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LEVEL 3

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

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

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

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

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

Example 2 (Financial Control)

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

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

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

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

MANAGING CONTROL (ORGANIZATIONS)

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

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SPECIAL TYPES OF ORGANIZATIONS

Governmental/Tribal Organizations: If a Federal, State, county, city or other level of government, or an Indian tribe, will be legally and financially responsible for Medicare payments received (including any potential overpayments), the name of that government or Indian tribe should be reported as an owner. The provider must submit a letter on the letterhead of the responsible government (e.g., government agency) or tribal organization, which attests that the government or tribal organization will be legally and financially responsible in the event that there is any outstanding debt owed to CMS. This letter must be signed by an "authorized official" of the government or tribal organization who has the authority to legally and financially bind the government or tribal organization to the laws, regulations, and program instructions of Medicare. See Section 15 for further information on and a definition of "authorized officials."

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

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

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

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

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

If the provider is uncertain as to whether the owning or managing organization falls within one of the adverse legal action categories, the provider should query the Healthcare Integrity and Protection Data Bank. If the provider needs information on how to access the data bank, call 1-800-767-6732 or visit www.npdb-hipdb.com.

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5. Ownership Interest and/or Managing Control Information (Organizations)

This section is to be completed with information about all organizations that have 5% or more (direct or indirect) ownership interest of, any partnership interest in, and/or managing control of, the provider identified in Section 2B, as well as any information on adverse legal actions that have been imposed against that organization. See instructions for examples of organizations that should be reported here. If there is more than one organization, copy and complete this section for each.

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

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

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

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

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

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

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

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

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

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

This section is to be completed with information about any individual who has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the provider identified in Section 2B. In addition, all officers, directors, and managing employees of the provider must be reported in this section. If there is more than one individual, copy and complete this section for each. **The provider MUST have at least ONE owner and/or managing employee.** If this is a "one person" operation, then report yourself in this section as **both** a 5% or greater owner and a managing employee or director/officer.

NOTE: Hospitals Only: Hospitals that have checked "Yes" to having a compliance plan in accordance with Medicare requirements in Section 2.A.3.b. are not required to report their managing employees in this application. However, this section **must** be completed for the Authorized Official reported in Section 15 and all Delegated Officials reported in Section 16.

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

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

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

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

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

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

NOTE: A person who has the word "Director" in his/her job title may be a "managing employee," as defined below. Moreover, where a provider 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 provider has a governing body titled "Board of Trustees" (as opposed to "Board of Directors"), the individual trustees are considered "Directors" for Medicare enrollment purposes.

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

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

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

IMPORTANT **– Only Individuals should be reported in Section 6. Organizations must be reported in Section 5.**

1. Furnish the individual's name, title, date of birth, social security number, and Medicare identification number (if applicable).

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

2. Indicate the individual's relationship with the enrolling provider identified in Section 2B. If this individual has a title other than those listed in this section, check the "Other" box and specify the title used by this individual.

Example: A provider is 100% owned by Company C, which itself is 100% owned by Individual D. Assume that Company C is reported in Section 5B as an owner of the provider. Assume further that Individual D, as an indirect owner of the provider, is reported in Section 6A1. Based on this example, the provider would check the "5% or Greater Indirect Owner" box in Section 6A2.

B. Adverse Legal History - This section is to be completed with information concerning any adverse legal actions that have been imposed or levied against individuals reported in Section 6A. See Table A in Section 3 of this application for a list of adverse actions that must be reported.

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

1. The provider must state whether the individual reported in Section 6A, under any current or former name or business identity, has ever had any of the adverse legal actions listed in Section 3 (Table A) of this form imposed against him or her.

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

If the provider is uncertain as to whether this individual falls within one of the adverse legal action categories, the provider should query the Healthcare Integrity and Protection Data Bank. If the provider needs information on how to access the data bank, call 1-800-767-6732 or visit www.npdb-hipdb.com.

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6. Ownership Interest and/or Managing Control Information (Individuals)

This section is to be completed with information about any individual that has a 5% or greater (direct or indirect) ownership interest in, or any partnership interest in, the provider identified in Section 2B. All officers, directors, and managing employees of the provider must also be reported in this section. In addition, any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each individual.

A. Individual with Ownership Interest and/or Managing Control - Identification Information

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

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

Title	Date of Birth (MM/DD/YYYY)

Social Security Number	Medicare Identification Number (if applicable)

2. What is the above individual's relationship with the supplier in Section 2B? (Check all that apply.)

☐ 5% or Greater Direct Owner
☐ 5% or Greater Indirect Owner
☐ Other (Specify):_____
☐ Managing Employee
☐ Director/Officer
☐ Partner

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

This section is to be completed for the individual reported in Section 6A above.

1. Has the individual in Section 6A above, under any current or former name or business identity, ever had any of the adverse legal actions listed in Table A in Section 3A imposed against him or her? ☐ YES ☐ NO

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

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

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SECTION 7: CHAIN HOME OFFICE INFORMATION

All providers that are currently part of a chain organization or who are joining a chain organization must complete this section with information about the chain home office. This information will be used to ensure proper reimbursement when the provider year-end cost report is filed with the Medicare fiscal intermediary. It is important to furnish the information in this section to avoid overpayments and/or other administrative actions or penalties.

Chain organizations are generally defined as multiple providers owned, leased, or through any other devise, controlled by a single organization. The controlling organization is known as the chain "home office." Typically, the chain "home office":

- Maintains uniform procedures in each facility for handling admissions, utilization review, preparation and processing admission notices and bills, and
- Maintains and centrally controls individual provider cost reports and fiscal records. In addition, a major portion of the Medicare audit for each provider in the chain can be performed centrally at the chain "home office."

A few of the most common provider types that would typically be in a chain organization are Comprehensive Outpatient Rehabilitation Facilities (CORFs), Skilled Nursing Facilities (SNFs), and Home Health Agencies (HHAs).

A. Check Box - If this section does not apply to this provider, check the box provided and skip to Section 8.

B. Type of Action this Provider is Reporting - Check the appropriate box to indicate the type of action this provider is reporting about its relationship to the chain organization.

Check the:

- 1st box if this provider is enrolling in Medicare for the 1st time, or is undergoing a change of ownership. If this box is checked, complete this entire section.
- 2nd box if the provider is no longer associated with the chain organization previously reported. Furnish the effective date of this action, and identify the old chain home office in Section 7D.
- 3rd box if the provider has changed from one chain to another. Furnish the effective date of this action, and complete Section 7D with information about the NEW chain home office.
- 4th box if only the name of the chain home office is changing and all other information remains the same. Furnish the effective date of this action, and furnish the new chain home office name in Section 7D1.

C. Chain Home Office Administrator Information - If this section is being completed to report a change to the information previously reported about the chain home office administrator, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

- Furnish the name of the chain home office administrator, and his/her title, social security number, and date of birth.

D. Chain Home Office Information - If this section is being completed to report a change to the information previously reported about the chain home office, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. Furnish the legal business name of the chain home office as reported to the IRS.
2. Furnish the street address, telephone number, fax number, and e-mail address of the home office corporate headquarters. Do not give a P.O. Box or Drop Box address.
3. Furnish the home office tax identification number and the home office "cost report" year-end date.
4. Furnish the name of the home office fiscal intermediary and the home office chain number. If this is a new chain organization, furnish the name of the fiscal intermediary of choice for the home office and write "pending" in the space for chain number.

E. Type of Business Structure of the Chain Home Office - If this section is being completed to report a change to the information previously reported about the chain home office's business structure, check "Change," provide the effective date of the change, check the appropriate box in this section, and sign and date the certification statement. Otherwise:

- Check one of the choices given that best describes the home office business structure.

F. Provider's Affiliation to the Chain Home Office - If this section is being completed to report a change to the information previously reported about the provider's affiliation to the chain home office, check "Change," provide the effective date of the change, check the appropriate box, and sign and date the certification statement. Otherwise:

- Check the appropriate box to indicate how this provider is affiliated with the home office.

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7. Chain Home Office Information

This section is to be completed with information about the "Home Office" for those providers that are members of, or are joining, a chain organization.

A. Check here ☐ if this section does not apply and skip to Section 8.

B. Type of Action this Provider is Reporting

Check one:

☐ Provider in chain for first time (Initial Enrollment or Change of Ownership)

☐ Provider dropped out of current chain Effective date:_____

☐ Provider in a different chain since last report Effective date:_____

☐ Provider in same chain under new chain name Effective date:_____

C. Chain Home Office Administrator Information ☐ **Change** **Effective Date:**_____

Name of Home Office Administrator or CEO First	Middle	Last	Jr., Sr., etc.
Title of Home Office Administrator	Social Security Number	Date of Birth (MM/DD/YYYY)	

D. Chain Home Office Information ☐ **Change** **Effective Date:**_____

1. Name of Home Office as Reported to the IRS

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

Home Office Business Street Address Line 2 (Suite, Room, etc.)

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

3. Home Office Tax Identification Number	Home Office Cost Report Year-End Date (MM/DD)
4. Home Office Intermediary	Home Office Chain Number

E. Type of Business Structure of the Chain Home Office ☐ **Change** **Effective Date:**_____

Check one:

Voluntary:

☐ Non-Profit – Religious Organization

☐ Non-Profit – Other (Specify):_____

Proprietary:

☐ Individual

☐ Corporation

☐ Partnership

☐ Other (Specify):_____

Government:

☐ Federal

☐ State

☐ City

☐ County

☐ City-County

☐ Hospital District

☐ Other (Specify below):

_____

F. Provider's Affiliation to the Chain Home Office ☐ **Change** **Effective Date:**_____

Check one:

☐ Joint Venture/Partnership ☐ Managed/Related ☐ Leased

☐ Operated/Related ☐ Wholly Owned ☐ Other (Specify):_____

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SECTION 8: BILLING AGENCY

The purpose of collecting this information is to develop effective monitoring of agents/agencies that prepare and/or submit claims to bill the Medicare program on behalf of the provider. A billing agency is a company or individual that the provider hires or contracts with to furnish claims processing functions for its business locations. Any entity that meets this description must be reported in this section.

A. Check Box - If this provider does not use a billing agency, check the box and skip to Section 10.

B. Billing Agency Name and Address - If reporting a change to information about a previously reported billing agency, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. Furnish the name and tax identification number of the billing agency.

2. Furnish the "doing business as" name of the billing agency.

3. Furnish the complete address and telephone number of the billing agency.

C. Billing Agreement/Contract Information - If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement.

The provider that is enrolling is responsible for responding to the questions listed.

These questions are designed to show that the provider fully understands and comprehends its billing agreement and that it intends to adhere to all Medicare laws, regulations, and program instructions. At any time, the fiscal intermediary or CMS may request copies of all agreements/contracts associated with this billing agency.

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8. Billing Agency

This section is to be completed with information about all billing agencies this provider uses or contracts with that submit claims to Medicare on the provider's behalf. If more than one billing agency is used, copy and complete this section for each. The provider may be required to submit a copy of its current signed billing agreement/contract if Medicare cannot verify the information in this section.

A. Check here ☐ if this section does not apply and skip to Section 10.

B. Billing Agency Name and Address ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Legal Business Name as Reported to the IRS	Tax Identification Number
2. "Doing Business As" Name (if applicable)	
3. Business Street Address Line 1	
Business Street Address Line 2	

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

C. Billing Agreement/Contract Information ☐ **Change** **Effective Date:**_____

Answer the following questions about the provider's agreement/contract with the above billing agency.

1. Does the provider have unrestricted access to its Medicare remittance notices? ☐ YES ☐ NO
2. Does the provider's Medicare payment go directly to the provider? ☐ YES ☐ NO
   IF NO, proceed to Question 3.
   IF YES, skip Questions 3, 4 and 5.
3. Does the provider's Medicare payment go directly to a bank? ☐ YES ☐ NO
   IF NO, proceed to Question 4.
   IF YES, answer the following questions and skip Questions 4 and 5.
   a) Is the bank account only in the name of the provider? ☐ YES ☐ NO
   b) Does the provider have unrestricted access to the bank account and statements? ☐ YES ☐ NO
   c) Does the bank only answer to the provider regarding what the provider wants from the bank (e.g., sweep account instructions, bank statements, closing account, etc.)? ☐ YES ☐ NO
4. Does the provider's Medicare payment go directly to the billing agent? ☐ YES ☐ NO
   IF NO, proceed to Question 5.
   IF YES, answer the following question and skip Question 4.
   a) Does the billing agent cash the provider's check? ☐ YES ☐ NO
      IF NO, proceed to Question b.
      IF YES, are <u>all</u> of the following conditions included in the billing agreement? ☐ YES ☐ NO
      1) The agent receives payment under an agency agreement with the provider. ☐ YES ☐ NO
      2) The agent's compensation is not related in any way to the dollar amounts billed or collected. ☐ YES ☐ NO
      3) The agent's compensation is not dependent upon the actual collection of payment. ☐ YES ☐ NO
      4) The agent acts under payment disposition instructions that the provider may modify or revoke at any time. ☐ YES ☐ NO
      5) In receiving payment, the agent acts only on behalf of the provider (except insofar as the agent uses part of that payment as compensation for the agent's billing and collection services). ☐ YES ☐ NO
   b) Does the billing agent either give the Medicare payment directly to this provider or deposit the payment into this provider's bank account? ☐ YES ☐ NO
5. Who receives the provider's Medicare payment?_____

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SECTION 9: FUTURE USE

This section is being reserved for possible future use.

SECTION 10: STAFFING COMPANY

The purpose of collecting this data is to develop effective internal controls to promote adherence to applicable Federal and State laws.

A staffing company is an organization that contracts with health care professionals to furnish health care at medical facilities (such as hospital emergency rooms) where it is also under contract (or some similar agreement) to furnish such. A staffing company cannot bill Medicare in the staffing company's name for medical services or supplies furnished under this arrangement. If the provider has an agreement/contract with a staffing company to furnish services to Medicare beneficiaries, complete this section. At any time, the fiscal intermediary may request a copy of the agreement/contract signed by the provider and the staffing company.

NOTE: If the provider uses a staffing company but the individual physicians or non-physician practitioners reassign their benefits directly to the provider this section does not need to be completed. If the staffing company acts as the billing agent for the physicians or non-physician practitioners it should be reported in Section 8.

A. Check Box - If the provider does not use a staffing company, check the box provided and skip to Section 11.

B. 1st Staffing Company Name and Address - Indicate if this provider is making a change concerning its relationship with a staffing company by checking the appropriate box "add," "delete," or "change." Provide the new information and the effective date of the change, and sign and date the certification statement. Otherwise:

1. Furnish the legal business name and tax identification number of the staffing company.

2. If applicable, furnish the staffing company's "doing business as" (DBA) name. If the reported staffing company uses more than one DBA name with this provider, report all that apply for Medicare claims.

3. Furnish the complete mailing address, telephone number, fax number and e-mail address for the staffing company.

C. 1st Staffing Company Contract/Agreement Information - The enrolling provider must respond to the questions listed to verify that it fully understands and comprehends its contract and that it plans to adhere to all Medicare laws, regulations, and program instructions. At any time, the fiscal intermediary or carrier can request a copy of the agreement/contract signed by the provider and the staffing company.

D-E. 2nd Staffing Company - Sections D and E are to be used to report information on a 2nd staffing company that the provider may be working for (or under contract with) to provide medical services. See instructions for Sections B and C above.

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9. Future Use — This Section Not Applicable

10. Staffing Company

This section is to be completed with information about all staffing companies that this provider uses, either under written contract or by an unwritten agreement. If this provider uses more than one staffing company, copy and complete this section for each. The provider may be required to submit a copy of its current signed staffing company agreement/contract.

A. Check here ☐ if this section does not apply and skip to Section 11.

B. 1st Staffing Company Name and Address ☐ Add ☐ Delete ☐ Change Effective Date:_____

1. Legal Business Name as Reported to the IRS	Tax Identification Number
2. "Doing Business As" Name (if applicable)	
3. Business Street Address Line 1	
Business Street Address Line 2	

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

C. 1st Staffing Company Contract/Agreement Information

Answer the following questions about the staffing company and the provider's contract/agreement with them.

1. Does the staffing company shown in Section 10B above **and** the billing agency identified in Section 8B have a common owner(s)? ☐ YES ☐ NO
2. If applicable, are there any provisions in the staffing company contract/agreement that supersede or contradict the enrolling provider's billing agreement? ☐ Not applicable ☐ YES ☐ NO
3. What department(s) of this provider does this company staff?_____ _____

D. 2nd Staffing Company Name and Address ☐ Add ☐ Delete ☐ Change Effective Date:_____

1. Legal Business Name as Reported to the IRS	Tax Identification Number
2. "Doing Business As" Name (if applicable)	
3. Business Street Address Line 1	
Business Street Address Line 2	

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

E. 2nd Staffing Company Contract/Agreement Information

Answer the following questions about the staffing company and the provider's contract/agreement with them.

1. Does the staffing company shown in Section 10D above **and** the billing agency identified in Section 8B have a common owner(s)? ☐ YES ☐ NO
2. If applicable, are there any provisions in the staffing company contract/agreement that supersede or contradict the enrolling provider's billing agreement? ☐ Not applicable ☐ YES ☐ NO
3. What department(s) of this provider does this company staff?_____ _____

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SECTION 11: SURETY BOND INFORMATION

This section is to be completed by those provider types mandated by law to obtain a surety bond in order to enroll in and bill the Medicare program. Furnish all requested information about the provider's insurance agent, surety company, and the surety bond. To determine which provider types currently require a surety bond, check the CMS web-site, or contact the local State Agency or provider group association. Provider types that may be required to obtain a surety bond are home health agencies, comprehensive outpatient rehabilitation facilities, and rehabilitation agencies.

The surety bond must be an annual bond, continuous bond, or a government security in lieu of a bond (i.e., a Treasury note, United States bond, or other Federal public debt obligation). Annual surety bond renewals must be reported to the fiscal intermediary on a timely basis to ensure continuance of claim payments. A certified true or notarized copy of the original surety bond must be submitted with this application. Failure to submit the surety bond will prevent the processing of this application. If an insurance agent or an insurance broker issues the bond, the provider must supply a certified copy of the agent's Power of Attorney with this application.

A. Check Box – Check the box if this provider is not required to obtain a surety bond for Medicare enrollment and skip to Section 12.

B. Check Box - Check the box if this provider qualifies for an exemption as a government entity and skip to Section 12

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

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

1. Furnish the legal business name and tax identification number of the surety bond company liable for this bond.
2. Furnish the complete business address, telephone number and e-mail address of the surety bond company.

D. Name and Address of Insurance Agency/Broker - If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. Provide the legal business name of the agency that issued the bond.
2. Provide the name of the individual agent who issued the bond for the bond agency.
3. Furnish the complete business address, telephone number and e-mail address of the agency.

E. Surety Bond Information - If the supplier has a Government Security check "Not Applicable" and skip to Section F below. If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise, complete this section with specific information about the bond as follows:

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

F. Government Security - If the supplier has a Surety Bond check "Not Applicable," skip this section and complete Section E above. If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise, complete this section with specific information about the government security as follows:

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

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11. Surety Bond Information

This section is to be completed by providers mandated by law to obtain a surety bond in order to enroll in and bill the Medicare program. See instructions to determine whether this provider is required to obtain a surety bond. Furnish all requested information about the provider's insurance agent, surety company, and the surety bond.

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

B. Check here ☐ if this provider qualifies for a waiver of the bond requirement based on its operation as a government entity. See instructions for specific documentation requirements and skip to Section 12.

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

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

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

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

2. Check the appropriate box below:

a) Is the Treasury Bill: ☐ Not Applicable ☐ 3 months? ☐ 6 months? ☐ 1 year?

b) Is the Treasury Note: ☐ Not Applicable ☐ 2 years? ☐ 5 years? ☐ 10 years?

c) Is the government security a 30-year Treasury Bond? ☐ YES ☐ NO ☐ Not Applicable

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

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SECTION 12: CAPITALIZATION REQUIREMENTS FOR HOME HEALTH AGENCIES (HHAs)

All HHAs and HHA sub-units enrolling in the Medicare program must complete this section. HHAs and HHA sub-units initially enrolling in Medicare, Medicaid, or both programs on or after January 1, 1998 are required to provide documentation supporting that they have sufficient initial reserve operating funds (capitalization) to operate for the first three months of operation in the Medicare and/or Medicaid program(s). The capitalization requirement applies to all HHAs and HHA sub-units that are enrolling in the Medicare program, including HHAs or HHA sub-units currently participating in the Medicare program that, as a result of a change of ownership, will be issued a new provider number. The capitalization requirement does not apply to a branch of an HHA. Regulations found at 42 CFR 489.28 require that an intermediary determine the required amount of reserve operating funds needed for the enrolling HHA or HHA sub-unit by comparing the enrolling HHA or HHA sub-unit to at least three other new HHAs that it serves which are comparable to the enrolling HHA or HHA sub-unit. Factors to be considered are geographic location, number of visits, type of HHA or HHA sub-unit and business structure of the HHA or HHA sub-unit. The fiscal intermediary then verifies that the enrolling HHA or HHA sub-unit has the required funds. To assist the fiscal intermediary in determining the amount of funds necessary, the enrolling HHA or HHA sub-unit should complete this section. For additional information on capitalization requirements, see Volume 63, Number 2 of the Federal Register published on January 5, 1998, beginning at page 292.

A. Check Box - Check the box provided if this section does not apply and skip to Section 13.

B. Type of Home Health Agency - Check the appropriate box to indicate if this HHA is operated as a non-profit agency, or a proprietary (for-profit) agency.

C. Projected Number of Visits by this Home Health Agency - Furnish the number of visits this HHA projects it will make during the first (next) three months of operations and the first (next) 12 months of operations. If this is an established HHA that is currently providing services, furnish the projected number of visits for the next three and twelve months, beginning with next month.

D. Financial Documentation - Although not required with this application, in order to expedite the enrollment process the HHA may attach a copy of its most current savings, checking or other financial statement(s) that verifies the initial reserve operating funds.

1. These documents should be submitted with:

   a) An attestation from an officer of the bank or other financial institution stating that the funds are in the account(s) and are immediately available for the HHA's use, and

   b) Certification from the HHA regarding any borrowed funds.

2. Indicate whether or not the HHA will be submitting the required documentation (financial statements and attestations) with this application.

NOTE: If the HHA chooses not to submit the above documents with this application, the HHA will be requested to do so prior to being issued a Medicare billing number.

E. Additional Information

Use this space to explain or justify any unique financial situations of this HHA that may be helpful in determining the HHA's compliance with the capitalization requirements.

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12. Capitalization Requirements for Home Health Agencies (HHAs)

This section is to be completed by Home Health Agencies with information about capitalization. As of January 1, 1998 all HHAs are required to provide documentation verifying that they have sufficient initial reserve operating funds (capitalization) to operate for the first three months of operation in the Medicare program. See instructions for further details on capitalization requirements.

A. Check here ☐ if this section does not apply and skip to Section 13.

B. Type of Home Health Agency

Check one: ☐ Non-profit Agency ☐ Proprietary Agency

C. Projected Number of Visits by this Home Health Agency

How many visits does this HHA project it will make in the first: three months of operation?_____
twelve months of operation?_____

D. Financial Documentation

1. Although not required to be submitted concurrently with this application, in order to expedite the enrollment process the HHA may attach a copy of its most current savings, checking or other financial statement(s) that verifies the initial reserve operating funds, accompanied by:
   a) An attestation from an officer of the bank or other financial institution stating that the funds are in the account(s) and are immediately available for the HHA's use, and
   b) Certification from the HHA attesting that at least 50% of the reserve operating funds are non-borrowed funds.

2. Will the HHA be submitting the above documentation with this application? ☐ YES ☐ NO

NOTE: The Fiscal Intermediary may require a subsequent attestation that the funds are still available. If the Fiscal Intermediary determines that the HHA requires funds in addition to those indicated on the originally submitted account statement(s), it will require verification of the additional amount as well as a new attestation statement.

E. Additional Information

Provide any additional information, either in the space below or through documentation, necessary to assist the fiscal intermediary or State agency in properly comparing this HHA with other comparable HHAs.

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SECTION 13: CONTACT PERSON(S)

To assist in the timely processing of the provider's application, provide the full name, e-mail address, telephone number, and mailing address of an individual who can be reached to answer questions regarding the information furnished in this application (preferably the individual who completed this application). The provider is not required to furnish a contact person in this section. It should be noted that if a contact person is not provided, all questions about this application will be directed to the authorized official named in Section 15B.

A. Check Box - If this section does not apply, check the box and skip to Section 14.

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

- Provide the name, e-mail address, telephone number, and mailing address of an individual who can answer questions about the information furnished in this application.

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION ON THIS ENROLLMENT APPLICATION

The provider should review this section to understand those penalties that can be applied against it for deliberately furnishing false information to enroll or maintain enrollment in the Medicare program.

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13. Contact Person(s)

Furnish the name(s) and telephone number(s) of a person(s) who can answer questions about the information furnished in this application (preferably the individual who completed this application). If a contact person is not reported in this section, all questions will be directed to the authorized official named in Section 15B.

A. Check here ☐ if this section does not apply and skip to Section 14.

B. Contact Name and Telephone Number ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:_____**

Name: First	Last	
Address Line 1 (Street Name and Number)		
Address Line 2 (Suite, Room, etc.)		
City	State	ZIP Code + 4
E-mail Address (if applicable)	Telephone Number ( )	(Ext.) ( )

14. Penalties for Falsifying Information on this Enrollment Application

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

1. 18 U.S.C. § 1001 authorizes criminal penalties against an individual who, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry.

Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000 (18 U.S.C. § 3571). Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against any individual who, "knowingly and willfully," makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program.

The offender is subject to fines of up to $25,000 and/or imprisonment for up to five years.

3. The Civil False Claims Act, 31 U.S.C. § 3729, imposes civil liability, in part, on any person who:

a.) knowingly presents, or causes to be presented, to an officer or any employee of the United States Government a false or fraudulent claim for payment or approval;

b.) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or

c.) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

The Act imposes a civil penalty of $5,000 to $10,000 per violation, plus three times the amount of damages sustained by the Government.

4. Section 1128A(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency...a claim...that the Secretary determines is for a medical or other item or service that the person knows or should know:

a.) was not provided as claimed; and/or

b.) the claim is false or fraudulent.

This provision authorizes a civil monetary penalty of up to $10,000 for each item or service, an assessment of up to three times the amount claimed, and exclusion from participation in the Medicare program and State health care programs.

5. The government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment."

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

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SECTION 15: CERTIFICATION STATEMENT

This section is used to officially notify the provider of additional requirements that must be met and maintained in order for the provider to be enrolled in the Medicare program. This section also requires the signature and date signed of an authorized official who can legally and financially bind the provider to the laws, regulations, and program instructions of the Medicare program. Section 16 permits the authorized official to delegate signature authority to certain individual(s) (delegated officials) for the purpose of reporting changes to the provider's enrollment record after the provider has been enrolled. The provider may have no more than one currently active authorized official at any given time. See 15B below to determine who within the provider organization qualifies as an authorized official.

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

B. 1st Authorized Official Signature - If adding a new, or deleting an existing authorized official, check the appropriate box and indicate the effective date of that change.

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

- The authorized official must sign and date this application.

By his/her signature, the authorized official binds the provider to all of the requirements listed in the Certification Statement and acknowledges that the provider may be denied entry to or revoked from the Medicare program if any requirements are not met. **All signatures must be original.** Faxed, photocopied, or stamped signatures will not be accepted.

C. 2nd Authorized Official Signature - This section provided to report a second (optional) authorized official for this provider. See instructions above for Section 15B.

An authorized official is an appointed official to whom the provider has granted the legal authority to enroll it in the Medicare program, to make changes and/or updates to the provider's status in the Medicare program (e.g., new practice locations, change of address, etc.), and to commit the provider to fully abide by the laws, regulations, and program instructions of Medicare. The authorized official must be the provider's general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of 5% or more of the provider (see Section 5 for definition of a "direct owner"), or must hold a position of similar status and authority within the provider's organization.

Only the authorized official has the authority to sign (1) the initial CMS 855A enrollment application on behalf of the provider and (2) the CMS 855A enrollment application that must be submitted as part of the periodic revalidation process. The delegated official has no such authority.

By signing this form for initial enrollment in the Medicare program or for revalidation purposes, the authorized official agrees to immediately notify the fiscal intermediary if any information in the application is not true, correct, or complete. In addition, the authorized official, by his/her signature, agrees to notify the fiscal intermediary of any future changes to the information contained in this form, after the provider is enrolled in Medicare, within 90 days of the effective date of the change.

Governmental/Tribal Organizations

As stated in the instructions for Governmental/Tribal Organizations in Section 5, the authorized official signing the CMS 855A in Section 15 must be the same person submitting the letter attesting that the governmental or tribal organization will be legally and financially responsible for any outstanding debts owed to CMS. For instance, the head of a County Department of Health and Human Services would ordinarily qualify as an authorized official of the governmental entity.

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SPECIAL REPORTING REQUIREMENTS

To change authorized officials, the provider must:

- Check the "Delete" box in Section 15B,
- Provide the effective date of the deletion, and
- Have the authorized official being deleted provide his/her printed name, signature, and date of signature.

NOTE: If the current authorized official's signature is unattainable (e.g., person has left the company), the Medicare contractor may request documentation verifying that the person is no longer the authorized official.

To then add a new authorized official, the provider must:

- Copy the page containing the Certification Statement,
- Check the "Add" box in Section 15B and provide the effective date of the addition,
- Have the new authorized official provide the information requested in 15B, and
- Have the new authorized official provide his/her signature and date of signature.

By signing his or her name, the new authorized official assumes from the prior authorized official all of the powers (e.g., the power to delegate authority to a delegated official, etc.) previously held by the latter, and also agrees to adhere to all Medicare requirements, including those outlined in Sections 15A and 15B of the Certification Statement. However, a change of the authorized official has no bearing on the authority of existing delegated officials to make changes and/or updates to the provider's status in the Medicare program.

If the provider is reporting a change of information about the current authorized official (e.g., change in job title), this section should be completed as follows:

- Check the box to indicate a change and furnish the effective date,
- Provide the new information, and
- Have the authorized official sign and date this section.

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15. Certification Statement

This section is used to officially notify the provider of additional requirements that must be met and maintained in order for the provider to be enrolled in the Medicare program. This section also requires the signature and date signed of an "Authorized Official" who can legally and financially bind the provider to the laws, regulations, and program instructions of the Medicare program. Section 16 permits the "Authorized Official" to delegate signature authority to other individual(s) (Delegated Officials) employed by the provider for the purpose of reporting future changes to the provider's enrollment record. See instructions to determine who within the provider qualifies as an Authorized Official and a Delegated Official.

A. Additional Requirements for Medicare Enrollment

By his/her signature(s), the authorized official named below and the delegated official(s) named in Section 16 agree to adhere to the following requirements stated in this Certification Statement:

1.) I agree to notify the Medicare contractor of any future changes to the information contained in this form within 90 days of the effective date of the change. I understand that any change in the business structure of this provider may require the submission of a new application.
2.) I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare billing number(s), and/or the imposition of fines, civil damages, and/or imprisonment.
3.) I agree to abide by the Medicare laws, regulations, and program instructions that apply to this provider. The Medicare laws, regulations, and program instructions are available through the Medicare contractor.
4.) Neither this provider, nor any 5% or greater owner, partner, officer, director, managing employee, authorized official, or delegated official thereof is currently sanctioned, suspended, debarred, or excluded by the Medicare or Medicaid program, or any other Federal program, or is otherwise prohibited from providing services to Medicare or other Federal program beneficiaries.
5.) I agree that any existing or future overpayment made to the provider by the Medicare program may be recouped by Medicare through the withholding of future payments.
6.) I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.
7.) I authorize the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Osteopathic Association (AOA), or any other 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).

B. 1st Authorized Official Signature ☐ **Add** ☐ **Delete** **Effective Date:**_____

I have read the contents of this application. My signature legally and financially binds this provider to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete to the best of my knowledge, and I authorize the Medicare program contractor to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare program contractor of this fact immediately.

Authorized Official Name **Print** First	Middle	Last	Jr., Sr., etc.
Authorized Official **Signature** (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)		Title/Position	Date (MM/DD/YYYY) Signed

C. 2nd Authorized Official Signature ☐ **Add** ☐ **Delete** **Effective Date:**_____

I have read the contents of this application. My signature legally and financially binds this provider to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete to the best of my knowledge, and I authorize the Medicare program contractor to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare program contractor of this fact immediately.

Authorized Official Name **Print** First	Middle	Last	Jr., Sr., etc.
Authorized Official **Signature** (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)		Title/Position	Date (MM/DD/YYYY) Signed

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SECTION 16: DELEGATED OFFICIAL (OPTIONAL)

A delegated official must be a W-2 managing employee of the provider, or an individual with a 5% or greater direct ownership interest in, or any partnership interest in, the enrolling provider. Delegated officials are persons who are delegated the legal authority by the authorized official reported in Section 15B to make changes and/or updates to the provider's status in the Medicare program. This individual must also be able to commit the provider to fully abide by the laws, regulations, and program instructions of Medicare. For purposes of this section only, if the individual being assigned as a delegated official is a managing employee, that individual **must** be an actual W-2 employee of the enrolling provider. The Medicare contractor may request evidence indicating that the delegated official is an actual employee of the provider. Independent contractors are not considered "employed" by the provider. A provider can have no more than three delegated officials at any given time.

The signature of the authorized official in Section 16B2 constitutes a legal delegation of authority to any and all delegated official(s) assigned in Section 16.

A. Check Box - If the provider chooses not to assign any delegated officials in this application, check the box in this section. There is no requirement that the provider have a delegated official. However, if no delegated officials are assigned, the authorized official will be the only person who can make changes and/or updates to the provider's status in the Medicare program. All delegated officials must meet the following requirements:

- The delegated official must sign and date this application.
- The delegated official must furnish his/her title/position, and
- The delegated official must check the box furnished if they are a W-2 employee.

NOTE: Section 6 **MUST** be completed for **all** delegated officials. This requirement also includes delegated officials of a hospital that indicated it has a compliance plan and did not report any managing individuals in Section 6.

B. Delegated Official Signature

If the provider chooses to add delegated officials or to delete existing ones, this section should be completed as follows:

- Check the appropriate box indicating if the delegated official is being added or deleted and furnish the effective date,
- The authorized official must provide his or her signature and date of signature in Sections 15B and 16B2,
- The delegated official(s) to be added must provide the information and their signature in Section 16B, and
- The delegated official(s) to be deleted does not have to sign or date the application.

NOTE: All signatures must be original. Faxed, photocopied, or stamped signatures will not be accepted.

If the provider is reporting a change of information about an existing delegated official (e.g., change in job title), this section should be completed as follows:

- Check the box marked "Change" and furnish the effective date,
- Provide the new information, and
- The authorized official must sign and date Sections 15B and 16B2.

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

In addition, the delegated official, by his/her signature, agrees to notify the Medicare contractor of any changes to the information contained in this application within 90 days of the effective date of the change.

B. 2nd Delegated Official Signature - This section provided to report a second (optional) delegated official for this provider. See instructions above for Section 15B.

C. 3rd Delegated Official Signature - This section provided to report a third (optional) delegated official for this provider. See instructions above for Section 15B.

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SECTION 17: ATTACHMENTS

This section contains a list of documents that, if applicable, must be submitted with this enrollment application. Failure to provide the required documents will delay the enrollment process.

- Check the appropriate boxes indicating which documents are being submitted with this application.

NOTE: The licenses, certifications and registrations which must be submitted with this application are those required by Medicare and the State to function as the provider type for which this provider is enrolling (e.g., CLIA and FDA mammography certificates, hazardous waste disposal license, etc.). Local licenses/permits that are not of a medical nature are not required but any business license required to operate as a health care facility **must** be included with this application. Required documents that can only be obtained after a State Survey are not required as part of the application submission but **must** be furnished within 30 days of the provider receiving them. The Medicare contractor will furnish specific licensing requirements for your provider type upon request.

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

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

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16. Delegated Official (Optional)

The signature of the authorized official below constitutes a legal delegation of authority to the official(s) named in this section to make changes and/or updates to this provider's enrollment information. The signature(s) of the delegated official(s) shall have the same force and effect as that of the authorized official, and shall legally and financially bind the provider to all the laws, regulations, and program instructions of the Medicare program. By his or her signature, the delegated official certifies that he or she has read the Certification Statement in Section 15 and agrees to adhere to all of the stated requirements. The delegated official also certifies that he/she meets the definition of a delegated official. When making changes and/or updates to the provider's enrollment information maintained by the Medicare program, the delegated official certifies that the information provided is true, correct, and complete to the best of his/her knowledge. If assigning more than one delegated official (maximum of three), copy and complete this section as needed.

A. Check here ☐ if this provider will not be assigning any delegated official(s) and skip to Section 17.

B. 1st Delegated Official Signature ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Delegated Official Name **Print** First	Middle	Last	Jr., Sr., etc.
Delegated Official **Signature** (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed
Title/Position	☐Check here only if Delegated Official is a W-2 employee		
2. **Signature** of Authorized Official Assigning this Delegation (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed

C. 2nd Delegated Official Signature ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Delegated Official Name **Print** First	Middle	Last	Jr., Sr., etc.
Delegated Official **Signature** (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed
Title/Position	☐Check here only if Delegated Official is a W-2 employee		
2. **Signature** of Authorized Official Assigning this Delegation (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed

D. 3rd Delegated Official Signature ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Delegated Official Name **Print** First	Middle	Last	Jr., Sr., etc.
Delegated Official **Signature** (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed
Title/Position	☐Check here only if Delegated Official is a W-2 employee		
2. **Signature** of Authorized Official Assigning this Delegation (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed

17. Attachments

This section is a list of documents that, if applicable, should be submitted with this completed enrollment application.

Place a check next to each document (as applicable or required) from the list below that is being included with this completed application.

☐Copy(s) of all CLIA Certificates, FDA Mammography Certificates, and Diabetes Education Certificates
☐Copy(s) of all State Pharmacy licenses
☐Copy(s) of all adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters)
☐Copy(s) of all surety bonds and/or Agent's Power of Attorney
☐Copy(s) of all sales agreements (CHOWS, Acquisitions/Mergers, and Consolidations only) (2 copies)
☐Copy(s) of all documents that demonstrate meeting capitalization requirements (HHAs only)
☐Completed Form HCFA-588-Authorization Agreement for Electronic Funds Transfer
☐IRS documents confirming the tax identification number and legal business name (e.g., CP 575)
☐Any additional documentation or letters of explanation as needed

MEDICARE

FEDERAL HEALTH CARE
PROVIDER/SUPPLIER ENROLLMENT APPLICATION

Application for Health Care Suppliers that will Bill Medicare Carriers

CENTERS FOR MEDICARE & MEDICAID SERVICES