



MEDICARE AND OTHER FEDERAL HEALTH CARE PROGRAMS PROVIDER/SUPPLIER ENROLLMENT APPLICATION INSTRUCTIONS

General Application - HCFA 855

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

Xact Provider Enrollment Services
P.O. Box 890157
Camp Hill, PA 17089-0157



General

This application must be completed by all providers and suppliers of medical and other health services for enrollment in the Medicare or any other federal health care program.

Some applicants may also need to be surveyed and/or certified by the appropriate State Agency or Regional Medicare Office when required to meet Medicare conditions of enrollment. In this case, those applicants must initially contact the State Agency or Regional Medicare Office prior to completion and submission of this application.

If you need assistance or have any questions concerning the completion of this application, contact your local Medicare or other federal health care contractor.

A separate application must be submitted for each classification of provider/supplier type (e.g., physician in private practice, physician in group practice) even if the different types of services are furnished within the same organization or entity (e.g., hospitals and all affiliated units).

Each entity of an organization must submit a separate application (e.g., hospital based skilled nursing facility, hospices, outpatient clinics, etc.). Each entity of a chain organization must submit a separate application.

Providers and/or suppliers enrolling in the Medicare or any other federal health care program as a group member, partner, or individual contractor who reassigns their Medicare or other federal health care program benefits to the enrolling applicant must also complete HCFA Form 855R (Individual Reassignment of Benefits Application).

Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies must enroll in the Medicare or any other federal health care program using HCFA Form 855S (DMEPOS Supplier Enrollment Application) instead of this application.

Upon completion and approval of this application, the applicant will be issued a provider/supplier billing number. This number will be automatically deactivated if it is inactive for 12 consecutive months. A new HCFA Form 855 must be completed and approved to re-activate the billing number.

For your convenience, the application form of this package has been perforated for easy removal of individual pages. It is not necessary to return the instructions or unused attachments when returning this completed application.

Note: Any changes in the information reported in this application must be reported to the Medicare or other federal health care contractor within 30 calendar days of said change.

Definitions

Authorized Representative: The appointed official (e.g., officer, chief executive officer, general partner, etc.) who has the authority to enroll the entity in Medicare or other federal health care programs as well as to make changes and/or updates to the applicant's status, and to commit the corporation to Medicare or other federal health care program laws and regulations.

The Authorized Representative may be contacted to answer questions regarding the information furnished in this application.

Chain Organization: Multiple providers and/or suppliers (chains) are owned, leased or through any other devices, controlled by a single business entity. The chain organization must consist of two or more health care facilities. The controlling business entity is called the chain "Home Office." Each entity in the chain may have a different owner (generally chains are not owned by the "Home Office").

Typically, the chain "Home Office:"

- maintains uniform procedures in each facility for handling admissions, utilization review, preparation and processing admission notices and bills;

- maintains and controls centrally, individual provider/supplier cost reports and fiscal records and a major part of the Medicare audit for each component can be performed centrally.

Examples of provider types that would typically be chain organizations are: Certified Outpatient Rehabilitation Facilities (CORFs); Skilled Nursing Facilities (SNFs); and Home Health Agencies (HHAs).

Clinical Laboratory Improvement Amendments (CLIA) Number : This number is assigned to laboratories who are certified by the Health Care Financing Administration (HCFA) under the Clinical Laboratory Improvement Amendments.

Note: Any laboratory soliciting or accepting specimens for laboratory testing is required to hold a valid certificate issued by the Secretary of the United States Department of Health and Human Services or hold a license from a CLIA exempt State.

Consolidated Cost Report: A cost report compiled for multiple facilities joined together and filed under the parent facility's Medicare Identification Number.

Contractor: Any individual, entity, facility, organization, business, group practice, etc., receiving an Internal Revenue Service (IRS) Form 1099 for services provided to this applicant (e.g., independent contractor, subcontractor).

Distinct Part Unit [of a facility]: A separate psychiatric, rehabilitation, or skilled nursing unit that is attached to a hospital paid under the Prospective Payment System (PPS) but which is paid on a cost reimbursement or other non-PPS basis. It must be a clearly identifiable unit, such as an entire ward, wing, floor, or building, including all the beds and related services in the unit, that meets all the requirements for a type of facility other than the one in which it is located, and houses all the beneficiaries and recipients for whom payment is made under Medicare for services in the other type of facility.

Food and Drug Administration Number (FDA): This is the certification number assigned by the FDA for equipment used in mammography screening and diagnostic services.

Group Member: A physician or non-physician practitioner who renders services in a group practice and who reassigns benefits to the group.

Independent Diagnostic Testing Facility (IDTF) (formerly Independent Physiological Laboratories (IPL's)): An entity independent of a hospital or physician's office in which diagnostic tests are performed by licensed, certified non-physician personnel under appropriate physician supervision (e.g., free standing cardiac catheterization facility, imaging center, etc.).

Legal Business Name: The legal name of the individual or entity applying for enrollment. This name should be the same name the applicant uses in reporting to the Internal Revenue Service.

Medicaid Number: This number uniquely identifies the applicant as a Medicaid provider and/or supplier in a given State.

Medicare Identification Number: This number uniquely identifies the applicant as a Medicare provider and/or supplier and is the number used on claim forms. The Medicare Identification Number is also known as Medicare Provider Number and Provider Identification Number (PIN). Examples of Medicare Identification Numbers are the UPINs, OSCAR numbers, and NSC numbers.

Note: If the applicant is enrolling in the Medicare or other federal health care programs for the first time, the applicant will receive a Medicare or other federal health care program identification number upon enrollment.

National Provider Identifier (NPI): This number is assigned using the National Provider System to identify health care providers and/or suppliers. In the future, it will replace the Medicare Identification Number.

National Supplier Clearinghouse Number (NSC): This number uniquely identifies the applicant as a supplier of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). It is the number used by DMEPOS suppliers on claim forms.

On-Line Survey Certification and Reporting System (OSCAR): National database used for maintaining and retrieving survey and certification data for certified providers and/or suppliers that are approved to participate in the Medicare, Medicaid and CLIA programs. OSCAR numbers are assigned by the Regional Medicare office.

Other Affiliated Units: Entities that are either a Provider Based Facility, a Distinct Part Unit, or file a consolidated cost report.

Provider Based Facility: Entities operating under the control of a parent organization (e.g., hospital based End Stage Renal Disease Unit, Skilled Nursing Facility, etc.).

Reassignee: An individual or organization that allows another organization to bill Medicare or other federal health care programs on their behalf for services rendered.

Unique Physician Identification Number (UPIN): This number is assigned to physicians, non-physician practitioners and groups to identify the referring or ordering physician on Medicare claims.

APPLICATION COMPLETION INSTRUCTIONS

Furnish all requested information in its entirety. If a field is not applicable, write N/A in the field. If entire section is not applicable, check the box at the beginning of the section indicating the entire section is not applicable. Any section of the application that does not have a check box at the beginning of the section indicating the entire section is not applicable must be completed by applicant.

Check Type of Business: (For administrative purposes only)

Check appropriate box indicating how applicant's business is structured. The answer to this item will not affect the amount of reimbursement or enrollment status.

Note: If applicant's business structure is a **partnership**, applicant must provide a copy of its partnership agreement signed by all parties and identifying the general partner (if any) and attest that the partnership meets all State requirements.

Partnerships see group instruction.

Check "Applicant Enrolling As" Type: (For administrative purposes only) The answer to this item will not affect the amount of reimbursement or enrollment status.

See the instructions below that identify which sections the applicant is responsible for completing.

Individual: An individual person enrolling as a physician, supplier or non-physician practitioner (e.g., physician, nurse, midwife, etc.).

Note: An individual who is registered as a business is considered a sole proprietor for the purpose of completing this application and should not check this box.

Individuals complete sections 1a, 1d, 2, 3, 4, 5, 6, 7, 8, 9, 12, 13, 14, 15, 17, and 18.

Sole Proprietor: An individual person registered as a business and issued a tax identification number from the IRS and rendering services under the business name.

Sole Proprietors complete sections 1a, 1b, 1d, 2, 3, 4, 5, 6, 7, 8, 9, 12, 13, 14, 15, 17 and 18.

Organization: A company, not-for-profit entity, governmental agency (Federal, State, or Local) or a qualified health care delivery system which renders medical care (e.g., pharmacy, equipment manufacturer, hospital, Public Health Clinic, laboratory, skilled nursing facility, Ambulance Service Supplier, Independent Diagnostic Testing Facility, etc.).

Organizations complete sections 1b, 1d, 2, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, and 18.

Ambulance Service Suppliers must also complete Attachment 1.

Independent Diagnostic Testing Facilities must also complete Attachment 2.

Home Health Agencies must also complete Attachment 3.

Group: Two or more physicians, non-physician practitioners or other health care providers/suppliers who form a practice together (as authorized by State law) and bill Medicare or other federal health care programs as a single unit. A group has individual practitioners. The individual members must be enumerated and enrolled in the Medicare or other federal health care program as individuals in order to enroll as members of the group.

Only those health care practitioners who are authorized to bill Medicare or other federal health care programs directly in their individual capacities are allowed to form a group. A group can only be enrolled if it can meet the conditions for reassignment (see instructions for the Reassignment of Benefits section).

The above definition of a group is to be used for Medicare or other federal health care programs' enrollment purposes only. It is not the group definition described in section 1877(h) of the Social Security Act.

Groups/Partnerships complete sections 1c, 1d, 2, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 17 and 18.

All group member/partners must complete HCFA Form 855R.

Note: PARTNERSHIPS: For purposes of this application, partnerships should check that they are "enrolling as" a group.

Note: RURAL HEALTH CLINICS: Rural Health Clinics that meet the definition of a group, should also submit HCFA Form 855R (Individual Reassignment of Benefits Application) for each member of the group. This is not applicable to those Rural Health Clinics that are provider based.

Mass Immunization Biller Only: A health care provider/supplier who roster bills Medicare or other federal health care programs solely for mass immunizations.

Mass Immunization/Roster Billers complete sections 1a, 1b, 1d, 2, 5, 6, 7, 8, 9, 12, 13, 14, 15, 17 and 18.

Note: Applicants enrolling in the Medicare or other federal health care program as mass immunization/roster billers cannot bill the Medicare or other federal health care program for any other services. The applicant agrees to accept assignment of the influenza/pneumococcus benefit as payment in full and cannot "balance bill" the beneficiary.

For those who are only applying to enroll in the Medicare or other federal health care program to roster bill for mass immunization, enter "Roster" under primary speciality in Section 1A if applicant is an individual, or enter "Roster" under type of facility in Section 1B if applicant is an organization.

Check appropriate federal health care program:

If applicant is enrolling in a federal health care program other than Medicare, check the appropriate box. Check only one box. For each federal health care program in which the applicant wishes to enroll, the applicant must complete a separate enrollment application and submit it to that federal health care program.

Check Application For:

Initial Enrollment: Applicant is enrolling in the Medicare or other federal health care programs for the first time, or re-activating a prior Medicare billing number.

Enrollment of Additional Location(s): Currently enrolled provider/supplier is applying to enroll a new practice location.

Recertification: Currently enrolled provider/supplier is completing application to comply with mandatory periodic re-survey and/or recertification through the State agency or Regional Medicare Office.

Change of Ownership (CHOW): This term applies to certain limited circumstances as defined in 42 CFR § 489.18 as described below.

A new or prospective new owner must complete this application to report new or prospective new ownership. In addition, the applicant must also submit an Individual Reassignment of Benefits Application (HCFA Form 855R) identifying all individuals who will reassign their benefits to the applicant.

A change of ownership is defined as:

- In the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable State law;
- In the case of an unincorporated sole proprietorship, transfer of title and property to another party;
- In the case of a corporation, the merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation (transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute a change of ownership); and
- In the case of leasing, the lease of all or part of a provider/supplier facility constitutes a change of ownership of the leased portion.

Note: A currently enrolled provider/supplier who is reporting new information on the current owners (i.e., addition(s) or deletion(s) of owner(s)) which is not expected to result in a CHOW as defined above, must make the appropriate changes using the ownership information section of this application. This action is considered a change of information (see below).

Change of Information: Currently enrolled provider/supplier is completing applicable sections of the application to report a change in information other than a CHOW as defined above. Currently enrolled provider/suppliers can use HCFA Form 855C (Change of Information Form) to report changes in name, specialty, e-mail address, practice location address, billing agency address, pay to address, surety bond changes/renewals, mailing address, pricing locality, telephone number(s), fax number(s), deactivation of Medicare or other federal health care billing number(s), addition or deletion of authorized representatives, and potential termination of current ownership.

Changes not listed above must be reported using this application.

When using this application to notify the Medicare or other federal health care program that a practice location(s), owner(s), or various personnel are no longer associated with this entity, check the appropriate deletion box in the applicable section(s) and identify the practice location and/or personnel.

All changes must be reported in writing and have an original signature. For individuals, the applicant must sign and for organizations and group practices, an "Authorized Representative" must sign to confirm the requested change(s). Faxed or photocopied signatures will **not** be accepted.

Check Where Applicant Will Be Submitting Bills:**MEDICARE APPLICANTS ONLY**

Fiscal Intermediary: Applicant will be enrolled to bill the fiscal intermediary only. The fiscal intermediary is generally known as the Part A Medicare Contractor. The applicant will generally be a hospital or other health care facility.

Carrier: Applicant will be enrolled to bill the carrier only. The carrier is generally known as the Part B Medicare Contractor. The applicant will generally be a physician or non-physician practitioner.

Both: Application will automatically be forwarded to bill both the fiscal intermediary and the carrier for enrollment consideration.

Regional Home Health Intermediary: Applicant will be enrolled to bill the regional home health intermediary.

If applicant checked that they will be billing a fiscal intermediary, indicate applicant's preferred choice of fiscal intermediary from the separate list included in this package.

Check other federal health care program(s) where applicant is currently enrolled:

If applicant is currently enrolled in any other federal health care program(s), check all appropriate boxes.

1. Applicant Identification**A. Individuals Only**

Complete all items in this section if applicant plans to bill the Medicare or other federal health care program as an individual practitioner.

If an individual or sole proprietorship, complete applicant's full name (this is the name payment will be made in), date and place of birth (county and/or city). If applicant has previously practiced or operated a business under another name, including applicant's maiden name, supply that name under Other Name.

If applicable, check if applicant is a resident or intern at a hospital.

If applicant is enrolling as an individual or sole proprietor, furnish the applicant's primary speciality (e.g. general practitioner, urologist, nurse practitioner, etc.). Listing a secondary speciality is optional.

Gender and Race/Ethnicity information is optional. This data will only be used to assist HCFA in uniquely identifying the applicant.

A. Individuals Only (continued)

If applicant is employed by an entity that will receive payments for the applicant's services, applicant must complete and sign the HCFA Form 855R (Individual Reassignment of Benefits Application).

B. Organizations Only

Complete this section if applicant is a sole proprietor of the business or if applicant is a publicly or privately held business entity.

Complete all items in this section. For Legal Business Name, supply the name that the business, organization or group practice reports to the IRS (this is the name payment will be made in). For Type of Facility give the classification that designates the entity (e.g., hospital, skilled nursing facility, home health agency, ambulance company, etc.), and check whether this facility is accredited or non-accredited.

Note: Clinical laboratories and independent diagnostic testing facilities should annotate this section "LABORATORY" (LAB).

All organizations must identify if they are considered a Provider Based Facility, a Distinct Part Unit, or file a consolidated cost report under another provider/supplier Medicare identification number. If an organization is a Distinct Part Unit, then the organization also falls under the broader category of Provider Based Facility.

If the organization is a:

- Provider Based Facility;
- Distinct Part Unit;
- or files a consolidated cost report,

then the organization must provide the name and Medicare identification number of their parent provider.

Note: The final determination as to whether an entity is truly a Provider Based Facility will be made by HCFA prior to completion of the enrollment process.

In addition to the parent provider relationship described above, the organization must identify how many Provider Based Facilities, Distinct Part Units, Branches, or Multi-campus sites the organization is responsible for. For each of those locations identified, the Practice Location(s) section of this application must be completed.

If applicant receives payment from Medicare or any other federal health care agency for any services rendered by a contractor, when permitted by Medicare or other federal health care program requirements, the contractor must complete and sign the HCFA Form 855R (Individual Reassignment of Benefits Application).

C. Physician and Non-Physician Practitioner Groups Only

Complete all items in this section. Furnish the group's legal business name. This should be the legal name used in reporting to the IRS. Furnish the group's primary specialty (the primary specialty of the majority of the group's members). Designation of a secondary specialty is optional. All group members who the group will be billing the Medicare or other federal health care program in their behalf, must be individually enrolled in the given Medicare or other federal health care program.

Note: The group's members must be enrolled within the same federal health care program as the group enrollment. Otherwise, the group member must enroll separately as an individual in the group's federal health care program prior to becoming a member of that group practice.

Each group member must complete and sign the HCFA Form 855R (Individual Reassignment of Benefits Application).

Note: PARTNERSHIPS: When completing this section, provide legal business name of partnership, date partnership was incorporated, and the State where the partnership is incorporated. Place "n/a" in the specialty block.

D. All Applicants

Provide applicant's mailing address. This is where the applicant can receive correspondence and bulletins from Medicare or other federal health care program contractors. This address may be the applicant's home address or a Post Office Box. Applicant must supply fax number and e-mail address if available. If applicable, provide applicant's previously assigned Medicare Identification Number(s) and the name(s) of the Carrier and/or Fiscal Intermediary to which applicant most recently submitted bills using this number. If applicable, provide applicant's most recent Medicaid number and the State in which it was issued. Applicant must provide his/her social security number and when applicable, his/her employer identification number(s).

Note: All applicants must provide either their social security number and/or, when applicable, their employer identification number (EIN). **If applicant uses more than one EIN, list all, starting with the EIN(s) currently used or to be used for tax reporting purposes relating to this application. Attach a copy of IRS Form CP 575 to verify the applicant's EIN.**

Applicant must answer all questions related to criminal activity. Answering "yes" to any of these questions will not automatically deny enrollment into Medicare or other federal health care programs. For purposes of these questions related to criminal activity, an "immediate family member" of the applicant is defined as:

- a husband or wife;
- the natural or adoptive parent, child or sibling;
- the stepparent, stepchild, stepbrother or stepsister;
- the father, mother, daughter, son, brother or sister;
- parent-in-law, brother-in-law or sister-in-law;
- the grandparent or grandchild; and
- the spouse of a grandparent or grandchild.

For purposes of these questions related to criminal activity, "member of household" with respect to the applicant is defined as any individual sharing a common abode as part of a single family unit with the applicant, including domestic employees and others who live together as a family unit, but not including a roomer or boarder.

Indicate whether the applicant (under the name of the applicant shown on this application or any other name) has any outstanding overpayments with Medicare, Medicaid or any other federal program. If the applicant has an outstanding overpayment, furnish the name of the federal program where the overpayment exists. If this outstanding overpayment is in a name other than the name identified in the Applicant Identification section, furnish the other name in the space provided.

2. Professional and Business License, Certification, and Registration Information

All applicants are required to furnish information on all Federal, State and local (city/county) professional and business licenses, certifications and/or registrations required to practice as applicant's provider/supplier type in applicant's (e.g. State medical license for physician, State certification and/or registration for Nurses, Federal DEA number, Business Occupancy License, local business license, etc.). The local Medicare or other federal health care contractor will supply specific credentialing requirements for applicant's provider/supplier type upon request.

Notarized or "certified true" copies of the above information are optional, but will speed the processing of this application.

Notarized: A notarized copy of an original document that will have a stamp which states "Official Seal" along with the name and signature of the notary public, State, County, and the date the notary's commission expires.

Certified True: This is a copy of the original document obtained from where it originated or is stored, and it has a raised seal which identifies the State and County in which it originated or is stored.

In lieu of copies of the above requested documents, the applicant may submit a notarized or "certified true" Certificate of Good Standing from the applicant's State licensing/certification board or other medical association. This certificate cannot be more than 30 days old.

Non-physician practitioners who must meet Medicare or other federal health care program requirements for professional experience should submit evidence of practice and the dates of employment.

If applicant's enrollment requires a State survey and/or certification, the applicant is required to forward copies of State survey and/or certification documents to the Medicare or other federal health care contractor once they are received from the State agency or Regional Medicare Office.

Note: Temporary licenses are acceptable submissions with this application. However, once received, a copy of the applicant's permanent license must be forwarded to the Medicare or other federal health care program contractor within 30 days of receipt.

If applicant's State licensure is dependent upon State survey and/or certification, check applicable box and furnish information on all other required licensing information.

Note: A business license is required for each practice location.

If applicant had a previously revoked or suspended license, certification, or registration reinstated, attach a copy of the reinstatement notice(s) with this application, if applicable.

3. Professional School Information (Individuals Only)

If applicable, supply information about the educational institution from which applicant received medical, professional, or related degree or training as required by applicant's State. Enclose copies of diploma, degree or evidence of qualifying course work.

Non-physician practitioners who must meet HCFA or other federal health care program requirements for education must provide documentation of courses or degrees taken that satisfy Medicare or other federal health care program requirements. Contact the local Medicare or other federal health care program representative for requirements needed for applicant's provider/supplier type.

4. Board Certification

If applicant is Board Certified, furnish requested information for each Board Certification obtained by the applicant.

5. Exclusion/Sanction Information

Supply all requested information. If applicable, attach copy(s) of any official documentation related to the adverse legal action identified, including reinstatement notices. If applicant has not had any adverse legal actions, check the "none of these" box.

6. Practice Location(s)

Provide all information requested for each location where applicant will render services to Medicare or other federal health care program beneficiaries.

Individual practitioners should include all hospitals and/or other health care facilities where they render service or have privileges to treat patients. Individual practitioners who only render services in the patient's home (house calls) should supply his/her home address in this section. If individual practitioners render services in retirement or assisted living communities, complete this section using the names and addresses of these communities.

Hospitals must list all off-site clinics, distinct part units, and provider based facilities (e.g., skilled nursing facility, rural health clinic, etc.) and multi-campus sites.

Home health agencies and hospices must list all branches.

Note: Listing the facilities, clinics, units, and multi-campus sites controlled by a hospital or other entity does not automatically enroll them in the Medicare or other federal health program. The HCFA Form 855 (General Enrollment Application) must also be completed for each of these entities.

Post Office boxes and drop boxes are **not** acceptable as practice location addresses. The phone number must be a number where patients and/or customers can reach the applicant to ask questions or register complaints.

Furnish the "Pay To" address for payment of services rendered at this practice location. Payments will be made in the legal business name that the individual, organization, or group/partnership uses to report to the IRS, as reported in Section 1 of this application. In most circumstances, payment will be made in the name of the individual who furnished the service unless a valid Reassignment of Benefits Statement has been completed. The "Pay To" address may be a Post Office box.

Furnish the name and social security number of the primary managing/directing employee of this practice location.

If applicable, provide the CLIA number or FDA certification number associated with each piece of equipment at each practice location and submit a copy of the most current certification.

6. Practice Location(s) (continued)

Indicate whether patient records are kept on the premises. If not, supply the name of the storage facility/location and the physical address where the records are maintained. Post Office boxes and drop boxes are **not** acceptable as the physical address where patient records are maintained.

7. Prior Practice Information

FOR MEDICARE ENROLLMENT ONLY

If applicant has previously billed Medicare or Medicaid, supply requested information about the prior practice. Indicate whether applicant was a participating or non-participating provider/supplier in the prior practice.

8. Ownership Information

Complete this section for all individuals and/or entities who have an ownership or control interest in the applicant's business/entity. If owner is an individual, complete owner name, social security number and employer identification number. If applicant is owned by another entity, complete legal business name and employer identification number of the owning entity as well as the name(s) and social security number of each owner of that entity. Entities with ownership interest must provide their legal business name(s).

A person or entity with an ownership or control interest is one that:

- has an ownership interest totaling 5% or more in the provider/supplier;
- has a direct, indirect, or combination of direct and indirect ownership interest equal to 5% or more in the provider/supplier, where the amount of an indirect ownership interest is determined by multiplying the percentages of ownership in each entity (for example, if A owns 10% of the stock in a corporation that owns 80% of the provider/supplier, A's interest equates to an 8% indirect ownership interest in the provider/supplier and must be reported);
- owns an interest of 5% or more in any mortgage, deed of trust, note or other obligation secured by the provider/supplier if that interest equals at least 5% of the value of the property or assets of the provider/supplier;
- is an officer or director of a provider/supplier that is organized as a corporation; and/or
- is a partner in a provider/supplier that is organized as a partnership.

Supply all requested information about the owner's past and present billing relationships with Medicare. Furnish past history for the last 10 years. If data is not known or is incomplete, check the appropriate box.

Supply all requested adverse legal action information about the owner(s). If applicable, attach copy(s) of any official documentation related to the adverse legal action identified, including reinstatement notices. If none of the owner(s) has had any adverse legal actions, check the "none of these" box.

Attach a copy of the applicant's IRS Form CP 575 pertaining to this business. The IRS Form CP 575 will be used to verify the employer identification number (EIN).

In lieu of the IRS Form CP 575, the applicant may use any official correspondence, such as the quarterly tax payment coupon, from the IRS showing the name of the entity as shown on this application and the EIN.

9. Managing/Directing Employees

Complete this section for all managing and/or directing employees, employed by the applicant. This section should include, but is not limited to, general manager(s), business manager(s), administrator(s), director(s), or other individuals who exercise operational or managerial control over the provider/supplier, or who directly or indirectly conduct the applicant's day-to-day operations.

Note: This section **is not** to be completed with information about billing agency or management service organization employees. If applicant uses a billing agency or management service organization, complete the appropriate section of this application.

Note: Non-profit organizations should complete this section with information about the members on the Board of Directors and the managing and/or directing employees and submit a copy of the 501(C)(3) approval notification from the IRS.

Note: For large business organizations, furnish only the top 20 compensated managing and/or directing personnel. Social security numbers **must** be provided for all persons listed in this section.

Applicant must include all managing and/or directing employees for each practice location. Organizations must also complete this section for all corporate officers. Include the name(s) and address(es) of all practice location(s) where this employee manages and/or directs.

Supply all requested information about the managing and/or directing employee's past and present billing relationships with Medicare or other federal health care programs.

Supply all requested information about other entities this managing and/or directing employee managed or directed that previously billed or are presently billing the Medicare or other federal health care programs. Furnish past history for the last 10 years. If data is not known or is incomplete, check the box indicating this.

Supply all requested information about other entities this managing and/or directing employee had ownership interest in that previously billed or are presently billing the Medicare or other federal health care programs. Furnish past history for the last 10 years. If data is not known or is incomplete, check the appropriate box.

Supply all requested adverse legal information about the managing/directing employee(s). If applicable, attach copy(s) of any official documentation related to the adverse legal action identified, including reinstatement notices. If none of the managing/directing employee(s) has had any adverse legal actions, check the "none of these" box.

10. Parent/Joint Venture or Subsidiary Information

If applicant is a subsidiary (wholly or partially owned by another organization or business), or a joint venture (equally owned by another individual(s), organization(s) or business(s)), complete all information requested in this section about the parent company or joint venture. Attach a copy of the parent company's or other owner's IRS Form CP 575 pertaining to this business.

11. Chain Organization Information

When applicable, this section to be completed by Medicare Part A Institutional provider/suppliers ONLY. This includes all institutional chain provider/suppliers that bill fiscal intermediaries (e.g., Home Health Agencies and Skilled Nursing Facilities).

If applicant is in a chain organization, check appropriate action block for this chain, then supply all information requested about the chain home office.

12. Contractor Information (Business Organizations)

This section is to be completed with information about all business organizations that the applicant contracts with that:

- provide medical or diagnostic services or medical supplies for which the cost or value is \$10,000 or more in a 12 month period; OR
- will reassign benefits to the applicant, regardless of annual cost or value of medical or diagnostic services or medical supplies provided.

Provide all requested information about the contractor's past and present billing relationships with Medicare or Medicaid.

Supply all requested adverse legal action information about the contractor(s). If applicable, attach copy(s) of any official documentation related to the adverse legal action identified, including reinstatement notices. If none of the contractor(s) has had any adverse legal actions, check the "none of these" box.

If a business or group contractor will be reassigning Medicare or other federal health care program benefits to the applicant, an authorized representative of the business or group contractor must complete and sign the Reassignment of Benefits section of this application. See instructions below for additional reassignment of benefits information.

Note: Individuals with whom the applicant contracts with to do business and who will reassign benefits to the applicant must complete the **HCFA Form 855R** (Individual Reassignment of Benefits Application).

If a currently enrolled provider/supplier is obtaining the services of a new contractor that will be reassigning its benefits, complete only the Application Identification section, the Contractor Information section and the Reassignment of Benefits Statement.

13. Reassignment of Benefits Statement

In general, Medicare and other federal health care programs make payment only to the beneficiary or the individual or entity that directly provides the service.

Reassigned benefits must be within the same federal health care program (e.g., Medicare to Medicare, CHAMPUS to CHAMPUS, etc.).

If the applicant receives payment on behalf of other business organizations for services provided, the other business organization must complete and sign the Reassignment of Benefits Statement. Failure to do so will cause a delay in processing the application and limit the Medicare or other federal health care program contractor's ability to make payment.

This section must be signed by an Authorized Representative of the entity reassigning its benefits to this applicant.

The reassignee is permitted by Federal law to reassign Medicare benefits to an employer, the facility where the service is rendered, a health care delivery system, or agent. For further information on Federal requirements on reassignment of benefits the applicant should contact the local Medicare or other federal health care program contractor before signing the application.

The Legal Business Name of the applicant must be the same as the Legal Business Name of the applicant identified in Section 1 of this application.

Individual practitioners, including individual contractors and group members, who reassign Medicare or other federal health care program benefits to this applicant must complete the HCFA Form 855R. Individual practitioners who are contracted by the applicant, but do not reassign their benefits to the applicant do not need to complete the HCFA Form 855R.

14. Billing Agency/Management Service Organization Address

A Billing Agency is a company contracted by the applicant to furnish all claims processing functions for the applicant's practice.

A Management Service Organization is a company contracted by the applicant to furnish some or all administrative, clerical and claims processing functions of the applicant's practice.

If the applicant currently uses or will be using a billing agency and/or management service organization to submit bills, complete all requested information and attach a current copy of the signed contract between the applicant and the billing agency or management service organization.

Note: If applicant uses a billing agency and/ or management service organization but no written contract exists between applicant and billing agency and/or management service organization, a contract must be written and furnished with this application.

Any change in the contract between the applicant and the billing agency and/or management service organization must be reported to the Medicare or other federal health care program contractor within 30 calendar days of said change.

15. Electronic Claims Submission Information

If applicant plans to submit bills electronically, or would like information about electronic billing, supply a contact name and phone number. The Medicare or other federal health care program contractor will be in contact with further instructions about qualifying for electronic billing submissions.

Note: Electronic Funds Transfer can only be made into an account controlled exclusively by the applicant.

16. Surety Bond Information

Complete all requested information.

Annual surety bond renewals must be reported to the Medicare or other federal health care program contractor using HCFA Form 855C (Change of Information Form).

16. Surety Bond Information (continued)

An original copy of the surety bond must be submitted with this application. Failure to submit a copy of the surety bond will prevent the processing of this application. In addition, the applicant must obtain and submit a certified copy of the agent's Power of Attorney with this application, if the bond is issued by an agent.

17. Contact Person

Provide the full name and telephone number of an individual who can be reached to answer questions regarding the information furnished in this application.

18. Certification Statement

This statement includes the minimum standards to which the applicant must adhere to be enrolled in Medicare or other federal health care programs. Read these statements carefully.

By signing the Certification Statement, the applicant agrees to adhere to all the conditions listed and is aware that the applicant may be denied entry to or revoked from the program if any conditions are violated. The Certification Statement must contain an original signature. Faxed or photocopied signatures will not be accepted.

Note: If applicant is applying as an individual or sole proprietor, **applicant** must sign and date the Certification Statement. If applicant is applying as an organization or as a group practice, **an authorized representative of the organization/group practice** must sign the Certification Statement. If applicant has more than one authorized representative, furnish the names and signatures of those authorized representatives who will be directly involved with the Medicare or other federal health care contractors.

Attachment 1 Ambulance Service Suppliers

This attachment is to be completed by the applicant for each ambulance service company being enrolled in the Medicare or other federal health care program.

1. State License Information

If applicant is currently State licensed and certified to operate as an ambulance service supplier, complete this section and attach copy(s) of all State licenses and documents.

A copy of applicant's current license or certificate must be attached to this form. The effective date and expiration date must be stated on the license or certificate. Claims will be paid based on these dates. The applicant must provide this office with a copy of the renewal license in order to receive payment after the expiration date.

2. Description of Vehicle(s)

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

The applicant's vehicle(s) must be specially designed and equipped for transporting the sick or injured. It must have customary patient care equipment including, but not limited to, a stretcher, clean linens, first aid supplies and oxygen equipment, and it must have all other safety and lifesaving equipment as required by State and local authorities. If the ambulance will supply Advanced Life Support services, list all the necessary equipment and provide documentation of certification from the authorized licensing and regulation agency for applicant's area of operation.

Vehicles must be regularly inspected and recertified according to applicable State and local licensure laws. Evidence of recertification must be submitted to the Medicare or other federal health care program contractor on an ongoing basis, as required by State or local law.

Note: Air Ambulance

To qualify for air ambulance, the following is required:

- a written statement that gives the name and address of the facility where the aircraft is hangared signed by the President, Chief Executive Officer, or Chief Operating Officer of the airport; and
- proof that the air ambulance applicant or its leasing company possess a valid charter flight license (FAA 135 Certificate) for the aircraft being used as an air ambulance. If the air medical transportation company owns the aircraft, the owner's name on the FAA 135 Certificate must be the same as the applicant's name on this enrollment application. If the air medical transportation company leases the aircraft, a copy of the lease agreement must accompany this enrollment application. The name of the company leasing the aircraft must be the same as the applicant's name on this enrollment application.

3. Qualification of Crew

The ambulance crew must consist of at least two members. Those crew members charged with the care or handling of the patient must include one individual with adequate first aid training, (i.e., training at least equivalent to that provided by the basic and advanced Red Cross first aid courses). If the ambulance crew will provide ALS services, they must list their ALS training courses.

Training "equivalent" to the basic and advanced Red Cross first aid courses include ambulance service training and experience acquired in military service and/or successful completion by the individual of a comparable first aid course furnished by or under the sponsorship of State or local authorities, an educational institution, a fire department, a hospital, a professional organization, or other such qualified organization.

Applicant must enclose a certificate(s) showing that crew members have successfully completed the required first aid training, or give a description of the equivalent military training, where and when it was received. Crew must continue to pursue and complete continuing education requirements in accordance with State and local licensure laws. Evidence of recertification must be submitted to the Medicare or other federal health care program contractor on an ongoing basis, as required by State and local law.

4. Billing Method

FOR MEDICARE ENROLLMENT ONLY

Answer all applicable questions regarding billing methods. Supply the name of the Medical Director and the geographic area the applicant services.

Note: Paramedic Intercept Services:

- A basic life support (BLS) ambulance supplier may arrange with a paramedic/Emergency Medical Technician (EMT) organization or another advanced life support (ALS) ambulance supplier to provide the advanced life support services while it provides for the transportation component. The BLS would bill for the ALS services and make arrangement to pay the organization providing the ALS services. As an alternative, the BLS could arrange for the organization providing the ALS to be its billing agent.
- If this alternate arrangement exists, applicant must complete the Billing Agency/Management Service Organization and Reassignment of Benefits section and submit a copy of the signed contract.

Check the appropriate box indicating if applicant bills for nautical miles or statute miles.

If applicant is not enrolling in the Medicare program skip this section.

5. Exclusion/Sanction Information

Supply all requested adverse legal action information about the ambulance crew member(s). If applicable, attach copy(s) of any official documentation related to the adverse legal action identified, including reinstatement notices. If none of the ambulance crew members has had any adverse legal actions, check the "none of these" box.

Attachment 2 Independent Diagnostic Testing Facilities (IDTFs)

Formerly known as Independent Physiological Laboratories.

This attachment is to be completed by the applicant for each Independent Diagnostic Testing Facility being enrolled in the Medicare or other federal health care program.

Definition:

Independent Diagnostic Testing Facility (IDTF): An entity independent of a hospital or physician's office in which diagnostic tests are performed by licensed, certified non-physician personnel under appropriate physician supervision (e.g., free standing cardiac catheterization facility, imaging center).

Note: A cardiac catheterization facility which is a physician's office is not an IDTF. The term "free standing" means that the cardiac catheterization facility, whether office or IDTF, is independent of a hospital.

1. Identification of Practice Location

Indicate whether this practice location is operating as a mobile unit. If so, provide vehicle identification number and expiration date of vehicle license. If operating mobile units, the vehicles must be regularly inspected and recertified according to State and local licensure laws.

Evidence of recertification must be submitted to the Medicare or other federal health care program contractor on an ongoing basis, as required by State and local law.

Identify practice location of IDTF for which this attachment is being completed. If this is a mobile unit, furnish the address where the vehicle is stored.

If applicable, complete all information concerning applicant's practice location.

2. Identification of Supervising/Directing Physician(s)

The information in this section is required only if applicant's State requires that a supervising physician be associated with all IDTFs.

Supervising physicians must perform their duties as described by State requirements. Each supervising/directing physician is required to be enrolled as an individual practitioner in Medicare or other federal health care program for which the applicant is applying.

3. Service Performance

List all Current Procedural Terminology, Version 4 (CPT-4) and HCFA Common Procedure Coding System (HCPCS) codes this IDTF or its contractors intend to perform, supervise, interpret, or bill. Describe the setting where the service will be rendered, and identify each physician who will be performing, supervising, and/or interpreting the test results.

4. Referral Records

Explain how referral records, physician's written order and the name of the technician who rendered the service are maintained.

5. Supervising/Directing Physician Exclusion/Sanction Information

Supply all requested adverse legal action information about the supervising/directing physician(s). If applicable, attach copy(s) of any official documentation related to the adverse legal action identified, including reinstatement notices. If none of the supervising/directing physician(s) has had any adverse legal actions, check the "none of these" box.

6. Signature of Supervising/Directing Physician(s)

Each supervising/directing physician identified in Section 2 of this attachment must sign this attachment.

Attachment 3**Home Health Agencies (HHAs)**

This attachment is to be completed by all Home Health Agencies for enrollment in the Medicare or other federal health care program.

This attachment must be completed with information about other related business interests in which the HHA itself has a 5% or more ownership interest in or control of the other related business.

In addition, each owner listed in the Ownership Information section **and** each managing/directing employee listed in the Managing/Directing Employee section who has a 5% or more ownership interest in or controls the other related businesses (as defined below) must complete this attachment.

Copy and submit a separate Attachment 3 for the HHA, each owner and each managing/directing employee, as applicable.

Definitions:

Related to the Provider: Related to the provider (HHA) means that the provider (HHA), to a significant extent, is associated or affiliated with or has control of or is controlled by an organization furnishing services, facilities, or supplies to the provider.

Common Ownership: Common ownership exists if an individual or individuals possess significant ownership or equity in the provider (HHA) **and** the institution or organization serving the provider (HHA).

Control Interest: Control exists if an owner of the HHA has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution furnishing services, facilities, or supplies to the provider (HHA).

1. Other Related Business Interests

The HHA itself and all owners and managing/directing employees of the enrolling Home Health Agency are required to furnish identifying information about all other related businesses in which they have a 5% or more ownership in and/or control interest.

In general, businesses that furnish services, facilities, and supplies to the provider (HHA) that are related to the provider (HHA) by common ownership or control interest are to be listed in this attachment.

Supply all requested information about the related businesses.

For purposes of this application, the definition of related businesses as found in 42 CFR § 413.17 which concerns ownership and control, and is limited to businesses who actually do business with the HHA being enrolled will be used. These rules apply regardless of that business' relationship to Medicare, Medicaid or any other health care program, industry, or business.

Examples of related businesses:

- if an HHA, or the owner, or the managing/directing employee owns a small retail store that has no business dealings with the HHA, the store is not considered to be a related business;
- a consulting firm owned by the HHA, one of the HHA owners, or one of the HHA managing/directing employees, which provides management services to the HHA would be considered a related business; and
- a retail business owned by the HHA, one of the HHA owners, or one of the HHA managing/directing employees, which provides supplies to the HHA would be considered a related business.

Identify the type of business in which the related business is engaged (e.g., durable medical equipment company, consulting firm).

Identify the relationship of the related business to the HHA (e.g., affiliate, joint venture, supplier).

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 at 1 ½ - 3 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: HCFA, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.