Tell Your Boss Takeaways from **"Healthcare Organizations & Medicare Enrollments"**

Speakers: Yesenia Servin, CPMSM, PESC and Larry G. DeHoyos, CPCS

Thesis: The Medicare Program Integrity Manual for Medicare Enrollment is very clear on what you need to do for your organization or it is? As a member of the leadership team you need reassurance that every section of the 855 application is accurate and compliant. Will facility site visits be required? What needs to be detailed in the mortgage and ownership sections? What payment amount is required and for which organization? What is the timeline for revalidations and what does that entail? Has your provider enrollment team followed the rules and regulations for Medicare enrollment for all your practice locations, including Part A and Part B providers? Let's discuss this together and review each portion. Compliant Medicare enrollments equal a healthy revenue cycle.

Learning Objective#1: Review the Medicare Provider Enrollment program for entity providers (facilities, REH, RHC, groups, clinics, etc) and the extensive list of requirements for a successful enrollment and revalidation

Key points:

1. Compliant, accurate application data	**2.** Required documentation

Learning Objective#2: Analyze the PECOS process for initial Part A and Part B enrollments and revalidations and the urgency on your organizations enrollment and revenue cycle

Key points:

1. Part A data **2.** Part A documents	**3.** Part B data **4.** Part B documents

Learning Objective#3: Apply expert guidance and tips for accurate completion of the 855A and 855B via the PECOS port

Key points:

1. Build strong, successful Medicare enrollment process	

FORM APPROVED
OMB No. 0938-0266

HEALTH INSURANCE BENEFITS AGREEMENT

(AGREEMENT WITH AMBULATORY SURGICAL CENTER PURSUANT TO SECTION 1832(a)(2)(F) OF THE SOCIAL SECURITY ACT)

For the purpose of establishing eligibility for payment under title XVIII of the Social Security Act,

_____

(Insert Name of Facility)

hereinafter referred to as the Ambulatory Surgical Center, hereby agrees:

(A) to maintain compliance with the conditions set forth in part 416 of chapter IV, title 42 of the Code of Federal Regulations, and to report promptly to the Centers for Medicare & Medicaid Services (CMS) any failure to do so;

(B) not to charge a Medicare beneficiary or any other person for items or services for which the beneficiary is entitled to have payment made in accordance with part 416 of chapter IV, title 42 of the Code of Federal Regulations;

(C) to refund as promptly as possible any money incorrectly collected from beneficiaries or from someone on his or her behalf;

(D) to furnish to CMS, if requested, information necessary to establish payment rates specified in §416.120 and §416.130 in the form and manner that CMS requires;

(E) to accept assignment for all facility services furnished in connection with covered surgical procedures as specified in §416.85; and

(F) to comply with statutory and regulatory requirements regarding revision of the Quality Improvement Organization that contracts with CMS to review ambulatory surgical procedures.

This agreement, upon submission by the Ambulatory Surgical Center and upon acceptance for filing by the Secretary of Health and Human Services, shall be binding on the Ambulatory Surgical Center and the Secretary. The agreement may be terminated by either party in accordance with regulations. In the event of termination, payment will not be available for Ambulatory Surgical Center services furnished on or after the effective date of termination.

This agreement shall become effective on the date specified below by the Secretary or the Secretary's delegate, and shall remain in effect unless terminated. In the event of a transfer of ownership of the Ambulatory Surgical Center, **this Agreement Shall Remain Effective** as between the Secretary of Health and Human Services and the Transferee.

ATTENTION: Read the following provision of Federal law carefully before signing.

Whoever, 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 make any false, fictitious or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement, or entry, shall be fined not more than $10,000 or imprisoned not more than 5 years or both (18 U.S.C. section 1001).

Accepted for the Ambulatory Surgical Center by:	Accepted for the Secretary of Health and Human Services by:
NAME (SIGNATURE)	NAME (SIGNATURE)
TITLE	TITLE
DATE	DATE

EFFECTIVE DATE OF AGREEMENT

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0266. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

ILLINOIS GENERAL BILL OF SALE

Date: _____ (mm/dd/yyyy)

Seller

Full Name: _____ Street Address: _____

City: _____ State: Illinois ZIP: _____

Phone Number (#): _____ Email: _____

Buyer

Full Name: _____ Street Address: _____

City: _____ State: _____ ZIP: _____

Phone Number (#): _____ Email: _____

Description of property:

Purchase price: $_____

I, the undersigned **Seller**, agree to sell the above described personal property for the purchase price and certify that all of the information contained in this document is true and accurate to the best of my knowledge.

I the undersigned **Buyer**, recognize this document as a receipt for the personal property in exchange for the purchase price. I understand that the personal property is being sold in “as is” condition and that after the sale I will agree not to hold the Seller liable for any found defects.

Illinois Department of Financial and Professional Regulation

Lookup Detail View

Contact

Contact Information

Name	City/State/Zip	DBA / AKA
Resilience Healthcare-W Suburban Med Ctr LLC	Oak Park, IL 60302	• dba West Suburban Medical Center

License

License Information

License Number	Description	Status	First Effective Date	Effective Date	Expiration Date	Ever Disciplined
32*****40	LICENSED CONTROLLED PHARMACY SUBSTANCE (Schedules II III IV V)	ACTIVE	03/30/2022	01/09/2024	03/31/2026	N

Other Licenses

Other Licenses

License Number	Description	Status	First Effective Date	Effective Date	Expiration Date	Ever Disciplined
054021166	LICENSED PHARMACY	ACTIVE	05/07/2021	01/09/2024	03/31/2026	N

Generated on: 9/4/2024 12:29:08 PM

Department of Health and Human Services
Health Resources and Services Administration

Notice of Award
FAIN#
Federal Award Date: 11/06/2020

Recipient Information

1. Recipient Name
   John Doe Community Health Center
2. Congressional District of Recipient
   02
3. Payment System Identifier (ID)
4. Employer Identification Number (EIN)
5. Data Universal Numbering System (DUNS)
6. Recipient's Unique Entity Identifier
7. Project Director or Principal Investigator
8. Authorized Official

Federal Agency Information

9. Awarding Agency Contact Information
10. Program Official Contact Information

Federal Award Information

11. Award Number
    H80CS12345
12. Unique Federal Award Identification Number (FAIN)
13. Statutory Authority
    42 U.S.C. § 254b
14. Federal Award Project Title
    Health Center Program
15. Assistance Listing Number
    93.224
16. Assistance Listing Program Title
    Community Health Centers
17. Award Action Type
    Administrative
18. Is the Award R&D?
    No

Summary Federal Award Financial Information

19. Budget Period Start Date 06/01/2020 - End Date 05/31/2021	
20. Total Amount of Federal Funds Obligated by this Action	$0.00
20a. Direct Cost Amount	
20b. Indirect Cost Amount	
21. Authorized Carryover	$0.00
22. Offset	$0.00
23. Total Amount of Federal Funds Obligated this budget period	$3,859,527.00
24. Total Approved Cost Sharing or Matching, where applicable	$7,149,309.00
25. Total Federal and Non-Federal Approved this Budget Period	$11,008,836.00
26. Project Period Start Date 06/01/2[illegible] – End Date 05/31/2022	
27. [illegible] Matching this Project Period	$29,620,327.00

Each current Health Center Program award recipient should use the Project Period End Date on the most recent H80 Notice of Award to determine the correct Service Area Competition (SAC) Notice of Funding Opportunity (NOFO) number for submitting their competing continuation application.

28. Authorized Treatment of Program Income
    Addition
29. Grants Management Officer – Signature

30. Remarks

OMB Control Number 0945-0008
Exp. Date: 04/30/2026

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

ASSURANCE OF COMPLIANCE

Under the Paperwork Reduction Act of 1995, as amended, and 5 C.F.R. § 1320.5(b)(2)(i), persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The OMB control number for this collection is 0945-0008. In lieu of completing this hard copy form and mailing it in, the Applicant may provide this assurance via the U.S. Department of Health and Human Services' Assurance of Compliance online portal at https://ocrportal.hhs.gov/ocr/aoc/instruction.jsf.

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, SECTION 1557 OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, AND FEDERAL CONSCIENCE AND NONDISCRIMINATION LAWS

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964, as amended (codified at 42 U.S.C. § 2000d *et seq*.), and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin (including limited English proficiency) be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973, as amended (codified at 29 U.S.C. § 794), and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of their disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Education Amendments of 1972, as amended (codified at 20 U.S.C. § 1681 *et seq*.), and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex (including pregnancy, sexual orientation, and gender identity), be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975, as amended (codified at 42 U.S.C. § 6101 *et seq*.), and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

5. Section 1557 of the Patient Protection and Affordable Care Act, as amended (codified at 42 U.S.C. § 18116), and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin (including limited English proficiency), age, disability, or sex (including pregnancy, sexual orientation, and gender identity) be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

As applicable, the Church Amendments, as amended (codified at 42 U.S.C. § 300a-7), the Coats-Snowe Amendment (codified at 42 U.S.C. § 238n), the Weldon Amendment (*e.g.,* Consolidated Appropriations Act, 2022, Pub. L. No.

117-103, Div. H, Title V § 507(d), 136 Stat 49, 496 (Mar. 15, 2022)) as extended by the Continuing Appropriations and Ukraine Supplemental Appropriations Act, 2023, Pub. L. No. 117-180, Div. A, § 101(8) (Sep. 30, 2022); , Section 1553 of the Patient Protection and Affordable Care Act, as amended (codified at 42 U.S.C. § 18113), and Section 1303(b)(4) of the Patient Protection and Affordable Care Act, as amended (codified at 42 U.S.C. § 18023(b)(4)), and 45 C.F.R. Part 88, to the extent that the rights of conscience are protected and associated discrimination and coercion are prohibited, in any program or activity for which the Applicant receives Federal financial assistance. Consistent with applicable court orders, the version of Part 88 in effect as of [October 20, 2022] is found at 76 Fed. Reg. 9968-9977 (Feb. 23, 2011).

The Applicant agrees that compliance with this assurance constitutes a material condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees, and assignees for the period during which such assistance is provided.

If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The person whose signature appears below is authorized to sign this assurance and commit the Applicant to the above provisions.

_____
Date

_____
Signature of Authorized Official

Please mail form to:

U.S. Department of Health & Human Services Office for Civil Rights
200 Independence Ave., S.W. Room 509F Washington, D.C. 20201

_____
Name and Title of Authorized Official (please print or type)

_____
Name of Agency Receiving/Requesting Funding

_____
Street Address

_____
City, State, Zip Code

The Applicant may provide this assurance via the U.S. Department of Health and Human Services' Assurance of Compliance online portal at https://ocrportal.hhs.gov/ocr/aoc/instruction.jsf in lieu of mailing it to the address provided.

Transfer Agreement Example

This agreement is made and entered into by and between YOUR FACILITY NAME, CITY, STATE, a nonprofit corporation (hereinafter called "YOUR FACILITY") and RECEIVING FACILITY NAME, CITY, STATE, a nonprofit corporation, (hereinafter called "RECEIVING FACILITY"):

WHEREAS, both YOUR FACILITY and RECEIVING FACILITY desire, by both means of this Agreement, to assist physicians and the parties hereto in the treatment of trauma patients (e.g., burn, traumatic brain injuries, spinal cord injuries, pediatrics); and whereas the parties specifically wish to facilitate: (a) the timely transfer of patients and information necessary or useful in the care and treatment of trauma patients transferred, (b) the continuity of the care and treatment appropriate to the needs of trauma patients, and (c) the utilization of knowledge and other resources of both facilities in a coordinated and cooperative manner to improve the professional health care of trauma patients.

IT IS, THEREFORE, AGREED by and between the parties as follows:

1. PATIENT TRANSFER: The need for transfer of a patient from YOUR FACILITY to RECEIVING FACILITY shall be determined and recommended by the patient's attending physician in such physician's own medical judgment. When a transfer is recommended as medically appropriate, a trauma patient at YOUR FACILITY shall be transferred and admitted to RECEIVING FACILITY as promptly as possible under the circumstances, provided that beds and other appropriate resources are available. Acceptance of the patient by RECEIVING FACILITY will be made pursuant to admission policies and procedures of RECEIVING FACILITY.

2. YOUR FACILITY agrees that it shall:

    a. Notify RECEIVING FACILITY as far in advance as possible of transfer of a trauma patient.
    b. Transfer to RECEIVING FACILITY the personal effects, including money and valuables and information relating to same.
    c. Make every effort within its resources to stabilize the patient to avoid all immediate threats to life and limbs. If stabilization is not possible, YOUR FACILITY shall either establish that the transfer is the result of an informed written request of the patient or his or her surrogate or shall have obtained a written certification from a physician or other qualified medical person in consultation with a physician that the medical benefits expected from the transfer outweigh the increased risk of transfer.
    d. Affect the transfer to RECEIVING FACILITY through qualified personnel and appropriate transportation equipment, including the use of necessary and medically appropriate life support measures.

3. YOUR FACILITY agrees to transmit with each patient at the time of transfer, or in the case of emergency, as promptly as possible thereafter, pertinent medical information and records necessary to continue the patient's treatment and to provide identifying and other information.

4. RECEIVING FACILITY agrees to state where the patient is to be delivered and agrees to provide information about the type of resources it has available.

5. Bills incurred with respect to services preformed by either party to the Agreement shall be collected by the party rendering such services directly from the patient, third party, and neither party shall have any liability to the other for such charges.

6. This agreement shall be effective from the date of execution and shall continue in effect indefinitely. Either party may terminate this agreement on thirty (30) days notice in writing to the other party. If either party shall have its license to operate revoked by the state, this Agreement shall terminate on the date such revocation becomes effective.

7. Each party to the Agreement shall be responsible for its own acts and omissions and those of their employees and contractors and shall not be responsible for the acts and omissions of the other institutions.

8. Nothing in this Agreement shall be construed as limiting the right of either to affiliate or contract with any hospital or nursing home on either a limited or general basis while this agreement is in effect.

9. Neither party shall use the name of the other in any promotional or advertising material unless review and written approval of the intended use shall first be obtained from the party whose name is to be used.

10. This agreement shall be governed by the laws of the State of INSERT STATE. Both parties agree to comply with the Emergency Medical Treatment and Active Labor Act of 1986, and the Health Insurance Portability and Accountability Act of 1996 and the rules now and hereafter promulgated thereunder.

11. This Agreement may be modified or amended from time to time by mutual agreement of the parties, and any such modification or amendment shall be attached to and become part of the Agreement.

YOUR FACILITY	RECEIVING FACILITY
SIGNED BY:	SIGNED BY:
DATE:	DATE:

EXHIBIT 177

(Rev. 85, Issued: 07-19-13, Effective: 07-19-13, Implementation: 07-19-13)

ATTESTATION STATEMENT FOR FEDERALLY QUALIFIED HEALTH CENTER

INSTRUCTIONS FOR COMPLETING

1. ***Name of Entity:*** *The FQHC applicant must fill in its legal business name of the FQHC entity, as reported to the Internal Revenue Service. The legal business name must match the information listed in section 2B of the Form CMS 855A.*

2. ***D/B/A Name:*** *If the FQHC applicant does business under a different name than its legal business name, it must enter that name here. If the applicant does not have a different D/B/A name, this space should be left blank. If the applicant enters a D/B/A name, it must match the information entered in section 2B of the Form CMS 855A if the "doing business as" block is checked.*

3. ***Address:*** *The FQHC applicant must enter the same address as it entered in Section 4A of the Form CMS 855A as the "practice location" of the FQHC. The applicant must enter the street name and number, the city/town, state and zip code. If there is a suite number, this must be entered as well.*

4. ***Type of FQHC:*** *The FQHC applicant must check one, and only one, of lines (A)(i), (A)(ii), (B) or (C), indicating the basis on which it qualifies to be an FQHC.*

5. ***Signature:*** *The attestation must be signed on behalf of the applicant by one individual whose name and signature appears in the Form CMS 855A, either in Section 15 as an authorized individual, or in Section 16 as a delegated official, if the FQHC has identified any delegated officials. The individual's name, title and date of signature must be entered. Before signing the individual must review the regulations at 42 CFR Part 405 Subpart X, and Part 491, as described in §405.2434(a), since the signature attests to compliance with these regulations. The regulations may be found at http://www.ecfr.gov/cgi-bin/text-idx?sid=614cb89fc17db8dae88af84c6b174bf1&c=ecfr&tpl=/ecfrbrowse/Title42/42tab_02.tpl*

ATTESTATION STATEMENT FOR
FEDERALLY QUALIFIED HEALTH CENTER

This attestation statement applies to _____
(name of entity)

*D/B/A*_____

located at:
_____***(address, including street name and number, suite number if applicable, city, state, zip code).***

The *above-named entity* complies with all applicable Federal requirements related to the following provision of §1861(aa)(4) of the Social Security Act (check the appropriate box):

___ (A)(i) Is receiving a grant under §330 of the Public Health Service Act, or

___ (ii)(I) Is receiving funding from such a grant under a contract with the recipient of such a grant, and (II) meets the requirements to receive a grant under §330 of such Act;

___ (B) *Has been notified by the Health Resources and Services Administration that it has been* determined to meet the requirements for receiving such a grant: or

___ (C) Is an outpatient health program or facility operated by a *tribe or* tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act.

The *above-named entity* agrees to remain in compliance with the all of the federally qualified health center requirements specified in 42 CFR Part 405 Subpart X, and Part 491, as described in §405.2434(a).

I certify that I have reviewed each Federal requirement in §1861(aa)(4) of the Social Security Act and the federally qualified health center requirements specified in 42 CFR Part 405 Subpart X, and Part 491, as described in §405.2434(a) and that *the above-named entity* is currently in compliance with these requirements and regulations and has been in compliance with these requirements and regulations. *The above-named entity* agree*s* to inform the Centers for Medicare & Medicaid Services of any changes that result in noncompliance.

Attention: Read the following provisions of Federal law carefully before signing:

STATEMENTS OR ENTRIES GENERALLY: Whoever, 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 or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than five years or both. (18 U.S.C. §1001).

Attestation on behalf of the above-named entity by:

Signature _____ *Title*_____

Printed Name _____ *Date* _____

Accepted for the Secretary of Health and Human Service*s* by:

Signature _____ *Title*_____

Printed Name _____ *Effective Date*_____

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0360

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0360 (Expires 03/31/2022). The time required to complete this information collection is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244- 1850. ****CMS Disclosure****Please do not send applications, claims, payments, medical records, or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact ESRDQuestions@cms.hhs.gov.

END STAGE RENAL DISEASE APPLICATION AND SURVEY AND CERTIFICATION REPORT

PART I – APPLICATION – TO BE COMPLETED BY FACILITY

1. Type of Application/Notification (check all that apply; if "Other," specify in "Remarks" section [Item33]): (V1)

☐ 1. Initial ☐2. Recertification ☐3. Relocation ☐4. Expansion/change of services

☐ 5. Change of ownership ☐6. Other, specify_____

2. Name of Dialysis Facility_____3. CCN _____

4. Street Address_____5. NPI _____

6. City_____7. County_____8. Fiscal Year End Date _____

9. State_____10. Zip Code: _____

11. Administrator's Email Address_____

12. Telephone No._____13. Facsimile No. _____

14. Medicare Enrollment (CMS 855A) completed? ☐Yes ☐No ☐NA

15. Dialysis Facility Administrator Name:_____Business Address: _____

City:_____ State:_____Zip Code:_____Telephone No: _____

16. Ownership (V2) ☐1. For Profit ☐2. Not for Profit ☐3.Public

17. Is this dialysis facility independent (i.e., not owned or managed by a hospital)? (V3)☐1. Yes ☐2. No

Is this dialysis facility owned and managed by a hospital and on the hospital campus (i.e., hospital- based)? (V4) ☐1. Yes ☐2. No

Is this dialysis facility owned and managed by a hospital and located off the hospital campus (i.e., satellite)? (V5)☐1. Yes ☐2. No

18. Is this dialysis facility located in a SNF/NF (LTC) (check one): (V6) ☐1. Yes ☐2.No

If SNF/NF owned and managed by a hospital: hospital name: (V7)_____CCN: (V8) _____

If Yes, SNF/NF name: (V9)_____CCN: (V10) _____

19. Is this dialysis facility owned &/or managed by a multi-facility organization? (V11) ☐1. No ☐2. Yes, Owned ☐3. Yes, Managed

If Yes, name of multi-facility organization: (V12) _____

Multi-facility organization's address: _____

20. Current modalities/services for dialysis facilities requesting recertification only (check all that apply): (V13)

☐ 1. In-center Hemodialysis (HD) ☐2. In-center Peritoneal Dialysis (PD)

☐ 3. In-center Nocturnal HD ☐4. Home HD Training & Support ☐5. HD in LTC

☐ 6. Home PD Training & Support ☐7. PD in LTC ☐8. Dialyzer Reuse

21. New modalities/services being requested (check all that apply; must have 1 permanent patient for any modality requested): (V14)

☐ 1. In-center HD ☐2. In-center PD ☐3. In-center Nocturnal HD

☐ 4. Home HD Training & Support ☐5. HD in LTC

☐ 6. Home PD Training & Support ☐7. PD in LTC ☐8. Dialyzer Reuse ☐9. N/A

NOTE: For dialysis in more than 1 LTC facility, record this same information in the "Remarks" (item 33) section or attach list

22. Does the dialysis facility have any dialysis (PD/HD) patients physically receiving dialysis within long-term care (LTC) facilities? (V15)

☐ 1. Yes ☐2. No

LTC (SNF/NF) facility name: (V16)_____ CCN: (V17) _____

Staffing for home dialysis in LTC provided by: (V18)

☐ 1. This dialysis facility ☐2. LTC staff ☐3. Other, specify: _____

Number of dialysis residents by modality receiving dialysis within this LTC facility: (V19)

☐1. HD_____ ☐2. PD_____

23. Number of dialysis patients currently on census:

In-Center HD: (V20)_____ In-Center Nocturnal HD: (V21) _____

In-Center PD: (V22)_____ Home PD: (V23) _____

Home HD <= 3x/week: (V24)_____ Home HD >3x/week: (V25) _____

24. Number of currently approved in-center dialysis stations: (V26) _____

Are onsite home training room(s) provided? (V27) ☐1. Yes ☐2. N/A

25. Additional in-center stations requested: (V28)_____ or ☐ None

26. How is isolation provided? (V29) ☐1. Room ☐2. Area (existing 2/9/2009 only) ☐3. CMS Waiver/Agreement (Attach copy)

27. If applicable, number of hemodialysis stations designated for isolation: (V30) _____

28. Days/times for in-center shifts or operating hours if home only (check all days that apply and complete time field in military time): (V31)

1st in-center shift starts or home only facility opens: M_____ T_____ W_____ Th_____ F_____ Sat_____ Sun_____

Last in-center shift ends or home only facility closes: M_____ T_____ W_____ Th_____ F_____ Sat_____ Sun _____

29. Dialyzer reprocessing: (V32) ☐1. Onsite ☐2. Centralized/Offsite ☐3. N/A

30. Staff (List full-time equivalents):

Registered Nurse: (V33)_____ Certified Patient Care Technician: (V34) _____

LPN/LVN: (V35)_____ Technical Staff (water, machine): (V36) _____

Registered Dietitian: (V37)_____ Masters Social Worker: (V38) _____

Others: (V39) _____

31. State license number (if applicable): (V40) _____

32. Certificate of Need required? (V41) ☐1. Yes ☐2. No ☐3. NA

33. Remarks (copy if more and attach additional pages if needed):_____

_____

_____

_____

_____

_____

34. The information contained in this Application Survey and Certification Report (Part I) is true and correct to the best of my knowledge. I understand that incorrect or erroneous statements may cause the request for approval to be denied, or facility approval to be rescinded, under 42 C.F.R. 494.1 and 488.604 respectively.

I have reviewed this form and it is accurate:

Signature of Administrator/Medical Director	Title	Date

PART II TO BE COMPLETED BY STATE AGENCY

35. Medicare Enrollment (CMS 855A recommended for approval by the Medicare Administrative Contractor)? (V42) ☐1. Yes ☐ 2. No

(*Note: approved CMS 855A required prior to certification*)

36. Type of Survey: (V43)

☐ 1. Initial ☐2. Recertification ☐3. Relocation ☐ 4. Expansion/change of services ☐ 5. Change of ownership

☐ 6. Complaint ☐7. Revisit ☐8. Other, specify_____

37. State Region: (V44)_____ 38. State County Code: (V45) _____

39. Network Number: (V46) _____

My signature below indicates that I have reviewed this form and it is complete.

40. Surveyor Team Leader (sign)	41. Name/Number (print)	42. Professional Discipline (print)	43. Survey Exit Date

INSTRUCTIONS FOR FORM CMS-3427

PART I – DOCUMENTATION NEEDED TO PROCESS FACILITY APPLICATION/NOTIFICATION TO BE COMPLETED BY APPLICANT

A completed request for approval as a supplier of End Stage Renal Disease (ESRD) services in the Medicare program (Part I – Form CMS-3427) must include a copy of the Certificate of Need approval, if such approval is required by the state.

TYPE OF APPLICATION (ITEM 1)

Check appropriate category. A "change of service" refers to an addition or deletion of services, e.g. home dialysis, dialysis in LTC, dialyzer reuse, in-center nocturnal HD, in-center PD, etc. "Expansion" refers to addition of in-center stations. If you relocate one of your services to a different physical location, you may be required to obtain a separate CCN for that service at the new location.

IDENTIFYING INFORMATION (ITEMS 2-19)

Enter the name and address *(actual physical location)* of the dialysis facility where the services are performed. If the mailing address is different, show the mailing address in Remarks (*Item 33*). Check the applicable blocks (*Item 17* and *Item 18*) to indicate the dialysis facility's hospital and/or SNF/NF affiliation, if any. If so, enter the CCN of the hospital and/or SNF/NF. Check whether the dialysis facility is owned and/or managed by a "multi-facility" organization (*Item 19*) and provide the name and address of the parent organization. A "multi-facility organization" is defined as a corporation or a LLC that owns more than one dialysis facility.

TYPES OF MODALITIES/SERVICES, DIALYSIS STATIONS, AND DAYS/HOURSOF OPERATION (ITEMS 20-29)

Check the modalities/services that are already offered ("current modalities/services") by a dialysis facility requesting recertification (*Item 20*). Check N/A or check each **NEW** modality/service for which you are requesting approval. Any new modality/service must be requested on the CMS-3427 and filed with the State agency. At the time of survey, one permanent patient must be on the dialysis facility's census in-center or in training/trained by the facility for each modality requested (*Item 21*). Note that dialysis facilities providing home therapies must provide both training and support. If you are requesting to offer home training and support **only** (*Item 21*), you must have a functional plan/arrangement to provide backup dialysis as needed. If you request any home training and support program (*Item 21*), you must also indicate "Yes" for a training room (only count stations for in-center dialysis, not for home training) (*Item 24*). **If you currently provide or support home dialysis within one or more LTC facilities (SNF/NF), complete *Item 22* and list for all LTCs: name, CCN, staffing provided by, and number of dialysis patients treated by modality under Remarks (*Item 33*). Notifications of any agreement initiated between the facility and a LTC facility for providing home dialysis to residents within any LTC facility require completion of *Item 22* (and 33 if applicable) and submission of this form to the State agency .** You must answer *Yes* (*Item 22*) and have at least one LTC dialysis resident for addition of services for home dialysis in LTC. Enter the number of additional in-center stations for which you are asking approval (*Item 25*). Provide information on isolation *(Items 26-27).* Dialysis facilities not existing prior to October 14, 2008 which do not have an isolation room must attach evidence of CMS waiver and written agreement with geographically proximal facility with isolation room. Provide current information on all days and start time for the first shift and end time for the last shift of in-center patients (in military time) for each day of operation. If the dialysis facility offers home training and support only, provide current operating hours for each day *(Item 28)*. Provide information on dialyzer reprocessing *(Item 29)*.

STAFFING (ITEM 30)

"Other" includes non-certified patient care technicians, administrative personnel, etc. To calculate the number of full-time equivalents of any discipline (*Item 30*), add the total number of hours that all members of that discipline work at this dialysis facility and enter that number in the numerator. Enter into the denominator the number of hours that facility policy defines as full-time work for that discipline. Report FTEs in 0.25 increments only. Example: An RD works 20 hours a week at Facility A. Facility A defines full time work as 40 hours/week. To calculate FTEs for the RD, divide 20 by 40. The RD works 0.50 FTE at Facility A.

LICENSING AND CERTIFICATE OF NEED, IF APPLICABLE (Items 31-32)

If your state requires licensing for ESRD facilities, include your current license number in Item 31. If your state requires a Certificate of Need (CON) for an initial ESRD or for the change you are requesting, mark the applicable box in Item 32 and include a copy of the documentation of the CON approval.

REMARKS (ITEM 33)

You may use this block for explanatory statements related to Items 1-32.

The administrator/medical director signs and dates. Upon completion, forward a copy of form CMS-3427 (Part I) to the State agency.

PART II - TO BE COMPLETED BY STATE AGENCY

The surveyor should review and verify the information in Part I with administrator or medical director and complete Part II of this form.

Recognize that CMS cannot issue a CCN for an initial survey until all required steps are complete, including recommended approval of the CMS-855A by the applicable MAC. Complete the Statement of Deficiencies (CMS Form 2567) in ASPEN. Complete the CMS-1539 in ASPEN entering recommended action(s). All required information must be entered in ASPEN and uploaded in order for the survey to be counted in the state workload.

HEALTH INSURANCE BENEFIT AGREEMENT

(Agreement with Provider Pursuant to Section 1866 of the Social Security Act (as amended) and Title 42 Code of Federal Regulations (CFR) Title IV, Part 489)

AGREEMENT

Between

THE SECRETARY OF HEALTH AND HUMAN SERVICES

and

(Insert name of provider)

doing business as (D/B/A)

(Insert business name of provider, if applicable)

In order to receive payment under title XVIII of the Social Security Act,

(Insert name of provider)

D/B/A

(Insert business name of provider, if applicable)

as the provider of services, agrees to conform to the provisions of section of 1866 of the Social Security Act and applicable provisions in 42 CFR.

This agreement, upon submission by the provider of services of acceptable assurance of compliance with title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 as amended, and upon acceptance by the Secretary of Health and Human Services, shall be binding on the provider of services and the Secretary.

In the event of a transfer of ownership, this agreement is automatically assigned to the new owner subject to the conditions specified in this agreement and 42 CFR 489, to include existing plans of correction and the duration of this agreement, if the agreement is time limited.

ATTENTION: Read the following provision of Federal law carefully before signing.

Whoever, 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 make any false, fictitious or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than 5 years or both (18 U.S.C. section 1001).

ACCEPTED FOR PROVIDER OF SERVICES BY:

Signature	Title
Printed Name	**Date**

HEALTH INSURANCE BENEFIT AGREEMENT
CMS-1561

ACCEPTED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES BY:

Signature	Title
Printed Name	**Date**

ACCEPTED FOR THE SUCCESSOR PROVIDER OF SERVICES BY:

Signature	Title
Printed Name	**Date**

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-0832 (Expires 01/31/2027)**. This is a **mandatory** information collection. The time required to complete this information collection is estimated to average **1 hour** per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

****CMS Disclosure****

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact CMS at **QSOG_AccreditationCO@cms.hhs.gov**.

INSTRUCTIONS FOR COMPLETING THE EFT AUTHORIZATION AGREEMENT

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

PART I: REASON FOR SUBMISSION

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

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

PART II: ACCOUNT HOLDER INFORMATION

- Enter the provider's/supplier's legal business name or the name of the physician or individual practitioner, **as reported to the Internal Revenue Service (IRS)**. The account to which EFT payments made must bear the name of the physician or individual practitioner, or the legal business name of the person or entity enrolled with Medicare. **NOTE: Providers/suppliers must report the legal business name provided on the IRS CP-575 form.** Physicians and individual practitioners who have granted a Medicare-enrolled provider or supplier the right to receive payments for all of their services, is not required to complete this form. The account holder information should be of the person or entity receiving the reassigned benefits (e.g., Medicare Identification Number, Authorized/Delegated Official signature).
- Enter the Chain Home Office (CHO) legal business name. A CHO is an entity that provides centralized management and administrative services to the providers or suppliers under common ownership and common control, such as centralized accounting, purchasing, personnel services, management direction and control, and other similar services.
  NOTE: Providers/suppliers must report the legal business name provided on the IRS CP-575 form.
- Enter the account holder's street address.
  NOTE: Do Not Include PO Boxes.
- Enter the account holder's city, state, and zip code.
- Enter the tax identification number as reported to the IRS. If the business is a group, organization or corporation, provide the Federal employer identification number. If enrolling as an individual provide your Social Security Number.
- Enter the 10 digit NPI number. The NPI is required to process this form.
- A provider/supplier may only have one EFT account per enrollment.
- If issued, enter the Medicare identification number assigned by a Medicare Administrative Contractor (MAC). If you are not enrolled in Medicare, leave this field blank. If more than one Medicare identification number is attached to this NPI, include the Medicare identification numbers on this form.
  NOTE: Institutional providers enter only ONE Medicare Identification Number (if issued).

PART III: FINANCIAL INSTITUTION INFORMATION

- **Please include a confirmation of account information on bank letterhead or a voided check. When submitting the documentation, it should contain the name on the account, electronic routing transit number, account number and type. If submitting bank letterhead, the bank officer's name and signature is also required. This information will be used to verify your account number.**
  NOTE: Supporting bank documents must be in the provider's/supplier's/entity's legal business name only.
- Enter your Financial Institution's name (this is the name of the bank or qualifying depository that will receive the funds).
  NOTE: The Financial Institution's name must be the Legal Business Name on the account, electronic routing transit number and type.
  NOTE: The account name to which EFT payments will be paid is to the name submitted on Part II of this form.
- Enter the financial institution's street address.
  NOTE: Do Not Include PO Boxes.
- Enter the financial institution's city or town, state or province, and zip/postal code.
- Enter the bank or financial institutional telephone number and contact person's name.
- Enter the bank or financial institutional nine-digit routing number, including applicable leading zeros.
- Enter the provider's/supplier's account number with the financial institution, including applicable leading zeros. Select the account type.
  NOTE: Supporting bank documents must be in the provider's/supplier's/entity's legal business name only.

PART IV: CONTACT PERSON

- Enter the name and title of a contact person who can answer questions about the information submitted on this CMS-588 form.
- Enter the contact person's telephone number. Enter the contact person's e-mail address.

PART V: AUTHORIZATION

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

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

Upload this form to PECOS or mail this form to the Medicare contractor that services your geographical area. An EFT authorization form must be submitted for each Medicare contractor to whom you submit claims for Medicare payment. To locate the mailing address for your Medicare Administrative Contractor fee-for-service contractor, go to: **CMS.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/**.

Form Approved
OMB No. 0938-0626
Expires 11/2026

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

PART I: REASON FOR SUBMISSION

Reason for Submission:

☐ New EFT Enrollment
☐ Individual ☐ Group

☐ Change to Current EFT Enrollment
(e.g. account or bank changes)

☐ Check here if EFT payment is being made to the Chain Home Office
(Attach letter Authorizing EFT payment to Chain Home Office)

PART II: ACCOUNT HOLDER INFORMATION

Provider/Supplier Legal Business Name *(If individual, please provide first name, middle initial, last name, and suffix)*

Chain Organization Name or Home Office Legal Business Name *(if different from Chain Organization Name)*	Chain Home Office number

Account Holder's Street Address (Do Not Include PO Boxes.)

Account Holder's City	Account Holder's State	Account Holder's Zip Code

Tax Identification Number (TIN)

Designate TIN:
☐ SSN (enrolling as an individual) OR
☐ EIN (enrolling as a group/organization/corporation

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

Medicare Identification Number *(if issued)*	Medicare Identification Number *(if issued)*

PART III: FINANCIAL INSTITUTION INFORMATION

Financial Institution's Name

Financial Institution's Street Address (Do Not Include PO Boxes.)

Financial Institution's City/Town	Financial Institution's State/Province	Financial Institution's Zip Postal Code

Financial Institution's Telephone Number *(optional)*	Financial Institution's Contact Person *(optional)*

Financial Institution Routing Transit Number *(must be 9 digits)*

Provider's/Supplier's Depositor Account Number with Financial Institution *(include all zeroes)*	Type of Account *(check one)*
	☐ Checking Account ☐ Savings Account

NOTE: Starter checks are not acceptable for EFT confirmations.

PLEASE NOTE: In accordance with section 1104 of the Affordable Care Act, enrollment of electronic fund transfer (EFT) is for electronic fund transfer authorization only. EFT enrollment does not constitute enrollment as a provider or supplier in the Medicare program.

PART IV: CONTACT PERSON

This is the person we will contact for any questions regarding this EFT.

Contact Person's Name	Contact Person's Title
Contact Person's Telephone Number	Contact Person's E-mail Address

PART V: AUTHORIZATION

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

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

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

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

SIGNATURE LINE

Authorized/Delegated Official Name *(Print)*	Authorized/Delegated Official Telephone Number

Authorized/Delegated Official E-mail Address *(optional)*

Authorized/Delegated Official Signature *(Note: Must be signed and dated to process.)*	Date

PRIVACY ACT ADVISORY STATEMENT

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

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

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

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0626. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. **DO NOT MAIL THIS FORM TO THIS ADDRESS. MAILING YOUR APPLICATION TO THIS ADDRESS WILL SIGNIFICANTLY DELAY PROCESSING.**

FORM APPROVED
OMB NO. 0938-0373
EXPIRES 11/30/2025

MEDICARE PARTICIPATING PHYSICIAN OR SUPPLIER AGREEMENT

Name(s) and Address of Participant*	National Provider Identifier (NPI)*

*List all names and the NPI under which the participant files claims with the Medicare Administrative Contractor (MAC) with whom this agreement is being filed.

The above named person or organization, called "the participant," hereby enters into an agreement with the Medicare program to accept assignment of the Medicare Part B payment for all services for which the participant is eligible to accept assignment under the Medicare law and regulations and which are furnished while this agreement is in effect.

1. **Meaning of Assignment:** For purposes of this agreement, accepting assignment of the Medicare Part B payment means requesting direct Part B payment from the Medicare program. Under an assignment, the approved charge, determined by the MAC, shall be the full charge for the service covered under Part B. The participant shall not collect from the beneficiary or other person or organization for covered services more than the applicable deductible and coinsurance.
2. **Effective Date:** If the participant files the agreement with any MAC during the enrollment period, the agreement becomes effective _____.
3. **Term and Termination of Agreement:** This agreement shall continue in effect through December 31 following the date the agreement becomes effective and shall be renewed automatically for each 12-month period January 1 through December 31 thereafter unless one of the following occurs:
    a. During the enrollment period provided near the end of any calendar year, the participant notifies in writing every MAC with whom the participant has filed the agreement or a copy of the agreement that the participant wishes to terminate the agreement at the end of the current term. In the event such notification is mailed or delivered during the enrollment period provided near the end of any calendar year, the agreement shall end on December 31 of that year.
    b. The Centers for Medicare & Medicaid Services may find, after notice to and opportunity for a hearing for the participant, that the participant has substantially failed to comply with the agreement. In the event such a finding is made, the Centers for Medicare & Medicaid Services will notify the participant in writing that the agreement will be terminated at a time designated in the notice. Civil and criminal penalties may also be imposed for violation of the agreement.

Signature of participant (or authorized representative of participating organization)		Date
Title (if signer is authorized representative of organization)		Office Phone Number (including area code)
Received by (name of MAC)	Initials of MAC Official	Effective Date

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0373 (Expires 11/30/2025). The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

INSTRUCTIONS FOR THE MEDICARE PARTICIPATING PHYSICIAN AND SUPPLIER AGREEMENT (CMS-460)

To sign a participation agreement is to agree to accept assignment for all covered services that you provide to Medicare patients.

WHY PARTICIPATE?

If you bill for physicians' professional services, services and supplies provided incident to physicians' professional services, outpatient physical and occupational therapy services, diagnostic tests, or radiology services, your Medicare fee schedule amounts are 5 percent higher if you participate. Also, providers receive direct and timely reimbursement from Medicare.

Regardless of the Medicare Part B services for which you are billing, participants have "one stop" billing for beneficiaries who have Medigap coverage not connected with their employment and who assign both their Medicare and Medigap payments to participants. After we have made payment, Medicare will send the claim on to the Medigap insurer for payment of all coinsurance and deductible amounts due under the Medigap policy. The Medigap insurer must pay the participant directly.

Currently, the large majority of physicians, practitioners and suppliers are billing under Medicare participation agreements.

WHEN THE DECISION TO PARTICIPATE CAN BE MADE:

- Toward the end of each calendar year, all MAC have an open enrollment period. The open enrollment period generally is from mid-November through December 31. During this period, providers who are currently enrolled in the Medicare Program can change their current participation status beginning the next calendar year on January 1. This is the only time these providers are given the opportunity to change their participation status. These providers should contact their MAC to learn where to send the agreement, and get the exact dates for the open enrollment period when the agreement will be accepted.
- New physicians, practitioners, and suppliers can sign the participation agreement and become a Medicare participant at the time of their enrollment into the Medicare Program. The participation agreement will become effective on the date of filing; i.e., the date the participant mails (post-mark date) the agreement to the MAC or delivers it to the MAC.

Contact your MAC to get the exact dates the participation agreement will be accepted, and to learn where to send the agreement.

WHAT TO DO DURING OPEN ENROLLMENT:

If you choose to be a participant:

- Do nothing if you are currently participating, or
- If you are not currently a Medicare participant, complete the blank agreement (CMS-460) and mail it (or a copy) to each to which you submit Part B claims. (On the form show the name(s) and identification number(s) under which you bill.)

If you decide not to participate:

- Do nothing if you are currently not participating, or
- If you are currently a participant, write to each MAC to which you submit claims, advising of your termination effective the first day of the next calendar year. This written notice must be postmarked prior to the end of the current calendar year.

WHAT TO DO IF YOU'RE A NEW PHYSICIAN, PRACTITIONER OR SUPPLIER:

If you choose to be a participant:

- Complete the blank agreement (CMS-460) and submit it with your Medicare enrollment application to your MAC.
- If you have already enrolled in the Medicare program, you have 90 days from when you are enrolled to decide if you want to participate. If you decide to participate within this 90-day timeframe, complete the CMS-460 and send to your MAC.

If you decide not to participate:

- Do nothing. All new physicians, practitioners, and suppliers that are newly enrolled are automatically non-participating. You are not considered to be participating unless you submit the CMS-460 form to your MAC.

We hope you will decide to be a Medicare participant.

Please call the MAC in your jurisdiction if you have any questions or need further information on participation.

DO NOT SEND YOUR CMS-460 FORM TO CMS, SEND TO YOUR MAC. IF YOU SEND YOUR FORMS TO CMS, IT WILL DELAY PROCESSING OF YOUR CMS-460 FORMS.

To view updates and the latest information about Medicare, or to obtain telephone numbers of the various Medicare Administrative Contractor (MAC) contacts including the MAC medical directors, please visit the CMS web site at *http://www.cms.gov/*.

Form Approved
OMB No. 0938-0065

REQUEST FOR CERTIFICATION IN THE MEDICARE AND/OR MEDICAID PROGRAM TO PROVIDE OUTPATIENT PHYSICAL THERAPY (OPT) AND/OR SPEECH PATHOLOGY SERVICES (OSP)- INITIAL AND EXTENSION SITE REQUESTS

PART I- REQUEST INFORMATION

A. If this request is an initial request by an organization to be certified as a participating OPT/OSP, please complete the following and proceed to Part II:

REQUEST TO ESTABLISH ELIGIBILITY IN	INITIAL REQUEST	COUNTY	STATE	SEEKING DEEMED STATUS
☐ MEDICARE ☐ MEDICAID ☐ BOTH	☐ YES ☐ NO			☐ YES ☐ NO

NAME OF ACCREDITING ORGANIZATION

B. If this request is to establish a new extension site, please complete the following and proceed to Part II:

CMS CERTIFICATION NUMBER OF PRIMARY SITE	EXTENSION SITE REQUEST	NAME OF ACCREDITING ORGANIZATION (IF DEEMED):
	☐ YES ☐ NO	

PART II- PRIMARY SITE WHERE THE OPT/OSP SERVICES ARE PROVIDED

I. IDENTIFYING INFORMATION	LEGAL NAME OF ORGANIZATION		
	DOING BUISNESS AS (DBA) NAME OF ORGANIZATION	STREET ADDRESS	
	CITY, COUNTY, AND STATE	ZIP CODE	TELEPHONE NO. *(INCLUDE AREA CODE)*

III. SERVICES PROVIDED *(CHECK ALL THAT APPLY)*

1. ☐ PHYSICAL THERAPY 2. ☐ SPEECH PATHOLOGY 3. ☐ OCCUPATIONAL THERAPY 4. ☐ ALL

IV. TYPE OF ORGANIZATION *(CHECK ONE)*

1. ☐ HOSPITAL
2. ☐ SKILLED NURSING FACILITY
3. ☐ HOME HEALTH AGENCY
4. ☐ REHABILITATION
5. ☐ PUBLIC CLINIC
6. ☐ PRIVATE CLINIC
7. ☐ PUBLIC HEALTH AGENCY

PART II CONTINUED- PRIMARY SITE WHERE THE OPT/OSP SERVICES ARE PROVIDED

V. TYPE OF CONTROL *(CHECK ONE)*	1. ☐ VOLUNTARY NON-PROFIT OTHER THAN CHURCH	4. ☐ LOCAL GOVERNMENT
	2. ☐ VOLUNTARY NON-PROFIT CHURCH	5. ☐ COMBINATION GOVERNMENT & VOLUNTARY
	3. ☐ STATE GOVERNMENT	6. ☐ PROPRIETARY

VI. HOURS OF OPERATION

DOES YOUR PRIMARY LOCATION OPERATE: (check one) ☐ Full-time ☐ Part-time

Full-Time Hours of Operation: _____

IF PART-TIME, IDENTIFY DAYS AND HOURS OF OPERATION:

Hours of Operation: Monday (from) _____ (to) _____ Tuesday (from) _____ (to) _____ Wednesday (from) _____ (to) _____ Thursday (from) _____ (to) _____ Friday (from) _____ (to) _____

VII. QUALIFIED STAFF

PHYSICAL THERAPISTS	1. TOTAL (2 & 3)	2. ON STAFF	3. BY ARRANGEMENT
SPEECH PATHOLOGISTS	1. TOTAL (2 & 3)	2. ON STAFF	3. BY ARRANGEMENT
OCCUPATIONAL THERAPISTS	1. TOTAL (2 & 3)	2. ON STAFF	3. BY ARRANGEMENT

PART III- NEW EXTENSION SITE REQUEST WHERE THE OPT/OSP SERVICES ARE PROVIDED

I. IDENTIFYING INFORMATION	LEGAL NAME OF ORGANIZATION		
	DOING BUISNESS AS (DBA) NAME OF ORGANIZATION	STREET ADDRESS	
	CITY, COUNTY, AND STATE	ZIP CODE	TELEPHONE NO. *(INCLUDE AREA CODE)*

II. SERVICES PROVIDED *(CHECK ALL THAT APPLY)*

1. ☐ PHYSICAL THERAPY 2. ☐ SPEECH PATHOLOGY 3. ☐ OCCUPATIONAL THERAPY 4. ☐ ALL

PART III CONTINUED- NEW EXTENSION SITE WHERE THE OPT/OSP SERVICES ARE PROVIDED

III. HOURS OF OPERATION

WILL YOUR NEW EXTENSION LOCATION OPERATE: (check one) ☐ Full-time ☐ Part-time

Hours of Operation: _____

IF PART-TIME, IDENTIFY DAYS AND HOURS OF OPERATION:

_____ Monday _____ Tuesday _____ Wednesday _____Thursday _____Friday

Hours of Operation: _____

PART IV- EXISTING OR CLOSURES FOR EXTENSION SITES (Complete only for address changes and/or closures)

☐ CLOSURE	NAME OF ORGANIZATION	EXTENSION IDENTIFICATION NUMBER
☐ ADDRESS CHANGE	NEW ADDRESS, STATE, ZIP CODE	
	IF CLOSURE (DATE OF TERMINATION: _____/_____/_____	

PART V- REQUEST TO CHANGE EXISTING EXTENSION SITE TO PRIMARY SITE (Complete only if your organization is already participating)

Is this a request to change an existing extension site to a primary site? Or is the existing primary location relocating and the current primary site requested to be the extension location?

☐ YES ☐ NO

If YES, COMPLETE BELOW:

I. PRIMARY LOCATION CONVERTING TO EXTENSION SITE	NAME OF ORGANIZATION	PRIMARY SITE CMS CERTIFICATION NUMBER
	ADDRESS	STATE/ZIP CODE
II. EXTENSION SITE CONVERTING TO PRIMARY SITE	NAME OF ORGANIZATION	EXISTING EXTENSION IDENTIFICATION NUMBER
	ADDRESS	STATE/ZIP CODE

PART VI- EXISTING EXTENSION SITES (Complete only if your organization is already participating)

I. LOCATION #1	NAME OF ORGANIZATION	EXTENSION IDENTIFICATION NUMBER
	ADDRESS	STATE/ZIP CODE
II. LOCATION #2	NAME OF ORGANIZATION	EXTENSION IDENTIFICATION NUMBER
	ADDRESS	STATE/ZIP CODE
III. LOCATION #3	NAME OF ORGANIZATION	EXTENSION IDENTIFICATION NUMBER
	ADDRESS	STATE/ZIP CODE
IV. LOCATION #4	NAME OF ORGANIZATION	EXTENSION IDENTIFICATION NUMBER
	ADDRESS	STATE/ZIP CODE

For additional extension sites, please attach Part VII addendum.

PART VII- LEGAL CONTACT INFORMATION

PRIMARY POINT OF CONTACT AT ORGANIZATION:

NAME: TITLE/POSITION:

EMAIL: TELEPHONE:

WHOEVER KNOWINGLY AND WILLINGLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWING AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THIS INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE, OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OF CONTRACT WITH THE STATE AGENCY OR THE SECRETARY AS APPROPRIATE.

SIGNATURE OF AUTHORIZED OFFICIAL	TITLE	DATE

R17

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0273. Expiration Date: July 31, 2027. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. *******CMS Disclaimer***** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact QSOG_OPT@cms.hhs.gov**

Form Approved
OMB No. 0938-0065

INSTRUCTIONS FOR THE COMPLETION OF THE REQUEST TO ESTABLISH ELIGIBILITY IN THE MEDICARE AND/OR MEDICAID PROGRAM TO PROVIDE OUTPATIENT PHYSICAL THERAPY AND/OR SPEECH PATHOLOGY SERVICES

INSTRUCTIONS FOR COMPLETING FORM CMS-381

General Instructions

- All new prospective organizations wishing to participate as an OPT/OSP provider in the Medicare program and existing Medicare-certified OPTs requesting extension location requests must complete Form CMS-381. Answer all questions as of the current date of the request. Part VII is required for all submissions.
- The requesting organization must identify the primary site and any extension locations for the facility.
- If your organization is uncertain about how to complete some of the fields, contact your State Survey Agency (SA).
- For multiple extension site requests, each extension site(s) must be listed in Part III of the form. If necessary, an additional document may be provided as long as the information in Part III is included for each extension site.
- If an organization is requesting multiple extension sites at the same time, the organization is not required to submit a CMS-855 for every location. One CMS-855 and this form will suffice. Follow the instructions below.

NOTE: If an organization has submitted a CMS-855 to the MAC and submits an additional request within 90 days, please note that processing delays could occur as the MAC will be required to complete the first requested change prior to starting the second request.

For Initial Enrollment:

- Please complete this form and include this form in the application submission of the CMS-855 to the Medicare Administrative Contractor (MAC). (Part I, A; Part II)
- If the organization is submitting an extension site request in addition to the initial enrollment and certification of the primary site location, please complete Part III in addition to Part I. A.
- The MAC will review for enrollment criteria and submit this form in addition to their recommendation for approval to the State Agency (SA) and Accrediting Organization (AO) (if applicable).
- You may also copy the SA or AO in your request to the MAC. Contact information may be found at https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc.

For Existing Medicare-participating OPT/OSP:

- Please complete this form and include it with the CMS-855 application submission to the Medicare Administrative Contractor (MAC) for any changes following the guidance below.
- The MAC will review for enrollment criteria and submit this form in addition to their recommendation for approval to the State Agency (SA) and Accrediting Organization (AO) (if applicable).
- You may also copy the SA or AO in your request to the MAC. Contact information may be found at https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc.
- **Request to add new Extension Site**: Please complete this form any time your OPT is requesting a new extension site or changing/removing an extension site. (Part I.A- Select "No" for initial request; Complete Part I.B through Part III)
- **Request to Close an Existing Extension Site or Update Address of an Existing Extension Site**: (Part I.A- Select "No" for initial request; Complete Part I.B through Part II and Part IV)
- **Request to Convert an Existing Extension Site to the Primary Site, or Primary Site to an Extension Site:** If your organization is relocating its primary site to an extension location, please complete (Part I.A- Select "No" for initial request; Complete Part I.B through Part II and Part V). It is recommended that organizations clearly identify whether the organization is making a change to a primary site and an extension site in a cover letter submitted to the MAC, SA and AO (if applicable). Extension sites have specific identifiers within the CMS Certification Number (CCN). In the event of conversions, the primary site CCN and extension site identifiers will need to be adjusted.
- **Completing the Request at Resurvey**: The SA Surveyor (non-deemed) will bring this form to any resurvey and either request that a facility representative complete, sign, date, and return it at the completion of the onsite visit, at which time the surveyor will review it for completeness and accuracy; or the surveyor may complete the form and have the facility representative review and sign it.

Additional Guidance - Detailed instructions or definitions are given below for questions other than those considered self-explanatory.

- **CMS CERTIFICATION NUMBER—**Leave blank on all initial certifications. On all recertifications, insert the facility's assigned six-digit provider number.
- **EXTENSION IDENTIFICATION NUMBER—**Leave blank on all initial certifications for extension locations. Insert extension identification numbers for all CMS-approved extension locations.
- **County—**Leave blank if not known.
- **Name of Accrediting Organization**- only insert if requesting deemed status or if already accredited. List of CMS-approved AOs may be found https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Accrediting-Organization-Contacts-for-Prospective-Clients-.pdf
- **Type of Organization**:
  - **Hospital-** self explanatory
  - **Skilled Nursing Facility**- self explanatory
  - **Home Health Agency**- self explanatory
  - **Rehabilitation agency** is an agency which provides an integrated multidisciplinary program designed to upgrade the physical function of disabled individuals by bringing together as a team specialized rehabilitation personnel. At a minimum, it must provide physical therapy or speech pathology services, and a rehabilitation program which, in addition to physical therapy or speech pathology services, includes social or vocational adjustment services.
  - **Clinic** is a facility established primarily for providing outpatient physician's services. It must meet the following test of physician participation: (1) The medical services of the clinic are provided by a group of physicians, i.e., more than two, practicing medicine together, and (2) a physician is present in the clinic at all times to perform medical (rather than administrative) services.
  - **Public Health Agency** is an official agency established by a State or local government, the primary function of which is to maintain the health of the population served by performing environmental health services, preventive medical services, and, in certain cases, therapeutic services.
- **Qualified Staff (refer to § 485.705 Personnel qualifications).—**To determine full-time equivalents, add the total number of hours worked by the appropriate professionals in the week ending prior to the week of filing the request and divide by the number of hours in the standard work week. If the result is not a whole number, express it as a quarter fraction (e.g., .00, .25, .50, .75). Include only qualified physical therapists and qualified speech pathologists.
  - **A qualified physical therapist** is a person who is licensed as a physical therapist by the State in which practicing and (1) has graduated from a physical therapy curriculum approved by the American Physical Therapy Association or by the Council on Medical Education and Hospitals of the American Medical Association, or jointly by the Council on Medical Education and Hospitals of the American Medical Association and the American Physical Therapy Association; or (2) prior to January 1, 1966: (a) was admitted to membership by the American Physical Therapy Association; or (b) was admitted to registration by the American Registry of Physical Therapists; or (c) has graduated from a physical therapy curriculum in a 4-year college or university approved by a State department of education; or (3) has 2 years of appropriate experience as a physical therapist and has achieved a satisfactory grade on a proficiency examination approved by the Secretary, except that such determinations of proficiency shall not apply with respect to persons initially licensed by a State or seeking qualification as a physical therapist after December 31, 1977; or (4) was licensed or registered prior to January 1, 1966, and prior to January 1, 1970, had 15 years of full-time experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending and referring physicians; or (5) if trained outside the United States: (a) was graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy; (b) meets the requirements for membership in a member organization of the World Confederation for Physical Therapy; (c) has 1 year of experience under the supervision of an active member of the American Physical Therapy Association; and (d) has successfully completed a qualifying examination as prescribed by the American Physical Therapy Association.
  - **A qualified speech pathologist** is a person who is licensed, if applicable, by the State in which practicing: (1) is eligible for a certificate of clinical competence in speech pathology granted by the American Speech and Hearing Association under its requirements in effect on January 17, 1974; or (2) meets the educational requirements for certification, and is in the process of accumulating the supervised experience required for certification.

CENTERS FOR MEDICARE & MEDICAID SERVICES

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

CERTIFICATE OF COMPLIANCE

LABORATORY NAME AND ADDRESS

LABORATORY
12345 MAIN STREET
SPRINGFIELD, ST 67890

CLIA ID NUMBER

22D0981035

EFFECTIVE DATE

12/02/2018

EXPIRATION DATE

12/01/2020

LABORATORY DIRECTOR

JACOB LEE Ph.D.

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Karen W. Dyer

Karen W. Dyer, Acting Director
Division of Laboratory Services
Survey and Certification Group
Center for Clinical Standards and Quality