

# Provider Enrollment: Opioid Treatment Program

8/19/2024

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



# Agenda

- [Overview](#)
- [Enroll in Medicare](#)
- [Supporting Documents](#)
- [Process after Submission](#)
- [Check Application Status](#)
- [Contact Information](#)
- [Resources](#)

# Overview

# Overview Part B

- Part B OTP provider
  - Beginning 1/1/2020, Part B benefit for Medicare beneficiaries with OUD
  - Submit claims via 837P transaction to transmit health care electronically, or CMS-1500 form
  - HCPCS Codes G1028, range G2067–G2080 and G2215 to G2216
  - Place of Service 58 – Nonresidential Opioid Treatment Facility
  - CMS pays OTPs through bundled payments for OUD treatment services in an episode of care provided to people with Medicare Part B (Medical Insurance)
  - [Opioid Treatment Programs \(OTPs\) Medicare Billing and Payment](#)
  - NGS [Coding and Billing for OTP Services](#) Web Page

# Overview Part A

- Part A OTP provider
  - Beginning 1/1/2021, Medicare Part B covers hospital outpatient OTP services
  - Submit claims via 837I transaction to transmit health care electronically or CMS-1450 form
  - HCPCS codes G1028, range G2067 – G2080 and G2215 to G2216
  - Type of bill code Freestanding Nonresidential Opioid Treatment Programs (087x)
  - Hospital-based providers bill OTP services on TOB 013X and 085X
  - Condition code for a provider-based OTP (89) CMS pays OTPs through bundled payments for OUD treatment services in an episode of care provided to people with Medicare Part B (Medical Insurance)
  - [Opioid Treatment Programs \(OTPs\) Medicare Billing and Payment](#)
  - NGS [Coding and Billing for OTP Services](#) Web Page



# Overview Requirements

- [Certified by the Substance Abuse and Mental Health Services Administration \(SAMHSA\)](#)
- State Operation License
- Registration through the local Drug Enforcement Administration office
- [CMS-1561 Provider Agreement](#) signed by an authorized official

# Overview

- NPI
  - Separate NPI for OTP services (optional)
- Select “OTP” specialty or “Other,” type “Opioid Treatment Provider”
- Application fee required
- Revalidate every five years
- [Opioid Treatment Programs \(OTPs\) Medicare Enrollment](#)
- Part A enrollments for provider-based billing, after the OTP enrollment is approved the OTP then must add the OTP location on the Hospital’s enrollment record by submitting a change of information application to add the OTP practice locations with the OTP NPI and PTAN for proper billing

Enroll In Medicare

# Enroll In Medicare Paper

- Submit via CMS-855 Paper Application
  - [CMS-855A](#) (Institutional Providers)
  - [CMS-855B](#) (Clinics/Group Practices and Certain Other Suppliers)
  - [CMS-588](#) (EFT Authorization Agreement)
- [Opioid Treatment Programs \(OPTs\) Medicare Enrollment](#)
- Mailing addresses
  - [NGS website](#) > Resources > Contact Us > Mailing Addresses > Business Function (Provider Enrollment)

# Enroll In Medicare PECOS

- Submitting via internet-based [PECOS](#)
  - User ID and password
  - Access to enrollment records
  - Enroll as OTP Part A or B provider, but not both
  - Upload supporting documentation function
  - E-Signature/Upload signed and dated certification statement

# PECOS 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.

#### SYSTEM NOTIFICATIONS

- PECOS users are no longer able to mail documents that require a signature. When submitting your application, be prepared to provide an e-signature or upload your documents that require a signature.
- To better protect your identity and information, PECOS will be implementing Multi-Factor Authentication (MFA) in April 2020. If you have not setup your MFA account already, please navigate to the following [site](#) to setup your account.

#### 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

The screenshot displays a user interface for managing associates. It features a 'Welcome' header, a 'Release Notes' section with a link to a PDF, and a 'Manage Medicare and Account Information' section. This section contains two main buttons: 'MY ASSOCIATES' and 'ACCOUNT MANAGEMENT', each with a list of actions. Below these is a 'REVALIDATION NOTIFICATION CENTER' button with its own list of actions. The bottom section is 'Manage Signatures', which includes a sub-section for 'Applications Requiring Signatures' and a message stating 'You currently have no pending signatures.' with a 'VIEW ALL SIGNATURES' button.

**Welcome**

**Release Notes**

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

**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 Enrollment

### 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

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

**Associate Legal Business Name**  
  
TIN  
XXX-XX-XXXX

**Associate Last Name**  
  
NPI  
10 Digits

**Associate First Name**  
  
State  
All States

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

#### Organizations

Records 1 - 1 of 1

Name: ABC CARE TIN:

Records 1 - 1 of 1



# 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](#)

## Existing Enrollments

**Contractor:** NATIONAL GOVERNMENT SERVICES, INC. [VIEW](#)

**State:** [REVALIDATE](#)

**Type/Specialty:** Hospital [MORE OPTIONS](#)

**Enrollment Type:** 855A

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

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

**Practice Location:**

**Existing Reassignments:** 0

**Pending Reassignments Applications:** 0

[View/Manage Reassignments](#)

**Contractor:** NATIONAL GOVERNMENT SERVICES, INC. [VIEW](#)

**State:** [MORE OPTIONS](#)

**Type/Specialty:** FEDERALLY QUALIFIED HEALTH CENTER (FQHC) [MORE OPTIONS](#)

**Enrollment Type:** 855A

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

**Status:** DEACTIVATED [View Deactivated Enrollment Record](#)

**Existing Reassignments:** 0

**Pending Reassignments Applications:** 0

[View/Manage Reassignments](#)

# Application Questionnaire

**Application Questionnaire**

(\*) Red asterisk indicates a required field.

**Healthcare Services Rendered**

\* Please select the option that best represents the healthcare service rendered for this application.

- Institutional Provider (e.g., Hospital, Skilled Nursing Facility, Hospice, Home Health Agency)
- Clinics/Group Practices and Certain Other Suppliers (e.g., Ambulance Service Supplier, Clinic, Independent Diagnostic Testing Facility, Sole Owner of a Professional Association (PA), Professional Corporation (PC), or Limited Liability Corporation (LLC))
- Durable Medicare Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
- Medicare Diabetes Prevention Program Supplier (MDPP)

[NEXT PAGE](#)

[CANCEL](#)

**Application Questionnaire**

(\*) Red asterisk indicates a required field.

**State/Territory Where Healthcare Services Rendered**

Please select a single state/territory where the applicant renders healthcare services.

\* **State/Territory**

Select State/Territory

[NEXT PAGE](#)

# Part B

### Application Questionnaire

(\*) Red asterisk indicates a required field.

#### Primary Medicare Services Rendered

**Note:** A separate application is required for each primary healthcare service rendered.

\* Please select the primary Medicare Services rendered by the applicant.

Part B Supplier Services

Select Supplier Type ▼

Undefined Type Specification

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

#### Select Supplier Type

- AMBULANCE SERVICE SUPPLIER
- AMBULATORY SURGICAL CENTER
- CENTRALIZED FLU BILLER
- CLINIC/GROUP PRACTICE
- HOSPITAL DEPARTMENT(S)
- INDEPENDENT CLINICAL LABORATORIES (CLIA)
- INDEPENDENT DIAGNOSTIC TESTING FACILITY (IDTF)
- INTENSIVE CARDIAC REHABILITATION
- INTERVENTIONAL CARDIOLOGY
- MAMMOGRAPHY SCREENING CENTER
- MANAGED CARE PLAN (NON-MEDICARE + CHOICE)
- MASS IMMUNIZATION (ROSTER BILLER ONLY)
- MEDICAL FACULTY PRACTICE PLAN
- MEDICARE + CHOICE ORGANIZATION
- OPIOID TREATMENT PROGRAM (OTP)
- OTHER
- OTHER MEDICAL CARE GROUP
- PART B CAP DRUG VENDOR
- PHARMACY
- PHYSICAL/OCCUPATIONAL THERAPY GROUP IN PRIVATE PRACTICE
- PORTABLE X-RAY SUPPLIER
- PUBLIC HEALTH/WELFARE AGENCY
- RADIATION THERAPY CENTER
- SLEEP LABORATORY/MEDICINE
- SPORTS MEDICINE
- VOLUNTARY HEALTH/CHARITY AGENCY

### Application Questionnaire

(\*) Red asterisk indicates a required field.

#### IHS Provider

\* Is the applicant an Indian Health Service (IHS) facility?

Yes

No

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

# Part A

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

**Primary Medicare Services Rendered**

**Note:** A separate application is required for each primary healthcare service rendered.

\* Please select the primary Medicare Services rendered by the applicant.

Part A Provider Services

Select Provider Type

Undefined Type Specification

- Select Provider Type
- COMMUNITY MENTAL HEALTH CENTER
  - COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY
  - CRITICAL ACCESS HOSPITAL
  - END-STAGE RENAL DISEASE FACILITY (ESRD)
  - FEDERALLY QUALIFIED HEALTH CENTER (FQHC)
  - HISTOCOMPATIBILITY LABORATORY
  - HOME HEALTH AGENCY
  - HOSPICE
  - HOSPITAL
  - INDIAN HEALTH SERVICES FACILITY
  - ORGAN PROCUREMENT ORGANIZATION (OPO)
  - OTHER
  - OUTPATIENT PHYSICAL THERAPY/OCCUPATIONAL THERAPY/SPEECH PATHOLOGY SERVICES
  - RELIGIOUS NON-MEDICAL HEALTH CARE INSTITUTION (RNHC)
  - RURAL HEALTH CLINIC
  - SKILLED NURSING FACILITY

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

**Change of Ownership**

\* Is the facility where the services are provided currently enrolled under a different tax identification number?

Yes

No

# 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 enrolling in the Medicare program for the first time.


The application is for:


Legal Business Name	Tax Identification Number (TIN)	Supplier Type	State
ABC CARE		OPIOID TREATMENT PROGRAM (OTP)	

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 for processing
- An Authorized Official representing the supplier 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)
- The Medicare enrollment is finalized 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 15

Enrollment ID:  
PaclID:  
Web Tracking ID:

**Reason for Application**

Supplier is Enrolling in Medicare for the First Time

**Reports**

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

**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="#">Organization Information</a> <span style="font-size: small;">+ more information about Organization Information</span>
✓	<a href="#">Supplier Type</a> <span style="font-size: small;">+ more information about Supplier Type</span>
—	<a href="#">PAR Status Information</a> <span style="font-size: small;">+ more information about PAR Status Information</span>
—	<a href="#">Physical Location and "Special Payments" Address</a> <span style="font-size: small;">+ more information about Physical Location and "Special Payments" Address</span>
—	<a href="#">Vehicle Information</a> <span style="font-size: small;">+ more information about Vehicle Information</span>
— N/A	<a href="#">Geographic Location</a> <span style="font-size: small;">+ more information about Geographic Location</span>
—	<a href="#">Rendering Healthcare Services at a Patient's Home</a> <span style="font-size: small;">+ more information about Rendering Healthcare Services at a Patient's Home</span>

- [Correspondence Address](#) + more information about Correspondence Address
- [License and Certification Information](#) + more information about License and Certification Information
- [Final Adverse Legal Actions](#) + more information about Final Adverse Legal Actions
- [Organization Control](#) + more information about Organization Control
- [Individual Control](#) + more information about Individual Control
- [Patient Records Storage Location](#) + more information about Patient Records Storage Location
- [Billing Agency/Agent](#) + more information about Billing Agency/Agent
- ✓ [Contact Person](#) + more information about Contact Person
- [Electronic Funds Transfer](#) + more information about Electronic Funds Transfer
- [Required and/or Supporting Documentation](#) + more information about Required and/or Supporting Documentation

**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

# Organization Information

### Organization Information

#### Topic Summary

This topic requests information about the provider's corporate information. Organization data includes information about the organization's other name, corporate structure type, and incorporation information. [\(more information about Organization Information\)](#)

**ADD INFORMATION >>**

#### Organization Information

No Organization Information has been listed. Please click "Add Information" above.

**RETURN TO TOPICS**   **GO TO ERROR CHECK >>**   **NEXT TOPIC >>**

### Organization Information

(\*) Red asterisk indicates a required field.

#### Provider Identity for Institutional Providers, Clinics, Group Practices, DMEPOS Suppliers, and MDPP Suppliers

Legal Business Name: ABC CARE **EDIT LBN**

Tax Identification Number (TIN):

Other Name

Type of Other Name  
Select Type Of Other Name

Other(Specify)

Are you an Indian Health Service (IHS) facility?

Yes

No

**NEXT PAGE >**

**CANCEL**

# Organization Information

### Organization Information

#### IRS Proprietary/Non-Profit Status

Note: If your business is a Federal and/or State government provider or supplier, indicate "Non-Profit" below.

Identify how your business is registered with the IRS

Proprietary

Non-Profit

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

### Organization Information

(\*) Red asterisk indicates a required field.

#### Organization Structure for Institutional Providers and Clinics/Group Practices

Incorporation Date  
  
MM/DD/YYYY

State Where Incorporated

\* Type of Organization Structure

Other(Specify)

[< PREVIOUS PAGE](#) [SAVE >](#)



# Organization Information Summary

## Organization Information

**Information**

- Organization Information was successfully added.

**Topic Summary**

This topic requests information about the provider's corporate information. Organization data includes information about the organization's other name, corporate structure type, and incorporation information. [+ \(more information about Organization Information\)](#)

**Organization Information**

**ABC CARE**

Type of Organization Structure: Corporation  
IRS Proprietary/Non-Profit Status: Non-Profit  
Incorporation Date: 01/01/2020  
State Where Incorporated:  
Indian Health Facility: No

[EDIT](#)

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

# Supplier Type

## Supplier Type

**Topic Summary**

The supplier type for this enrollment is listed below for your reference. No further information is required for this topic. [+ \(more information about Supplier Type\)](#)

**Supplier Type Information**

**Supplier Type**

OPIOID TREATMENT PROGRAM (OTP)

[<< PREVIOUS TOPIC](#)   [GO TO ERROR CHECK >>](#)   [NEXT TOPIC >>](#)

# PAR Status

## PAR Status

### Topic Summary

This topic requests information to determine if the applicant agrees to accept assignment for all covered services provided to Medicare patients. [+ \(more information about PAR Status\)](#)

**If you select "Yes" below, the following form must be completed and submitted along with your application:**

[CMS-460 Medicare Participating Physician or Supplier Agreement](#)

### PAR Status Information

\* Does the applicant agree to accept assignment for all covered services provided to Medicare patients?

Yes

No

You have indicated that the applicant has PAR Status Information. Please click the "Next Topic" button or change the answer to the question above.

[<< PREVIOUS TOPIC](#)   [GO TO ERROR CHECK >>](#)   [NEXT TOPIC >>](#)

# Physical Location

### Physical Location and "Special Payments" Address

**Information**

- PAR Status Information was successfully added.

**Topic Summary**

This topic requests information about the Physical Location and "Special Payments" Address of the applicant's practice location and/or base of operations. [+ \(more information about Physical Location and "Special Payments" Address\)](#)

**ADD INFORMATION** >>

**Filter Physical Location and "Special Payments" Address**

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

[+ Advanced Search](#)

**Physical Location and "Special Payments" Address Information**

No Physical Location and "Special Payments" address has been listed. Please click "Add Information" above.

[<< PREVIOUS TOPIC](#)   [GO TO ERROR CHECK >>](#)   [NEXT TOPIC >>](#)

### Physical Location and "Special Payments" Address

(\*) Red asterisk indicates a required field.

**Physical Location Type**

\* Is this physical location:


- A Practice Location?
- A Base of Operations for Mobile Facility or Portable Units? (e.g. Home or Mobile/Portable Service Provider)
- Both a Practice and a Base of Operations Location?

**NEXT PAGE** >

# Physical Location Address

**Physical Location and "Special Payments" Address**  
(\* Red asterisk indicates a required field.)

**Previously Entered Address Information**

Select an address or enter a new address in the fields below:  
Select address  

**Physical Location Address**

**Note:** The Physical Location address being added or modified must be in the state in which you are enrolling.

**Location Type:** Practice Location

\* **Effective Date of Information**  
  
MM/DD/YYYY

\* **Location Name**

\* **Address Line 1**

**Address Line 2**

\* **City**

**State/Territory:** CONNECTICUT

\* **ZIP Code +4**  
   
XXXXX XXXXX

\* **Telephone**  x **Extension**   
No Format Required

**E-mail Address**

**Is this the Primary Practice Location?**  
**Note:** The primary practice location is only for Physician Compare.

# Address Verification

### Address Verification

(\*) Red asterisk indicates a required field.

You must resolve the following error(s) to continue

- The provided address cannot be confirmed as a valid United States Postal Service (USPS) delivery point. Please provide a reason to continue with this address, or select Previous Page to return to the previous page.

### Address Verification

The address you provided could not be confirmed as a valid United States Postal Service (USPS) delivery point.

Address Footnotes:

- The input address primary number is valid, but the secondary (apartment, suite, etc.) number is missing.

You may proceed with the address as entered after providing a reason or select Previous Page to try a different address.

**Address you entered:**

**\* Reason why an address not verified by the US Postal Service (USPS) is being used:**

Maximum of 255 characters. You have 255 characters remaining.

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

# Claims Information

**Physical Location and "Special Payments" Address**

(\*) Red asterisk indicates a required field.

**Claims Information**

Please provide the following information, which can be found in the NPPES Validation Letter or Medicare Contractor correspondence associated with this location.

**Medicare Identification Number (if issued)**

**\* National Provider Identifier (NPI)**  
  
10 Digits

**TIN Type: EIN**

**Tax Identification Number (TIN)**  
  
XX-XXXXXXX

**\* Is the CP-575 Legal Business Name of ABC CARE the name printed on the NPPES Validation Letter?**

Yes

No

**\* Effective Date of this Practice Location**  
  
MM/DD/YYYY

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

**Physical Location and "Special Payments" Address**

**CLIA Numbers**

Please provide any CLIA numbers that apply to this physical location.

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

**CLIA Number**

[ADD MORE \(+\)](#)

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

**Physical Location and "Special Payments" Address**

**FDA Numbers**

Please provide any FDA/Radiology (Mammography) Certification numbers that apply to this physical location.

**Note:** Use the Add More button to add more than one FDA/Radiology (Mammography) Certification number.

**FDA/Radiology (Mammography) Certification Number**

[ADD MORE \(+\)](#)

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

# Special Payment Address

**Physical Location and "Special Payments" Address**

(\*) Red asterisk indicates a required field.

**Practice Location Type**

\* Is this practice location a:  
Select Type

Other Health Care Facility (Specify)  
\_\_\_\_\_

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

**Physical Location and "Special Payments" Address**

(\*) Red asterisk indicates a required field.

**Previously Entered Address Information**

Select an address or enter a new address in the fields below:  
Select address  
[APPLY](#)

**"Special Payments" Address (Domestic)**

**Note:** If you choose to enter a Special Payments Address on this page, Effective Date of Information, Country, Address Line 1, City, State, and Zip Code are required fields. If you wish to not enter a Special Payments Address at this time and enter it at a later point before you submit this application, ensure that all fields are blank or returned to their default values before saving this page.

**Country**  
United States [SELECT](#)

**Payment Location Name:** ABC Healthcare

**Effective Date of Information**  
MM/DD/YYYY

**Address Line 1**  
\_\_\_\_\_

**Address Line 2**  
\_\_\_\_\_

**City**  
\_\_\_\_\_

**State/Territory**  
Select State/Territory

**ZIP Code +4**  
XXXXX XXXX

[PREVIOUS PAGE](#) [SAVE](#)



# Physical Location Summary

**Information**

- Physical Location and "Special Payments" Address Information was successfully added for ABC Healthcare at 300 George St.

**Topic Summary**

This topic requests information about the Physical Location and "Special Payments" Address of the applicant's practice location and/or base of operations. [\(more information about Physical Location and "Special Payments" Address\)](#)

[ADD INFORMATION](#)

**Filter Physical Location and "Special Payments" Address**

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

[Advanced Search](#)

Records 1 - 1 of 1

**Physical Location and "Special Payments" Address Information**

**ABC Healthcare**

Location Type: Practice Location

Practice Location Type: Other Health Care Facility : OTP [EDIT](#)

Physical Location Address	Special Payment Address
Physical Address:	Payment Address:

Effective Date of Information: 01/01/2020	Effective Date of Information: 01/01/2020
--	--

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

**Claims Information:**

[ADD](#)

**Physical Location Contact Information:**

Telephone Number:  
(999) 999-9999

Fax Number:

E-mail address:

[EDIT](#)

**Medicare Identification Number:**  
pending

**National Provider Identifier (NPI):**

**Tax Identification Number (TIN)**  
Type: EIN  
TIN:  
CP-575 Indicator?: Yes  
Effective Date of this Practice  
Location: 01/01/2020

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

**CLIA and FDA Certification Number(s):**

[ADD](#)

Records 1 - 1 of 1

[PREVIOUS TOPIC](#) [GO TO ERROR CHECK](#) [NEXT TOPIC](#)

# Individual Control

### Individuals with Ownership Interest and/or Managing Control

**Topic Summary**

This topic requests information about individuals with ownership interest in and/or managing control of the applicant. All managing employees for the practice locations listed on this enrollment must be reported. [\(more information about Individuals with Managing Control\)](#)

[ADD INFORMATION](#)

**Individuals with Ownership Interest and/or Managing Control Information**

No Individuals with Ownership Interest and/or Managing Control have been listed. Please click "Add Information" above.

[PREVIOUS TOPIC](#) [GO TO ERROR CHECK](#) [NEXT TOPIC](#)

### Individuals with Ownership Interest and/or Managing Control

**Information**

- Individuals with Ownership Interest and/or Managing Control Information was successfully added for Susan Stafford.

**Topic Summary**

This topic requests information about individuals with ownership interest in and/or managing control of the applicant. All managing employees for the practice locations listed on this enrollment must be reported. [\(more information about Individuals with Managing Control\)](#)

[ADD INFORMATION](#)

**Individuals with Ownership Interest and/or Managing Control Information**

Records 1 - 1 of 1

Tax Identification Number (SSN): XXX-XX-XXXX	Final Adverse Legal Action <a href="#">ADD</a>
Date of Birth:	
Title: President	
<b>Individual's Relationship to the Applicant:</b>	
DIRECTOR/OFFICER	
Effective Date: 01/01/2020	
MANAGING EMPLOYEE	
Effective Date: 01/01/2020	
AUTHORIZED OFFICIAL	
Effective Date: 01/01/2020	

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

Records 1 - 1 of 1

[PREVIOUS TOPIC](#) [GO TO ERROR CHECK](#) [NEXT TOPIC](#)

# Contact Person Information

## 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

Address: 300 GEORGE ST  
  
Telephone:  
E-mail Address:  
  
**EDIT >** **DELETE >**

**REVIEW COMPLETE >>**

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

# Electronic Funds Transfer

## Electronic Funds Transfer

(\*) Red asterisk indicates a required field.

### Topic Summary

This topic requests information about the Electronic Funds Transfer (EFT) authorization agreement. This topic is the electronic CMS-588 Form. Data collected in this topic includes financial institution and account information, and information for the contact person for the electronic funds transfer. [\(more information about Electronic Funds Transfer\)](#)

**ADD INFORMATION** >>

### Electronic Funds Transfer Information

No EFT authorization information has been entered. Please click "Add Information" above.

<< PREVIOUS TOPIC      GO TO ERROR CHECK >>      NEXT TOPIC >>

# Required and/or Supporting Documentation

## Required and/or Supporting Documentation

(\*) Red asterisk indicates a required field.

### Topic Summary

This topic covers information pertaining to required and/or supporting documentation you will need to furnish to your Medicare Administrative Contractor (MAC) to process your Medicare enrollment application. Based on information you provide in your enrollment application, PECOS displays a checklist of the types of required and/or supporting documentation you need to provide to your MAC.

For each document, you have the option of selecting which delivery method to use - upload a digital copy or send a hard copy via U.S. Mail. PECOS provides a feature to upload digital copies of documents from your computer that you want to deliver to your MAC with the Internet-based PECOS enrollment application.

### Medicare Administrative Contractor Information:

N/A

Please remember that your application could be delayed or not processed if any required and/or supporting documentation is missing from your Medicare enrollment application. If you have questions about required and/or supporting documentation, please contact your MAC.

### Instructions for Completing This Topic

There are three steps to complete for this topic. Step 1 and Step 2 are required; Step 3 is required only if you are uploading digital copies of documents identified in Step 1 now.

Step 1. Review the required and/or supporting documentation, optionally, identify the delivery method for each document; optionally, print the other required documentation; and save the checklist.

Step 2. Confirm that you want to upload digital copies of the required or supporting documents.

Step 3. Upload digital copies of the documents. (Step 3 might not appear depending on your response in Step 2)

## Step 2: Confirm that you want to upload digital copies of the documents now

**Instructions for this step:** If you selected the Upload delivery method for any documentation selected in Step 1, and you want to upload them now, please select "Yes". If you did not select the Upload delivery method for any documentation Step 1, you did not complete Step 1, or you do not want to upload the documents now, please select "No".

You may return to this topic at a later time - but before application submission - to upload documents.

**\* Do you want to upload one or more documents with your Medicare enrollment application now?**

Yes, I would like to upload one or more documents now.

No, I do not want to upload any documents now. (You may upload documents at a later time.)

### Document Information

No documents have been listed. Please answer the question above.

[PREVIOUS TOPIC](#)

[GO TO ERROR CHECK](#)

[RETURN TO TOPICS](#)

# View and Print Certification Statements

Required and/or Supporting Documentation		
Documentation Requiring Signatures: MUST E-SIGN or UPLOAD	View and Print Documentation	Comments
<a href="#">+ Authorized Official Certification Statement for Clinics and Group Practices [PDF]</a>	<a href="#">View and Print [PDF]</a> 	<input type="text"/> Maximum of 500 characters. You have 500 characters remaining.
<b>Note:</b> Please do not mail a signed Certification Statement. Signature documents must be either e-signed or uploaded.		
<a href="#">+ Form CMS-588, Electronic Funds Transfer (EFT) Authorization Agreement</a>	<a href="#">View and Print [PDF]</a> 	<input type="text"/> Maximum of 500 characters. You have 500 characters remaining.
<b>Note:</b> Please do not mail a signed Certification Statement. Signature documents must be either e-signed or uploaded.		
<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>  .		

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

# Upload Documents

## Step 3: Upload digital copies of the documents.

**Instructions for this step:** This step is required only if you selected the Upload delivery method for any documents you identified in Step 1. Complete Step 2 before Step 3.

Please select any required or supporting documents you identified in Step 1 with the Upload delivery method and upload them below as attachments to your Medicare enrollment application. Please select the document type, the document name, and click the UPLOAD button to attach each file to your Medicare enrollment application.

Documents you upload appear in the Current Uploaded Documents table.

Send hard copies of the documents you identified with the Mail delivery method in Step 1 to your MAC via U.S. Mail.

**Note:** Please do not upload your signed documents in this section. You will be able to upload them on the Manage Signatures page of the submission process.

**Please do not upload the following documentation. Doing so might delay processing your application and could require further action:**

- Form CMS-855A, Form CMS-855B, Form CMS-855I, Form CMS-855R, Form CMS-855S, or Form CMS-855O.

### File Upload Constraints:

- You may upload only PDF or TIFF formatted document files that are 10MB or less.
- You may upload only 100 or fewer documents per application submission.
- Each uploaded file may only contain one document. Files with multiple documents are not valid.

* Document Type	* Document Name
Select Document Type	Browse...
<input type="button" value="UPLOAD"/>	

[PREVIOUS TOPIC](#)

[GO TO ERROR CHECK](#)

[RETURN TO TOPICS](#)

## Select Document Type

Document not in List  
 Accreditations  
 Adverse Legal Action/Conviction  
 Attestation Letter  
 Bank Waiver Letter  
 Bill of Sale/Sale Agreement  
 Business License/Certification/Registration  
 CMS-1561 Provider Agreement  
 Centralized Flu Biller Approval Letter  
 Contracts for interpreting physicians who read off site  
 Copy of the Opioid Treatment Program's Operating Certificate  
 Delegated Official's W-2  
 Employment agreements for technicians  
 Form CMS-460  
 IRS Determination Letter (Non-Profit) (501(c)(3))  
 IRS Form 8832, IRS Confirmation (Disregarded Entity)  
 Lease/Rental Agreement  
 Official IRS document confirming TIN and LBN  
 Organization Diagram  
 Passport  
 Pay.gov receipt/Waiver Request  
 Phone/Power Bill  
 Proof of Death Document  
 Proof of Overpayment Resolution  
 Stock Certificate/Transfer  
 Voided Check/Account Verification

## Current Uploaded Documents

Document Type	File Name	Document ID	Date Uploaded	Actions
Voided Check/Account Verification	This is void check.pdf		01/08/2020	<input type="button" value="VIEW"/> <input type="button" value="REMOVE"/>

[PREVIOUS TOPIC](#)

[GO TO ERROR CHECK](#)

[RETURN TO TOPICS](#)

# Error/Warning Check

[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.



# Manage Signatures

### Manage Signatures

(\*) Red asterisk indicates a required field.

Name: ABC CARE  
Web Tracking ID:  TIN: XX-XXXXXXX

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: <input type="text"/> [You] SSN: XXX-XX-XXXX * Signature Method for <input type="text"/>	Role: AUTHORIZED OFFICIAL Document: ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT
<input checked="" type="radio"/> E-Sign (Sign Now) <input type="radio"/> Upload	Role: AUTHORIZED OFFICIAL Document: AUTHORIZED OFFICIAL CERTIFICATION STATEMENT FOR CLINICS AND GROUP PRACTICES

Sign Now

### E-Signature Submission

(\*) Red asterisk indicates a required field.

#### E-Signature Instructions

Review all application documentation prior to e-signing. Acceptance of all applicable Terms and Conditions is a requirement to e-sign. To e-sign the enrollment application, follow the steps below:

1. Review all applicable Terms and Conditions.
2. Read and scroll to the end of each document window to enable the acceptance checkbox.
3. Select each checkbox to accept all applicable Terms and Conditions.

#### Certification Statement 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.

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.

#### Certification Statement Terms and Conditions

##### CERTIFICATION STATEMENT FOR INDIVIDUAL PRACTITIONERS

As an individual practitioner, you are the only one who may sign this application. The authority to sign the application on your behalf may not be delegated to any other person. The Certification Statement contains certain standards that must be met for initial and continuous enrollment in the Medicare program. Review these requirements carefully.

By signing the Certification Statement, you agree to adhere to the following requirements listed therein and acknowledge that you may be denied entry to or revoked from the Medicare program if any requirements are not met. You must sign the Certification Statement below in order to be enrolled in the Medicare program. In doing so, you are attesting to meeting and maintaining the Medicare requirements stated below.

1. I have read the contents of this application, and the information contained

\* Do you accept the Terms and Conditions?

Yes, I have read and 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.

# Manage Signatures

Manage Signatures

(\*) Red asterisk indicates a required field.

Name: ABC CARE  
 Web Tracking ID:  TIN: XX-XXXXXXX

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:

SSN: XXX-XX-XXXX

\* Signature Method for :

Electronic  
 Upload

Role: AUTHORIZED OFFICIAL  
 Document: ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

Role: AUTHORIZED OFFICIAL  
 Document: AUTHORIZED OFFICIAL CERTIFICATION STATEMENT FOR CLINICS AND GROUP PRACTICES

\* Email Address

\* Confirm Email Address

Name:  [You]

SSN: XXX-XX-XXXX

\* Signature Method for :

E-Sign (Sign Now)  
 Upload

Role: AUTHORIZED OFFICIAL  
 Document: ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

Role: AUTHORIZED OFFICIAL  
 Document: AUTHORIZED OFFICIAL CERTIFICATION STATEMENT FOR CLINICS AND GROUP PRACTICES

**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: ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT ⓘ

Browse...

Document: AUTHORIZED OFFICIAL CERTIFICATION STATEMENT FOR CLINICS AND GROUP PRACTICES ⓘ

Browse...

# Complete Submission

**Submission Page**

(\*) Red asterisk indicates a required field.

**Contact and Processing**

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.**

**Note:** It is recommended that the applicant select the Medicare Contractor of the Chain Home Office.

\* **Fee-For-Service Contractor**

Select Medicare Contractor
NATIONAL GOVERNMENT SERVICES, INC.
APPLY

**Application Fee Payment Information**

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

- Revalidations
- Reactivations, unless the deactivation was a result of non-submission of claims for four consecutive quarters

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: ... 2024  
Amount: \$709

\* Would you like to pay the application fee now?

Yes  
 No  
 I have already submitted payment for this application

APPLY

Click the Refresh button to view the latest Payment Information.

REFRESH

**Reason(s) for submission:**

- A Medicare Part B supplier is enrolling in the Medicare program for the first time to bill for Part B services.

**Reports**

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

**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
<a href="#">Authorized Official Certification Statement for Clinics and Group Practices [PDF]</a> <p style="font-size: x-small; color: red; margin-top: 5px;"><b>Note :</b> Please do not mail a signed Certification Statement. Signature documents must be either e-signed or uploaded.</p>	<a href="#">View and Print [PDF]</a>	
<a href="#">Form CMS-588, Electronic Funds Transfer (EFT) Authorization Agreement</a> <p style="font-size: x-small; color: red; margin-top: 5px;"><b>Note :</b> Please do not mail a signed Certification Statement. Signature documents must be either e-signed or uploaded.</p>	<a href="#">View and Print [PDF]</a>	

PREVIOUS PAGE
COMPLETE SUBMISSION

# Submission Confirmation

 **IMPORTANT!**

Your enrollment application with any uploaded documentation has been submitted to your fee-for-service contractor.

Required and/or supporting documentation not e-signed or uploaded must be mailed in to the fee-for-service contractor.

You indicated the following documentation will be provided by mail/paper:


- Form CMS-460, Medicare Participating Physician or Supplier Agreement
- Copy of IRS Form CP 575 or other official IRS communication confirming Tax Identification Number and Legal Business Name

Your application may be delayed or not processed if any required/supporting documentation is missing.

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!

# Enrollment Records

**Existing Enrollments**

Contractor: NATIONAL GOVERNMENT SERVICES, INC. [VIEW](#)  
State: ILLINOIS [REVALIDATE](#)  
Type/Specialty: [MORE OPTIONS](#)

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

Practice Location: 701 W NORTH AVE,

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

**New Enrollments**

Contractor: NATIONAL GOVERNMENT SERVICES, INC. [VIEW](#)  
State: CONNECTICUT [MANAGE SIGNATURES](#)  
Type/Specialty: OPIOID TREATMENT PROGRAM (OTP)

Enrollment Type: 855B  
Medicare ID: pending  
Status: AWAITING PROCESSING [View Awaiting Processing Application](#)  
Practice Location: 300 George St,  
Tracking ID:

# Supporting Documents

# Supporting Documents

- [SAMHSA](#) certification and/or copy of renewal letter
- State Operation License
- Drug Enforcement Administration License
- [CMS-1561 Provider Agreement](#)
- IRS CP575 or CP147c
  - Tax Identification for Legal Business Name
- Nonprofit IRS determination letter

# Supporting Documents

- Voided check or bank confirmation letter
- Organizational flow chart (Managing Control)
- Final adverse legal action documentation and solution
- Attestation for government entities and tribal organizations



# Application Fee

- Application Fee receipt
  - 2024 application fee = **\$709**
  - [Pay fee online](#) via credit card, debit card or check
  - No hardcopy checks can be accepted by NGS
  - Submit receipt of payment with application
    - Enables contractor to quickly verify payment was made

# Process after Submission

# Process 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, view and manage signatures
  - Response letter
    - Rejection letter for incomplete/no response to development request
    - Approval

# Check Application Status

# 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)'. The search area is divided into two columns: 'Option 1' with a label 'Case Number / Web Tracker Id' and a text input field; and 'Option 2' with labels 'NPI' and 'TIN (last five digits)' and two corresponding text input fields. At the bottom of the form are two buttons: 'Submit' (dark blue) and 'Clear' (light blue).

# PECOS 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

**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.

## 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 & Referring List](#) - View the Ordering & Referring List to verify eligibility to order or refer Medicare services for beneficiaries.
- [Ordering and Referring Information \[PDF, 1.64MB\]](#) - Learn about the Ordering & Referring 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](#)

# Contact Information


# Contact Information

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

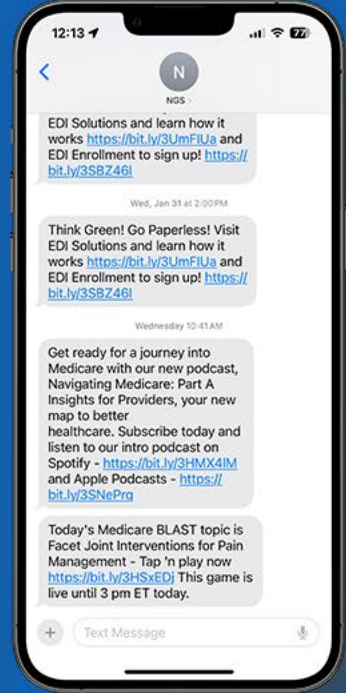
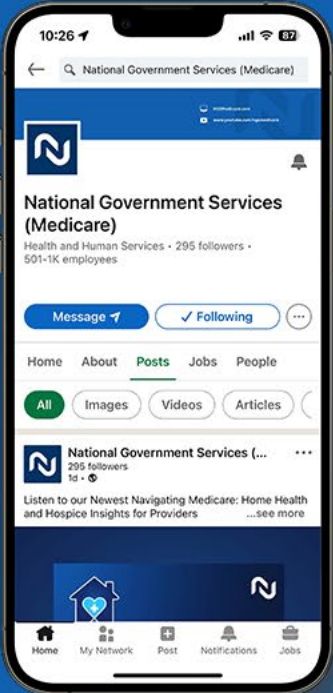
# Resources


# CMS Opioid Treatment Programs


The screenshot shows the CMS.gov website with the following elements:

- Header:** CMS.gov logo, "Centers for Medicare & Medicaid Services", and navigation links for "About CMS", "Newsroom", and "Data & Research".
- Primary Navigation:** Medicare, Medicaid/CHIP, Marketplace & Private Insurance, Priorities, and Training & Education.
- Breadcrumb:** Home > Medicare > Payment > Opioid Treatment Programs (OTP).
- Secondary Navigation:** Overview, Enrollment, Billing/Payment, Medicaid, and Medicare Advantage Plans.
- Sidebar:** Opioid Treatment Programs (OTP) with sub-links for Enrollment, Billing & Payment, Medicaid, and Medicare Advantage plans.
- Main Content:**
  - New for CY 2024:**
    - The [CY 2024 Physician Fee Schedule](#) final rule:
      - Extends the flexibility through the end of CY 2024 to provide periodic assessments via audio-only when video isn't available, when authorized by SAMHSA and DEA.
    - The [CY 2024 Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System](#) final rule:
      - Establishes a weekly payment adjustment for an Intensive Outpatient Program (IOP) provided by an OTP for opioid use disorder treatment; the IOP service:
        - Must be medically reasonable and necessary
        - Can't be duplicative of any service paid for under any bundled payments billed for an episode of care in a given week

# Connect with us on social media



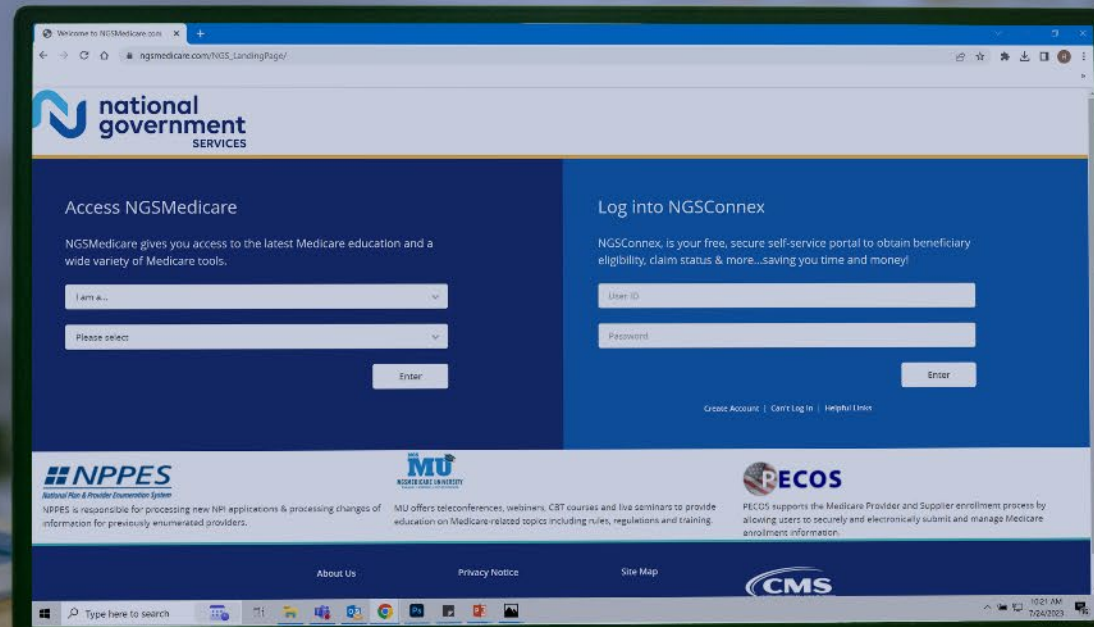
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Self-paced online learning

medicare **mobile**  
Text NEWS to 37702; Text GAMES to 37702

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[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!