How to Complete the Medicare CMS-855I Enrollment Application

Presented by
Provider Outreach & Education
and Provider Enrollment
Welcome to the Computer-Based Training (CBT) module for Provider Enrollment.

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

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

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

- Larger font and plain language;
- Tips on how to avoid delays;
- Updated instructions to help you know which application to submit;
- Redesigned Section 17.
Is this the correct form for you?

The CMS-855I form is for the following:

- All Physicians
- Non-Physician Practitioners
  - Anesthesiology Assistant
  - Audiologist
  - Certified nurse midwife
  - Certified registered nurse anesthetist
  - Clinical nurse specialist
  - Clinical social worker
  - Mass immunization roster biller
  - Nurse practitioner
  - Occupational therapist in private practice
  - Physical therapist in private practice
  - Physician assistant
  - Psychologist, Clinical
  - Psychologist billing independently
  - Registered Dietitian or Nutrition Professional
Do You Have the CMS-855I Form?

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

The form is located on the CMS Web site at:

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

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

- Virginia
  (866) 697-9670

- DC/Delaware/Maryland
  (866) 828-6254
Providers are required to submit the new version of the enrollment form and additional information with all initial enrollment applications and changes of information.

Required additional information includes:

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

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

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

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

The Website of the NPI Enumerator is: [https://nppes.cms.hhs.gov/NPPES/Welcome.do](https://nppes.cms.hhs.gov/NPPES/Welcome.do)
**Electronic Funds Transfer (EFT)**

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

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

The application is to be included with your enrollment form.

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

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

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

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

This CBT will review each section of the CMS-855I form.
Section 1A: Basic Information

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

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

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

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

Complete in blue or black ink. NO PENCIL.
Changes of Medicare information must identify any Medicare identification numbers, NPI and complete Section 1B.

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

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

<table>
<thead>
<tr>
<th>Section 1: Basic Information (continued)</th>
</tr>
</thead>
</table>
| ✓ You are changing your Medicare information
  Medicare Identification Number (if issued):
  NPI: |
| Go to Section 1B |
| □ You are revalidating your Medicare enrollment
  Enter your Medicare Identification Number (if issued) and the NPI you would like to link to this number in Section 4. |
| Complete all sections |

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

<table>
<thead>
<tr>
<th>REQUIRED SECTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifying Information</td>
</tr>
<tr>
<td>Adverse Legal Actions / Convictions</td>
</tr>
<tr>
<td>Practice Location Information, Payment Address and Medical Record Storage Information</td>
</tr>
<tr>
<td>Individuals Having Managing Control</td>
</tr>
<tr>
<td>Billing Agency Information</td>
</tr>
</tbody>
</table>
Section 2A is personal information.

The entire section must be completed.

Non-physician practitioners complete the certification information section.

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

Include copies of all licenses and/or certifications.
Section 2B is where the applicant in 2A can be contacted.

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

Section 2B: Identifying Information

B. Correspondence Address

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

Mailing Address Line 1 (Street Name and Number)
101 Main St.

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

<table>
<thead>
<tr>
<th>City/Town</th>
<th>State</th>
<th>ZIP Code + 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plano</td>
<td>TX</td>
<td>12345-6789</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Telephone Number</th>
<th>Fax Number (if applicable)</th>
<th>E-mail Address (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(999) 999-9999</td>
<td>(888) 888-8888</td>
<td><a href="mailto:Johnq@email.net">Johnq@email.net</a></td>
</tr>
</tbody>
</table>

CMS-855I (06/06) EF 07/2006
Physicians are required to complete this section.

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

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

The date of completion in question 2 must be furnished.
Section 2D1: - Identifying Information

Designate your **Primary** and all **Secondary** specialties using a **P** and **S** in the appropriate box.

### SECTION 2: IDENTIFYING INFORMATION (Continued)

#### D. Medical Specialties

1. **PHYSICIAN SPECIALTY**
   Designate your primary specialty and all secondary specialty(s) below using:
   - **P**=Primary
   - **S**=Secondary

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

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

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

**Physicians who bill for diagnostic tests (other than clinical laboratory or pathology tests)—**

As a physician, you may bill for these diagnostic tests as long as you do not provide a substantial portion of the diagnostic tests to patients who are not your own patients. Patients are considered your own patients if:

- They have a prior relationship with you and are receiving medical treatment from you for a specific medical condition, or
- You are also billing for patient evaluation and management (E & M) codes.
Section 2D.2: Identifying Information

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

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

- Anesthesiology assistant
- Audiologist
- Certified nurse midwife
- Certified registered nurse anesthetist
- Clinical nurse specialist
- Clinical social worker
- Mass immunization roster biller
- Nurse practitioner
- Occupational therapist in private practice

- Physical therapist in private practice
- Physician assistant
- Psychologist, clinical
- Psychologist billing independently
- Registered dietitian or nutrition professional
- Undefined non-physician practitioner type (Specify):

__________________________________________________________________________
### Section 2E,F,G: Identifying Information

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

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

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

#### E. Physician Assistants: Establishing Employment Arrangement(s)

<table>
<thead>
<tr>
<th>Employer’s Name</th>
<th>Effective Date of Employment</th>
<th>Employer’s Medicare Identification Number (if issued)</th>
<th>Employer’s NPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Jane A Doe MD</td>
<td>01/01/2007</td>
<td>XX23045</td>
<td>1234567890</td>
</tr>
</tbody>
</table>

#### F. Physician Assistants: Terminating Employment Arrangement(s)

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

<table>
<thead>
<tr>
<th>Employer’s Name</th>
<th>Effective Date of Departure</th>
<th>Employer’s Medicare Identification Number (if issued)</th>
<th>Employer’s NPI</th>
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#### G. Employer Terminating Employment Arrangement With One or More Physician Assistants

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

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<thead>
<tr>
<th>Physician Assistant’s Name</th>
<th>Effective Date of Departure</th>
<th>Physician Assistant’s Medicare Identification Number (if issued)</th>
<th>Physician Assistant’s NPI</th>
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These sections are to be completed if applicable to your specific specialty.

Physical and Occupational Therapists who are reassigning their benefits do not complete Section 2J.
Section 3: Adverse Legal Actions

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

You must answer question number one.

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

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

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

SECTION 3: ADVERSE LEGAL ACTIONS/CONVICTIONS (Continued)

ADVERSE LEGAL HISTORY

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

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

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

<table>
<thead>
<tr>
<th>Adverse Legal Action</th>
<th>Date</th>
<th>Taken By</th>
<th>Resolution</th>
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pg. 13
Complete Section 4A only if you are the sole owner of a **Professional Corporation, Professional Association** or a **Limited Liability Company** and enrolling using an EIN.

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

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

After completing this section, skip to Section 4C and complete the information about your business entity.
This section identifies the groups/organizations to which you will reassign benefits

B. Individual Affiliations

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

Beginning with Section 4B1, answer “Yes” or “No” to each question. If you answer “yes” to any question, furnish the requested information about each group/organization to which you will reassign your benefits. In addition, either you or each group/organization reported in this section must complete and submit a CMS 855R(s) (Individual Reassignment of Benefits) with this application. Reassigning benefits means that you are authorizing the group/organization to bill and receive payment from Medicare for the services you have rendered at the group/organization’s practice location.

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

If you are an individual who is reassigning all of your benefits to a group, neither you nor the group needs to submit a CMS-588 (Electronic Funds Transfer) form to facilitate that reassignment.
**Situation # 1**

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

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

Skip to Section 4C.
Situation # 2

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

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

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

Go to 4C and enter your private practice information.
Section 4B: Practice Location Information

Situation # 3

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

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

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

Skip to Section 13.
Section 4C: Practice Location Information

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

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

C. Practice Location Information

- If you completed Section 4A, complete Section 4C through Section 17 for your business.
- All locations disclosed on claims forms should be identified in this section as practice locations.
- Complete this section for each of your practice locations where you render services to Medicare beneficiaries. However, you should only report those practice locations within the jurisdiction of the Medicare fee-for-service contractor to which you will submit this application. If you render services in a hospital and/or other health care facility, furnish the name and address of that hospital or facility.
- Each practice location must be a specific street address as recorded by the United States Postal Service. Do not report a P.O. Box.
- If you only render services in patients' homes (house calls), you may supply your home address in this section if you do not have an office. In Section 4H, explain that this address is for administrative purposes only and that all services are rendered in patients' homes.
- If you render services in a retirement or assisted living community, complete this section with the names, telephone numbers and addresses of those communities.

If you have a CLIA number and/or FDA/Radiology Certification Number for this practice location, provide that information and submit a copy of the most current CLIA and FDA certification for each practice location reported.
**Section 4: Practice Location Information**

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

Initial enrollees should write pending or leave Medicare field blank.

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

Identify the type of practice location you have.

Enter your CLIA number and FDA number if applicable.

<table>
<thead>
<tr>
<th>CHECK ONE</th>
<th>CHANGE</th>
<th>ADD</th>
<th>DELETE</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE (mm/dd/yyyy)</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Practice Location Name ("Doing Business As" name if different from Legal Business Name)
The Greenville Texas Clinic (DBA name for John Smith MD’s private practice)

Practice Location Street Address Line 1 (Street Name and Number – NOT a P.O. Box)
123 Main St
Suite 456

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

City/town
Greenville

State
TX

ZIP Code + 4
12345

Telephone Number
(123) 456-7890

Fax Number (if applicable)
(123) 098-7654

E-mail Address (if applicable)
GTC@email.net

Medicare Identification Number (if issued)

NPI
1234567890

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

Is this practice location a:
- [x] Private practice office setting
- [ ] Retirement/assisted living community
- [ ] Hospital
- [ ] Other health care facility (Specify:)

CLIA Number for this location (if applicable)

FDA/Radiology (Mammography) Certification Number for this location (if issued)
If you provide services in patients' homes you will need to complete Section 4D.

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

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

If you do not render services in patient's homes, skip Section 4D.
Section 4E: Practice Location Information

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

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

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

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

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

The three bulleted requirements listed must be met.

Enter your EIN.

---

**F. Employer ID Number Information**

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

To qualify for this payment arrangement, you:

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

**Employer Identification Number (EIN)**

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Section 4G, H: Practice Location Information

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

In 4H, explain any unique circumstances concerning your practice locations.
Section 6: Individuals Having Managing Control

This section is to be completed by sole proprietors.

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

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

Adverse legal actions must be completed for each individual reported.

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

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**SECTION 6: INDIVIDUALS HAVING MANAGING CONTROL**

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

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

**A. Managing Employee – Identifying Information**

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

<table>
<thead>
<tr>
<th>CHECK ONE</th>
<th>Q CHANGE</th>
<th>Q ADD</th>
<th>Q DELETE</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE (mm/dd/yyyy)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. First Name: Jane
2. Title: Office Manager
3. Social Security Number (Required): 123-45-6789
4. Date of Birth (mm/dd/yyyy): 12/15/1972

**B. Adverse Legal History**

Complete this section for the individual reported in Section 6A above. If you are changing or adding information, check the “change” box, furnish the effective date, and complete the appropriate fields in this section.

<table>
<thead>
<tr>
<th>Question</th>
<th>Action</th>
<th>Date</th>
<th>Taken By</th>
<th>Resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has this individual in Section 6A above, under any current or former name or business identity, ever had an adverse legal action listed on page 12 of this application imposed against him/her?</td>
<td>YES – Continue Below</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. If yes, report each adverse legal action, when it occurred, the Federal or State agency or court/administrative body that imposed the action, and the resolution, if any.</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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Section 8: Billing Agency

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

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

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

SECTION 8: BILLING AGENCY INFORMATION

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

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

BILLING AGENCY NAME AND ADDRESS

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

<table>
<thead>
<tr>
<th>CHECK ONE</th>
<th>CHANGE</th>
<th>ADD</th>
<th>DELETE</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE (mm/dd/yyyy)</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

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

“Doing Business As” Name (if applicable)

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

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

City/Town | State | ZIP Code + 4

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

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Section 13: Contact Person

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

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

If no one is listed, Medicare will contact the provider directly.
Section 14 outlines the penalties for falsifying information and should be read by the provider listed in Section 2.

This section does not have an area to be completed.
Section 15: Certification Statement

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

The individual practitioner must read and understand page 25.

SECTION 15: CERTIFICATION STATEMENT

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

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

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

Certification Statement

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

I, the undersigned, certify to the following:

1. I have read the contents of this application, and the information contained herein is true, correct, and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare fee-for-service contractor of this fact immediately.

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

3. I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on an application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare identification number(s), and/or the imposition of fines, civil damages, and/or imprisonment.

4. I agree to abide by the Medicare laws, regulations and program instructions that apply to me or to the organization listed in Section 4A of this application. The Medicare laws, regulations, and program instructions are available through the fee-for-service contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the supplier’s compliance with all applicable conditions of participation in Medicare.

5. Neither I nor any managing employee listed on this application, is currently sanctioned, suspended, debared, or excluded by the Medicare or State Health Care Program, e.g., Medicaid program, or any other Federal program, or is otherwise prohibited from providing services to Medicare or other Federal program beneficiaries.

6. I agree that any existing or future overpayment made to me (or to the organization listed in Section 4A of this application) by the Medicare program may be recouped by Medicare through the withholding of future payments.

7. I understand that the Medicare identification number issued to me can only be used by me or by a provider or supplier to whom I have reassigned my benefits under current Medicare regulations, when billing for services rendered by me.

8. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

9. I further certify that I am the individual practitioner applying for Medicare billing privileges.
Section 15: Certification Statement

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

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

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Initial</th>
<th>Last Name</th>
<th>MD., D.O., etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>John</td>
<td>Q.</td>
<td>Doe</td>
<td>MD</td>
</tr>
</tbody>
</table>

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

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

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

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Section 17: Supporting Documents

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

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

According to the Framework Reduction Act of 1995, providers are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 1506-0120. The time required to complete this information collection is estimated to it from per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimated or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Allen, PA, Office of the National Coordinator for Health Information Technology, P.O. Box 20911, Baltimore, Maryland 21209-0911.
Prescreening

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

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

This process applies to all applications.
**Prescreening – Missing Information**

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

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

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

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

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

- No signature on application.
- Old version of application submitted.
- Copies or stamped signature.
- CMS-855I signed by someone other than individual practitioner applying for enrollment.
- Applicant failed to submit all forms needed to process a reassignment package.
- Completed application in pencil.
- Wrong application submitted.
- Web-generated application submitted but does not appear to have been downloaded off of CMS' Web site.
- Application not mailed (i.e., it was faxed or e-mailed).

- Application received more than 30-days prior to the effective date listed on the application. (This does not apply to certified providers, ASCs or portable X-ray suppliers.)
- Provider submitted new enrollment application prior to expiration of time in which provider is entitled to appeal the denial of its previously submitted application.
- Submitted CMS-855 for sole purpose of enrolling in Medicaid.
- CMS-855 not needed for the transaction in question.
- CMS-588 sent in as a stand-alone change of information request (i.e., it was not accompanied by a CMS-855) but was 1) unsigned, 2) undated, or 3) contained copied, stamped or faxed signature.
Most Common Reasons for Delays

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

- Missing NPI notification.
- Failure to document the reason for application submittal.
- "Change" was selected in 1A, but no indication of what was changing.
- The effective date for the change, add or deletion was missing.
- Application not signed or dated.
- IRS tax identification or documentation not received.
Once it is determined that the application will not be returned, it goes through different phases of verification, validation, and then on to final processing.

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

This phone call or letter will be directed to the person listed on this application as the Contact Person in Section 13 of the CMS-855I form.
1. Request and obtain an National Provider Identifier (NPI) before enrolling or making a change.

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

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

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

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

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

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

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

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

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

- Virginia
  (866) 697-9670

- DC/Delaware/Maryland
  (866) 828-6254
Thank you for participating in this Computer-Based Training

Provider Outreach and Education and Provider Enrollment