# AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

**AgendaTitle:**
Medicare Enrollment Application

**Action Requested:** Board of County Commissioners' Signature

**Parties to the Agreement:** Gunnison County / Centers for Medicare and Medicaid

**Term Begins:** **Term Ends:** **Grant Contract #:**

**Summary:**
This contract will allow Gunnison Public Health to bill Medicare for influenza vaccinations during the upcoming flu season. This application is a revalidation of our existing Medicare Provider Number.

**Fiscal Impact:** Revenue in the Community Health Activity

**Submitted by:** Randy Morgan **Submitter's Email Address:** rmorgan@gunnisoncounty.org

**Finance Review:** (●) Required ( ) Not Required

Comments:

This Agreement allows Public Health to bill Medicare Insurance for flu shots and has been included in the budget as fee revenue. Jane Wyman

Reviewed by: Bcowan Discharge Date: 4/24/2013

**County Attorney Review:** (●) Required ( ) Not Required

Comments:

Reviewed by: ATrezise Discharge Date: 4/24/2013 Certificate of Insurance Required

Yes ( ) No (●)

**County Manager Review:**

Comments:

Reviewed by: MBirnie Discharge Date: 4/25/2013

(●) Consent Agenda ( ) Regular Agenda ( ) Worksession Time Allotted:

Agenda Date: 5/7/2013 Follow Up Agenda Date: N/A

*Revised April 2013*

# MEDICARE ENROLLMENT APPLICATION

## Clinics/Group Practices and Certain Other Suppliers

## CMS-855B

SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION.

SEE PAGE 2 FOR INFORMATION ON WHERE TO MAIL THIS APPLICATION.

SEE PAGE 35 TO FIND A LIST OF THE SUPPORTING DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION.

## WHO SHOULD SUBMIT THIS APPLICATION

Clinics and group practices can apply for enrollment in the Medicare program or make a change in their enrollment information using either:

- The Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or
- The paper enrollment application process (e.g., CMS 855B).

For additional information regarding the Medicare enrollment process, including Internet-based PECOS, go to *http://www.cms.gov/MedicareProviderSupEnroll*.

Clinics and group practices who are enrolled in the Medicare program, but have not submitted the CMS 855B since 2003, are required to submit a Medicare enrollment application (i.e., Internet-based PECOS or the CMS 855B) as an initial application when reporting a change for the first time.

The following suppliers must complete this application to initiate the enrollment process:

- Ambulance Service Supplier
- Ambulatory Surgical Center
- Clinic/Group Practice
- Independent Clinical Laboratory
- Independent Diagnostic Testing Facility (IDTF)
- Intensive Cardiac Rehabilitation Supplier
- Mammography Center
- Mass Immunization (Roster Biller Only)
- Part B Drug Vendor
- Portable X-ray Supplier
- Radiation Therapy Center

If your supplier type is not listed above, contact your designated fee-for-service contractor before you submit this application.

Complete and submit this application if you are an organization/group that plans to bill Medicare and you are:

- A **medical practice or clinic that will bill for Medicare Part B services** (e.g., group practices, clinics, independent laboratories, portable x-ray suppliers).
- A **hospital or other medical practice or clinic** that may bill for Medicare Part A services but will also bill for Medicare Part B practitioner services or provide purchased laboratory tests to other entities that bill Medicare Part B.
- **Currently enrolled with a Medicare fee-for-service contractor but need to enroll in another fee-for-service contractor's jurisdiction** (e.g., you have opened a practice location in a geographic territory serviced by another Medicare fee-for-service contractor).
- **Currently enrolled in Medicare and need to make changes to your enrollment data** (e.g., you have added or changed a practice location). Changes must be reported in accordance with the timeframes established in 42 C.F.R. § 424.516(d). (IDTF changes of information must be reported in accordance with 42 C.F.R. § 410.33.)

## BILLING NUMBER INFORMATION

The National Provider Identifier (NPI) is the standard unique health identifier for health care providers and is assigned by the National Plan and Provider Enumeration System (NPPES). **As a Medicare health supplier, you must obtain an NPI prior to enrolling in Medicare or before submitting a change for your existing Medicare enrollment information.** Applying for an NPI is a process separate from Medicare enrollment. As a supplier, it is your responsibility to determine if you have "subparts." A subpart is a component of an organization (supplier) that furnishes healthcare and is not itself a legal entity. If you do have subparts, you must determine if they should obtain their own unique NPIs. Before you complete this enrollment application, you need to make those determinations and obtain NPI(s) accordingly.

**Important: For NPI purposes, sole proprietors and sole proprietorships are considered to be "Type 1" providers. Organizations (e.g., corporations, partnerships) are treated as "Type 2" entities. When reporting the NPI of a sole proprietor on this application, therefore, the individual's Type 1 NPI should be reported; for organizations, the Type 2 NPI should be furnished.**

To obtain an NPI, you may apply online at *https://NPPES.cms.hhs.gov*. For more information about subparts, visit *www.cms.gov/NationalProvIdentStand* to view the "Medicare Expectations Subparts Paper."

The Medicare Identification Number, often referred to as a Provider Transaction Access Number (PTAN) or Medicare "legacy" number, is a generic term for any number other than the NPI that is used to identify a Medicare supplier.

## INSTRUCTIONS FOR COMPLETING AND SUBMITTING THIS APPLICATION

- Type or print all information so that it is legible. Do not use pencil.
- Report additional information within a section by copying and completing that section for each additional entry.
- Attach all required supporting documentation.
- Keep a copy of your completed Medicare enrollment package for your records.
- Send the completed application with original signatures and all required documentation to your designated Medicare fee-for-service contractor.

## AVOID DELAYS IN YOUR ENROLLMENT

To avoid delays in the enrollment process, you should:

- Complete all required sections.
- Ensure that the legal business name shown in Section 2 matches the name on the tax documents.
- Ensure that the correspondence address shown in Section 2 is the supplier's address.
- Enter your NPI in the applicable sections.
- Enter all applicable dates.
- Ensure that the correct person signs the application.
- Send your application and all supporting documentation to the designated fee-for-service contractor.

## ADDITIONAL INFORMATION

For additional information regarding the Medicare enrollment process, visit *www.cms.gov/MedicareProviderSupEnroll*.

The fee-for-service contractor may request, at any time during the enrollment process, documentation to support and validate information reported on the application. You are responsible for providing this documentation in a timely manner.

Certain information you provide on this application is considered to be protected under 5 U.S.C. Section 552(b)(4) and/or (b)(6), respectively. For more information, see the last page of this application for the Privacy Act Statement.

## MAIL YOUR APPLICATION

The Medicare fee-for-service contractor (also referred to as a carrier or a Medicare administrative contractor) that services your State is responsible for processing your enrollment application. To locate the mailing address for your fee-for-service contractor, go to *www.cms.gov/MedicareProviderSupEnroll*.

## NEW ENROLLEES AND THOSE WITH A NEW TAX ID NUMBER

If you are:

- Enrolling in the Medicare program for the first time with this Medicare fee-for-service contractor under this tax identification number.
- Already enrolled with a Medicare fee-for-service contractor but are establishing a practice location in another fee-for-service contractor's jurisdiction.
- Enrolled with a Medicare fee-for-service contractor but have a new tax identification number. If you are reporting a change to your tax identification number, you must complete a new application.
- A hospital or an individual hospital department that is enrolling with a fee-for-service contractor to bill for Part B services.

The following actions apply to Medicare suppliers already enrolled in the program:

## ENROLLED MEDICARE SUPPLIERS

### Reactivation

To reactivate your Medicare billing privileges, submit this enrollment application. In addition, prior to being reactivated, you must be able to submit a valid claim and meet all current requirements for your supplier type before reactivation may occur.

### Voluntary Termination

A supplier should voluntarily terminate its Medicare enrollment when it:

- Will no longer be rendering services to Medicare patients, or
- Is planning to cease (or has ceased) operations.

### Change of Ownership

If a hospital, ambulatory surgical center, or portable X-ray supplier is undergoing a change of ownership (CHOW) in accordance with the principles outlined in 42 C.F.R. 489.18, the entity must submit a new application for the new ownership.

### Change of Information

A change of information should be submitted if you are changing, adding or deleting information under your current tax identification number.

Changes in your existing enrollment data must be reported to the fee-for-service contractor in accordance with 42 C.F.R. § 424.516 (Physician and Non Physician Practitioner Organizations). (IDTF changes of information must comply with the provisions found at 42 C.F.R. § 410.33.)
If you are already enrolled in Medicare and are not receiving Medicare payments via EFT, any change to your enrollment information will require you to submit a CMS-588 form. All future payments will then be made via EFT.

### Revalidation

CMS may require you to submit or update your enrollment information. The fee-for-service contractor will notify you when it is time for you to revalidate your enrollment information. Do not submit a revalidation application until you have been contacted by the fee-for-service contractor.

## SECTION 1: BASIC INFORMATION
## ALL APPLICANTS MUST COMPLETE THIS SECTION *(See instructions for details.)*

**A. Check one box and complete the required sections.**

| REASON FOR APPLICATION | BILLING NUMBER INFORMATION | REQUIRED SECTIONS |
|---|---|---|
| ☐ You are a **new enrollee** in Medicare | Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4. | **Complete all applicable sections**<br>**Ambulance suppliers** must complete **Attachment 1**<br>**IDTF suppliers** must complete **Attachment 2** |
| ☐ You are **enrolling in another fee-for-service contractor's jurisdiction** | Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4. | **Complete all applicable sections**<br>**Ambulance suppliers** must complete **Attachment 1**<br>**IDTF suppliers** must complete **Attachment 2** |
| ☒ You are **reactivating** your Medicare enrollment | Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4.<br>Medicare Identification Number(s) *(if issued)*: C 30196<br>National Provider Identifier *(if issued)*: 1942366612 | **Complete all applicable sections**<br>**Ambulance suppliers** must complete **Attachment 1**<br>**IDTF suppliers** must complete **Attachment 2** |
| ☐ You are **voluntarily terminating** your Medicare enrollment. (This is not the same as "opting out" of the program) | Effective Date of Termination:<br>Medicare Identification Number(s) to Terminate *(if issued)*:<br>National Provider Identifier *(if issued)*: | Sections **1, 2B1, 13,** and either **15 or 16**<br>If you are terminating an employment arrangement with a physician assistant, complete Sections **1A, 2G, 13,** and either **15 or 16** |

## SECTION 1: BASIC INFORMATION *(Continued)*
## ALL APPLICANTS MUST COMPLETE THIS SECTION *(See instructions for details.)*

**A. Check one box and complete the required sections.**

| REASON FOR APPLICATION | BILLING NUMBER INFORMATION | REQUIRED SECTIONS |
|---|---|---|
| ☐ You are **changing** your Medicare information | Medicare Identification Number:<br>National Provider Identifier *(if issued)*: | 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 applicable sections**<br>**Ambulance suppliers** must complete **Attachment 1**<br>**IDTF suppliers** must complete **Attachment 2** |

## SECTION 1: BASIC INFORMATION *(Continued)*

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

| | REQUIRED SECTIONS |
|---|---|
| ☐ Identifying Information | **1, 2** (complete only those sections that are changing), **3, 13,** and either **15** (if you are an authorized official) **or 16** (if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier |
| ☐ Final Adverse Actions/Convictions | **1, 2B1, 3, 13,** and either **15** (if you are an authorized official) **or 16** (if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier |
| ☐ Practice Location Information, Payment Address & Medical Record Storage Information | **1, 2B1, 3, 4** (complete only those sections that are changing), **13,** and either **15** (if you are an authorized official) **or 16** (if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier |
| ☐ Change of Ownership (Hospitals, Portable X-Ray Suppliers & Ambulatory Surgical Centers Only) | **Complete all sections and provide a copy of the sales agreement** |
| ☐ Ownership Interest and/or Managing Control Information (Organizations) | **1, 2B1, 3, 5, 13,** and either **15** (if you are an authorized official) **or 16** (if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier |
| ☐ Ownership Interest and/or Managing Control Information (Individuals) | **1, 2B1, 3, 6, 13,** and either **15** (if you are an authorized official) **or 16** (if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier |
| ☐ Billing Agency Information | **1, 2B1, 3, 8** (complete only those sections that are changing), **13,** and either **15** (if you are an authorized official) **or 16** (if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier |
| ☐ Authorized Official(s) | **1, 2B1, 3, 13, 15 or 16** (if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier |
| ☐ Delegated Official(s) (Optional) | **1, 2B1, 3, 13, 15, 16,** and **6** for the signer if that delegated official has not been established for this supplier. |

## SECTION 1: BASIC INFORMATION *(Continued)*

| ATTACHMENT 1: AMBULANCE SERVICE SUPPLIERS (ONLY) | REQUIRED SECTIONS |
|---|---|
| ☐ Geographic Area | **1, 2B1, 3, 13, and 15** if you are the authorized official **or 16** if you are the delegated official **Attachment 1(A)** |
| ☐ State License Information | **1, 2B1, 3, 13, and 15** if you are the authorized official **or 16** if you are the delegated official **Attachment 1(B)** |
| ☐ Paramedic Intercept Services Information | **1, 2B1, 3, 13, and 15** if you are the authorized official **or 16** if you are the delegated official **Attachment 1(C)** |
| ☐ Vehicle Information | **1, 2B1, 3, 13, and 15** if you are the authorized official **or 16** if you are the delegated official **Attachment 1(D)** |
| **ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (ONLY)** | **REQUIRED SECTIONS** |
| ☐ CPT-4 and HCPCS Codes | **1, 2B1, 3, 13, and 15** if you are the authorized official **or 16** if you are the delegated official **Attachment 2(B)** |
| ☐ Interpreting Physician Information | **1, 2B1, 3, 13, and 15** if you are the authorized official **or 16** if you are the delegated official **Attachment 2(C)** |
| ☐ Personnel (Technicians) Who Perform Tests | **1, 2B1, 3, 13, and 15** if you are the authorized official **or 16** if you are the delegated official **Attachment 2(D)** |
| ☐ Supervising Physician(s) | **1, 2B1, 3, 13, and 15** if you are the authorized official **or 16** if you are the delegated official **Attachment 2(E)** |
| ☐ Liability Insurance Information | **1, 2B1, 3, 13, and 15** if you are the authorized official **or 16** if you are the delegated official **Attachment 2(F)** |

## SECTION 2: IDENTIFYING INFORMATION

### A. Type of Supplier

Check the appropriate box to identify the type of supplier you are enrolling as with Medicare. If you are more than one type of supplier, submit a separate application for each type. If you change the type of service that you provide (i.e., become a different supplier type), submit a new application.

Your organization must meet all Federal and State requirements for the type of supplier checked below.

**TYPE OF SUPPLIER:** ***(Check one only)***

- ☐ Ambulance Service Supplier
- ☐ Ambulatory Surgical Center
- ☐ Clinic/Group Practice
- ☐ Hospital Department(s)
- ☐ Independent Clinical Laboratory
- ☐ Independent Diagnostic Testing Facility
- ☐ Intensive Cardiac Rehabilitation
- ☐ Mammography Center
- ☒ Mass Immunization (Roster Biller Only)
- ☐ Pharmacy
- ☐ Physical/Occupational Therapy Group in Private Practice
- ☐ Portable X-ray Supplier
- ☐ Radiation Therapy Center
- ☐ Other *(Specify)*: _____

### B. Supplier Identification Information

#### 1. BUSINESS INFORMATION

Legal Business Name (not the "Doing Business As" name) as reported to the Internal Revenue Service

Gunnison County

Tax Identification Number

84-6000-770

| Other Name | Type of Other Name |
|---|---|
| Gunnison County Public Health | ☐ Former Legal Business Name<br>☒ Doing Business As Name<br>☐ Other *(Specify)*: _____ |

Identify how your business is registered with the IRS. (**NOTE:** If your business is a Federal and/or State government provider or supplier, indicate "Non-Profit" below.)

☐ Proprietary ☒ Non-Profit

**NOTE:** If a checkbox indicating Proprietary or non-profit status is not completed, the provider/supplier will be defaulted to "Proprietary."

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

☐ Corporation ☐ Limited Liability Company ☐ Partnership
☐ Sole Proprietor ☒ Other *(Specify)*: County Government

| Incorporation Date *(mm/dd/yyyy) (if applicable)* | State Where Incorporated *(if applicable)* |
|---|---|
| 3/9/1877 | CO |

Is this supplier an Indian Health Facility enrolling with the designated Indian Health Service (IHS) Medicare Administrative Contractor (MAC)?

☐ Yes ☒ No

## SECTION 2: IDENTIFYING INFORMATION *(Continued)*

### 2. STATE LICENSE INFORMATION/CERTIFICATION INFORMATION

Provide the following information if the supplier has a State license/certification to operate as the supplier type for which you are enrolling.

☐ State License Not Applicable

| License Number | State Where Issued |
|---|---|
| Effective Date *(mm/dd/yyyy)* | Expiration/Renewal Date *(mm/dd/yyyy)* |

### Certification Information

☐ Certification Not Applicable

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

### 3. CORRESPONDENCE ADDRESS

Provide contact information for the entity or person listed in Question 1 of this section. 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)*

200 East Virginia Ave

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

| City/Town | | State | ZIP Code + 4 |
|---|---|---|---|
| Gunnison | | CO | 81230 |
| Telephone Number | Fax Number *(if applicable)* | E-mail Address *(if applicable)* | |
| 970 641 - 0209 | 970 - 641 - 8346 | rmorgan@gunnisoncounty.org | |

### C. Hospitals Only

This section should only be completed by hospitals that are currently enrolled or enrolling with a fee-for-service contractor (the Part A Medicare contractor), and will be billing a fee-for-service contractor for Medicare Part B services, as follows:

- Hospitals that need departmental billing numbers to bill for Part B practitioner services.
- Hospitals requiring a Part B billing number to provide pathology services.
- Hospitals requiring a Medicare Part B billing number to provide purchased tests to other Medicare Part B billers.
- If the hospital requires more than one departmental Part B billing number, list each department needing a number.

If your organization is not a hospital, and believes it will need a Part B billing number, contact the designated fee-for-service contractor to determine if this form should be submitted.

## SECTION 2: IDENTIFYING INFORMATION *(Continued)*

### C. Hospitals Only *(Continued)*

**NOTE:** If your hospital is enrolling a clinic that is not provider-based, do not complete this section.

**Check ☐ "Clinic/Group Practice" in Section 2A and complete this entire application for the clinic.**

1. Are you going to:
   ☐ bill for the entire hospital with one billing number? (If yes, continue to Section 2D.)
   ☐ separately bill for each hospital department? (If yes, answer Question 2.)
2. List the hospital departments for which you plan to bill separately:

| DEPARTMENT | MEDICARE IDENTIFICATION NUMBER | NPI |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

### D. Comments/Special Circumstances

Explain any unique circumstances concerning your practice location, the method by which you render health care services, etc.

_____

_____

_____

_____

_____

### E. Physical Therapy (PT) and Occupational Therapy (OT) Groups Only

1. Are all of the group's PT/OT services rendered in patients' homes or in the group's private office space? ☐ YES ☐ NO
2. Does this group maintain private office space? ☐ YES ☐ NO
3. Does this group own, lease, or rent its private office space? ☐ YES ☐ NO
4. Is this private office space used exclusively for the group's private practice? ☐ YES ☐ NO
5. Does this group provide PT/OT services outside of its office and/or patients' homes? ☐ YES ☐ NO

If you responded YES to any of the questions 2–5 above, submit a copy of the lease agreement that gives the group exclusive use of the facilities for PT/OT services.

### F. Accreditation for Ambulatory Surgical Centers (ASCs) Only

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

Check one of the following and furnish any additional information as requested:

☐ The enrolling ASC supplier is accredited.

☐ The enrolling ASC supplier is not accredited (includes exempt providers).

Name of Accrediting Organization

| Effective Date of Current Accreditation *(mm/dd/yyyy)* | Expiration of Current Accreditation *(mm/dd/yyyy)* |
|---|---|
| | |

## SECTION 2: IDENTIFYING INFORMATION *(Continued)*

### G. Termination of Physician Assistants *(Only)*

Complete this section to delete employed physician assistants from your group or clinic.

| EFFECTIVE DATE OF DEPARTURE | PHYSICIAN ASSISTANT'S NAME | PHYSICIAN ASSISTANT'S MEDICARE IDENTIFICATION NUMBER | PHYSICIAN ASSISTANT'S NPI |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

### H. Advanced Diagnostic Imaging (ADI) Suppliers Only

This section must be completed by all suppliers that also furnish and will bill Medicare for ADI services. All suppliers furnishing ADI services MUST be accredited in each ADI Modality checked below to qualify to bill Medicare for those services.

Check each ADI modality this supplier will furnish and the name of the Accrediting Organization that accredited that ADI Modality for this supplier.

☐ **Magnetic Resonance Imaging (MRI)**

Name of Accrediting Organization for MRI

| Effective Date of Current Accreditation *(mm/dd/yyyy)* | Expiration Date of Current Accreditation *(mm/dd/yyyy)* |
|---|---|
| | |

☐ **Computed Tomography (CT)**

Name of Accrediting Organization for CT

| Effective Date of Current Accreditation *(mm/dd/yyyy)* | Expiration Date of Current Accreditation *(mm/dd/yyyy)* |
|---|---|
| | |

☐ **Nuclear Medicine (NM)**

Name of Accrediting Organization for NM

| Effective Date of Current Accreditation *(mm/dd/yyyy)* | Expiration Date of Current Accreditation *(mm/dd/yyyy)* |
|---|---|
| | |

☐ **Positron Emission Tomography (PET)**

Name of Accrediting Organization for PET

| Effective Date of Current Accreditation *(mm/dd/yyyy)* | Expiration Date of Current Accreditation *(mm/dd/yyyy)* |
|---|---|
| | |

## SECTION 3: FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS

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

### Convictions

1. The provider, supplier, or any owner of the provider or supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include:

   Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicare program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Act.

2. Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
5. Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

### Exclusions, Revocations, or Suspensions

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation or suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any current Medicare payment suspension under any Medicare billing number.
5. Any Medicare revocation of any Medicare billing number.

## SECTION 3: FINAL ADVERSE ACTIONS/CONVICTIONS *(Continued)*

### FINAL ADVERSE HISTORY

1. Has your organization, under any current or former name or business identity, ever had any of the final adverse actions listed on page 13 of this application imposed against it?

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

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

| FINAL ADVERSE ACTION | DATE | TAKEN BY | RESOLUTION |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## SECTION 4: PRACTICE LOCATION INFORMATION

### INSTRUCTIONS

This section captures information about the physical location(s) where you currently provide health care services. If you operate a mobile facility or portable unit, provide the address for the "Base of Operations," as well as vehicle information and the geographic area serviced by these facilities or units.

Only report those practice locations within the jurisdiction of the Medicare fee-for-service contractor to which you will submit this application. If you have practice locations in another Medicare fee-for-service contractor's jurisdiction, complete a separate enrollment application (CMS-855B) for those practice locations and submit it to the Medicare fee-for-service contractor that has jurisdiction over those locations.

Provide the specific street address as recorded by the United States Postal Service. Do not provide a P.O. Box. If you provide services in a hospital and/or other health care facility for which you bill Medicare directly for the services rendered at that facility, provide the name and address of the hospital or facility.

### MOBILE FACILITY AND/OR PORTABLE UNIT

A "mobile facility" is generally a mobile home, trailer, or other large vehicle that has been converted, equipped, and licensed to render health care services. These vehicles usually travel to local shopping centers or community centers to see and treat patients inside the vehicle.

A "portable unit" is when the supplier transports medical equipment to a fixed location (e.g., physician's office, nursing home) to render services to the patient.

The most common types of mobile facilities/portable units are mobile IDTFs, portable X-ray suppliers, portable mammography, and mobile clinics. Physicians and non-physician practitioners (e.g., nurse practitioners, physician assistants) who perform services at multiple locations (e.g., house calls, assisted living facilities) are not considered to be mobile facilities/portable units.

## SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

### A. Practice Location Information

If you see patients in more than one practice location, copy and complete Section 4A for each location.

To ensure that CMS establishes the correct association between your Medicare legacy number and your NPI, providers and suppliers must list a Medicare legacy number—NPI combination for each practice location. If you have multiple NPIs associated with both a single legacy number and a single practice location, please list below all NPIs and associated legacy numbers for that practice location.

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

| CHECK ONE | ☐ CHANGE | ☐ ADD | ☐ DELETE |
|---|---|---|---|
| DATE *(mm/dd/yyyy)* | | | |

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

Practice Location Name *("Doing Business As" name if different from Legal Business Name)*
Gunnison County Public Health

Practice Location Street Address Line 1 *(Street Name and Number – NOT a P.O. Box)*
225 N Pine St Suite E

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

| City/Town | State | ZIP Code + 4 |
|---|---|---|
| Gunnison | CO | 81230 |

| Telephone Number | Fax Number *(if applicable)* | E-mail Address *(if applicable)* |
|---|---|---|
| 970-641-0209 | 970-641-8346 | rmorgan@gunnisoncounty.org |

Date you saw your first Medicare patient at this practice location *(mm/dd/yyyy)*
Years ago Reactivating a Medicare Number for the upcoming flu seaso

| Medicare Identification Number *(if issued)* | National Provider Identifier |
|---|---|
| C - 30196 | 1942366612 |
| | |
| | |
| | |
| | |

Is this practice location a:
☒ Group practice office/clinic (County Public Health Dept.)
☐ Hospital
☐ Retirement/assisted living community
☐ Skilled Nursing Facility and/or Nursing Facility
☐ Other health care facility *(Specify):*_____

CLIA Number for this location *(if applicable)*
06D0667929

Attach a copy of the most current CLIA certifications for each of the practice locations reported on this application

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

Attach a copy of the most current FDA certifications for each of the practice locations reported on this application.

## SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

**B. Where do you want remittance notices or special payments sent?**

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

| CHECK ONE | ☐ CHANGE | ☐ ADD | ☐ DELETE |
|---|---|---|---|
| DATE *(mm/dd/yyyy)* | | | |

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

☒ "Special Payments" address is the same as the practice location (only one address is listed in Section 4A). Skip to Section 4C.

☐ "Special Payments" address is different than that listed in Section 4A, or multiple locations are listed. Provide address below.

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

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

| City/Town | State | ZIP Code + 4 |
|---|---|---|
| | | |

**C. Where do you keep patients' medical records?**

If you store patients' medical records (current and/or former patients) at a location other than the location in Section 4A or 4E, complete this section with the address of the storage location.

Post Office boxes and drop boxes are not acceptable as physical addresses where patients' records are maintained. For IDTFs and mobile facilities/portable units, the patients' medical records must be under the supplier's control. The records must be the supplier's records, not the records of another supplier. If this section is not completed, you are indicating that all records are stored at the practice locations reported in Section 4A or 4E.

## SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

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

### First Medical Record Storage Facility (for current and former patients)

| CHECK ONE | ☐ CHANGE | ☐ ADD | ☐ DELETE |
|---|---|---|---|
| DATE *(mm/dd/yyyy)* | | | |

Storage Facility Address Line 1 *(Street Name and Number)*

Storage Facility Address Line 2 *(Suite, Room, etc.)*

| City/Town | State | ZIP Code + 4 |
|---|---|---|
| | | |

### Second Medical Record Storage Facility (for current and former patients)

| CHECK ONE | ☐ CHANGE | ☐ ADD | ☐ DELETE |
|---|---|---|---|
| DATE *(mm/dd/yyyy)* | | | |

Storage Facility Address Line 1 *(Street Name and Number)*

Storage Facility Address Line 2 *(Suite, Room, etc.)*

| City/Town | State | ZIP Code + 4 |
|---|---|---|
| | | |

## SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

### D. Rendering Services in Patients' Homes

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

| CHECK ONE | ☐ CHANGE | ☐ ADD | ☐ DELETE |
|---|---|---|---|
| DATE *(mm/dd/yyyy)* | | | |

Furnish the city/town, State and ZIP code for all locations where health care services are rendered in patients' homes. If you provide health care services in more than one State and those States are serviced by different Medicare fee-for-service contractors, complete a separate CMS-855B enrollment application for each Medicare fee-for-service contractor's jurisdiction.

If you are adding or deleting an entire State, it is not necessary to report each city/town. Simply check the box below and specify the State.

☐ Entire State of _____

If you are providing services in selected cities/towns, furnish the locations below. Only list ZIP codes if you are not servicing the entire city/town.

| CITY/TOWN | STATE | ZIP CODE |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

### E. Base of Operations Address for Mobile or Portable Suppliers (Location of Business Office or Dispatcher/Scheduler)

The base of operations is the location from where personnel are dispatched, where mobile/portable equipment is stored, and when applicable, where vehicles are parked when not in use.

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

| CHECK ONE | ☐ CHANGE | ☐ ADD | ☐ DELETE |
|---|---|---|---|
| DATE *(mm/dd/yyyy)* | | | |

**Check here ☐ and skip to Section 4F if the "Base of Operations" address is the same as the "Practice Location" listed in Section 4A.**

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

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

| City/Town | State | ZIP Code + 4 |
|---|---|---|
| | | |

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

### F. Vehicle Information

If the mobile health care services are rendered inside a vehicle, such as a mobile home or trailer, furnish the following vehicle information. Do not provide information about vehicles that are used only to transport medical equipment (e.g., when the equipment is transported in a van but is used in a fixed setting, such as a doctor's office) or ambulance vehicles. If more than two vehicles are used, copy and complete this section as needed.

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

| CHECK ONE FOR EACH VEHICLE | TYPE OF VEHICLE *(van, mobile home, trailer, etc.)* | VEHICLE IDENTIFICATION NUMBER |
|---|---|---|
| ☐ CHANGE ☐ ADD ☐ DELETE | | |
| Effective Date: | | |
| ☐ CHANGE ☐ ADD ☐ DELETE | | |
| Effective Date: | | |

**For each vehicle, submit a copy of all health care related permits/licenses/registrations.**

## SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

### G. Geographic Location for Mobile Or Portable Suppliers Where the Base of Operations and/or Vehicle Renders Services

Provide the city/town, State, and ZIP Code for all locations where mobile and/or portable services are rendered.

**NOTE:** If you provide mobile or portable health care services in more than one State and those States are serviced by different Medicare fee-for-service contractors, complete a separate enrollment application (CMS-855B) for each Medicare fee-for-service contractor's jurisdiction.

#### INITIAL REPORTING AND/OR ADDITIONS

If you are reporting or adding an entire State, it is not necessary to report each city/town. Simply check the box below and specify the State.

☐ Entire State of _____

If services are provided in selected cities/towns, provide the locations below. Only list ZIP codes if you are not servicing the entire city/town.

| CITY/TOWN | STATE | ZIP CODE |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

#### DELETIONS

If you are deleting an entire State, it is not necessary to report each city/town. Simply check the box below and specify the State.

☐ Entire State of _____

If services you are deleting are furnished in selected cities/towns, provide the locations below. Only list ZIP codes if you are not servicing the entire city/town.

| CITY/TOWN | STATE | ZIP CODE |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

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

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

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

## MANAGING CONTROL (ORGANIZATIONS)

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

## 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 supplier must submit a letter on the letterhead of the responsible government (e.g., government agency) or tribal organization that attests that the government or tribal organization will be legally and financially responsible in the event that there is any outstanding debt owed to CMS. This letter must be signed by an appointed or elected official of the government or tribal organization who has the authority to legally and financially bind the government or tribal organization to the laws, regulations, and program instructions of the Medicare program.

### Non-Profit, Charitable and Religious Organizations

Many non-profit organizations are charitable or religious in nature, and are operated and/or managed by a board of trustees or other governing body. The actual name of the board of trustees or other governing body should be reported in this section. While the organization should be listed in Section 5, individual board members should be listed in Section 6. Each non-profit organization should submit a copy of a 501(c)(3) document verifying its non-profit status.

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

All organizations that have any of the following must be reported in Section 5:

- 5 percent or more ownership of the supplier,
- Managing control of the supplier, or
- A partnership interest in the supplier, regardless of the percentage of ownership the partner has.

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

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

### A. Organization with Ownership Interest and/or Managing Control—Identification Information

☐ Not Applicable

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

| CHECK ONE | ☐ CHANGE | ☐ ADD | ☐ DELETE |
|---|---|---|---|
| DATE *(mm/dd/yyyy)* | | | |

Check all that apply:

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

Legal Business Name as Reported to the Internal Revenue Service

Gunnison County

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

Gunnison County Public Health

Address Line 1 *(Street Name and Number)*

200 E. Virginia Ave.

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

| City/Town | State | ZIP Code + 4 |
|---|---|---|
| Gunnison | CO | 81230 |

| Telephone Number | Fax Number *(if applicable)* | E-mail Address *(if applicable)* |
|---|---|---|
| 970-641-0209 | 970-641-8346 | rmorgan@gunnisoncounty.org |
| **NPI** *(if issued)* | **Tax Identification Number** *(Required)* | **Medicare Identification Number(s)** *(if issued)* |
| 194 236 6612 | 84 6000 770 | C 301 96 |

What is the effective date this owner acquired ownership of the provider identified in Section 2B1 of this application? *(mm/dd/yyyy)* _____

What is the effective date this organization acquired managing control of the provider identified in Section 2B1 of this application? *(mm/dd/yyyy)* 01/01/1977

**NOTE:** Furnish both dates if applicable.

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

### B. Final Adverse Legal Action History

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

☐ Change
Effective Date:_____

1. Has this individual in Section 5A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 13 of this application imposed against him/her?

   ☐ YES–Continue Below ☐ NO–Skip to Section 6

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

| FINAL ADVERSE LEGAL ACTION | DATE | TAKEN BY | RESOLUTION |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

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

**NOTE:** Only Individuals should be reported in Section 6. Organizations must be reported in Section 5. For more information on "direct" and "indirect" owners, go to *www.cms.hhs.gov/MedicareProviderSupEnroll.*

**The supplier MUST have at least ONE owner and/or managing employee.**

The following individuals must be reported in Section 6A:

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

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

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

**Non-Profit, Charitable or Religious Organizations:** If you are a non-profit charitable or religious organization that has no organizational or individual owners (only board members, directors or managers), you should submit with your application a 501(c)(3) document verifying non-profit status.

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

**Officer** is any person whose position is listed as being that of an officer in the supplier's "articles of incorporation" or "corporate bylaws," or anyone who is appointed by the board of directors as an officer in accordance with the supplier's corporate bylaws.

**Director** is a member of the supplier's "board of directors." It does not necessarily include a person who may have the word "director" in his/her job title (e.g., departmental director, director of operations). Moreover, where a supplier has a governing body that does not use the term "board of directors," the members of that governing body will still be considered "directors." Thus, if the supplier has a governing body titled "board of trustees" (as opposed to "board of directors"), the individual trustees are considered "directors" for Medicare enrollment purposes.

**Managing Employee** means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operations of the supplier, either under contract or through some other arrangement, regardless of whether the individual is a W-2 employee of the supplier.

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

Any information on final adverse actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each individual. Owners, Authorized Officials and/or Delegated Officials must complete this section.

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

### A. Individuals with Ownership Interest and/or Managing Control—Identification Information

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

| CHECK ONE | ☐ CHANGE | ☐ ADD | ☐ DELETE |
|---|---|---|---|
| DATE *(mm/dd/yyyy)* | | | |

The name, date of birth, and social security number of each person listed in this Section must coincide with the individual's information as listed with the Social Security Administration.

| First Name | Middle Initial | Last Name | Jr., Sr., etc. | Title |
|---|---|---|---|---|
| | | | | |

| Date of Birth *(mm/dd/yyyy)* | Place of Birth *(State)* | Country of Birth |
|---|---|---|
| | | |

| Social Security Number *(Required)* | Medicare Identification Number *(if issued)* | NPI *(if issued)* |
|---|---|---|
| | | |

What is the above individual's relationship with the supplier in Section 2B1? *(Check all that apply.)*

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

What is the effective date this owner acquired ownership of the provider identified in Section 2B1 of this application? *(mm/dd/yyyy)* _____

What is the effective date this individual acquired managing control of the provider identified in Section 2B1 of this application? *(mm/dd/yyyy)* _____

**NOTE:** Furnish both dates if applicable.

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

### B. Final Adverse Legal Action History

Complete this section for the individual reported in Section 6A above. If reporting a change to existing information, check "change," provide the effective date of the change and complete the appropriate fields in this section.

☐ Change
Effective Date:_____

1. Has this individual in Section 6A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 13 of this application imposed against him/her?

   ☐ YES–Continue Below ☐ NO–Skip to Section 8

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

| FINAL ADVERSE LEGAL ACTION | DATE | TAKEN BY | RESOLUTION |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## SECTION 7: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

## SECTION 8: BILLING AGENCY INFORMATION

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

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

### BILLING AGENCY NAME AND ADDRESS

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

| CHECK ONE | ☐ CHANGE | ☐ ADD | ☐ DELETE |
|---|---|---|---|
| DATE *(mm/dd/yyyy)* | | | |

| Legal Business/Individual Name as Reported to the Social Security Administration or the Internal Revenue Service | If Individual, Billing Agent Date of Birth *(mm/dd/yyyy)* |
|---|---|
| "Doing Business As" Name *(if applicable)* | Tax Identification/Social Security Number *(required)* |

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

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

| City/Town | State | ZIP Code + 4 |
|---|---|---|

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

## SECTION 9: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

## SECTION 10: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

## SECTION 11: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

## SECTION 12: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

## SECTION 13: CONTACT PERSON

If questions arise during the processing of this application, the fee-for-service contractor will contact the individual shown below. If the contact person is either an authorized or delegated official, check the appropriate box below.

☐ Contact an Authorized Official listed in Section 15.

☐ Contact a Delegated Official listed in Section 16.

| First Name | Middle Initial | Last Name | Jr., Sr., etc. |
|---|---|---|---|
| Randy | H. | Morgan | |

| Telephone Number | Fax Number *(if applicable)* | E-mail Address *(if applicable)* |
|---|---|---|
| 970-641-0209 | 970-641-8346 | rmorgan@gunnisoncounty.org |

Address Line 1 *(Street Name and Number)*

225 N. Pine St. Ste E

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

| City/Town | State | ZIP Code + 4 |
|---|---|---|
| Gunnison | CO | 81230 |

## SECTION 14: PENALTIES FOR FALSIFYING INFORMATION

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

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

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

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

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

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

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

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

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

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

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

   a) was not provided as claimed; and/or

   b) the claim is false or fraudulent.

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

5. 18 U.S.C. 1035 authorizes criminal penalties against individuals in any matter involving a health care benefit program who knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact; or makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items or services. The individual shall be fined or imprisoned up to 5 years or both.

6. 18 U.S.C. 1347 authorizes criminal penalties against individuals who knowing and willfully execute, or attempt, to executive a scheme or artifice to defraud any health care benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by or under the control of any, health care benefit program in connection with the delivery of or payment for health care benefits, items, or services. Individuals shall be fined or imprisoned up to 10 years or both. If the violation results in serious bodily injury, an individual will be fined or imprisoned up to 20 years, or both. If the violation results in death, the individual shall be fined or imprisoned for any term of years or for life, or both.

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

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

## SECTION 15: CERTIFICATION STATEMENT

An **AUTHORIZED OFFICIAL** means an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program.

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

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

**NOTE:** Authorized officials and delegated officials must be reported in Section 6, either on this application or on a previous application to this same Medicare fee-for-service contractor. **If this is the first time an authorized and/or delegated official has been reported on the CMS-855B, you must complete Section 6 for that individual.**

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

Only an authorized official has the authority to sign (1) the initial enrollment application on behalf of the supplier or (2) the enrollment application that must be submitted as part of the periodic revalidation process. A delegated official does not have this authority.

By signing this application, an authorized official agrees to immediately notify the Medicare fee-for-service contractor if any information furnished on the application is not true, correct, or complete. In addition, an authorized official, by his/her signature, agrees to notify the Medicare fee-for-service contractor of any future changes to the information contained in this form, after the supplier is enrolled in Medicare, in accordance with the timeframes established in 42 C.F.R. 424.520(b). (IDTF changes of information must be reported in accordance with 42 C.F.R. 410.33.)

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

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

## SECTION 15: CERTIFICATION STATEMENT *(Continued)*

### A. Additional Requirements for Medicare Enrollment

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

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

1. I authorize the Medicare contractor to verify the information contained herein. I agree to notify the Medicare contractor of any future changes to the information contained in this application in accordance with the timeframes established in 42 C.F.R. § 424.516. I understand that any change in the business structure of this supplier may require the submission of a new application.
2. I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare billing privileges, and/or the imposition of fines, civil damages, and/or imprisonment.
3. I agree to abide by the Medicare laws, regulations and program instructions that apply to this supplier. The Medicare laws, regulations, and program instructions are available through the Medicare 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.
4. Neither this supplier, nor any five percent or greater owner, partner, officer, director, managing employee, authorized official, or delegated official thereof is currently sanctioned, suspended, debarred, or excluded by the Medicare or State Health Care Program, e.g., Medicaid program, or any other Federal program, or is otherwise prohibited from supplying services to Medicare or other Federal program beneficiaries.
5. I agree that any existing or future overpayment made to the supplier by the Medicare program may be recouped by Medicare through the withholding of future payments.
6. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and I will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.
7. I authorize any national accrediting body whose standards are recognized by the Secretary as meeting the Medicare program participation requirements, to release to any authorized representative, employee, or agent of the Centers for Medicare & Medicaid Services (CMS) a copy of my most recent accreditation survey, together with any information related to the survey that CMS may require (including corrective action plans).

## SECTION 15: CERTIFICATION STATEMENT *(Continued)*

### B. 1ST Authorized Official Signature

I have read the contents of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete and I authorize the Medicare fee-for-service 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 fee-for-service contractor of this fact in accordance with the time frames established in 42 CFR § 424.516.

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

| CHECK ONE | ☐ CHANGE | ☐ ADD | ☐ DELETE |
|---|---|---|---|
| DATE *(mm/dd/yyyy)* | | | |

**Authorized Official's Information and Signature**

| First Name | Middle Initial | Last Name | Suffix *(e.g., Jr., Sr.)* |
|---|---|---|---|
| Telephone Number | Title/Position | | |
| Authorized Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)* | | | Date Signed *(mm/dd/yyyy)* |

**(blue ink preferred)**

### C. 2ND Authorized Official Signature

I have read the contents of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete and I authorize the Medicare fee-for-service 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 fee-for-service contractor of this fact in accordance with the time frames established in 42 CFR § 424.516.

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

| CHECK ONE | ☐ CHANGE | ☐ ADD | ☐ DELETE |
|---|---|---|---|
| DATE *(mm/dd/yyyy)* | | | |

**Authorized Official's Information and Signature**

| First Name | Middle Initial | Last Name | Suffix *(e.g., Jr., Sr.)* |
|---|---|---|---|
| Telephone Number | Title/Position | | |
| Authorized Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)* | | | Date Signed *(mm/dd/yyyy)* |

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

## SECTION 16: DELEGATED OFFICIAL (OPTIONAL)

- You are not required to have a delegated official. However, if no delegated official is assigned, the authorized official(s) will be the only person(s) who can make changes and/or updates to the supplier's status in the Medicare program.
- The signature of a delegated official shall have the same force and effect as that of an authorized official, and shall legally and financially bind the supplier to the laws, regulations, and program instructions of the Medicare program. By his or her signature, the delegated official certifies that he or she has read the Certification Statement in Section 15 and agrees to adhere to all of the stated requirements. A delegated official also certifies that he/she meets the definition of a delegated official. When making changes and/or updates to the supplier's enrollment information maintained by the Medicare program, a delegated official certifies that the information provided is true, correct, and complete.
- Delegated officials being deleted do not have to sign or date this application.
- Independent contractors are not considered "employed" by the supplier, and therefore cannot be delegated officials.
- The signature(s) of an authorized official in Section 16 constitutes a legal delegation of authority to all delegated official(s) assigned in Section 16.
- If there are more than two individuals, copy and complete this section for each individual.

### A. 1ST Delegated Official Signature

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

| CHECK ONE | ☐ CHANGE | ☐ ADD | ☐ DELETE |
|---|---|---|---|
| DATE *(mm/dd/yyyy)* | | | |

| Delegated Official First Name | Middle Initial | Last Name | Suffix *(e.g., Jr., Sr.)* |
|---|---|---|---|
| | | | |

| Delegated Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)* | Date Signed *(mm/dd/yyyy)* |
|---|---|
| | |

| ☐ Check here if Delegated Official is a W-2 Employee | Telephone Number |
|---|---|
| | |

| Authorized Official's Signature Assigning this Delegation *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)* | Date Signed *(mm/dd/yyyy)* |
|---|---|
| | |

**(blue ink preferred)**

## SECTION 16: DELEGATED OFFICIAL (OPTIONAL)

### B. 2ND Delegated Official Signature

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

| CHECK ONE | ☐ CHANGE | ☐ ADD | ☐ DELETE |
|---|---|---|---|
| DATE *(mm/dd/yyyy)* | | | |

| Delegated Official First Name | Middle Initial | Last Name | Suffix *(e.g., Jr., Sr.)* |
|---|---|---|---|
| | | | |

| Delegated Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)* | Date Signed *(mm/dd/yyyy)* |
|---|---|
| | |

| ☐ Check here if Delegated Official is a W-2 Employee | Telephone Number |
|---|---|
| | |

| Authorized Official's Signature Assigning this Delegation *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)* | Date Signed *(mm/dd/yyyy)* |
|---|---|
| | |

**(blue ink preferred)**

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

## SECTION 17: SUPPORTING DOCUMENTS

This section lists the documents that, if applicable, must be submitted with this enrollment application. If you are newly enrolling, or are reactivating or revalidating your enrollment, you must provide all applicable documents. For changes, only submit documents that are applicable to that change.

**The fee-for-service contractor may request, at any time during the enrollment process, documentation to support or validate information reported on the application. The Medicare fee-for-service contractor may also request documents from you, other than those identified in this Section 17, as are necessary to bill Medicare.**

### MANDATORY FOR ALL PROVIDER/SUPPLIER TYPES

- ☐ Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name (e.g., IRS form CP 575) provided in Section 2.
  (**NOTE:** This information is needed if the applicant is enrolling their professional corporation, professional association, or limited liability corporation with this application or enrolling as a sole proprietor using an Employer Identification Number.)"
- ☐ Completed Form CMS-588, for Electronic Funds Transfer Authorization Agreement.
  (**NOTE:** If a supplier already receives payments electronically and is not making a change to its banking information, the CMS-588 is not required.)

### MANDATORY FOR SELECTED PROVIDER/SUPPLIER TYPES

- ☐ Copy(s) of all documentation verifying IDTF Supervisory Physician(s) proficiency and/or State licenses or certification for IDTF non-physician personnel.
- ☐ Copy(s) of all documentation verifying the State licenses or certifications of the laboratory Director or non-physician practitioner personnel of an independent clinical laboratory.

### MANDATORY, IF APPLICABLE

- ☐ Copy of IRS Determination Letter, if supplier is registered with the IRS as non-profit.
- ☐ Written confirmation from the IRS confirming your Limited Liability Company (LLC) is automatically classified as a Disregarded Entity. (e.g., Form 8832).
  (**NOTE:** A disregarded entity is an eligible entity that is treated as an entity not separate from its single owner for income tax purposes.
- ☐ Statement in writing from the bank. If Medicare payment due a supplier of services is being sent to a bank (or similar financial institution) with whom the supplier has a lending relationship (that is, any type of loan), then the supplier must provide a statement in writing from the bank (which must be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.
- ☐ Copy(s) of all final adverse action documentation (e.g., notifications, resolutions, and reinstatement letters).
- ☐ Completed Form(s) CMS 855R, Reassignment of Medicare Benefits.
- ☐ Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement.
- ☐ Copy of an attestation for government entities and tribal organizations.
- ☐ Copy of FAA 135 certificate (air ambulance suppliers).
- ☐ Copy(s) of comprehensive liability insurance policy (IDTFs only).

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0685. The time required to complete this information collection is estimated to 6 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

**DO NOT MAIL APPLICATIONS TO THIS ADDRESS.** Mailing your application to this address will significantly delay application processing.

## ATTACHMENT 1: AMBULANCE SERVICE SUPPLIERS

All ambulance service suppliers enrolling in the Medicare program must complete this attachment.

### A. Geographic Area

This section is to be completed with information about the geographic area in which this company provides ambulance services. If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

Provide the city/town, State, and ZIP code for all locations where this ambulance company renders services.

| CHECK ONE | ☐ CHANGE | ☐ ADD | ☐ DELETE |
|---|---|---|---|
| DATE *(mm/dd/yyyy)* | | | |

**NOTE:** If the ambulance company has vehicles garaged within a different Medicare contractor's jurisdiction, a separate CMS-855B enrollment application must be submitted to that fee-for-service contractor.

### 1. INITIAL REPORTING AND/OR ADDITIONS

If services are provided in selected cities/towns, provide the locations below. List ZIP codes only if they are not within the entire city/town.

| CITY/TOWN | STATE | ZIP CODE |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

### 2. DELETIONS

If services are no longer provided in selected cities/towns, provide the locations below. List ZIP codes only if they are not within the entire city/town.

| CITY/TOWN | STATE | ZIP CODE |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**B. State License 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.

Crew members must complete continuing education requirements in accordance with State and local licensing laws. Evidence of re-certification must be retained with the employer in case it is required by the Medicare fee-for-service contractor.

| CHECK ONE | ☐ CHANGE | ☐ ADD | ☐ DELETE |
|---|---|---|---|
| DATE *(mm/dd/yyyy)* | | | |

Is this ambulance company licensed in the State where services are rendered and billed for? ☐ YES ☐ NO

If **NO**, explain why:

If **YES**, provide the license information for the State where this ambulance service supplier will be rendering services and billing Medicare. Attach a copy of the current State license.

| License Number | Issuing State *(if applicable)* | Issuing City/Town *(if applicable)* |
|---|---|---|
| | | |

| Effective Date *(mm/dd/yyyy)* | Expiration Date *(mm/dd/yyyy)* |
|---|---|
| | |

**C. Paramedic Intercept Services Information**

Paramedic Intercept Services involve an arrangement between a Basic Life Support (BLS) ambulance company and an Advanced Life Support (ALS) ambulance company whereby the latter provides the ALS services and the BLS ambulance company provides the transportation component. If such an arrangement exists between the enrolling ambulance company and another ambulance company, the enrolling ambulance company must attach a copy of the signed contract. For more information, see 42 C.F.R. 410.40.

If reporting a change to information about a previously reported agreement/contract, check "Change" and provide the effective date of the change.

☐ Change
Effective Date:_____

Does this ambulance company currently participate in a paramedic intercept services arrangement?

☐ YES ☐ NO

### D. Vehicle Information

Complete this section with information about the vehicles used by this ambulance company and the services they provide. If there is more than one vehicle, copy and complete this section as needed. Attach a copy of each vehicle registration.

To qualify as an air ambulance supplier, the following is required:

- A written statement, signed by the President, Chief Executive Officer or Chief Operating Officer of the airport from where the aircraft is hangared that gives the name and address of the facility, and
- Proof that the enrolling ambulance company, or the company leasing the air ambulance vehicle to the enrolling ambulance company, possesses a valid charter flight license (FAA 135 Certificate) for the aircraft being used as an air ambulance. If the enrolling ambulance company owns the aircraft, the owner's name on the FAA 135 Certificate must be the same as the enrolling ambulance company's name (or the ambulance company owner as reported in Sections 5 or 6) in this application. If the enrolling ambulance company leases the aircraft from another company, a copy of the lease agreement must accompany this enrollment application.

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

| **CHECK ONE** | ☐ **CHANGE** | ☐ **ADD** | ☐ **DELETE** |
|---|---|---|---|
| **DATE** *(mm/dd/yyyy)* | | | |

| Type *(automobile, aircraft, boat, etc.)* | Vehicle Identification Number |
|---|---|
| | |

| Make *(e.g., Ford)* | Model *(e.g., 350T)* | Year *(yyyy)* |
|---|---|---|
| | | |

Does this vehicle provide:

| | | | | | |
|---|---|---|---|---|---|
| Advanced life support (Level 1) | ☐ YES | ☐ NO | Specialty care transport | ☐ YES | ☐ NO |
| Advanced life support (Level 2) | ☐ YES | ☐ NO | Land ambulance | ☐ YES | ☐ NO |
| Basic life support | ☐ YES | ☐ NO | Air ambulance–fixed wing | ☐ YES | ☐ NO |
| Emergency runs | ☐ YES | ☐ NO | Air ambulance–rotary wing | ☐ YES | ☐ NO |
| Non-emergency runs | ☐ YES | ☐ NO | Marine ambulance | ☐ YES | ☐ NO |

# ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES

## INDEPENDENT DIAGNOSTIC TESTING FACILITY (IDTF) PERFORMANCE STANDARDS

Below is a list of the performance standards that an IDTF must meet in order to obtain or maintain their Medicare billing privileges. These standards, in their entirety, can be found in 42 C.F.R section 410.33(g).

1. Operate its business in compliance with all applicable Federal and State licensure and regulatory requirements for the health and safety of patients.
2. Provides complete and accurate information on its enrollment application. Changes in ownership, changes of location, changes in general supervision, and adverse legal actions must be reported to the Medicare fee-for-service contractor on the Medicare enrollment application within 30 calendar days of the change. All other changes to the enrollment application must be reported within 90 calendar days.
3. Maintain a physical facility on an appropriate site. For the purposes of this standard, a post office box, commercial mail box, hotel or motel is not considered an appropriate site.
   (i) The physical facility, including mobile units, must contain space for equipment appropriate to the services designated on the enrollment application, facilities for hand washing, adequate patient privacy accommodations, and the storage of both business records and current medical records within the office setting of the IDTF, or IDTF home office, not within the actual mobile unit.
   (ii) IDTF suppliers that provide services remotely and do not see beneficiaries at their practice location are exempt from providing hand washing and adequate patient privacy accommodations.
4. Have all applicable diagnostic testing equipment available at the physical site excluding portable diagnostic testing equipment. A catalog of portable diagnostic equipment, including diagnostic testing equipment serial numbers, must be maintained at the physical site. In addition, portable diagnostic testing equipment must be available for inspection within two business days of a CMS inspection request. The IDTF must maintain a current inventory of the diagnostic testing equipment, including serial and registration numbers, provide this information to the designated fee-for-service contractor upon request, and notify the contractor of any changes in equipment within 90 days.
5. Maintain a primary business phone under the name of the designated business. The primary business phone must be located at the designated site of the business, or within the home office of the mobile IDTF units. The telephone number or toll free numbers must be available in a local directory and through directory assistance.
6. Have a comprehensive liability insurance policy of at least $300,000 per location that covers both the place of business and all customers and employees of the IDTF. The policy must be carried by a non-relative owned company. Failure to maintain required insurance at all times will result in revocation of the IDTF's billing privileges retroactive to the date the insurance lapsed. IDTF suppliers are responsible for providing the contact information for the issuing insurance agent and the underwriter. In addition, the IDTF must:
   (i) Ensure that the insurance policy must remain in force at all times and provide coverage of at least $300,000 per incident; and
   (ii) Notify the CMS designated contractor in writing of any policy changes or cancellations.
7. Agree not to directly solicit patients, which include, but is not limited to, a prohibition on telephone, computer, or in-person contacts. The IDTF must accept only those patients referred for diagnostic testing by an attending physician, who is furnishing a consultation or treating a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Nonphysician practitioners may order tests as set forth in §410.32(a)(3).

8. Answer, document, and maintain documentation of a beneficiary's written clinical complaint at the physical site of the IDTF (For mobile IDTFs, this documentation would be stored at their home office.) This includes, but is not limited to, the following:
   (i) The name, address, telephone number, and health insurance claim number of the beneficiary.
   (ii) The date the complaint was received; the name of the person receiving the complaint; and a summary of actions taken to resolve the complaint.
   (iii) If an investigation was not conducted, the name of the person making the decision and the reason for the decision.
9. Openly post these standards for review by patients and the public.
10. Disclose to the government any person having ownership, financial, or control interest or any other legal interest in the supplier at the time of enrollment or within 30 days of a change.
11. Have its testing equipment calibrated and maintained per equipment instructions and in compliance with applicable manufacturers suggested maintenance and calibration standards.
12. Have technical staff on duty with the appropriate credentials to perform tests. The IDTF must be able to produce the applicable Federal or State licenses or certifications of the individuals performing these services.
13. Have proper medical record storage and be able to retrieve medical records upon request from CMS or its fee-for-service contractor within 2 business days.
14. Permit CMS, including its agents, or its designated fee-for-service contractors, to conduct unannounced, on-site inspections to confirm the IDTF's compliance with these standards. The IDTF must be accessible during regular business hours to CMS and beneficiaries and must maintain a visible sign posting the normal business hours of the IDTF.
15. With the exception of hospital-based and mobile IDTFs, a fixed base IDTF does not include the following:
   (i) Sharing a practice location with another Medicare-enrolled individual or organization.
   (ii) Leasing or subleasing its operations or its practice location to another Medicare enrolled individual or organization.
   (iii) Sharing diagnostic testing equipment using in the initial diagnostic test with another Medicare-enrolled individual or organization.
16. Enrolls in Medicare for any diagnostic testing services that it furnishes to a Medicare beneficiary, regardless of whether the service is furnished in a mobile or fixed base location.
17. Bills for all mobile diagnostic services that are furnished to a Medicare beneficiary, unless the mobile diagnostic service is part of a service provided under arrangement as described in section 1861(w)(1) of the Act.

### Instructions

If you perform diagnostic tests, other than clinical laboratory or pathology tests, and are required to enroll as an IDTF, you must complete this attachment. CMS requires the information in this attachment to determine whether the enrolling supplier meets all IDTF standards including, but not limited to, those listed on page 40 of this application. Not all suppliers that perform diagnostic tests are required to enroll as an IDTF.

### Diagnostic Radiology

Many diagnostic tests are radiological procedures that require the professional services of a radiologist. A radiologist's practice is generally different from those of other physicians because radiologists usually do not bill E&M codes or treat a patient's medical condition on an ongoing basis. A radiologist or group practice of radiologists is not necessarily required to enroll as an IDTF. If enrolling as a diagnostic radiology group practice or clinic and billing for the technical component of diagnostic radiological tests without enrolling as an IDTF (if the entity is a free standing diagnostic facility), it should contact the carrier to determine that it does not need to enroll as an IDTF.

A mobile IDTF that provides X-ray services is not classified as a portable X-ray supplier.

Regulations governing IDTFs can be found at 42 C.F.R. 410.33.

**CPT-4 and HCPCS Codes**—Report all CPT-4 and HCPCS codes for which this IDTF will bill Medicare. Include the following:

- Provide the CPT-4 or HCPCS codes for which this IDTF intends to bill Medicare,
- The name and type of equipment used to perform the reported procedure, and
- The model number of the reported equipment.

The IDTF should report all Current Procedural Terminology, Version 4 (CPT-4) codes, Healthcare Common Procedural Coding System codes (HCPCS), and types of equipment (including the model number), for which it will perform tests, supervise, interpret, and/or bill. All codes reported must be for diagnostic tests that an IDTF is allowed to perform. Diagnostic tests that are clearly surgical in nature, which must be performed in a hospital or ambulatory surgical center, should not be reported.

Consistent with IDTF supplier standard 6 on page 40 of this application, all IDTFs enrolling in Medicare must have a comprehensive liability insurance policy of at least $300,000 per location, that covers both the place of business and all customers and employees of the IDTF. The policy must be carried by a non-relative owned company. Failure to maintain the required insurance at all times will result in revocation of the Medicare supplier billing number, retroactive to the date the insurance lapsed. Malpractice insurance policies do not demonstrate compliance with this requirement.

All IDTFs must submit a complete copy of the aforementioned liability insurance policy with this application.

## ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES *(Continued)*

### A. Standards Qualifications

Provide the date this Independent Diagnostic Testing Facility met all current CMS standards *(mm/dd/yyyy)*

### B. CPT-4 and HCPCS Codes

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

| CHECK ONE | ☐ CHANGE | ☐ ADD | ☐ DELETE |
|---|---|---|---|
| DATE *(mm/dd/yyyy)* | | | |

All codes reported here must be for diagnostic tests that an IDTF is allowed to perform. Diagnostic tests that are clearly surgical in nature, which must be performed in a hospital or ambulatory surgical center, should not be reported. Clinical laboratory and pathology codes should not be reported. This page may be copied for additional codes or equipment.

| | CPT–4 OR HCPCS CODE | EQUIPMENT | MODEL NUMBER *(Required)* |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |
| 9. | | | |
| 10. | | | |
| 11. | | | |
| 12. | | | |
| 13. | | | |
| 14. | | | |
| 15. | | | |

### C. Interpreting Physician Information

Check here ☐ if this section does not apply because the interpreting physician will bill separate from the IDTF.

All physicians whose interpretations will be billed by this IDTF with the technical component (TC) of the test (i.e., global billing) must be listed in this section. If there are more than three physicians, copy and complete this section as needed. All interpreting physicians must be currently enrolled in the Medicare program.

If you are billing for interpretations as an individual reassigning benefits, the interpreting physician must complete the Reassignment of Benefits Form (CMS 855R). Note: Both the IDTF and individual physician must be enrolled with the fee-for-service contractor where the IDTF is located.

If you are billing for purchased interpretations, all requirements for purchased interpretations must be met.

When a mobile unit of the IDTF performs a technical component of a diagnostic test and the interpretive physician is the same physician who ordered the test, the IDTF cannot bill for the interpretation. Therefore, these interpreting physicians should not be reported since the interpretive physician must submit his/her own claims for these tests.

#### 1ST Interpreting Physician Information

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

| CHECK ONE | ☐ CHANGE | ☐ ADD | ☐ DELETE |
|---|---|---|---|
| DATE *(mm/dd/yyyy)* | | | |

| First Name | Middle Initial | Last Name | Suffix *(e.g., Jr., Sr.)* |
|---|---|---|---|
| Social Security Number *(Required)* | | Date of Birth *(mm/dd/yyyy) (Required)* | |
| Medicare Identification Number *(if issued)* | | NPI | |

#### 2ND Interpreting Physician Information

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

| CHECK ONE | ☐ CHANGE | ☐ ADD | ☐ DELETE |
|---|---|---|---|
| DATE *(mm/dd/yyyy)* | | | |

| First Name | Middle Initial | Last Name | Suffix *(e.g., Jr., Sr.)* |
|---|---|---|---|
| Social Security Number *(Required)* | | Date of Birth *(mm/dd/yyyy) (Required)* | |
| Medicare Identification Number *(if issued)* | | NPI | |

### 3RD Interpreting Physician Information

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

| CHECK ONE | ☐ CHANGE | ☐ ADD | ☐ DELETE |
|---|---|---|---|
| DATE *(mm/dd/yyyy)* | | | |

| First Name | Middle Initial | Last Name | Suffix *(e.g., Jr., Sr.)* |
|---|---|---|---|
| Social Security Number *(Required)* | | Date of Birth *(mm/dd/yyyy) (Required)* | |
| Medicare Identification Number *(if issued)* | | NPI | |

### D. Personnel (Technicians) Who Perform Tests

Complete this section with information about all non-physician personnel who perform tests for this IDTF. Notarized or certified true copies of the State license or certificate should be attached.

### 1ST PERSONNEL (TECHNICIAN) INFORMATION

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

| CHECK ONE | ☐ CHANGE | ☐ ADD | ☐ DELETE |
|---|---|---|---|
| DATE *(mm/dd/yyyy)* | | | |

| First Name | Middle Initial | Last Name | Suffix *(e.g., Jr., Sr.)* |
|---|---|---|---|
| Social Security Number *(Required)* | | Date of Birth *(mm/dd/yyyy) (Required)* | |

Is this technician State licensed or State certified? *(see instructions for clarification)* ☐ YES ☐ NO

| License/Certification Number *(if applicable)* | License/Certification Issue Date *(mm/dd/yyyy) (if applicable)* |
|---|---|

Is this technician certified by a national credentialing organization? ☐ YES ☐ NO

| Name of credentialing organization *(if applicable)* | Type of Credentials *(if applicable)* |
|---|---|

Is this technician employed by a hospital? ☐ YES ☐ NO

If **YES**, provide the name of the hospital here: _____

**2ND Personnel (Technician) Information**

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

| CHECK ONE | ☐ CHANGE | ☐ ADD | ☐ DELETE |
|---|---|---|---|
| DATE *(mm/dd/yyyy)* | | | |

| First Name | Middle Initial | Last Name | Suffix *(e.g., Jr., Sr.)* |
|---|---|---|---|
| | | | |

| Social Security Number *(Required)* | Date of Birth *(mm/dd/yyyy) (Required)* |
|---|---|
| | |

Is this technician State licensed or State certified? *(see instructions for clarification)* ☐ YES ☐ NO

| License/Certification Number *(if applicable)* | License/Certification Issue Date *(mm/dd/yyyy) (if applicable)* |
|---|---|
| | |

Is this technician certified by a national credentialing organization? ☐ YES ☐ NO

| Name of credentialing organization *(if applicable)* | Type of Credentials *(if applicable)* |
|---|---|
| | |

Is this technician employed by a hospital? ☐ YES ☐ NO

If **YES**, provide the name of the hospital here: _____

**E. Supervising Physicians**

Complete this section with identifying information about the physician(s) who supervise the operation of the IDTF and who provides the personal, direct, or general supervision per 42 C.F.R. 410.32(b)(3). The supervising physician must also attest to his/her supervising responsibilities for the enrolling IDTF.

Information concerning the type of supervision (personal, direct, or general) required for performance of specific IDTF tests can be obtained from your Medicare fee-for-service contractor. All IDTFs must report at least one supervisory physician, and at least one supervising physician must perform the supervision requirements stated in 42 C.F.R. 410.32(b)(3). All supervisory physician(s) must be currently enrolled in Medicare.

The type of supervision being performed by each physician who signs the attestation on page 47 of this application should be listed in this section.

Definitions of the types of supervision are as follows:

- **Personal Supervision** means a physician must be in attendance in the room during the performance of the procedure.
- **Direct Supervision** means the physician must be present in the office suite and immediately available to provide assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.
- **General Supervision** means the procedure is provided under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. General supervision also includes the responsibility that the non-physician personnel who perform the tests are qualified and properly trained and that the equipment is operated properly, maintained, calibrated and that necessary supplies are available.

### E. Supervising Physicians *(Continued)*

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

| CHECK ONE | ☐ CHANGE | ☐ ADD | ☐ DELETE |
|---|---|---|---|
| DATE *(mm/dd/yyyy)* | | | |

| First Name | Middle Initial | Last Name | Suffix *(e.g., Jr., Sr.)* |
|---|---|---|---|
| | | | |

| Social Security Number *(Required)* | Date of Birth *(mm/dd/yyyy) (Required)* |
|---|---|
| Medicare Identification Number *(if issued)* | NPI |

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

### TYPE OF SUPERVISION PROVIDED

Check the appropriate box below indicating the type of supervision provided by the physician reported above for the tests performed by the IDTF in accordance with 42 C.F.R. 410.32 (b)(3) (See instructions for definitions).

☐ Personal Supervision ☐ Direct Supervision ☐ General Supervision

For each physician performing General Supervision, at least one of the three functions listed here must be checked. However, to meet the General Supervision requirement, in accordance with 42 C.F.R. 410.33(b), the enrolling IDTF must have at least one supervisory physician for each of the three functions. For example, two physicians may be responsible for function 1, a third physician may be responsible for function 2, and a fourth physician may be responsible for function 3. All four supervisory physicians must complete and sign the supervisory physician section of this application. Each physician should only check the function(s) he/she actually performs.

☐ Assumes responsibility for the overall direction and control of the quality of testing performed.

☐ Assumes responsibility for assuring that the non-physician personnel who actually perform the diagnostic procedures are properly trained and meet required qualifications.

☐ Assumes responsibility for the proper maintenance and calibration of the equipment and supplies necessary to perform the diagnostic procedures.

### OTHER SUPERVISION SITES

Does this supervising physician provide supervision at any other IDTF? ☐ YES ☐ NO

If yes, list all other IDTFs for which this physician provides supervision. For more than five, copy this sheet.

| | NAME OF FACILITY | ADDRESS | TAX IDENTIFICATION NUMBER | LEVEL OF SUPERVISION |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |

## E. Supervising Physicians *(Continued)*

### ATTESTATION STATEMENT FOR SUPERVISING PHYSICIANS

All Supervising Physician(s) rendering supervisory services for this IDTF must sign and date this section. All signatures must be original.

1. I hereby acknowledge that I have agreed to provide (IDTF Name)_____ with the Supervisory Physician services checked above for all CPT-4 and HCPCS codes reported in this Attachment. (See number 2 below if all reported CPT-4 and HCPCS codes do not apply). I also hereby certify that I have the required proficiency in the performance and interpretation of each type of diagnostic procedure, as reported by CPT-4 or HCPCS code in this Attachment (except for those CPT-4 or HCPCS codes identified in number 2 below). I have read and understand the Penalties for Falsifying Information on this Enrollment Application, as stated in Section 14 of this application. I am aware that falsifying information may result in fines and/or imprisonment. If I undertake supervisory responsibility at any additional IDTFs, I understand that it is my responsibility to notify this IDTF at that time.
2. I am not acting as a Supervising Physician for the following CPT-4 and/or HCPCS codes reported in this Attachment.

| CPT–4 OR HCPCS CODE | CPT–4 OR HCPCS CODE | CPT–4 OR HCPCS CODE |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

| 3. Signature of Supervising Physician *(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)* | Date *(mm/dd/yyyy)* |
|---|---|
| | |

**All signatures must be original and signed and dated in ink (blue ink preferred). Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.**

# MEDICARE SUPPLIER ENROLLMENT APPLICATION PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) is authorized to collect the information requested on this form by sections 1124(a)(1), 1124A(a)(3), 1128, 1814, 1815, 1833(e), and 1842(r) of the Social Security Act [42 U.S.C. §§ 1320a-3(a)(1), 1320a-7, 1395f, 1395g, 1395(l)(e), and 1395u(r)] and section 31001(1) of the Debt Collection Improvement Act [31 U.S.C. § 7701(c)].

The purpose of collecting this information is to determine or verify the eligibility of individuals and organizations to enroll in the Medicare program as suppliers of goods and services to Medicare beneficiaries and to assist in the administration of the Medicare program. This information will also be used to ensure that no payments will be made to providers who are excluded from participation in the Medicare program. All information on this form is required, with the exception of those sections marked as "optional" on the form. Without this information, the ability to make payments will be delayed or denied.

The information collected will be entered into the Provider Enrollment, Chain and Ownership System (PECOS). The information in this application will be disclosed according to the routine uses described below.

Information from these systems may be disclosed under specific circumstances to:

1. CMS contractors to carry out Medicare functions, collating or analyzing data, or to detect fraud or abuse;
2. A congressional office from the record of an individual health care provider in response to an inquiry from the congressional office at the written request of that individual health care practitioner;
3. The Railroad Retirement Board to administer provisions of the Railroad Retirement or Social Security Acts;
4. Peer Review Organizations in connection with the review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XVIII of the Social Security Act;
5. To the Department of Justice or an adjudicative body when the agency, an agency employee, or the United States Government is a party to litigation and the use of the information is compatible with the purpose for which the agency collected the information;
6. To the Department of Justice for investigating and prosecuting violations of the Social Security Act, to which criminal penalties are attached;
7. To the American Medical Association (AMA), for the purpose of attempting to identify medical doctors when the National Plan and Provider Enumeration System is unable to establish identity after matching contractor submitted data to the data extract provided by the AMA;
8. An individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, or to the restoration or maintenance of health;
9. Other Federal agencies that administer a Federal health care benefit program to enumerate/enroll providers of medical services or to detect fraud or abuse;
10. State Licensing Boards for review of unethical practices or non-professional conduct;
11. States for the purpose of administration of health care programs; and/or
12. Insurance companies, self insurers, health maintenance organizations, multiple employer trusts, and other health care groups providing health care claims processing, when a link to Medicare or Medicaid claims is established, and data are used solely to process supplier's health care claims.

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

### Protection of Proprietary Information

Privileged or confidential commercial or financial information collected in this form is protected from public disclosure by Federal law 5 U.S.C. § 552(b)(4) and Executive Order 12600.

### Protection of Confidential Commercial and/or Sensitive Personal Information

If any information within this application (or attachments thereto) constitutes a trade secret or privileged or confidential information (as such terms are interpreted under the Freedom of Information Act and applicable case law), or is of a highly sensitive personal nature such that disclosure would constitute a clearly unwarranted invasion of the personal privacy of one or more persons, then such information will be protected from release by CMS under 5 U.S.C. §§ 552(b)(4) and/or (b)(6), respectively.

Gunnison County
COLORADO

**HEALTH AND HUMAN SERVICES DEPARTMENTS**
Human Services Phone: (970) 641-3244 Fax: (970) 641-3738
Public Health Phone: (970) 641-0209 Fax: (970) 641-8346
225 N Pine St, Gunnison, CO 81230
Website: www.GunnisonCounty.org

May 1, 2013

To whom it may concern,

Gunnison County Public Health is a department within Gunnison County Government. Gunnison Public Health is the primary provider of influenza vaccine for the community. Billing for the influenza vaccine for Part B recipients will be accomplished through the Roster Billing for Mass Immunizers. Gunnison County will be legally and financially responsible for providing this service to Medicare clients. Gunnison County will be responsible if there is any outstanding debt owed to the Centers for Medicare and Medicaid Services.

Sincerely,

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0626

# ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

## PART I: REASON FOR SUBMISSION

**Reason for Submission:**

- [x] New EFT Authorization
- [ ] Revision to Current Authorization (e.g. account or bank changes)
- [ ] Check here if EFT payment is being made to the Home Office of Chain (Attach letter Authorizing EFT payment to Chain Home Office)

**Since your last EFT authorization agreement submission, have you had a:**

- [ ] Change of Ownership, and/or
- [ ] Change of Practice Location?

If you checked either a change of ownership or change of practice location above, you must submit a change of information (using the Medicare enrollment application) to the Medicare contractor that services your geographical area(s) prior to or accompanying this EFT authorization agreement submission.

## PART II: PROVIDER OR SUPPLIER INFORMATION

Provider/Supplier Legal Business Name

Chain Organization Name or Home Office Legal Business Name (if different from Chain Organization Name)
GUNNISON COUNTY, COLORADO

Account Holder's Street Address
200 E Virginia Ave.

| Account Holder's City | Account Holder's State | Account Holder's Zip Code |
|---|---|---|
| Gunnison | CO | 81230 |

Tax Identification Number: (designate ☐ SSN or ☒ EIN)
8 4 6 0 0 0 7 7 0

Medicare Identification Number (if issued)
C - 3 0 1 9 6

National Provider Identifier (NPI)
1 9 4 2 3 6 6 6 1 2

## PART III: FINANCIAL INSTITUTION INFORMATION

Financial Institution Name
WELLS FARGO BANK, N.A.

| Financial Institution City/Town | Financial Institution State |
|---|---|
| GUNNISON | COLORADO |

| Financial Institution Telephone Number | Financial Institution Contact Person |
|---|---|
| 970-240-1042 | NICOLETTE ALLEN |

Financial Institution Routing Transit Number (nine digit)
1 0 2 0 0 0 0 7 6

| Depositor Account Number | Type of Account (check one) |
|---|---|
| 7 9 3 8 6 3 9 4 1 1 | ☐ Checking Account ☒ Savings Account |

Please include a confirmation of account information on bank letterhead or a voided check. When submitting the documentation, it should contain the name on the account, electronic routing transit number, account number and type. If submitting bank letterhead, the bank officer's name and signature is also required. This information will be used to verify your account number.

## PART IV: CONTACT PERSON

| Contact Person's Name | Contact Person's Title |
|---|---|
| Randy H Morgan | Public Health, Admin Services Supervisor |

| Contact Person's Telephone Number | Contact Person's E-mail Address |
|---|---|
| 970 641 0209 | rmorgan@gunnisoncounty.org |

## PART V: AUTHORIZATION

I hereby authorize the Centers for Medicare & Medicaid Services (CMS) to initiate credit entries, and in accordance with 31 CFR part 210.6(f) initiate adjustments for any duplicate or erroneous entries made in error to the account indicated above. I hereby authorize the financial institution/bank named above to credit and/or debit the same to such account. CMS may assign its rights and obligations under this agreement to CMS' designated fee-for-service contractor. CMS may change its designated contractor at CMS' discretion.

If payment is being made to an account controlled by a Chain Home Office, the Provider of Services hereby acknowledges that payment to the Chain Office under these circumstances is still considered payment to the Provider, and the Provider authorizes the forwarding of Medicare payments to the Chain Home Office.

If the account is drawn in the Physician's or Individual Practitioner's Name, or the Legal Business Name of the Provider/ Supplier, the said Provider or Supplier certifies that he/she has sole control of the account referenced above, and certifies that all arrangements between the Financial Institution and the said Provider or Supplier are in accordance with all applicable Medicare regulations and instructions.

This authorization agreement is effective as of the signature date below and is to remain in full force and effect until CMS has received written notification from me of its termination in such time and such manner as to afford CMS and the Financial Institution a reasonable opportunity to act on it. CMS will continue to send the direct deposit to the Financial Institution indicated above until notified by me that I wish to change the Financial Institution receiving the direct deposit. If my Financial Institution information changes, I agree to submit to CMS an updated EFT Authorization Agreement.

## SIGNATURE LINE

| | |
|---|---|
| Authorized/Delegated Official Name (Print) | Authorized/Delegated Official Telephone Number |
| Authorized/Delegated Official Title | Authorized/Delegated Official E-mail Address |
| Authorized/Delegated Official Signature<br>*(Note: Must be original signature in black or blue ink.)* | Date |

## PRIVACY ACT ADVISORY STATEMENT

Sections 1842, 1862(b) and 1874 of title XVIII of the Social Security Act authorize the collection of this information. The purpose of collecting this information is to authorize electronic funds transfers.

Per 42 CFR 424.510(e)(1), providers and suppliers are required to receive electronic funds transfer (EFT) at the time of enrollment, revalidation, change of Medicare contractors or submission of an enrollment change request; and (2) submit the CMS-588 form to receive Medicare payment via electronic funds transfer.

The information collected will be entered into system No. 09-70-0501, titled "Carrier Medicare Claims Records," and No. 09-70-0503, titled "Intermediary Medicare Claims Records" published in the Federal Register Privacy Act Issuances, 1991 Comp. Vol. 1, pages 419 and 424, or as updated and republished. Disclosures of information from this system can be found in this notice.

You should be aware that P.L. 100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government, under certain circumstances, to verify the information you provide by way of computer matches.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0626. The time required to complete this information collection is estimated to average 60 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

DO NOT MAIL THIS FORM TO THIS ADDRESS.
MAILING YOUR APPLICATION TO THIS ADDRESS WILL SIGNIFICANTLY DELAY PROCESSING.

# INSTRUCTIONS FOR COMPLETING THE EFT AUTHORIZATION AGREEMENT

All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicare direct deposits are made.

## PART I: REASON FOR SUBMISSION

Indicate your reason for completing this form by checking the appropriate box: New EFT authorization or change to your account information. If you are authorizing EFT payments to the home office of a chain organization of which you are a member, you must attach a letter authorizing the contractor to make payment due the provider of service to the account maintained by the home office of the chain organization. The letter must be signed by an authorized official of the provider of service and an authorized official of the chain home office.

## PART II: PROVIDER OR SUPPLIER INFORMATION

**Line 1**: Enter the provider's/supplier's legal business name or the name of the physician or individual practitioner, as reported to the Internal Revenue Service (IRS). The account to which EFT payments made must exclusively bear the name of the physician or individual practitioner, or the legal business name of the person or entity enrolled with Medicare.

**Line 2**: Enter the chain organization's name or the home office legal business name if different from the chain organization name.

**Line 3**: Enter the account holder's street address.

**Line 4**: Enter the account holder's city, state, and zip code.

**Line 5**: Enter the tax identification number as reported to the IRS. If the business is a corporation, provide the Federal employer identification number, otherwise provide your Social Security Number.

**Line 6**: If issued, enter the Medicare identification number assigned by a Medicare fee-for-service contractor. If you are not enrolled in Medicare, leave this field blank.

**Line 7**: Enter the 10 digit NPI number. The NPI is required to process this form.

## PART III: FINANCIAL INSTITUTION INFORMATION

**Line 8**: Enter your Financial Institution's name (this is the name of the bank or qualifying depository that will receive the funds). Note: The account name to which EFT payments will be paid is to the name submitted on Part II of this form.

**Line 9**: Enter the city or town where your financial institution is located. Enter the state where your financial institution is located.

**Line 10**: Enter the bank or financial institutional telephone number and contact person's name.

**Line 11**: Enter the bank or financial institutional nine-digit routing number, including applicable leading zeros.

**Line 12**: Enter the depositor's account number, including applicable leading zeros. Select the account type.

**If you do not submit this information, your EFT authorization agreement will be returned without further processing.**

## PART IV: CONTACT PERSON

**Line 13**: Enter the name and title of a contact person who can answer questions about the information submitted on this CMS-588 form.

**Line 14**: Enter the contact person's telephone number. Enter the contact person's e-mail address.

## PART V: AUTHORIZATION

**Line 15**: By your signature on this form you are certifying that the account is drawn in the Name of the Physician or Individual Practitioner, or the Legal Business Name of the Provider or Supplier. The Provider or Supplier has sole control of the account to which EFT deposits are made in accordance with all applicable Medicare regulations and instructions. All arrangements between the Financial Institution and the said Provider or Supplier are in accordance with all applicable Medicare regulations and instructions with the effective date of the EFT authorization. You must notify CMS regarding any changes in the account in sufficient time to allow the contractor and the Financial Institution to act on the changes.

The EFT authorization form must be signed and dated by the same Authorized Representative or a Delegated Official named on the CMS-855 Medicare enrollment application which the Medicare contractor has on file. Include a telephone number where the Authorized Representative or Delegated Official can be contacted.

Mail this form with the original signature in black or blue ink (no facsimile signatures can be accepted) to the Medicare contractor that services your geographical area. An EFT authorization form must be submitted for each Medicare contractor to whom you submit claims for Medicare payment. To locate the mailing address for your fee-for-service contractor, go to: *www.cms.gov/MedicareProviderSupEnroll.*

# Medicare Enrollment
for Providers and Suppliers

## Welcome

**Application Fee Information**

Institutional Providers who are submitting applications for the following reasons are required to pay the Provider Enrollment Medicare Application Fee:

- Initial Enrollment
- Revalidation
- Change of Information - Adding Practice Location
- Enrolling a New DMEPOS Business Location
- Change of Ownership via CMS-855A - Buyer not accepting assignment of current Provider Agreement

Providers who are enrolled in Medicare but have not yet established a record in PECOS may be required to submit an Initial Enrollment application to establish a record in PECOS. If the reason for the application submittal is to change the information on the existing Medicare enrollment, and is not for the purpose of adding a practice location, then the Provider is not required to pay the application fee.

**Year:** 2013

**Amount:** $532

CONTINUE

Medicare Application Fee Factsheet [PDF,131KB] | Pay.gov Factsheet [PDF, 113KB] | Pay.gov FAQs [PDF, 104KB] | Medicare Fee-for-Service Contact Information [PDF, 255KB]

Web Policies & Important Links | Department of Health & Human Services | CMS.gov | PECOS FAQs | Accessibility

CENTERS FOR MEDICARE & MEDICAID SERVICES, 7500 SECURITY BOULEVARD, BALTIMORE, MD 21244

WELLS FARGO

MAC C7435-011
909 North Main Street
Gunnison, CO 81230
970 641-6204

Wells Fargo Bank, N.A.

March 22, 2012

Melody Marks
Gunnison County Treasurer
200 E. Virginia Ave.
Gunnison, CO 81230

Dear Melody,

Per your request, here is the information needed to facilitate ACH payments to your account at Wells Fargo Bank, N.A.

| | |
|---|---|
| BANK: | Wells Fargo Bank, N.A. |
| BRANCH: | Gunnison<br>909 N. Main St.<br>Gunnison, CO 81230<br>Ph: 970.641.6204 |
| ABA: | 102000076 |
| Account: | 7938639411 |
| EIN: | 84-6000770 |

Please don't hesitate to let me know if you need anything else.

Regards,

Christina Haupert
Business Relationship Manager
Wells Fargo Bank, N.A. - Gunnison