

# PECOS: View and Manage Reassignments through Group Enrollment

7/2/2024

**Closed Captioning:** *Auto-generated closed captioning is enabled in this course and is at best 70-90% accurate. Words prone to error include specialized terminology, proper names and acronyms.*



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# Today's Presenters



## Provider Outreach and Education Consultants

- Laura Brown, CPC
- Susan Stafford PMP, COA, AMR



# Agenda

- [View Reassignment Report](#)
- [Add Reassignment for Provider with Active Enrollment](#)
- [Terminate Reassignment](#)
- [Respond to E-Signature Email](#)
- [Manage Signatures, Verify Completion](#)
- [Process After Submission](#)
- [Check Application Status](#)
- [Resources](#)

[View Reassignment Report](#)

# PECOS Home Page to Login

## Medicare Enrollment for Providers and Suppliers

Welcome to the Medicare Provider Enrollment, Chain, and Ownership System (PECOS)

(\*) Red asterisk indicates a required field.

PECOS supports the Medicare Provider and Supplier enrollment process by allowing registered users to securely and electronically submit and manage Medicare enrollment information.

New to PECOS? View our [videos](#) at the bottom of this page.

### USER LOGIN

Please use your I&A (Identity & Access Management System) user ID and password to log in.

\* User ID

\* Password

[LOG IN](#)

[Forgot Password?](#)

[Forgot User ID?](#)

[Manage/Update User Profile](#)

[Who Should I Call? \[PDF, 155KB\]](#) - CMS Provider Enrollment Assistance Guide

### BECOME A REGISTERED USER

You may register for a user account if you are: an Individual Practitioner, Authorized or Delegated Official for a Provider or Supplier Organization, or an individual who works on behalf of Providers or Suppliers.

[Register for a user account](#)

Questions? [Learn more about registering for an account](#)

**Note:** If you are a Medical Provider or Supplier, you must [register for an NPI](#) before enrolling with Medicare.

### Helpful Links

[Application Status](#) - Self Service Kiosk to view the status of an application submitted within the last 90 days.

[Pay Application Fee](#) - Pay your application fee online.

[View the list of Providers and Suppliers \[PDF, 94KB\]](#) who are required to pay an application fee.

[E-Sign your PECOS application](#) - Access the PECOS E-Signature website using your identifying information, email address, and unique PIN to electronically sign your application.

### Provider & Supplier Resources

- [CMS.gov/Providers](#) - Section of the CMS.gov website that is designed to provide Medicare enrollment information for providers, physicians, non-physician practitioners, and other suppliers.
- [Enrollment Checklists](#) - Review checklists of information needed to complete an application for various provider and supplier types.
- [Medicare Learning Network® \(MLN\)](#) - Helpful articles and tutorials about changes in Medicare enrollment.
- [Revalidation Notice Sent List](#) - Check to see if you have been sent a notice to revalidate your information on file with Medicare.
- [Ordering, Certifying, or Prescribing Practitioners List](#) - View the Ordering, Certifying, or Prescribing Practitioners List to verify eligibility to order or certify items or services to Medicare beneficiaries, or prescribe part D drugs.
- [Ordering, Certifying, or Prescribing Information \[PDF, 1.64MB\]](#) - Learn about the Ordering, Certifying, or Prescribing enrollment process.

### Enrollment Tutorials

- Initial Enrollment:**  
Step-by-step demonstration of an initial enrollment application in PECOS.  
[Individual Provider](#) or [Organization/Supplier](#)
- Change of Information:**  
Step-by-step demonstration of how to update or change information for an existing enrollment already on file with CMS.  
[Individual Provider](#) or [Organization/Supplier](#)
- Revalidation:**  
Step-by-step demonstration on how to submit your revalidation application using PECOS.  
[Individual Provider](#) or [Organization/Supplier](#)
- Deactivated:**  
Example of how to deactivate an existing enrollment record.  
[Individual Provider](#)
- Reactivation:**  
Step-by-step demonstration of how to re-enroll based on enrollment information that already exists in PECOS.  
[Organization/Supplier](#)
- Adding a Practice Location (DMEPOS Only):**  
Demonstration of how to add a new practice location for DMEPOS supplier who is already enrolled with CMS.  
[DME Supplier](#)

# My Associates

**Welcome**

**Release Notes**

Want to learn what's new in the latest PECOS release? Please review the [Release Notes \[PDF\]](#).

**System Notifications**

**Note:** JavaScript must be enabled in your internet browser for PECOS to work properly. If JavaScript is currently disabled in your browser, refer to the Accessibility section in PECOS Help for instructions on enabling JavaScript.

**Manage Medicare and Account Information**

**MY ASSOCIATES** >>

- Enroll in Medicare for the first time
- View and update existing Medicare information
- Continue working on saved applications

**ACCOUNT MANAGEMENT** >>

- Update your user account information, request or remove access to organizations
- Manage access to Medicare enrollments

**REVALIDATION NOTIFICATION CENTER** >>

- View All Applications requiring revalidation
- Start or continue revalidation application

**Manage Signatures**

**Applications Requiring Signatures**

You currently have no pending signatures.

**VIEW ALL SIGNATURES** >>



# View Enrollments

### My Associates

#### Initial Enrollment

Create an application for initial enrollment **ONLY** if you are:

- Enrolling in Medicare for the first time
- Enrolling in a new state, or
- Enrolling with a new specialty

**! IMPORTANT:**

If you are responding to a request for Revalidation, do not create an initial enrollment application. Instead, select a provider from the "Existing Associates" section below then select from the list of existing enrollments.

**Please Note:** If your organization is currently enrolled in Medicare but you do not see your enrollment, please take the following steps to confirm your access to the enrollment.

- If you are a Staff End User of the organization, please contact the organization's Authorized/Delegated Official to ensure your account has access to PECOS.
- If you are an Authorized/Delegated Official of the organization, please confirm your role with the organization and ensure access to PECOS is active. To verify your account status, select the Account Management button on the Home Page and then choose Update user account information option.

The following checklists will help you gather the information needed to enroll via Internet-based PECOS:

- Checklist for Sole Proprietor or Solely Owned Organizations (eg. LLC, PC) using PECOS
- Checklist for Individual Physician and Non-Physician Practitioners using PECOS
- Checklist for Provider or Supplier Organization using PECOS

Select the Create Initial Enrollment Application button **ONLY** if you are enrolling for the first time, or enrolling in a new state or specialty.

[CREATE INITIAL ENROLLMENT APPLICATION](#)

### Existing Associates

Please provide one or more of the following options to filter your associates. Selecting the reset button will clear the options selected and load the full list of associates.

**Enrollment Type**  
All Types [SELECT](#)

**Provider/Supplier Type**  
All Provider/Supplier Types

**Associate Legal Business Name**

**Associate Last Name**

**Associate First Name**

**TIN**  
XXX-XX-XXXX

**NPI**  
10 Digits

**State**  
All States

[FILTER](#) [RESET](#)

In order to view Medicare applications and enrollments for an associate, please select the "View Enrollments" button next to an associate listed below.

#### Individuals

Records 1 - 2 of 2

Name: <b>Provider</b>	NPI: XXXXXXXX	<a href="#">VIEW ENROLLMENTS</a>
Name: <b>Provider</b>	NPI: XXXXXXXX	<a href="#">VIEW ENROLLMENTS</a>

#### Organizations

Records 1 - 2 of 2

Name: <b>Group</b>	TIN: XX-XXX	<a href="#">VIEW ENROLLMENTS</a>
Name: <b>Group</b>	TIN: XX-XXX	<a href="#">VIEW ENROLLMENTS</a>

# My Enrollments

### My Enrollments

#### Initial Enrollment

Create an application for initial enrollment **ONLY** if you are:

- Enrolling in Medicare for the first time
- Enrolling in a new state, or
- Enrolling with a new specialty

**! IMPORTANT:**

If you are responding to a request for Revalidation, please do not create an initial enrollment application. Instead, select one of your current enrollment records below.

**Please Note:** If your organization is currently enrolled in Medicare but you do not see your enrollment, please take the following steps to confirm your access to the enrollment.

- If you are a Staff End User of the organization, please contact the organization's Authorized/Delegated Official to ensure your account has access to PECOS.
- If you are an Authorized/Delegated Official of the organization, please confirm your role with the organization and ensure access to PECOS is active. To verify your account status, select the Account Management button on the Home Page and then choose Update user account information option.

The following checklists will help you gather the information needed to enroll via Internet-based PECOS:

- [Checklist for Sole Proprietor or Solely Owned Organizations \(eg. LLC, PC\) using PECOS](#)
- [Checklist for Individual Physician and Non-Physician Practitioners using PECOS](#)
- [Checklist for Provider or Supplier Organization using PECOS](#)

Select the Create Initial Enrollment Application button **ONLY** if you are enrolling for the first time, or enrolling in a new state or specialty.

[CREATE INITIAL ENROLLMENT APPLICATION](#)

### Filter Existing Medicare Applications and Enrollments Section

Please provide one or more of the following options to filter your enrollments. Selecting the reset button will clear the options selected and load the full list of enrollments.

Enrollment Type:  [SELECT](#)

Provider/Supplier Type:  Enrollment Status:

State:  Medicare ID:

[FILTER](#) [RESET](#)

Records 1 - 2 of 2

### Existing Enrollments

Contractor: NATIONAL GOVERNMENT SERVICES, INC. [VIEW](#)  
State: NEW YORK [REVALIDATE](#)  
Type/Specialty: CLINIC/GROUP PRACTICE [MORE OPTIONS](#)

Enrollment Type: 855B  
Medicare ID: [View Medicare ID Report](#)  
Status: APPROVED [View Approved Enrollment Record](#)

Current ADI Accreditation?: No  
Revalidation Status: Revalidation Due [Sample Revalidation Notice](#)  
Revalidation Due Date: 02/28/2017  
Practice Location: , ROCHESTER, NY

Existing Reassignments: 2  
Pending Reassignments Applications: 0  
[View/Manage Reassignments](#)

# Existing Enrollments

## Existing Enrollments

Contractor: NATIONAL GOVERNMENT SERVICES, INC.  
State: NEW YORK  
Type/Specialty: CLINIC/GROUP PRACTICE

[VIEW](#)

[REVALIDATE](#)

[MORE OPTIONS](#)

Enrollment Type: 855B

Medicare ID: [View Medicare ID Report](#)

Status: APPROVED [View Approved Enrollment Record](#)

Current ADI Accreditation?: No

Revalidation Status: Revalidation Due [i](#)

[Sample Revalidation Notice](#)

Revalidation Due Date: 02/28/2017

Practice Location: ROCHESTER, NY

Existing Reassignments: 2

Pending Reassignments Applications: 0

[View/Manage Reassignments](#)



# View/Manage Reassignments

### View/Manage Reassignments

#### Pending Reassignments Applications

Pending Reassignments Applications Details					
Name/LBN	NPI	Status	Tracking ID	Action	
Provider	XXXXXXXXXX	PENDING E-SIGNATURES <a href="#">View Pending E-Signatures Application</a>	TXXXXX	<a href="#">MANAGE SIGNATURES</a>	<a href="#">CORRECT &amp; RE-SUBMIT</a>
Provider	XXXXXXXXXX	PENDING E-SIGNATURES <a href="#">View Pending E-Signatures Application</a>	TXXXXX	<a href="#">MANAGE SIGNATURES</a>	<a href="#">CORRECT &amp; RE-SUBMIT</a>

#### Reassignments Report

Filter Reassignment Records

Please provide one or more of the following options to filter the enrollments. Selecting the reset button will clear the options selected and load the full list of enrollments.

Reassignment Status ?

All Statuses ▼

Enrollment Status

All Statuses ▼

Relationship Status

All Relationships ▼

[FILTER](#) [RESET](#)

Records 1 - 1 of 1

The table below displays Reassignment Information for Approved, Deactivated, Revoked, and Rejected enrollment records. Any changes that you submit will display here only after the Medicare Administrative Contractor has processed the submitted enrollment.

Reassignments Report Details							
Relationship	Provider Name/LBN	NPI	Current Enrollment Status	Medicare ID	Effective Date	Reassignment End Date	Revalidation Due Date
Receiving Benefits from	Provider	XXXXXXXXXX	APPROVED	ptan	05/01/2018	N/A	N/A

Records 1 - 1 of 1

Note: Please select on the "Download Report" button to download this report in CSV format.

[PRINT](#) [DOWNLOAD REPORT](#)

[RETURN TO MY ENROLLMENTS](#)
[MANAGE REASSIGNMENTS](#)

# Add Reassignment for Provider with Active Enrollment

# Verify Active Enrollment

- [NGS Website](#) > Enrollment > Hot Topics > [How to Determine if the Provider is Active and Get the Provider Enrolled in Medicare Part B](#)

# Manage Reassignments

View/Manage Reassignments

**Pending Reassignments Applications**  
You currently do not have any Pending Reassignments.

**Reassignments Report**

**Filter Reassignment Records**  
Please provide one or more of the following options to filter the enrollments. Selecting the reset button will clear the options selected and load the full list of enrollments.

Reassignment Status ?

All Statuses

Enrollment Status

All Statuses

Relationship Status

All Relationships

[FILTER](#) [RESET](#)

The table below displays Reassignment Information for Approved, Deactivated, Revoked, and Rejected enrollment records. Any changes that you submit will display here only after the Medicare Administrative Contractor has processed the submitted enrollment.

Reassignments Report Details

Relationship	Provider Name/LBN	NPI	Current Enrollment Status	Medicare ID	Effective Date	Reassignment End Date	Revalidation Due Date
Receiving Benefits from	XXXXXX, XXXXX	XXXXXXXXXX	APPROVED	N/A	05/02/2005	01/01/2008	N/A
Receiving Benefits from	XXXXXX, XXXXX	XXXXXXXXXX	DEACTIVATED	N/A	12/15/2009	02/14/2014	N/A
Receiving Benefits from	XXXXXX, XXXXX	XXXXXXXXXX	DEACTIVATED	N/A	12/05/2005	02/14/2014	05/13/2013
Receiving Benefits from	XXXXXX, XXXXX	XXXXXXXXXX	APPROVED		09/28/2015	N/A	N/A
Receiving Benefits from	XXXXXX, XXXXX	XXXXXXXXXX	APPROVED		12/15/2009	N/A	N/A
Receiving Benefits from	XXXXXX, XXXXX	XXXXXXXXXX	APPROVED		06/23/2013	02/14/2014	N/A
Receiving Benefits from	XXXXXX, XXXXX	XXXXXXXXXX	APPROVED		10/06/2008	N/A	N/A
Receiving Benefits from	XXXXXX, XXXXX	XXXXXXXXXX	APPROVED		07/24/2003	N/A	11/00/2017

**Note:** Please select on the "Download Report" button to download this report in CSV format.

[PRINT](#) [DOWNLOAD REPORT](#)

[RETURN TO MY ENROLLMENTS](#)

MANAGE REASSIGNMENTS ?

# Application Questionnaire

## Medicare Enrollment

for Providers and Suppliers

Home | Help | Log Out

My Application Progress  0%

[Home](#) > [My Associates](#) > [My Enrollments](#) > Application Questionnaire

### Application Questionnaire

(\*) Red asterisk indicates a required field.

#### Supplier Reassignment Options

\* Please select an activity you would like to perform:

- Add reassignment of benefits where someone is reassigning benefits to the group or organization
- Remove existing reassignment of benefits (where someone is reassigned to the group/organization)
- Change of information to Reassignment

Home | Help | Log Out



# Application Questionnaire

## Medicare Enrollment

for Providers and Suppliers

CMS Validation  
Home | Help | Log Out

My Application Progress  0%

[Home](#) > [My Associates](#) > [My Enrollments](#) > Application Questionnaire

### Application Questionnaire

(\*) Red asterisk indicates a required field.

#### Additional Changes

You are about to add a reassignment of benefits (where someone is reassigning benefits to the group/organization).

\* Does the applicant need to make any other updates or changes to this enrollment information?

Yes, I need to make other updates to my enrollment.

No, I only need to make Reassignment Updates.

Home | Help | Log Out

# Start Application

### Confirm Reason for Application

#### Medicare Part B Enrollment

Based on your responses, the following reason for application was identified.

- A Medicare Part B Supplier is accepting benefits from a Part B practitioner.

The application is for:

Legal Business Name	Tax Identification Number (TIN)	Supplier Type	State
FAMILY PRACTICE LLC	XX-XXXX	CLINIC/GROUP PRACTICE	ILLINOIS

Clicking on the 'Start Application' button will create a Medicare application using the above information.  
**Please note:** After you click 'Start Application' a Web Tracking ID will be created. This does not mean that your application has been submitted.

At the conclusion of this process:

- The application is submitted to the appropriate Medicare fee-for-service contractor (s) for processing
- An Authorized Official or Delegated Official must sign a statement certifying the submitted information
- The certification statement, additional required signatures, and required attachments must be electronically signed or mailed to the identified fee-for-service contractor(s)
- Medicare benefits to the practitioner are reassigned to the supplier after the fee-for-service contractor processes this application and approves the information
- Any required and/or supporting documentation not uploaded must be mailed in to the fee-for-service contractor

**START APPLICATION** >>

<< **CANCEL**

# Topic View

**Topic View** | **Fast Track View** | **Error/Warning Check 2**

Enrollment ID:  
PaclD:  
Web Tracking ID:

**Reason for Application**

Reassignment of Benefits Between an Enrolled Practitioner and another Enrolled Practitioner(s), Supplier(s), or Provider(s)

**Reports**

Select the hyperlink to view the Application being edited:  
[View Application being edited](#)

Select the hyperlink to view the Medicare ID Report:  
[View Medicare ID Report](#)

**Topics**

The data required for this enrollment application is grouped into topics. In order to electronically submit this enrollment application, you must complete all of the following topics.

You may view and print this enrollment application at any time during the enrollment process by clicking the View and Print button below.

This application is collecting the following topics:

Completed	Topics
—	<a href="#">Reassignment</a> <small>more information about Reassignment</small>
✓	<a href="#">Contact Person</a> <small>more information about Contact Person</small>

**Note:**

- Once you have completed all the topics and no errors are present, the 'Begin Submission' button will be enabled. You may review errors at any time by clicking the 'Error Check' tab. Clicking 'Begin Submission' will initiate the Submission Process.

**BEGIN SUBMISSION** | **NEXT PAGE**

# Add Reassignment Information

[Home](#) > [My Associates](#) > [My Enrollments](#) > [Reassignment](#) > Reassignment

## Reassignment of Benefits

### Topic Summary

This topic captures information to identify Medicare providers with whom the applicant will establish a reassignment of benefits. [\(more information about Reassignment of Benefits\)](#)

### Filter Reassignment of Benefits


Please provide one or more of the following options to filter your enrollments. Selecting on the Clear Filter button will clear the options and load the full list of enrollments.

[Advanced Search](#)

[ADD INFORMATION](#) 

### Reassignment Information

Records 1 - 1 of 1

[RETURN TO TOPICS](#) [GO TO ERROR CHECK](#) [NEXT TOPIC](#) 



# Provider Information

Home > My Associates > My Enrollments > Reassignment > Reassignment > ADD

### Accept Reassignment

(\*) Red asterisk indicates a required field.

Accept Reassignment

\* Effective Date of Information  
MM/DD/YYYY

\* First Name

Middle Name

\* Last Name

Suffix  
Select Suffix

\* Social Security Number (SSN)  
XXX-XX-XXXX

\* Date of Birth  
MM/DD/YYYY

\* National Provider Identifier (NPI)  
10 Digits

\* Please choose the Specialty Type for the reassigning practitioner:

Physician

Non-Physician

[NEXT PAGE](#)

[CANCEL](#)

# Group Information

[Home](#) > [My Associates](#) > [My Enrollments](#) > [Reassignment](#) > [Reassignment](#) > ADD

### Reassignment of Benefits

**Medicare Identification Numbers**

**Name:** \_\_\_\_\_

**National Provider Identifier (NPI):** \_\_\_\_\_

Please provide any Medicare Identification numbers that apply to the group/provider that you are reassigning your benefits.

**Note:** Use the Add More button to add more than one Medicare Identification number.

**Medicare Identification Number**

[Home](#) > [My Associates](#) > [My Enrollments](#) > [Reassignment](#) > [Reassignment](#) > ADD

### Accept Reassignment

**Practice Location Address from where benefits are accepted**

**Note:**

- To add Practice Locations (a location is not listed or dropdown lists are disabled), go to the Physical Location topic.
- The locations you select here will be used to populate Physician Compare on [Medicare.gov](#).

**Primary Practice Location:**

Please select the Primary Practice Location where you render services:

**Secondary Practice Location:**

Please select the Secondary Practice Location where you render services:

# Reassignment Topic Summary

### Topic Summary

This topic captures information to identify Medicare providers with whom the applicant will establish a reassignment of benefits. [\(more information about Reassignment of Benefits\)](#)

#### Filter Reassignment of Benefits

Please provide one or more of the following options to filter your enrollments. Selecting on the Clear Filter button will clear the options and load the full list of enrollments.

[Advanced Search](#)

[ADD INFORMATION](#)

Records 1 - 1 of 1

Accepting Reassignment from:	Provider Name
<b>Effective Date of Information:</b> 05/01/2018 <b>Social Security Number (SSN):</b> XXX-XX-XXXX <b>Date of Birth:</b> 12/17/XXXX <b>National Provider Identifier:</b> XXXXXXXX 1	<b>Medicare ID(s) for provider receiving reassignment of benefits:</b> ptan <a href="#">ADD</a>
<b>Practice Location Address:</b> <b>Primary Practice Location Address:</b> 137 CHICAGO, IL 60603 -56	<b>Medicare ID(s) for provider reassigning benefits:</b> IL

[DELETE](#)

[DELETE](#)

# Review Contact Information

Home > My Associates > My Enrollments > Revalidation > Contact Person

## Contact Person

**Topic Summary**

The topic requests information about the person or persons that the Medicare contractor should contact if any questions exist about the application. [\(more information about Contact Person\)](#)

**ADD INFORMATION**

**Contact Person Information**

**Frosty Snowman**

Relationship/Affiliation to Provider/Supplier: Manager  
Address: 1234 Main Street  
Chicago, IL 60602  
Telephone: (919) 999-9999  
E-mail Address: nppes.test@

**EDIT** **DELETE**

**White Snowman**

Address:  
NEW HAVEN, CT 06511-6624  
Telephone: 999-999-9999  
E-mail Address: : @anthem.com

**EDIT** **DELETE**

**REVIEW COMPLETE**

**PREVIOUS TOPIC** **GO TO ERROR CHECK** **NEXT TOPIC**



# Error/Warning Check and Begin Submission

[Topic View](#) | [Fast Track View](#) | **Error/Warning Check**

### Enrollment Submission

Note: Your application is ready for submission. Please select the Begin Submission button.

**BEGIN SUBMISSION** >>

Enrollment ID:  
PacID: .  
Web Tracking ID:


### Errors for this Enrollment

No Errors were found for this enrollment application.

### Warnings for this Enrollment

No Warnings were found for this enrollment application.

# Authorized/Delegated Official Selection

My Application Progress  90%

[Home](#) > [My Associates](#) > [My Enrollments](#) > [Reassignment](#) > Submission Process


### Select Signatories


(\*) Red asterisk indicates a required field.

#### Signatory for Organization Enrollment

The selected Signer will be responsible the Electronic Funds Transfer Agreement and Certification Statement for the Organization Enrollment.

\* Authorized Signer  
Please select authorized signer

[NEXT PAGE](#) 

[RETURN TO MY ENROLLMENTS](#) 

# Manage Signatures

### Manage Signatures

(\*) Red asterisk indicates a required field.

**Group Name** ..... **TIN: XXX-XX-XXXX**  
Web Tracking ID ..... NPI .....

PECOS now allows users to upload signed documents. Please upload your certification statement(s), authorization statement(s), and CMS-588 forms on this page, or after submission, by navigating to the My Enrollments page and selecting the Manage Signatures option.

**Note:** Users will no longer be able to mail in signature documents. Please select either Electronic or Upload.

Any Authorized or Delegated Officials with an ITIN will not be able to submit electronic signatures. Authorized or Delegated Officials with an ITIN entered on this application **must now upload their signature documents.**

**Please select a signature method for each signer:**

**Name:** DONALD DUCK **Role:** PRACTITIONER  
**SSN:** XXX-XX-XXXX **Document:** AUTHORIZATION STATEMENT FOR INDIVIDUAL PRACTITIONERS (855R)  
\* **Signature Method for DONALD DUCK:**

Electronic  
 Upload

**Name:** ..... [You] **Role:** AUTHORIZED OFFICIAL  
**SSN:** XXX-XX-XXXX **Document:** AUTHORIZATION STATEMENT FOR ORGANIZATIONS (855R)  
\* **Signature Method for St**

E-Sign (Sign Now)  
 Upload

[PREVIOUS PAGE](#) [NEXT PAGE](#)

[RETURN TO MY ENROLLMENTS](#)

# Manage Signatures – Sign Now

Name: [You]  
SSN: XXX-XX-XXXX  
\* Signature Method for

Role: AUTHORIZED OFFICIAL  
Document: AUTHORIZATION STATEMENT FOR ORGANIZATIONS (855R)

E-Sign (Sign Now)  
 Upload

Sign Now

[PREVIOUS PAGE](#) [NEXT PAGE](#)

[RETURN TO MY ENROLLMENTS](#)

**Review And Sign Your Document**

**E-Signature Instructions** (\*) Red asterisk indicates a required field.

To complete your E-Signature follow the steps below:

1. Click here if you wish to review the application
2. View and read the terms and conditions for the applicable document(s) that you wish to e-sign.
3. Check the box if you agree with the terms and conditions
4. Click the Submit button to complete your E-Signature

**Terms and Conditions**

**PENALTIES FOR FALSIFYING INFORMATION**

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

**AUTHORIZATION STATEMENT FOR ORGANIZATIONS (855R)**

The signatures below authorize the reassignment of benefits to a supplier or the termination of a reassignment of benefits to a supplier, as indicated in Section 1 Title XVIII of the Social Security Act.

\* Do you accept the Terms and Conditions?

Yes, I agree to the certification statement terms and conditions. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my traditional handwritten signature.

[PREVIOUS PAGE](#) [NEXT PAGE](#)

[CANCEL](#)

# Manage Signatures –Select Method

Name: DONALD DUCK      Role: PRACTITIONER  
SSN: XXX-XX-XXXX      Document: AUTHORIZATION STATEMENT  
FOR INDIVIDUAL PRACTITIONERS (855R)

\* Signature Method for DONALD DUCK:

Electronic ←  
 Upload

\* Email Address  ←

\* Confirm Email Address

Name: DONALD DUCK      Role: PRACTITIONER  
SSN: XXX-XX-XXXX      Document: AUTHORIZATION STATEMENT  
FOR INDIVIDUAL PRACTITIONERS (855R)

\* Signature Method for DONALD DUCK

Electronic  
 Upload ←

**Note:** You may upload a signature document now, prior to application submission, or after the submission of this application. To upload a signature document after submission, or to change the signature method, navigate to the My Enrollments page, find this application, and select the Manage Signatures option.

The following documents can be used to upload a signature:

- Signature page from the corresponding Medicare provider/supplier enrollment application form available on the CMS website.
- Signature page from the Required/Supporting Documentation topic, or from the My Enrollments Page select this application then select View > View Printable Certification

To upload a signature document now, browse for the file then select the Upload button.

Document: AUTHORIZATION STATEMENT FOR INDIVIDUAL PRACTITIONERS (855R) ⓘ

Browse...  ←

# Submission Page

Home > My Associates > My Enrollments > Revalidation > Submission Process

## Submission Page

(\*) Red asterisk indicates a required field.

### Medicare Contractor

The Medicare Contractor(s) listed here would be responsible for processing your electronic and printed application materials. If more than one contractor is listed, you must mail copies of print documents to each contractor listed. You must mail all required print documents within 15 days of submitting the electronic part of your application.

Medicare Contractor: NATIONAL GOVERNMENT SERVICES, INC.

NATIONAL GOVERNMENT SERVICES, INC.  
PO BOX  
INDIANAPOLIS, IN

### Reason(s) for submission:

- A Medicare Part B Supplier is accepting benefits from a Part B practitioner.

### Required and Supporting Documents

The following Required and Supporting Documents must be mailed in, e-signed or uploaded as part of your submission. Some documents may not be uploaded. Please read the notes below.









#### Do not upload to your submission:

- A copy of the Medicare provider/supplier enrollment application form (such as a CMS-855 form).

#### Required and/or Supporting Documents:

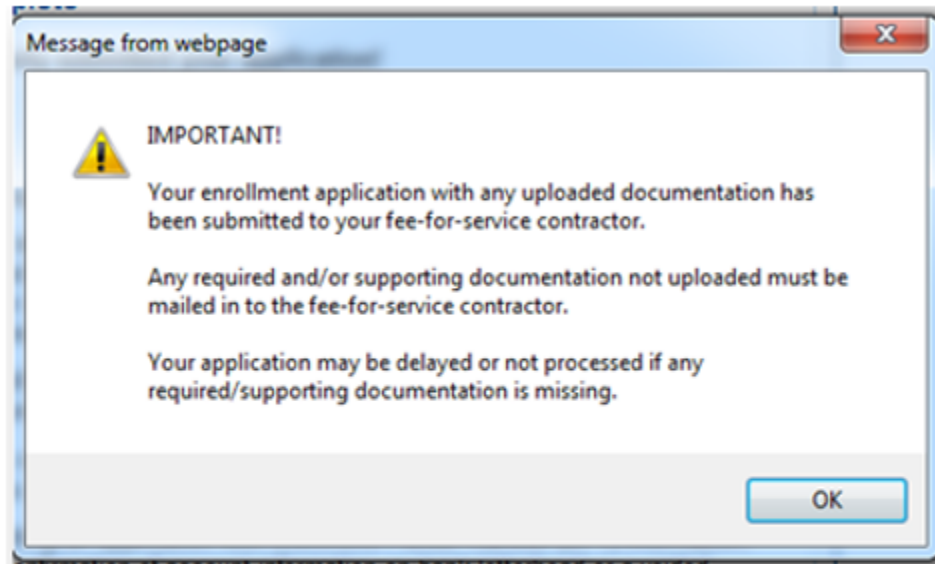
Note: Expand  for document details.

If you wish to upload a document or change the delivery method for a document prior to submitting this application, please select the Cancel button and return to the Required and/or Supporting Documentation topic.

Documentation Requiring Signatures: MUST E-SIGN or UPLOAD	View and Print Documentation	Comments
 Authorized Official Certification Statement for Clinics and Group Practices [PDF]	View and Print [PDF] 	
<p>Note: Please do not mail a signed Certification Statement. Signature documents must be either e-signed or uploaded.</p>		
 Form CMS-855R, Authorization Statement for Reassignment of Medicare Benefits	View and Print [PDF] 	
<p>Note: Please do not mail a signed Certification Statement. Signature documents must be either e-signed or uploaded.</p>		
Required Documentation	Delivery Method	Comments
 Form CMS-460, Medicare Participating Physician or Supplier Agreement	Unspecified	
Optional Documentation	Delivery Method	Comments
 Other Documentation requested by your Medicare Contractor(s)	Unspecified	
<p>Note: Documents in PDF format require the <a href="#">Adobe Acrobat Reader®</a> . If you experience problems with PDF documents, please <a href="#">download the latest version of the Reader®</a> .</p>		
<span>PREVIOUS PAGE</span> <span>COMPLETE SUBMISSION</span>		
<span>CANCEL</span>		


# Submission Confirmation

My Application Progress  100%



## Submission Confirmation - Print Your Receipt

### Submission Complete

You have successfully submitted your application! 

#### Remember to:

- Make sure all required and supporting documents that require a signature are signed.
- Mail all required and supporting documents that has not been uploaded to your Medicare Contractor within 15 days of submitting the electronic part of your application. Your application is not complete until the Medicare Contractor(s) receives the signed required documentation of your application in the mail.
- Any required and/or supporting documentation not uploaded must be mailed in to the fee-for-service contractor.
- Your application may be delayed or not processed if any required/supporting documentation is missing.
- If you are submitting an application with Electronic Funds Transfer (EFT) Information, please include confirmation of account information on bank letterhead or a voided check.
- Print this page for your records. **Note:** You can print and/or save copies of the application and required documents for your records by visiting the "My Enrollments" page.
- You will receive e-mails about your application status. Make sure to add "customerservice-donotreply@cms.hhs.gov" to your safe sender list.

You have successfully submitted your application!

Terminate Reassignment



# Manage Reassignments

**View/Manage Reassignments**

**Pending Reassignments Applications**  
You currently do not have any Pending Reassignments.

**Reassignments Report**

**Filter Reassignment Records**  
Please provide one or more of the following options to filter the enrollments. Selecting the reset button will clear the options selected and load the full list of enrollments.

Reassignment Status <sup>1</sup>

Enrollment Status

Relationship Status

The table below displays Reassignment information for Approved, Deactivated, Revoked, and Rejected enrollment records. Any changes that you submit will display here only after the Medicare Administrative Contractor has processed the submitted enrollment.

**Reassignments Report Details**

Relationship	Provider Name/LBN	NPI	Current Enrollment Status	Medicare ID	Effective Date	Reassignment End Date	Revalidation Due Date
Receiving Benefits from	XXXXXX, XXXXX	XXXXXXXXXX	APPROVED	N/A	05/02/2005	01/01/2008	N/A
Receiving Benefits from	XXXXXX, XXXXX	XXXXXXXXXX	DEACTIVATED	N/A	12/15/2009	02/14/2014	N/A
Receiving Benefits from	XXXXXX, XXXXX	XXXXXXXXXX	DEACTIVATED	N/A	12/05/2005	02/14/2014	05/13/2013
Receiving Benefits from	XXXXXX, XXXXX	XXXXXXXXXX	APPROVED		09/28/2015	N/A	N/A
Receiving Benefits from	XXXXXX, XXXXX	XXXXXXXXXX	APPROVED		12/15/2009	N/A	N/A
Receiving Benefits from	XXXXXX, XXXXX	XXXXXXXXXX	APPROVED		06/23/2013	02/14/2014	N/A
Receiving Benefits from	XXXXXX, XXXXX	XXXXXXXXXX	APPROVED		10/06/2008	N/A	N/A
Receiving Benefits from	XXXXXX, XXXXX	XXXXXXXXXX	APPROVED		07/24/2003	N/A	11/30/2017

**Note:** Please select on the "Download Report" button to download this report in CSV format.

# Application Questionnaire

## Medicare Enrollment

for Providers and Suppliers

Home | Help | Log Out

My Application Progress  0%

[Home](#) > [My Associates](#) > [My Enrollments](#) > Application Questionnaire

### Application Questionnaire

(\*) Red asterisk indicates a required field.

**Supplier Reassignment Options**

\* Please select an activity you would like to perform:

- Add reassignment of benefits where someone is reassigning benefits to the group or organization
- Remove existing reassignment of benefits (where someone is reassigned to the group/organization)
- Change of information to Reassignment

Home | Help | Log Out

# Application Questionnaire

The screenshot shows a web application interface for Medicare Enrollment. At the top, there is a blue header with the text "Medicare Enrollment for Providers and Suppliers". On the right side of the header, there are links for "CMS Validation", "Home", "Help", and "Log Out". Below the header, a progress bar indicates "My Application Progress" at 0%. A breadcrumb trail reads "Home > My Associates > My Enrollments > Application Questionnaire". The main content area is titled "Application Questionnaire" and includes a red asterisk legend: "(\*) Red asterisk indicates a required field." The section "Additional Changes" contains a text box with the instruction: "You are about to add a reassignment of benefits (where someone is reassigning benefits to the group/organization)." Below this, a required question is asked: "Does the applicant need to make any other updates or changes to this enrollment information?" with two radio button options: "Yes, I need to make other updates to my enrollment." and "No, I only need to make Reassignment Updates." At the bottom of the form, there are three buttons: "PREVIOUS PAGE", "NEXT PAGE", and "CANCEL". The footer of the page contains the same navigation links: "Home | Help | Log Out".

# Start Application

### Confirm Reason for Application

#### Medicare Part B Enrollment

Based on your responses, the following reason for application was identified.

- A Medicare Part B supplier is terminating a current reassignment of benefits from a practitioner.

The application is for:

Legal Business Name	Tax Identification Number (TIN)	Supplier Type	State
FAMILY PRACTICE LLC		CLINIC/GROUP PRACTICE	ILLINOIS

Clicking on the 'Start Application' button will create a Medicare application using the above information.  
**Please note:** After you click 'Start Application' a Web Tracking ID will be created. This does not mean that your application has been submitted.

At the conclusion of this process:

- The application is submitted to the appropriate Medicare fee-for-service contractor (s) for processing
- An Authorized Official or Delegated Official must sign a statement certifying the submitted information
- The certification statement, additional required signatures, and required attachments must be electronically signed or mailed to the identified fee-for-service contractor(s)
- Medicare benefits reassigned to the supplier are terminated after the fee-for-service contractor processes this application and approves the information
- Any required and/or supporting documentation not uploaded must be mailed in to the fee-for-service contractor

[START APPLICATION >>](#)

[<< CANCEL](#)

# Topic View

Topic View Fast Track View Error/Warning Check **2**

Enrollment ID:  
PaclD:  
Web Tracking ID:

**Reason for Application**

Practitioner, Supplier, or Provider is Terminating a Current Reassignment of Benefits

**Reports**

Select the hyperlink to view the Application being edited:  
[View Application being edited](#)

Select the hyperlink to view the Medicare ID Report:  
[View Medicare ID Report](#)

**Topics**

The data required for this enrollment application is grouped into topics. In order to electronically submit this enrollment application, you must complete all of the following topics.

You may view and print this enrollment application at any time during the enrollment process by clicking the View and Print button below.

This application is collecting the following topics:

Completed	Topics
<input type="checkbox"/>	<a href="#">Reassignment</a> <a href="#">more information about Reassignment</a>
<input type="checkbox"/>	<a href="#">Contact Person</a> <a href="#">more information about Contact Person</a>

**Note:**

- Once you have completed all the topics and no errors are present, the 'Begin Submission' button will be enabled. You may review errors at any time by clicking the 'Error Check' tab. Clicking 'Begin Submission' will initiate the Submission Process.

**BEGIN SUBMISSION**

# Remove Reassignment

My Application Progress  90%

[Home](#) > [My Associates](#) > [My Enrollments](#) > [Reassignment](#) > Reassignment

## Reassignment of Benefits

### Topic Summary

This topic captures information to identify Medicare providers with whom the applicant will establish a reassignment of benefits. [\(more information about Reassignment of Benefits\)](#)

### Filter Reassignment of Benefits

Please provide one or more of the following options to filter your enrollments. Selecting on the Clear Filter button will clear the options and load the full list of enrollments.

#### Advanced Search

Enter search criteria

Reassignment Information  Pending Reassignment Information

#### Individual

First Name

Last Name

#### Tax Identification Number (TIN)

#### Medicare Identification Number

#### National Provider Identifier (NPI)

#### Application Status

[FILTER](#)

[CLEAR FILTER](#)

[ADD INFORMATION](#)

### Reassignment Information

Records 1 - 2 of 2

Accepting Reassignment from:

Effective Date of Information: 05/01/2018  
Social Security Number (SSN): XXX-XX-XXXX  
Date of Birth: 12/17/XXXX  
National Provider Identifier: (unverified)

Medicare Identification Number(s):

[ADD](#)

Medicare Identification Number:

[DELETE](#)

Practice Location Address:

Primary Practice Location Address:  
137 S STATE ST  
CHICAGO, IL 60603 -5606

[DELETE](#)

Accepting Reassignment from:

Effective Date of Information: 05/01/2018  
Social Security Number (SSN): XXX-XX-XXXX  
Date of Birth: 12/17/XXXX  
National Provider Identifier:

Medicare ID(s) for provider receiving reassignment of benefits:

[ADD](#)

Medicare ID(s) for provider reassigning benefits:

Practice Location Address:

Primary Practice Location Address:  
137 S STATE ST  
CHICAGO, IL 60603 -5606


Records 1 - 2 of 2

[RETURN TO TOPICS](#)

[GO TO ERROR CHECK](#)

[NEXT TOPIC](#)

# Termination Date

My Application Progress  90%

[Home](#) > [My Associates](#) > [My Enrollments](#) > [Reassignment](#) > [Reassignment](#) > DELETE

### Reassignment of Benefits

(\*) Red asterisk indicates a required field.

#### Delete Existing Information

The following information is on file with Medicare. To remove the information from your enrollment, please enter a termination date.

\* Termination Date  
  
MM/DD/YYYY

#### Information to be Deleted

Effective Date of Information: 05/01/2018  
Name: XXXX XXXXX  
Social Security Number (SSN): XXX-XX-XXXX  
Date of Birth: 12/17/XXXX  
National Provider Identifier (NPI):  
  
Practice Location Address:  
  
Primary Practice Location  
137 S STATE ST  
CHICAGO, IL 60603 -5606

# Reassignment Topic Summary

### Reassignment of Benefits

**Topic Summary**

This topic captures information to identify Medicare providers with whom the applicant will establish a reassignment of benefits. [\(more information about Reassignment of Benefits\)](#)

**Filter Reassignment of Benefits**

Please provide one or more of the following options to filter your enrollments. Selecting on the Clear Filter button will clear the options and load the full list of enrollments.

Advanced Search

[ADD INFORMATION](#)

---

**Reassignment Information**

Records 1 - 1 of 1

Provider Name	
<b>Accepting Reassignment from:</b>	
Effective Date of Information: 05/01/2018	Medicare ID(s) for provider receiving reassignment of benefits:
Social Security Number (SSN): XXX-XX-XXXX	<input type="button" value="ADD"/>
Date of Birth: 12/17/XXXX	
National Provider Identifier:	<input type="button" value="DELETE"/>
	Medicare ID(s) for provider reassigning benefits:
<b>Practice Location Address:</b>	
Primary Practice Location Address:	
137 S STATE ST	
CHICAGO, IL 60603-5608	
<input type="button" value="DELETE"/>	

Records 1 - 1 of 1

[RETURN TO TOPICS](#) [GO TO ERROR CHECK](#) [NEXT TOPIC](#)



# Review Contact Information

Home > My Associates > My Enrollments > Reassignment > Contact Person

## Contact Person

**Topic Summary**

The topic requests information about the person or persons that the Medicare contractor should contact if any questions exist about the application. [\(more information about Contact Person\)](#)

[ADD INFORMATION](#)

### Contact Person Information

**Frosty Snowman**

Relationship/Affiliation to Provider/Supplier: Employee  
Address: DR  
HARRISBURG, PA 17110 -9436  
Telephone:  
E-mail Address: @anthem.com

[EDIT](#) [DELETE](#)

**Snowman**


Relationship/Affiliation to Provider/Supplier: Authorized Official  
Address: DR  
HARRISBURG, PA 17110 -9436  
Telephone:  
E-mail Address: @anthem.com

[EDIT](#) [DELETE](#)

[REVIEW COMPLETE](#)

[PREVIOUS TOPIC](#) [GO TO ERROR CHECK](#) [RETURN TO TOPICS](#)

# Error/Warning Check and Begin Submission


My Application Progress  90%

[Home](#) > [My Associates](#) > [My Enrollments](#) > Reassignment

[Topic View](#) [Fast Track View](#) **Error/Warning Check**

**Enrollment Submission**

Note: Your application is ready for submission. Please select the **Begin Submission** button.

**BEGIN SUBMISSION** 

Enrollment ID:  
PaclD:  
Web Tracking ID:


**Errors for this Enrollment**

No Errors were found for this enrollment application.

**Warnings for this Enrollment**

No Warnings were found for this enrollment application.

# Authorized/Delegated Official Selection

My Application Progress  90%

[Home](#) > [My Associates](#) > [My Enrollments](#) > [Reassignment](#) > Submission Process

## Select Signatories

**(\*) Red asterisk indicates a required field.**

### Signatory for Organization Enrollment

The selected Signer will be responsible the Electronic Funds Transfer Agreement and Certification Statement for the Organization Enrollment.

\* Authorized Signer  
Please select authorized signer

[NEXT PAGE >](#)

[RETURN TO MY ENROLLMENTS <<](#)

# Manage Signatures – Sign Now

Name: [You]  
SSN: XXX-XX-XXXX  
\* Signature Method for  
 E-Sign (Sign Now)  
 Upload

Role: AUTHORIZED OFFICIAL  
Document: AUTHORIZATION STATEMENT FOR ORGANIZATIONS (855R)

Sign Now

[PREVIOUS PAGE](#) [NEXT PAGE](#)

[RETURN TO MY ENROLLMENTS](#)

**Review And Sign Your Document**

**E-Signature Instructions** (\*) Red asterisk indicates a required field.

To complete your E-Signature follow the steps below:

1. [Click here if you wish to review the application](#)
2. View and read the terms and conditions for the applicable document(s) that you wish to e-sign.
3. Check the box if you agree with the terms and conditions
4. Click the Submit button to complete your E-Signature

**Terms and Conditions**

**PENALTIES FOR FALSIFYING INFORMATION**

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

**AUTHORIZATION STATEMENT FOR ORGANIZATIONS (855R)**

The signatures below authorize the reassignment of benefits to a supplier or the termination of a reassignment of benefits to a supplier, as indicated in Section 1, Title XVIII of the Social Security Act

\* Do you accept the Terms and Conditions?

Yes, I agree to the certification statement terms and conditions. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my traditional handwritten signature.

[PREVIOUS PAGE](#) [NEXT PAGE](#)

[CANCEL](#)

# Manage Signatures – Select Method

Name: DONALD DUCK  
SSN: XXX-XX-XXXX  
\* Signature Method for DONALD DUCK:      Role: AUTHORIZED OFFICIAL  
Document: AUTHORIZATION STATEMENT  
FOR ORGANIZATIONS (855R)

Electronic ←  
 Upload

\* Email Address  
 ←

\* Confirm Email Address

Name: DONALD DUCK  
SSN: XXX-XX-XXXX  
\* Signature Method for DONALD DUCK      Role: PRACTITIONER  
Document: AUTHORIZATION STATEMENT  
FOR INDIVIDUAL PRACTITIONERS (855R)

Electronic  
 Upload ←

**Note:** You may upload a signature document now, prior to application submission, or after the submission of this application. To upload a signature document after submission, or to change the signature method, navigate to the My Enrollments page, find this application, and select the Manage Signatures option.

The following documents can be used to upload a signature:

- Signature page from the corresponding Medicare provider/supplier enrollment application form available on the CMS website.
- Signature page from the Required/Supporting Documentation topic, or from the My Enrollments Page select this application then select View > View Printable Certification

To upload a signature document now, browse for the file then select the Upload button.

Document: AUTHORIZATION STATEMENT FOR INDIVIDUAL PRACTITIONERS (855R) ⓘ

Browse... **UPLOAD** » ←

# Submission Page

[Home](#) > [My Associates](#) > [My Enrollments](#) > [Revalidation](#) > Submission Process

Submission Page

(\*) Red asterisk indicates a required field.

**Medicare Contractor**

The Medicare Contractor(s) listed here would be responsible for processing your electronic and printed application materials. If more than one contractor is listed, you must mail copies of print documents to each contractor listed. You must mail all required print documents within 15 days of submitting the electronic part of your application.

**Medicare Contractor:** NATIONAL GOVERNMENT SERVICES, INC.

NATIONAL GOVERNMENT SERVICES, INC.  
PO BOX  
INDIANAPOLIS, IN

---

**A Medicare Part B supplier is terminating a current reassignment of benefits from a practitioner.**

**Required and Supporting Documents**

The following Required and Supporting Documents must be mailed in, e-signed or uploaded as part of your submission. Some documents may not be uploaded. Please read the notes below.

**Do not upload to your submission:**

- A copy of the Medicare provider/supplier enrollment application form (such as a CMS-855 form).

**Required and/or Supporting Documents:**

**Note:** Expand for document details.

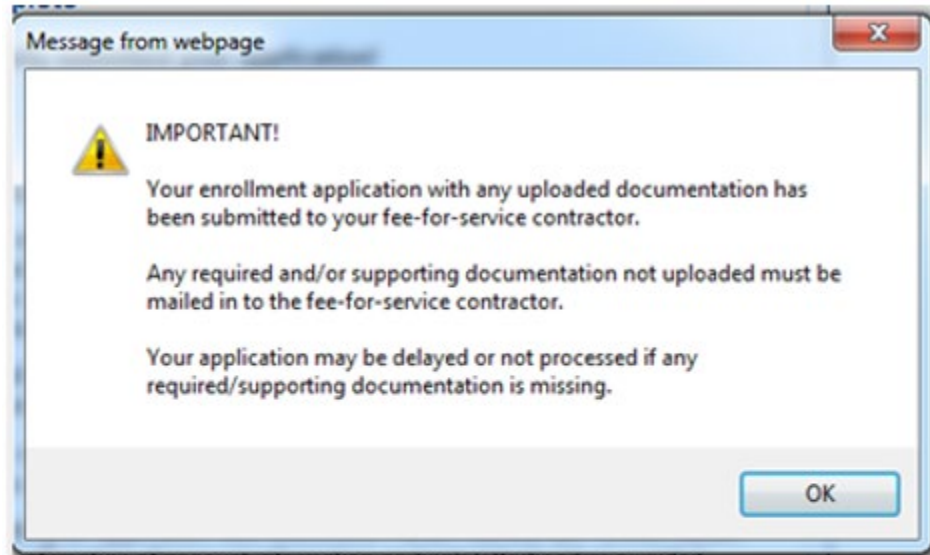
If you wish to upload a document or change the delivery method for a document prior to submitting this application, please select the Cancel button and return to the Required and/or Supporting Documentation topic.

Documentation Requiring Signatures: MUST E-SIGN or UPLOAD	View and Print Documentation	Comments
<input checked="" type="checkbox"/> Authorized Official Certification Statement for Clinics and Group Practices [PDF]	<a href="#">View and Print [PDF]</a>	<p><b>Note:</b> Please do not mail a signed Certification Statement. Signature documents must be either e-signed or uploaded.</p>
Optional Documentation	Delivery Method	Comments
<input checked="" type="checkbox"/> Other Documentation requested by your Medicare Contractor(s)	Unspecified	<p><b>Note:</b> Documents in PDF format require the <a href="#">Adobe Acrobat Reader®</a> . If you experience problems with PDF documents, please <a href="#">download the latest version of the Reader®</a> .</p>

PREVIOUS PAGE
COMPLETE SUBMISSION

CANCEL

# Submission Confirmation



My Application Progress  100%

## Submission Confirmation - Print Your Receipt

### Submission Complete

You have successfully submitted your application!

#### Remember to:

- Make sure all required and supporting documents that require a signature are signed.
- Mail all required and supporting documents that has not been uploaded to your Medicare Contractor within 15 days of submitting the electronic part of your application. Your application is not complete until the Medicare Contractor(s) receives the signed required documentation of your application in the mail.
- Any required and/or supporting documentation not uploaded must be mailed in to the fee-for-service contractor.
- Your application may be delayed or not processed if any required/supporting documentation is missing.
- If you are submitting an application with Electronic Funds Transfer (EFT) Information, please include confirmation of account information on bank letterhead or a voided check.
- Print this page for your records. **Note:** You can print and/or save copies of the application and required documents for your records by visiting the "My Enrollments" page.
- You will receive e-mails about your application status. Make sure to add "customerservice-donoreply@cms.hhs.gov" to your safe sender list.

You have successfully submitted your application!

# Respond to E-Signature Email



# Email

Mon 12/13/2021 2:58 PM  
customerservice-donotreply@cms.hhs.gov  
PECOS Electronic Signature Request

DONALD DUCK,

A Medicare application for DONAL DUCK LLC for Reassignment has been submitted by application for which CMS allows you to provide an electronic signature using the instructions below. Please disregard this email if you have already submitted a signature. You have been identified as an authorized signer for this application.

**Enrollment Application Information:**  
Provider/Supplier Name Group Name  
Provider/Supplier Specialty Type: CLINIC/GROUP PRACTICE  
State: RI  
Form Type: AUTHORIZATION STATEMENT FOR ORGANIZATIONS (855R)  
Practice Location , RI 029041824  
NPI: -----  
Web Tracking ID:  
Signatory Name: DONALD DUCK  
Signatory Role: AUTHORIZED OFFICIAL  
Topic/s Changed: Reassignment

**The email will provide 2 options for e-signing the application:**  
1. Log into Internet-based PECOS using your existing PECOS ID and password  
2. E-sign via the PECOS e-signature website if you don't have an existing PECOS ID and password

**Instructions:**  
You may provide an electronic signature using your PECOS user ID at ([https://urldefense.com/v3/https://pecos.cms.hhs.gov/!!IZ3IH8c1kfqmU5O9gm\\_J0tUE0IFnXqFbO2V8cBID9bmSEESXKJAsZL23LYqFqUz37DeaFkkvXQ\\$](https://urldefense.com/v3/https://pecos.cms.hhs.gov/!!IZ3IH8c1kfqmU5O9gm_J0tUE0IFnXqFbO2V8cBID9bmSEESXKJAsZL23LYqFqUz37DeaFkkvXQ$)) OR through the PECOS E-Signature website ([https://urldefense.com/v3/https://pecos.cms.cmsval/pecos/eSign/opin.do/!!IZ3IH8c1kfqmU5O9gm\\_J0tUE0IFnXqFbO2V8cBID9bmSEESXKJAsZL23LYqFqUz37DebtYbf0\\$](https://urldefense.com/v3/https://pecos.cms.cmsval/pecos/eSign/opin.do/!!IZ3IH8c1kfqmU5O9gm_J0tUE0IFnXqFbO2V8cBID9bmSEESXKJAsZL23LYqFqUz37DebtYbf0$)), using your identifying information, e-mail address, and unique PIN : xxxxxxxx Continue to the 'Pending Signatures' section and locate the respective enrollment application to review and apply your E-Signature.

Please note the PIN is valid for 14 days from the time the submitter completed the application. If 14 days or more have elapsed, you can access the PECOS E-Signature website to request a new PIN or contact the submitter identified above.

This email message is an automated notification. Do not reply to this message as it is sent from an unmonitored account. If you require assistance at any point in the process, please call PECOS External User Services (EUS) at: 1-866-484-8049/TTY: 1-866-523-4759 or visit us at ([https://urldefense.com/v3/https://eus.custhelp.com/!!IZ3IH8c1kfqmU5O9gm\\_J0tUE0IFnXqFbO2V8cBID9bmSEESXKJAsZL23LYqFqUz37DeF\\_5utgQ\\$](https://urldefense.com/v3/https://eus.custhelp.com/!!IZ3IH8c1kfqmU5O9gm_J0tUE0IFnXqFbO2V8cBID9bmSEESXKJAsZL23LYqFqUz37DeF_5utgQ$)).

Unauthorized interception of this communication could be a violation of Federal and State Law. This communication and any files transmitted with it are confidential and may contain protected health information. This communication is solely for the use of the person or entity to which it was addressed. If you are not the intended recipient, any use, distribution, printing or acting in reliance on the contents for this message is strictly prohibited. If you have received this message in error, please notify the sender and destroy all copies of the message.

# E-Signature – PECOS

**Welcome** [User Name]

**Release Notes**

Want to learn what's new in the latest PECOS release? Please review the [Release Notes\(PDF\)](#).

**System Notifications**

**Note:** JavaScript must be enabled in your internet browser for PECOS to work properly. If JavaScript is currently disabled in your browser, refer to the Accessibility section in PECOS Help for instructions on enabling JavaScript.

**Details**

- There are no notifications at this time.

**Manage Medicare and Account Information**

**MY ASSOCIATES** [2]

- Enroll in Medicare for the first time
- View and update existing Medicare information
- Continue working on saved applications

**ACCOUNT MANAGEMENT** [2]

- Update your user account information, request or remove access to organizations
- Manage access to Medicare enrollments

**REVALIDATION NOTIFICATION CENTER** [3]

- View All Applications requiring revalidation
- Start or continue revalidation application

**Manage Signatures**

**Applications Requiring Signatures**

Applicant Name: [Redacted]  
TIN (EIN): [Redacted]  
Web Tracking ID: [Redacted]  
Form Type: 855R  
Application Submitted: 02/21/2018  
Organization:  
Role: AUTHORIZED OFFICIAL  
Document: AUTHORIZATION STATEMENT FOR ORGANIZATIONS (855R)

[VIEW AND SIGN](#) [2]

[VIEW ALL SIGNATURES](#) [3]

# E-Signature – PIN

- Provider/AO or DO
- First and last name
- Date of birth
- SSN
- Telephone
- Email
- PIN

The screenshot shows a web form titled "Welcome to PECOS E-Signature Application". A red asterisk indicates a required field. The page is a "Remote Authentication Page" and contains a warning message. Below the warning, there is a section for "Verify Your Identity and Validate Your Application Record" which asks the user to "Enter the required Identity information:". This section includes input fields for First Name, Last Name, Date of Birth (with a MM/DD/YYYY format hint), and SSN (with a "No Format Required" note). Below this, there is a section for "Enter the email address and PIN you received in the PECOS emails:" with input fields for Email Address and PIN. A "LOG IN" button is located at the bottom right of the form area. A link is provided at the bottom of the page: "If your PIN is lost or expired, click here to generate a new one."

# View and Sign

Welcome [Redacted]

**Signatures**

**Applications Requiring Signatures**

Applicant Name:  
Organization:  
TIN (EIN):  
Web Tracking ID:  
Form Type: 855R  
Role: AUTHORIZED OFFICIAL  
Document: AUTHORIZATION STATEMENT FOR ORGANIZATIONS (855R) **VIEW AND SIGN**  
Application Submitted: 02/21/2018

**Documents Signed in the Last 30 Days**

No signature completed in the last 30 days

**RETURN TO HOME**

**Review And Sign Your Document** (\*) Red asterisk indicates a required field.

**E-Signature Instructions**

To complete your E-Signature follow the steps below:

1. [Click here if you wish to review the application](#)
2. View and read the terms and conditions for the applicable document(s) that you wish to e-sign.
3. Check the box if you agree with the terms and conditions
4. Click the Submit button to complete your E-Signature

**Terms and Conditions**

**PENALTIES FOR FALSIFYING INFORMATION**

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

**AUTHORIZATION STATEMENT FOR ORGANIZATIONS (855R)**

The signatures below authorize the reassignment of benefits to a supplier or the termination of a reassignment of benefits to a supplier, as indicated in Section 1, Title XVIII of the Social Security Act

\* Do you accept the Terms and Conditions?

Yes, I agree to the certification statement terms and conditions. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my traditional handwritten signature.

**SUBMIT**

**CANCEL**


# Confirmation Page

### E-Signature Confirmation

**Your E-Signature Has Been Accepted**

You have successfully e-signed the following document(s):

**Web tracking ID:**


[View Submitted Application](#) 

**Signer Name:**

**Role:** AUTHORIZED OFFICIAL

**Document:** AUTHORIZATION STATEMENT FOR ORGANIZATIONS (855R)

**Signed Date:** Wed Feb 21 13:25:51 EST 2018

[HOME](#) 

# Manage Signatures, Verify Completion

# Select View/Manage Reassignments

## Existing Enrollments

Contractor: NATIONAL GOVERNMENT SERVICES, INC.  
State: NEW YORK  
Type/Specialty: CLINIC/GROUP PRACTICE

[VIEW](#)

[REVALIDATE](#)

[MORE OPTIONS](#)

Enrollment Type: 855B

Medicare ID: [View Medicare ID Report](#)

Status: APPROVED [View Approved Enrollment Record](#)

Current ADI Accreditation?: No

Revalidation Status: Revalidation Due i

[Sample Revalidation Notice](#)

Revalidation Due Date: 02/28/2017

Practice Location: ROCHESTER, NY

Existing Reassignments: 2

Pending Reassignments Applications: 0

[View/Manage Reassignments](#)



# Verify Signature

The screenshot displays the Medicare Enrollment system interface for providers and suppliers. The main heading is "Medicare Enrollment for Providers and Suppliers". In the top right corner, there are links for "Home", "Help", and "Log Out", along with "CMS Validation". The breadcrumb trail indicates the user is in "Home > My Associates > My Enrollments > View/Manage Reassignments".

The primary section is "View/Manage Reassignments", which contains a sub-section for "Pending Reassignments Applications". This section features a table titled "Pending Reassignments Applications Details" with the following columns: Name/LBN, NPI, Status, Tracking ID, and Action.

Name/LBN	NPI	Status	Tracking ID	Action
XXXX XXXXX		PENDING E-SIGNATURES <a href="#">View Pending E-Signatures Application</a>		<a href="#">MANAGE SIGNATURES</a> <a href="#">CORRECT &amp; RE-SUBMIT</a>
XXX XXXXX		PENDING E-SIGNATURES <a href="#">View Pending E-Signatures Application</a>		<a href="#">MANAGE SIGNATURES</a> <a href="#">CORRECT &amp; RE-SUBMIT</a>

Two red arrows point to the "MANAGE SIGNATURES" and "CORRECT & RE-SUBMIT" buttons in the Action column of the table.

Below the table is a "Reassignments Report" section with the sub-heading "Filter Reassignment Records". It includes a note: "Please provide one or more of the following options to filter the enrollments. Selecting the reset button will clear the options selected and load the full list of enrollments." There are three dropdown menus: "Reassignment Status" (set to "All Statuses"), "Enrollment Status" (set to "All Statuses"), and "Relationship Status" (set to "All Relationships"). Below these are "FILTER" and "RESET" buttons.

At the bottom of the report section, it states: "You currently do not have any Existing Reassignments." There are two buttons at the very bottom: "RETURN TO MY ENROLLMENTS" on the left and "MANAGE REASSIGNMENTS" on the right.



# Signature Status

**Manage Signatures**

Name: TIN: XXX-XX-XXXX  
Web Tracking ID: NPI:

**NEW!** - Any Authorized or Delegated Officials with an ITIN will not be able to submit electronic signatures. Authorized or Delegated Officials with an ITIN entered on this application **must now upload their signature documents**.

Name: SSN: XXX-XX-XXXX Signature Method: ELECTRONIC Email: test@.com	Role: PRACTITIONER Document: AUTHORIZATION STATEMENT FOR INDIVIDUAL PRACTITIONERS (855R) Status: Pending
---	--

[UPDATE](#) [RE-SEND EMAIL](#)

Name: Organization: Family Practice LLC SSN: XXX-XX-XXXX Signature Method: ELECTRONIC Email:	Role: AUTHORIZED OFFICIAL Document: AUTHORIZATION STATEMENT FOR ORGANIZATIONS (855R) Status: Complete Date: 08/03/2018
--	---

[UPDATE](#) [RE-SEND EMAIL](#)

Medicare Supplier Enrollment Application  
Privacy Act Statement for Individual Practitioners

[RETURN TO MY ENROLLMENTS](#)

**Manage Signatures**

Name: FAMILY PRACTICE LLC TIN: ;  
Web Tracking ID:

**NEW!** - Any Authorized or Delegated Officials with an ITIN will not be able to submit electronic signatures. Authorized or Delegated Officials with an ITIN entered on this application **must now upload their signature documents**.

Name: Organization: SSN: XXX-XX-XXXX Signature Method: ELECTRONIC Email: nppes.test@yahoo.com	Role: AUTHORIZED OFFICIAL Document: AUTHORIZATION STATEMENT FOR ORGANIZATIONS (855R) Status: Complete Date: 09/26/2018
---	---

Name: SSN: XXX-XX-XXXX Signature Method: UPLOAD	Role: PRACTITIONER Document: AUTHORIZATION STATEMENT FOR INDIVIDUAL PRACTITIONERS (855R) Status: Pending
---	--

**Note:** One or more signature documents have not been uploaded. To upload a signature document or change the signature method, please select the Update button for the appropriate document(s).

[UPDATE](#)  
Medicare Supplier Enrollment Application  
Privacy Act Statement for Clinics and Group Practices

[RETURN TO MY ENROLLMENTS](#)

# Upload

Home > My Associates > My Enrollments > Signatures

### Electronic Signature Status

(\*) Red asterisk indicates a required field.

**Information**

- Upload Certification was successfully added.

**Update Signature Record**

**NEW!** - Any Authorized or Delegated Officials with an ITIN will not be able to submit electronic signatures. Authorized or Delegated Officials with an ITIN entered on this application must now upload their signature documents.

**Name**

**Role**  
AUTHORIZED OFFICIAL

**Document**  
AUTHORIZATION STATEMENT

**E-Sign Status**  
Pending

**Selected Signature Method**  
Upload

**Update Signature Method to:**

Electronic

The following documents can be used to upload a signature:

- Signature page from the corresponding Medicare provider/supplier enrollment application form available on the CMS website.
- Signature page from the Required/Supporting Documentation topic, or from the My Enrollments Page select this application then select View > View Printable Certification

To upload a signature document now, browse for the file then select the Upload button.

File Name: [This is void check.pdf](#)  
Date Uploaded: 09/28/2018

# Process After Submission

# After Submission

- Contact person on application will receive by email
  - Acknowledgement Notice
    - Add to safe sender list
      - [customerservice-donotreply@cms.hhs.gov](mailto:customerservice-donotreply@cms.hhs.gov)
      - [NGS-PE-Communications@elevancehealth.com](mailto:NGS-PE-Communications@elevancehealth.com)
  - Development requests for additional information
    - Respond within 30 days
    - Log into PECOS to make necessary corrections or upload the required documents, verify and manage signatures
  - Response letter
    - Rejection letter for incomplete/no response to development request
    - Approval

# After Submission Reminder

- Update Individual Enrollment Record
  - Correspondence address
  - Contact information

Check Application Status

# Check Application Status PECOS

- [PECOS](#)
- Helpful Links
  - Application Status

**Medicare Enrollment**  
for Providers and Suppliers

Welcome to the Medicare Provider Enrollment, Chain, and Ownership System (PECOS)

(\*) Red asterisk indicates a required field.

PECOS supports the Medicare Provider and Supplier enrollment process by allowing registered users to securely and electronically submit and manage Medicare enrollment information.

New to PECOS? View our [videos](#) at the bottom of this page.

**USER LOGIN**

You may use your NPPES or PECOS username and password to login.

\* User ID

\* Password

**LOGIN**

[Forgot Password?](#)

[Forgot User ID?](#)

[Manage/Update User Profile](#)

[Who Should I Call? \[PDF, 155KB\]](#) - CMS Provider Enrollment Assistance Guide

**BECOME A REGISTERED USER**

You may register for a user account if you are: an Individual Practitioner, Authorized or Delegated Official for a Provider or Supplier Organization, or an individual who works on behalf of Providers or Suppliers.

[Register for a user account](#)

Questions? [Learn more about registering for an account](#)

**Note:** If you are a Medical Provider or Supplier, you must register for an NPI before enrolling with Medicare.

**Helpful Links**

[Application Status](#) - Self Service Kiosk to view the status of an application submitted within the last 90 days.

[Pay Application Fee](#) - Pay your application fee online.

[View the list of Providers and Suppliers \[PDF, 94KB\]](#) who are required to pay an application fee.

# Check Application Status Tool

- Go to [our website](#) > Resources > Tools & Calculators > [Check Provider Enrollment Application Status](#)

The screenshot shows a web interface for checking the status of a CMS-855 enrollment application. At the top, there is a breadcrumb trail: 'Resources > Tools & Calculators'. Below this is a blue header with the title 'CHECK PROVIDER ENROLLMENT APPLICATION STATUS'. The main content area contains the following text: 'This inquiry tool can be used to check on the status of your CMS-855 enrollment application.' followed by 'How to Search' and 'To perform a search please enter into a field below either a valid case number/web tracker ID (Option 1) or a valid National Provider Identifier (NPI) and last five digits of the Tax Identification Number (TIN) combination (Option 2)'. There are two input sections: 'Option 1' with a single text box labeled 'Case Number / Web Tracker Id', and 'Option 2' with two stacked text boxes labeled 'NPI' and 'TIN (last five digits)'. At the bottom, there are two buttons: a dark blue 'Submit' button and a white 'Clear' button with a blue border.



# Check Application Status: IVR System

- IVR system
  - [Our website](#) > Resources > Contact Us > Interactive Voice Response System
  - IVR will request following information after selecting Provider Enrollment
    - Case number/web tracker ID; or
    - National Provider Identifier (NPI) and Tax Identification Number (TIN of group) or Social Security Number (SSN of individual)

# Resources

# Online Account Self-Service Features

Welcome to the Medicare Provider Enrollment, Chain, and Ownership System (PECOS)

(\*) Red asterisk indicates a required field.

PECOS supports the Medicare Provider and Supplier enrollment process by allowing registered users to securely and electronically submit and manage Medicare enrollment information.

New to PECOS? View our [videos](#) at the bottom of this page.

### USER LOGIN

Please use your I&A (Identity & Access Management System) user ID and password to log in.

\* User ID

\* Password

[LOG IN](#)

[Forgot Password?](#)

[Forgot User ID?](#)

[Manage/Update User Profile](#)

[Who Should I Call? \[PDF, 155KB\]](#) - CMS Provider Enrollment Assistance Guide

### BECOME A REGISTERED USER

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[Register for a user account](#)

Questions? [Learn more about registering for an account](#)

**Note:** If you are a Medical Provider or Supplier, you must [register for an NPI](#) before enrolling with Medicare.

### Helpful Links

[Application Status](#) - Self Service Kiosk to view the status of an application submitted within the last 90 days.

**Important Note:** CMS is using its authority under Section 1135 of the Social Security Act to waive the application fee for any applications submitted on or after March 1, 2020 in response to COVID-19. Please do not submit an application fee with your application. For more information on provider enrollment flexibilities related to COVID-19, please visit the [CMS website \[PDF\]](#).

[Pay Application Fee](#) - Pay your application fee online.

[View the list of Providers and Suppliers \[PDF, 94KB\]](#) who are required to pay an application fee.

[E-Sign your PECOS application](#) - Access the PECOS E-Signature website using your identifying information, email address, and unique PIN to electronically sign your application.

# Internet-Based PECOS Tutorials

## Enrollment Tutorials


- **Initial Enrollment:**  
Step-by-step demonstration of an initial enrollment application in PECOS.  
[Individual Provider - WMV \[ZIP, 52MB\]](#) or [Organization/Supplier - WMV \[ZIP, 53MB\]](#)
- **Change of Information:**  
Step-by-step demonstration of how to update or change information for an existing enrollment already on file with CMS.  
[Individual Provider - WMV \[ZIP, 46MB\]](#) or [Organization/Supplier - WMV \[ZIP, 48MB\]](#)
- **Revalidation:**  
Step-by-step demonstration on how to submit your revalidation application using PECOS.  
[Individual Provider - WMV \[ZIP, 29MB\]](#) or [Organization/Supplier - WMV \[ZIP, 32MB\]](#)
- **Deactivated:**  
Example of how to deactivate an existing enrollment record.  
[Individual Provider - WMV \[ZIP, 11MB\]](#)
- **Reactivation:**  
Step-by-step demonstration of how to re-enroll based on enrollment information that already exists in PECOS.  
[Organization/Supplier - WMV \[ZIP, 39MB\]](#)
- **Adding a Practice Location (DMEPOS Only):**  
Demonstration of how to add a new practice location for DMEPOS supplier who is already enrolled with CMS.  
[DME Supplier - WMV \[ZIP, 64MB\]](#)

# Resources


For Assistance With	Contact	Contact Information
<ul style="list-style-type: none"><li>• Changing an NPPES password</li><li>• Establishing a new user ID and password for NPPES</li><li>• Questions related to the NPI application</li></ul>	NPI Enumerator	Phone: 800-465-3203 TTY: 800-692-2326 Email: <a href="mailto:customerservice@npienumerator.com">customerservice@npienumerator.com</a>
<ul style="list-style-type: none"><li>• Errors encountered while accessing or entering information in PECOS</li><li>• Forgotten PECOS user IDs and passwords</li></ul>	EUS Help Desk	Phone: 866-484-8049 TTY: 866-523-4759 Email: <a href="mailto:EUSSupport@cgi.com">EUSSupport@cgi.com</a> Live Chat: <a href="https://eus.custhelp.com/">https://eus.custhelp.com/</a>

# NGS Website

Contact Us NGSConnex Subscribe for Email Updates Part A Provider in Connecticut ( JK ) ▾

 national government SERVICES

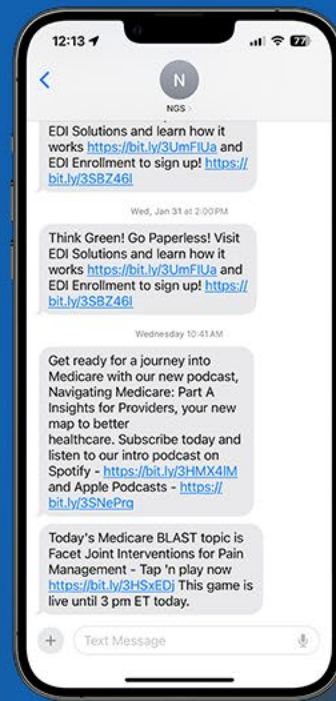
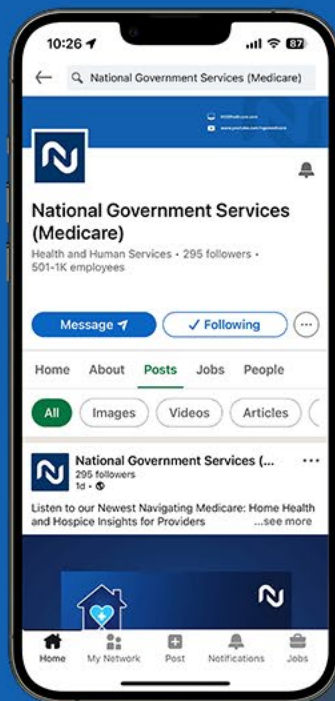
HOME EDUCATION ▾ RESOURCES ▾ EVENTS ENROLLMENT APPS ▾



## Mailing Addresses

For ADRs, claims, EDI, FOIA, medical policy, enrollment, or other inquiries.

## Provider Enrollment



# Connect with us on social media



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[www.MedicareUniversity.com](http://www.MedicareUniversity.com)  
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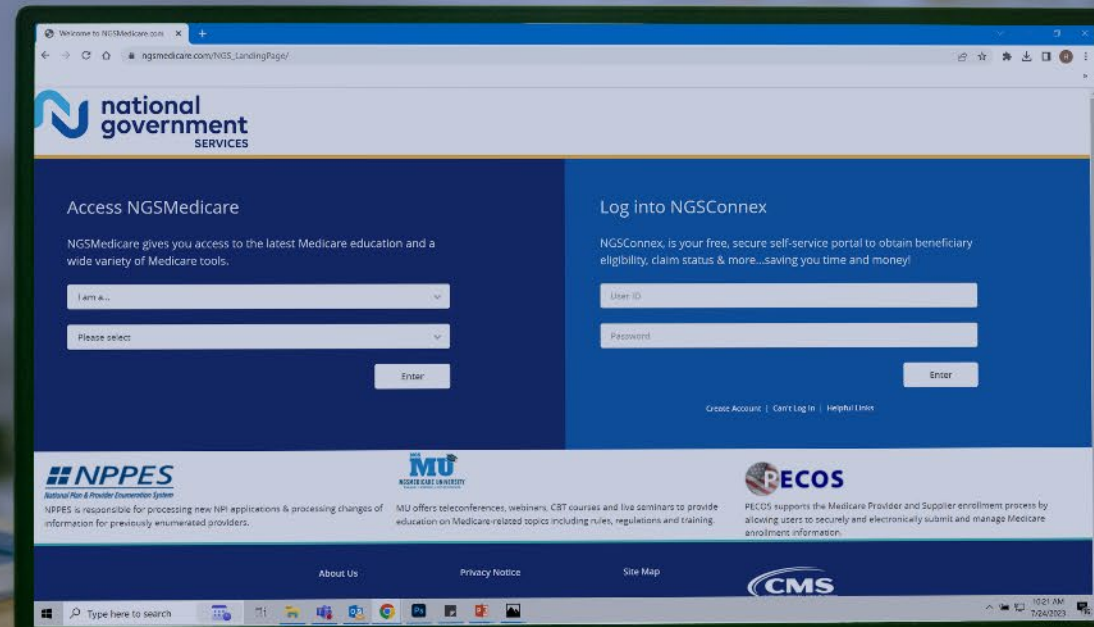
medicare **mobile**

Text NEWS to 37702; Text GAMES to 37702



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# Find us online



[www.NGS Medicare.com](http://www.NGS Medicare.com)

Online resources, event calendar, LCD/NCD, and tools



IVR System

The interactive voice response system (IVR) is available 24-hours a day, seven days a week to answer general inquiries



[NGSConnex](#)

Web portal for claim information



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# Questions?

Thank you!