national government SERVICES

NGS PROVIDER EXPERIENCE
Innovation | Education | Collaboration

Provider Enrollment: Initially Enrolling a Dentist in the Medicare Program

3/20/2025

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.*

NGSMU
NGS Medicare University
Meaningful | Informative | Simplified

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

2624_0325

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Today's Presenters

NGS PROVIDER EXPERIENCE
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- Provider Outreach and Education Consultants
  - Susan Stafford PMP, COA, AMR
  - Laura Brown, CPC

Agenda

- Overview
- Dental Specialties
- Electronic Application: PECOS
  - Sole Owner Questionnaire
  - Sole Proprietor Questionnaire
  - Group Member Questionnaire
  - Errors/Warnings Check
- Paper Application: CMS-855I
- Supporting Documentation
- Process After Submission
- Check Application Status
- Contact Information and Resources

Overview

Overview

- Obtain NPI from NPPES
  - NPI Type 1 for individual physicians or nonphysicians practitioners
  - NPI Type 2 for organization, clinics and/or group practices
- Dental Specialties
- Complete and Submit Medicare Application
  - PECOS Application
  - Paper Application
    - CMS-855I – Physicians and Nonphysician Practitioners
      - Reassigning all benefits
      - Sole owner
      - Sole proprietor
    - CMS-855B – Clinic/Group Practices and other Suppliers
      - Clinic/Group practices with multiple owners
      - One owner but not the practitioner
  - Additional Forms
    - Sole owner, sole proprietor and clinic/group practices
      - CMS-588 –EFT Authorization Agreement
      - CMS-460 – Medicare Participating Physician or Supplier Agreement (optional)

Overview

- Resources
  - Federal Register Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program
  - CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 10.2.3.11
  - How to Determine if the Provider is Active and Get the Provider Enrolled in Medicare Part B
  - Understanding Participating, Nonparticipating and Opt Out Status
  - Provider Enrollment: Announcement About Medicare Participation for Calendar Year 2025
  - Issues with Medicare Beneficiary Submitted Claims – We Need Your Help

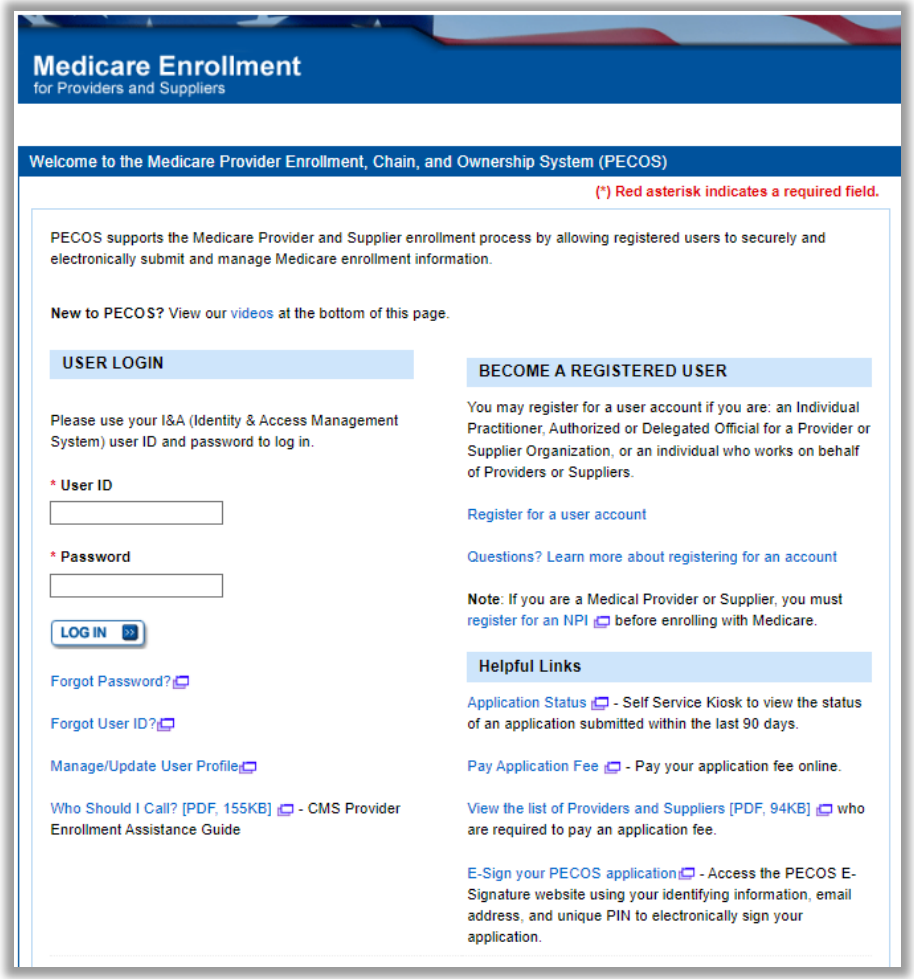
Dental Specialties

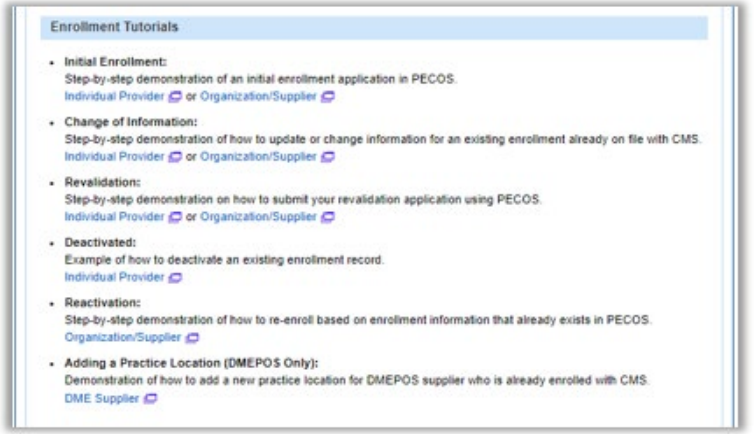
Dental Specialties

- **Physician Specialty Codes for Dentist**
  - 19 Oral Surgery (dentists only)
  - 85 Maxillofacial Surgery
  - C5 Dentist
  - E3 Dental Anesthesiology
  - E4 Dental Public Health
  - E5 Endodontics
  - E6 Oral and Maxillofacial Pathology
  - E7 Oral and Maxillofacial Radiology
  - E9 Oral Medicine
  - F1 Orofacial Pain
  - F2 Orthodontics and Dentofacial Orthopedics
  - F3 Pediatric Dentistry
  - F4 Periodontics
  - F5 Prosthodontic

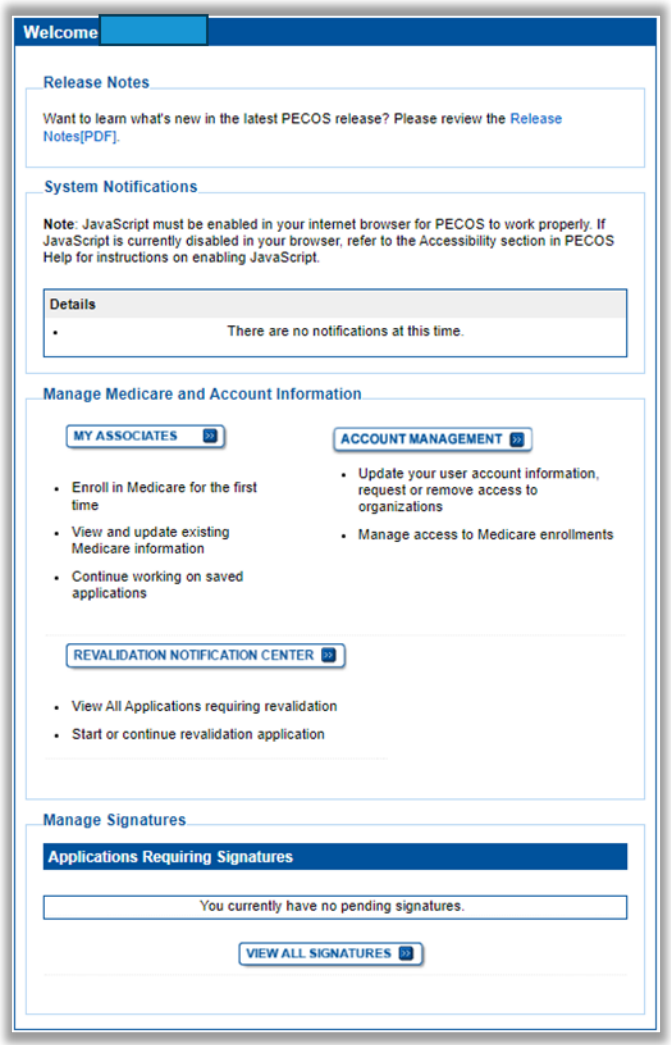
Electronic Application: Provider Enrollment Chain and Ownership System

PECOS Home Page to Login

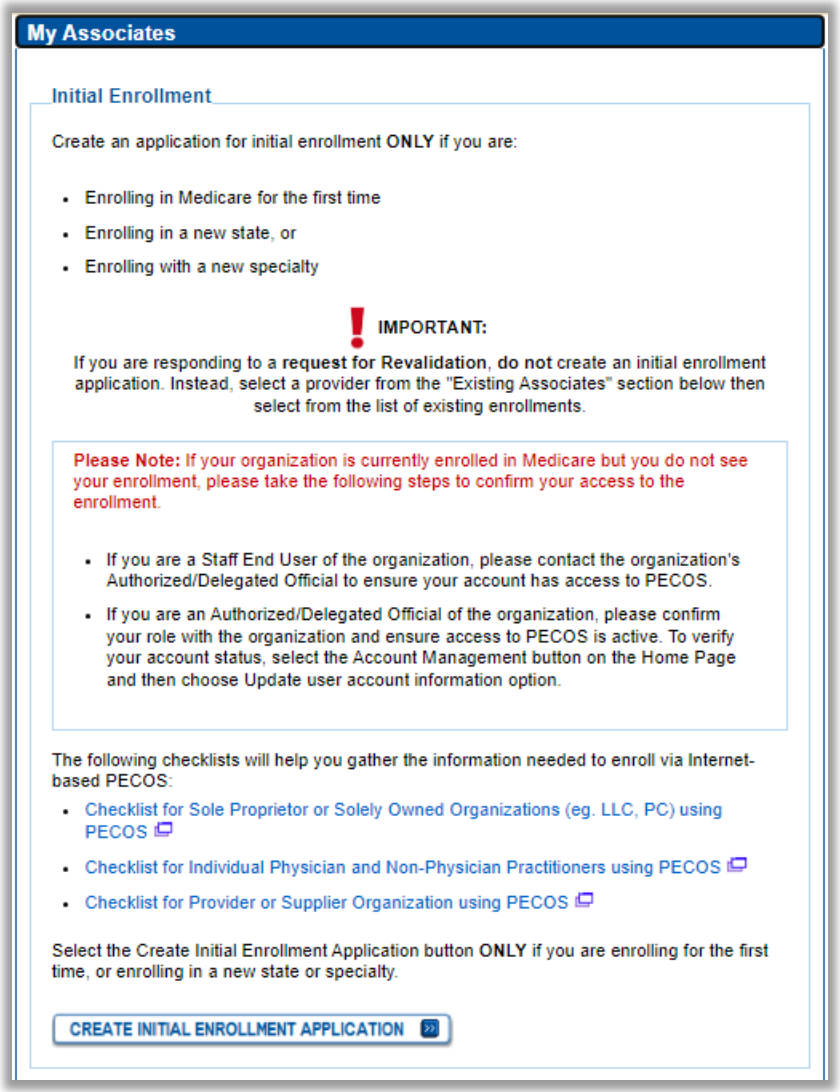




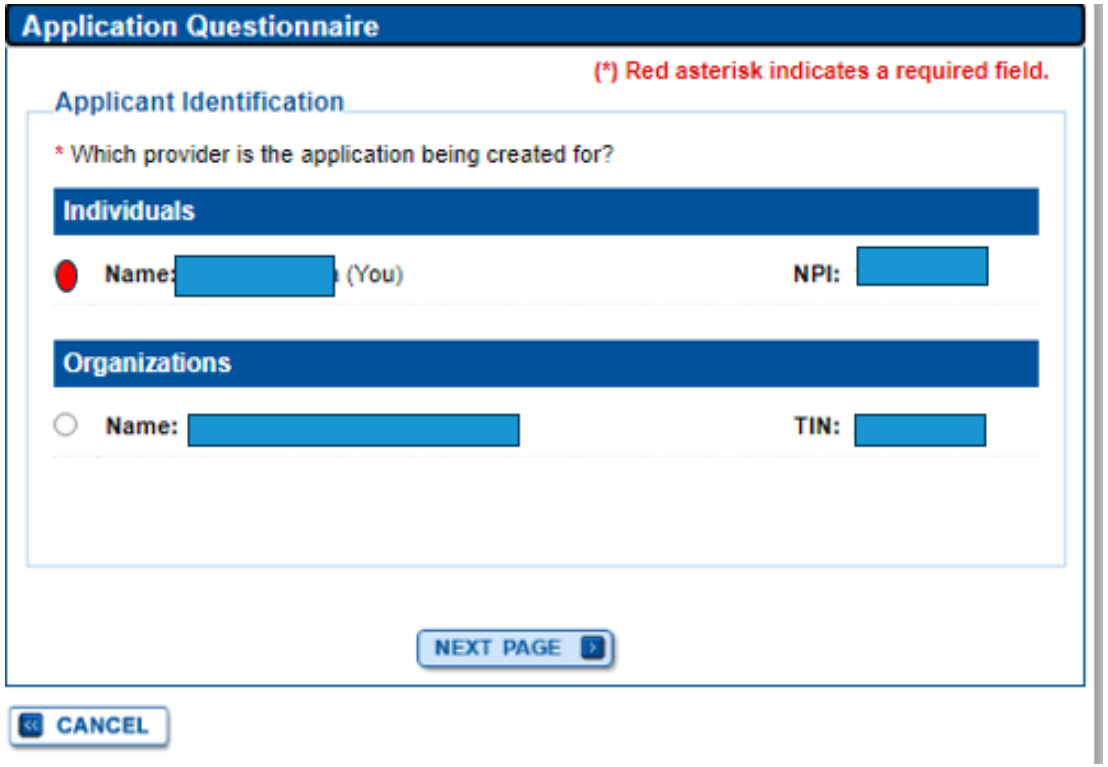
Welcome – My Associates



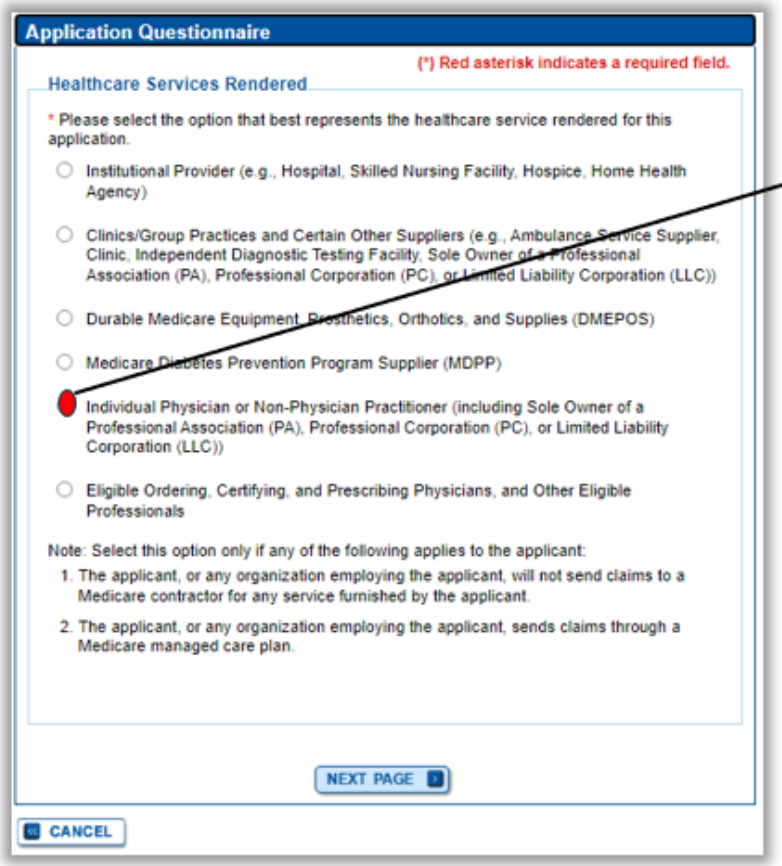
Create Initial Enrollment Application

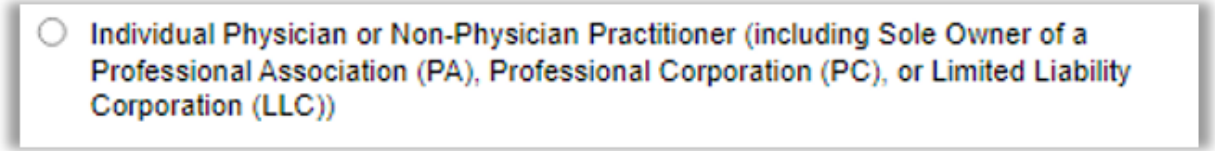


Application Questionnaire

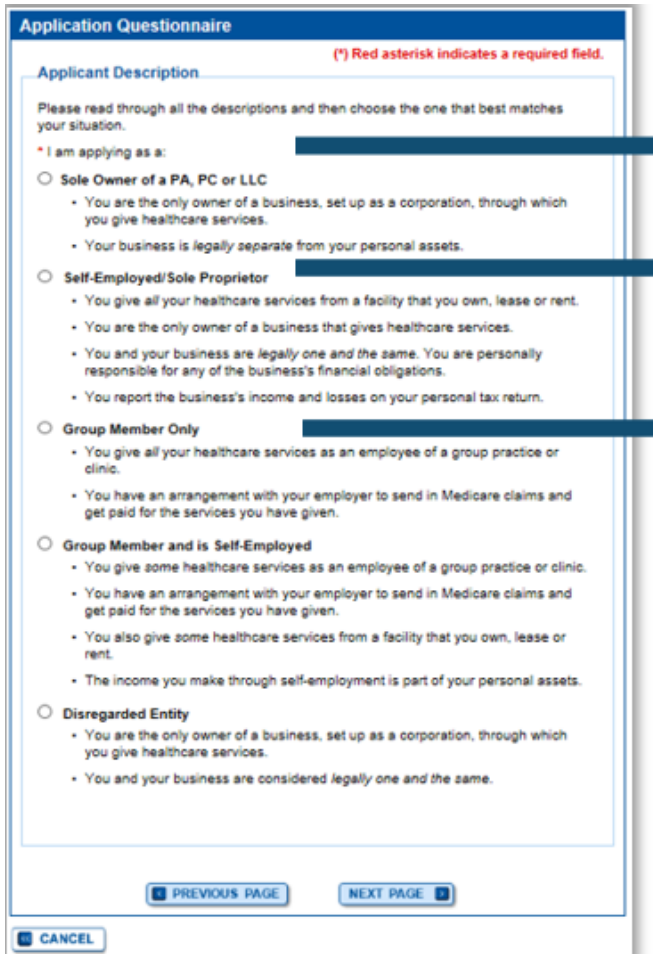


Healthcare Services Rendered





Applicant Description



Sole Owner of a PA, PC or LLC

- You are the only owner of a business, set up as a corporation, through which you give healthcare services.
- Your business is *legally separate* from your personal assets.

Self-Employed/Sole Proprietor

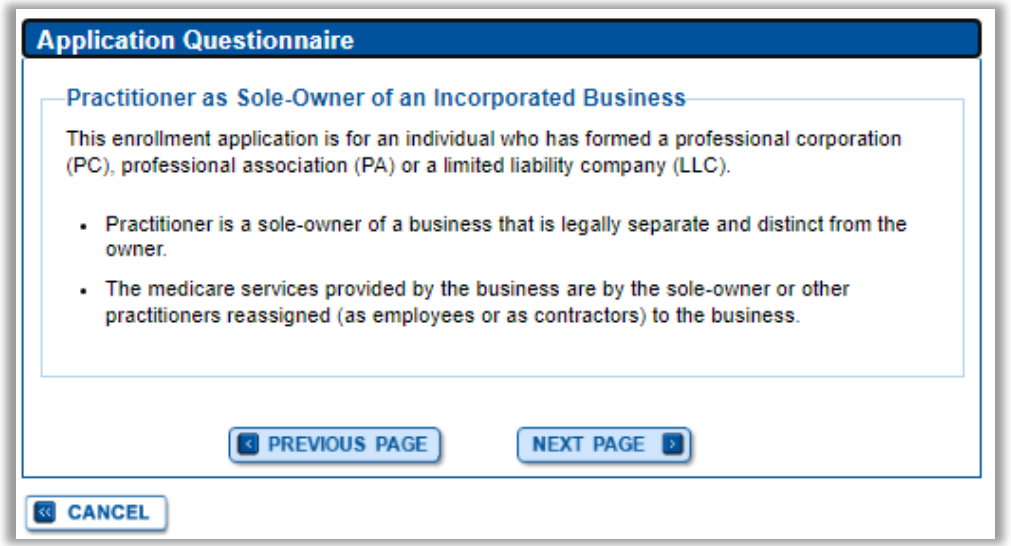
- You give *all* your healthcare services from a facility that you own, lease or rent.
- You are the only owner of a business that gives healthcare services.
- You and your business are *legally one and the same*. You are personally responsible for any of the business's financial obligations.
- You report the business's income and losses on your personal tax return.

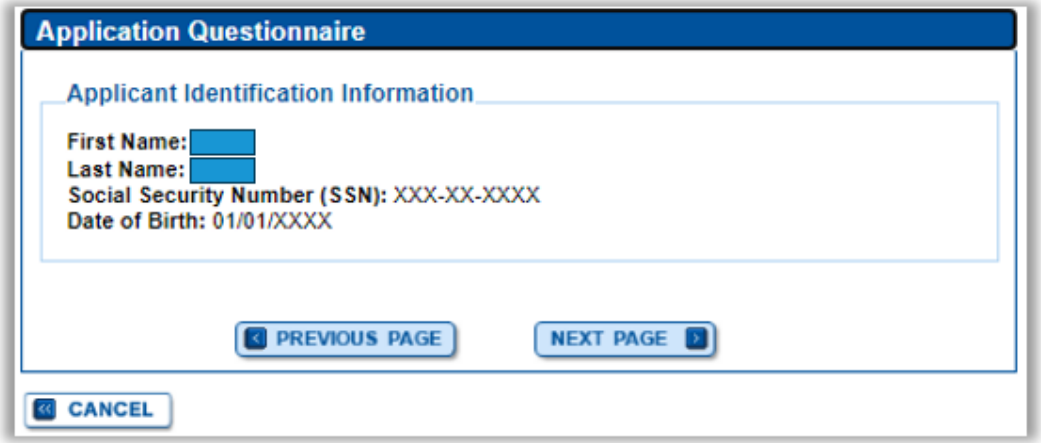
Group Member Only

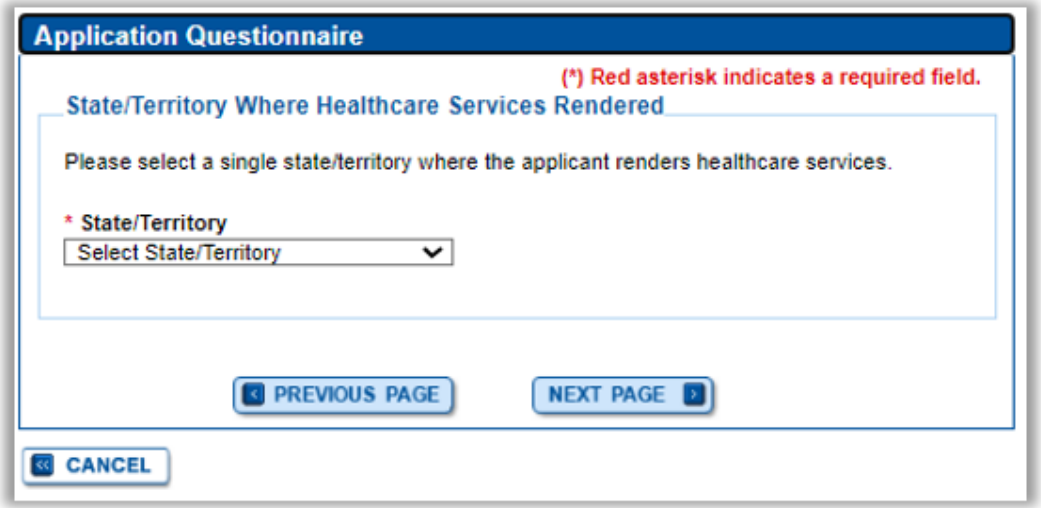
- You give *all* your healthcare services as an employee of a group practice or clinic.
- You have an arrangement with your employer to send in Medicare claims and get paid for the services you have given.

Sole Owner Questionnaire

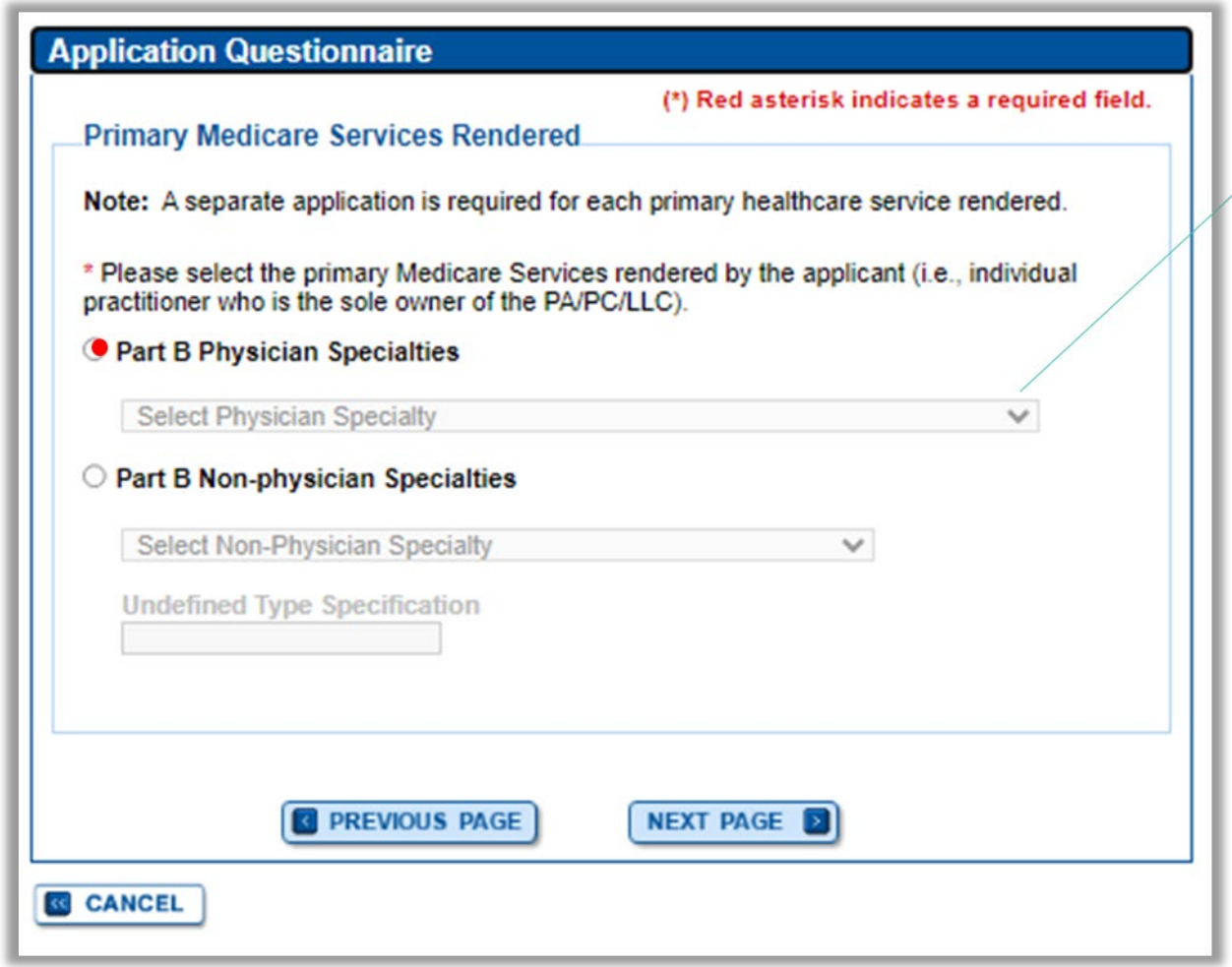
Sole Owner Questionnaire

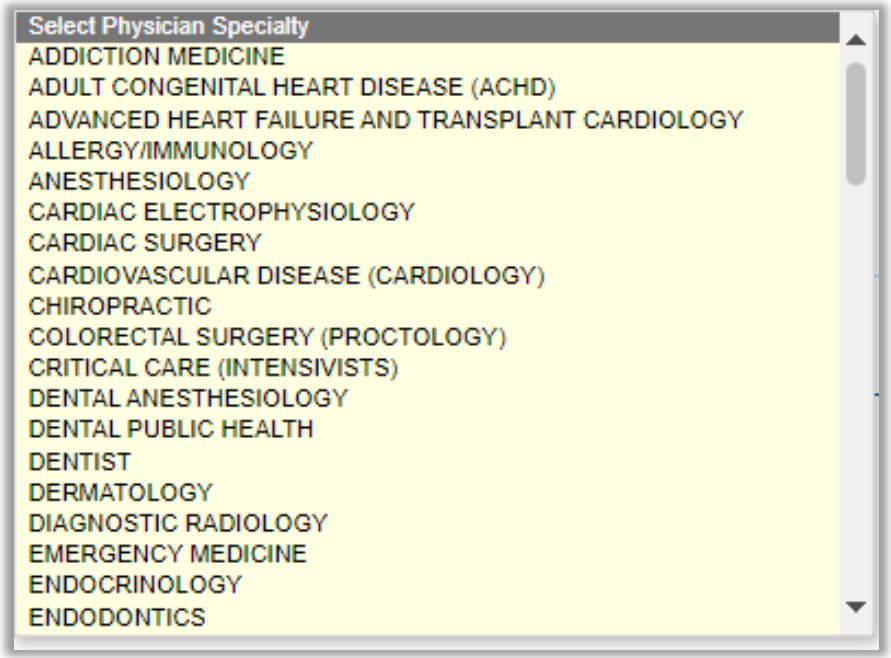




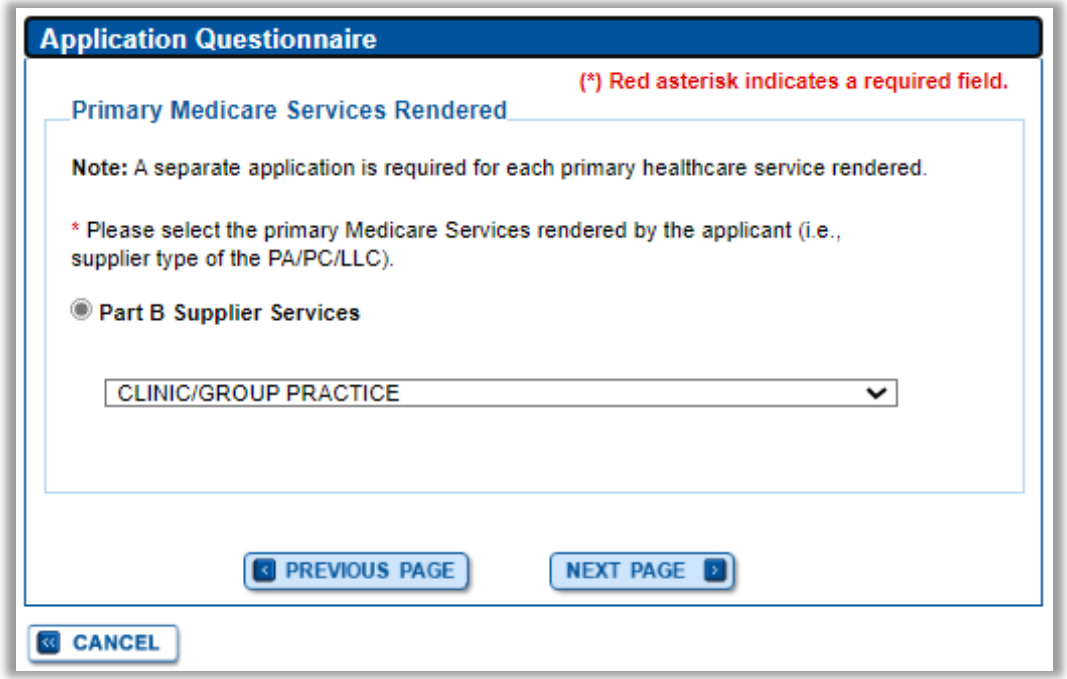


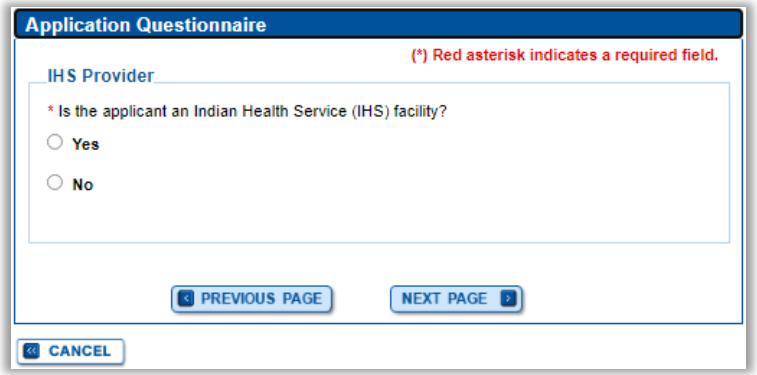
Sole Owner Questionnaire

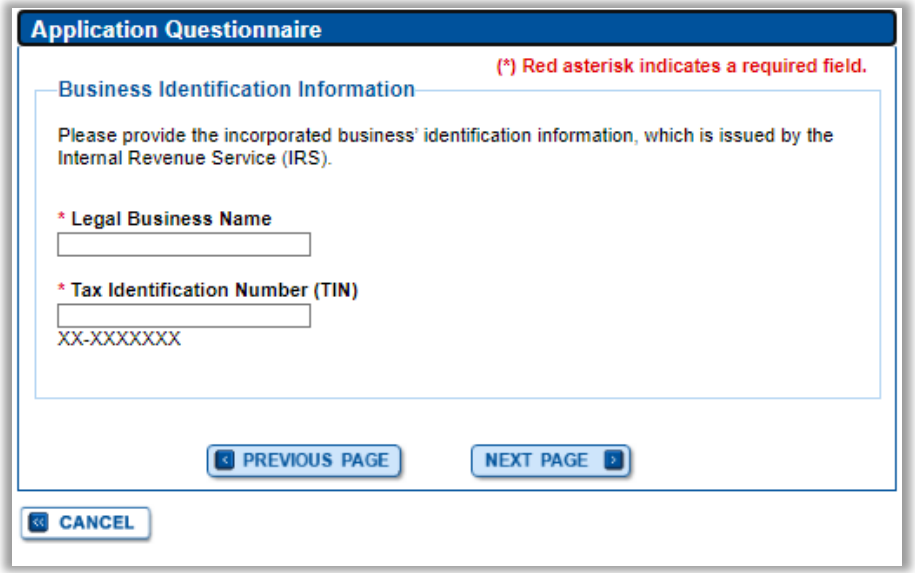




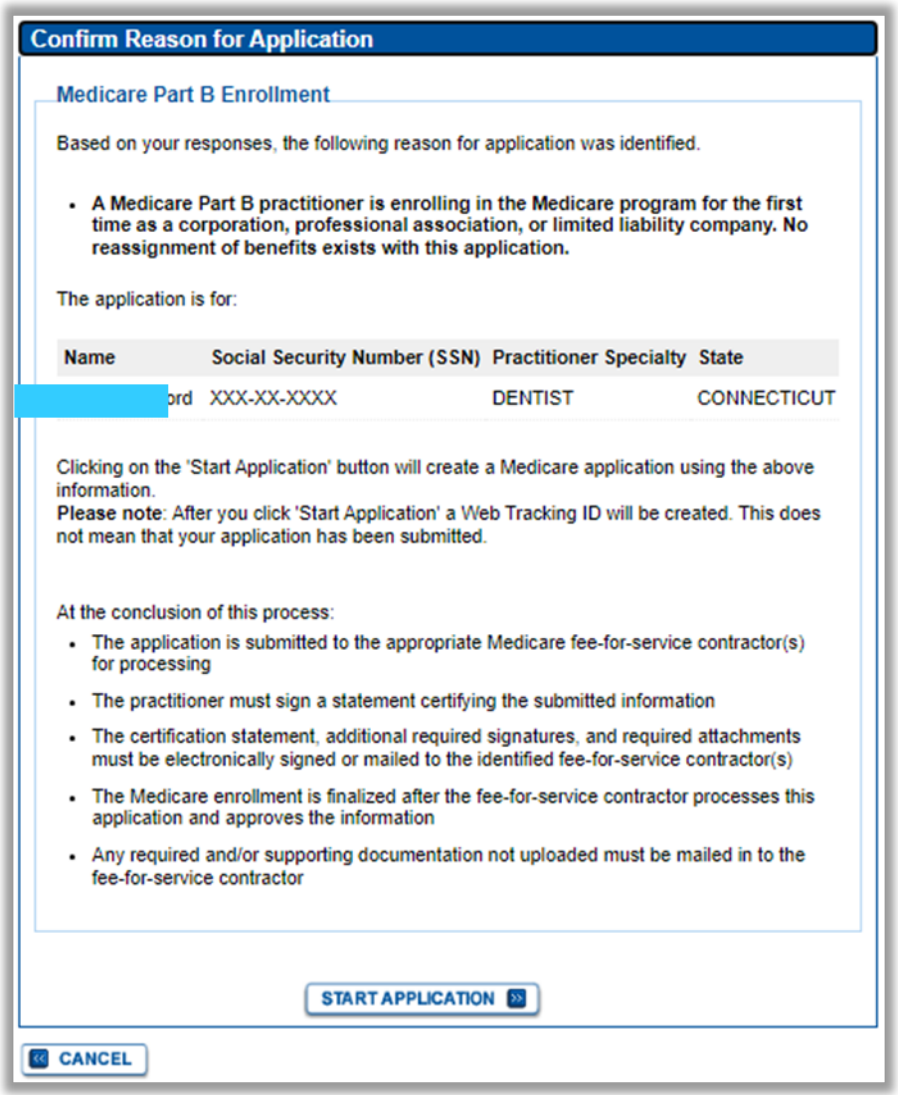
Sole Owner Questionnaire







Sole Owner - Reason for Application



Confirm Reason for Application

Medicare Part B Enrollment

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

- **A Medicare Part B practitioner is enrolling in the Medicare program for the first time as a corporation, professional association, or limited liability company. No reassignment of benefits exists with this application.**

The application is for:

Name	Social Security Number (SSN)	Practitioner Specialty	State
[redacted]ord	XXX-XX-XXXX	DENTIST	CONNECTICUT

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.

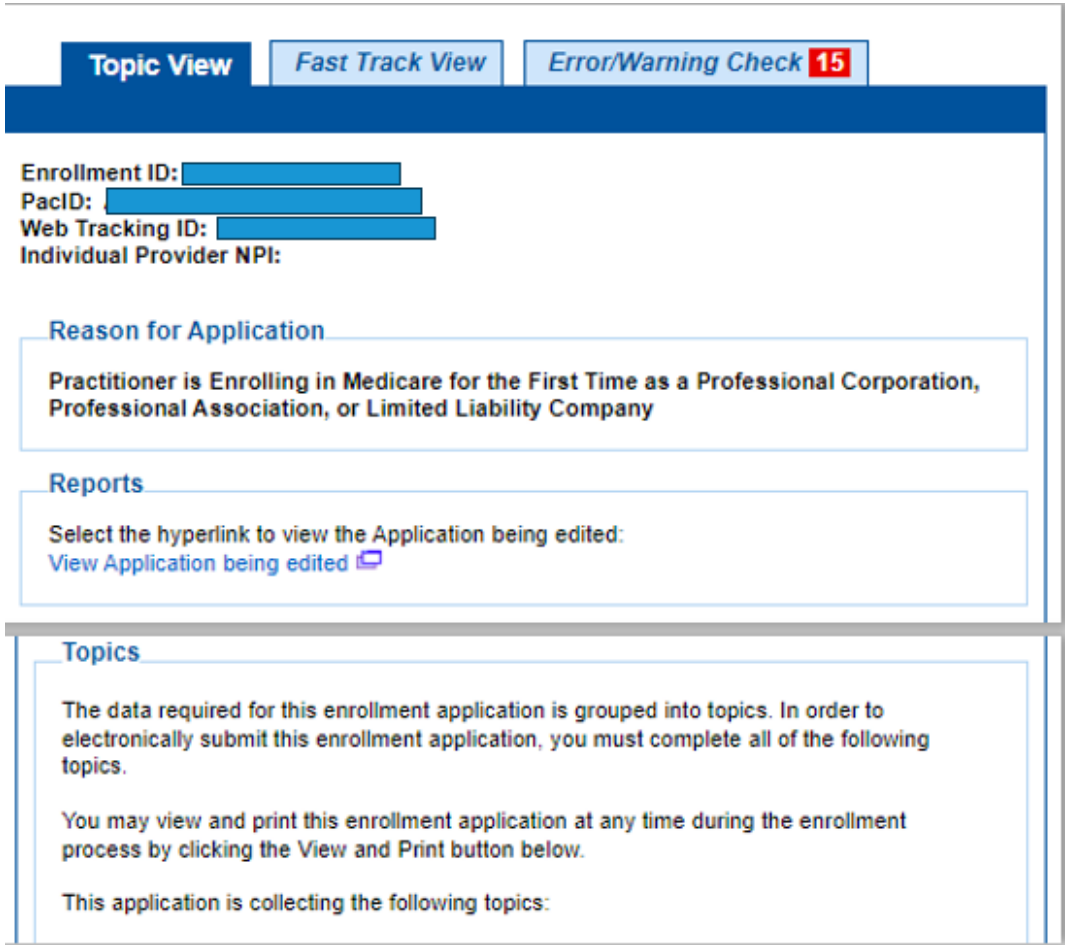
At the conclusion of this process:

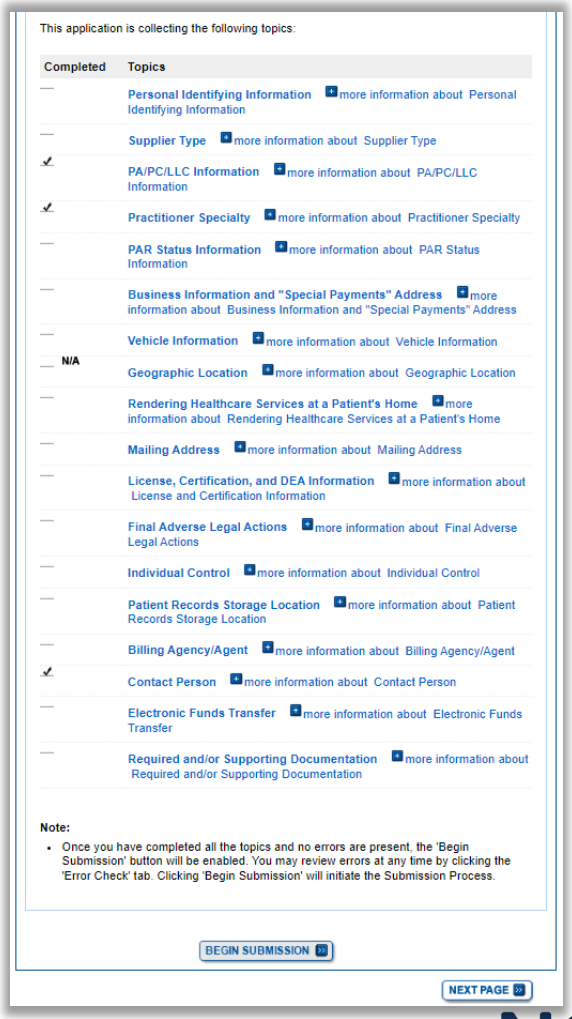
- The application is submitted to the appropriate Medicare fee-for-service contractor(s) for processing
- The practitioner must sign a statement certifying the submitted information
- The certification statement, additional required signatures, and required attachments must be electronically signed or 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

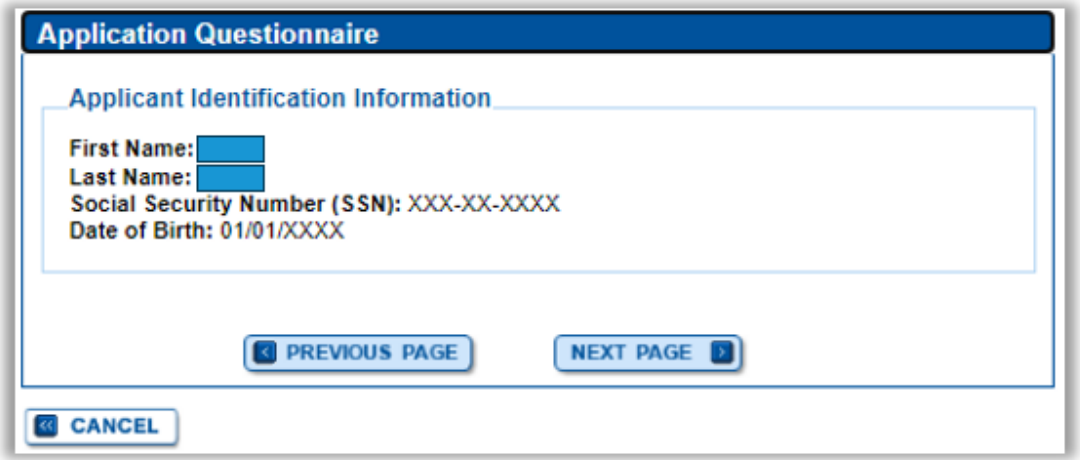
Sole Owner – Topic View

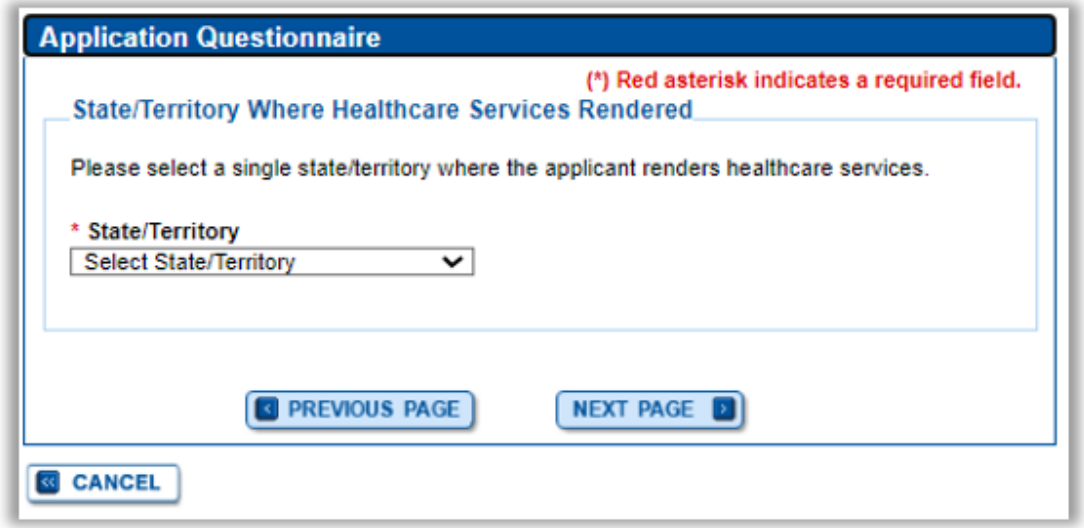




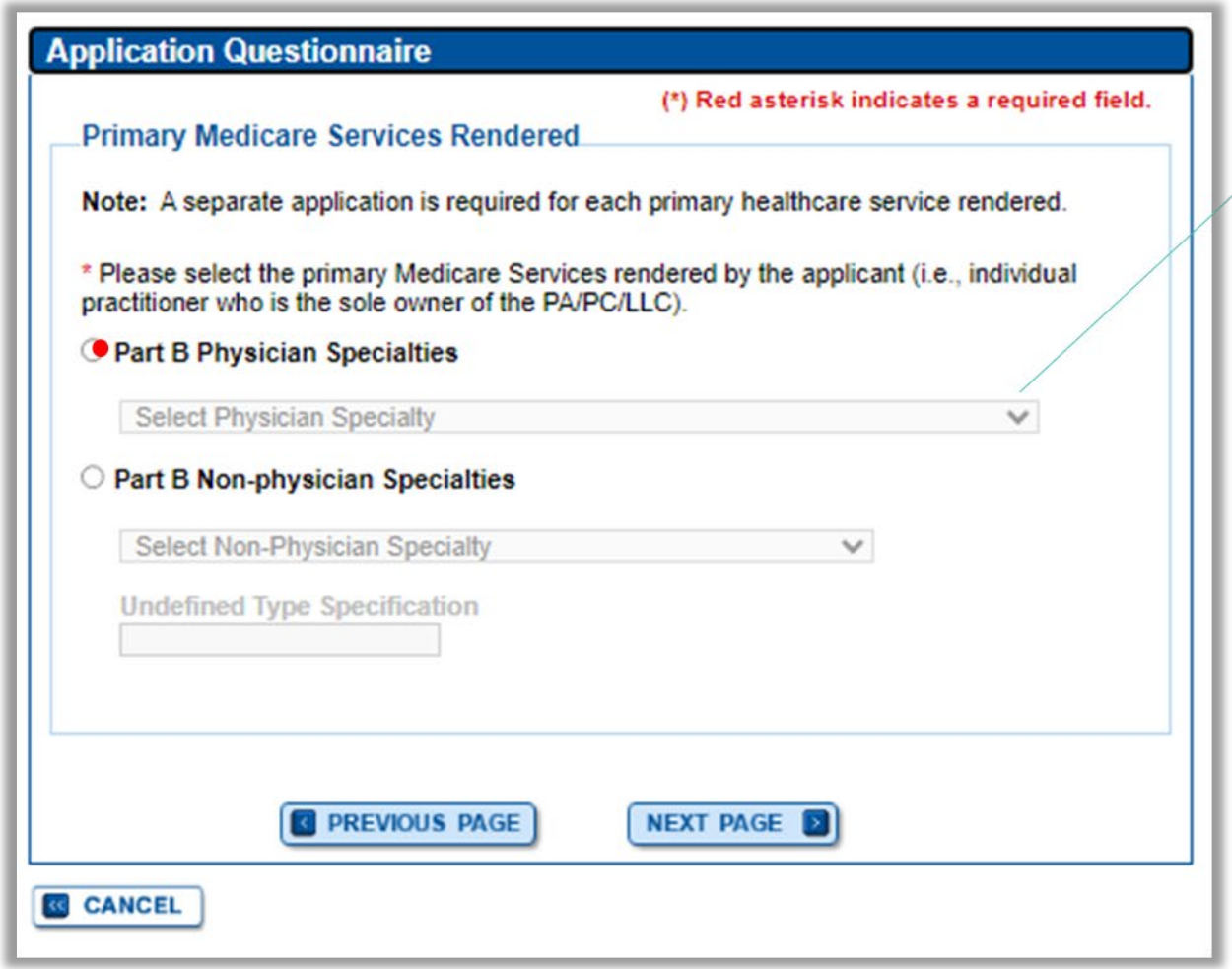
Sole Proprietor Questionnaire

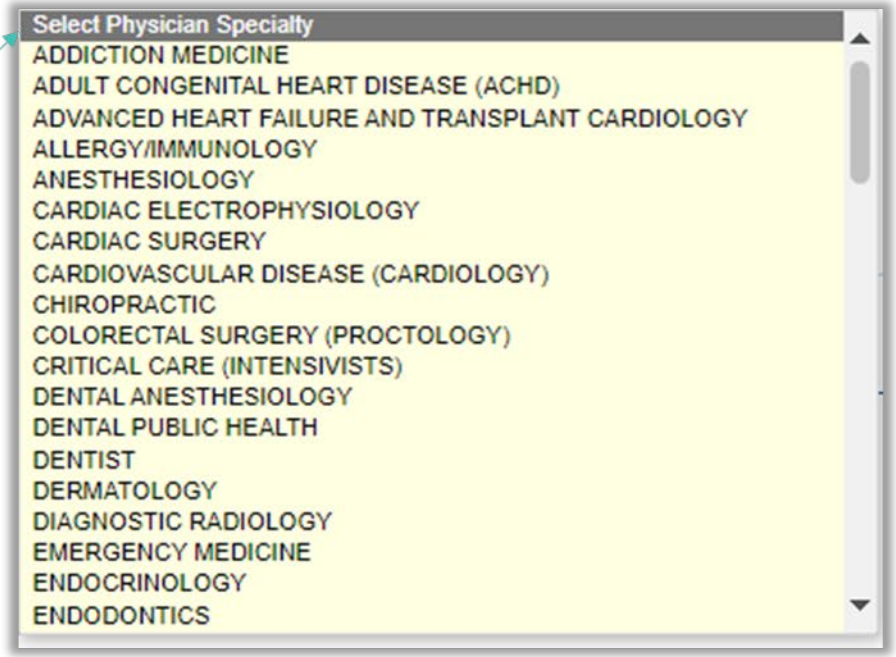
Sole Proprietor Questionnaire



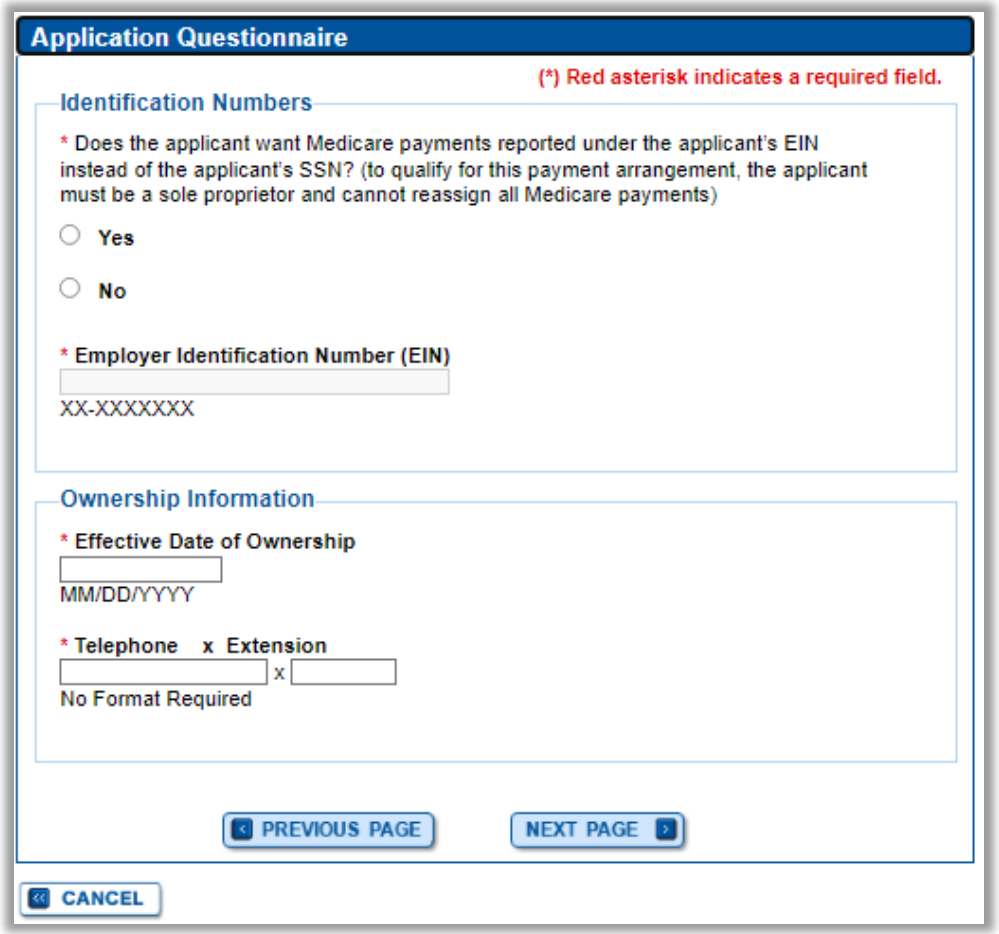


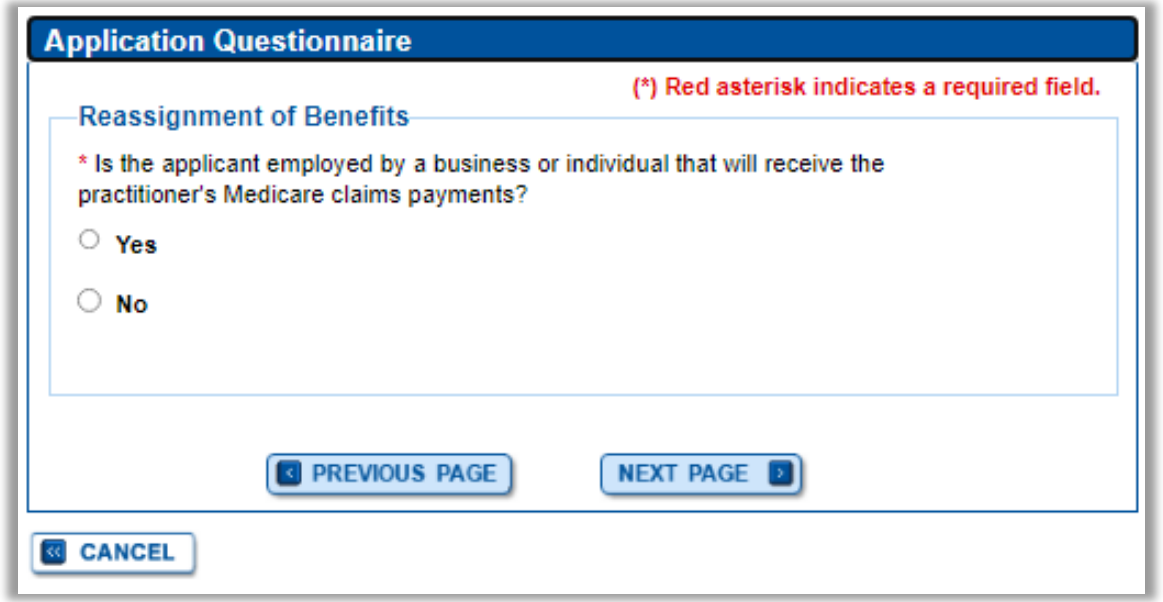
Sole Owner Questionnaire



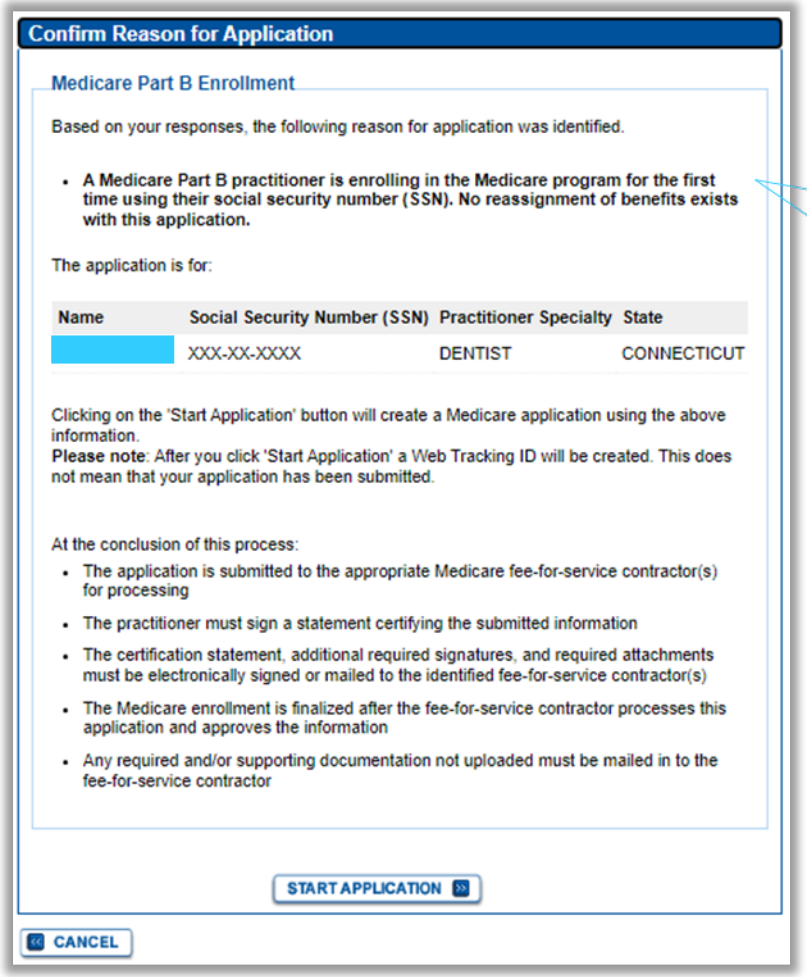


Sole Proprietor Questionnaire





Sole Proprietor - Reason for Application



Confirm Reason for Application

Medicare Part B Enrollment

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

- **A Medicare Part B practitioner is enrolling in the Medicare program for the first time using their social security number (SSN). No reassignment of benefits exists with this application.**

The application is for:

Name	Social Security Number (SSN)	Practitioner Specialty	State
	XXX-XX-XXXX	DENTIST	CONNECTICUT

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
- The practitioner must sign a statement certifying the submitted information
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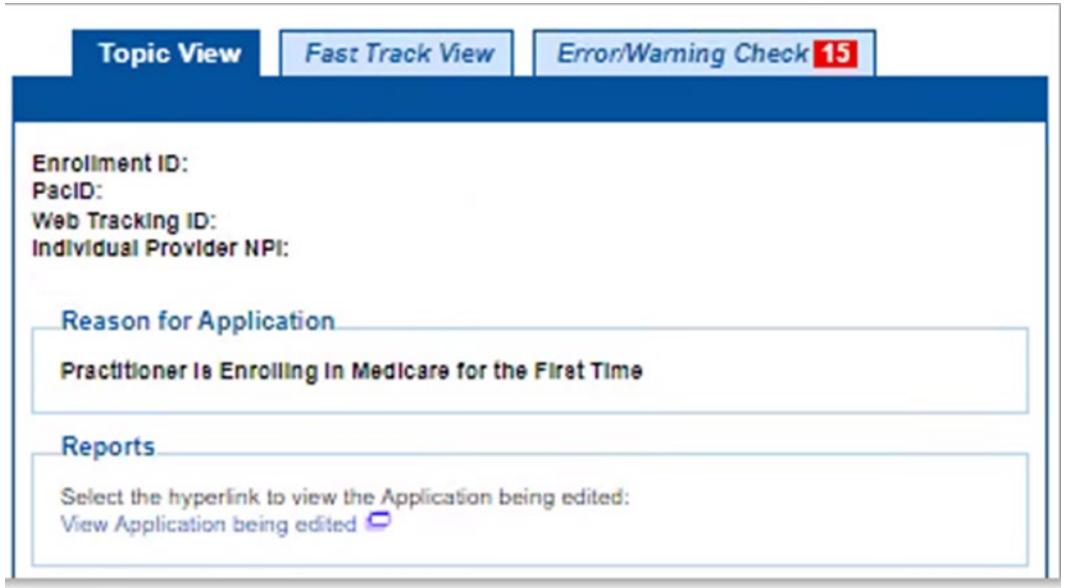
START APPLICATION

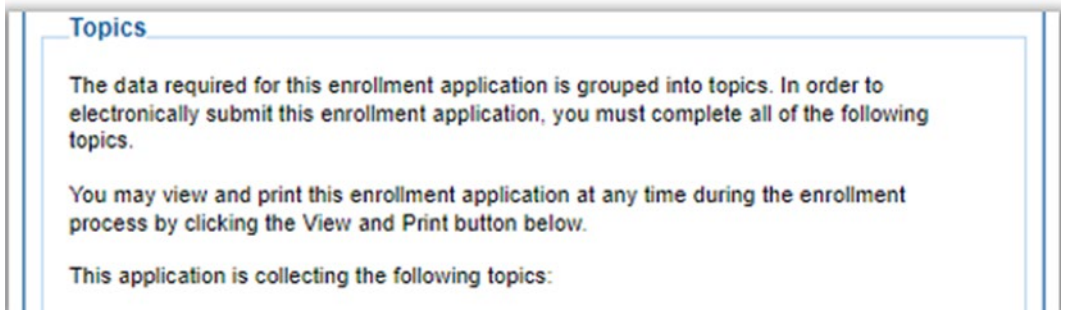
CANCEL

- **A Medicare Part B practitioner is enrolling in the Medicare program for the first time using their social security number (SSN). No reassignment of benefits exists with this application.**

- **A Medicare Part B practitioner is enrolling in the Medicare program for the first time using their social security number (SSN). The Medicare Part B practitioner will be billing using 99-9999999 (EIN). No reassignment of benefits exists with this application.**

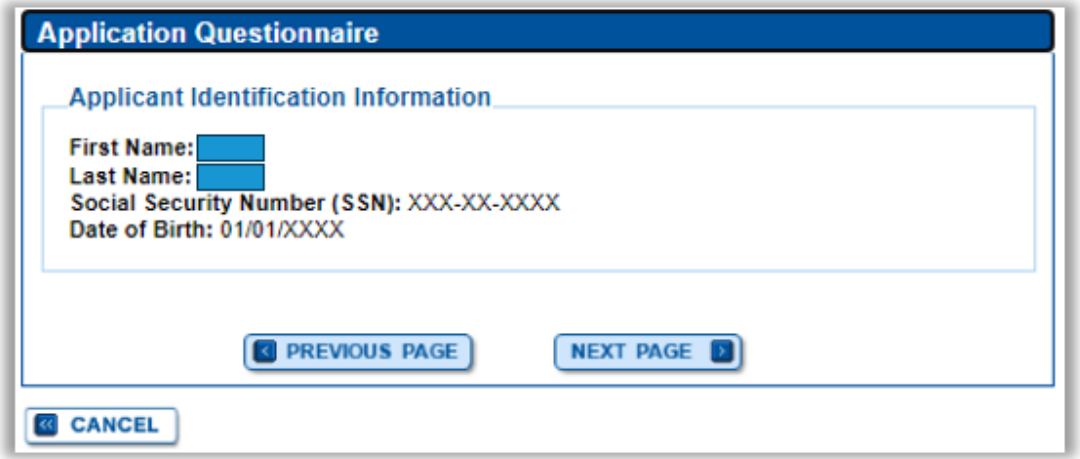
Sole Proprietor – Topic View

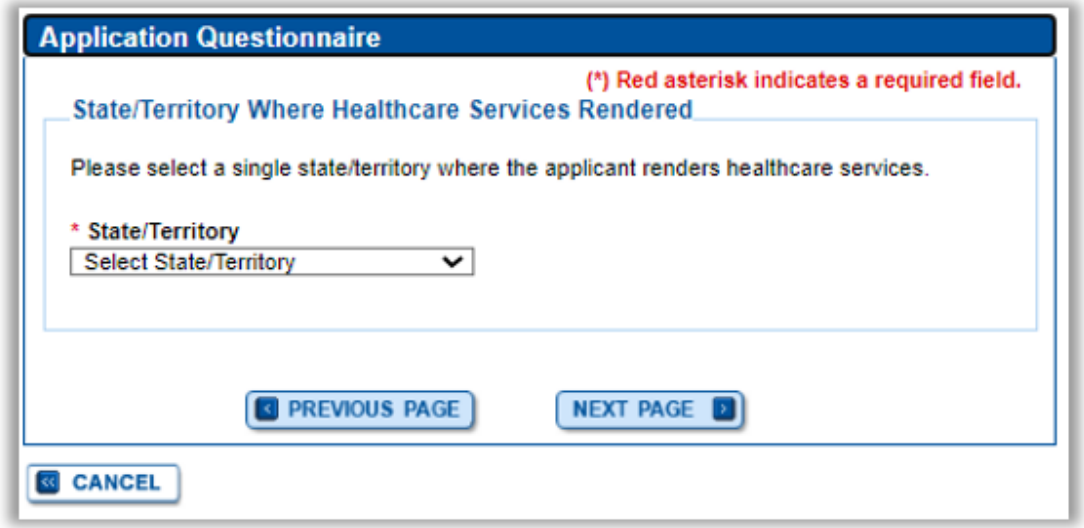




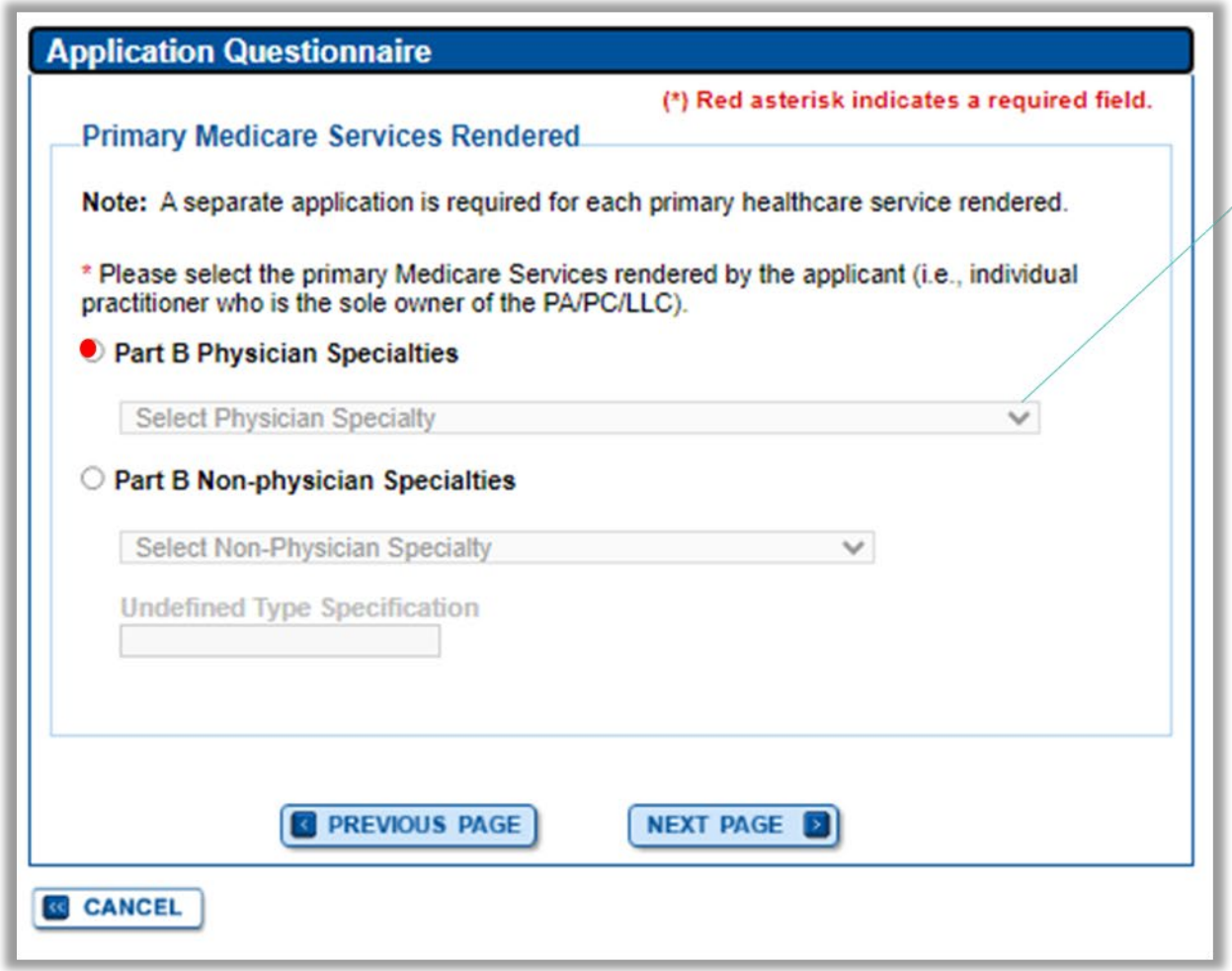
Group Member Questionnaire

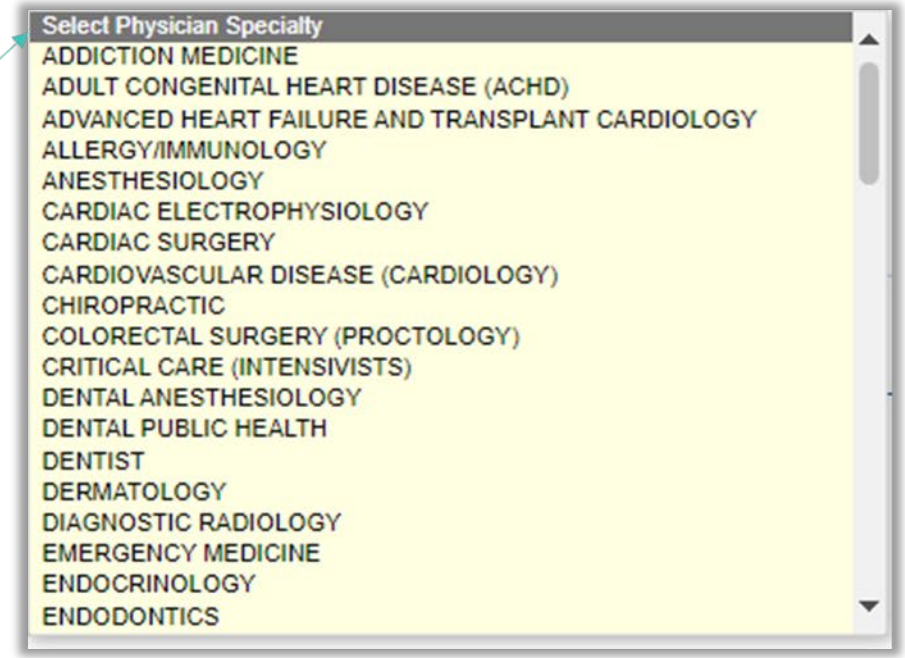
Group Member Questionnaire



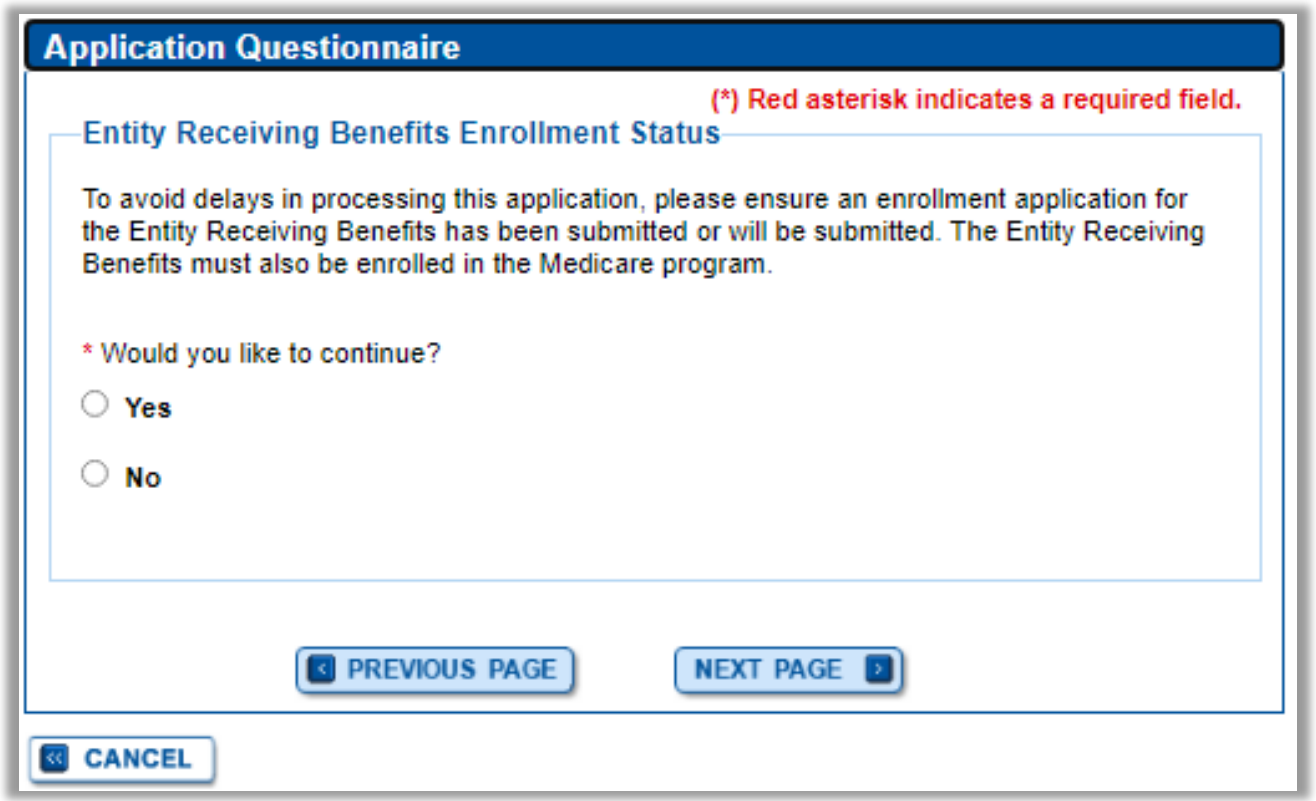


Sole Owner Questionnaire

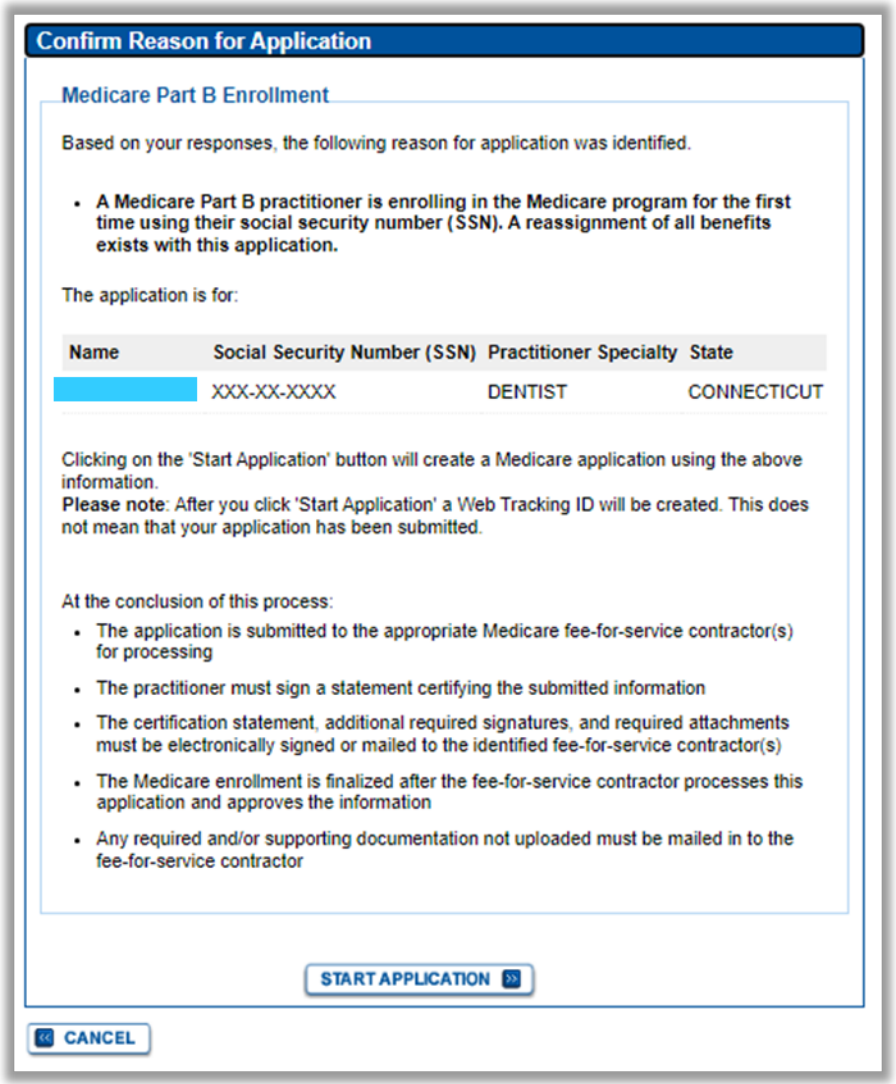




Group Member Questionnaire



Group Member - Reason for Application



Confirm Reason for Application

Medicare Part B Enrollment

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

- **A Medicare Part B practitioner is enrolling in the Medicare program for the first time using their social security number (SSN). A reassignment of all benefits exists with this application.**

The application is for:

Name	Social Security Number (SSN)	Practitioner Specialty	State
	XXX-XX-XXXX	DENTIST	CONNECTICUT

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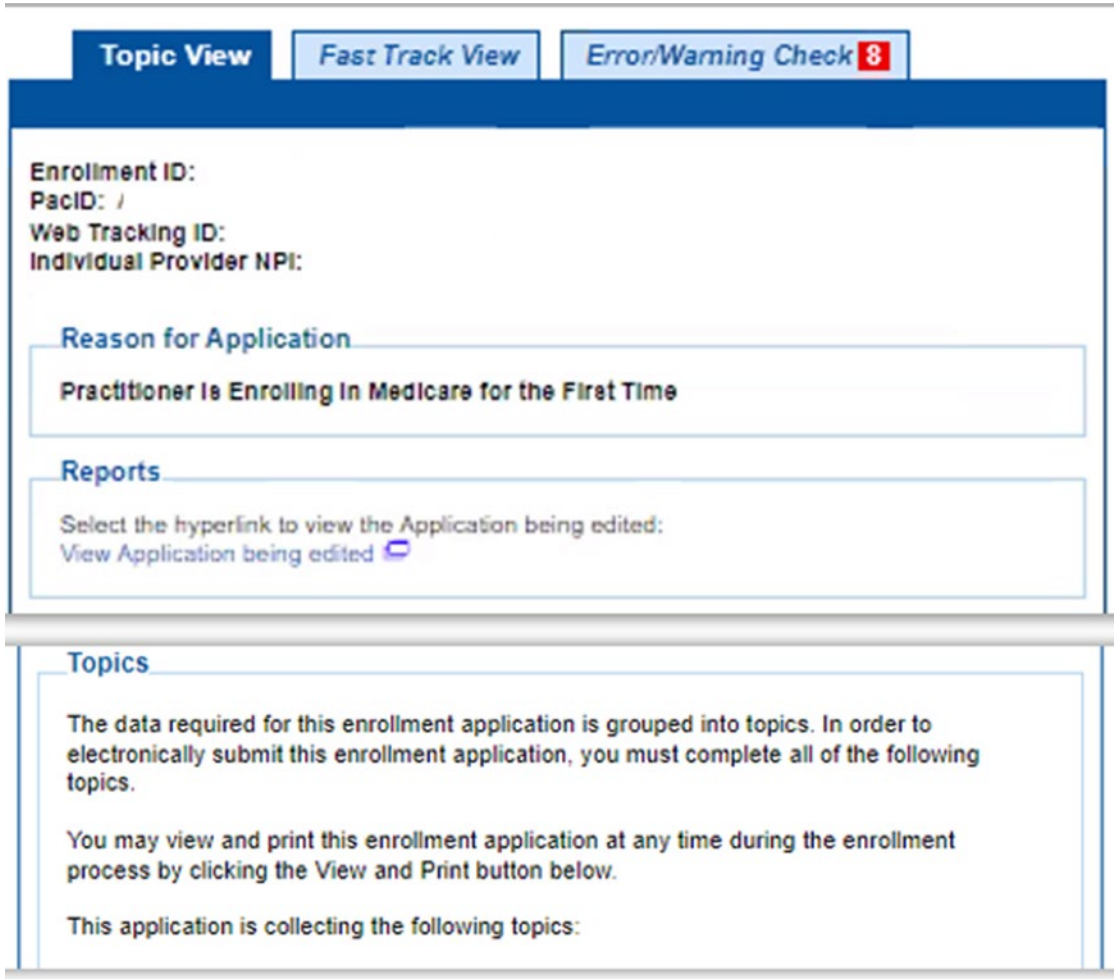
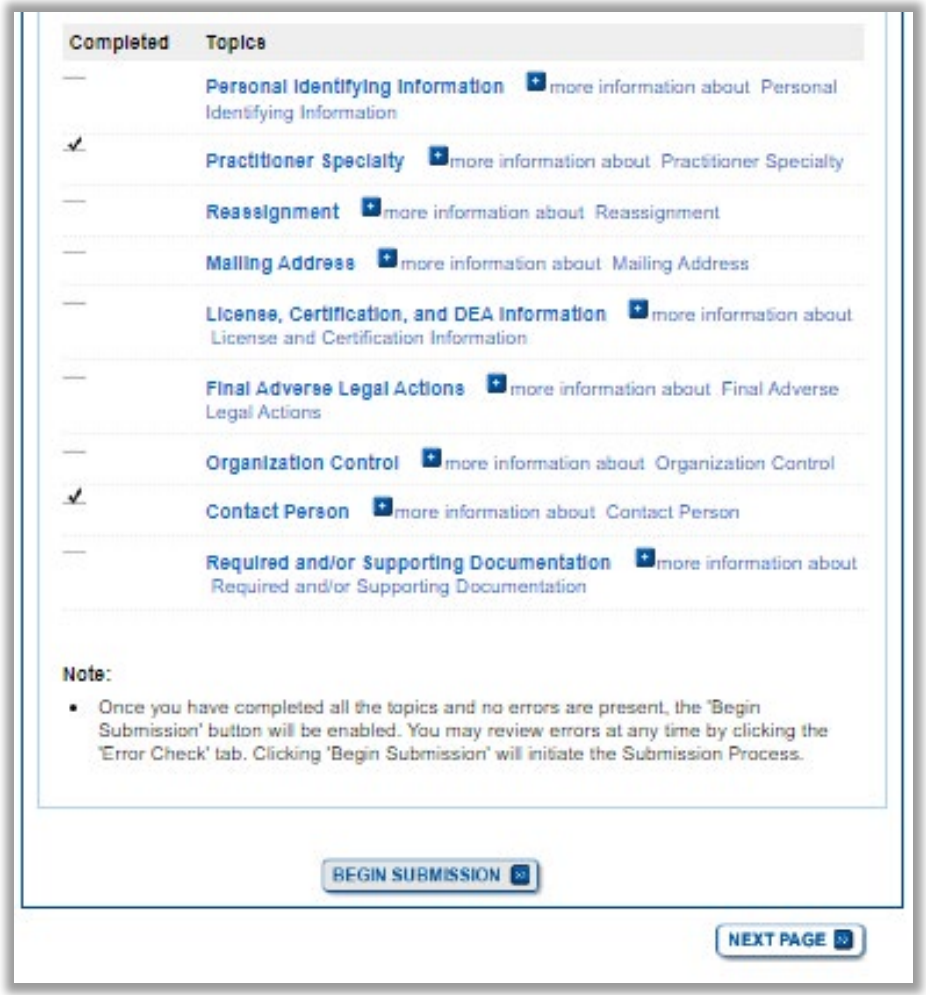
START APPLICATION

CANCEL

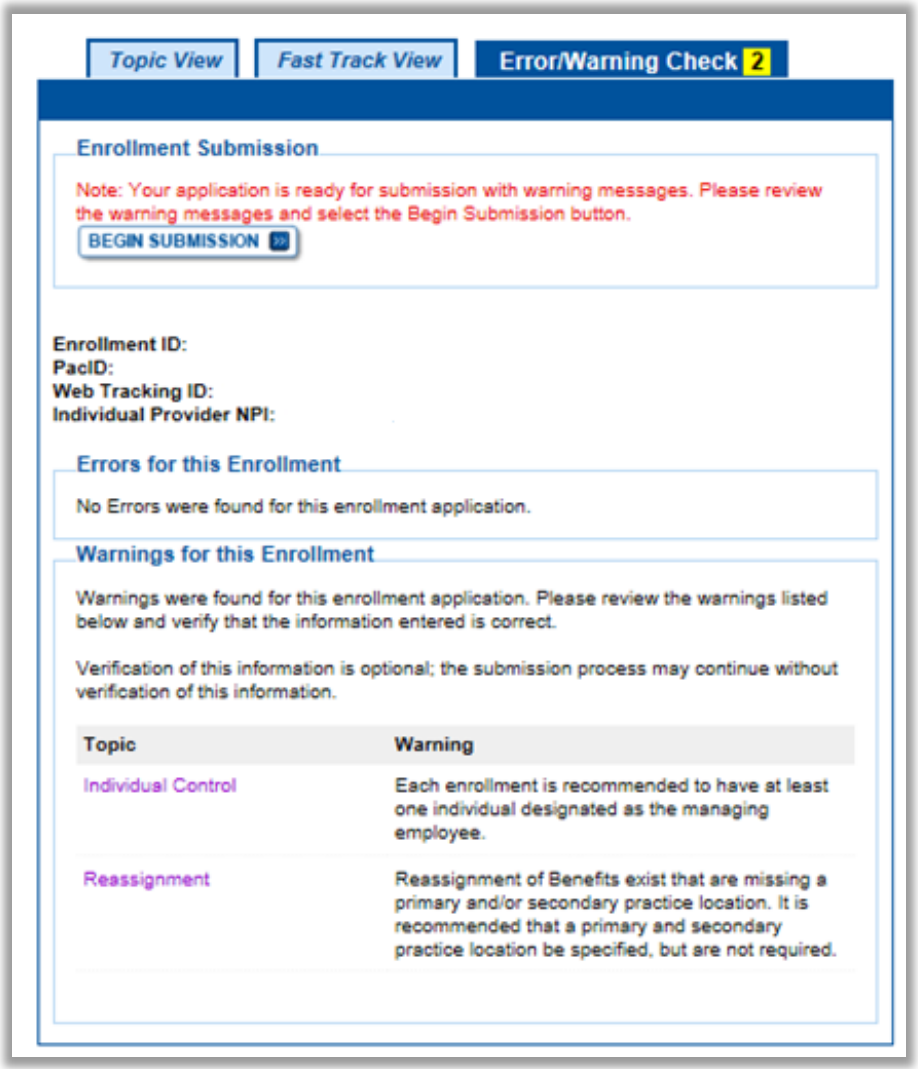
Group Member – Topic View



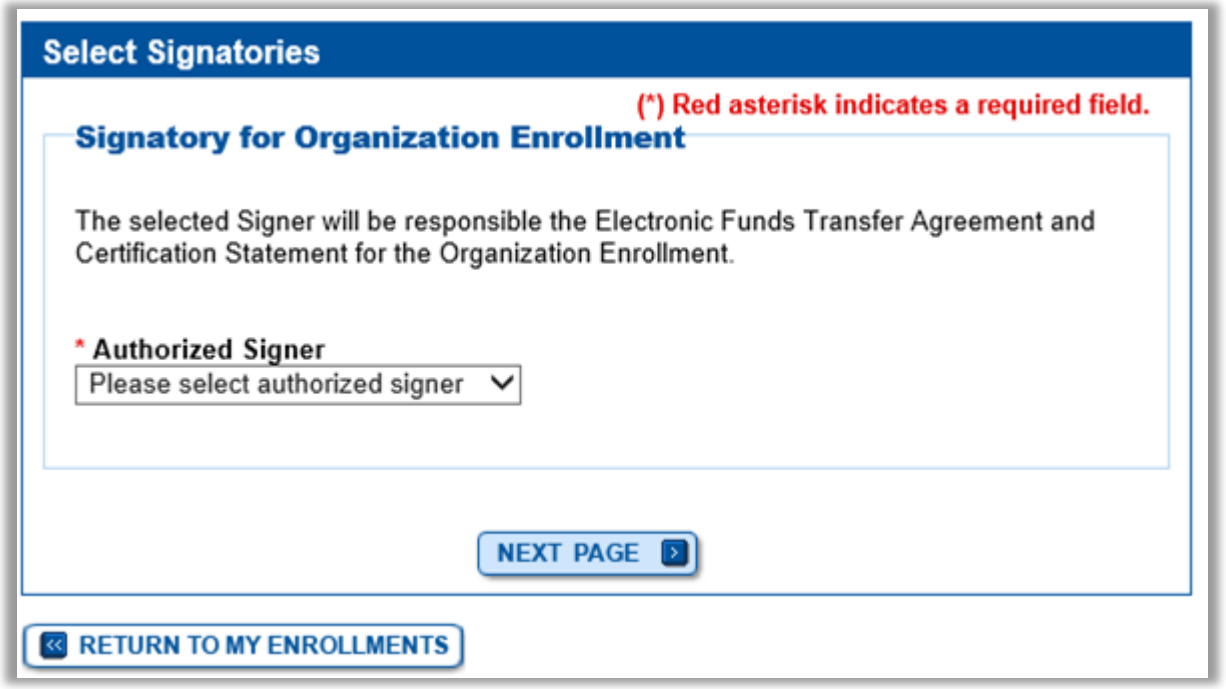


Errors/Warning Check

Error/Warning Check



Manage Signatures



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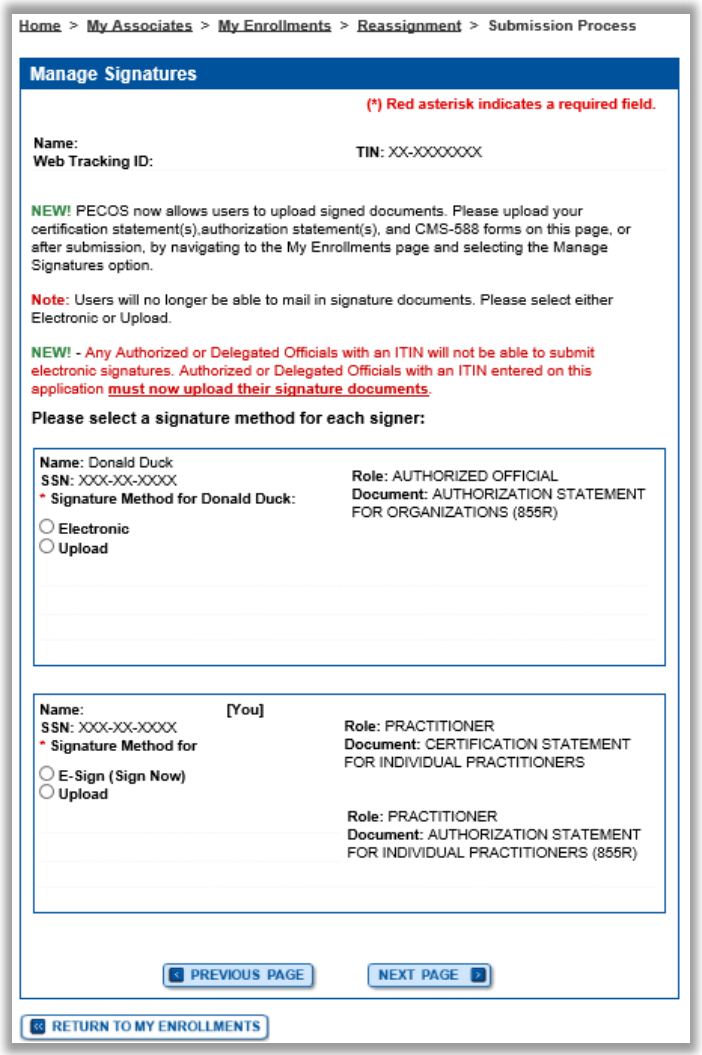


Home > My Associates > My Enrollments > Reassignment > Submission Process

Manage Signatures

(*) Red asterisk indicates a required field.

Name:
Web Tracking ID:

TIN: XX-XXXXXXX

NEW! 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.

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**.

Please select a signature method for each signer:

Name: Donald Duck
SSN: XXX-XX-XXXX
* **Signature Method for Donald Duck:**

○ **Electronic**
○ **Upload**

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

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

○ **E-Sign (Sign Now)**
○ **Upload**

Role: PRACTITIONER
Document: CERTIFICATION STATEMENT FOR INDIVIDUAL PRACTITIONERS

Role: PRACTITIONER
Document: AUTHORIZATION STATEMENT FOR INDIVIDUAL PRACTITIONERS (855R)

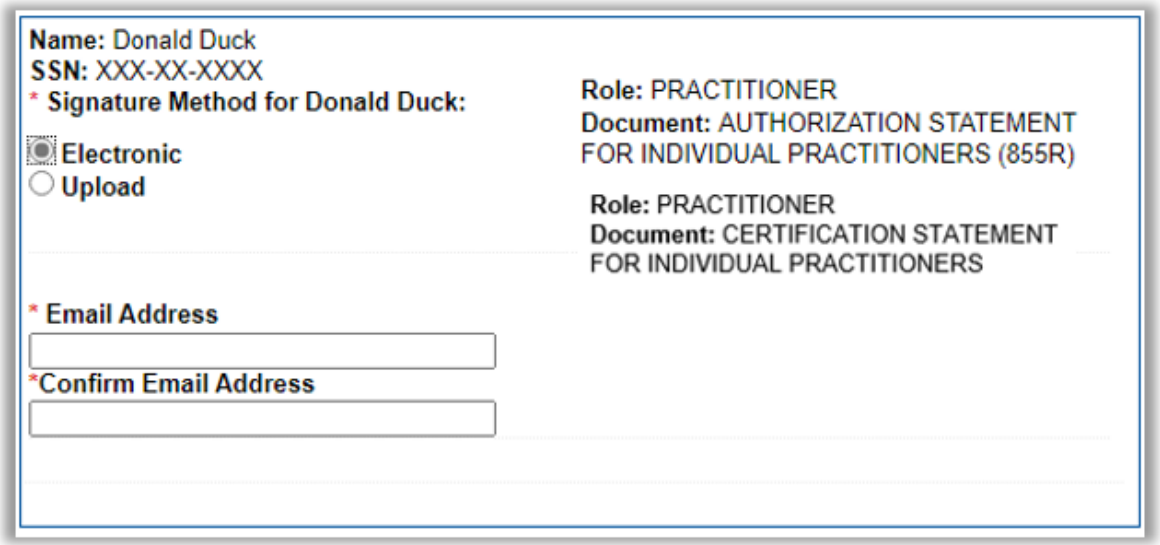
PREVIOUS PAGE NEXT PAGE

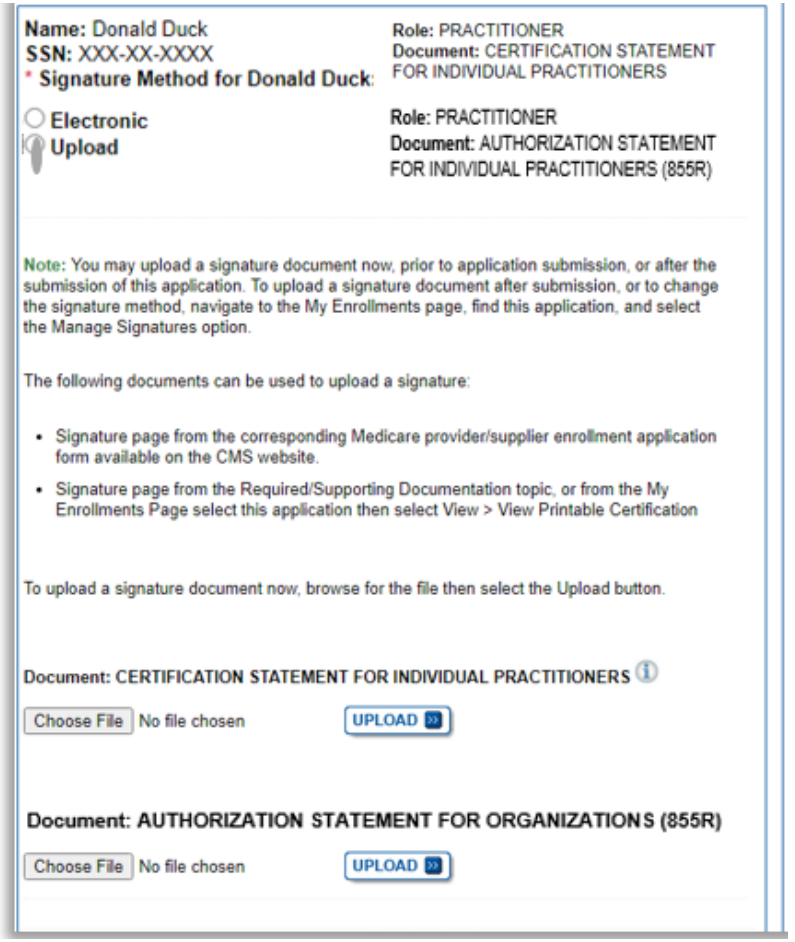
RETURN TO MY ENROLLMENTS

national government SERVICES

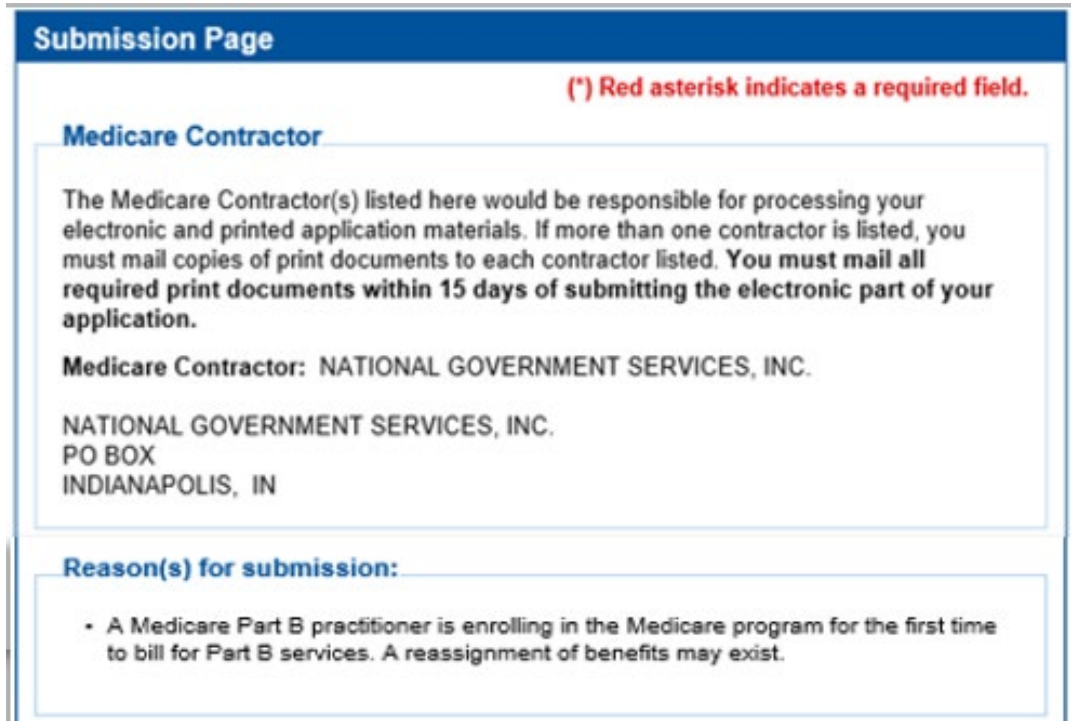
NGSMU

Manage Signatures





Complete Submission



Submission Page

(*) Red asterisk indicates a required field.

Medicare Contractor

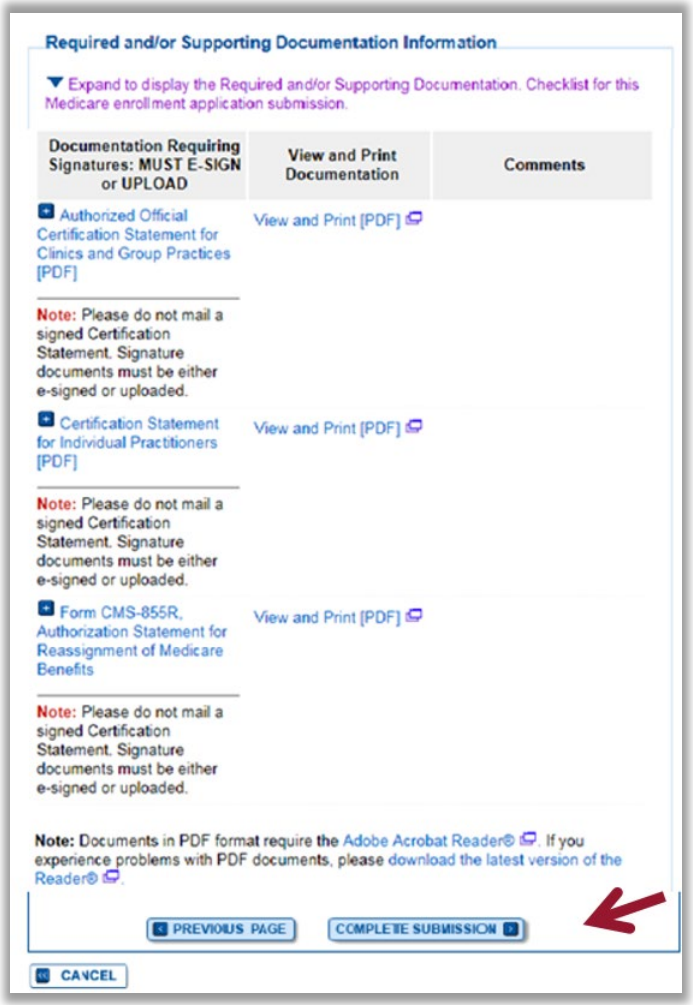
The Medicare Contractor(s) listed here would be responsible for processing your electronic and printed application materials. If more than one contractor is listed, you must mail copies of print documents to each contractor listed. **You must mail all required print documents within 15 days of submitting 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 practitioner is enrolling in the Medicare program for the first time to bill for Part B services. A reassignment of benefits may exist.



Required and/or Supporting Documentation Information

Expand to display the Required and/or Supporting Documentation. Checklist for this Medicare enrollment application submission.

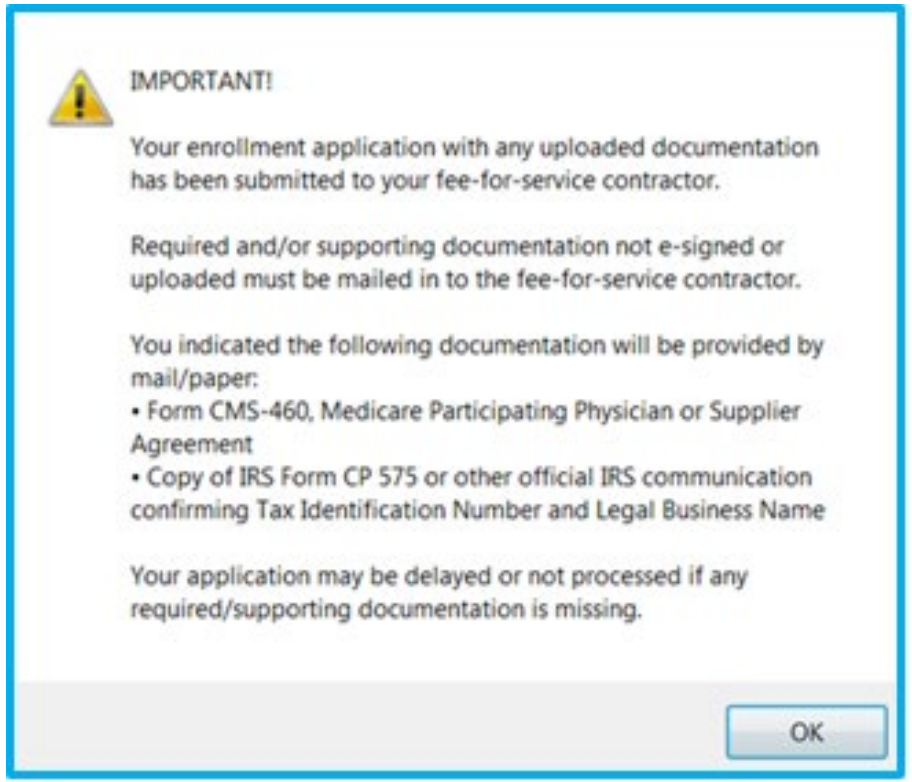
Documentation Requiring Signatures: MUST E-SIGN or UPLOAD	View and Print Documentation	Comments
Authorized Official Certification Statement for Clinics and Group Practices [PDF]	View and Print [PDF]	
Note: Please do not mail a signed Certification Statement. Signature documents must be either e-signed or uploaded.		
Certification Statement for Individual Practitioners [PDF]	View and Print [PDF]	
Note: Please do not mail a signed Certification Statement. Signature documents must be either e-signed or uploaded.		
Form CMS-855R, Authorization Statement for Reassignment of Medicare Benefits	View and Print [PDF]	
Note: Please do not mail a signed Certification Statement. Signature documents must be either e-signed or uploaded.		

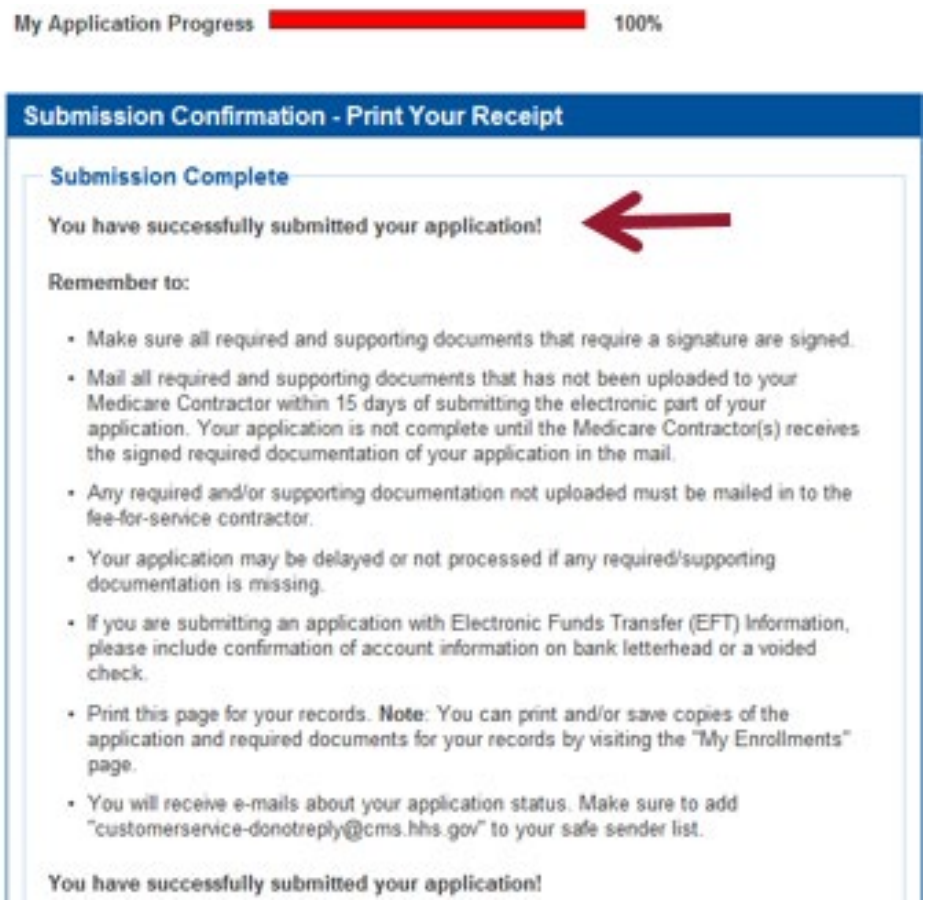
Note: Documents in PDF format require the Adobe Acrobat Reader®. If you experience problems with PDF documents, please download the latest version of the Reader®.

PREVIOUS PAGE | COMPLETE SUBMISSION

CANCEL

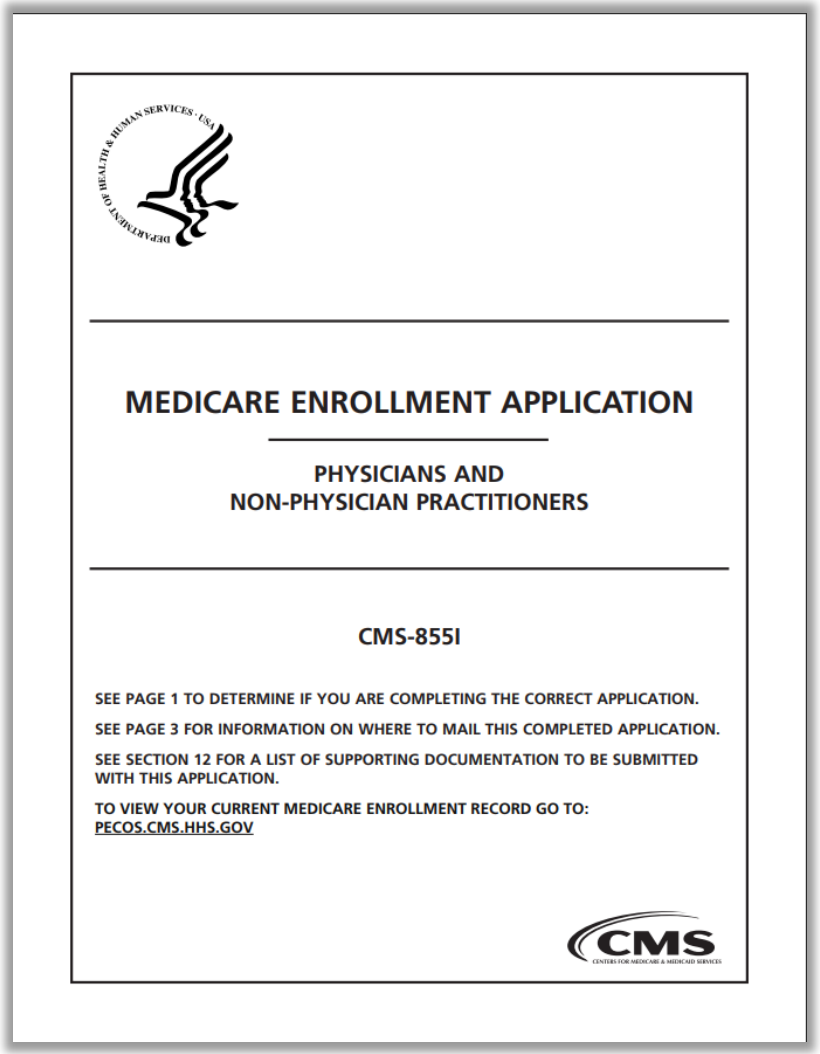
Submission Confirmation





Paper Application: CMS-855I

CMS-855I



MEDICARE ENROLLMENT APPLICATION

PHYSICIANS AND
NON-PHYSICIAN PRACTITIONERS

CMS-855I

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

SEE PAGE 3 FOR INFORMATION ON WHERE TO MAIL THIS COMPLETED APPLICATION.

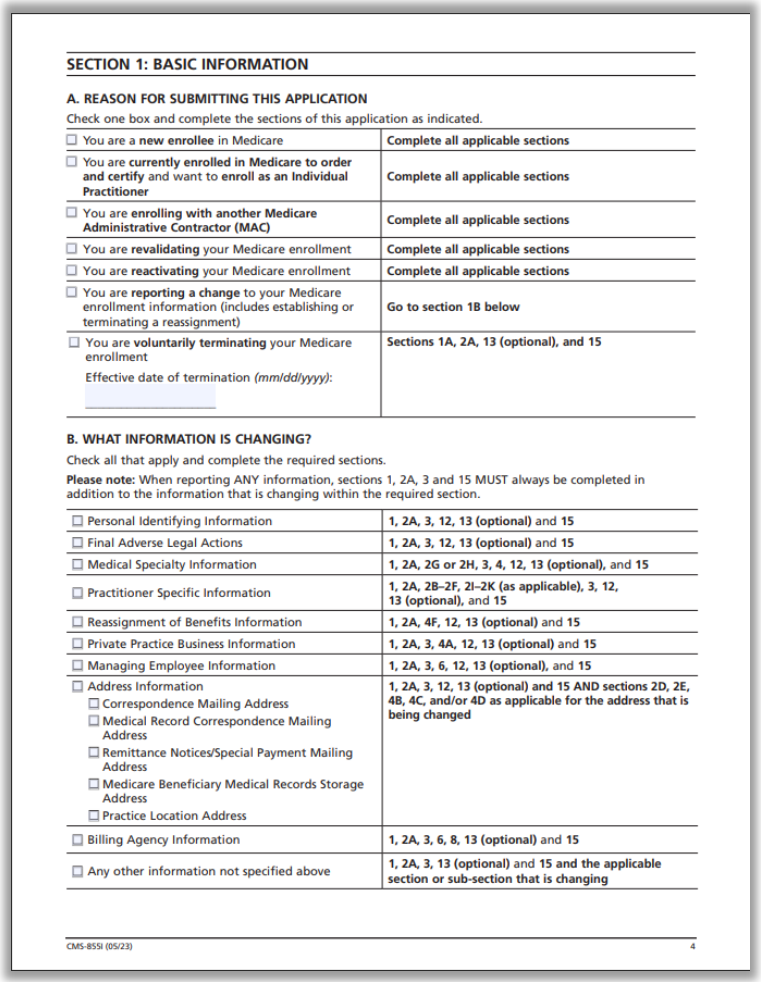
SEE SECTION 12 FOR A LIST OF SUPPORTING DOCUMENTATION TO BE SUBMITTED WITH THIS APPLICATION.

TO VIEW YOUR CURRENT MEDICARE ENROLLMENT RECORD GO TO:
PECOS.CMS.HHS.GOV

Section 1: Basic Information

A. Reason for Submitting this Application

- Mark and complete entire application for
  - New enrollee
  - Currently enrolled to order/refer only and want to enroll to bill Medicare
  - Enrolling with another MAC
  - Revalidating
  - Reactivating
- Mark and complete specified section if
  - Reporting a change; or
  - Voluntarily terminating



SECTION 1: BASIC INFORMATION

A. REASON FOR SUBMITTING THIS APPLICATION

Check one box and complete the sections of this application as indicated.

☐ You are a **new enrollee** in Medicare	**Complete all applicable sections**
☐ You are **currently enrolled in Medicare to order and certify** and want to **enroll as an Individual Practitioner**	**Complete all applicable sections**
☐ You are **enrolling with another Medicare Administrative Contractor (MAC)**	**Complete all applicable sections**
☐ You are **revalidating** your Medicare enrollment	**Complete all applicable sections**
☐ You are **reactivating** your Medicare enrollment	**Complete all applicable sections**
☐ You are **reporting a change** to your Medicare enrollment information (includes establishing or terminating a reassignment)	**Go to section 1B below**
☐ You are **voluntarily terminating** your Medicare enrollment Effective date of termination *(mm/dd/yyyy)*:	**Sections 1A, 2A, 13 (optional), and 15**

B. WHAT INFORMATION IS CHANGING?

Check all that apply and complete the required sections.

Please note: When reporting ANY information, sections 1, 2A, 3 and 15 MUST always be completed in addition to the information that is changing within the required section.

☐ Personal Identifying Information	**1, 2A, 3, 12, 13 (optional)** and **15**
☐ Final Adverse Legal Actions	**1, 2A, 3, 12, 13 (optional)** and **15**
☐ Medical Specialty Information	**1, 2A, 2G or 2H, 3, 4, 12, 13 (optional),** and **15**
☐ Practitioner Specific Information	**1, 2A, 2B–2F, 2I–2K (as applicable), 3, 12, 13 (optional),** and **15**
☐ Reassignment of Benefits Information	**1, 2A, 4F, 12, 13 (optional)** and **15**
☐ Private Practice Business Information	**1, 2A, 3, 4A, 12, 13 (optional)** and **15**
☐ Managing Employee Information	**1, 2A, 3, 6, 12, 13 (optional),** and **15**
☐ Address Information ☐ Correspondence Mailing Address ☐ Medical Record Correspondence Mailing Address ☐ Remittance Notices/Special Payment Mailing Address ☐ Medicare Beneficiary Medical Records Storage Address ☐ Practice Location Address	**1, 2A, 3, 12, 13 (optional) and 15 AND sections 2D, 2E, 4B, 4C, and/or 4D as applicable for the address that is being changed**
☐ Billing Agency Information	**1, 2A, 3, 6, 8, 13 (optional)** and **15**
☐ Any other information not specified above	**1, 2A, 3, 13 (optional)** and **15 and the applicable section or sub-section that is changing**

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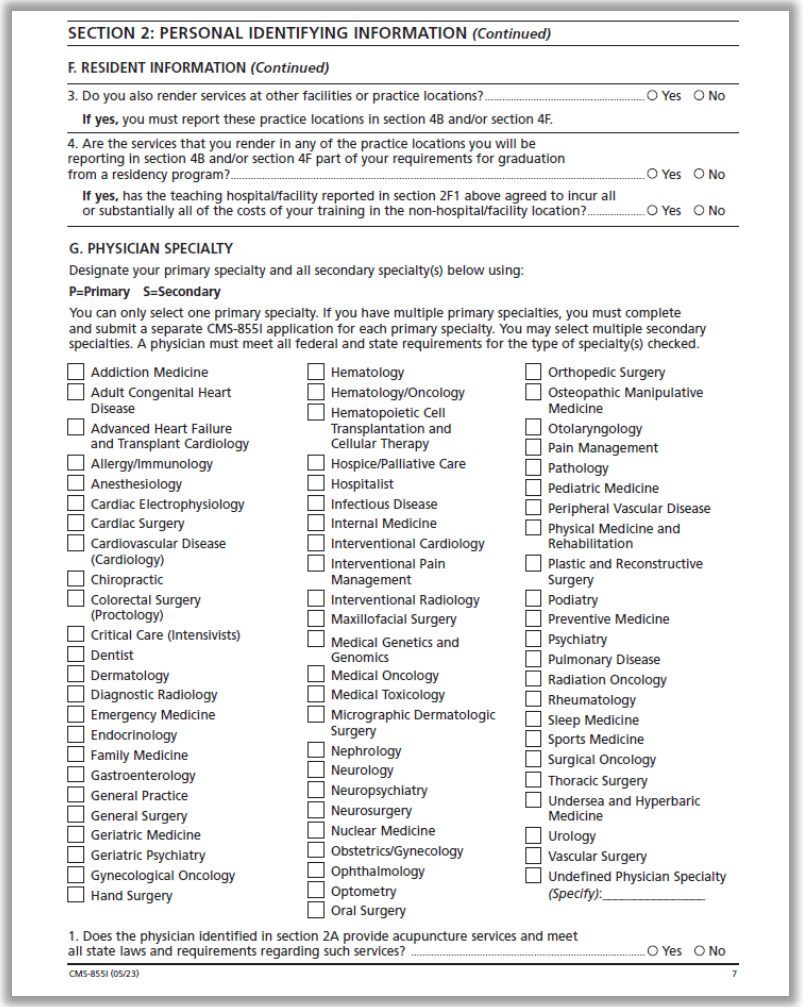
Section 2: Personal Identifying Information

G. Physician Specialty

- Select a primary specialty (designated with a “P”)
  - you may select multiple secondary specialties (designated with “S”)
- Must meet all federal and state requirements for specialty checked



SECTION 2: PERSONAL IDENTIFYING INFORMATION *(Continued)*

F. RESIDENT INFORMATION *(Continued)*

3. Do you also render services at other facilities or practice locations? ○ Yes ○ No

If yes, you must report these practice locations in section 4B and/or section 4F.

4. Are the services that you render in any of the practice locations you will be reporting in section 4B and/or section 4F part of your requirements for graduation from a residency program? ○ Yes ○ No

If yes, has the teaching hospital/facility reported in section 2F1 above agreed to incur all or substantially all of the costs of your training in the non-hospital/facility location? ○ Yes ○ No

G. PHYSICIAN SPECIALTY

Designate your primary specialty and all secondary specialty(s) below using:

P=Primary S=Secondary

You can only select one primary specialty. If you have multiple primary specialties, you must complete and submit a separate CMS-855I application for each primary specialty. You may select multiple secondary specialties. A physician must meet all federal and state requirements for the type of specialty(s) checked.

- ☐ Addiction Medicine
- ☐ Adult Congenital Heart Disease
- ☐ Advanced Heart Failure and Transplant Cardiology
- ☐ Allergy/Immunology
- ☐ Anesthesiology
- ☐ Cardiac Electrophysiology
- ☐ Cardiac Surgery
- ☐ Cardiovascular Disease (Cardiology)
- ☐ Chiropractic
- ☐ Colorectal Surgery (Proctology)
- ☐ Critical Care (Intensivists)
- ☐ Dentist
- ☐ Dermatology
- ☐ Diagnostic Radiology
- ☐ Emergency Medicine
- ☐ Endocrinology
- ☐ Family Medicine
- ☐ Gastroenterology
- ☐ General Practice
- ☐ General Surgery
- ☐ Geriatric Medicine
- ☐ Geriatric Psychiatry
- ☐ Gynecological Oncology
- ☐ Hand Surgery
- ☐ Hematology
- ☐ Hematology/Oncology
- ☐ Hematopoietic Cell Transplantation and Cellular Therapy
- ☐ Hospice/Palliative Care
- ☐ Hospitalist
- ☐ Infectious Disease
- ☐ Internal Medicine
- ☐ Interventional Cardiology
- ☐ Interventional Pain Management
- ☐ Interventional Radiology
- ☐ Maxillofacial Surgery
- ☐ Medical Genetics and Genomics
- ☐ Medical Oncology
- ☐ Medical Toxicology
- ☐ Micrographic Dermatologic Surgery
- ☐ Nephrology
- ☐ Neurology
- ☐ Neuropsychiatry
- ☐ Neurosurgery
- ☐ Nuclear Medicine
- ☐ Obstetrics/Gynecology
- ☐ Ophthalmology
- ☐ Optometry
- ☐ Oral Surgery
- ☐ Orthopedic Surgery
- ☐ Osteopathic Manipulative Medicine
- ☐ Otolaryngology
- ☐ Pain Management
- ☐ Pathology
- ☐ Pediatric Medicine
- ☐ Peripheral Vascular Disease
- ☐ Physical Medicine and Rehabilitation
- ☐ Plastic and Reconstructive Surgery
- ☐ Podiatry
- ☐ Preventive Medicine
- ☐ Psychiatry
- ☐ Pulmonary Disease
- ☐ Radiation Oncology
- ☐ Rheumatology
- ☐ Sleep Medicine
- ☐ Sports Medicine
- ☐ Surgical Oncology
- ☐ Thoracic Surgery
- ☐ Undersea and Hyperbaric Medicine
- ☐ Urology
- ☐ Vascular Surgery
- ☐ Undefined Physician Specialty *(Specify):*_____

1. Does the physician identified in section 2A provide acupuncture services and meet all state laws and requirements regarding such services? ○ Yes ○ No

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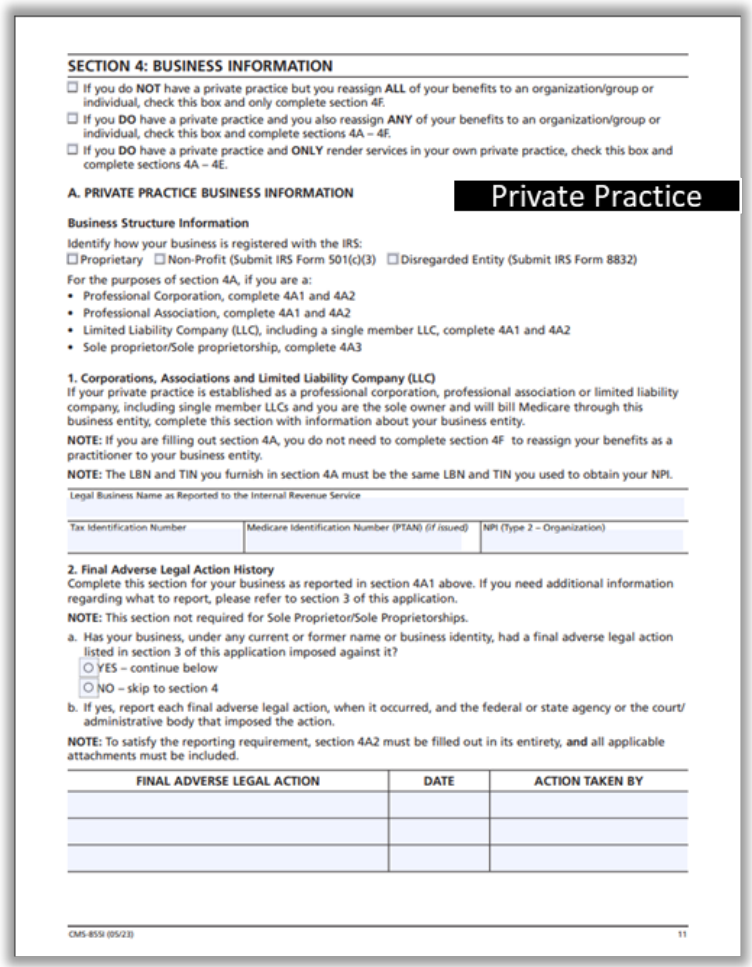
Section 4: Business Information

- Check applicable box for additional instructions
  - Individual reassigning all benefits, 4F only
  - Private Practice and reassigning benefits, 4A – 4F
  - Private practice and not reassigning benefits, 4A – 4E

A. Private Practice Business Information
- Identify business structure
- Sole Owner: PC, PA or LLC complete sections 4A1 and 4A2
- Sole Proprietor complete section 4A3

1. Corporations, Associations and Limited Liability Company (LLC)
   - Indicate legal business name and TIN as it appears on the IRS document
2. Final Adverse Legal Action History
   - Indicate any final adverse legal action history on the entity identified in this section



SECTION 4: BUSINESS INFORMATION

☐ If you do **NOT** have a private practice but you reassign **ALL** of your benefits to an organization/group or individual, check this box and only complete section 4F.

☐ If you **DO** have a private practice and you also reassign **ANY** of your benefits to an organization/group or individual, check this box and complete sections 4A – 4F.

☐ If you **DO** have a private practice and **ONLY** render services in your own private practice, check this box and complete sections 4A – 4E.

A. PRIVATE PRACTICE BUSINESS INFORMATION Private Practice

Business Structure Information

Identify how your business is registered with the IRS:
☐ Proprietary ☐ Non-Profit (Submit IRS Form 501(c)(3) ☐ Disregarded Entity (Submit IRS Form 8832)

For the purposes of section 4A, if you are a:
- Professional Corporation, complete 4A1 and 4A2
- Professional Association, complete 4A1 and 4A2
- Limited Liability Company (LLC), including a single member LLC, complete 4A1 and 4A2
- Sole proprietor/Sole proprietorship, complete 4A3

1. Corporations, Associations and Limited Liability Company (LLC)
If your private practice is established as a professional corporation, professional association or limited liability company, including single member LLCs and you are the sole owner and will bill Medicare through this business entity, complete this section with information about your business entity.

NOTE: If you are filling out section 4A, you do not need to complete section 4F to reassign your benefits as a practitioner to your business entity.

NOTE: The LBN and TIN you furnish in section 4A must be the same LBN and TIN you used to obtain your NPI.

Legal Business Name as Reported to the Internal Revenue Service		
Tax Identification Number	Medicare Identification Number (PTAN) *(if issued)*	NPI (Type 2 – Organization)

2. Final Adverse Legal Action History
Complete this section for your business as reported in section 4A1 above. If you need additional information regarding what to report, please refer to section 3 of this application.

NOTE: This section not required for Sole Proprietor/Sole Proprietorships.

a. Has your business, under any current or former name or business identity, had a final adverse legal action listed in section 3 of this application imposed against it?
○ YES – continue below
○ NO – skip to section 4

b. If yes, report each final adverse legal action, when it occurred, and the federal or state agency or the court/ administrative body that imposed the action.

NOTE: To satisfy the reporting requirement, section 4A2 must be filled out in its entirety, **and** all applicable attachments must be included.

FINAL ADVERSE LEGAL ACTION	DATE	ACTION TAKEN BY

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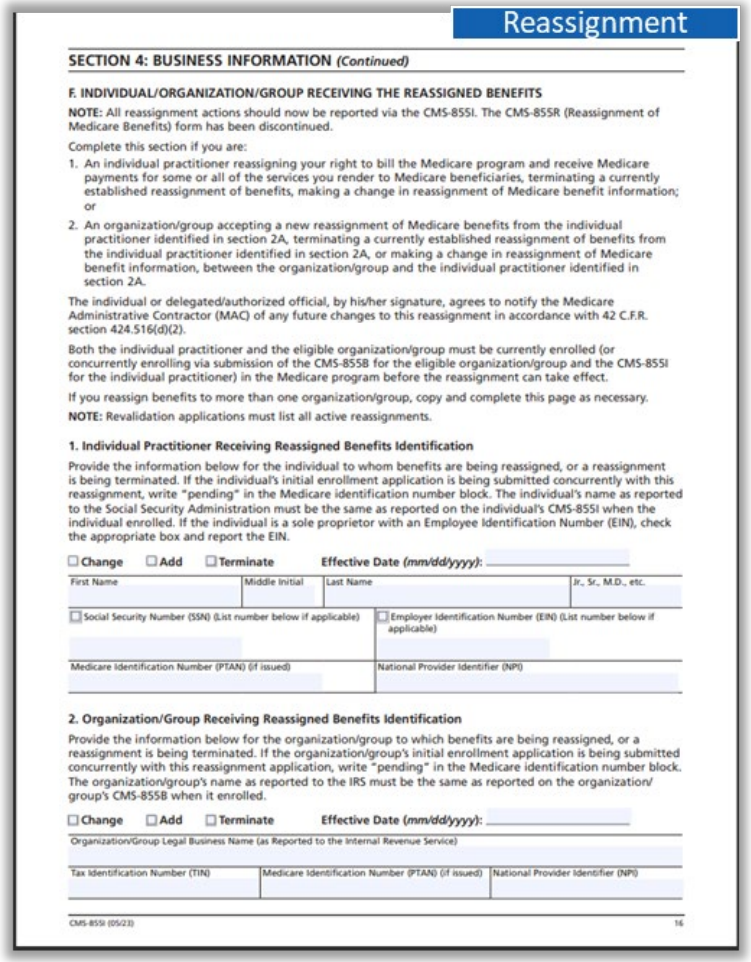
Section 4: Business Information

F. Individual/Organization/Group Receiving the Reassigned Benefits

1. Individual Practitioner Receiving Reassigned Benefits Identification
   - Legal Name
   - SSN or EIN
2. Organization/Group Receiving Reassigned Benefits Identification
   - Legal Business Name
   - TIN



Reassignment

SECTION 4: BUSINESS INFORMATION *(Continued)*

F. INDIVIDUAL/ORGANIZATION/GROUP RECEIVING THE REASSIGNED BENEFITS

NOTE: All reassignment actions should now be reported via the CMS-855I. The CMS-855R (Reassignment of Medicare Benefits) form has been discontinued.

Complete this section if you are:

1. An individual practitioner reassigning your right to bill the Medicare program and receive Medicare payments for some or all of the services you render to Medicare beneficiaries, terminating a currently established reassignment of benefits, making a change in reassignment of Medicare benefit information; or
2. An organization/group accepting a new reassignment of Medicare benefits from the individual practitioner identified in section 2A, terminating a currently established reassignment of benefits from the individual practitioner identified in section 2A, or making a change in reassignment of Medicare benefit information, between the organization/group and the individual practitioner identified in section 2A.

The individual or delegated/authorized official, by his/her signature, agrees to notify the Medicare Administrative Contractor (MAC) of any future changes to this reassignment in accordance with 42 C.F.R. section 424.516(d)(2).

Both the individual practitioner and the eligible organization/group must be currently enrolled (or concurrently enrolling via submission of the CMS-855B for the eligible organization/group and the CMS-855I for the individual practitioner) in the Medicare program before the reassignment can take effect.

If you reassign benefits to more than one organization/group, copy and complete this page as necessary.

NOTE: Revalidation applications must list all active reassignments.

1. Individual Practitioner Receiving Reassigned Benefits Identification

Provide the information below for the individual to whom benefits are being reassigned, or a reassignment is being terminated. If the individual's initial enrollment application is being submitted concurrently with this reassignment, write "pending" in the Medicare identification number block. The individual's name as reported to the Social Security Administration must be the same as reported on the individual's CMS-855I when the individual enrolled. If the individual is a sole proprietor with an Employee Identification Number (EIN), check the appropriate box and report the EIN.

☐ Change ☐ Add ☐ Terminate **Effective Date** *(mm/dd/yyyy)*: _____

First Name	Middle Initial	Last Name	Jr., Sr., M.D., etc.

☐ Social Security Number (SSN) (List number below if applicable)	☐ Employer Identification Number (EIN) (List number below if applicable)

Medicare Identification Number (PTAN) (if issued)	National Provider Identifier (NPI)

2. Organization/Group Receiving Reassigned Benefits Identification

Provide the information below for the organization/group to which benefits are being reassigned, or a reassignment is being terminated. If the organization/group's initial enrollment application is being submitted concurrently with this reassignment application, write "pending" in the Medicare identification number block. The organization/group's name as reported to the IRS must be the same as reported on the organization/group's CMS-855B when it enrolled.

☐ Change ☐ Add ☐ Terminate **Effective Date** *(mm/dd/yyyy)*: _____

Organization/Group Legal Business Name (as Reported to the Internal Revenue Service)		
Tax Identification Number (TIN)	**Medicare Identification Number (PTAN) (if issued)**	**National Provider Identifier (NPI)**

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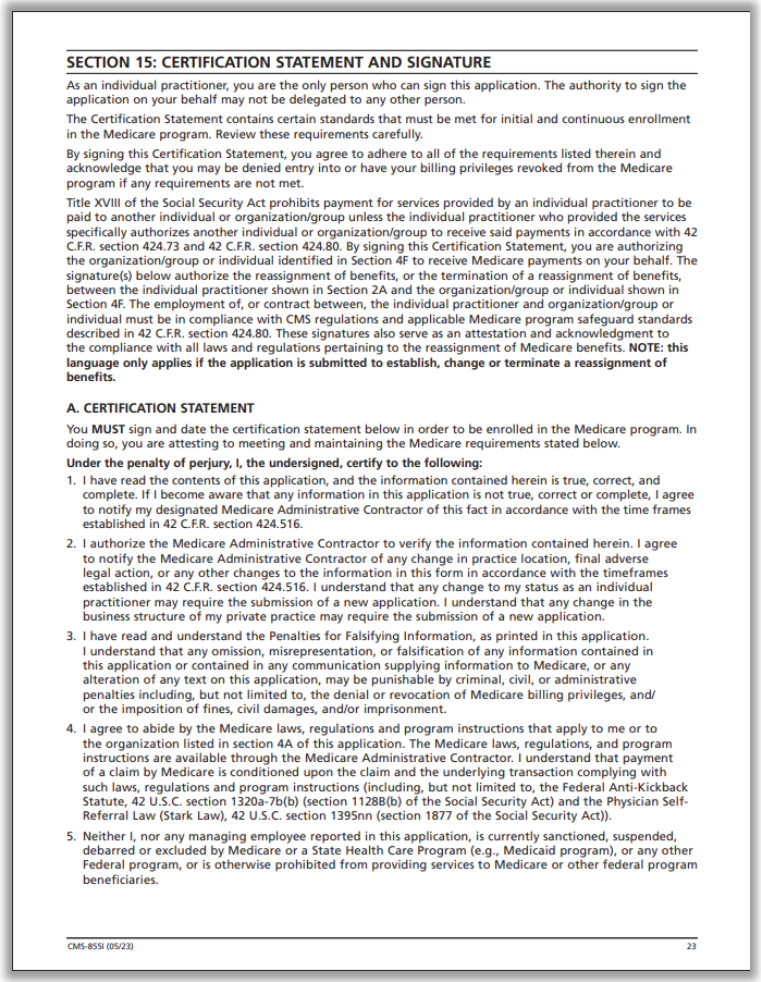
Section 15: Certification Statement and Signature

A. Certification Statement

- Medicare requirements providers must meet and maintain in order to bill Medicare
- By signing the form, the individual provider agrees to adhere to the requirements listed



SECTION 15: CERTIFICATION STATEMENT AND SIGNATURE

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

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

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

Title XVIII of the Social Security Act prohibits payment for services provided by an individual practitioner to be paid to another individual or organization/group unless the individual practitioner who provided the services specifically authorizes another individual or organization/group to receive said payments in accordance with 42 C.F.R. section 424.73 and 42 C.F.R. section 424.80. By signing this Certification Statement, you are authorizing the organization/group or individual identified in Section 4F to receive Medicare payments on your behalf. The signature(s) below authorize the reassignment of benefits, or the termination of a reassignment of benefits, between the individual practitioner shown in Section 2A and the organization/group or individual shown in Section 4F. The employment of, or contract between, the individual practitioner and organization/group or individual must be in compliance with CMS regulations and applicable Medicare program safeguard standards described in 42 C.F.R. section 424.80. These signatures also serve as an attestation and acknowledgment to the compliance with all laws and regulations pertaining to the reassignment of Medicare benefits. **NOTE: this language only applies if the application is submitted to establish, change or terminate a reassignment of benefits.**

A. CERTIFICATION STATEMENT

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

Under the penalty of perjury, I, the undersigned, certify to the following:

1. I have read the contents of this application, and the information contained herein is true, correct, and complete. If I become aware that any information in this application is not true, correct or complete, I agree to notify my designated Medicare Administrative Contractor of this fact in accordance with the time frames established in 42 C.F.R. section 424.516.
2. I authorize the Medicare Administrative Contractor to verify the information contained herein. I agree to notify the Medicare Administrative Contractor of any change in practice location, final adverse legal action, or any other changes to the information in this form in accordance with the timeframes established in 42 C.F.R. section 424.516. I understand that any change to my status as an individual practitioner may require the submission of a new application. I understand that any change in the business structure of my private practice may require the submission of a new application.
3. I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any alteration of any text on this application, may be punishable by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare billing privileges, and/or the imposition of fines, civil damages, and/or imprisonment.
4. I agree to abide by the Medicare laws, regulations and program instructions that apply to me or to the organization listed in section 4A of this application. The Medicare laws, regulations, and program instructions are available through the Medicare Administrative Contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations and program instructions (including, but not limited to, the Federal Anti-Kickback Statute, 42 U.S.C. section 1320a-7b(b) (section 1128B(b) of the Social Security Act) and the Physician Self-Referral Law (Stark Law), 42 U.S.C. section 1395nn (section 1877 of the Social Security Act)).
5. Neither I, nor any managing employee reported in this application, is currently sanctioned, suspended, debarred or excluded by Medicare or a State Health Care Program (e.g., Medicaid program), or any other Federal program, or is otherwise prohibited from providing services to Medicare or other federal program beneficiaries.

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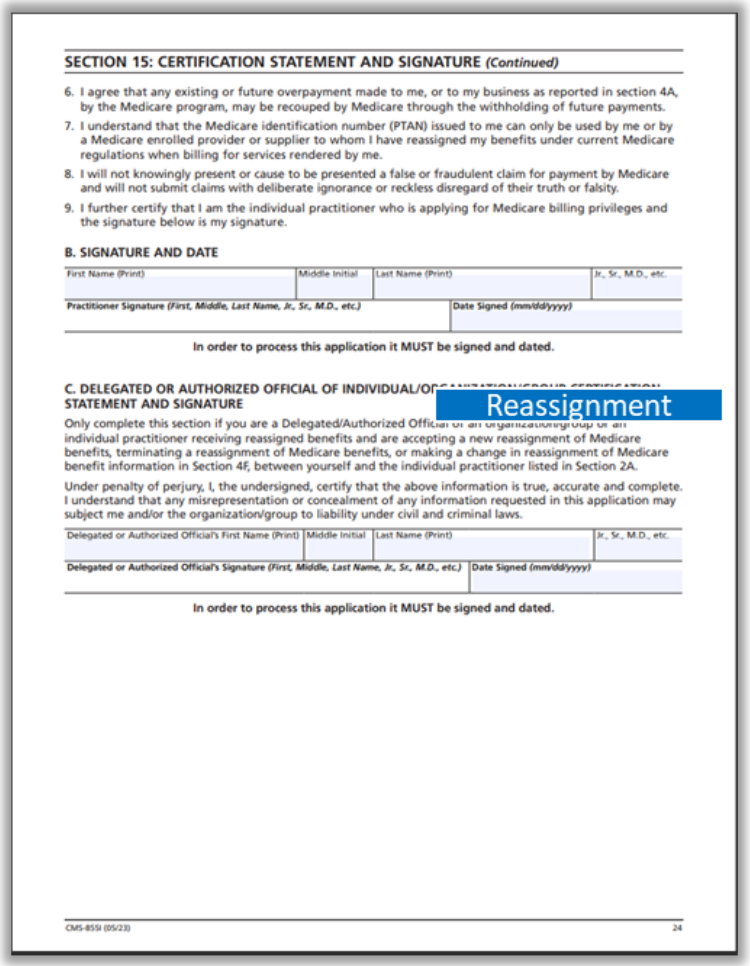
Section 15: Certification Statement and Signature

A. Certification Statement (continue)

B. Signature and Date
   - Signed only by the Individual provider

C. Delegated or Authorized Official of Individual/Organization/Group Certification Statement and Signature
   - Sign and date for reassignment of benefits

- **Note**
  - Must be original signature in ink
  - Stamped signatures are not acceptable
  - Reassignment
    - Add reassignment: B and C signatures are required
    - Terminating or making a change: B **or** C signature is required



SECTION 15: CERTIFICATION STATEMENT AND SIGNATURE *(Continued)*

6. I agree that any existing or future overpayment made to me, or to my business as reported in section 4A, by the Medicare program, may be recouped by Medicare through the withholding of future payments.
7. I understand that the Medicare identification number (PTAN) issued to me can only be used by me or by a Medicare enrolled provider or supplier to whom I have reassigned my benefits under current Medicare regulations when billing for services rendered by me.
8. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.
9. I further certify that I am the individual practitioner who is applying for Medicare billing privileges and the signature below is my signature.

B. SIGNATURE AND DATE

First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.

Practitioner Signature *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*	Date Signed *(mm/dd/yyyy)*

In order to process this application it MUST be signed and dated.

C. DELEGATED OR AUTHORIZED OFFICIAL OF INDIVIDUAL/OR... STATEMENT AND SIGNATURE

Reassignment

Only complete this section if you are a Delegated/Authorized Offici... individual practitioner receiving reassigned benefits and are accepting a new reassignment of Medicare benefits, terminating a reassignment of Medicare benefits, or making a change in reassignment of Medicare benefit information in Section 4F, between yourself and the individual practitioner listed in Section 2A.

Under penalty of perjury, I, the undersigned, certify that the above information is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me and/or the organization/group to liability under civil and criminal laws.

Delegated or Authorized Official's First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.

Delegated or Authorized Official's Signature *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*	Date Signed *(mm/dd/yyyy)*

In order to process this application it MUST be signed and dated.

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Supporting Documentation

Key Documents

- The following key documents are required when applicable
  - CMS-460 Medicare Participating Physician or Supplier Agreement (optional)
  - CMS-588 Electronic Funds Transfer Authorization Agreement and voided check or bank letter
  - IRS document with legal business name and TIN or EIN confirmation
    - IRS form CP-575, IRS form 147c. IRS form 501(c)(3) or Disregard entity IRS form 8832
  - Final adverse legal action documentation and resolution

Process After Submission

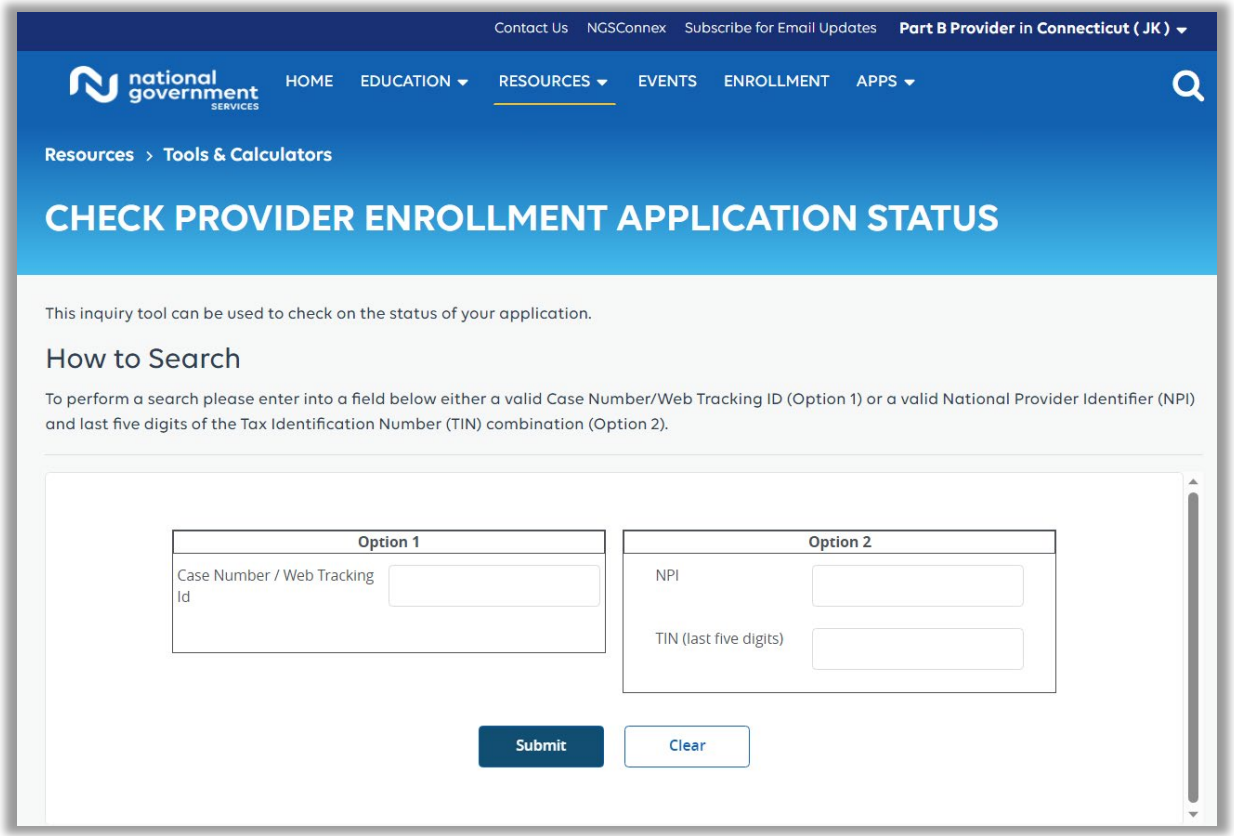
After Submission

- Contact person on application will receive by email
  - Acknowledgement Notice
    - Add to safe sender list
      - customerservice-donotreply@cms.hhs.gov
      - 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 for incomplete/no response to development request
    - Approval

Check Application Status

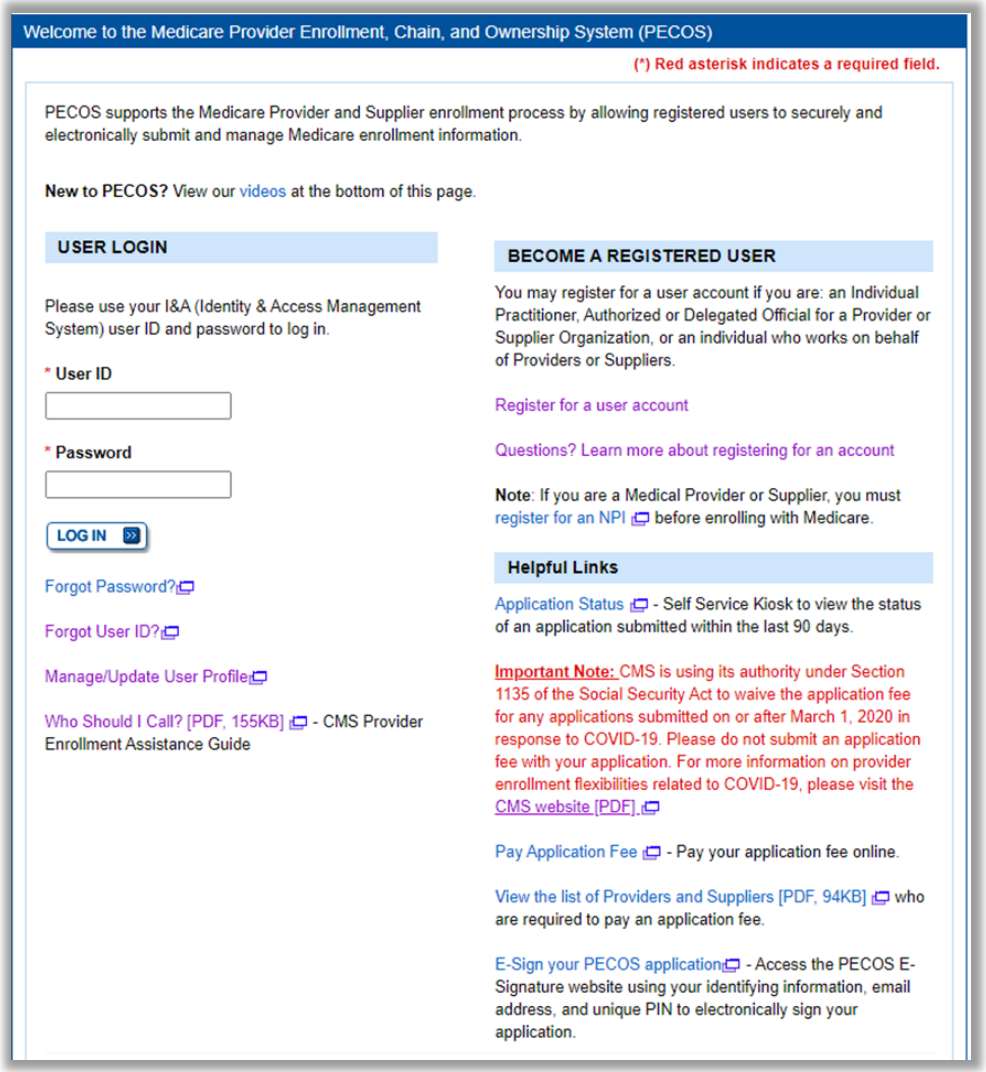
Check Provider Enrollment Application Status

- Go to our website > Resources > Tools & Calculators > Check Provider Enrollment Application Status



Contact Information and Resources

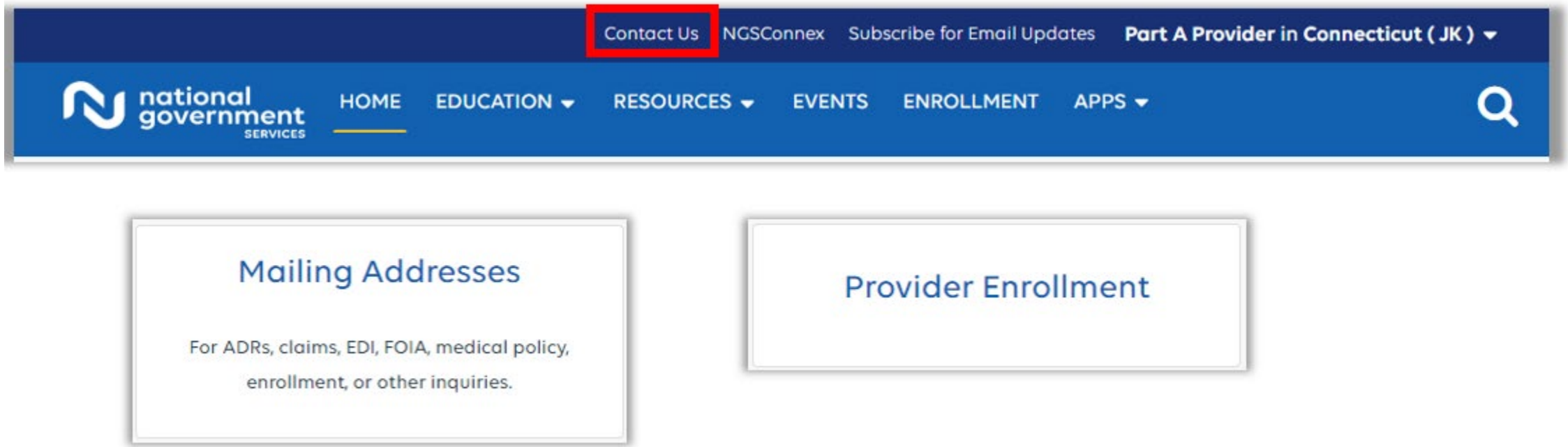
Online Account Self-Service Features



Contact Information

For Assistance With	Contact	Contact Information
• Changing an NPPES password • Establishing a new user ID and password for NPPES • Questions related to the NPI application	NPI Enumerator	Phone: 800-465-3203 TTY: 800-692-2326 Email: customerservice@npienumerator.com
• Errors encountered while accessing or entering information in PECOS • Forgotten PECOS user IDs and passwords	EUS Help Desk	Phone: 866-484-8049 TTY: 866-523-4759 Email: EUSSupport@cgi.com Live Chat: https://eus.custhelp.com/

NGS Website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RESOURCES
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ENROLLMENT
APPS
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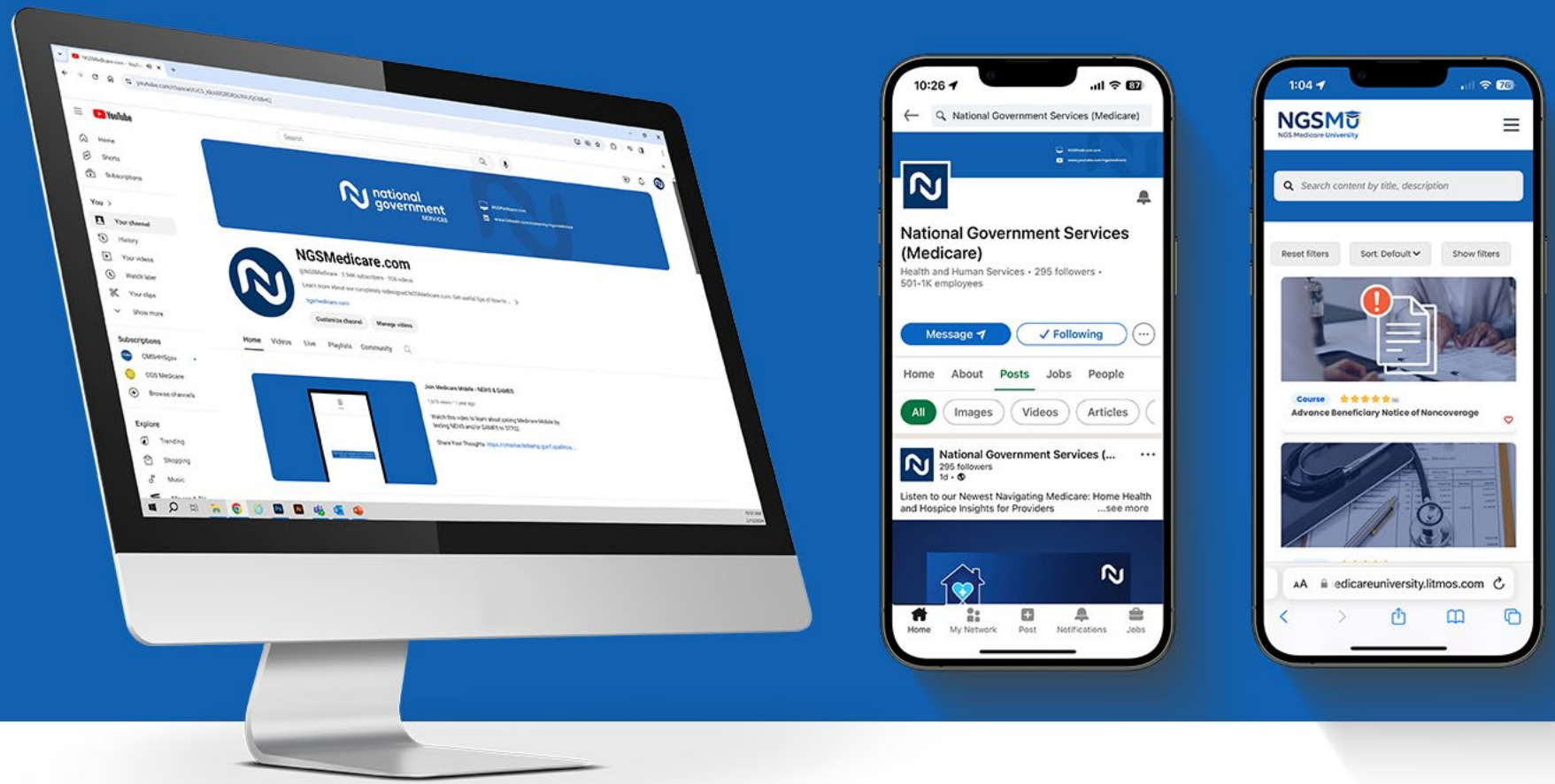
Provider Enrollment



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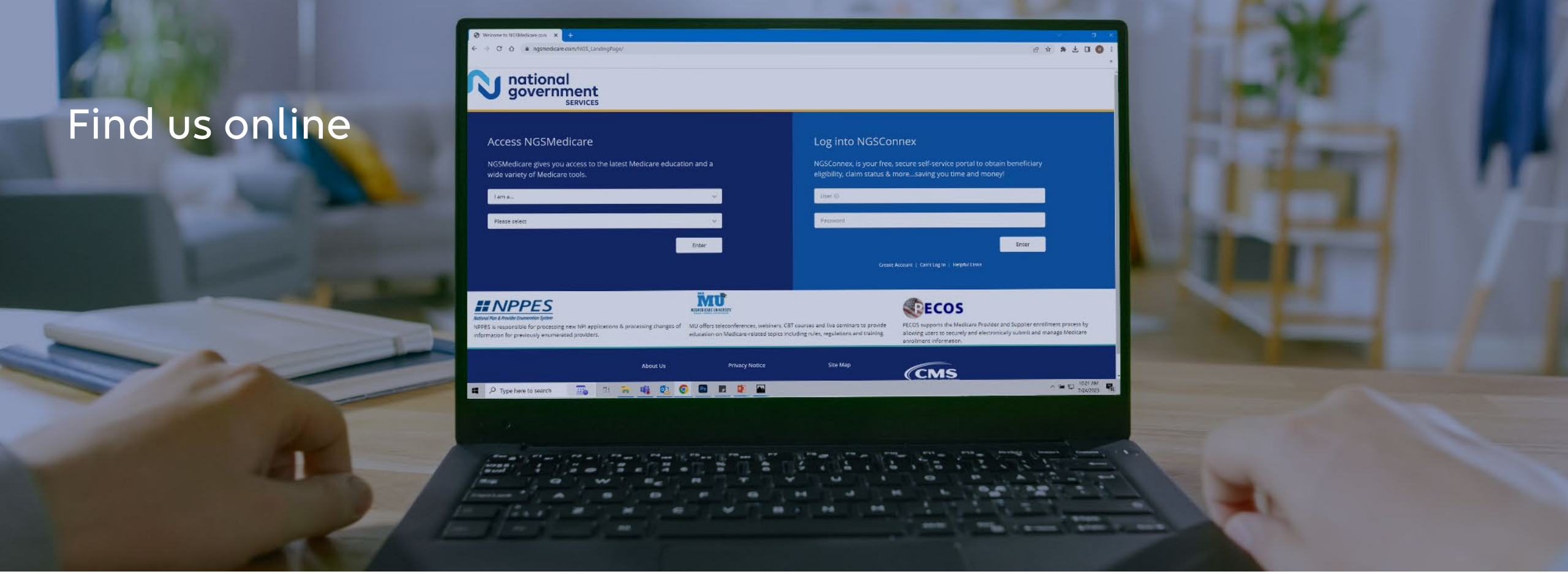

www.NGSMedicare.com
Online resources, event calendar, LCD/NCD, and tools

[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!