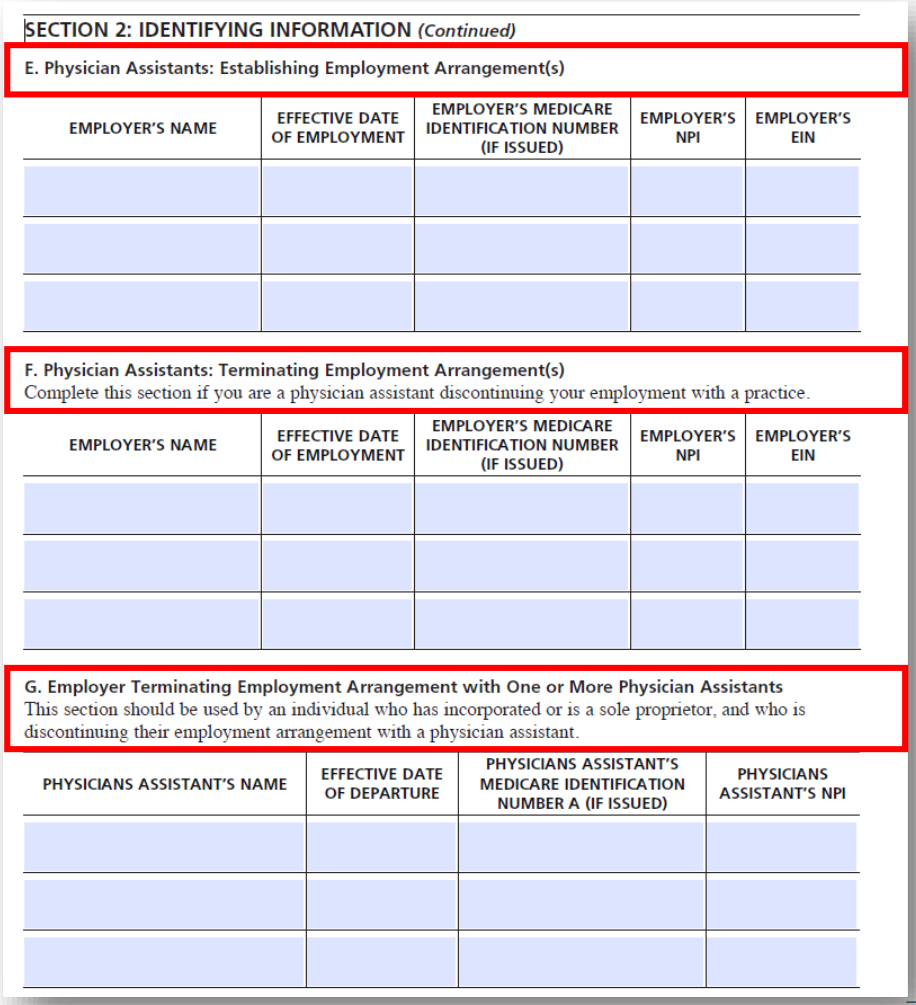
All non-physician practitioners must meet specific licensing, educational, and work experience requirements. If you need information concerning the specific requirements for your specialty, contact the Medicare fee-for-service contractor.

Check only one of the following: If you want to enroll as more than one non-physician specialty type, you must submit a separate CMS-855I application for each.

- ☐ Anesthesiology assistant
- ☐ Audiologist
- ☐ Certified nurse midwife
- ☐ Certified registered nurse anesthetist
- ☐ Clinical nurse specialist
- ☐ Clinical social worker
- ☐ Mass immunization roster biller
- ☐ Nurse practitioner
- ☐ Occupational therapist in private practice
- ☐ Physical therapist in private practice
- ☐ Physician assistant
- ☐ Psychologist, clinical
- ☐ Psychologist billing independently
- ☐ Registered dietitian or nutrition professional
- ☐ Speech Language Pathologist
- ☐ Undefined non-physician practitioner type *(Specify)*:

- **2D2:** Non-Physician Specialty
  - If a provider wants to enroll as multiple non-physician specialty types then he/she must submit a separate 855I for each specialty

Section 2: Identifying Information



SECTION 2: IDENTIFYING INFORMATION *(Continued)*

E. Physician Assistants: Establishing Employment Arrangement(s)

EMPLOYER'S NAME	EFFECTIVE DATE OF EMPLOYMENT	EMPLOYER'S MEDICARE IDENTIFICATION NUMBER (IF ISSUED)	EMPLOYER'S NPI	EMPLOYER'S EIN

F. Physician Assistants: Terminating Employment Arrangement(s)

Complete this section if you are a physician assistant discontinuing your employment with a practice.

EMPLOYER'S NAME	EFFECTIVE DATE OF EMPLOYMENT	EMPLOYER'S MEDICARE IDENTIFICATION NUMBER (IF ISSUED)	EMPLOYER'S NPI	EMPLOYER'S EIN

G. Employer Terminating Employment Arrangement with One or More Physician Assistants

This section should be used by an individual who has incorporated or is a sole proprietor, and who is discontinuing their employment arrangement with a physician assistant.

PHYSICIANS ASSISTANT'S NAME	EFFECTIVE DATE OF DEPARTURE	PHYSICIANS ASSISTANT'S MEDICARE IDENTIFICATION NUMBER A (IF ISSUED)	PHYSICIANS ASSISTANT'S NPI

- **2E:** Physician Assistant: Establishing Employment Arrangements
- **2F:** Physician Assistant: Terminating Employment Arrangements
- **2G:** Employer Terminating Employment Arrangements

Section 2: Identifying Information

- **2H:** Clinical Psychologists
  - Shall hold a doctorial degree in psychology
- **2I:** Psychologists Billing Independently

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

H. Clinical Psychologists

Do you hold a doctoral degree in psychology? ☐ YES ☐ NO

If YES, furnish the field of your psychology degree_____

Attach a copy of the degree with this application.

I. Psychologists Billing Independently

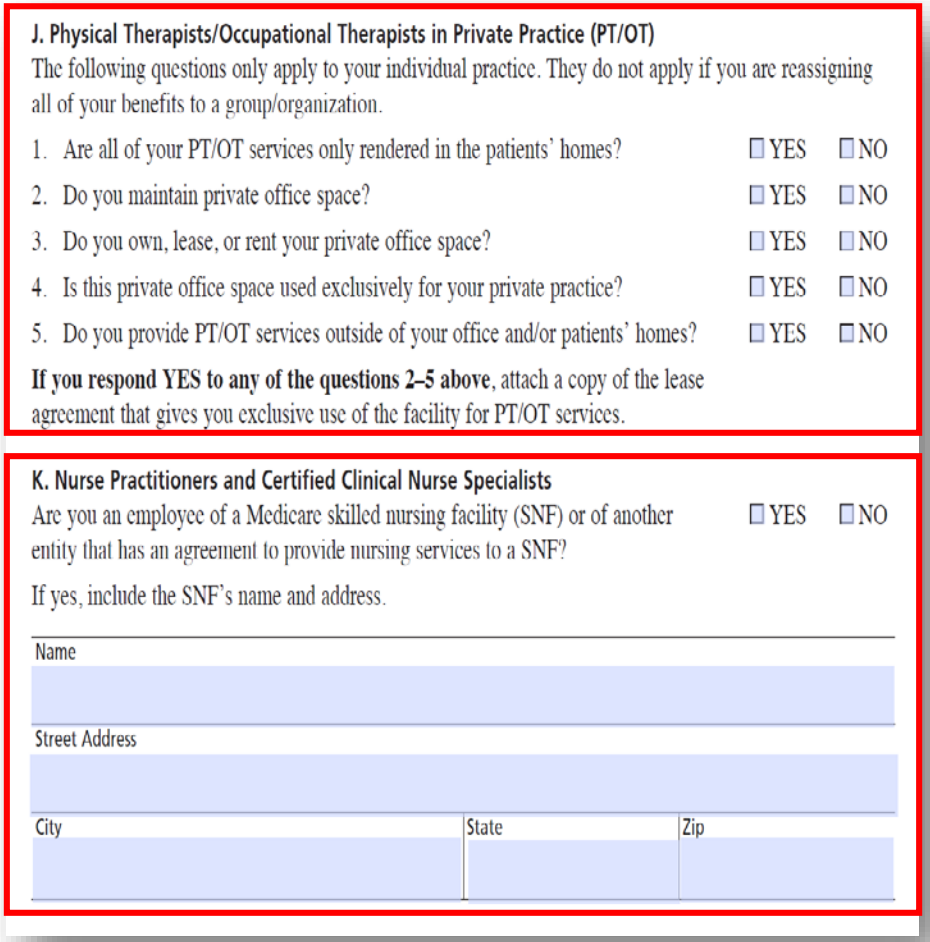
1. Do you render services of your own responsibility free from the administrative control of an employer such as a physician, institution, or agency? ☐ YES ☐ NO
2. Do you treat your own patients? ☐ YES ☐ NO
3. Do you have the right to bill directly, and to collect and retain the fee for your services? ☐ YES ☐ NO
4. Is this 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

Section 2: Identifying Information



J. Physical Therapists/Occupational Therapists in Private Practice (PT/OT)

The following questions only apply to your individual practice. They do not apply if you are reassigning all of your benefits to a group/organization.

1. Are all of your PT/OT 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 PT/OT services outside of your office and/or patients' homes? ☐ YES ☐ NO

If you respond YES to any of the questions 2–5 above, attach a copy of the lease agreement that gives you exclusive use of the facility for PT/OT services.

K. Nurse Practitioners and Certified Clinical Nurse Specialists

Are you an employee of a Medicare skilled nursing facility (SNF) or of another entity that has an agreement to provide nursing services to a SNF? ☐ YES ☐ NO

If yes, include the SNF's name and address.

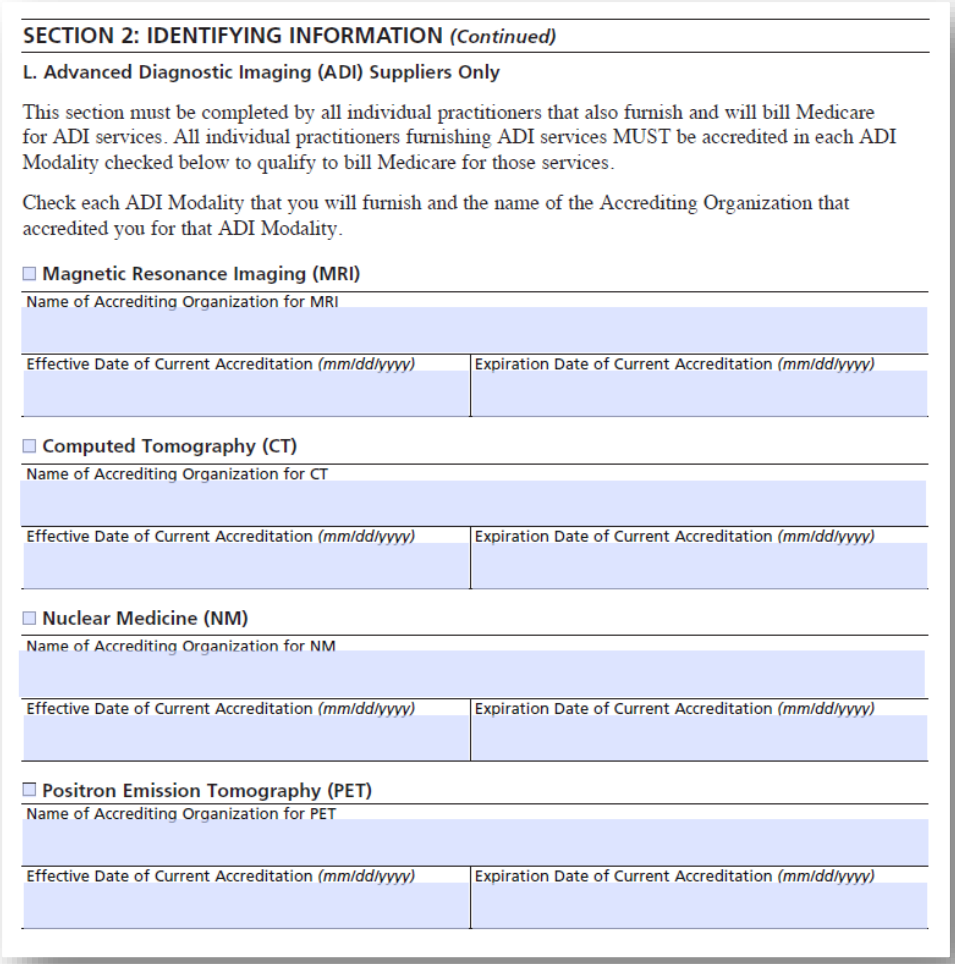
Name

Street Address

City | State | Zip

- **2J:** Physical Therapist/Occupational Therapists in Private Practice
  - Does not apply if PT/OT is reassigning all benefits to a group
- **2K:** Nurse Practitioners and Certified Clinical Nurse Specialists
  - Applies if you are an employee of a SNF or an entity that has an agreement to provide nursing services in a SNF

Section 2: Identifying Information



SECTION 2: IDENTIFYING INFORMATION *(Continued)*

L. Advanced Diagnostic Imaging (ADI) Suppliers Only

This section must be completed by all individual practitioners that also furnish and will bill Medicare for ADI services. All individual practitioners furnishing ADI services MUST be accredited in each ADI Modality checked below to qualify to bill Medicare for those services.

Check each ADI Modality that you will furnish and the name of the Accrediting Organization that accredited you for that ADI Modality.

☐ **Magnetic Resonance Imaging (MRI)**

Name of Accrediting Organization for MRI

Effective Date of Current Accreditation *(mm/dd/yyyy)*	Expiration Date of Current Accreditation *(mm/dd/yyyy)*

☐ **Computed Tomography (CT)**

Name of Accrediting Organization for CT

Effective Date of Current Accreditation *(mm/dd/yyyy)*	Expiration Date of Current Accreditation *(mm/dd/yyyy)*

☐ **Nuclear Medicine (NM)**

Name of Accrediting Organization for NM

Effective Date of Current Accreditation *(mm/dd/yyyy)*	Expiration Date of Current Accreditation *(mm/dd/yyyy)*

☐ **Positron Emission Tomography (PET)**

Name of Accrediting Organization for PET

Effective Date of Current Accreditation *(mm/dd/yyyy)*	Expiration Date of Current Accreditation *(mm/dd/yyyy)*

- **2L:** Advanced Diagnostic Imaging (ADI) Suppliers Only

Section 3: Final Adverse Legal Actions/Convictions

SECTION 3: FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Convictions

1. The provider, supplier, or any owner of the provider or supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include:

   Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicare program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.

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

Exclusions, Revocations, or Suspensions

1. 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.
2. Any revocation or suspension of accreditation.
3. 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.
4. Any current Medicare payment suspension under any Medicare billing number.
5. Any Medicare revocation of any Medicare billing number.

Section 3: Final Adverse Legal Actions/Convictions

SECTION 3: FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS *(Continued)*

FINAL ADVERSE LEGAL ACTION HISTORY

1. Have you, under any current or former name or business identity, ever had a final adverse legal action listed on page 12 of this application imposed against you?

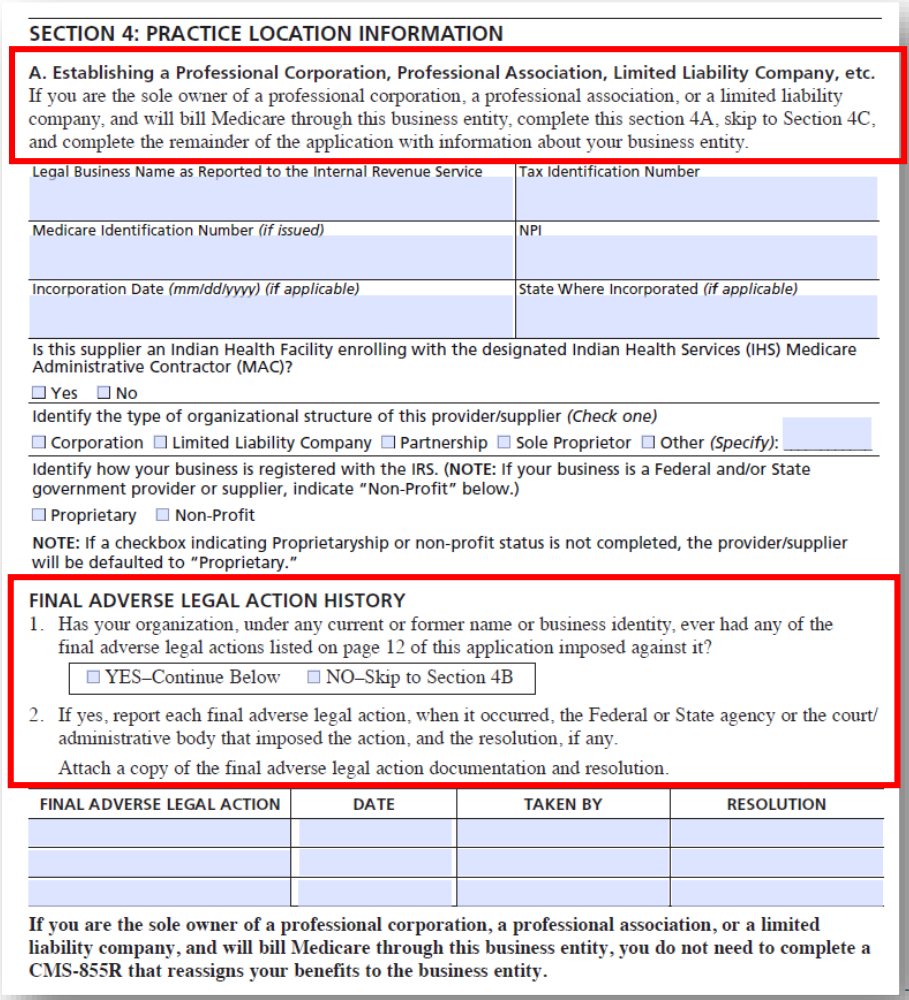
☐ YES–Continue Below ☐ NO–Skip to Section 4

2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

   Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

Section 4: Practice Location Information



SECTION 4: PRACTICE LOCATION INFORMATION

A. Establishing a Professional Corporation, Professional Association, Limited Liability Company, etc.
If you are the sole owner of a professional corporation, a professional association, or a limited liability company, and will bill Medicare through this business entity, complete this section 4A, skip to Section 4C, and complete the remainder of the application with information about your business entity.

Legal Business Name as Reported to the Internal Revenue Service	Tax Identification Number
Medicare Identification Number *(if issued)*	NPI
Incorporation Date *(mm/dd/yyyy) (if applicable)*	State Where Incorporated *(if applicable)*

Is this supplier an Indian Health Facility enrolling with the designated Indian Health Services (IHS) Medicare Administrative Contractor (MAC)?

☐ Yes ☐ No

Identify the type of organizational structure of this provider/supplier *(Check one)*

☐ Corporation ☐ Limited Liability Company ☐ Partnership ☐ Sole Proprietor ☐ Other *(Specify)*: _____

Identify how your business is registered with the IRS. **(NOTE:** If your business is a Federal and/or State government provider or supplier, indicate "Non-Profit" below.)

☐ Proprietary ☐ Non-Profit

NOTE: If a checkbox indicating Proprietaryship or non-profit status is not completed, the provider/supplier will be defaulted to "Proprietary."

FINAL ADVERSE LEGAL ACTION HISTORY

1. Has your organization, under any current or former name or business identity, ever had any of the final adverse legal actions listed on page 12 of this application imposed against it?

   ☐ YES–Continue Below ☐ NO–Skip to Section 4B

2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/ administrative body that imposed the action, and the resolution, if any.

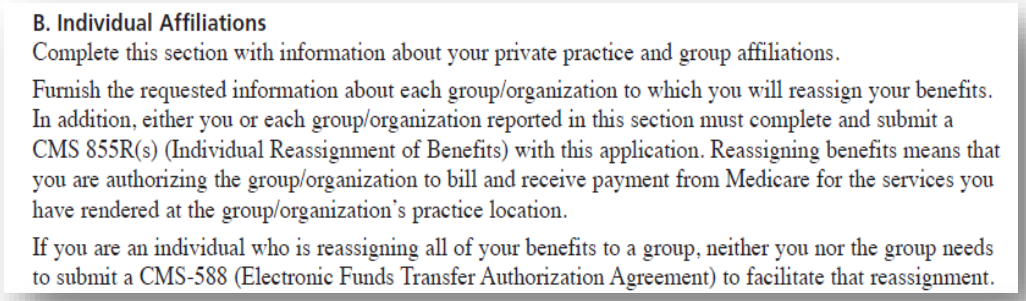
   Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

If you are the sole owner of a professional corporation, a professional association, or a limited liability company, and will bill Medicare through this business entity, you do not need to complete a CMS-855R that reassigns your benefits to the business entity.

- If you are reassigning all of your benefits, please proceed to **Section 4B**
- **4A:** Professional Corporation, Professional Association, Limited Liability Company

Section 4: Practice Location Information

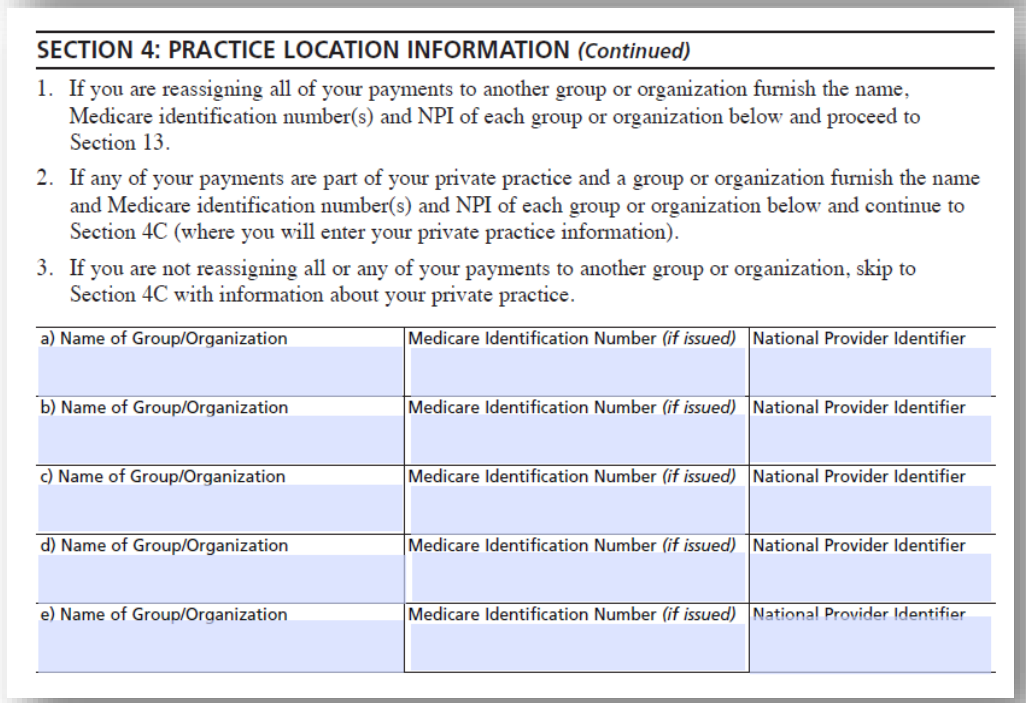


B. Individual Affiliations

Complete this section with information about your private practice and group affiliations.

Furnish the requested information about each group/organization to which you will reassign your benefits. In addition, either you or each group/organization reported in this section must complete and submit a CMS 855R(s) (Individual Reassignment of Benefits) with this application. Reassigning benefits means that you are authorizing the group/organization to bill and receive payment from Medicare for the services you have rendered at the group/organization's practice location.

If you are an individual who is reassigning all of your benefits to a group, neither you nor the group needs to submit a CMS-588 (Electronic Funds Transfer Authorization Agreement) to facilitate that reassignment.



SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

1. If you are reassigning all of your payments to another group or organization furnish the name, Medicare identification number(s) and NPI of each group or organization below and proceed to Section 13.
2. If any of your payments are part of your private practice and a group or organization furnish the name and Medicare identification number(s) and NPI of each group or organization below and continue to Section 4C (where you will enter your private practice information).
3. If you are not reassigning all or any of your payments to another group or organization, skip to Section 4C with information about your private practice.

a) Name of Group/Organization	Medicare Identification Number *(if issued)*	National Provider Identifier
b) Name of Group/Organization	Medicare Identification Number *(if issued)*	National Provider Identifier
c) Name of Group/Organization	Medicare Identification Number *(if issued)*	National Provider Identifier
d) Name of Group/Organization	Medicare Identification Number *(if issued)*	National Provider Identifier
e) Name of Group/Organization	Medicare Identification Number *(if issued)*	National Provider Identifier

4B: Individual Affiliations

- Complete with all your group affiliations **if reassigning all benefits,** complete and proceed to Section 13

Section 4: Practice Location Information

- **4C:** Practice Location Information

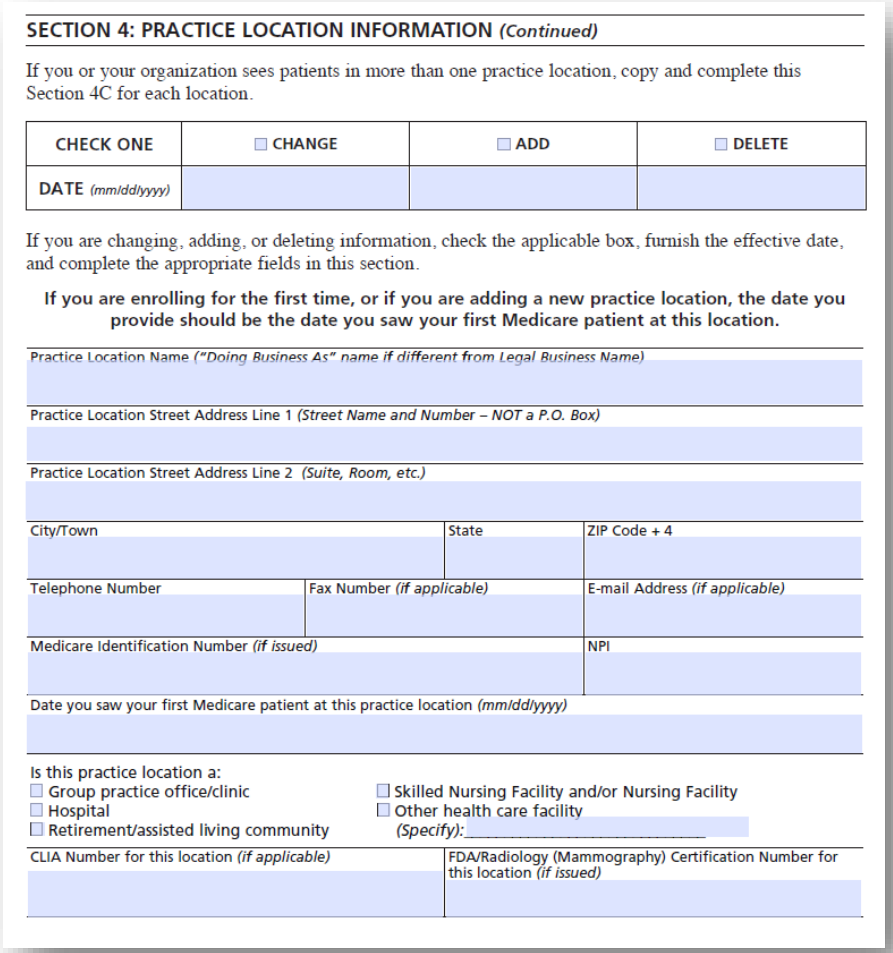
C. Practice Location Information

- If you completed Section 4A, complete Section 4C through Section 17 for your business.
- All locations disclosed on claims forms should be identified in this section as practice locations.
- Complete this section for each of your practice locations where you render services to Medicare beneficiaries.

  However, you should only report those practice locations within the jurisdiction of the Medicare fee-for-service contractor to which you will submit this application. If you render services in a hospital and/or other health care facility, furnish the name and address of that hospital or facility.
- Each practice location must be a specific street address as recorded by the United States Postal Service. Do not report a P.O. Box.
- If you only render services in patients' homes (house calls), you may supply your home address in this section if you do not have an office. In Section 4H, 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.

If you have a CLIA number and/or FDA/Radiology Certification Number for this practice location, provide that information and submit a copy of the most current CLIA and FDA certification for each practice location reported.

Section 4: Practice Location Information



SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

If you or your organization sees patients in more than one practice location, copy and complete this Section 4C for each location.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

If you are enrolling for the first time, or if you are adding a new practice location, the date you provide should be the date you saw your first Medicare patient at this location.

Practice Location Name *("Doing Business As" name if different from Legal Business Name)*

Practice Location Street Address Line 1 *(Street Name and Number – NOT a P.O. Box)*

Practice Location Street Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

Medicare Identification Number *(if issued)*	NPI

Date you saw your first Medicare patient at this practice location *(mm/dd/yyyy)*

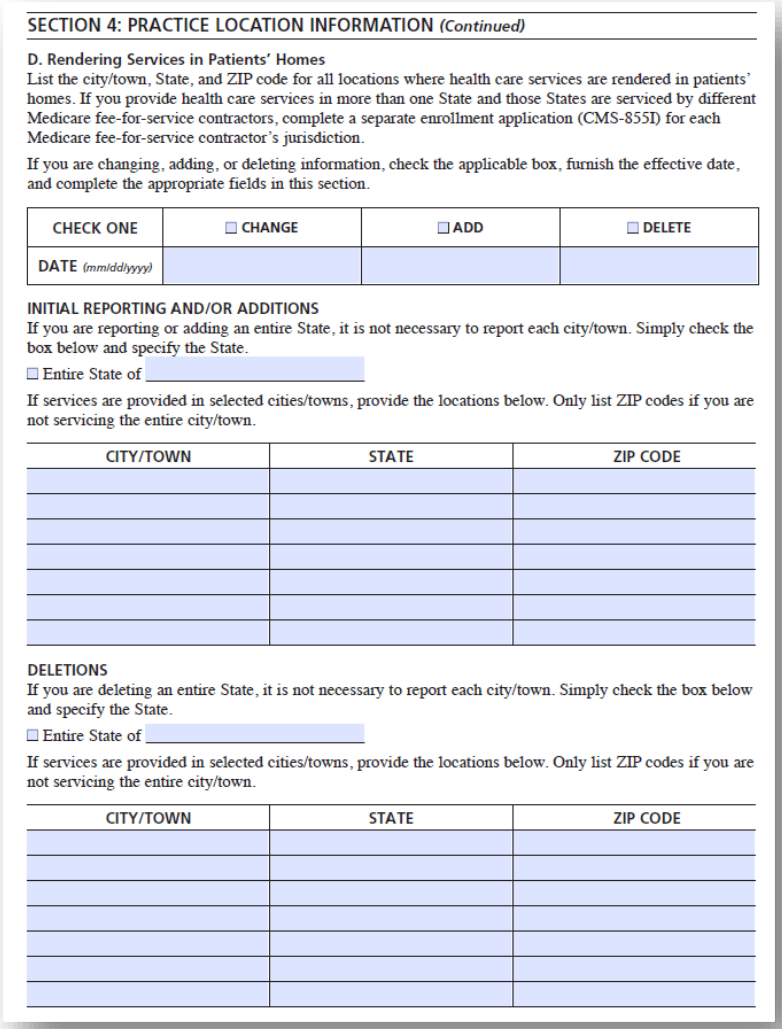
Is this practice location a:

☐ Group practice office/clinic
☐ Hospital
☐ Retirement/assisted living community
☐ Skilled Nursing Facility and/or Nursing Facility
☐ Other health care facility
(Specify): _____

CLIA Number for this location *(if applicable)*	FDA/Radiology (Mammography) Certification Number for this location *(if issued)*

- **4C:** Practice Location Information
  - List all practice locations where services are being rendered
  - Copy and complete entire section for each practice location
  - If adding new location, supply date first saw Medicare patient

Section 4: Practice Location Information



SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

D. Rendering Services in Patients' Homes

List the city/town, State, and ZIP code for all locations where health care services are rendered in patients' homes. If you provide health care services in more than one State and those States are serviced by different Medicare fee-for-service contractors, complete a separate enrollment application (CMS-855I) for each Medicare fee-for-service contractor's jurisdiction.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

INITIAL REPORTING AND/OR ADDITIONS

If you are reporting or adding an entire State, it is not necessary to report each city/town. Simply check the box below and specify the State.

☐ Entire State of _____

If services are provided in selected cities/towns, provide the locations below. Only list ZIP codes if you are not servicing the entire city/town.

CITY/TOWN	STATE	ZIP CODE

DELETIONS

If you are deleting an entire State, it is not necessary to report each city/town. Simply check the box below and specify the State.

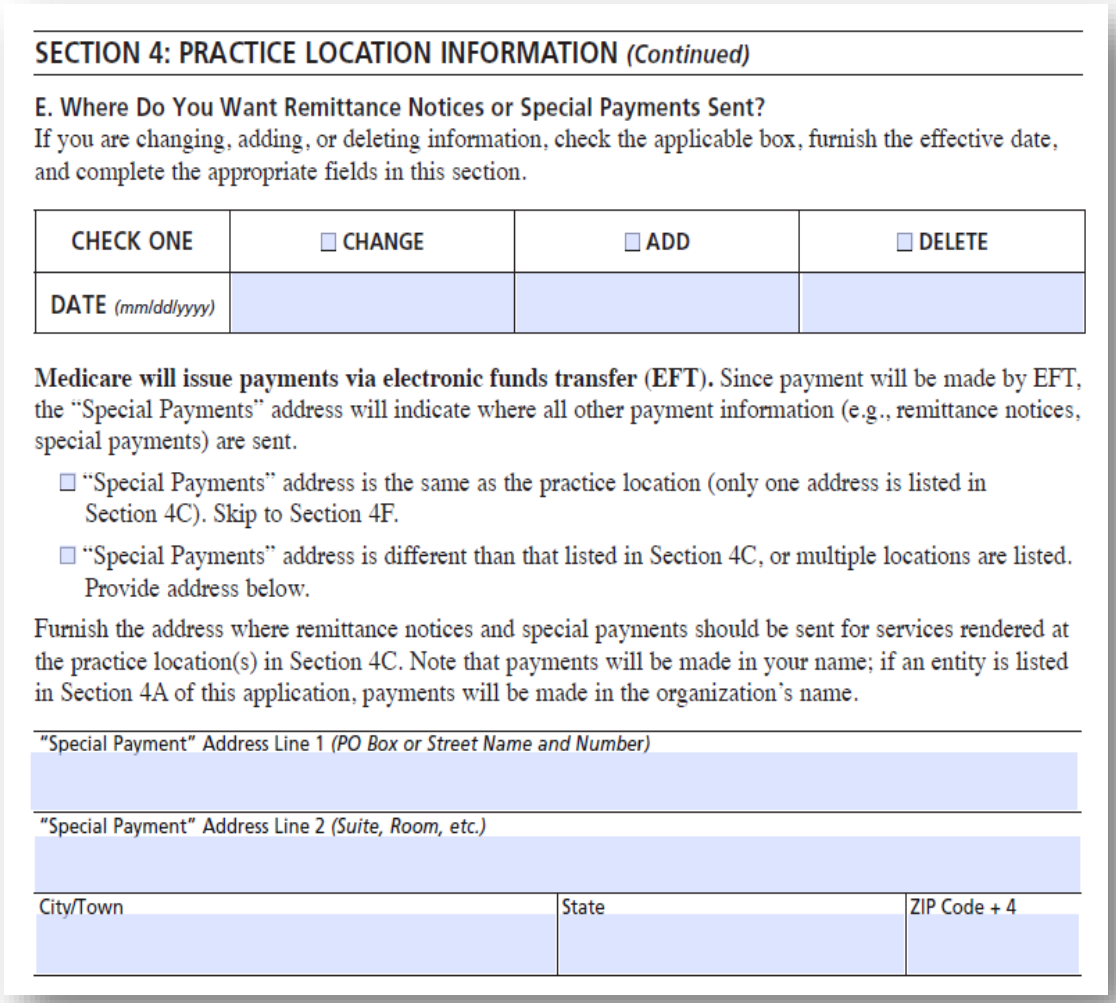
☐ Entire State of _____

If services are provided in selected cities/towns, provide the locations below. Only list ZIP codes if you are not servicing the entire city/town.

CITY/TOWN	STATE	ZIP CODE

- **4D:** Rendering Services in Patients' Homes
  - Indicate if rendering in patients homes either for entire state or indicate city/town and/or ZIP codes

Section 4: Practice Location Information



SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

E. Where Do You Want Remittance Notices or Special Payments Sent?
If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Medicare will issue payments via electronic funds transfer (EFT). Since payment will be made by EFT, the "Special Payments" address will indicate where all other payment information (e.g., remittance notices, special payments) are sent.

☐ "Special Payments" address is the same as the practice location (only one address is listed in Section 4C). Skip to Section 4F.

☐ "Special Payments" address is different than that listed in Section 4C, or multiple locations are listed. Provide address below.

Furnish the address where remittance notices and special payments should be sent for services rendered at the practice location(s) in Section 4C. Note that payments will be made in your name; if an entity is listed in Section 4A of this application, payments will be made in the organization's name.

"Special Payment" Address Line 1 *(PO Box or Street Name and Number)*

"Special Payment" Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

- **4E:** Remittance notices or special payment
  - Indicate if special payment address is the same (only one address listed in 4C)
  - If different or multiple practice locations, supply address

4F: Employer ID Number Information

- Sole proprietor payments to be reported under the EIN
  - Unless EIN is indicated, payments will be made under the Social Security Number (SSN)

F. Employer ID Number Information

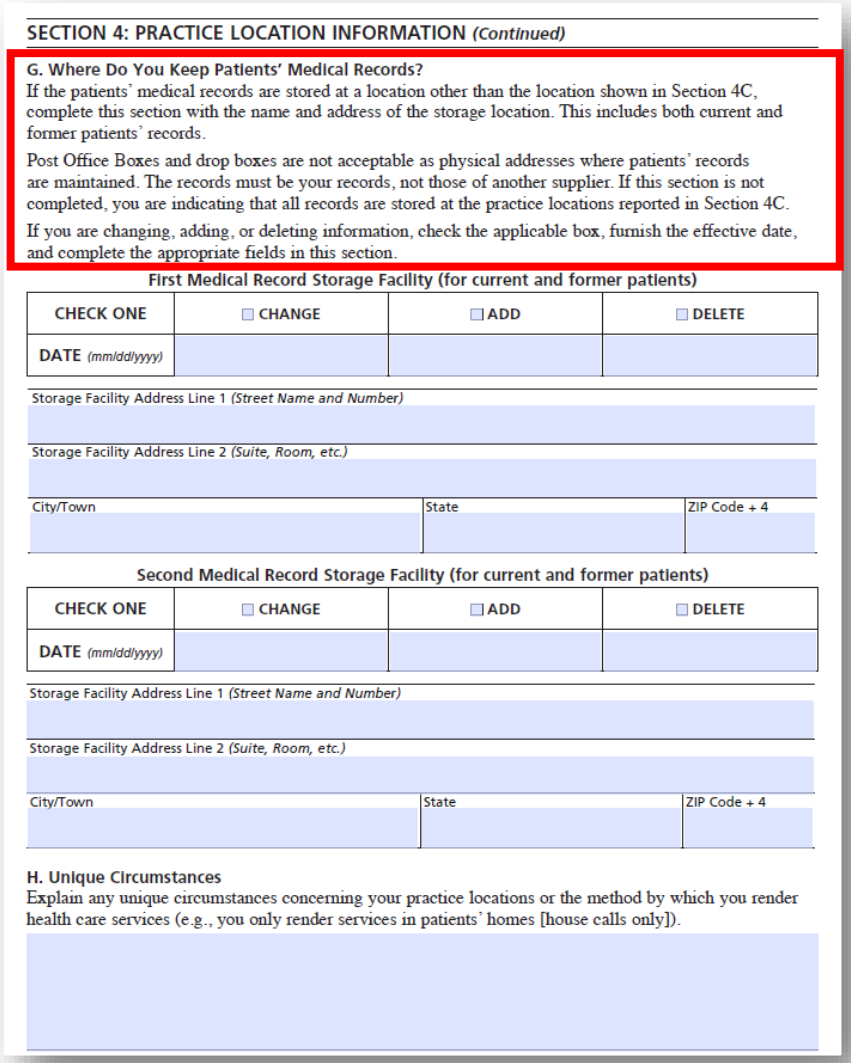
NOTE: If you are a sole proprietor and you want Medicare payments to be reported under your EIN, list it below. Unless indicated in this section, payments will be made to your SSN. You cannot use both an SSN and EIN. You can only use one EIN to bill Medicare.

To qualify for this payment arrangement, you:

- Must be a sole proprietor,
- Cannot reassign all of your Medicare payments, and,
- Want your payments to be made to your EIN. Furnish IRS documentation showing your EIN.

Employer Identification Number (EIN)

Section 4: Practice Location Information



SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

G. Where Do You Keep Patients' Medical Records?
If the patients' medical records are stored at a location other than the location shown in Section 4C, complete this section with the name and address of the storage location. This includes both current and former patients' records.

Post Office Boxes and drop boxes are not acceptable as physical addresses where patients' records are maintained. The records must be your records, not those of another supplier. If this section is not completed, you are indicating that all records are stored at the practice locations reported in Section 4C.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

First Medical Record Storage Facility (for current and former patients)

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Storage Facility Address Line 1 *(Street Name and Number)*

Storage Facility Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Second Medical Record Storage Facility (for current and former patients)

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Storage Facility Address Line 1 *(Street Name and Number)*

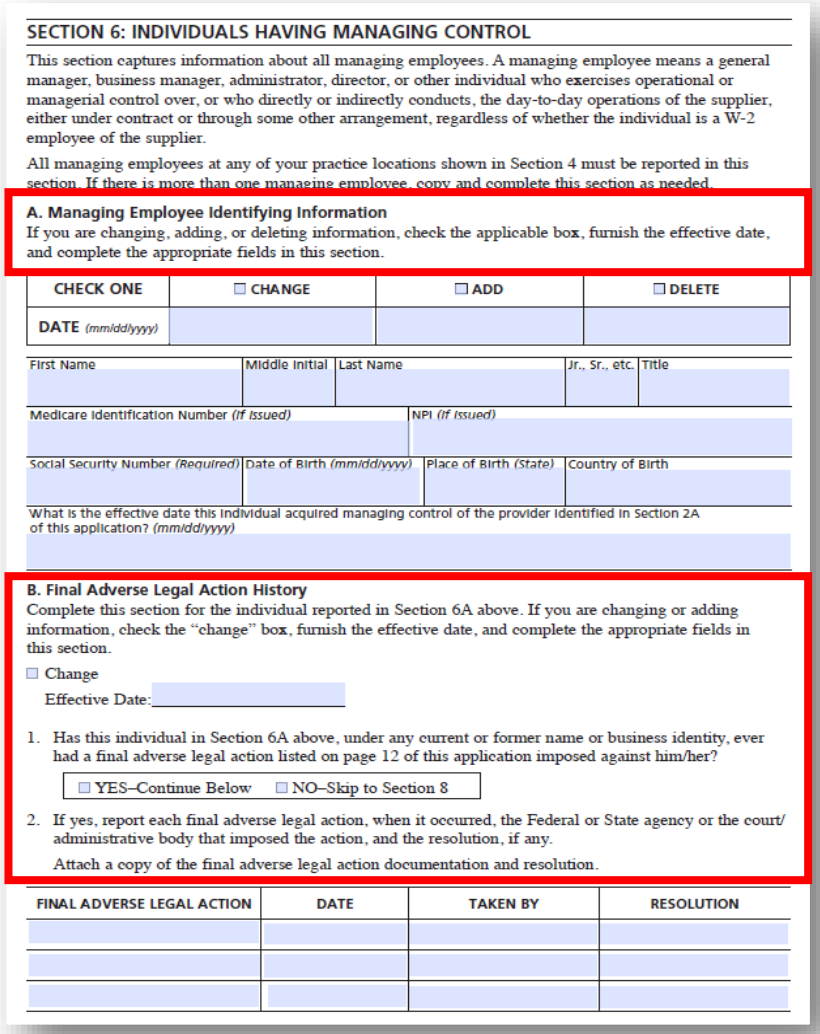
Storage Facility Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

H. Unique Circumstances
Explain any unique circumstances concerning your practice locations or the method by which you render health care services (e.g., you only render services in patients' homes [house calls only]).

- **4G:** Medical Record Storage
  - Complete if patient medical records are stored other than the practice location shown in Section 4C or 4E
  - Address cannot be P.O. Box or Drop Box
- **4H:** Unique Circumstances
  - Example: House Calls

Section 6: Individuals having Managing Control



SECTION 6: INDIVIDUALS HAVING MANAGING CONTROL

This section captures information about all managing employees. A managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operations of the supplier, either under contract or through some other arrangement, regardless of whether the individual is a W-2 employee of the supplier.

All managing employees at any of your practice locations shown in Section 4 must be reported in this section. If there is more than one managing employee, copy and complete this section as needed.

A. Managing Employee Identifying Information
If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

First Name	Middle Initial	Last Name	Jr., Sr., etc.	Title

Medicare Identification Number *(If Issued)*	NPI *(If Issued)*

Social Security Number *(Required)*	Date of Birth *(mm/dd/yyyy)*	Place of Birth *(State)*	Country of Birth

What is the effective date this individual acquired managing control of the provider identified in Section 2A of this application? *(mm/dd/yyyy)*

B. Final Adverse Legal Action History
Complete this section for the individual reported in Section 6A above. If you are changing or adding information, check the "change" box, furnish the effective date, and complete the appropriate fields in this section.

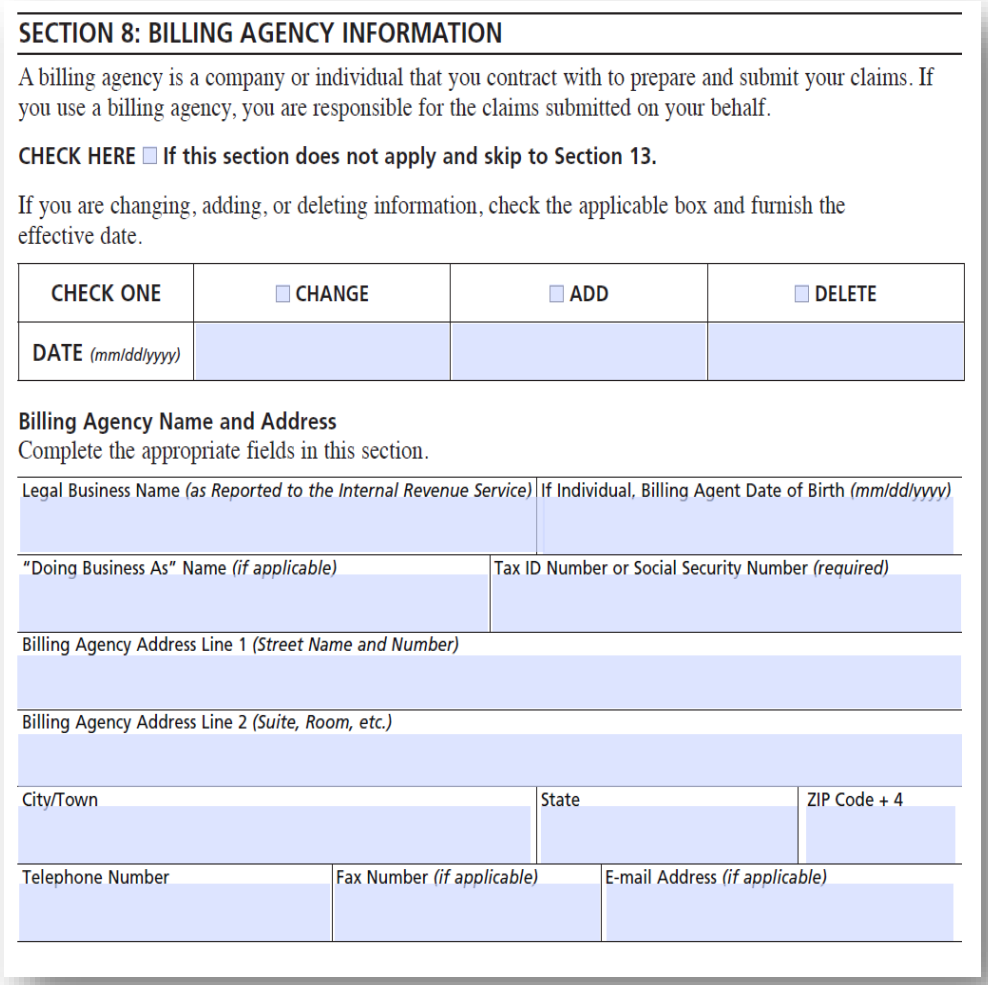
☐ Change
Effective Date:

1. Has this individual in Section 6A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 12 of this application imposed against him/her?
   ☐ YES–Continue Below ☐ NO–Skip to Section 8
2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/ administrative body that imposed the action, and the resolution, if any.
   Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

- **6A:** Managing Employee Identifying Information
  - Complete entire section for each individual with managing control
- **6B:** Final Adverse Legal Action History

Section 8: Billing Agency Information



SECTION 8: BILLING AGENCY INFORMATION

A billing agency is a company or individual that you contract with to prepare and submit your claims. If you use a billing agency, you are responsible for the claims submitted on your behalf.

CHECK HERE ☐ If this section does not apply and skip to Section 13.

If you are changing, adding, or deleting information, check the applicable box and furnish the effective date.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Billing Agency Name and Address

Complete the appropriate fields in this section.

Legal Business Name *(as Reported to the Internal Revenue Service)*		If Individual, Billing Agent Date of Birth *(mm/dd/yyyy)*
"Doing Business As" Name *(if applicable)*		Tax ID Number or Social Security Number *(required)*
Billing Agency Address Line 1 *(Street Name and Number)*		
Billing Agency Address Line 2 *(Suite, Room, etc.)*		
City/Town	State	ZIP Code + 4
Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

- Complete entire section if a billing agency is used

Note: Entities using a billing agency are responsible for claims submitted on their behalf.

Section 13: Contact Person

- Copy and complete entire section for each contact person
- 1st contact person listed will receive acknowledgement notice and be notified if any additional information is needed
- If no contact person is listed, the provider will be contacted directly if any additional information is needed

SECTION 13: CONTACT PERSON

This section captures information regarding the person you would like for us to contact regarding this application. If no one is listed below, we will contact you directly.

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

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

Address Line 1 *(Street Name and Number)*

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

City/Town	State	ZIP Code + 4

Section 14: Penalties for Falsifying Information

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION

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

1. 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. 18 U.S.C. 1035 authorizes criminal penalties against individuals in any matter involving a health care benefit program who knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact; or makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items or services. The individual shall be fined or imprisoned up to 5 years or both.

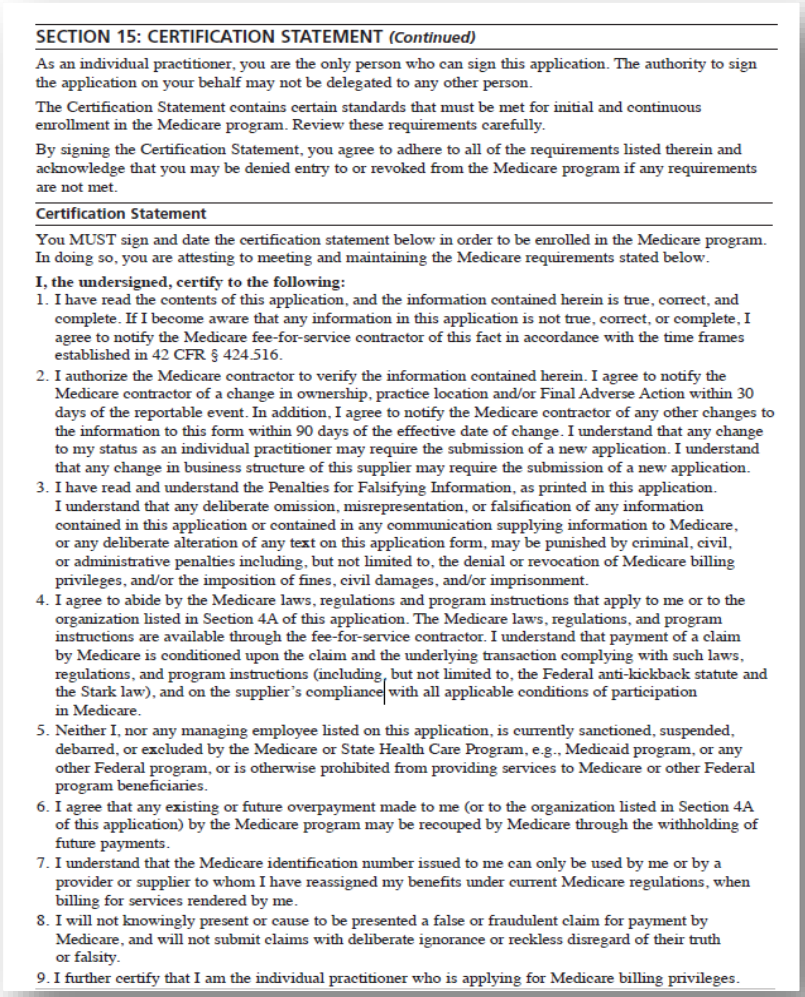
Section 14: Penalties for Falsifying Information (Continued)

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION *(Continued)*

6. 18 U.S.C. 1347 authorizes criminal penalties against individuals who knowing and willfully execute, or attempt, to executive a scheme or artifice to defraud any health care benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by or under the control of any, health care benefit program in connection with the delivery of or payment for health care benefits, items, or services. Individuals shall be fined or imprisoned up to 10 years or both. If the violation results in serious bodily injury, an individual will be fined or imprisoned up to 20 years, or both. If the violation results in death, the individual shall be fined or imprisoned for any term of years or for life, or both.
7. 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.

Section 15: Certification Statement



SECTION 15: CERTIFICATION STATEMENT *(Continued)*

As an individual practitioner, you are the only person who can sign this application. The authority to sign the application on your behalf may not be delegated to any other person.

The Certification Statement contains certain standards that must be met for initial and continuous enrollment in the Medicare program. Review these requirements carefully.

By signing the Certification Statement, you agree to adhere to all of the requirements listed therein and acknowledge that you may be denied entry to or revoked from the Medicare program if any requirements are not met.

Certification Statement

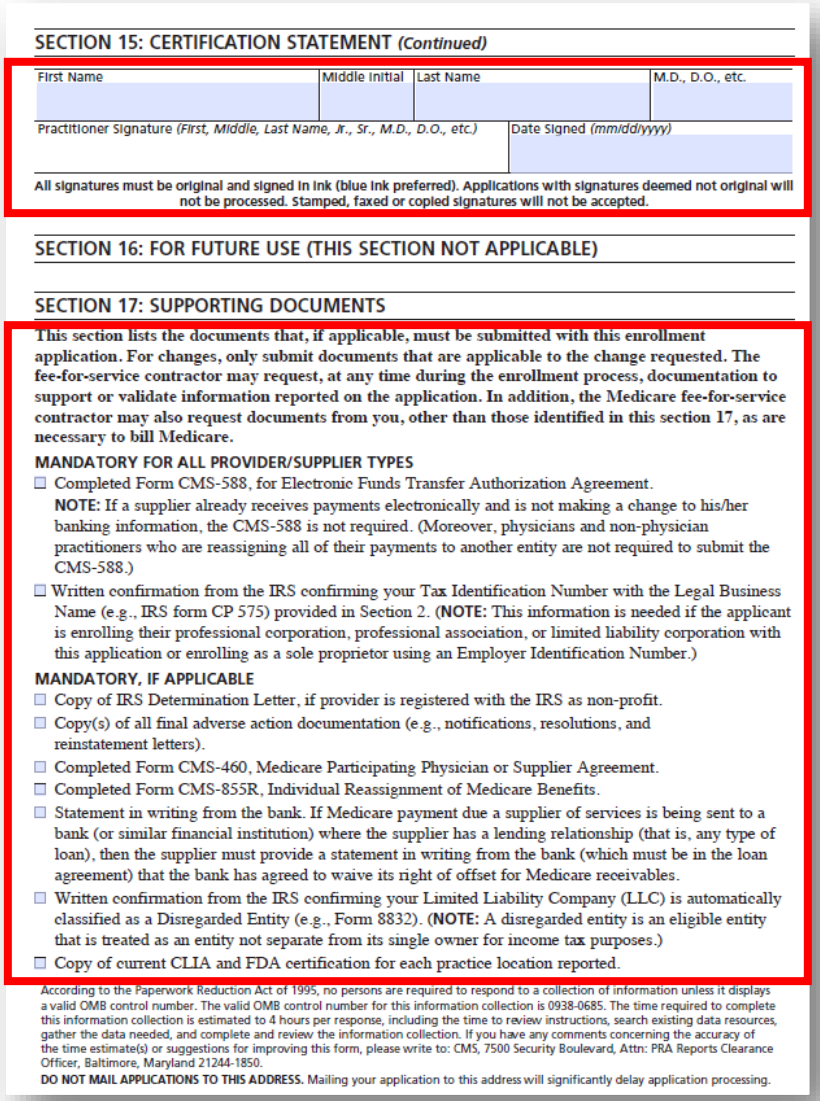
You MUST sign and date the certification statement below in order to be enrolled in the Medicare program. In doing so, you are attesting to meeting and maintaining the Medicare requirements stated below.

I, the undersigned, certify to the following:

1. I have read the contents of this application, and the information contained herein is true, correct, and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare fee-for-service contractor of this fact in accordance with the time frames established in 42 CFR § 424.516.
2. I authorize the Medicare contractor to verify the information contained herein. I agree to notify the Medicare contractor of a change in ownership, practice location and/or Final Adverse Action within 30 days of the reportable event. In addition, I agree to notify the Medicare contractor of any other changes to the information to this form within 90 days of the effective date of change. I understand that any change to my status as an individual practitioner may require the submission of a new application. I understand that any change in business structure of this supplier may require the submission of a new application.
3. 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 privileges, and/or the imposition of fines, civil damages, and/or imprisonment.
4. I agree to abide by the Medicare laws, regulations and program instructions that apply to me or to the organization listed in Section 4A of this application. The Medicare laws, regulations, and program instructions are available through the fee-for-service contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the supplier's compliance with all applicable conditions of participation in Medicare.
5. Neither I, nor any managing employee listed on this application, is currently sanctioned, suspended, debarred, or excluded by the Medicare or State Health Care Program, e.g., Medicaid program, or any other Federal program, or is otherwise prohibited from providing services to Medicare or other Federal program beneficiaries.
6. I agree that any existing or future overpayment made to me (or to the organization listed in Section 4A of this application) by the Medicare program may be recouped by Medicare through the withholding of future payments.
7. I understand that the Medicare identification number issued to me can only be used by me or by a provider or supplier to whom I have reassigned my benefits under current Medicare regulations, when billing for services rendered by me.
8. 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.
9. I further certify that I am the individual practitioner who is applying for Medicare billing privileges.

- By signing the form the individual provider agrees to adhere to the requirements listed

Section 15: Certification Statement



SECTION 15: CERTIFICATION STATEMENT *(Continued)*

First Name	Middle Initial	Last Name	M.D., D.O., etc.

Practitioner Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)* | Date Signed *(mm/dd/yyyy)*

All signatures must be original and signed in ink (blue ink preferred). Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

SECTION 16: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 17: SUPPORTING DOCUMENTS

This section lists the documents that, if applicable, must be submitted with this enrollment application. For changes, only submit documents that are applicable to the change requested. The fee-for-service contractor may request, at any time during the enrollment process, documentation to support or validate information reported on the application. In addition, the Medicare fee-for-service contractor may also request documents from you, other than those identified in this section 17, as are necessary to bill Medicare.

MANDATORY FOR ALL PROVIDER/SUPPLIER TYPES

- ☐ Completed Form CMS-588, for Electronic Funds Transfer Authorization Agreement.
  NOTE: If a supplier already receives payments electronically and is not making a change to his/her banking information, the CMS-588 is not required. (Moreover, physicians and non-physician practitioners who are reassigning all of their payments to another entity are not required to submit the CMS-588.)
- ☐ Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name (e.g., IRS form CP 575) provided in Section 2. (**NOTE:** This information is needed if the applicant is enrolling their professional corporation, professional association, or limited liability corporation with this application or enrolling as a sole proprietor using an Employer Identification Number.)

MANDATORY, IF APPLICABLE

- ☐ Copy of IRS Determination Letter, if provider is registered with the IRS as non-profit.
- ☐ Copy(s) of all final adverse action documentation (e.g., notifications, resolutions, and reinstatement letters).
- ☐ Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement.
- ☐ Completed Form CMS-855R, Individual Reassignment of Medicare Benefits.
- ☐ Statement in writing from the bank. If Medicare payment due a supplier of services is being sent to a bank (or similar financial institution) where the supplier has a lending relationship (that is, any type of loan), then the supplier must provide a statement in writing from the bank (which must be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.
- ☐ Written confirmation from the IRS confirming your Limited Liability Company (LLC) is automatically classified as a Disregarded Entity (e.g., Form 8832). (**NOTE:** A disregarded entity is an eligible entity that is treated as an entity not separate from its single owner for income tax purposes.)
- ☐ Copy of current CLIA and FDA certification for each practice location reported.

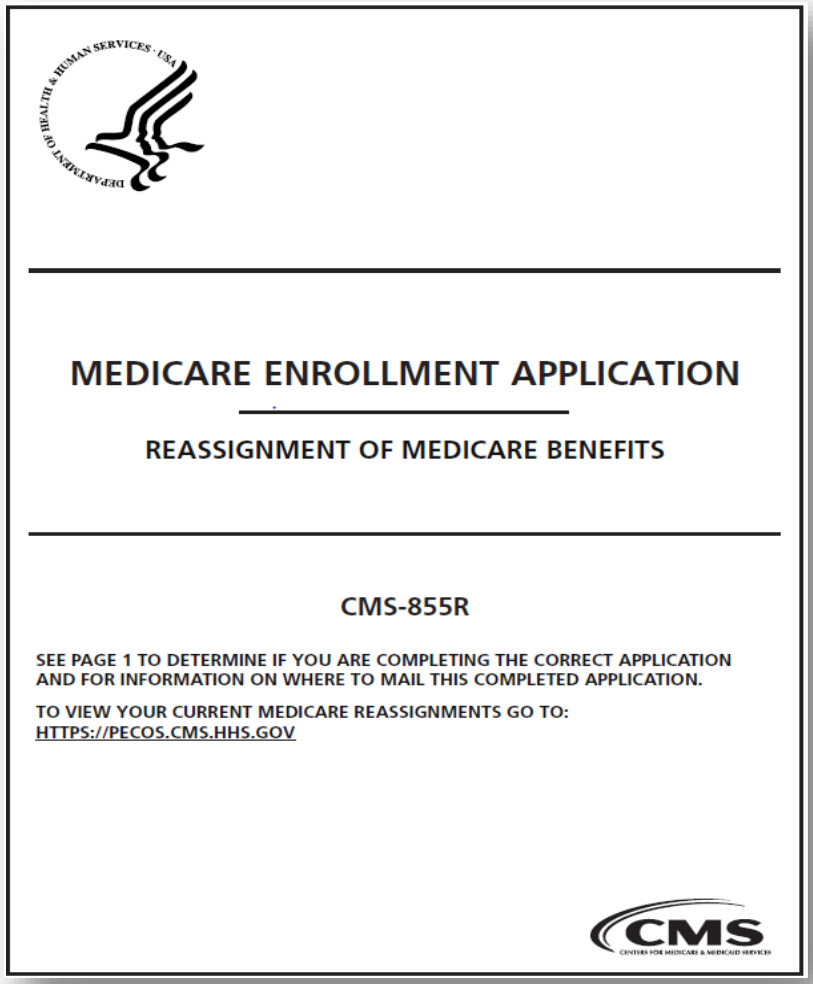
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0685. The time required to complete this information collection is estimated to 4 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

DO NOT MAIL APPLICATIONS TO THIS ADDRESS. Mailing your application to this address will significantly delay application processing.

- Signed only by the individual provider
- Paper: Must be original signature in ink if submitting a paper certification statement
- Web: Can submit e-signatures

Section 17: Supporting Documentation

Getting Started: CMS-855R Application



MEDICARE ENROLLMENT APPLICATION

REASSIGNMENT OF MEDICARE BENEFITS

CMS-855R

SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION AND FOR INFORMATION ON WHERE TO MAIL THIS COMPLETED APPLICATION.

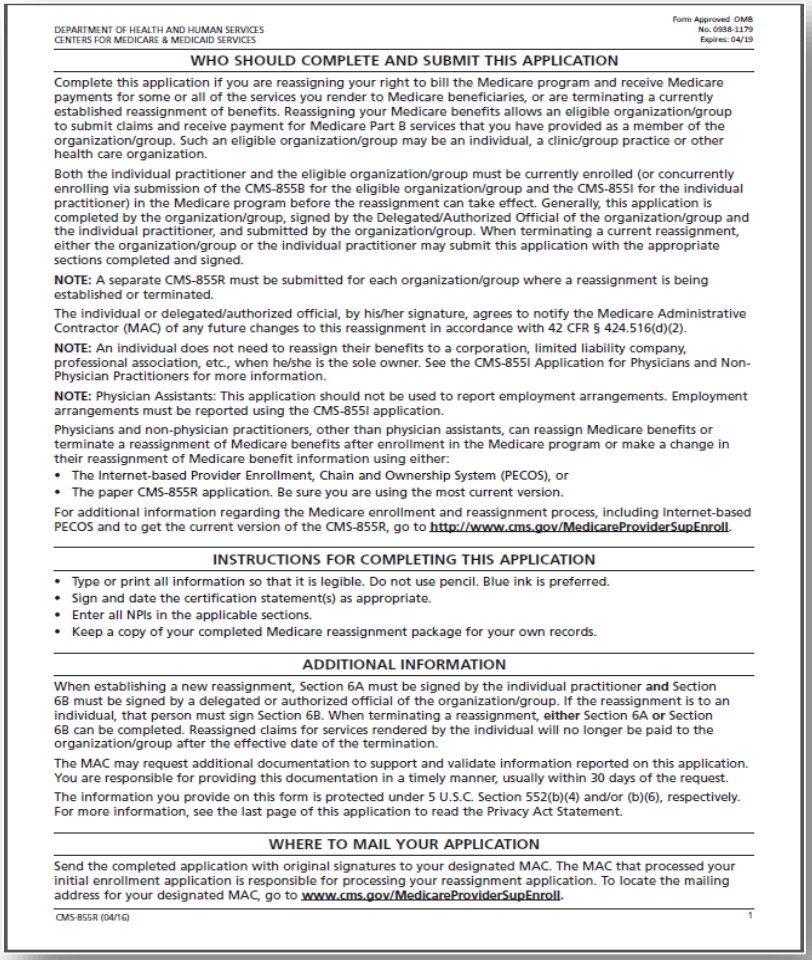
TO VIEW YOUR CURRENT MEDICARE REASSIGNMENTS GO TO:
HTTPS://PECOS.CMS.HHS.GOV

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

https://www.cms.gov/Medicare/CMS-Forms/CMSForms/Downloads/cms855r.pdf

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Who should complete this application?



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved OMB
No. 0938-1179
Expires: 04/19

WHO SHOULD COMPLETE AND SUBMIT THIS APPLICATION

Complete this application if you are reassigning your right to bill the Medicare program and receive Medicare payments for some or all of the services you render to Medicare beneficiaries, or are terminating a currently established reassignment of benefits. Reassigning your Medicare benefits allows an eligible organization/group to submit claims and receive payment for Medicare Part B services that you have provided as a member of the organization/group. Such an eligible organization/group may be an individual, a clinic/group practice or other health care organization.

Both the individual practitioner and the eligible organization/group must be currently enrolled (or concurrently enrolling via submission of the CMS-855B for the eligible organization/group and the CMS-855I for the individual practitioner) in the Medicare program before the reassignment can take effect. Generally, this application is completed by the organization/group, signed by the Delegated/Authorized Official of the organization/group and the individual practitioner, and submitted by the organization/group. When terminating a current reassignment, either the organization/group or the individual practitioner may submit this application with the appropriate sections completed and signed.

NOTE: A separate CMS-855R must be submitted for each organization/group where a reassignment is being established or terminated.

The individual or delegated/authorized official, by his/her signature, agrees to notify the Medicare Administrative Contractor (MAC) of any future changes to this reassignment in accordance with 42 CFR § 424.516(d)(2).

NOTE: An individual does not need to reassign their benefits to a corporation, limited liability company, professional association, etc., when he/she is the sole owner. See the CMS-855I Application for Physicians and Non-Physician Practitioners for more information.

NOTE: Physician Assistants: This application should not be used to report employment arrangements. Employment arrangements must be reported using the CMS-855I application.

Physicians and non-physician practitioners, other than physician assistants, can reassign Medicare benefits or terminate a reassignment of Medicare benefits after enrollment in the Medicare program or make a change in their reassignment of Medicare benefit information using either:

- The Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or
- The paper CMS-855R application. Be sure you are using the most current version.

For additional information regarding the Medicare enrollment and reassignment process, including Internet-based PECOS and to get the current version of the CMS-855R, go to **http://www.cms.gov/MedicareProviderSupEnroll**.

INSTRUCTIONS FOR COMPLETING THIS APPLICATION

- Type or print all information so that it is legible. Do not use pencil. Blue ink is preferred.
- Sign and date the certification statement(s) as appropriate.
- Enter all NPIs in the applicable sections.
- Keep a copy of your completed Medicare reassignment package for your own records.

ADDITIONAL INFORMATION

When establishing a new reassignment, Section 6A must be signed by the individual practitioner **and** Section 6B must be signed by a delegated or authorized official of the organization/group. If the reassignment is to an individual, that person must sign Section 6B. When terminating a reassignment, **either** Section 6A **or** Section 6B can be completed. Reassigned claims for services rendered by the individual will no longer be paid to the organization/group after the effective date of the termination.

The MAC may request additional documentation to support and validate information reported on this application. You are responsible for providing this documentation in a timely manner, usually within 30 days of the request.

The information you provide on this form is protected under 5 U.S.C. Section 552(b)(4) and/or (b)(6), respectively. For more information, see the last page of this application to read the Privacy Act Statement.

WHERE TO MAIL YOUR APPLICATION

Send the completed application with original signatures to your designated MAC. The MAC that processed your initial enrollment application is responsible for processing your reassignment application. To locate the mailing address for your designated MAC, go to **www.cms.gov/MedicareProviderSupEnroll**.

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- All individuals (physicians and NPPs) currently enrolled; except Physician Assistants
- All individuals (physician and NPPs) who reassign benefits; except Physician Assistants

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Section 1: Basic Information

- Check the applicable box, specify the effective date, and complete the required sections

SECTION 1: BASIC INFORMATION

REASON FOR SUBMITTING THIS APPLICATION

Check the applicable box and complete the required sections.

☐ You are enrolling or are currently enrolled in Medicare and will be reassigning your benefits	Effective Date *(mm/dd/yyyy)*:	**Complete all sections**
☐ You are an individual practitioner terminating a reassignment with an organization/group	Effective Date *(mm/dd/yyyy)*:	Complete sections **1, 2, 3, 5,** and **6A**
☐ You are the organization/group terminating a reassignment with an individual	Effective Date *(mm/dd/yyyy)*:	Complete sections **1, 2, 3, 5,** and **6B**

Section 2: Organization/Group Receiving The Reassigned Benefits

SECTION 2: ORGANIZATION/GROUP RECEIVING THE REASSIGNED BENEFITS

Organization/Group Identification

Provide the information below for the organization/group to whom benefits are being reassigned, or a reassignment is being terminated. If the organization/group's initial enrollment application is being submitted concurrently with this reassignment application, write "pending" in the Medicare identification number block. The organization/group's name as reported to the IRS must be the same as reported on the organization/group's CMS-855B when it enrolled.

Organization/Group Legal Business Name *(as Reported to the Internal Revenue Service)*		
Tax Identification Number (TIN)	Medicare Identification Number (PTAN) *(if issued)*	National Provider Identifier (NPI)

Section 3: Individual Practitioner Who Is Reassigning Benefits

- Information shall match the social security record and/or NPPES Registry exactly

SECTION 3: INDIVIDUAL PRACTITIONER WHO IS REASSIGNING BENEFITS

Individual Practitioner Identification

Provide the information below for the individual practitioner who will be reassigning his/her benefits, or who will be terminating a reassignment. If the individual's initial enrollment application is being submitted concurrently with this reassignment application, write "pending" in the Medicare identification number block.

First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.

Social Security Number (SSN)	Medicare Identification Number (PTAN) *(if issued)*	National Provider Identifier (NPI)

Section 4: Primary Practice Location (Optional)

- Enter the primary practice location of the organization/group where the individual practitioner will render services most of the time
- Practice location must be currently enrolled or enrolling in Medicare

SECTION 4: PRIMARY PRACTICE LOCATION (Optional)

Primary Practice Location

Identify the primary practice location of the organization/group where the individual practitioner will render services most of the time. This practice location must be currently enrolled or enrolling in Medicare.

Practice Location Name *("Doing Business As" Name)*		
Practice Location Address Line 1 *(Street Name and Number)*		
Practice Location Address Line 2 *(Suite, Room, Apt. #, etc.)*		
City/Town	State	ZIP Code +4
PTAN for this location *(if different than PTAN reported in Section 2)*	NPI for this location *(if different than NPI reported in Section 2)*	

Section 5: Contact Person Information

- Complete entire section for each contact person
- 1st contact person listed will receive acknowledgement notice and be notified if any additional information is needed
- If no contact person is listed, the provider will be contacted if any additional information is needed

SECTION 5: CONTACT PERSON INFORMATION (Optional)

If questions arise during the processing of this reassignment, the designated MAC will contact the individual indicated below. If a contact person is not furnished, the MAC will contact the individual practitioner is Section 3.

First Name	Middle Initial	Last Name	Jr., Sr., M.D., etc.

Contact Person Address Line 1 *(Street Name And Number)*

Contact Person Address Line 2 *(Suite, Room, Apt. #, etc.)*

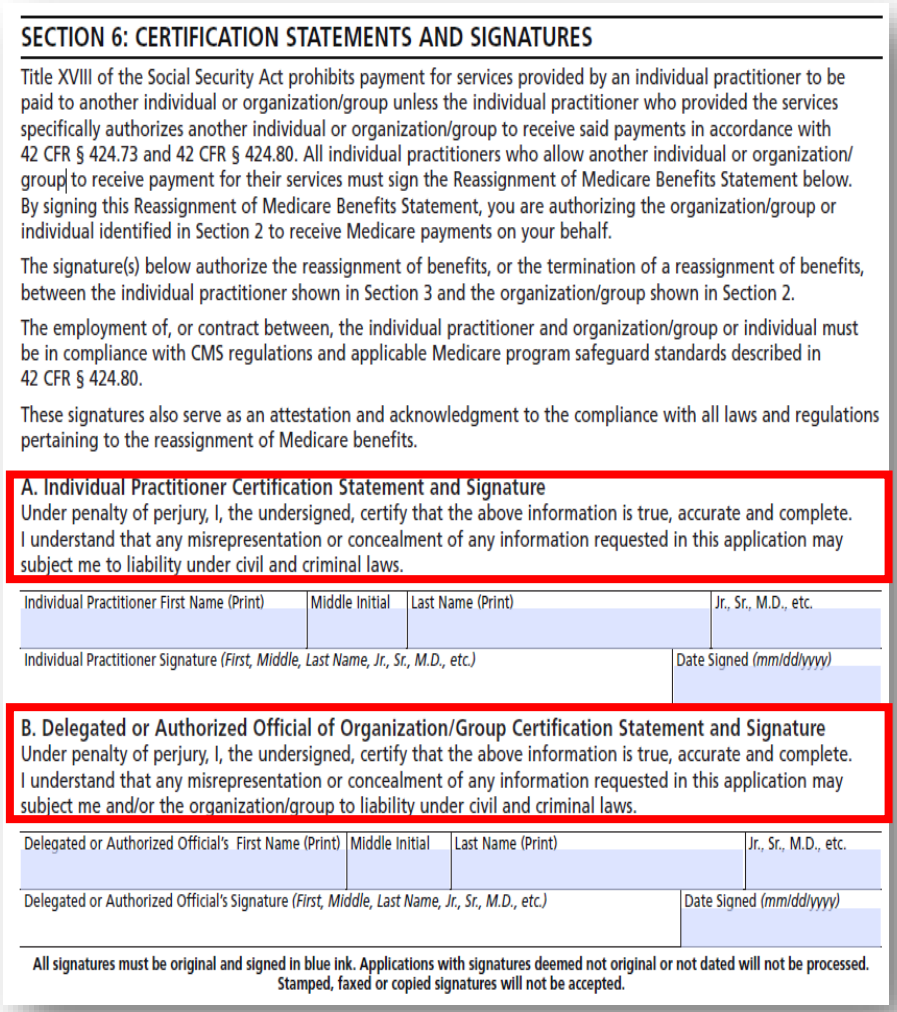
City/Town	State	ZIP Code +4

Telephone Number	Fax Number *(if applicable)*	Email Address *(if applicable)*

Relationship or Affiliation to Individual or Organization/Group *(Spouse, Secretary, Attorney, Billing Agent, etc.)*

NOTE: The Contact Person listed in this section will only be authorized to discuss issues concerning this reassignment. The designated MAC will not discuss any other Medicare issues about the organization/group or individual practitioner beyond this reassignment application with the above Contact Person.

Section 6: Certification Statements and Signatures



SECTION 6: CERTIFICATION STATEMENTS AND SIGNATURES

Title XVIII of the Social Security Act prohibits payment for services provided by an individual practitioner to be paid to another individual or organization/group unless the individual practitioner who provided the services specifically authorizes another individual or organization/group to receive said payments in accordance with 42 CFR § 424.73 and 42 CFR § 424.80. All individual practitioners who allow another individual or organization/group to receive payment for their services must sign the Reassignment of Medicare Benefits Statement below. By signing this Reassignment of Medicare Benefits Statement, you are authorizing the organization/group or individual identified in Section 2 to receive Medicare payments on your behalf.

The signature(s) below authorize the reassignment of benefits, or the termination of a reassignment of benefits, between the individual practitioner shown in Section 3 and the organization/group shown in Section 2.

The employment of, or contract between, the individual practitioner and organization/group or individual must be in compliance with CMS regulations and applicable Medicare program safeguard standards described in 42 CFR § 424.80.

These signatures also serve as an attestation and acknowledgment to the compliance with all laws and regulations pertaining to the reassignment of Medicare benefits.

A. Individual Practitioner Certification Statement and Signature
Under penalty of perjury, I, the undersigned, certify that the above information is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws.

Individual Practitioner First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.

Individual Practitioner Signature *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*	Date Signed *(mm/dd/yyyy)*

B. Delegated or Authorized Official of Organization/Group Certification Statement and Signature
Under penalty of perjury, I, the undersigned, certify that the above information is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me and/or the organization/group to liability under civil and criminal laws.

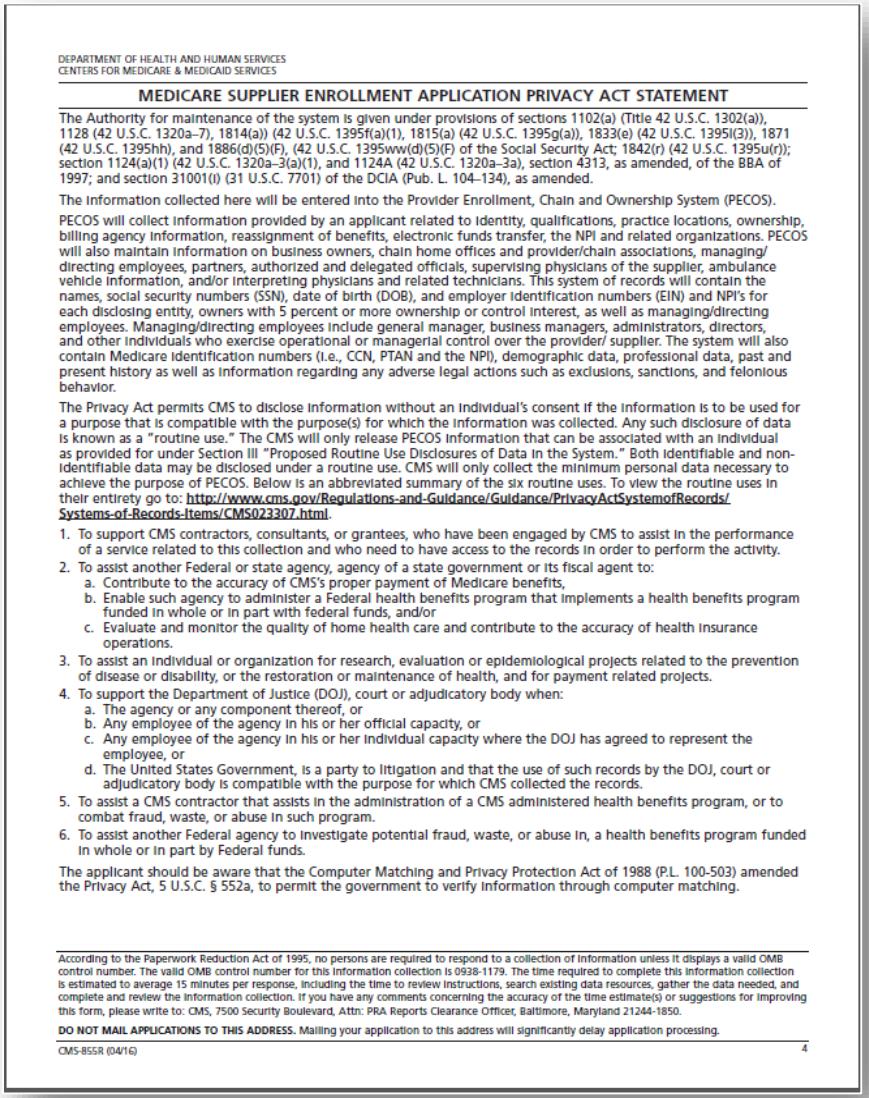
Delegated or Authorized Official's First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.

Delegated or Authorized Official's Signature *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*	Date Signed *(mm/dd/yyyy)*

All signatures must be original and signed in blue ink. Applications with signatures deemed not original or not dated will not be processed. Stamped, faxed or copied signatures will not be accepted.

- To add a new reassignment, both the individual practitioner and the group's AO or DO must sign
- To terminate a reassignment, only one signature is required

Privacy Statement



DEPARTMENT OF HEALTH AND HUMAN SERVICES
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MEDICARE SUPPLIER ENROLLMENT APPLICATION PRIVACY ACT STATEMENT

The Authority for maintenance of the system is given under provisions of sections 1102(a) (Title 42 U.S.C. 1302(a)), 1128 (42 U.S.C. 1320a–7), 1814(a)) (42 U.S.C. 1395f(a)(1), 1815(a) (42 U.S.C. 1395g(a)), 1833(e) (42 U.S.C. 1395l(3)), 1871 (42 U.S.C. 1395hh), and 1886(d)(5)(F), (42 U.S.C. 1395ww(d)(5)(F) of the Social Security Act; 1842(r) (42 U.S.C. 1395u(r)); section 1124(a)(1) (42 U.S.C. 1320a–3(a)(1), and 1124A (42 U.S.C. 1320a–3a), section 4313, as amended, of the BBA of 1997; and section 31001(i) (31 U.S.C. 7701) of the DCIA (Pub. L. 104–134), as amended.

The information collected here will be entered into the Provider Enrollment, Chain and Ownership System (PECOS).

PECOS will collect information provided by an applicant related to identity, qualifications, practice locations, ownership, billing agency information, reassignment of benefits, electronic funds transfer, the NPI and related organizations. PECOS will also maintain information on business owners, chain home offices and provider/chain associations, managing/directing employees, partners, authorized and delegated officials, supervising physicians of the supplier, ambulance vehicle information, and/or interpreting physicians and related technicians. This system of records will contain the names, social security numbers (SSN), date of birth (DOB), and employer identification numbers (EIN) and NPI's for each disclosing entity, owners with 5 percent or more ownership or control interest, as well as managing/directing employees. Managing/directing employees include general manager, business managers, administrators, directors, and other individuals who exercise operational or managerial control over the provider/ supplier. The system will also contain Medicare identification numbers (i.e., CCN, PTAN and the NPI), demographic data, professional data, past and present history as well as information regarding any adverse legal actions such as exclusions, sanctions, and felonious behavior.

The Privacy Act permits CMS to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. Any such disclosure of data is known as a "routine use." The CMS will only release PECOS information that can be associated with an individual as provided for under Section III "Proposed Routine Use Disclosures of Data in the System." Both identifiable and non-identifiable data may be disclosed under a routine use. CMS will only collect the minimum personal data necessary to achieve the purpose of PECOS. Below is an abbreviated summary of the six routine uses. To view the routine uses in their entirety go to: **http://www.cms.gov/Regulations-and-Guidance/Guidance/PrivacyActSystemofRecords/Systems-of-Records-Items/CMS023307.html**.

1. To support CMS contractors, consultants, or grantees, who have been engaged by CMS to assist in the performance of a service related to this collection and who need to have access to the records in order to perform the activity.
2. To assist another Federal or state agency, agency of a state government or its fiscal agent to:
   a. Contribute to the accuracy of CMS's proper payment of Medicare benefits,
   b. Enable such agency to administer a Federal health benefits program that implements a health benefits program funded in whole or in part with federal funds, and/or
   c. Evaluate and monitor the quality of home health care and contribute to the accuracy of health insurance operations.
3. To assist an individual or organization for research, evaluation or epidemiological projects related to the prevention of disease or disability, or the restoration or maintenance of health, and for payment related projects.
4. To support the Department of Justice (DOJ), court or adjudicatory body when:
   a. The agency or any component thereof, or
   b. Any employee of the agency in his or her official capacity, or
   c. Any employee of the agency in his or her individual capacity where the DOJ has agreed to represent the employee, or
   d. The United States Government, is a party to litigation and that the use of such records by the DOJ, court or adjudicatory body is compatible with the purpose for which CMS collected the records.
5. To assist a CMS contractor that assists in the administration of a CMS administered health benefits program, or to combat fraud, waste, or abuse in such program.
6. To assist another Federal agency to investigate potential fraud, waste, or abuse in, a health benefits program funded in whole or in part by Federal funds.

The applicant 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.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1179. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

DO NOT MAIL APPLICATIONS TO THIS ADDRESS. Mailing your application to this address will significantly delay application processing.

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http://www.cms.gov/Regulations-and-Guidance/Guidance/PrivacyActSystemofRecords/Systems-of-Records-Items/CMS023307.html

Questions?