Education Makes the Difference

How to Complete the Medicare CMS-855I Enrollment Application

Presented by

Provider Outreach & Education

and Provider Enrollment

CMS TrailBlazer Health Enterprises, LLC

2007 Part B
TX MS DC DE VA & Indian Health

Welcome

Welcome to the Computer-Based Training (CBT) module for Provider Enrollment.

This presentation was developed by the Provider Outreach and Education Department along with the Provider Enrollment Department in an attempt to assist you with correctly completing the CMS-855I enrollment form the first time.

Revised CMS-855I

On May 1, 2006, the Centers for Medicare & Medicaid Services (CMS) released and implemented a new version of the CMS-855 Medicare enrollment applications (versions 04/06 and 06/06).

The appearance and format of the enrollment applications were revised to help providers accurately complete the applications. Revisions included:

- Larger font and plain language;
- Tips on how to avoid delays;
- Updated instructions to help you know which application to submit;
- Redesigned Section 17.

Is this the correct form for you?

The CMS-855I form is for the following:

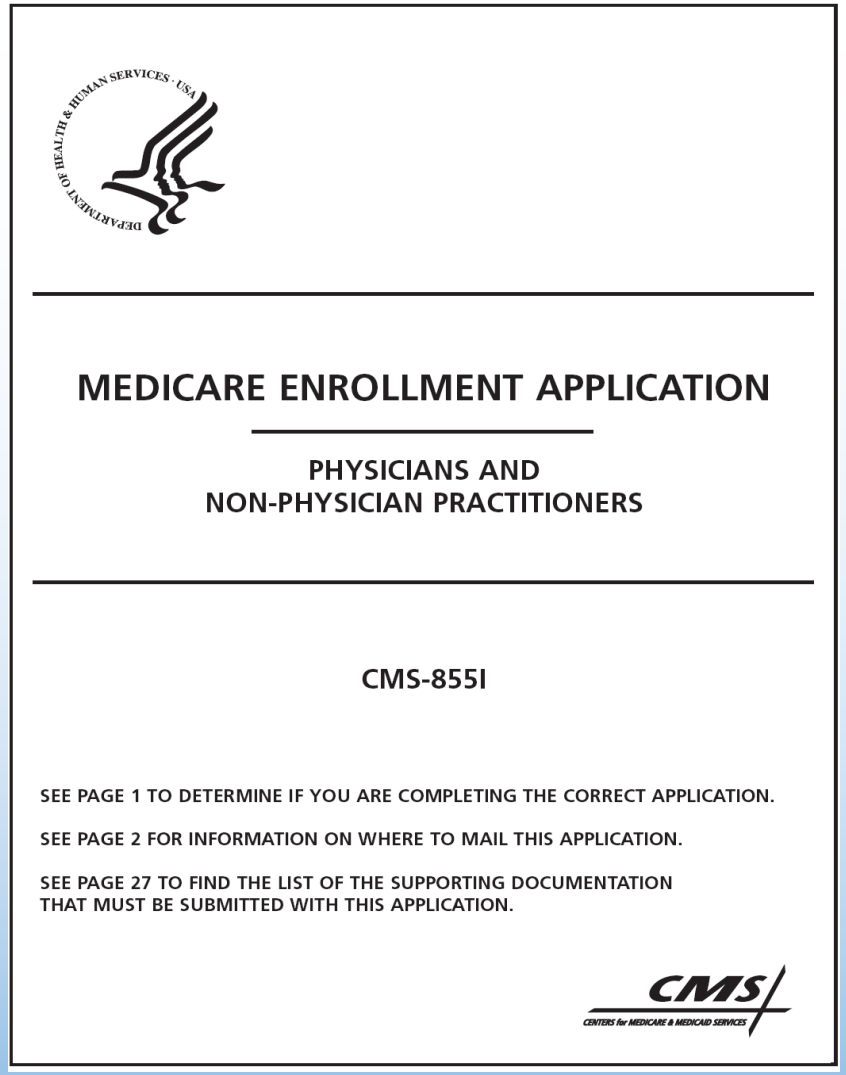
- All Physicians
- Non-Physician Practitioners
  - Anesthesiology Assistant
  - Audiologist
  - Certified nurse midwife
  - Certified registered nurse anesthetist
  - Clinical nurse specialist
  - Clinical social worker
  - Mass immunization roster biller
  - Nurse practitioner
  - Occupational therapist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

Do You Have the CMS-855I Form?

If you do not have the form please take a few minutes to print it. You will use it as a guide throughout this presentation.

The form is located on the CMS Web site at:

www.cms.hhs.gov/cmsforms/downloads/cms855i.pdf



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 27 TO FIND THE LIST OF THE SUPPORTING DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Provider Enrollment Hotline

If after completing the CBT you still have questions, contact the Provider Enrollment Department for your area:

- Texas and Indian Health facilities
  (866) 528-1602

- Virginia
  (866) 697-9670

- DC/Delaware/Maryland
  (866) 828-6254

Significant Changes

Providers are required to submit the new version of the enrollment form and additional information with all initial enrollment applications and changes of information .

Required additional information includes:

- The NPI Notification. (If it was not previously submitted with an application that was processed completely).
- Completed CMS-588 Form (Electronic Funds Transfer (EFT).
- All required documentation necessary to process the enrollment form.

Have You Applied for Your National Provider Identifier (NPI)?

As a Medicare health provider, you should obtain an NPI prior to enrolling in Medicare or before submitting a change of existing enrollment information. The NPI notification must be submitted with the enrollment form.

NPI was mandated by the Health Insurance Portability and Accountability Act. NPI is a 10-digit number that will replace current Medicare identifiers. The NPI will not change and will remain with the provider regardless of job and location changes.

Until testing is complete within the Medicare processing systems, CMS urges providers to continue submitting Medicare fee-for-service claims in one of two ways: **Use your legacy number**, such as your Provider Identification Number (PIN), NSC number, OSCAR number or UPIN; or Use **both** your NPI **and** your legacy number.

The Website of the NPI Enumerator is:
https://nppes.cms.hhs.gov/NPPES/Welcome.do

Electronic Funds Transfer (EFT)

EFT is a way for Medicare to pay providers with a money transfer from bank to bank. This eliminates the need for a provider to wait for a check to be mailed.

CMS requires that providers filing a CMS-855 form have EFT.

The application is to be included with your enrollment form.

The EFT form, CMS-588, is located at:

www.cms.hhs.gov/cmsforms/downloads/CMS588.pdf

Did you know you may not have to complete the entire application?

Not every circumstance requires the CMS-855I to be completed in it's entirety. Those include:

- Voluntarily terminating Medicare enrollment;
- Physician Assistants;
  - complete sections 1, 2, 3, 10, 13 and 15
- Changing information;
  - identifying information
  - adverse legal actions
  - practice location, payment address or record storage
  - individuals having managing control
  - billing agency information.

This CBT will review each section of the CMS-855I form.

Section 1A: Basic Information

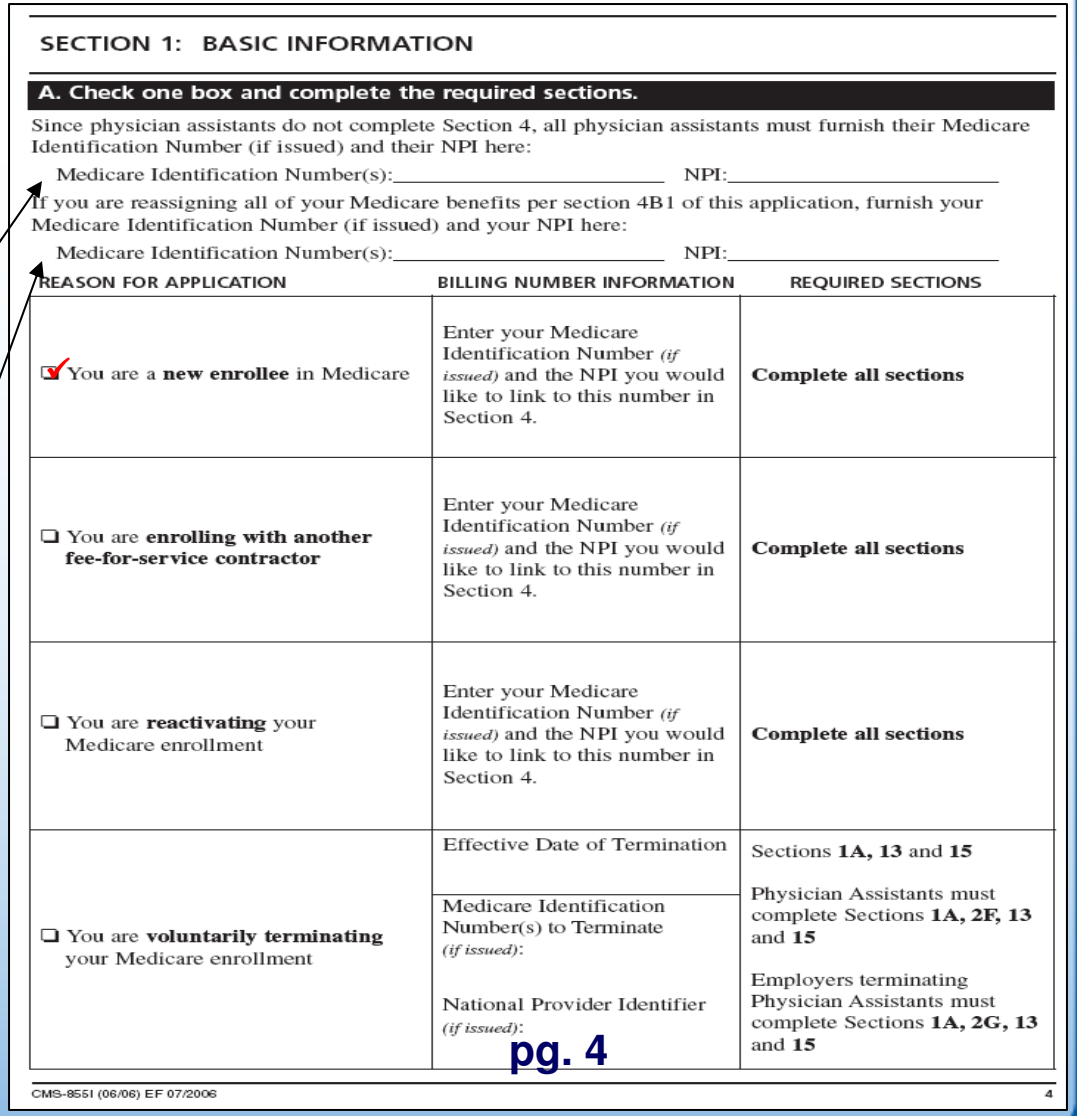
This section captures information about why you are completing the application. It also provides a list of required sections pertaining to your reason.

Find the section that applies to you. Only one reason for application should be checked.

Physician Assistants do not complete Section 4, therefore Medicare and NPI information is reported on this page.

Practitioners reassigning benefits report Medicare and NPI information on this page.

Complete in **blue** or **black ink.**
NO PENCIL



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 NPI here:

Medicare Identification Number(s):_____ NPI:_____

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 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 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 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**

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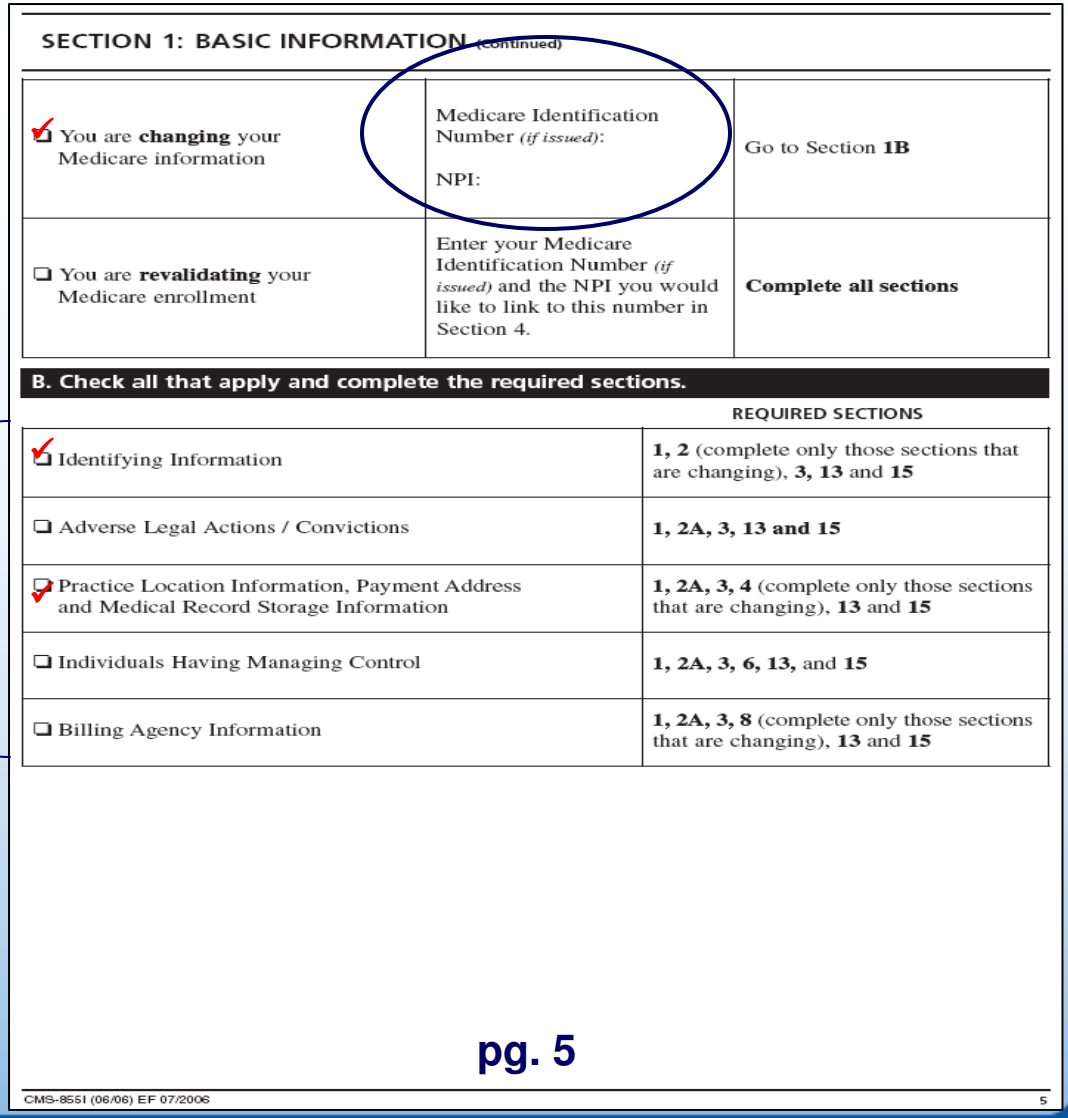
Section 1A & B: Basic Information

Changes of Medicare information must identify any Medicare identification numbers, NPI and complete Section 1B.

If you are reporting a change to your Medicare enrollment information, you will need to complete Section 1B. Check all areas that are being changed.

Read and follow each section required for the change(s) you've selected.



SECTION 1: BASIC INFORMATION (continued)

☑ 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 sections**

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**
☐ Adverse Legal 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**

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Section 2A: Identifying Information

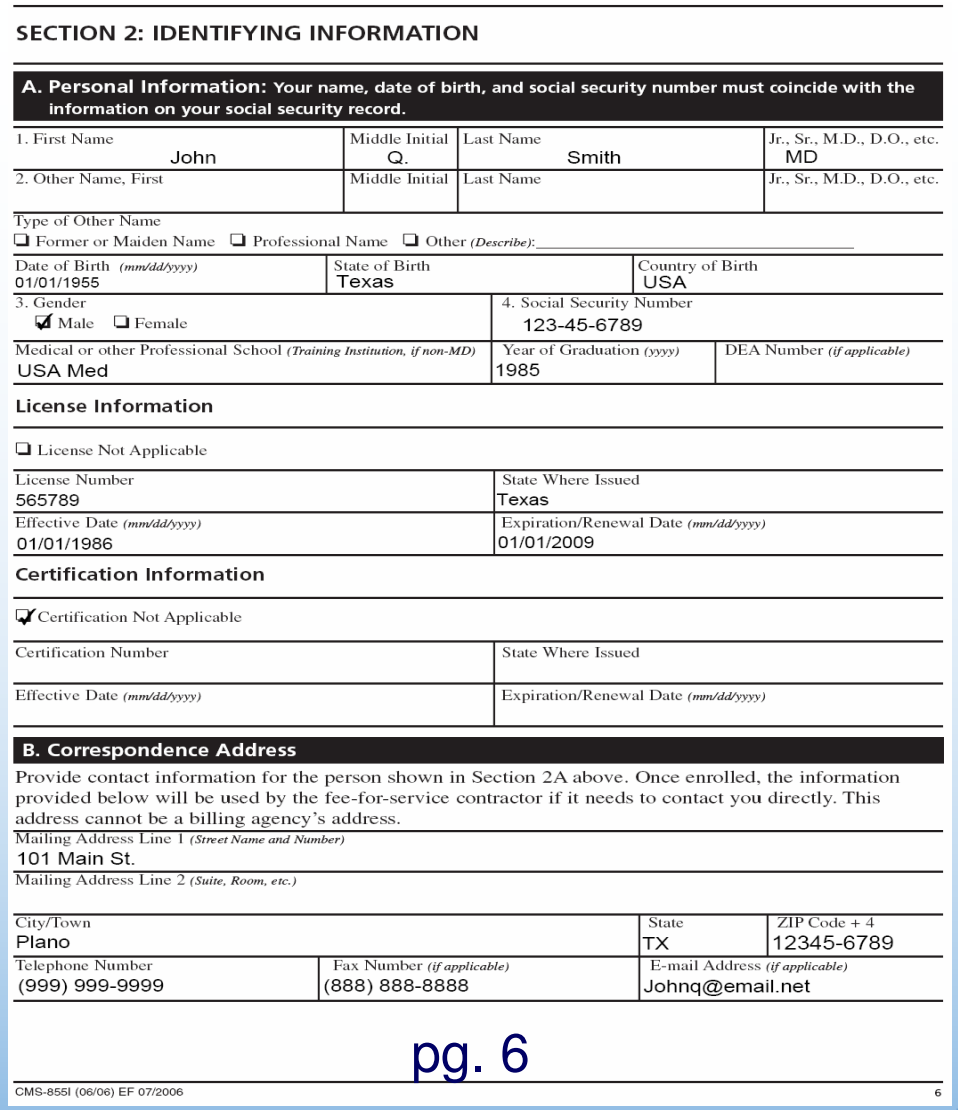
Section 2A is personal information.

The entire section must be completed.

Non-physician practitioners complete the certification information section.

You must check if a State license or certification is not applicable.

Include copies of all licenses and/or certifications.



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.

1. First Name	Middle Initial	Last Name	Jr., Sr., M.D., D.O., etc.
John	Q.	Smith	MD
2. 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
01/01/1955	Texas	USA

3. Gender	4. Social Security Number
☑ Male ☐ Female	123-45-6789

Medical or other Professional School *(Training Institution, if non-MD)*	Year of Graduation *(yyyy)*	DEA Number *(if applicable)*
USA Med	1985	

License Information

☐ License Not Applicable

License Number	State Where Issued
565789	Texas
Effective Date *(mm/dd/yyyy)*	Expiration/Renewal Date *(mm/dd/yyyy)*
01/01/1986	01/01/2009

Certification Information

☑ Certification Not Applicable

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

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)*
101 Main St.

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

City/Town	State	ZIP Code + 4
Plano	TX	12345-6789

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*
(999) 999-9999	(888) 888-8888	Johnq@email.net

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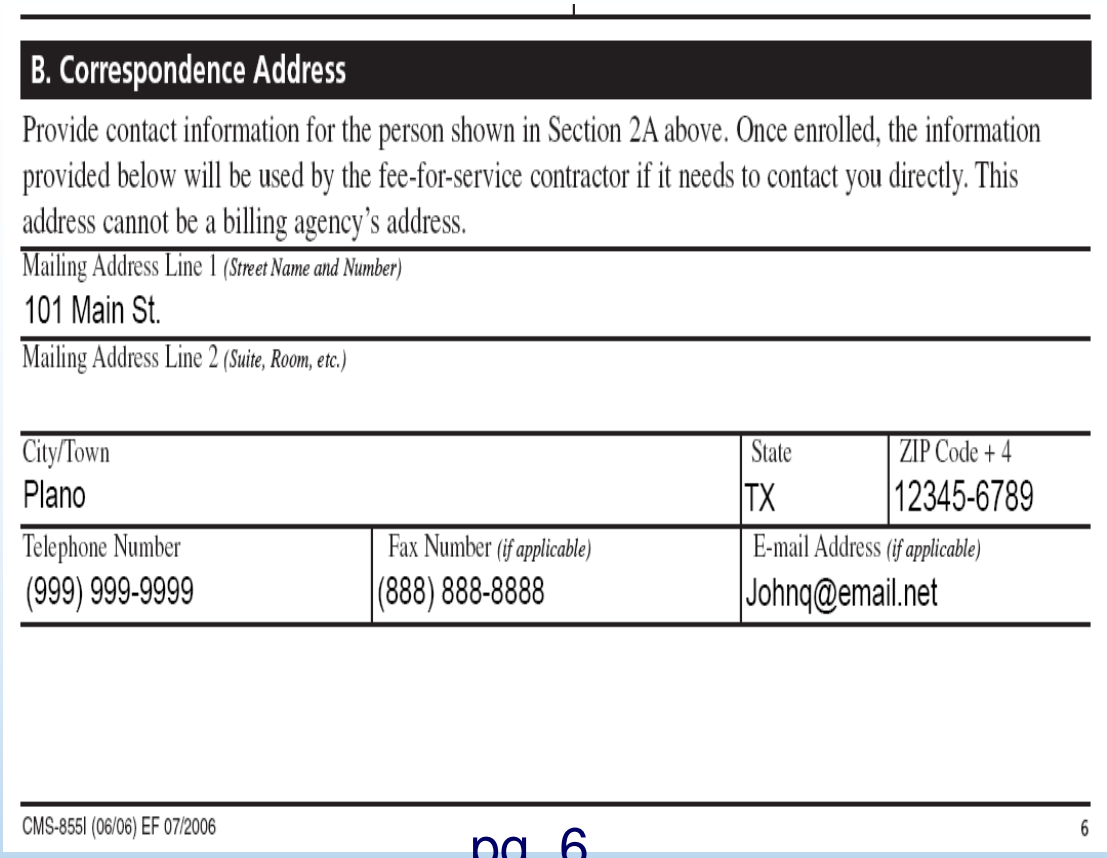
Section 2B: Identifying Information

Section 2B is where the applicant in 2A can be contacted.

This information cannot be a billing agency's address or the provider's representative.



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)*
101 Main St.

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

City/Town	State	ZIP Code + 4
Plano	TX	12345-6789

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*
(999) 999-9999	(888) 888-8888	Johnq@email.net

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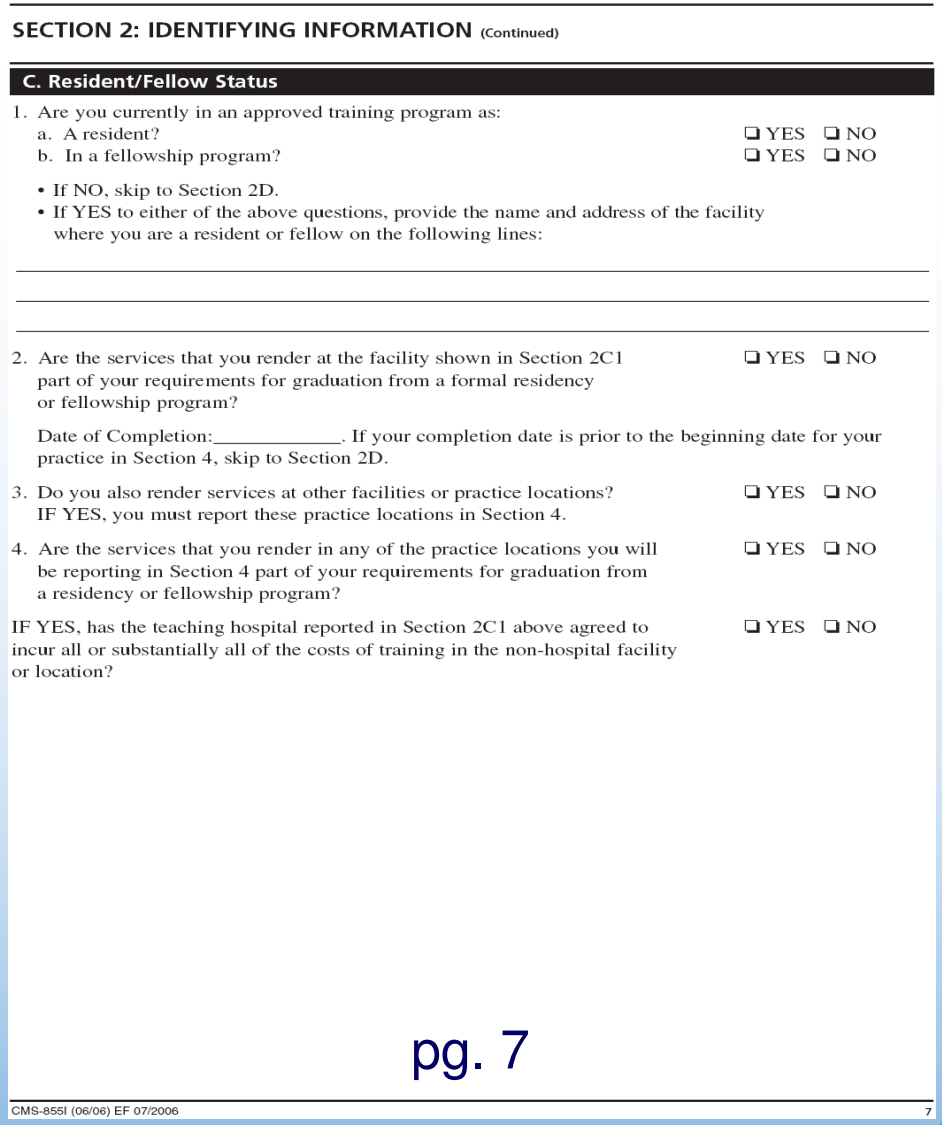
Section 2C: Identifying Information

Physicians are required to complete this section.

If the provider is not a resident or in a fellowship program, check "NO" in 1A and 1B and skip to Section 2D.

If there is a yes answer to these questions, then 2, 3, and 4 must be complete.

The date of completion in question 2 must be furnished



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 or location? ❑ YES ❑ NO

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Section 2D1: - Identifying Information

Designate your **P**rimary and all **S**econdary specialties using a **P** and **S** in the appropriate box.

SECTION 2: IDENTIFYING INFORMATION (Continued)

D. Medical Specialties

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

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

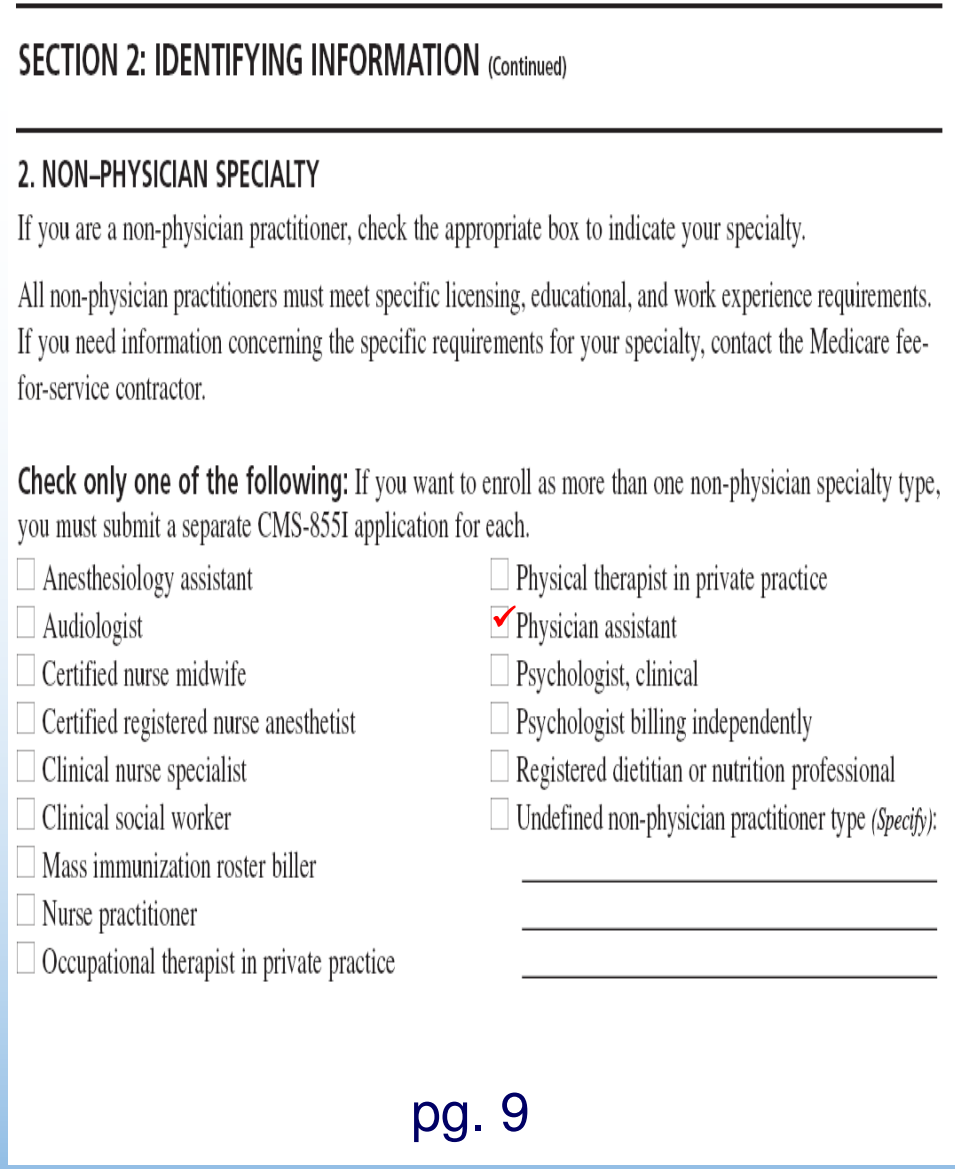
Physicians who bill for diagnostic tests (other than clinical laboratory or pathology tests)– As a physician, you may bill for these diagnostic tests as long as you do not provide a substantial portion of the diagnostic tests to patients who are not your own patients. Patients are considered your own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

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

Section 2D.2: Identifying Information

Section 2D2 is for Non-physician practitioners only. Check only one box.

If enrolling as more than one non-physician specialty type, you must submit a separate CMS-855I application for each



SECTION 2: IDENTIFYING INFORMATION (Continued)

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
- ☐ Undefined non-physician practitioner type *(Specify)*: _____

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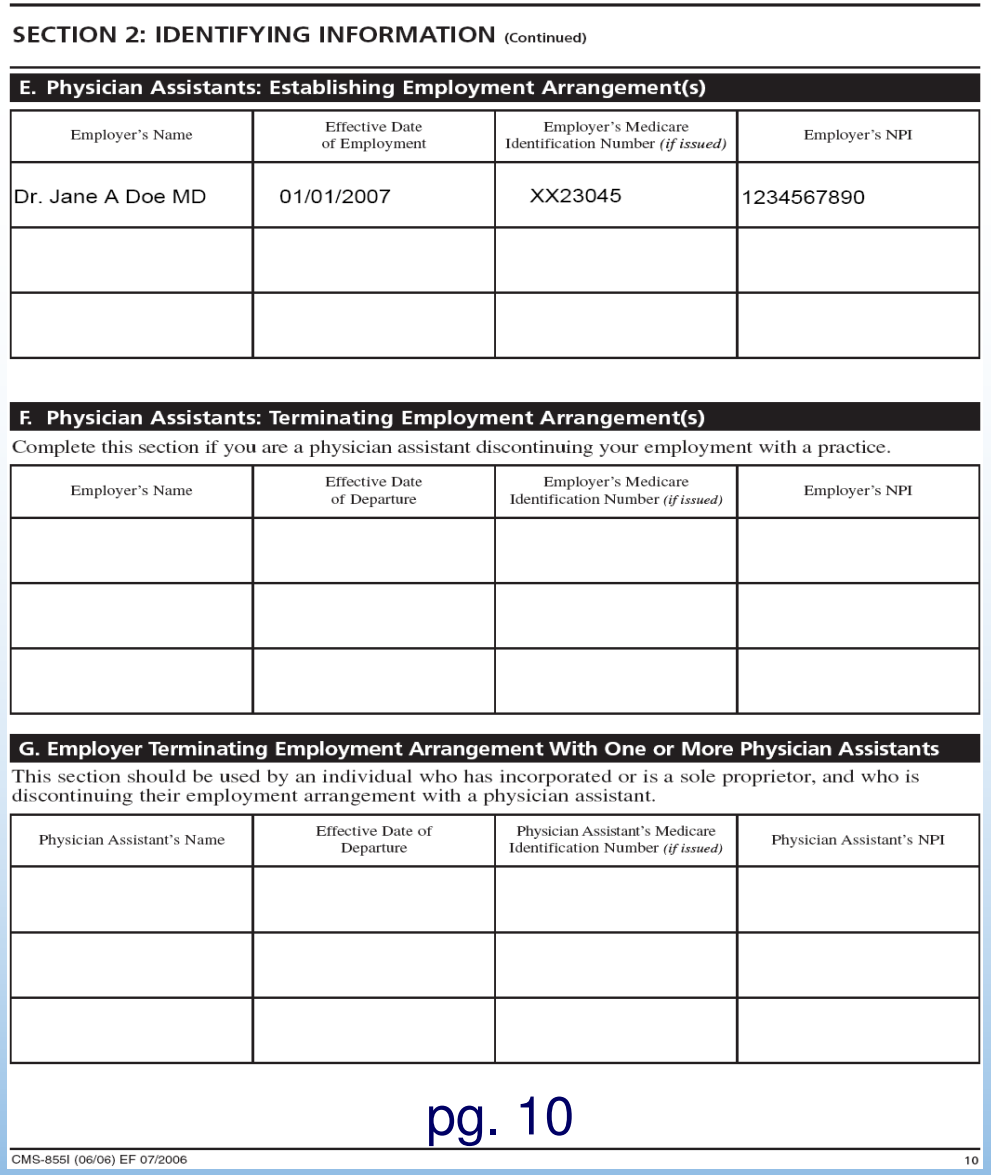
Section 2E,F,G: Identifying Information

Section 2E is to establish employment arrangement for the PA.

Section 2F is to terminate the employment arrangement for the PA.

Section 2G is completed by a sole proprietor or owner wishing
to terminate a PA's employment arrangement.



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
Dr. Jane A Doe MD	01/01/2007	XX23045	1234567890

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 Departure	Employer's Medicare Identification Number *(if issued)*	Employer's NPI

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.

Physician Assistant's Name	Effective Date of Departure	Physician Assistant's Medicare Identification Number *(if issued)*	Physician Assistant's NPI

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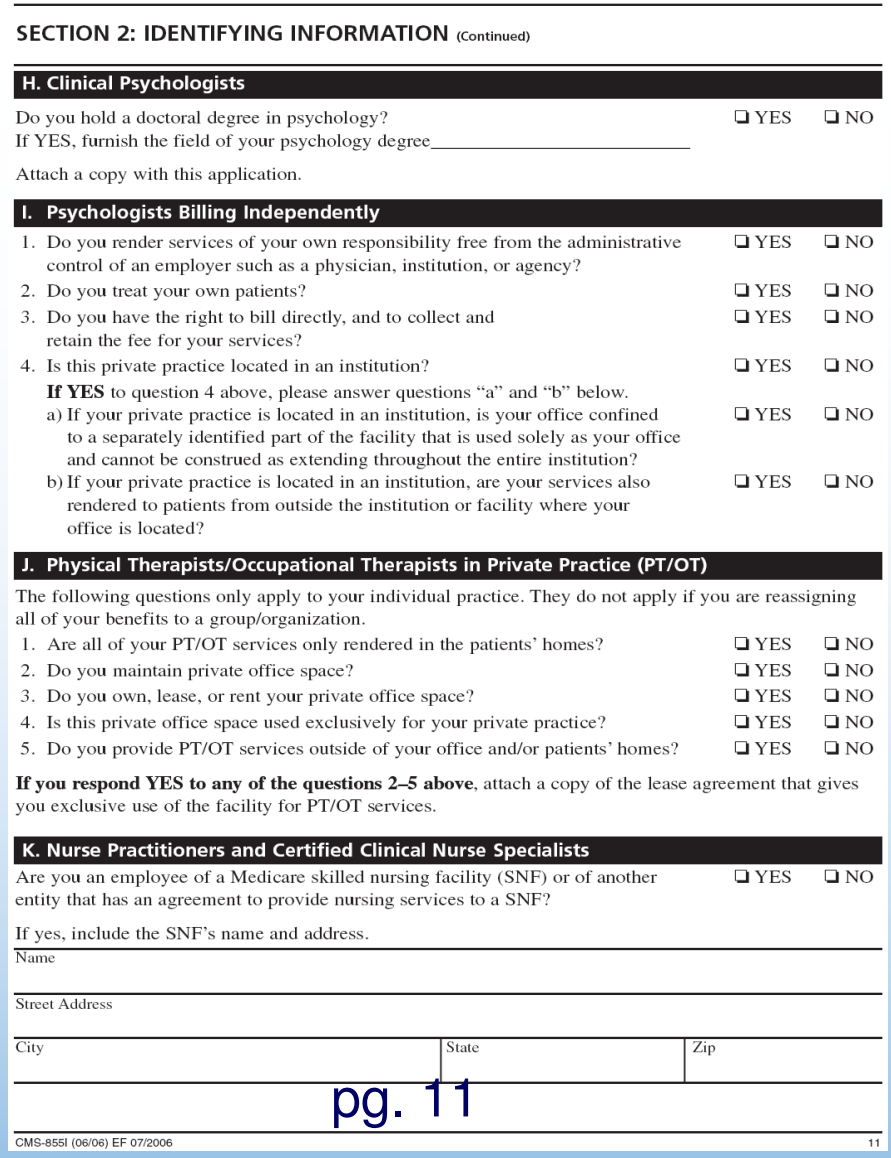
Section 2H,I,J,K: Identifying Information

These sections are to be completed if applicable to your specific specialty.

Physical and Occupational Therapists who are reassigning their benefits do not complete Section 2J.



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 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

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

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Section 3: Adverse Legal Actions

Complete Section 3 for all past or present convictions, exclusions, revocations and suspensions regardless of whether or not the record has been expunged or an appeal is pending. A list of reportable items is provided on page 12.

SECTION 3: ADVERSE LEGAL ACTIONS/CONVICTIONS

This section captures information on adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending. If you are uncertain as to whether a name reported on this application has an adverse legal action, query the Healthcare Integrity and Protection Data Bank. For 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.

ADVERSE LEGAL ACTIONS THAT MUST BE REPORTED

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.

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Section 3: Adverse Legal Actions

You must answer question number one.

If you answer "Yes" to question one you must complete question two and attach all adverse legal documentation.

List the legal action including date, taken by and the resolution.

Your application will be considered incomplete if the information is missing.

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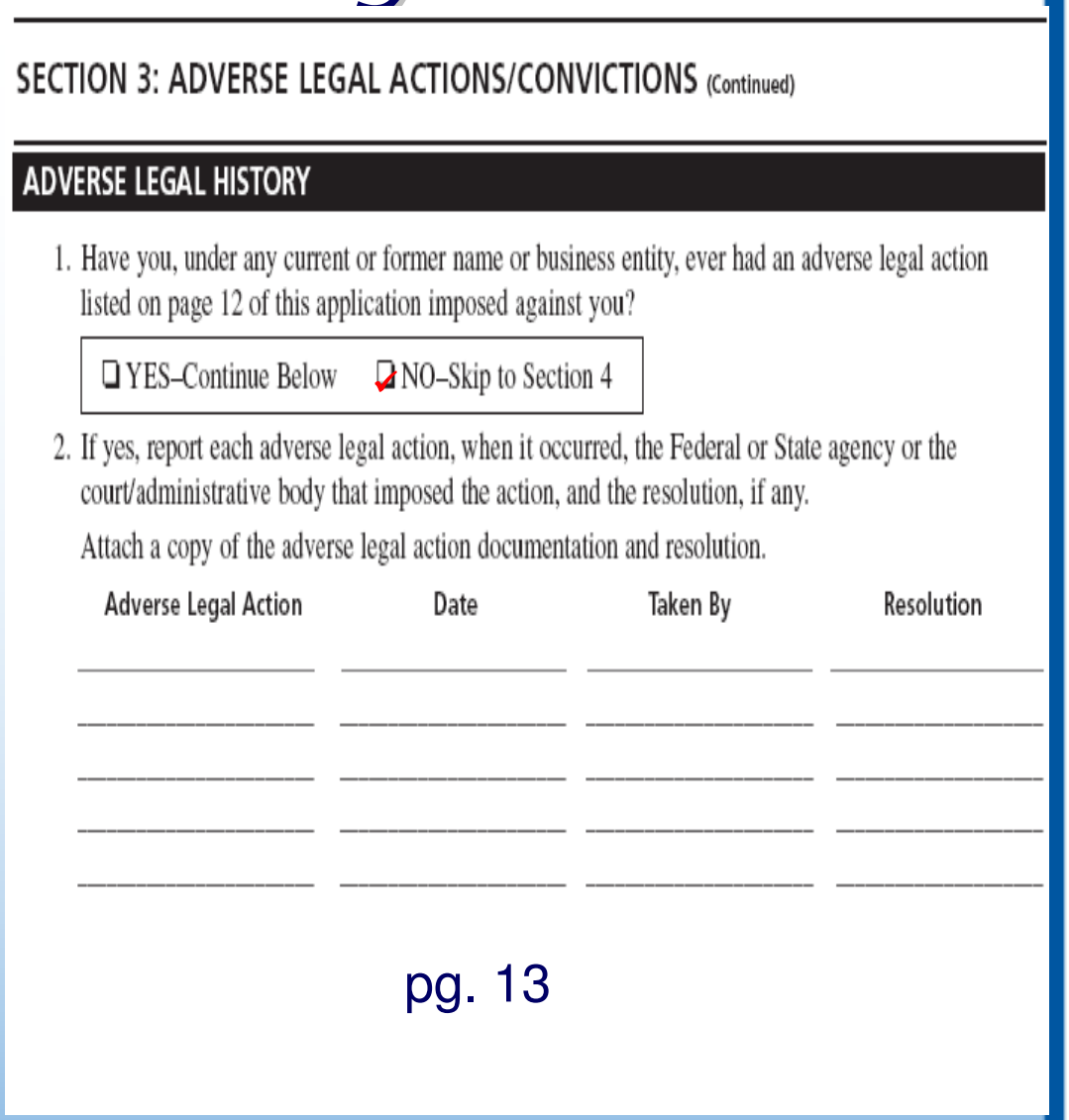

SECTION 3: ADVERSE LEGAL ACTIONS/CONVICTIONS (Continued)

ADVERSE LEGAL HISTORY

1. Have you, under any current or former name or business entity, ever had an 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 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 adverse legal action documentation and resolution.

Adverse Legal Action	Date	Taken By	Resolution

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Section 4A: Practice Location Information

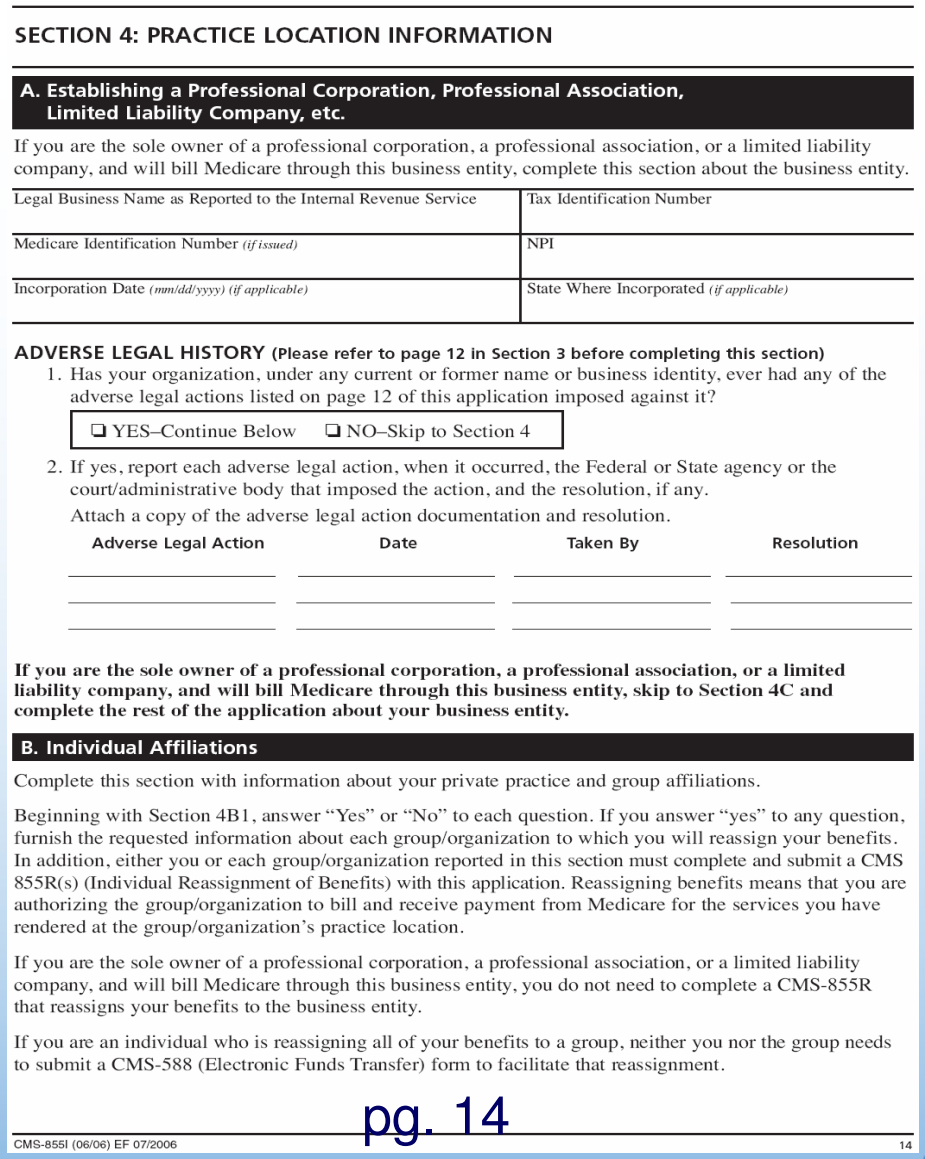
Complete Section 4A **only if** you are the sole owner of a **Professional Corporation, Professional Association** or a **Limited Liability Company** and enrolling using an EIN.

Example: John Q Smith MDPA. A tax document from the IRS (CP-575, tax coupon or letter from the IRS) showing this as your legal business name must be submitted with the application.

You must answer question number one.

If you answer "Yes" to question one you must complete question two.

After completing this section, skip to Section 4C and complete the information about your business entity.



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 about the 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)*

ADVERSE LEGAL HISTORY (Please refer to page 12 in Section 3 before completing this section)

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

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

2. If yes, report each 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 adverse legal action documentation and resolution.

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, skip to Section 4C and complete the rest of the application about your business entity.

B. Individual Affiliations

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

Beginning with Section 4B1, answer "Yes" or "No" to each question. If you answer "yes" to any question, 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 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 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) form to facilitate that reassignment.

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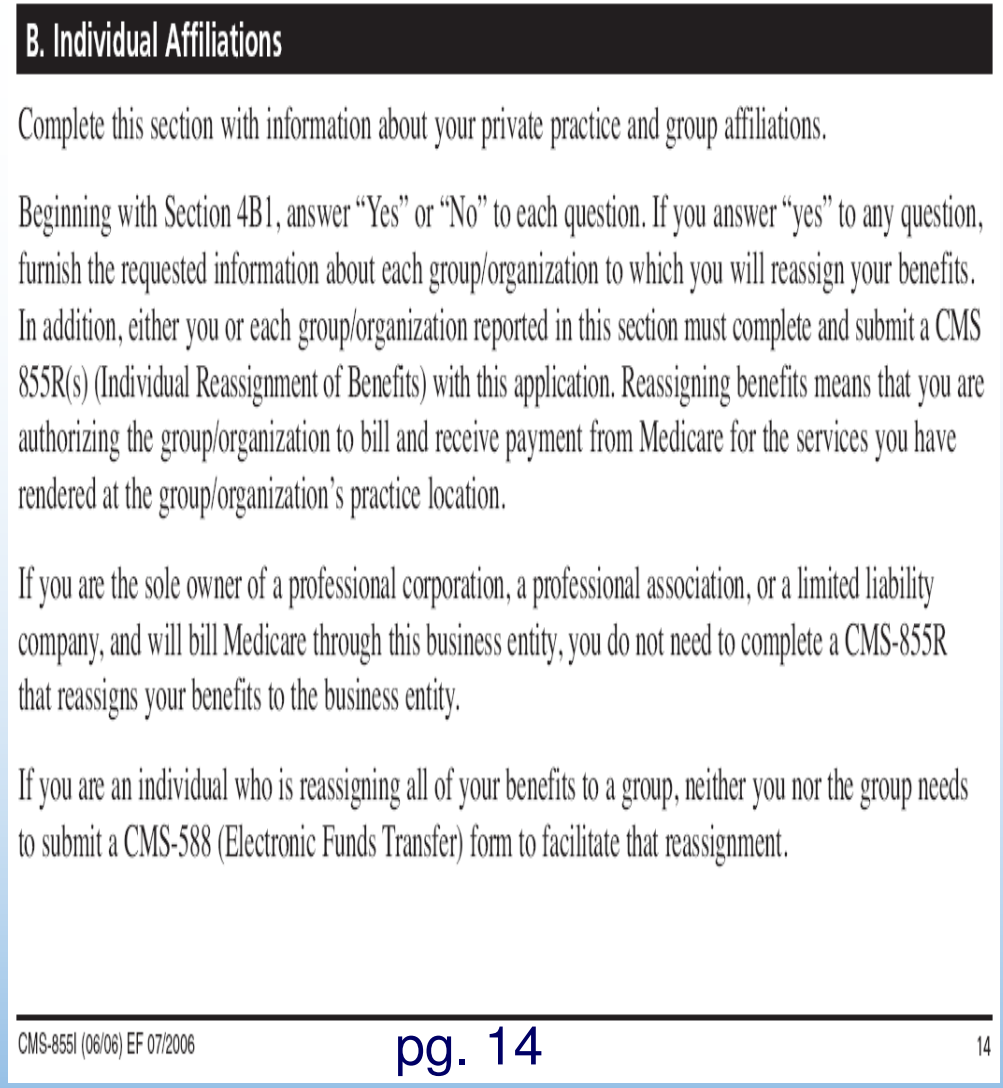
Section 4B: Practice Location Information

This section identifies the groups/organizations to which you will reassign benefits



B. Individual Affiliations

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

Beginning with Section 4B1, answer "Yes" or "No" to each question. If you answer "yes" to any question, 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 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 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) form to facilitate that reassignment.

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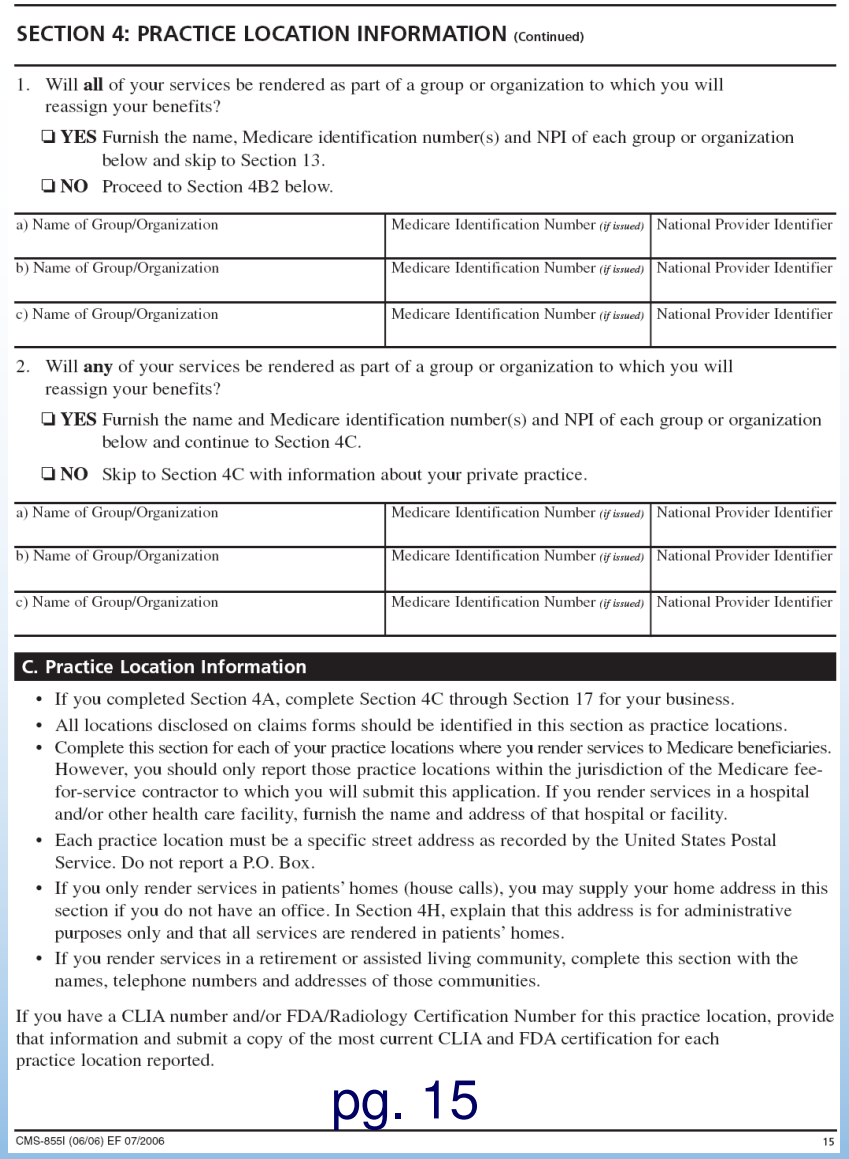
Section 4B: Practice Location Information

Situation # 1

You are enrolling as **"John Smith MD",** using your **SSN** and you are working in **your own private practice only**, you should:

Check "NO" for the first question ("Will all of your services be rendered … ")
Check "NO" for the second question ("Will any of your services be rendered… ")

Skip to Section 4C.



SECTION 4: PRACTICE LOCATION INFORMATION (Continued)

1. Will **all** of your services be rendered as part of a group or organization to which you will reassign your benefits?

❑ **YES** Furnish the name, Medicare identification number(s) and NPI of each group or organization below and skip to Section 13.

❑ **NO** Proceed to Section 4B2 below.

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

2. Will **any** of your services be rendered as part of a group or organization to which you will reassign your benefits?

❑ **YES** Furnish the name and Medicare identification number(s) and NPI of each group or organization below and continue to Section 4C.

❑ **NO** 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

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.

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Section 4B: Practice Location Information

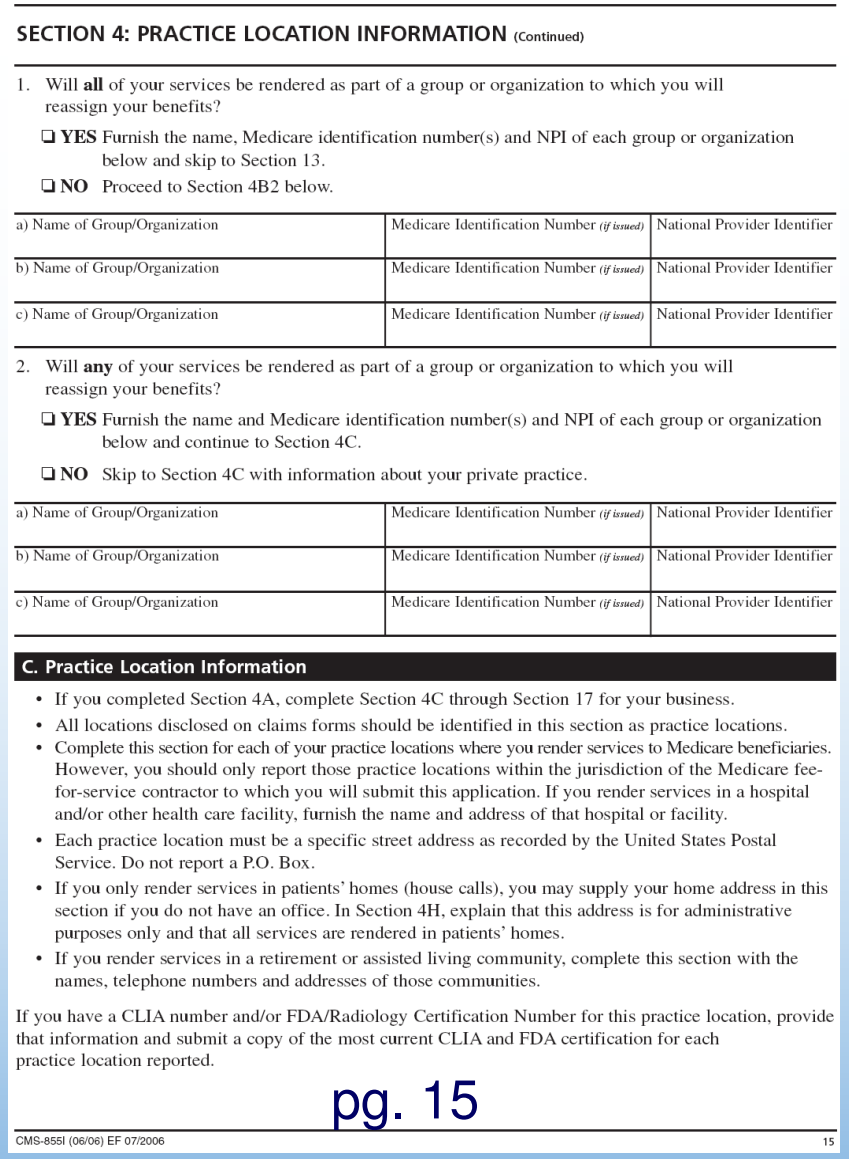
Situation # 2

You are enrolling as **"John Smith MD",** using your **SSN** and you are working in **your own private practice**, but you will also work at another facility from time to time, you should:

Check "NO" for the first question ("Will all of your services be rendered … ")
Check "YES" for the second question ("Will any of your services be rendered… ")

Enter the name of the Group/Organization, Medicare number and NPI where you will work from time to time.

Go to 4C and enter your private practice information.



SECTION 4: PRACTICE LOCATION INFORMATION (Continued)

1. Will **all** of your services be rendered as part of a group or organization to which you will reassign your benefits?

❑ **YES** Furnish the name, Medicare identification number(s) and NPI of each group or organization below and skip to Section 13.

❑ **NO** Proceed to Section 4B2 below.

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

2. Will **any** of your services be rendered as part of a group or organization to which you will reassign your benefits?

❑ **YES** Furnish the name and Medicare identification number(s) and NPI of each group or organization below and continue to Section 4C.

❑ **NO** 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

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.

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Section 4B: Practice Location Information

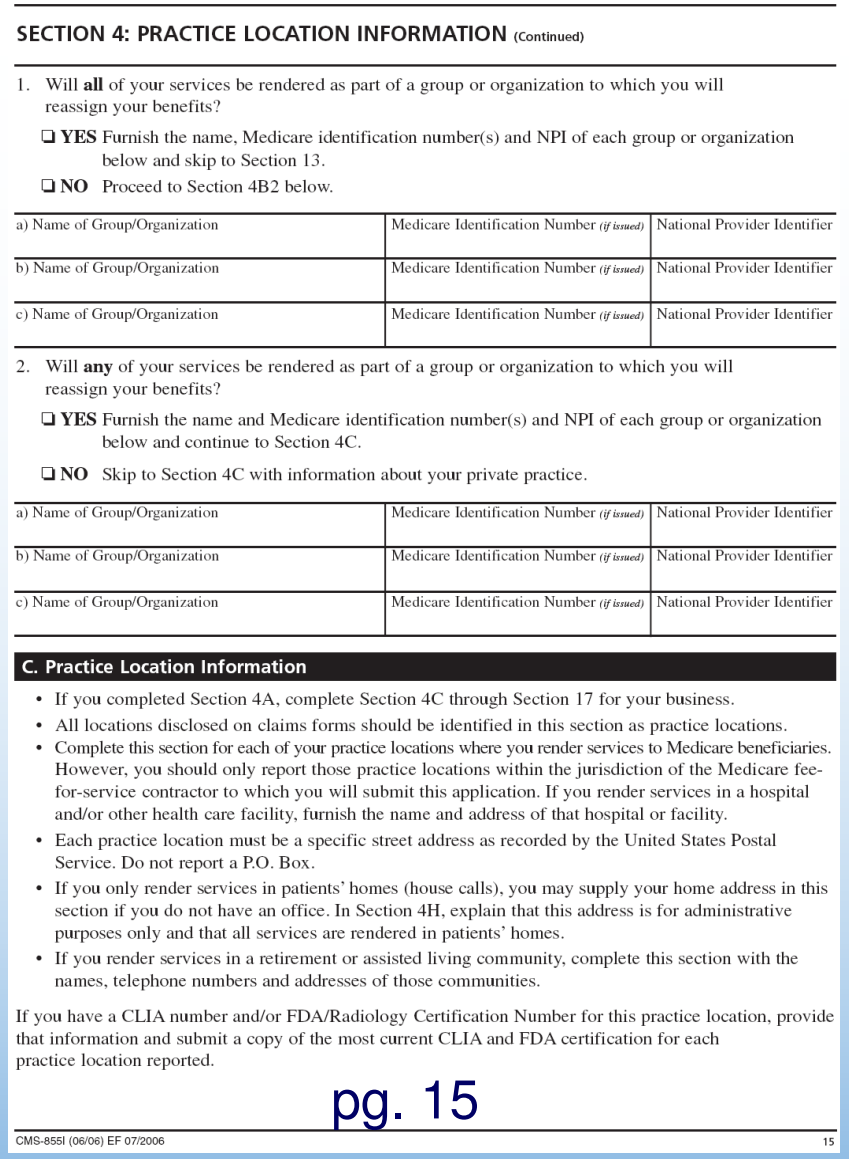
Situation # 3

You are enrolling as **"John Smith MD",** using your **SSN** and you are working for a Group/Organization, you should:

Check "YES" for the first question ("Will all of your services be rendered … ")

Enter the name of the Group/Organization, Medicare number and NPI where you will work.

Skip to Section 13.



SECTION 4: PRACTICE LOCATION INFORMATION (Continued)

1. Will **all** of your services be rendered as part of a group or organization to which you will reassign your benefits?

   ❑ **YES** Furnish the name, Medicare identification number(s) and NPI of each group or organization below and skip to Section 13.

   ❑ **NO** Proceed to Section 4B2 below.

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

2. Will **any** of your services be rendered as part of a group or organization to which you will reassign your benefits?

   ❑ **YES** Furnish the name and Medicare identification number(s) and NPI of each group or organization below and continue to Section 4C.

   ❑ **NO** 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

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.

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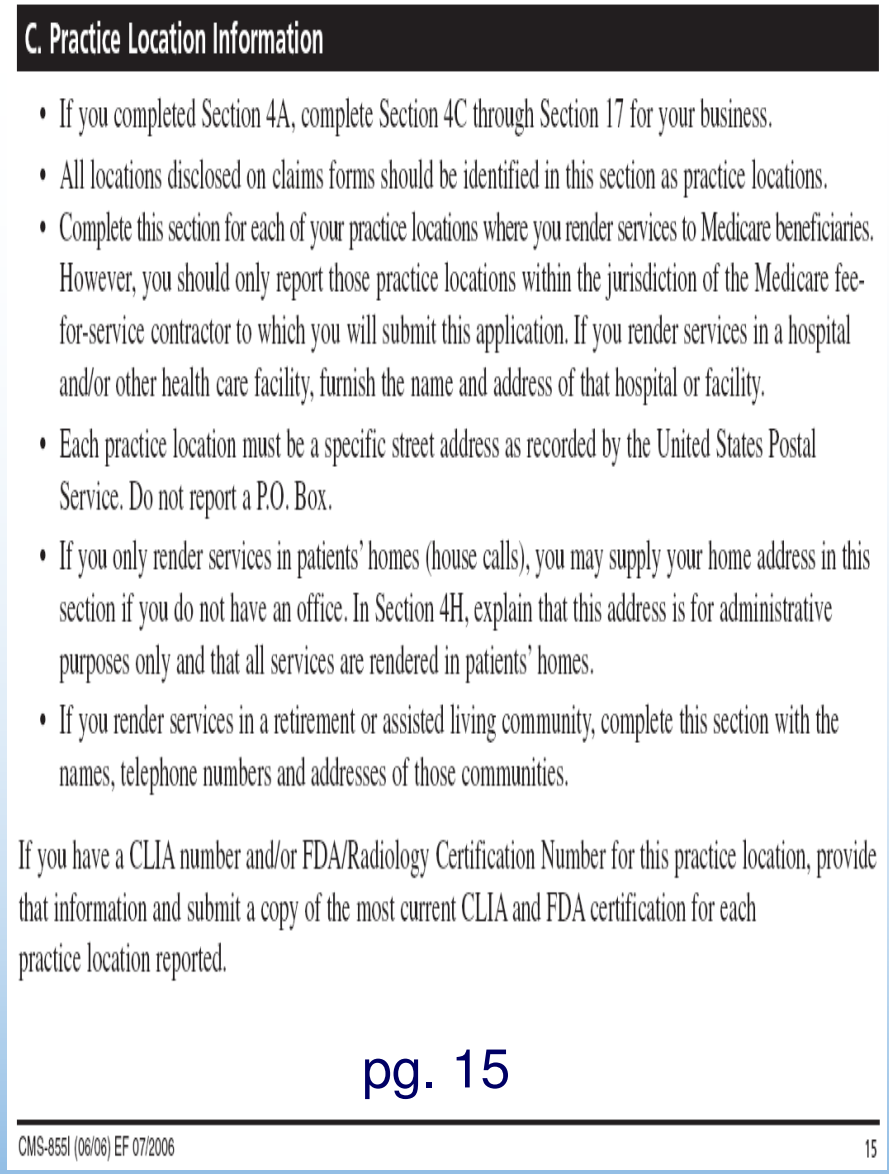
Section 4C: Practice Location Information

If you completed Section 4A or you are establishing your own private practice, list those locations in this section.

Do Not list the Groups/Organizations to which you are reassigning benefits.



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.

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Section 4: Practice Location Information

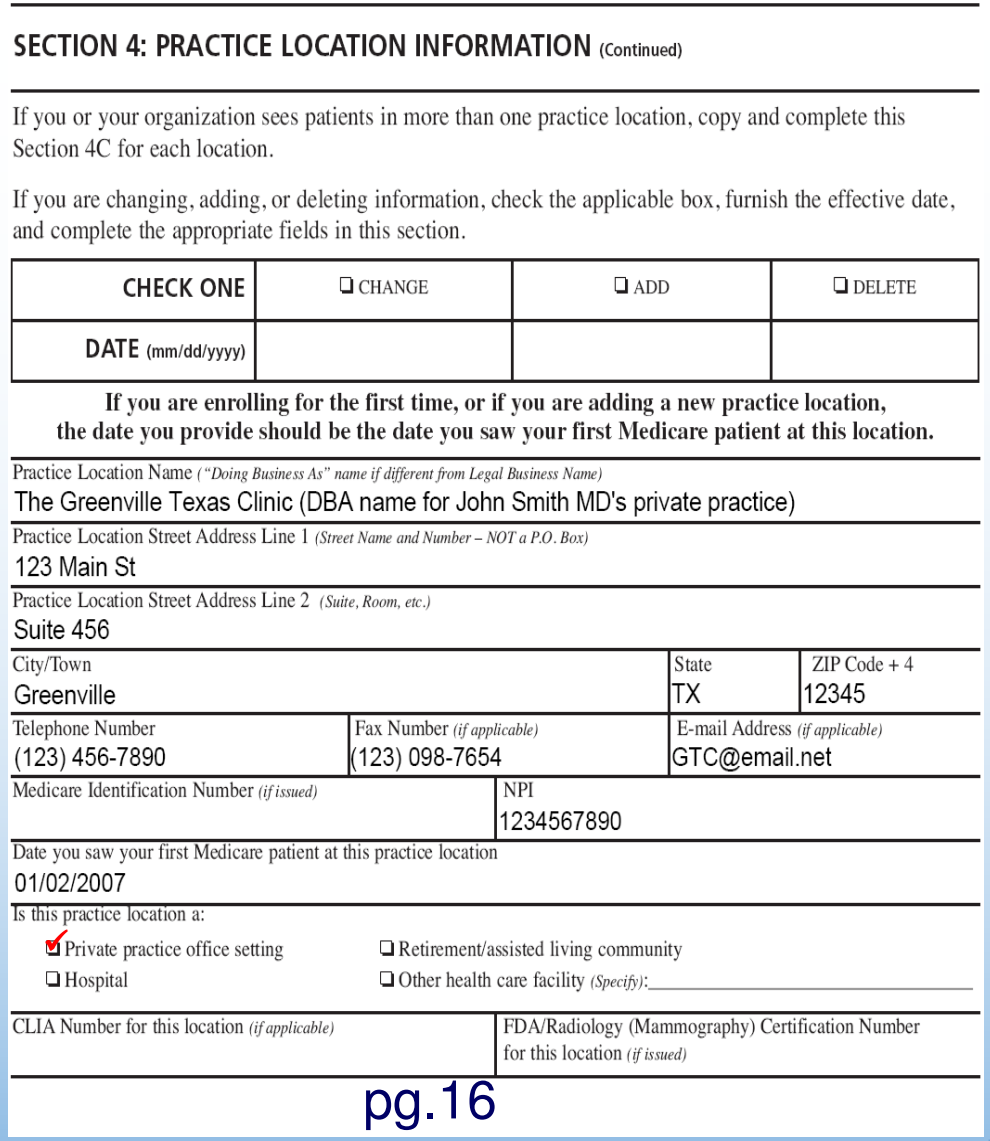
Enter the Practice Location name, (DBA name if different from the Legal Business Name), complete address, phone, fax and e-mail address.

Initial enrollees should write pending or leave Medicare field blank.

Enter your NPI number and the date you saw your first Medicare patient at this location. This does not have to be the date the location opened for business.

Identify the type of practice location you have.

Enter your CLIA number and FDA number if applicable.



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.

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)			

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)*
The Greenville Texas Clinic (DBA name for John Smith MD's private practice)

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

Practice Location Street Address Line 2 *(Suite, Room, etc.)*
Suite 456

City/Town	State	ZIP Code + 4
Greenville	TX	12345

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*
(123) 456-7890	(123) 098-7654	GTC@email.net

Medicare Identification Number *(if issued)*	NPI
	1234567890

Date you saw your first Medicare patient at this practice location
01/02/2007

Is this practice location a:

- ☑ Private practice office setting
- ❑ Retirement/assisted living community
- ❑ Hospital
- ❑ Other health care facility *(Specify)*:_____

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

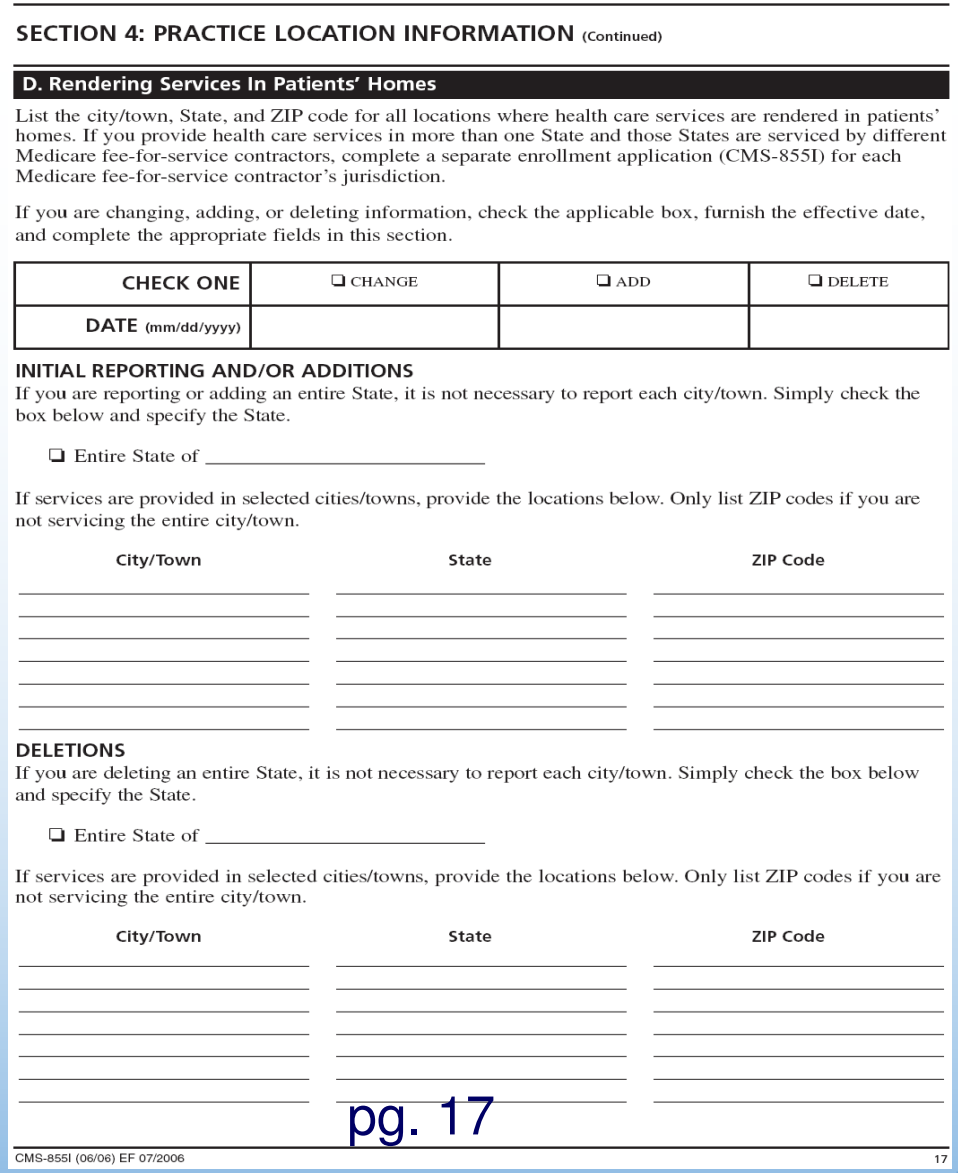
Section 4: Practice Location Information

If you provide services in patients' homes you will need to complete Section 4D.

If you provide services to an entire state, enter the State. You do not need to list each City/Town separately.

If you only provide services in a City or Town, enter the City or Towns' name and the state. The zip code is only required if you are not servicing the entire city/town.

If you do not render services in patient's homes, skip Section 4D.



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

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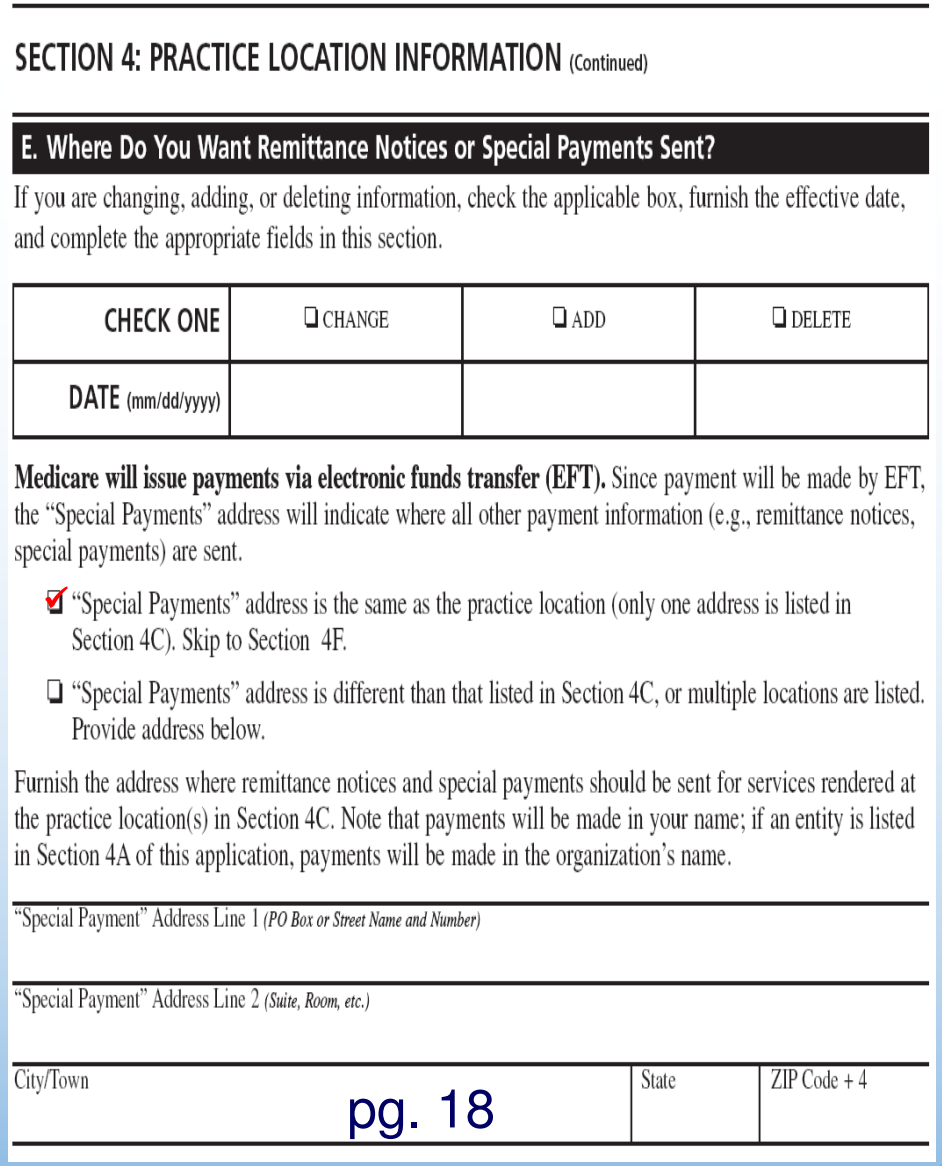
Section 4E: Practice Location Information

Section 4E is used to identify where you want remittance notices or Special payments sent .

If the address is the same as the practice location in Section 4C and only one address is listed check the indicated box and skip to 4F.

If the address is different from practice location in Section 4C or Multiple locations are listed check the Indicated box and furnish the address Where notices and special payments should be sent.



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

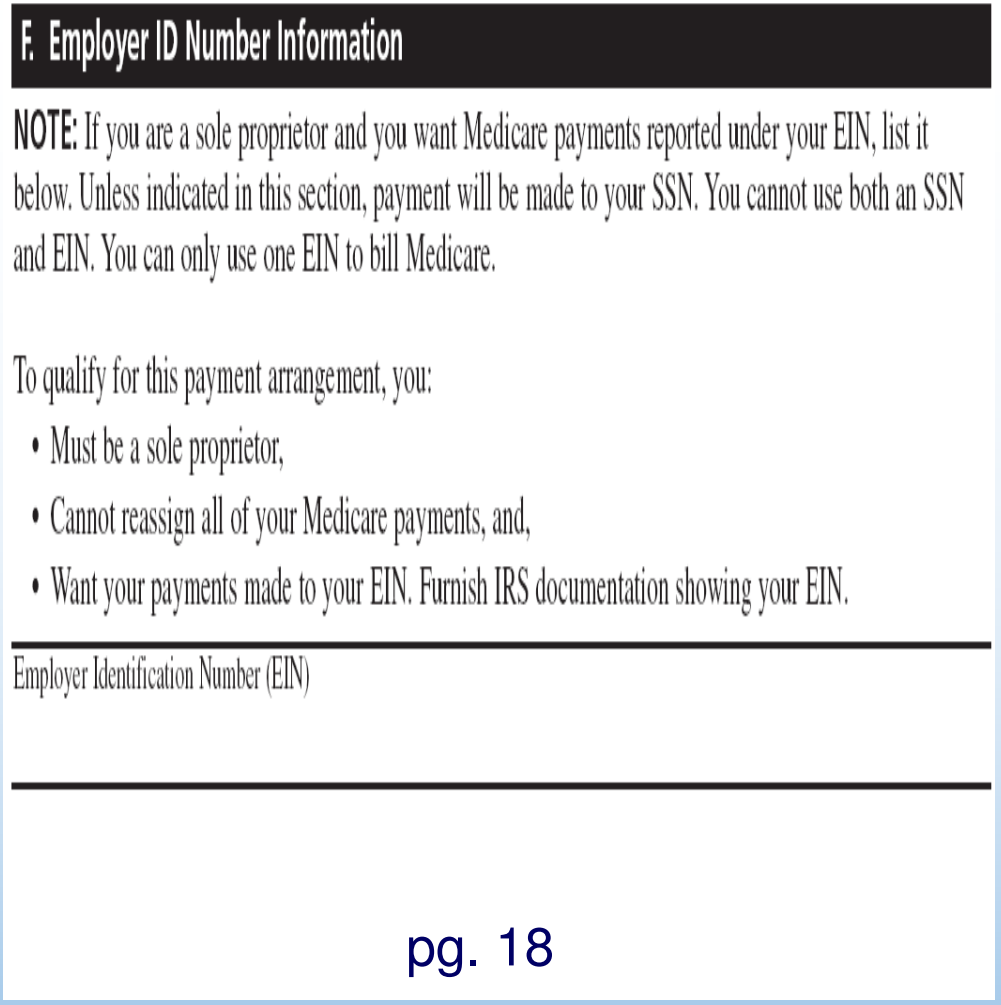
Section 4F: Practice Location Information

Section 4F is used when a sole proprietor wants Medicare payments reported under your EIN.

Example-John Smith MD has obtained an EIN from the IRS and the Legal Business Name on the IRS notice(CP-575) is John Smith MD.

The three bulleted requirements listed must be met.

Enter your EIN.



F. Employer ID Number Information

NOTE: If you are a sole proprietor and you want Medicare payments reported under your EIN, list it below. Unless indicated in this section, payment 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 made to your EIN. Furnish IRS documentation showing your EIN.

Employer Identification Number (EIN)

Section 4G, H: Practice Location Information

In 4G, If patients' medical records are stored at a location other than the location listed in 4C, complete this section with the name and address of the storage location.

In 4H, explain any unique circumstances concerning your practice locations.

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]).

Section 6: Individuals Having Managing Control

This section is to be completed by sole proprietors.

Section 6A is for the individual who will exercise operational or managerial control over the practice.

If there is more than one individual that needs to be reported, copy and complete this section for each individual.

Adverse legal actions must be completed for each individual reported.

You must check either "Yes" or "No" in response to question one in 6B.

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)			

1. First Name	Middle Initial	Last Name	Jr., Sr., etc.
Jane	L	Smith	

2. Title	Date of Birth (mm/dd/yyyy)
Office Manager	12/15/1972

3. Social Security Number (Required)	Medicare Identification Number (if issued)	NPI (if issued)
123-45-6789		

B. Adverse Legal 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 an 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 adverse legal action, when it occurred, the Federal or State agency or court/administrative body that imposed the action, and the resolution, if any.

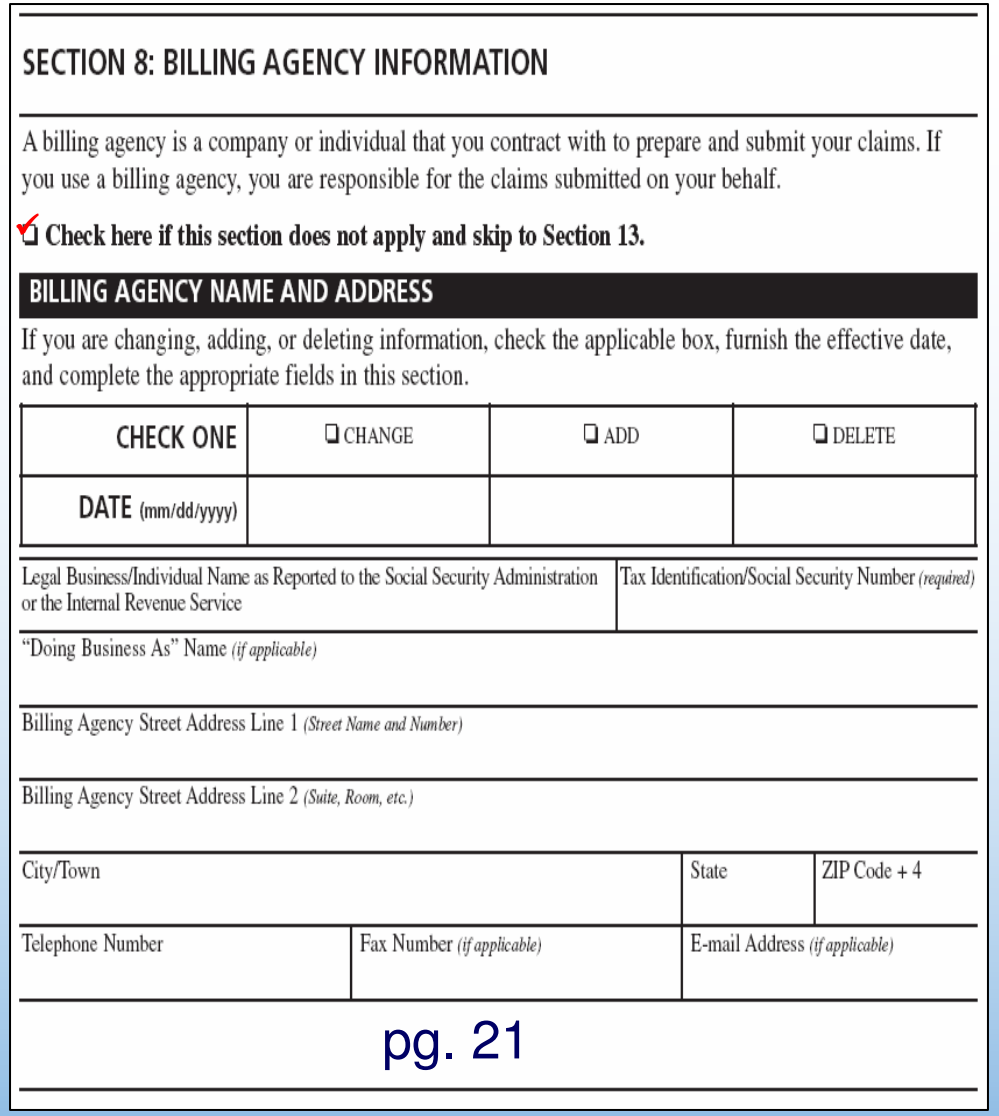
Adverse Legal Action	Date	Taken By	Resolution

Section 8: Billing Agency

Section 8 is looking for information about any individual or entity with whom you have contracted to prepare and submit claims for the business.

A billing agency may perform other services for you, but claims completion and/or submission are included in your contract.

If you do not use a billing agency, you must indicate by checking the first box.



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.**

BILLING AGENCY NAME AND ADDRESS

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)			

Legal Business/Individual Name as Reported to the Social Security Administration or the Internal Revenue Service	Tax Identification/Social Security Number *(required)*

"Doing Business As" Name *(if applicable)*

Billing Agency Street Address Line 1 *(Street Name and Number)*

Billing Agency Street Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

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

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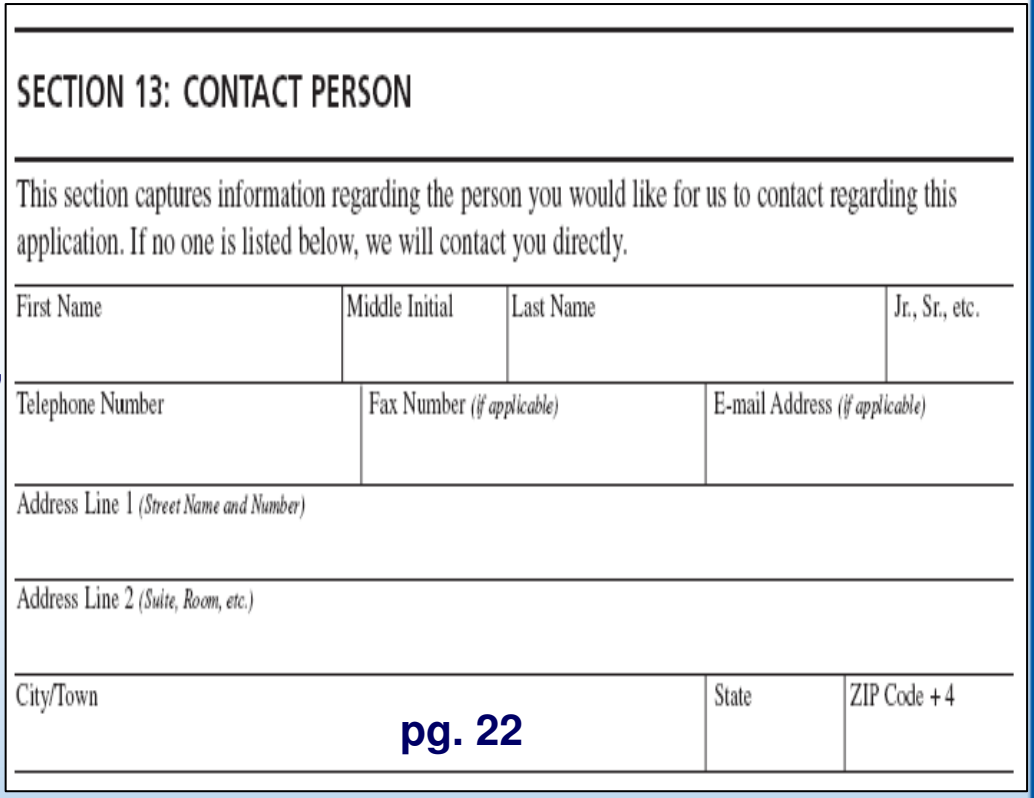
Section 13: Contact Person

The contact person should be someone who can answer questions about the information on the application.

Medicare will not list the contact person on the Medicare providers' record.

If no one is listed, Medicare will contact the provider directly.



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

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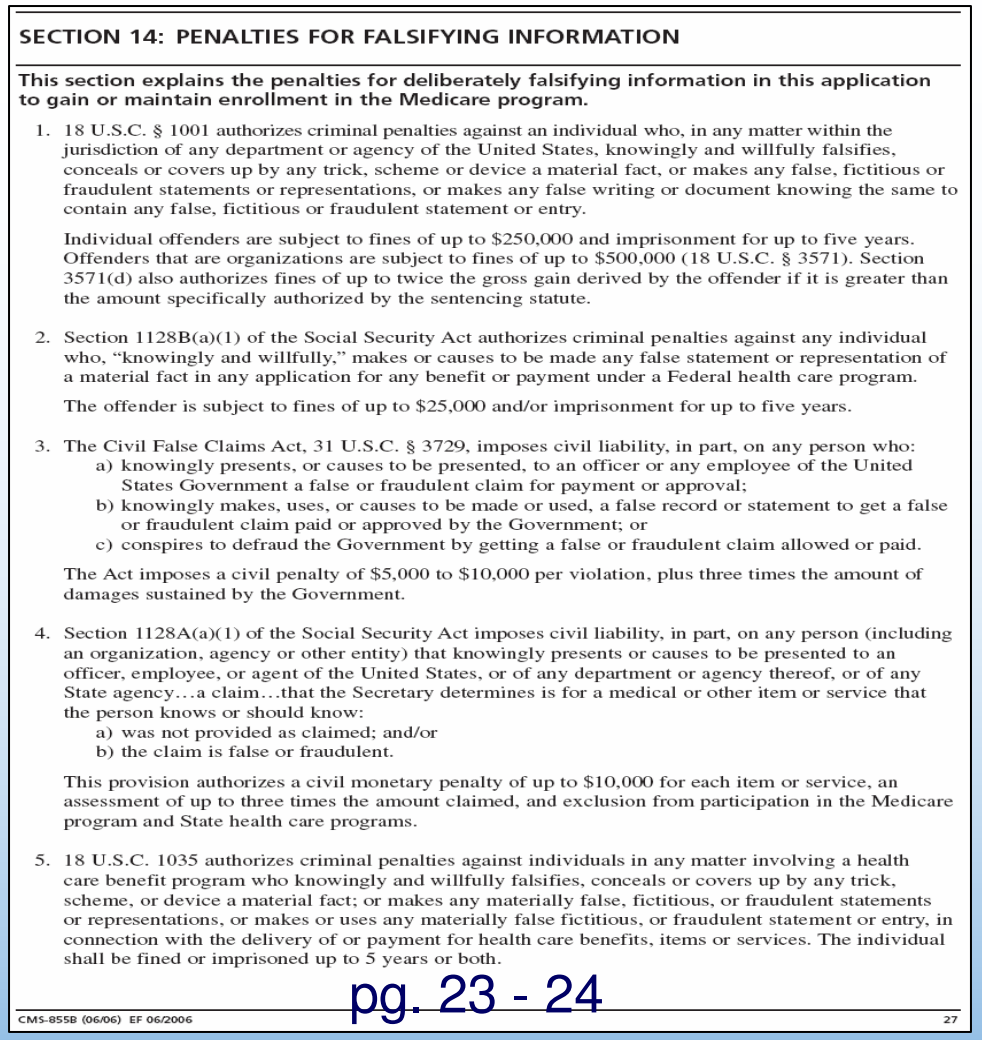
Section 14: Penalties for Falsifying Information

Section 14 outlines the penalties for falsifying information and should be read by the provider listed in Section 2.

This section does not have an area to be completed.



SECTION 14: PENALTIES FOR FALSIFYING INFORMATION

This section explains the penalties for deliberately falsifying 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. 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.

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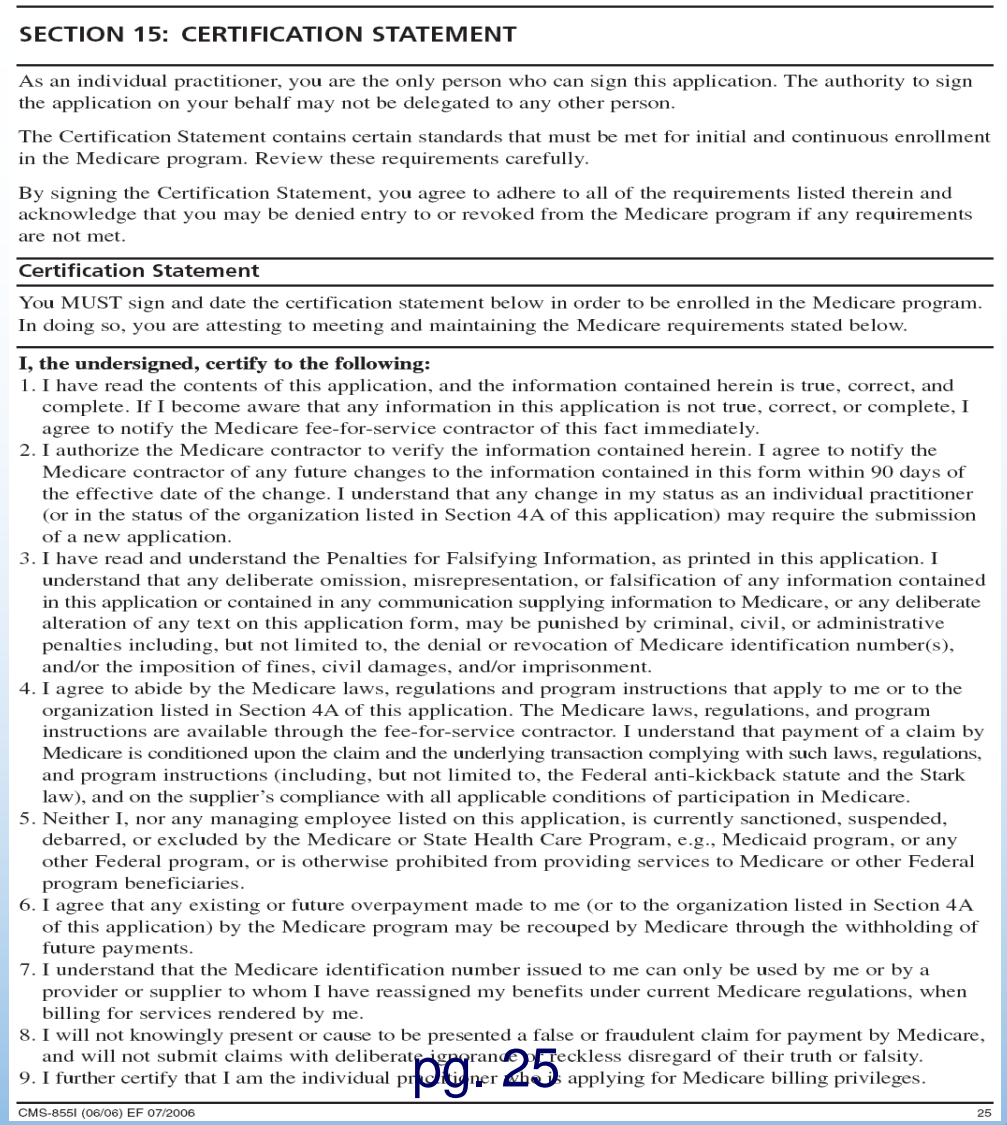
Section 15: Certification Statement

Only the individual practitioner has the authority to sign this application.

The individual practitioner must read and understand page 25.



SECTION 15: CERTIFICATION STATEMENT

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 immediately.
2. I authorize the Medicare contractor to verify the information contained herein. I agree to notify the Medicare contractor of any future changes to the information contained in this form within 90 days of the effective date of the change. I understand that any change in my status as an individual practitioner (or in the status of the organization listed in Section 4A of this application) 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 identification number(s), 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.

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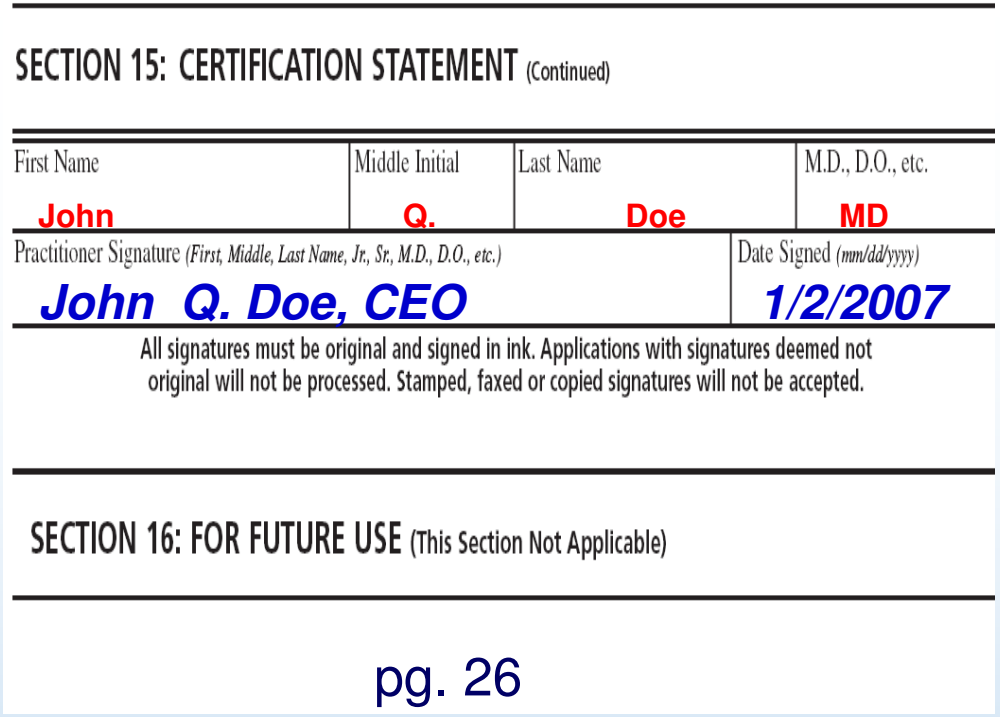
Section 15: Certification Statement

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

To indicate an original signature the practitioner should sign in blue ink.



SECTION 15: CERTIFICATION STATEMENT (Continued)

First Name	Middle Initial	Last Name	M.D., D.O., etc.
John	Q.	Doe	MD

Practitioner Signature (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)	Date Signed (mm/dd/yyyy)
John Q. Doe, CEO	1/2/2007

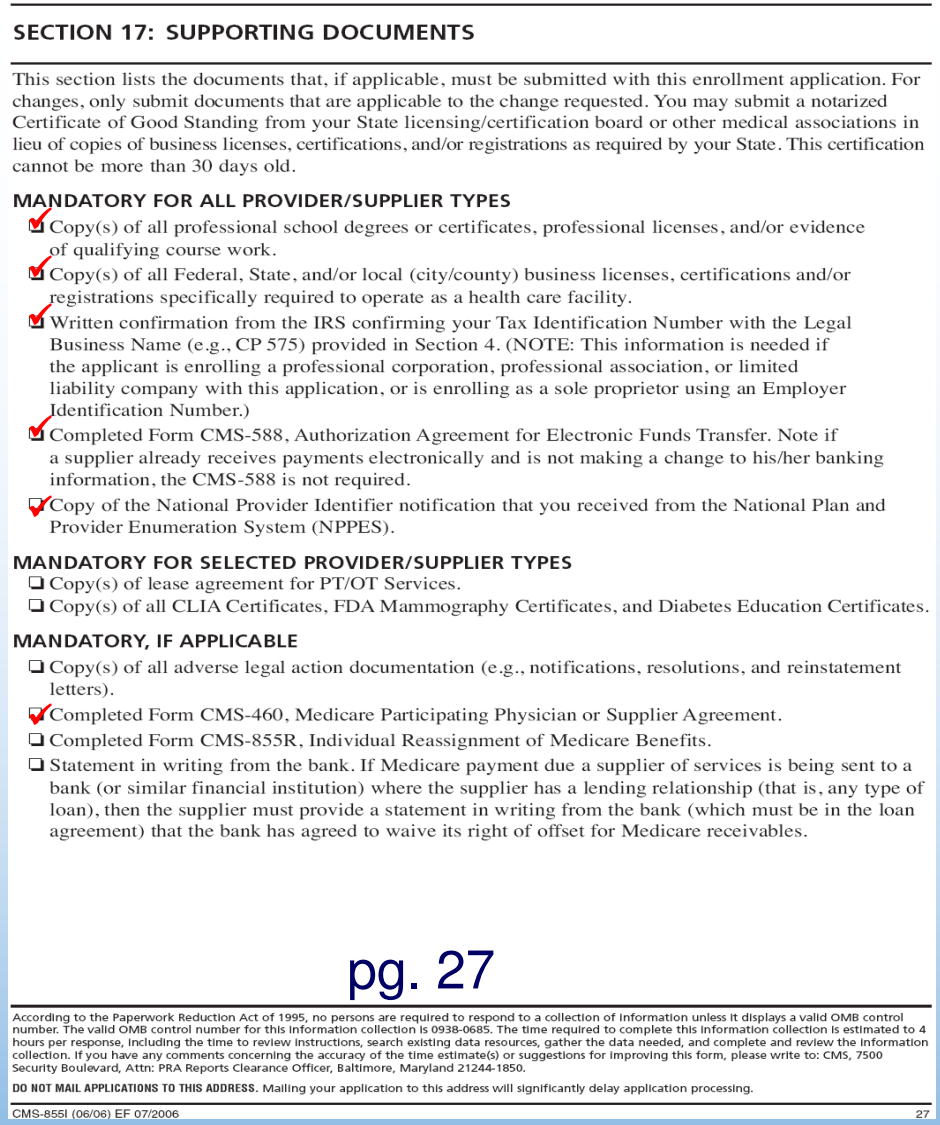
All signatures must be original and signed in ink. Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

SECTION 16: FOR FUTURE USE (This Section Not Applicable)

Section 17: Supporting Documents

Section 17 indicates what is attached to the application. Check the corresponding boxes for all information being attached to the application.

Don't forget:
- Tax documents (IRS CP-575, Tax Coupon or IRS Letter)
- CMS-588 Electronic Funds.
- NPI notification.
- Copies of any State licenses or certifications.
-Competed 855R for providers enrolling in a group practice
- If applicable, copies of CLIA, FDA and/or Diabetes Program certifications.
- Copy of attestation for government and tribal organizations.



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. You may submit a notarized Certificate of Good Standing from your State licensing/certification board or other medical associations in lieu of copies of business licenses, certifications, and/or registrations as required by your State. This certification cannot be more than 30 days old.

MANDATORY FOR ALL PROVIDER/SUPPLIER TYPES

- ☑ Copy(s) of all professional school degrees or certificates, professional licenses, and/or evidence of qualifying course work.
- ☑ Copy(s) of all Federal, State, and/or local (city/county) business licenses, certifications and/or registrations specifically required to operate as a health care facility.
- ☑ Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name (e.g., CP 575) provided in Section 4. (NOTE: This information is needed if the applicant is enrolling a professional corporation, professional association, or limited liability company with this application, or is enrolling as a sole proprietor using an Employer Identification Number.)
- ☑ Completed Form CMS-588, Authorization Agreement for Electronic Funds Transfer. 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.
- ☑ Copy of the National Provider Identifier notification that you received from the National Plan and Provider Enumeration System (NPPES).

MANDATORY FOR SELECTED PROVIDER/SUPPLIER TYPES

- ❑ Copy(s) of lease agreement for PT/OT Services.
- ❑ Copy(s) of all CLIA Certificates, FDA Mammography Certificates, and Diabetes Education Certificates.

MANDATORY, IF APPLICABLE

- ❑ Copy(s) of all adverse legal 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.

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Prescreening

All applications are prescreened, including changes of information and reassignments, within 15 calendar days of receipt.

Prescreening ensures providers submit all required supporting documentation and a complete enrollment application.

This process applies to all applications.

Prescreening – Missing Information

If an application is received that contains at least one missing required data element, or the provider fails to submit all required supporting documentation:

- TrailBlazer will send a letter to the provider (where appropriate we can send it by email or fax), that documents and requests the missing information.
- The letter must be sent to the provider within the 15-day prescreening period.
- TrailBlazer is not required to make any additional requests for the missing data elements or documentation after the initial letter.

Prescreening – Missing Information

The provider must furnish all of the missing information within 60 calendar days of the request. If the provider fails to do so the application is rejected. The provider will be notified by letter with the reasons for rejection and how to reapply. If the provider wishes to reapply they will be required to begin a new process.

Rejected vs. Returned

The difference between a rejected and returned application is that an application is rejected based on the provider's failure to respond to TrailBlazer's request for missing information or clarification.

An application is subject to immediate return based on specific criteria. All resubmissions must contain a newly signed and dated certification statement page.

Criteria For Returned Applications

- No signature on application.
- Old version of application submitted.
- Copies or stamped signature.
- CMS-855I signed by someone other than individual practitioner applying for enrollment.
- Applicant failed to submit all forms needed to process a reassignment package.
- Completed application in pencil.
- Wrong application submitted.
- Web-generated application submitted but does not appear to have been downloaded off of CMS' Web site.
- Application not mailed (i.e., it was faxed or e-mailed).
- Application received more than 30-days prior to the effective date listed on the application. (This does not apply to certified providers, ASCs or portable X-ray suppliers.)
- Provider submitted new enrollment application prior to expiration of time in which provider is entitled to appeal the denial of its previously submitted application.
- Submitted CMS-855 for sole purpose of enrolling in Medicaid.
- CMS-855 not needed for the transaction in question.
- CMS-588 sent in as a stand-alone change of information request (i.e., it was not accompanied by a CMS-855) but was 1) unsigned, 2) undated, or 3) contained copied, stamped or faxed signature.

Most Common Reasons for Delays

TrailBlazer is allowed to reject for missing information. The top reasons for rejections that we see in our Provider Enrollment area are:

- Missing NPI notification.
- Missing CMS-588 – Authorization Agreement for Electronic Funds Transfer.
- Failure to document the reason for application submittal.
- "Change" was selected in 1A, but no indication of what was changing.
- The effective date for the change, add or deletion was missing.
- Application not signed or dated.
- IRS tax identification or documentation not received.

Application Processing

Once it is determined that the application will not be returned, it goes through different phases of verification, validation, and then on to final processing.

If additional information is needed during these phases of processing the application, you could receive a telephone call or a letter requesting the information.

This phone call or letter will be directed to the person listed on this application as the Contact Person in Section 13 of the CMS-855I form.

Reminders

1. Request and obtain an National Provider Identifier (NPI) before enrolling or making a change.

2. The CMS-855I application is not complete.
A CMS-855I application must be completed by all individuals that will be billing Medicare carriers for medical services furnished to Medicare beneficiaries.

3. CP575 not submitted.
A CP575 must be submitted with the CMS-855I and the CMS-855B application any time a tax ID number is used. The CP575 is the official letter from the IRS confirming the tax identification number with the legal business name. If the CP575 is not available, we will also accept a copy of the quarterly tax payment coupon or any official letter from the IRS that lists the legal business name and tax ID number.

4. Include all the necessary supporting documentation.
This supporting documentation includes professional licenses, business licenses, certifications, IRS form (CP575), the National Provider Identifier (NPI) notification and the 588 authorization form for Electronic Funds Transfer (EFT).

5. Complete the application in its entirety.
Each section of the application should be completed. If a section does not apply, check the “not applicable” statement where appropriate and skip to the next section.

6. Identify a contact person.
Once your application has passed CMS prescreening guidelines, a provider enrollment analyst will conduct research and validation of the enrollment application. By identifying a contact person who is familiar with the application and who has access to the physician, practitioner or administrator, you can help our analyst obtain the necessary information and/or documentation in a timely manner.

7. Sign and date the application.
In accordance with CMS regulations, any unsigned CMS-855 applications will be returned to the applicant and any changes requested must include the effective date of the change.

Congratulations, you have completed the CMS-855I enrollment form.

Prior to mailing, review the application to ensure all items are completed, if appropriate, and copies of all attachments are included.

If you have any questions, contact Provider Enrollment for your area:

- Texas and Indian Health facilities
  (866) 528-1602

- Virginia
  (866) 697-9670

- DC/Delaware/Maryland
  (866) 828-6254

Education Makes the Difference

Thank you for participating in this Computer-Based Training

Provider Outreach and Education and
Provider Enrollment

CMS TrailBlazer Health Enterprises, LLC

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