MEDICARE ENROLLMENT APPLICATION

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers

CMS-855S

See page 1 for a list of the DMEPOS supplier standards. To enroll in the medicare program and be eligible to submit claims and receive payments, every DMEPOS supplier applicant must meet and maintain these enrollment standards.

See page 2 to determine if you are completing the correct application.

See page 4 for information on where to mail this application.

See section 12 for a list of supporting documentation to be submitted with this application.

To view your current medicare enrollment record go to:
PECOS.cms.hhs.gov

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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DMEPOS SUPPLIER STANDARDS FOR MEDICARE ENROLLMENT

Below is an abbreviated summary of the standards every Medicare DMEPOS supplier must meet in order to obtain and retain their billing privileges. These standards, in their entirety, including the surety bond provisions, are listed in 42 C.F.R. section 424.57(c) and (d) and can be found at:

CMS.gov/medicare/provider-enrollment-and-certification/enroll-as-a-dmepos-supplier.

1. A supplier must be in compliance with all applicable federal and state licensure and regulatory requirements.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. A supplier must have an authorized individual whose signature is binding sign the enrollment application for billing privileges.
4. A supplier must fill orders from its own inventory or contract with other companies for the purchase of items necessary to fill orders. A supplier cannot contract with any entity that is currently excluded from the Medicare program, any state health care programs, or any other federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable state law, and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site and must maintain a visible sign with posted hours of operation. The location must be accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records.
8. A supplier must permit CMS or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items this insurance must also cover product liability and completed operations.
11. A supplier is prohibited from direct solicitation to Medicare beneficiaries. For complete details on this prohibition see 42 C.F.R. section 424.57(c)(11).
12. A supplier is responsible for delivery of and must instruct beneficiaries on the use of Medicare covered items, and maintain proof of delivery and beneficiary instruction.
13. A supplier must answer questions and respond to complaints of beneficiaries and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair cost either directly or through a service contract with another company, any Medicare-covered items it has rented to beneficiaries.
15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these standards to each beneficiary it supplies a Medicare-covered item.
17. A supplier must disclose any person having ownership, financial or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number; i.e., the supplier may not sell or allow another entity to use its Medicare billing number.
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number and Medicare Beneficiary Identifier of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
21. A supplier must agree to furnish CMS any information required by the Medicare statute and regulations.
22. A supplier must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services for which the supplier is accredited in order for the supplier to receive payment for those specific products and services (unless an exception applies).
23. A supplier must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
25. A supplier must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
26. A supplier must meet the surety bond requirements specified in 42 C.F.R. section 424.57(d) (unless an exception applies).
27. A supplier must obtain oxygen from a state-licensed oxygen supplier.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 C.F.R. section 424.516(f).
29. A supplier is prohibited from sharing a practice location with other Medicare providers and suppliers.
30. A supplier must remain open to the public for a minimum of 30 hours per week except physicians (as defined in section 1848(j) (3) of the Act), physical and occupational therapists or DMEPOS suppliers working with custom made orthotics and prosthetics.

WHO SHOULD COMPLETE AND SUBMIT THIS APPLICATION

The following types of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers must complete this application to enroll in the Medicare program and receive a Medicare Billing number:

- Ambulatory Surgical Center
- Department Store
- Grocery Store
- Home Health Agency
- Hospital
- Indian Health Service or Tribal Facility
- Intermediate Care Nursing Facility
- Medical Supply Company
- Nursing Facility (other)
- Occularist
- Occupational Therapist
- Optician
- Orthotics Personnel
- Oxygen and/or Oxygen Related Equipment Supplier
- Pedorthic Personnel
- Pharmacy
- Physical Therapist
- Physician, including Dentist and Optometrist
- Prosthetics Personnel
- Prosthetic/Orthotic Personnel
- Rehabilitation Agency
- Skilled Nursing Facility
- Sleep Laboratory/Medicine
- Sports Medicine

If your DMEPOS supplier type is not listed, contact the National Supplier Clearinghouse Medicare Administrative Contractor (NSC MAC) before you submit this application.

Complete this application if you plan to bill or already bill Medicare for DMEPOS and you are:

- Enrolling in Medicare for the first time as a DMEPOS supplier.
- Currently enrolled in Medicare as a DMEPOS supplier and need to report changes to your current business, (e.g., you are adding, removing, or changing existing information under this Medicare supplier billing number). Changes must be reported within 30 days of the change.
- Currently enrolled in Medicare as a DMEPOS supplier and need to enroll a new business location using the same tax identification number already enrolled with the NSC MAC.
- Currently enrolled in Medicare as a DMEPOS supplier and need to enroll a new business location using a tax identification number not currently enrolled with the NSC MAC.
- Currently enrolled in Medicare as a DMEPOS supplier and received notice to revalidate your enrollment.
- Reactivating your Medicare DMEPOS supplier billing number.
- Voluntarily terminating your Medicare DMEPOS supplier billing number.

DMEPOS suppliers can apply for enrollment in the Medicare program or make a change in their enrollment information using either:

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

For additional information regarding the Medicare enrollment process, including Internet-based PECOS and to get the current version of the CMS-855S, go to **CMS.gov/MedicareProviderSupenroll**.

BILLING NUMBER AND NATIONAL PROVIDER IDENTIFIER INFORMATION

The Medicare Identification Number, often referred to as a Medicare supplier number or Medicare billing number is a generic term for any number other than the National Provider Identifier (NPI) that is used by a DMEPOS supplier to bill the Medicare program.

The NPI is the standard unique health identifier for health care providers and suppliers and is assigned by the National Plan and Provider Enumeration System (NPPES). **To enroll in Medicare, you must obtain an NPI and furnish it on this application prior to enrolling in Medicare or when submitting a change to your existing Medicare enrollment information.** Applying for the NPI is a process separate from Medicare enrollment. To obtain an NPI, you may apply online at **NPPES.cms.hhs.gov**. For more information about NPI enumeration, visit **CMS.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand**.

NOTE: The Name that you furnish in section 2A and if applicable Legal Business Name (LBN) and Tax Identification Number (TIN) you furnish in section 4A must be the same Name, LBN, and TIN you used to obtain your NPI. Once this information is entered into PECOS from this application, your Name, LBN, TIN and NPI ***must*** match exactly in both the Medicare Provider Enrollment Chain and Ownership System and the National Plan and Provider Enumeration System.

INSTRUCTIONS FOR COMPLETING AND SUBMITTING THIS APPLICATION

All information on this form is required with the exception of those fields specifically marked as "optional." Any field marked as optional is not required to be completed nor does it need to be updated or reported as a "change of information" as required in 42 C.F.R. section 424.516. However, it is highly recommended that if reported, these fields be kept up-to-date.

- Type or print all information so that it is legible. Do not use pencil. Blue ink is preferred.
- When necessary to report additional information, copy and complete the applicable section as needed.
- Attach all supporting documentation.
- Keep a copy of your completed Medicare enrollment package for your own records.

TIPS TO AVOID DELAYS IN YOUR ENROLLMENT

To avoid delays in the enrollment process, you should:

- The supplier pays the required application fee (via **PECOS.cms.hhs.gov/PECOS/FeePaymentWelcome.do**) upon initial enrollment, the addition of a new business location, revalidation and, if requested, reactivation PRIOR to completing and submitting this application to the NSC MAC. Please note the application fee must be paid in the calendar year you are submitting the CMS-855S application;
- Complete all required sections as shown in Section 1;
- Complete Section 6 for all Delegated and Authorized Officials reported in Section 15;
- Report at least one owner and one managing employee for each location;
- Enter your NPI in the applicable sections;
- Respond timely to development/information requests;
- Be sure the Legal Business Name shown in Section 4A matches the name on your tax documents;
- Include Copy of Certification of Insurance for comprehensive liability policy;
- Include the Electronic Funds Transfer (EFT) Authorization Agreement (when applicable) with your enrollment application with a voided check or bank letter;
- Sign and date section 15; and
- Ensure all supporting documents are sent to the NSC MAC.

Additional information and reasons for processing delays can be found at **palmettogba.com/nsc**.

PROCESS FOR OBTAINING MEDICARE APPROVAL

The standard process for becoming a Medicare DMEPOS supplier is as follows:

1. The supplier obtains the required National Provider Identification Number (NPI), surety bond and/or accreditation **prior** to completing and submitting this application to the NSC MAC.
2. The supplier pays the required application fee (via **PECOS.cms.hhs.gov/PECOS/FeePaymentWelcome.do**) upon initial enrollment, the addition of a new business location, revalidation and, if requested, reactivation **PRIOR** to completing and submitting this application to the NSC MAC.
3. The supplier completes and submits this enrollment application (CMS-855S) and all supporting documentation to the NSC MAC.
4. If requested by the NSC MAC, the supplier submits a fingerprint background check. **NOTE:** Contact Accurate Biometrics for fingerprinting procedures, to find a fingerprint collection site, and to ensure the fingerprint results are accurately submitted to the Federal Bureau of Investigation (FBI) and properly returned to CMS. Accurate Biometrics can be contacted at 866-361-9944 or visit their website at **CMSFingerPrinting.com**.
5. The NSC MAC reviews the application and conducts a site visit to verify compliance with the supplier standards found at 42 C.F.R. sections 424.57, 424.58, and 424.500 et seq.
6. After completing its review, the NSC MAC notifies the supplier in writing about its enrollment decision.
7. Billing privileges are not effective until the NSC MAC assigns your Medicare Identification Number.

ADDITIONAL INFORMATION

- You may visit our website to learn more about the enrollment process via the Internet-Based Provider Enrollment Chain and Ownership System (PECOS) at: **CMS.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/InternetbasedPECOS.html**.

  Also, all of the CMS-855 applications are located on the CMS webpage: **CMS.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List**.

  Simply enter "855" in the "Filter On" box on this page and only the application forms will be displayed to choose from.
- The NSC MAC may request additional documentation to support or validate information reported on this application. You are responsible for providing this documentation within 30 days of the request per 42 C.F.R. section 424.525(a)(1).
- The information you provide on this form is protected under 5 U.S.C. section 552(b)(4) and/or (b)(6), respectively. For more information, see the last page of this application to read the Privacy Act Statement.

ACRONYMS COMMONLY USED IN THIS APPLICATION

C.F.R.: Code of Federal Regulations

DME MAC: Durable Medical Equipment Medicare Administrative Contractor

DMEPOS: Durable Medical Equipment, Prosthetics, Orthotics and Supplies

EFT: Electronic Funds Transfer

IHS: Indian Health Service

IRS: Internal Revenue Service

LBN: Legal Business Name

LLC: Limited Liability Corporation

NPI: National Provider Identifier

NPPES: National Plan and Provider Enumeration System

NSC MAC: National Supplier Clearinghouse Medicare Administrative Contractor

PECOS: Provider Enrollment Chain and Ownership System

PTAN: Provider Transaction Access Number also referred to as the Medicare Identification Number

SSN: Social Security Number

TIN: Tax Identification Number

DEFINITIONS

NOTE: For the purposes of this CMS-855S application, the following definitions apply:

- **Add:** You are adding additional enrollment information to your existing information (e.g. practice locations).
- **Change:** You are replacing existing information with new information (e.g. billing agency, managing employee) or updating existing information (e.g. change in suite #, telephone #).
- **Remove:** You are removing existing enrollment information.

WHERE TO MAIL YOUR APPLICATION

The NSC MAC is responsible for processing your enrollment application. Mail this application to:

National Supplier Clearinghouse
Post Office Box 100142
Columbia, SC 29202-3142

Customer Service: 1-866-238-9652
Web: **palmettogba.com/nsc**

Overnight Mailing Address:
National Supplier Clearinghouse
Palmetto GBA* AG-495
2300 Springdale Drive, Bldg. 1
Camden, SC 29020

SECTION 1: BASIC INFORMATION

Read this in full prior to indicating the reason for submission in Section 1A.

NEW ENROLLEES AND THOSE REPORTING A NEW TAX ID NUMBER

You are considered a new enrollee if you are:

- Enrolling in the Medicare program as a DMEPOS supplier for the first time under the tax identification number reported in Section 2B.
- Currently enrolled in the Medicare program as a DMEPOS supplier but have a new tax identification number. If you are reporting a change to your tax identification number, you must complete a new CMS-855S enrollment application in its entirety.
- A currently enrolled DMEPOS supplier under new ownership with a different tax identification number. (**NOTE:** New owners of existing DMEPOS suppliers must submit a dated bill of sale with the effective date of the new ownership.)

CURRENTLY ENROLLED MEDICARE DMEPOS SUPPLIERS

Adding a new location
If you are currently enrolled as a Medicare DMEPOS supplier and are applying to enroll a new business location using a tax identification number that is already enrolled with the NSC MAC, you will need to complete only the required sections listed in Section 1A of this application for the new location.

Change of information other than adding a new location
If you are adding, removing, or changing information under your current Medicare supplier billing number, including a change of ownership that does not change the current tax identification number, you will need to complete the appropriate sections as instructed and submit any new documentation. Any change to your existing enrollment data must be reported within 30 days of the effective date of the change.

Reactivation
If your Medicare DMEPOS supplier billing number was deactivated, you will be required to submit an updated CMS-855S. You must also meet all current requirements for your supplier type to reactivate your supplier billing number.

Revalidation
If you have been contacted by the NSC MAC to revalidate your Medicare enrollment, you will be required to submit an updated enrollment application. Do not submit an application for revalidation until you have been contacted by the NSC MAC.

Voluntary termination
If you will no longer provide DMEPOS items or services to Medicare beneficiaries, you should voluntarily terminate your enrollment in the Medicare program as a DMEPOS supplier.

NOTE: Enrollment applications submitted for "NEW ENROLLEES" **MUST** be signed by an Authorized Official.

SECTION 1: BASIC INFORMATION *(Continued)*

A. REASON FOR SUBMITTING THIS APPLICATION

Check one box and complete the sections as indicated.

☐ You are a **new enrollee** in Medicare or are enrolling a new business location with a tax identification number not previously enrolled with the NSC MAC.	**Complete all sections**
☐ You are **adding a new business location** using a tax identification number currently enrolled with the NSC MAC.	**Complete sections 1 – 4, 6 (for managing employee only), 12, 13 (optional) and 15**
☐ You are **reactivating** your Medicare supplier billing number.	**Complete all sections**
☐ You are **revalidating** your Medicare enrollment.	**Complete all sections**
☐ You are **voluntarily terminating your Medicare enrollment**. Effective date of termination *(mm/dd/yyyy)*:	**Complete sections 1, 2B, 4B, 4D, 13 (optional), and 15**
☐ You are **changing your Medicare enrollment information** other than your tax identification number.	**Go to section 1B**
☐ You are **changing your Tax Identification Number**.	**Complete all sections**

B. WHAT INFORMATION IS CHANGING?

Check all that apply and complete the required sections.

Please note: When reporting ANY information, sections 1B, 2B, 3, and 15 **MUST** always be completed in addition to completing the information that is changing within the required section.

☐ Current Business Location	**1, 2B, 3, 12 (if applicable), 13 (optional), and 15**
☐ Supplier Type (submit licensure if applicable) ☐ Products and Services (submit accreditation if applicable)	**1, 2B, 2E1, 2E4, 3, 12 (if applicable), 13 (optional), and 15**
☐ Accreditation Information	**1, 2B, 2E, 3, 12 (if applicable), 13 (optional), and 15**
☐ Address Information ☐ 1099 Mailing Address ☐ Correspondence Mailing Address ☐ Medical Record Correspondence Address ☐ Revalidation Mailing Address ☐ Remittance/Special Payment Mailing Address ☐ Record Storage Address	**1, 2B, 3, 4 as applicable for the address(es) that is/are being changed, 12 (if applicable), 13 (optional), and 15**
☐ Comprehensive Liability Insurance Information	**1, 2B, 3, 7A, 12 (if applicable), 13 (optional), and 15**
☐ Surety Bond Information	**1, 2B, 3, 7B, 12 (if applicable), 13 (optional), and 15**
☐ Final Adverse Legal Actions	**1, 2B, 3, 12 (if applicable), 13 (optional), and 15**
☐ Ownership and/or Managing Control Information (Organizations and/or Individuals)	**1, 2B, 3, 5 and/or 6 (as applicable), 12 (if applicable), 13 (optional), and 15**
☐ Billing Agency Information	**1, 2B, 3, 8, 12 (if applicable), 13 (optional), and 15**
☐ Authorized Official	**1, 2B, 3, 12 (if applicable), 13 (optional), 15A and 15B**
☐ Delegated Official	**1, 2B, 3, 12 (if applicable), 13 (optional), 15C and 15D**
☐ Any other information not specified above	**1, 2B, 3, 12 (if applicable), 13 (optional), 15**

SECTION 2: IDENTIFYING INFORMATION

A. BUSINESS LOCATION

Provide the two-letter State Code (e.g., TX for Texas) where this business is physically located. ☐☐

1. Business Location Information

- DMEPOS suppliers must complete and submit a separate CMS-855S enrollment application to enroll each physical location (i.e., store or other retail establishment) used to furnish Medicare covered DMEPOS to Medicare beneficiaries, except for locations only used as warehouses or repair facilities.
- The address must be a specific street address as recorded by the United States Postal Service. Do not furnish a P.O. Box. If you are located in a hospital and/or other health care facility and you provide services to patients at that facility, furnish the name and address of the hospital or facility.
- A change to the business location address requires submission of professional and business licenses for the new address, and proof of insurance covering the new address.

If you are reporting a change of information to your current business location, check the box below and furnish the effective date. **NOTE:** if changing, this will replace your current business location address on file.

☐ Change Effective Date *(mm/dd/yyyy)*: _____

Business Location Name/Doing Business As Name

Business Location Address Line 1 *(Street Name and Number)*

Business Location Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

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

Date this Business Started at this Location *(mm/dd/yyyy)*	Date this Business Terminated at this Location *(if applicable) (mm/dd/yyyy)*

2. Hours of Operation

List your ***posted*** hours of operation as displayed at the business location in Section 2A1 above.

If you are reporting a change to your hours of operation, check the box below and furnish the effective date.

☐ Change Effective Date *(mm/dd/yyyy)*: _____

You must list all hours of each day you are open to the public.

Check and/or complete all boxes and/or sections for each day as appropriate.

☐ Open 24/7 (Open 24 hours a day, 7 days a week)

☐ By Appointment Only (no fixed days or hours)

NOTE: "By Appointment Only" can only be checked if you meet the exception requirements stated in 42 C.F.R. section 424.57(c)(30).

Day of Week	Hours (indicate A.M. or P.M.)		Hours (indicate A.M. or P.M.)		Total Hours Open to the Public Each Day
	Open	Close	Open	Close	
Sunday					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
				Total Hours Open to the Public Weekly	0

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

B. BUSINESS IDENTIFICATION INFORMATION

DMEPOS suppliers must furnish their Legal Business Name (LBN) as reported to the Internal Revenue Service (IRS), National Provider Identifier (NPI), Tax Identification Number (TIN), and supplier billing number (if issued) below.

NOTE: Each business location **MUST** have its own NPI, unless enrolling as a sole proprietor/proprietorship with multiple locations.

Legal Business Name (LBN)

National Provider Identifier (NPI)	Tax Identification Number (TIN)	Supplier Billing Number *(if issued)*

Other Name *(if applicable)*

Type of Other Name *(if applicable).* Check box indicating Type of Other Name:

☐ Former Legal Business Name

☐ Doing Business As Name

☐ Other *(Describe)*: _____

C. BUSINESS STRUCTURE INFORMATION

Identify how your business is registered with the IRS. (**NOTE:** If your business is a Federal and/or State government supplier, indicate "Non-Profit" below. In addition, government-owned entities do not need to provide an IRS Form 501(c)(3)).

☐ Disregarded Entity (Submit IRS Form 8832)

☐ Government-Owned

☐ Non-Profit (Submit IRS Form 501(c)(3)

☐ Non-Publically Traded Corporation (regardless of whether the supplier is "for-profit" or "non-profit")

☐ Proprietary

☐ Publically Traded Corporation (regardless of whether the supplier is "for-profit" or "non-profit")

NOTE: If a checkbox identifying how the business is registered with the IRS is not completed, the supplier will be defaulted to "Proprietary."

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

☐ Corporation

☐ Limited Liability Company

☐ Partnership

☐ Sole Proprietor

☐ Other *(Specify)*: _____

Is this supplier an Indian Health Service (IHS) Facility? ☐ Yes ☐ No

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

D. STATES WHERE ITEMS ARE PROVIDED

Select all State(s)/Territory(ies) where you provide items or services to Medicare beneficiaries from the business location in Section 2A. For each State/Territory selected, submit all required licenses for the products and services being provided. The NSC MAC website at **palmettogba.com/nsc** may offer guidance on licensure requirements.

Jurisdiction A:

☐ All States in Jurisdiction A

☐ Connecticut ..... ☐ Add ☐ Remove
☐ Delaware ..... ☐ Add ☐ Remove
☐ District of Columbia..... ☐ Add ☐ Remove
☐ Maine..... ☐ Add ☐ Remove
☐ Maryland ..... ☐ Add ☐ Remove
☐ Massachusetts ..... ☐ Add ☐ Remove
☐ New Hampshire ..... ☐ Add ☐ Remove
☐ New Jersey..... ☐ Add ☐ Remove
☐ New York ..... ☐ Add ☐ Remove
☐ Pennsylvania..... ☐ Add ☐ Remove
☐ Rhode Island..... ☐ Add ☐ Remove
☐ Vermont..... ☐ Add ☐ Remove

Jurisdiction B:

☐ All States in Jurisdiction B

☐ Illinois..... ☐ Add ☐ Remove
☐ Indiana..... ☐ Add ☐ Remove
☐ Kentucky..... ☐ Add ☐ Remove
☐ Michigan..... ☐ Add ☐ Remove
☐ Minnesota ..... ☐ Add ☐ Remove
☐ Ohio ..... ☐ Add ☐ Remove
☐ Wisconsin..... ☐ Add ☐ Remove

Jurisdiction C:

☐ All States in Jurisdiction C

☐ Alabama ..... ☐ Add ☐ Remove
☐ Arkansas ..... ☐ Add ☐ Remove
☐ Colorado..... ☐ Add ☐ Remove
☐ Florida..... ☐ Add ☐ Remove
☐ Georgia..... ☐ Add ☐ Remove
☐ Louisiana ..... ☐ Add ☐ Remove
☐ Mississippi..... ☐ Add ☐ Remove
☐ New Mexico..... ☐ Add ☐ Remove
☐ North Carolina ..... ☐ Add ☐ Remove
☐ Oklahoma..... ☐ Add ☐ Remove
☐ Puerto Rico ..... ☐ Add ☐ Remove
☐ South Carolina ..... ☐ Add ☐ Remove
☐ Tennessee ..... ☐ Add ☐ Remove
☐ Texas ..... ☐ Add ☐ Remove
☐ Virgin Islands..... ☐ Add ☐ Remove
☐ Virginia ..... ☐ Add ☐ Remove
☐ West Virginia..... ☐ Add ☐ Remove

Jurisdiction D:

☐ All States in Jurisdiction D

☐ Alaska ..... ☐ Add ☐ Remove
☐ Arizona ..... ☐ Add ☐ Remove
☐ California..... ☐ Add ☐ Remove
☐ Guam ..... ☐ Add ☐ Remove
☐ Hawaii..... ☐ Add ☐ Remove
☐ Idaho..... ☐ Add ☐ Remove
☐ Iowa ..... ☐ Add ☐ Remove
☐ Kansas..... ☐ Add ☐ Remove
☐ Missouri ..... ☐ Add ☐ Remove
☐ Montana..... ☐ Add ☐ Remove
☐ Nebraska..... ☐ Add ☐ Remove
☐ Nevada..... ☐ Add ☐ Remove
☐ North Dakota ..... ☐ Add ☐ Remove
☐ Oregon ..... ☐ Add ☐ Remove
☐ South Dakota ..... ☐ Add ☐ Remove
☐ Utah ..... ☐ Add ☐ Remove
☐ Washington..... ☐ Add ☐ Remove
☐ Wyoming..... ☐ Add ☐ Remove
☐ Northern Mariana Islands .... ☐ Add ☐ Remove
☐ American Samoa..... ☐ Add ☐ Remove

E. PRODUCTS AND ACCREDITATION INFORMATION

1. Type of Supplier

The supplier must meet all Medicare requirements for the DMEPOS supplier type checked. Any specialty personnel including, but not limited to, respiratory therapists, and orthotics/prosthetics personnel, must meet all licensure requirements applicable to its supplier type and applicable to the products and services checked in sections 2E3 and 2E4.

Check all that apply:

- ☐ Ambulatory Surgical Center ... ☐ Add ☐ Remove
- ☐ Department Store ... ☐ Add ☐ Remove
- ☐ Chiropractor ... ☐ Add ☐ Remove
- ☐ Grocery Store ... ☐ Add ☐ Remove
- ☐ Home Health Agency ... ☐ Add ☐ Remove
- ☐ Hospital ... ☐ Add ☐ Remove
- ☐ Indian Health Service or Tribal Facility ... ☐ Add ☐ Remove
- ☐ Intermediate Care Nursing Facility ... ☐ Add ☐ Remove
- ☐ Medical Supply Company ... ☐ Add ☐ Remove
- ☐ Medical Supply Company with Orthotics Personnel ... ☐ Add ☐ Remove
- ☐ Medical Supply Company with Pedorthic Personnel ... ☐ Add ☐ Remove
- ☐ Medical Supply Company with Prosthetics Personnel ... ☐ Add ☐ Remove
- ☐ Medical Supply Company with Prosthetic and Orthotic Personnel ... ☐ Add ☐ Remove
- ☐ Medical Supply Company with Registered Pharmacist ... ☐ Add ☐ Remove
- ☐ Medical Supply Company with Respiratory Therapist ... ☐ Add ☐ Remove
- ☐ Nursing Facility (other) ... ☐ Add ☐ Remove
- ☐ Occularist ... ☐ Add ☐ Remove
- ☐ Occupational Therapist ... ☐ Add ☐ Remove
- ☐ Optician ... ☐ Add ☐ Remove
- ☐ Orthotics Personnel ... ☐ Add ☐ Remove
- ☐ Oxygen and/or Oxygen Related Equipment Supplier ... ☐ Add ☐ Remove
- ☐ Pedorthic Personnel ... ☐ Add ☐ Remove
- ☐ Pharmacy ... ☐ Add ☐ Remove
- ☐ Physical Therapist ... ☐ Add ☐ Remove
- ☐ Physician ... ☐ Add ☐ Remove
- ☐ Physician/Dentist ... ☐ Add ☐ Remove
- ☐ Physician/Optometrist ... ☐ Add ☐ Remove
- ☐ Prosthetics Personnel ... ☐ Add ☐ Remove
- ☐ Prosthetic and Orthotic Personnel ... ☐ Add ☐ Remove
- ☐ Rehabilitation Agency ... ☐ Add ☐ Remove
- ☐ Skilled Nursing Facility ... ☐ Add ☐ Remove
- ☐ Sleep Laboratory/Medicine ... ☐ Add ☐ Remove
- ☐ Sports Medicine ... ☐ Add ☐ Remove
- ☐ Other *(specify)*: _____ ... ☐ Add ☐ Remove

NOTE: Only use "other" checkbox if your supplier type is eligible to enroll and bill the Medicare program but is not reflected in the list of suppliers. If you are unsure if you are eligible to enroll contact your designated NSC MAC before you submit this application.

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

2. Accreditation Information

To determine if you qualify for exemption, go to **palmettogba.com/nsc**.

☐ The enrolling supplier business location in Section 2A is accredited. (Complete the information about the accrediting organization below).

☐ The enrolling supplier business location in Section 2A is exempt from the accreditation requirement for the following reason:

- ☐ The supplier is exempt from DMEPOS accreditation based on supplier type.
- ☐ The supplier location is previously enrolled pharmacy with attestation on file.
- ☐ The supplier is a pharmacy providing only non-accredited products. Complete section 2E3.

NOTE: Copy and complete this section if more than one accreditation needs to be reported.

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

3. Non-Accredited Products

Check all that apply. These products do not require accreditation.

☐ Epoetin ..... ☐ Add ☐ Remove

☐ Immunosuppressive Drugs .... ☐ Add ☐ Remove

☐ Infusion Drugs ..... ☐ Add ☐ Remove

☐ Nebulizer Drugs ..... ☐ Add ☐ Remove

☐ Oral Anticancer Drugs ..... ☐ Add ☐ Remove

☐ Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics) ..... ☐ Add ☐ Remove

NOTE: ☐ Check here if the supplier provides one or more of the products shown above but does not furnish any of the products and/or services listed in Section 2E4. If checked, skip Section 2E4 and continue to Section 3.

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

4. Products and Services Furnished by this Supplier

- **Check all that apply** and submit all applicable licenses and/or certifications. Additionally, if you fill orders, fabricate, or fit items by contracting with other companies for the purchase of items necessary to fill the order, submit copies of all applicable contracts.
- If you are unsure of the licensure and/or certification and/or accreditation requirements for your product(s) or services(s), check with your state. The NSC MAC website at **palmettogba.com/nsc** may offer guidance. Failure to attach applicable licensure, certification and/or contracts could result in denial or revocation of your Medicare billing privileges and/or overpayment collection.

Add/Remove	Product/Services	Fills orders, fabricates or fits items from own inventory	Contracts with another company for the purchase of items necessary to fill orders
☐ Add ☐ Remove	Automatic External Defibrillators (AEDs) and/or Supplies	☐	☐
☐ Add ☐ Remove	Blood Glucose Monitors and/or Supplies (mail order)	☐	☐
☐ Add ☐ Remove	Blood Glucose Monitors and/or Supplies (non-mail order)	☐	☐
☐ Add ☐ Remove	Breast Prostheses and/or Accessories	☐	☐
☐ Add ☐ Remove	Canes and/or Crutches	☐	☐
☐ Add ☐ Remove	Cochlear Implants	☐	☐
☐ Add ☐ Remove	Commodes/Urinals/Bedpans	☐	☐
☐ Add ☐ Remove	Continuous Passive Motion (CPM) Devices	☐	☐
☐ Add ☐ Remove	Continuous Positive Airway Pressure (CPAP) Devices and/or Supplies	☐	☐
☐ Add ☐ Remove	Contracture Treatment Devices: Dynamic Splint	☐	☐
☐ Add ☐ Remove	Diabetic Shoes/Inserts	☐	☐
☐ Add ☐ Remove	Diabetic Shoes/Inserts – Custom	☐	☐
☐ Add ☐ Remove	Enteral Nutrients	☐	☐
☐ Add ☐ Remove	Enteral Equipment and/or Supplies	☐	☐
☐ Add ☐ Remove	External Infusion Pumps	☐	☐
☐ Add ☐ Remove	External Infusion Pump Supplies	☐	☐
☐ Add ☐ Remove	Facial Prostheses	☐	☐
☐ Add ☐ Remove	Gastric Suction Pumps	☐	☐
☐ Add ☐ Remove	Heat & Cold Applications	☐	☐
☐ Add ☐ Remove	High Frequency Chest Wall Oscillation (HFCWO) Devices and/or Supplies	☐	☐
☐ Add ☐ Remove	Hospital Beds: Electric	☐	☐
☐ Add ☐ Remove	Hospital Beds: Manual	☐	☐
☐ Add ☐ Remove	Implanted Infusion Pumps and/or Supplies	☐	☐
☐ Add ☐ Remove	Infrared Heating Pad Systems and/or Supplies	☐	☐

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

4. Products and Services Furnished by this Supplier *(Continued)*

Add/Remove	Product/Services	Fills orders, fabricates or fits items from own inventory	Contracts with another company for the purchase of items necessary to fill orders
☐ Add ☐ Remove	Insulin Infusion Pumps	☐	☐
☐ Add ☐ Remove	Insulin Infusion Pump Supplies	☐	☐
☐ Add ☐ Remove	Intermittent Positive Pressure Breathing (IPPB) Devices	☐	☐
☐ Add ☐ Remove	Intrapulmonary Percussive Ventilation Devices	☐	☐
☐ Add ☐ Remove	Limb Prostheses	☐	☐
☐ Add ☐ Remove	Mechanical In-Exsufflation Devices	☐	☐
☐ Add ☐ Remove	Nebulizer Equipment and/or Supplies	☐	☐
☐ Add ☐ Remove	Negative Pressure Wound Therapy Pumps and/or Supplies	☐	☐
☐ Add ☐ Remove	Neuromuscular Electrical Stimulators (NMES) and/or Supplies	☐	☐
☐ Add ☐ Remove	Neurostimulators and/or Supplies	☐	☐
☐ Add ☐ Remove	Ocular Prostheses	☐	☐
☐ Add ☐ Remove	Orthoses: Custom Fabricated	☐	☐
☐ Add ☐ Remove	Orthoses: Prefabricated (custom fitted)	☐	☐
☐ Add ☐ Remove	Orthoses: Off-the-Shelf	☐	☐
☐ Add ☐ Remove	Osteogenesis Stimulators	☐	☐
☐ Add ☐ Remove	Ostomy Supplies	☐	☐
☐ Add ☐ Remove	Oxygen	☐	☐
☐ Add ☐ Remove	Oxygen Equipment and/or Supplies	☐	☐
☐ Add ☐ Remove	Parenteral Nutrients	☐	☐
☐ Add ☐ Remove	Parenteral Equipment and/or Supplies	☐	☐
☐ Add ☐ Remove	Patient Lifts	☐	☐
☐ Add ☐ Remove	Penile Pumps	☐	☐
☐ Add ☐ Remove	Pneumatic Compression Devices and/or Supplies	☐	☐
☐ Add ☐ Remove	Power Operated Vehicles (Scooters)	☐	☐
☐ Add ☐ Remove	Prosthetic Lenses: Conventional Contact Lenses	☐	☐
☐ Add ☐ Remove	Prosthetic Lenses: Conventional Eyeglasses	☐	☐
☐ Add ☐ Remove	Prosthetic Lenses: Prosthetic Cataract Lenses	☐	☐
☐ Add ☐ Remove	Respiratory Assist Devices	☐	☐

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

4. Products and Services Furnished by this Supplier *(Continued)*

Add/Remove	Product/Services	Fills orders, fabricates or fits items from own inventory	Contracts with another company for the purchase of items necessary to fill orders
☐ Add ☐ Remove	Respiratory Suction Pumps	☐	☐
☐ Add ☐ Remove	Seat Lift Mechanisms	☐	☐
☐ Add ☐ Remove	Somatic Prostheses	☐	☐
☐ Add ☐ Remove	Speech Generating Devices	☐	☐
☐ Add ☐ Remove	Support Surfaces: Pressure Reducing Beds/Mattresses/ Overlays/Pads – New	☐	☐
☐ Add ☐ Remove	Support Surfaces: Pressure Reducing Beds/Mattresses/ Overlays/Pads – Used	☐	☐
☐ Add ☐ Remove	Surgical Dressings	☐	☐
☐ Add ☐ Remove	Tracheostomy Supplies	☐	☐
☐ Add ☐ Remove	Traction Equipment	☐	☐
☐ Add ☐ Remove	Transcutaneous Electrical Nerve Stimulators (TENS) and/or Supplies	☐	☐
☐ Add ☐ Remove	Ultraviolet Light Devices and/or Supplies	☐	☐
☐ Add ☐ Remove	Urological Supplies	☐	☐
☐ Add ☐ Remove	Ventilators: All Types – Not CPAP or RAD	☐	☐
☐ Add ☐ Remove	Voice Prosthetics	☐	☐
☐ Add ☐ Remove	Walkers	☐	☐
☐ Add ☐ Remove	Wheelchair Seating/Cushions	☐	☐
☐ Add ☐ Remove	Wheelchairs: Complex Rehabilitative Manual Wheelchairs	☐	☐
☐ Add ☐ Remove	Wheelchairs: Complex Rehabilitative Manual Wheelchair Related Accessories	☐	☐
☐ Add ☐ Remove	Wheelchairs: Complex Rehabilitative Power Wheelchairs	☐	☐
☐ Add ☐ Remove	Wheelchairs: Complex Rehabilitative Power Wheelchair Related Accessories	☐	☐
☐ Add ☐ Remove	Wheelchairs: Standard Manual	☐	☐
☐ Add ☐ Remove	Wheelchairs: Standard Manual Related Accessories and Repairs	☐	☐
☐ Add ☐ Remove	Wheelchairs: Standard Power	☐	☐
☐ Add ☐ Remove	Wheelchairs: Standard Power Related Accessories and Repairs	☐	☐

SECTION 3: FINAL ADVERSE LEGAL ACTIONS

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

NOTE: To satisfy the reporting requirement, section 3 must be filled out in its entirety, **and all applicable attachments must be included.**

A. FEDERAL AND STATE CONVICTIONS (Conviction as defined in 42 C.F.R. Section 1001.2) WITHIN THE PRECEDING 10 YEARS

1. Any federal or state felony conviction(s).
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 the theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any misdemeanor conviction, under federal or state law, related to the interference with or obstruction of any investigation into any criminal offence described in 42 C.F.R. section 1001.101 or 1001.201.
5. Any misdemeanor conviction, under federal or state law, related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

B. EXCLUSIONS, REVOCATIONS OR SUSPENSIONS

1. Any current or past revocation, suspension, or voluntary surrender of a medical license in lieu of further disciplinary action.
2. Any current or past revocation or suspension of accreditation.
3. Any current or past suspension or exclusion imposed by the U.S. Department of Health and Human Service's Office of Inspector General (OIG).
4. Any current or past debarment from participation in any Federal Executive Branch procurement or non-procurement program.
5. Any other current or past federal sanctions (A penalty imposed by a Federal governing body (e.g. Civil Monetary Penalties (CMP), Corporate Integrity Agreement (CIA)).
6. Any Medicaid exclusion, revocation, or termination of any billing number.

C. FINAL ADVERSE LEGAL ACTION HISTORY

1. Has your organization, under any current or former name or business identity, ever had a final adverse legal action listed above imposed against it?

   ☐ **YES** – continue below ☐ **NO** – skip to section 4

2. If yes, report each final adverse legal action, when it occurred, and the federal or state agency or the court/ administrative body that imposed the action.

FINAL ADVERSE LEGAL ACTION	DATE	ACTION TAKEN BY

SECTION 4: IMPORTANT ADDRESS INFORMATION

A. 1099 MAILING ADDRESS

1. Organizational Suppliers (e.g., Corporations, Partnerships, LLCs, Sub-Chapter S)

If you are an organizational supplier, furnish the supplier's legal business name (as reported to the IRS) and TIN. Furnish 1099 mailing address information where indicated. A copy of the IRS Form CP-575 or other document issued by the IRS showing the TIN and LBN for this business MUST be submitted.

If you are reporting a change to your 1099 mailing address, check the box below and furnish the effective date.

NOTE: if changing, this will replace your current 1099 address on file.

☐ Change Effective Date *(mm/dd/yyyy)*: _____

Organizational Suppliers: 1099 Mailing Address

Legal Business Name as Reported to the IRS		
Tax Identification Number	Prior Tax Identification Number *(if applicable)*	
1099 Mailing Address Line 1 *(P.O. Box or Street Name and Number)*		
1099 Mailing Address Line 2 *(Suite, Room, Apt. #, etc.)*		
1099 Mailing Address City/Town	1099 Mailing Address State	1099 Mailing Address ZIP Code + 4
Telephone Number *(if applicable)*	Fax Number *(if applicable)*	Email Address *(if applicable)*

2. Sole Proprietors

If you are a sole proprietor (the only owner of a business that is not incorporated), list your Social Security Number (SSN) and the full legal name associated with your SSN as reported to the IRS in the appropriate fields. If you want your Medicare payments reported under your Employer Identification Number (EIN), furnish it in the appropriate space below. Furnish 1099 mailing address information where indicated.

NOTE: Sole proprietors: If you furnish an EIN, payment will be made to your EIN. If you do not furnish an EIN, payment will be made to your SSN. You cannot use both an SSN and EIN. You can only use one number to bill Medicare. If furnishing an EIN, a copy of the IRS Form CP-575 or other document issued by the IRS showing the EIN and legal name for this business MUST be submitted.

If you are reporting a change to your 1099 mailing address, check the box below and furnish the effective date.

NOTE: if changing, this will replace your current 1099 address on file.

☐ Change Effective Date *(mm/dd/yyyy)*: _____

Sole Proprietors: 1099 Mailing Address

Social Security Number *(required)*	Employer Identification Number *(optional)*	Prior Employer Identification Number *(if applicable)*
Full Legal Name Associated with this Social Security Number		
1099 Mailing Address Line 1 *(P.O. Box or Street Name and Number)*		
1099 Mailing Address Line 2 *(Suite, Room, Apt. #, etc.)*		
1099 Mailing Address City/Town	1099 Mailing Address State	1099 Mailing Address ZIP Code + 4
Telephone Number *(if applicable)*	Fax Number *(if applicable)*	Email Address *(if applicable)*

SECTION 4: IMPORTANT ADDRESS INFORMATION *(Continued)*

B. CORRESPONDENCE ADDRESSES

1. Correspondence mailing address

This is the address where correspondence will be sent to you by the NSC MAC and/or the DME MAC. This address cannot be a billing agency, Management Services Organization, or the supplier's representative.

☐ Check here if you want all correspondence mailed to your Business Location Address in Section 2A and skip this section.

If you are reporting a change to your Correspondence Mailing Address, check the box below and furnish the effective date.

NOTE: If changing, this will replace your current correspondence address on file.

☐ Change Effective Date *(mm/dd/yyyy)*: _____

Business Location Name

Attention *(optional)*

Correspondence Mailing Address Line 1 *(P.O. Box or Street Name and Number)*

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

City/Town	State	ZIP Code + 4

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

2. Medical Record correspondence address

This is the address where the medical record correspondence will be sent to the supplier listed in section 2A by your designated MAC. This information will be used for any medical record review requests. This address cannot be a billing agency, Management Service Organization, or the supplier's representative.

☐ Check here if your Medical Record Correspondence Address should be mailed to your Correspondence Address in section 4B1 (above) and skip this section, **OR**

☐ Check here if you want all correspondence mailed to your Business Location Address in Section 2A and skip this section.

If you are reporting a change to your Medical Record Correspondence Address, check the box below and furnish the effective date.

NOTE: If changing, this will replace your current medical record correspondence address on file.

☐ Change Effective Date *(mm/dd/yyyy)*: _____

Attention *(optional)*

Medical Record Correspondence Mailing Address Line 1 *(P.O. Box or Street Name and Number)*

Medical Record Correspondence Mailing Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

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

SECTION 4: IMPORTANT ADDRESS INFORMATION *(Continued)*

C. REVALIDATION REQUEST PACKAGE MAILING ADDRESS

This is the address where the NSC MAC will send your enrollment revalidation request package. This address cannot be a billing agency, Management Services Organization, or the supplier's representative.

☐ Check here if your revalidation request package should be mailed to your Business Location Address in Section 2A and skip this section, **OR**

☐ Check here if your revalidation request package should be mailed to your Correspondence Mailing Address in Section 4B and skip this section.

If you are reporting a change to your Revalidation Request Package Mailing Address, check the box below and furnish the effective date.

NOTE: If changing, this will replace your current revalidation request package mailing address on file.

☐ Change Effective Date *(mm/dd/yyyy)*: _____

Business Location Name

Attention *(optional)*

Revalidation Request Package Mailing Address Line 1 *(P.O. Box or Street Name and Number)*

Revalidation Request Package Mailing Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

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

D. REMITTANCE NOTICES/SPECIAL PAYMENTS MAILING ADDRESS

Furnish an address where remittance notices and special payments should be sent for services rendered at the practice location reported in section 2A. Please note that payments will be made in your name or, if a business is reported in section 4A, payments will be made in the name of the business.

Medicare will issue all routine payments via electronic funds transfer (EFT). Since payment will be made by EFT, the special payments address below should indicate where all other payment information (e.g., remittance notices, non-routine special payments) should be sent.

☐ Check here if your Remittance Notices/Special Payments should be mailed to your Business Location Address in Section 2A and skip this section, **OR**

☐ Check here if your Remittance Notices/Special Payments should be mailed to your Correspondence Mailing Address in Section 4B and skip this section.

NOTE: If you are a new enrollee, you must submit an EFT Authorization Agreement (CMS-588) with this application.

If you need to make changes to your current EFT Authorization Agreement (CMS-588), contact your DME MAC.

If you are reporting a change to your Remittance Notice/Special Payment Mailing Address, check the box below and furnish the effective date.

NOTE: If changing, this will replace your current special payments address on file.

☐ Change Effective Date *(mm/dd/yyyy)*: _____

NOTE: Payments will be made in the supplier's legal business name as shown in Section 4A.

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

Special Payments Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

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

SECTION 4: IMPORTANT ADDRESS INFORMATION *(Continued)*

E. MEDICARE BENEFICIARY MEDICAL RECORDS STORAGE ADDRESS

If the Medicare beneficiaries' medical records are stored at a location other than the Business Location Address in Section 2A in accordance with 42 C.F.R. section 424.57 (c)(7)(E), complete this section with the name and address of the storage location. This includes the records for both current and former Medicare beneficiaries.

Post office boxes and drop boxes are not acceptable as a physical address where Medicare beneficiaries' records are maintained. The records must be the supplier's records, not the records of another supplier. If all records are stored at the Business Location Address reported in Section 2A, check the box below and skip this section.

☐ Records are stored at the Business Location Address reported in Section 2A.

If you are adding, removing, or changing a storage location, check the box below and furnish the effective date.

If removing, ensure the NSC MAC has a valid record storage address on file.

If changing, this will replace your current record storage address on file.

☐ **Add** ☐ **Remove** ☐ **Change** **Effective Date** *(mm/dd/yyyy)*: _____

1. Paper Storage

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

2. Electronic Storage

Do you store your patient medical records electronically? ☐ **Yes** ☐ **No**

If yes, identify where/how these records are stored below. This can be a website, URL, in-house software program, online service, vendor, etc. This must be a site that can be accessed by the NSC MAC if necessary.

Site Where Electronic Records and Signatures are Stored

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

NOTE: Only report organizations in this section. Individuals must be reported in section 6.

Complete this section with information about all organizations that have 5 percent or more (direct or indirect) ownership interest of, any partnership interest in, and/or managing control of, the supplier identified in Section 2, as well as information on any adverse legal actions that have been imposed against that organization. For examples of organizations that should be reported here, visit our Web site: **CMS.gov/MedicareProviderSupEnroll**. If there is more than one organization with ownership interest or managing control, copy and complete this section for each.

MANAGING CONTROL (ORGANIZATIONS)

Any organization that exercises operational or managerial control over the DMEPOS supplier, or conducts the day-to-day operations of the DMEPOS supplier, is a managing organization and must be reported. The organization need not have an ownership interest in the supplier in order to qualify as a managing organization.

Report the entity under the role of "managing control" if, for instance, an entity:

a. has direct responsibility for the performance of your organization AND
b. is capable of changing the leadership, allocation of resources, or other processes of your organization to improve performance.

Faculty practice plans, university-based health systems, hospital outpatient departments, medical foundations, and groups that primarily treat enrollees of group model HMOs should review this definition carefully to determine if it applies.

Suppliers should also report any managing relationship with a management services organization under contract with the supplier to furnish management services for the business.

SPECIAL TYPES OF ORGANIZATIONS

Governmental/Tribal Facilities:
If a federal, state, county, city or other level of government, the Indian Health Service (IHS), or an Indian tribe will be legally and financially responsible for Medicare payments received (including any potential overpayments), the name of that government, the IHS or Indian tribe must be reported as an owner or controlling entity. The DMEPOS supplier must submit a letter on the letterhead of the responsible government agency or tribal organization that attests that the government or tribal organization will be legally and financially responsible in the event that there is any outstanding debt owed to CMS. This letter must be signed by an appointed or elected official of the government or tribal organization who has the authority to legally and financially bind the government or tribal organization to the laws, regulations, and program instructions of Medicare. The appointed/elected official who signed the letter must be reported in Section 6.

Non-Profit, Charitable and Religious Organizations:
Many non-profit organizations are charitable or religious in nature, and are operated and/or managed by a Board of Trustees or other governing body. The actual name of the Board of Trustees or other governing body must be reported in this section. While the organization must be reported in Section 5, individual board members must be reported in Section 6. Each non-profit organization must submit a copy of the IRS Form 501(c)(3) verifying its non-profit status. **NOTE:** Government owned entities do not need to provide an IRS Form 501(c)(3).

SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (Organizations) *(Continued)*

A. ORGANIZATION IDENTIFICATION INFORMATION (OWNERSHIP AND/OR MANAGING CONTROL)

NOTE: All organizations that complete this section must also complete section 5B.

All organizations for which the following apply must be reported in Section 5:

- 5 percent or more ownership of the supplier,
- Managing control of the supplier,
- A partnership interest in the supplier, regardless of the percentage of ownership the partner has, or
- A management services organization under contract with the supplier to furnish management services for the business.

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

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

☐ Not Applicable

If you are changing information about your current ownership interest and/or managing control information for this organization, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ **Change** ☐ **Add** ☐ **Remove** **Effective Date *(mm/dd/yyyy)***: _____

Check all that apply:

☐ 5 Percent or More Ownership Interest ☐ Managing Control ☐ Partner

Legal Business Name as Reported to the Internal Revenue Service

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

Business Address Line 1 *(Street Name and Number)*

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

City/Town	State	ZIP Code + 4

Tax Identification Number *(Required)*	NPI *(if issued)*	Medicare Identification Number(s) *(if issued)*
Telephone Number	**Fax Number *(if applicable)***	**E-mail Address *(if applicable)***

What is the effective date this owner acquired ownership of the supplier identified in Section 2A1 of this application? *(mm/dd/yyyy)* _____

What is the effective date this organization acquired managing control of the supplier identified in Section 2A1 of this application? *(mm/dd/yyyy)* _____

NOTE: Furnish both dates if applicable.

SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (Organizations) *(Continued)*

B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for the organization reported in section 5A above. If you need additional information regarding what to report, please refer to section 3 of this application.

NOTE: If reporting more than one organization, copy and complete sections 5A and 5B for each organization reported.

1. Has the organization in section 5A above, under any current or former name or business identity, ever had a final adverse legal action listed in section 3 of this application imposed against it?

   ☐ **YES** – continue below ☐ **NO** – skip to section 6

2. If yes, report each final adverse legal action, when it occurred, and the federal or state agency or the court/ administrative body that imposed the action.

FINAL ADVERSE LEGAL ACTION	DATE	ACTION TAKEN BY

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (Individuals)

NOTE: Only report individuals in this section. Organizations must be reported in section 5.

NOTE: A supplier **MUST** have at least ONE organizational or individual owner, ONE managing employee and ONE Authorized Official. In addition, all Authorized Officials and/or Delegated Officials must complete this section, as well as the individuals listed below. An individual owner may also be the managing employee to satisfy this requirement.

The following individuals must be reported in Section 6A:

- All persons who have a 5 percent or greater direct or indirect ownership interest in the supplier (For more information on "direct" and "indirect" owners, go to **CMS.gov/MedicareProviderSupEnroll**);
- If (and only if) the supplier is a corporation (whether for-profit or non-profit), all officers and directors of the supplier;
- All managing employees of the DMEPOS supplier;
- All individuals with a partnership interest in the supplier, regardless of the percentage of ownership the partner has; and
- Authorized and Delegated Officials. All Authorized Officials must identify one other relationship of 5% or greater direct/indirect owner, Partner or Director/Officer. All Delegated Officials must identify one other relationship but can select W-2 managing employee as other relationship.

Example: A supplier is 100 percent owned by Company C, which itself is 100 percent owned by Individual D. Assume that Company C is reported in Section 5A as an owner of the supplier. Assume further that Individual D, as an indirect owner of the supplier, is reported in Section 6A. Based on this example, the supplier would check the "5 percent or Greater Direct/Indirect Owner" box in Section 6A.

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

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

- **Officer** is any person whose position is listed as being that of an officer in the supplier's "articles of incorporation" or "corporate bylaws," or anyone who is appointed by the board of directors as an officer in accordance with the supplier's corporate bylaws.
- **Director** is a member of the supplier's "board of directors." It does not necessarily include a person who may have the word "director" in his/her job title (e.g., departmental director, director of operations). Moreover, where a supplier has a governing body that does not use the term "board of directors," the members of that governing body will still be considered "directors." Thus, if the supplier has a governing body titled "board of trustees" (as opposed to "board of directors"), the individual trustees are considered "directors" for Medicare enrollment purposes.
- **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.

NOTE: If a governmental or tribal organization will be legally and financially responsible for Medicare payments received (per the instructions for Governmental/Tribal Organizations in Section 5), the supplier is only required to report its managing employees in Section 6. Owners, partners, officers, and directors do not need to be reported, except those who are listed as Authorized or Delegated Officials on this application.

Any information on final adverse actions that have been imposed against the individuals reported in section 6A must be furnished in section 6B. If there is more than one individual, copy and complete this section for each individual.

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (Individuals) *(Continued)*

A. INDIVIDUAL IDENTIFICATION INFORMATION (OWNERSHIP AND/OR MANAGING CONTROL)

If you are changing information about your current ownership interest and/or managing control information for this individual, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

NOTE: If a governmental or tribal organization will be legally and financially responsible for Medicare payments received (per the instructions for Governmental/Tribal Organizations in section 5), the supplier is only required to report its managing employees in section 6. Owners, partners, officers, and directors do not need to be reported, except those who are listed as Authorized or Delegated Officials on this application.

Any information on final adverse legal actions that have been imposed against the individuals reported in section 6A must be furnished in section 6B. If there is more than one individual, copy and complete this section for each individual.

☐ **Change** ☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

The name, date of birth, and social security number of each person listed in this section must coincide with the individual's information as listed with the Social Security Administration. IRS issues Individual Tax Identification Numbers (ITINs) to foreign nationals and others who have federal tax reporting or filing requirements and are not eligible to obtain a Social Security Number (SSN) from the Social Security Administration (SSA). Please report your ITIN in this section, if applicable.

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

Title	Date of Birth *(mm/dd/yyyy)*

Social Security Number (SSN) or Individual Tax Identification Number (ITIN)

What is the above individual's relationship with the supplier in section 2A1?

☐ 5 Percent or Greater Direct/Indirect Owner
☐ Authorized Official
☐ Delegated Official
☐ Partner
☐ Director/Officer
☐ Contracted Managing Employee
☐ W-2 Managing Employee

What is the effective date this owner acquired ownership of the supplier identified in Section 2A1 of this application? *(mm/dd/yyyy)* _____

What is the effective date this individual acquired managing control of the supplier identified in Section 2A1 of this application? *(mm/dd/yyyy)* _____

NOTE: Furnish both dates if applicable.

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (Individuals) *(Continued)*

B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for the individual reported in section 6A above. If you need additional information regarding what to report, please refer to section 3 of this application.

NOTE: If reporting more than one individual, copy and complete sections 6A and 6B for each individual reported.

1. Has the individual in section 6A above, under any current or former name or business identity, ever had a final adverse legal action listed in section 3 of this application imposed against it?

   ☐ **YES** – continue below ☐ **NO** – skip to section 7

2. If yes, report each final adverse legal action, when it occurred, and the federal or state agency or the court/ administrative body that imposed the action.

NOTE: To satisfy the reporting requirement, section 6B2 must be filled out in its entirety, **and** all applicable attachments must be included.

FINAL ADVERSE LEGAL ACTION	DATE	ACTION TAKEN BY

SECTION 7: COMPREHENSIVE LIABILITY INSURANCE INFORMATION AND SURETY BOND INFORMATION

A. COMPREHENSIVE LIABILITY INSURANCE INFORMATION

As required in 42 C.F.R. section 424.57(c)(10), all DMEPOS suppliers must have comprehensive liability insurance in the amount of at least $300,000 (for each incident) and the insurance must remain in force at all times.

The NSC MAC, with full mailing address as shown below, must be listed on the policy as a certificate holder.

National Supplier Clearinghouse
Post Office Box 100142
Columbia, SC 29202-3142

You must submit a copy of certificate of liability insurance or evidence of self-insurance with this application. Failure to maintain the required insurance at all times will result in revocation of your Medicare supplier billing number retroactive to the date the insurance lapsed, and/or overpayment collection.

Professional and malpractice insurance is not the same as comprehensive liability insurance and does not meet compliance for this requirement.

If you are changing your comprehensive liability insurance information, check the box below and furnish the effective date.

NOTE: If changing, this will replace your current insurance information on file.

☐ Change Effective Date *(mm/dd/yyyy)*: _____

Name of Insurance Company			
Insurance Policy Number	Date Policy Issued *(mm/dd/yyyy)*		Expiration Date of Policy *(mm/dd/yyyy)*
Insurance Agent's First Name	Middle Initial	Last Name	Jr., Sr., M.D., etc.
Agent's Telephone Number	Agent's Fax Number *(if applicable)*		Agent's E-mail Address *(if applicable)*
Underwriter's Company Name			
Underwriter's Telephone Number	Underwriter's Fax Number *(if applicable)*		Underwriter's E-mail Address *(if applicable)*

B. SURETY BOND INFORMATION

As required in 42 C.F.R. section 424.57(d), DMEPOS suppliers who are required to obtain a surety bond must complete this section. Furnish all requested information about the surety bond company and the surety bond. Submit a copy of the original surety bond, signed by a Delegated or Authorized Official, with this application.

☐ Check here if this supplier is not required to obtain a surety bond and skip to Section 7C.

1. Name and Address of Surety Bond Company

If you are changing your surety bond information, check the box below and furnish the effective date.

☐ Change Effective Date *(mm/dd/yyyy)*: _____

Legal Business Name of Surety Bond Company as Reported to the IRS	Tax Identification Number
Business Address Line 1 *(Street Name and Number)*	
Business Address Line 2 *(Suite, Room, Apt. #, etc.)*	

City/Town	State	ZIP Code + 4

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

SECTION 7: COMPREHENSIVE LIABILITY INSURANCE INFORMATION AND SURETY BOND INFORMATION *(Continued)*

2. Surety Bond Financial Information

☐ Change Effective Date *(mm/dd/yyyy)*: _____

Amount of Surety Bond	Surety Bond Number
$	
Effective Date of Surety Bond *(mm/dd/yyyy)*	If reporting a new bond, give cancellation date of the current bond *(mm/dd/yyyy)*

C. SURETY BOND EXCEPTION INFORMATION

☐ Check here if this supplier is not required to obtain a surety bond and select exception criteria below.

- ☐ Government-operated facilities that have a comparable bond under state law that lists CMS as the oblige (payee).
- ☐ The supplier is a federally owned or tribally owned or operated Indian Health Service.
- ☐ The supplier is a physician providing items to own patients as part of physician's own services.
- ☐ The supplier is a solely owned and operated OT/PT that furnishes only to their own patients and is only billing for orthotics/prosthetics and supplies.
- ☐ The supplier is an orthotist/prosthetist or occularist in private practice that is solely owned by the O/P personnel, is making custom-made orthotics/prosthetics and is only billing for orthotics/prosthetics and supplies.

SECTION 8: BILLING AGENCY INFORMATION

A billing agency/agent is a company or individual that you contract with to prepare and submit your claims. If you use a billing agency/agent you must complete this section. Even if you use a billing agency/agent, you remain responsible for the accuracy of the claims submitted on your behalf.

NOTE: The billing agency/agent address **cannot** be the correspondence mailing address completed in section 4B of this application

☐ Check here if this section does not apply and skip to section 12.

If you are changing information about your current billing agency or adding or removing a billing agency, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ **Change** ☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

BILLING AGENCY/AGENT NAME AND ADDRESS

Legal Business as reported to the Internal Revenue Service or Individual Name as Reported to the Social Security Administration

If Billing Agent: Date of Birth *(mm/dd/yyyy)*

Billing Agency Tax Identification Number or Social Security Number *(required)* or Billing Agent Social Security Number *(required)*

Billing Agency/Agent "Doing Business As" Name *(if applicable)*

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

Billing Agency/Agent Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town		State	ZIP Code + 4
Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*	

SECTION 9: INTENTIONALLY LEFT BLANK

SECTION 10: INTENTIONALLY LEFT BLANK

SECTION 11: INTENTIONALLY LEFT BLANK

SECTION 12: SUPPORTING DOCUMENTATION INFORMATION

This section lists the documents that must be submitted with this completed enrollment application.

If you are newly enrolling, adding a new location, reactivating or revalidating, you must provide all applicable documents. For changes, only submit documents that are applicable to the change requested. All enrolling DMEPOS suppliers are required to furnish information on all federal, state, and local professional and business licenses, certifications, and/or registrations required to practice as a DMEPOS supplier in the state of the business location as reported in Section 2A. Check the NSC MAC website for further guidance on supplier requirements. You are responsible for furnishing and adhering to all required licensure and/or certification requirements, etc. for the supplies/services you provide.

The enrolling DMEPOS supplier may submit a notarized Certificate of Good Standing from the DMEPOS supplier's business location's state licensing/certification board or other medical association, in lieu of copies of the requested documents. This certificate cannot be more than 30 days old at the time you submit this application.

If the enrolling DMEPOS supplier has had a previously revoked or suspended license, certification, or registration reinstated, attach a copy of the reinstatement notice with this application.

MANDATORY DOCUMENTATION FOR ALL NEW APPLICATIONS AND/OR ADDITIONAL LOCATIONS

- ☐ Copies of all federal, state, and/or local (city/county) professional and business licenses, certifications and/or registrations for applicable specialty supplier types, products and services.
- ☐ Copy of Certification of Insurance for comprehensive liability policy.
  NOTE: The NSC MAC must be listed as a certificate holder with the NSC MAC's full address as noted in section 7a.
- ☐ Written confirmation from the IRS confirming your Tax Identification Number and Legal Business Name provided in Section 4A (e.g., IRS Form CP-575).
  NOTE: This information is needed if the applicant is enrolling a professional corporation, professional association, or limited liability corporation with this application or enrolling as a sole proprietor using an Employer Identification Number.
- ☐ Completed Form CMS-588, Electronic Funds Transfer Authorization Agreement. Include a voided check.
- ☐ Copy of receipt of payment of application fee from **PECOS.cms.hhs.gov/pecos/feePaymentWelcome.do**.

MANDATORY DOCUMENTATION, IF APPLICABLE

- ☐ Copy of IRS Determination Letter, if supplier is registered with the IRS as non-profit (e.g., IRS Form 501(c)(3)).
  NOTE: Government owned entities do not need to provide an IRS Form 501(c)(3).
- ☐ Copies of all final adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters).
- ☐ If Medicare payments due a supplier are being sent to a bank (or similar financial institution) where the supplier has a lending relationship (that is, any type of loan), 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.
- ☐ Copy of Delegated Official's W-2 if one has been designated.
- ☐ Copy of your bill of sale if you purchased an existing DMEPOS supplier with an active Medicare supplier billing number.
- ☐ Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement, if you want to be a participating supplier.
- ☐ Copy of Surety Bond.
- ☐ Copies of all applicable contracts if you fill orders, fabricates, or fit items by contracting with other companies for the purchase of items necessary to fill the order.
- ☐ Copy of attestation letter for government entities and tribal facilities.
- ☐ Copy of receipt of payment of application for revalidation or reactivation from **PECOS.cms.hhs.gov/pecos/feePaymentWelcome.do**.

SECTION 13: CONTACT PERSON INFORMATION *(Optional)*

If questions arise during the processing of this application, the NSC MAC will contact the individual reported below.

☐ Contact any Authorized Official reported in Section 15.
☐ Contact any Delegated Official reported in Section 15.
☐ Contact the person reported below.

☐ **Change** ☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

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

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

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

City/Town	State	ZIP Code + 4

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

Relationship or Affiliation to this Supplier *(Spouse, Secretary, Attorney, Billing Agent, etc.)*

NOTE: The Contact Person reported in this section will only be authorized to discuss issues concerning this enrollment application. The NSC MAC will not discuss any other Medicare issues for this supplier with the above Contact Person.

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION ON THIS ENROLLMENT APPLICATION

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

1. 18 U.S.C. section 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. section 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. Section 3729, imposes civil liability, in part, on any person who, with actual knowledge, deliberate ignorance or reckless disregard of truth or falsity (a) presents or causes to be presented to the United States Government or its contractor or agent a false or fraudulent claim for payment or approval; (b) uses or causes to be used a false record or statement material either to a false or fraudulent claim or to an obligation to pay the Government; (c) conceals or improperly avoids or decreases an obligation to pay or transmit money or property to the Government; or (d) conspires to violate any provision of the False Claims Act. The False Claims Act imposes a civil penalty of between $5,000 and $10,000 per violation, as adjusted for inflation by the Federal Civil Penalties Inflation Adjustment Act, 28 U.S.C. 2461, 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.
6. 18 U.S.C. 1347 authorizes criminal penalties against individuals who knowing and willfully execute, or attempt, to executive a scheme or artifice to defraud any health care benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by or under the control of any, health care benefit program in connection with the delivery of or payment for health care benefits, items, or services. Individuals shall be fined or imprisoned up to 10 years or both. If the violation results in serious bodily injury, an individual will be fined or imprisoned up to 20 years, or both. If the violation results in death, the individual shall be fined or imprisoned for any term of years or for life, or both.
7. The government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment."

   Remedies include compensatory and punitive damages, restitution, and recovery of the amount of the unjust profit.

SECTION 15: CERTIFICATION STATEMENT

An **Authorized Official** is defined as, but not limited to a chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program.

A **Delegated Official** is defined as an individual who is delegated by an Authorized Official the authority to report changes and updates to the supplier's enrollment record. A Delegated Official must be an individual with an "ownership or control interest" in (as that term is defined in Section 1124(a) (3) of the Social Security Act), or be a W-2 managing employee of, the supplier.

Delegated Officials may not delegate their authority to any other individual. Only an Authorized Official may delegate the authority to make changes and/or updates to the supplier's Medicare status. Even when Delegated Officials are reported in this application, an Authorized Official retains the authority to make any such changes and/or updates by providing his or her printed name, signature, and date of signature as required in Section 15B.

NOTE: Authorized Officials and Delegated Officials must be reported in Section 6, either on this application or on a previous application to the NSC MAC. If this is the first time an Authorized and/or Delegated Official has been reported on the CMS-855S, you must complete section 6 for that individual and that individual must sign section 15.

By his/her signature(s), an Authorized Official binds the supplier to all of the requirements listed in the Certification Statement and acknowledges that the supplier may be denied entry to or revoked from the Medicare program if any requirements are not met. All signatures must be original and in ink. Faxed, photocopied, or stamped signatures will not be accepted.

Only an Authorized Official has the authority to sign (1) the initial enrollment application on behalf of the supplier and (2) add or remove additional Authorized Officials and Delegated Officials. Once the delegation of authority has been established all other enrollment application submissions can be signed by either an Authorized Official or Delegated Official.

By signing this application, an Authorized Official agrees to immediately notify the NSC MAC if any information furnished on this application is not true, correct, or complete. In addition, an Authorized Official, by his/her signature, agrees to notify the NSC MAC of any future changes to the information contained in this form, after the supplier is enrolled in Medicare, in accordance with the timeframes established in 42 C.F.R. 424.57.

The supplier can have as many Authorized Officials as it wants. If the supplier has more than two Authorized Officials, it should copy and complete this section as needed.

EACH AUTHORIZED AND DELEGATED OFFICIAL MUST HAVE AND DISCLOSED HIS/HER SOCIAL SECURITY NUMBER.

SECTION 15: CERTIFICATION STATEMENT *(Continued)*

A. ADDITIONAL REQUIREMENTS FOR MEDICARE ENROLLMENT FOR AUTHORIZED OFFICIALS

These are additional requirements that the supplier must meet and maintain in order to bill the Medicare program. Read these requirements carefully. By signing, the supplier is attesting to having read the requirements and understanding them.

By his/her signature(s), the Authorized Official(s) named below and the Delegated Official(s) named in section 15 agree to adhere to the following requirements stated in this Certification Statement:

1. 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 application in accordance with the timeframes established in 42 C.F.R. section 424.57. I understand that any change in the business structure of this supplier may require the submission of a new application.
2. I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare billing privileges, and/or the imposition of fines, civil damages, and/or imprisonment.
3. I agree to abide by the Medicare laws, regulations and program instructions that apply to me or to the organization listed in section 2A1 of this application. The Medicare laws, regulations, and program instructions are available through the Medicare Administrative 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, 42 U.S.C. section 1320a-7b (b) (section 1128B (b) of the Social Security Act) and the Physician Self-Referral Law (Stark Law), 42 U.S.C. section 1395nn (Section 1877 of the Social Security Act)).
4. Neither this supplier, nor any five percent or greater owner, partner, officer, director, managing employee, Authorized Official, or Delegated Official thereof is currently sanctioned, suspended, debarred, or excluded by the Medicare or State Health Care Program, e.g., Medicaid program, or any other Federal program, or is otherwise prohibited from supplying services to Medicare or other Federal program beneficiaries.
5. I agree that any existing or future overpayment made to the supplier by the Medicare program may be recouped by Medicare through the withholding of future payments.
6. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and I will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.
7. I authorize any national accrediting body whose standards are recognized by the Secretary as meeting the Medicare program participation requirements, to release to any authorized representative, employee, or agent of the Centers for Medicare & Medicaid Services (CMS) a copy of my most recent accreditation survey, together with any information related to the survey that CMS may require (including corrective action plans).

SECTION 15: CERTIFICATION STATEMENT *(Continued)*

B. AUTHORIZED OFFICIAL SIGNATURE(S)

1. 1st Authorized Official Signature

I have read the contents of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete and I authorize the MAC to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the MAC of this fact in accordance with the time frames established in 42 CFR section 424.57.

If you are adding or removing an Authorized and/or Delegated Official, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

Authorized Official's Information and Signature

First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.
Telephone Number	Title/Position	E-mail Address *(if applicable)*	
Authorized Official Signature ***(First, Middle, Last Name, Jr., Sr., M.D., etc.)***			**Date Signed** ***(mm/dd/yyyy)***

In order to process this application it MUST be signed and dated.
NOTE: Signatures must be less than 120 days old at the time of submission.

2. 2nd Authorized Official's Name and Signature *(if applicable)*

I have read the contents of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete and I authorize the MAC to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the MAC of this fact in accordance with the time frames established in 42 CFR section 424.57.

If you are adding or removing an Authorized and/or Delegated Official, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

Authorized Official's Information and Signature

First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.
Telephone Number	Title/Position	E-mail Address *(if applicable)*	
Authorized Official Signature ***(First, Middle, Last Name, Jr., Sr., M.D., etc.)***			**Date Signed** ***(mm/dd/yyyy)***

In order to process this application it MUST be signed and dated.
NOTE: Signatures must be less than 120 days old at the time of submission.

C. ADDITIONAL REQUIREMENTS FOR MEDICARE ENROLLMENT FOR DELEGATED OFFICIALS

NOTE: Delegated Officials are optional.

1. You are not required to have a Delegated Official. However, if no Delegated Official is assigned, the Authorized Official(s) will be the only person(s) who can make changes and/or updates to the supplier's status in the Medicare program.
2. The signature of a Delegated Official shall have the same force and effect as that of an Authorized Official, and shall legally and financially bind the supplier to the laws, regulations, and program instructions of the Medicare program. By his or her signature, the Delegated Official certifies that he or she has read the Certification Statement in Section 15 and agrees to adhere to all of the stated requirements. A Delegated Official also certifies that he/she meets the definition of a Delegated Official. When making changes and/or updates to the supplier's enrollment information maintained by the Medicare program, a Delegated Official certifies that the information provided is true, correct, and complete.
3. Delegated Officials being removed do not have to sign or date this application.
4. Independent contractors are not considered "employed" by the supplier, and therefore cannot be Delegated Officials.
5. The signature(s) of an Authorized Official in Section 15B constitutes a legal delegation of authority to all Delegated Official(s) assigned in Section 15D.
6. If there are more than two individuals, copy and complete this section for each individual.

SECTION 15: ASSIGNMENT OF DELEGATED OFFICIAL(s) *(Optional) (Continued)*

D. DELEGATED OFFICIAL SIGNATURE(S)

1. 1ST Delegated Official Signature *(if applicable)*

If you are adding or removing an Authorized and/or Delegated Official, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

Delegated Official's Information and Signature

Delegated Official First Name (Print)	Middle Initial	Last Name	Jr., Sr., M.D., etc.
Delegated Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*			Date Signed *(mm/dd/yyyy)*
☐ Check here if Delegated Official is a W-2 Employee		Telephone Number	
Authorized Official's Signature Assigning this Delegation *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*			Date Signed *(mm/dd/yyyy)*

In order to process this application it MUST be signed and dated.
NOTE: Signatures must be less than 120 days old at the time of submission.

2. 2ND Delegated Official Signature *(if applicable)*

If you are adding or removing an Authorized and/or Delegated Official, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

Delegated Official's Information and Signature

Delegated Official First Name (Print)	Middle Initial	Last Name	Jr., Sr., M.D., etc.
Delegated Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*			Date Signed *(mm/dd/yyyy)*
☐ Check here if Delegated Official is a W-2 Employee		Telephone Number	
Authorized Official's Signature Assigning this Delegation *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*			Date Signed *(mm/dd/yyyy)*

In order to process this application it MUST be signed and dated.
NOTE: Signatures must be less than 120 days old at the time of submission.

MEDICARE SUPPLIER ENROLLMENT APPLICATION PRIVACY ACT STATEMENT

The Authority for maintenance of the system is given under provisions of sections 1102(a) (Title 42 U.S.C. 1302(a)), 1128 (42 U.S.C. 1320a–7), 1814(a)) (42 U.S.C. 1395f (a)(1), 1815(a) (42 U.S.C. 1395g(a)), 1833(e) (42 U.S.C. 1395l(3)),1871 (42 U.S.C. 1395hh), and 1886(d)(5)(F), (42 U.S.C. 1395ww(d)(5)(F) of the Social Security Act; 1842(r) (42 U.S.C.1395u(r)); section 1124(a)(1) (42 U.S.C. 1320a–3(a)(1), and 1124A (42 U.S.C. 1320a–3a), section 4313, as amended, of the BBA of 1997; and section 31001(i) (31 U.S.C. 7701) of the DCIA (Pub. L. 04–134), as amended.

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

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

The Privacy Act permits CMS to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. Any such disclosure of data is known as a "routine use." The CMS will only release PECOS information that can be associated with an individual as provided for under Section III "Proposed Routine Use Disclosures of Data in the System." Both identifiable and non-identifiable data may be disclosed under a routine use. CMS will only collect the minimum personal data necessary to achieve the purpose of PECOS. Below is an abbreviated summary of the six routine uses. To view the routine uses in their entirety go to: **CMS.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/Downloads/0532-PECOS.pdf**.

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

The applicant should be aware that the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503) amended the Privacy Act, 5 U.S.C. section 552a, to permit the government to verify information through computer matching.