SECTION 1: BASIC INFORMATION

A. Provide the two-letter State Code (e.g., TX for Texas) where your business is located

☐☐

B. Check one box and provide the necessary information where requested

DMEPOS suppliers must furnish their Medicare Identification Number, often referred to as a supplier number, and their NPI below. Note: Each enrolled supplier of DMEPOS must obtain an NPI for each practice location.

Medicare Identification Number(s) *(if isssued)*:_____ NPI:_____

REASON FOR APPLICATION	REQUIRED SECTIONS
❑ You are a **new enrollee** in Medicare	**Complete all sections**
❑ You are **adding a new business location**	**Complete all sections**
❑ You are **reactivating** your Medicare Supplier Billing Number	**Complete all sections**
❑ You are **reenrolling**	**Complete all sections**
❑ You are **voluntarily terminating your Medicare enrollment.** Effective date of termination	**1B, 13, and either 15** or **16**
❑ You are **changing your Medicare information**	**Go to Section 1C**

SECTION 1: BASIC INFORMATION (Continued)

C. Check the item(s) listed that is changing and complete the applicable sections

MARK ALL THAT APPLY	REQUIRED SECTIONS
❑ Identifying Information (NOTE: Including supplier type and/or products and services)	**1C, 2** (complete only those data elements that are changing), **3, 13,** and either **15 (**if you are the authorized official) or **16** (if you are the delegated official), and **6** for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
❑ Adverse Legal Actions/Convictions	**1C, 3, 13,** and either **15 (**if you are the authorized official) or **16** (if you are the delegated official), and **6** for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
❑ Current Business Location	**1C, 3, 4** (complete only those data elements that are changing), **13**, and either **15 (**if you are the authorized official) or **16** (if you are the delegated official), and **6** for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
❑ Ownership and/or Managing Control Information (Organizations)	**1C, 3, 5, 13,** and either **15 (**if you are the authorized official) or **16** (if you are the delegated official), and **6** for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
❑ Ownership and/or Managing Control Information (Individuals)	**1C, 3, 6, 13,** and either **15 (**if you are the authorized official) or **16** (if you are the delegated official), and **6** for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
❑ Billing Agency Information	**1, 3, 8** (complete only those data elements that are changing), **13,** and either **15 (**if you are the authorized official) or **16** (if you are the delegated official), and **6** for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
❑ Authorized Official	**1C, 3, 6, 13** and **15**
❑ Delegated Official	**1C, 3, 6, 13, 15** and **16**

SECTION 2: IDENTIFYING INFORMATION

SECTION 2A1 INSTRUCTIONS

A. SUPPLIER IDENTIFICATION

All applicants new to Medicare or suppliers that are making changes to their Medicare information must complete this section. DO NOT PROVIDE BILLING AGENT INFORMATION HERE.

1. Where should we mail your 1099?

Furnish the supplier's legal business name (as reported to the IRS). A copy of the IRS CP-575 or other correspondence issued by the IRS showing the tax identification number (TIN) for this business MUST be submitted.

Legal Business Name as Reported to the IRS *(NOT "Doing Business As" Name)*		Tax Identification Number
1099 Mailing Address Line 1 *(Street Name and Number)*		Former Tax Identification Number *(if changed)*
1099 Mailing Address Line 2 *(Suite, Room, etc.)*		Medicaid Number *(if applicable)*
1099 Mailing Address City	1099 Mailing Address State	1099 Mailing Address ZIP Code + 4

2. Where Should Correspondence Be Mailed?

This is the address to which correspondence will be sent to you by the NSC and/or the DME MAC.

Business Location Name *(NOT your billing agent, staffing company, or managing organization)*		
Mailing Address Line 1 *(Street Name and Number)*		
Mailing Address Line 2 *(Suite, Room, etc.)*		
City/Town	State	ZIP Code + 4
Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

SECTION 2: IDENTIFYING INFORMATION (Continued)

3. Where Should We Mail Your Reenrollment Request Package if different from Section 2A2 above?

This is the address to which the NSC will send your reenrollment request package.

Business Location Name *(NOT your billing agent, staffing company, or managing organization)*

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

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

City/Town	State	ZIP Code + 4

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

4. Is this supplier currently enrolled in the Medicare program other than as a DMEPOS supplier?

❑ YES ❑ NO

If yes, please provide the following:

Medicare Contractor Name	Medicare Billing Number	NPI

B. TYPE OF SUPPLIER

The supplier must meet all Medicare requirements for the DMEPOS supplier type checked. Any specialty personnel including, but not limited to, Registered Pharmacists, Respiratory Therapists, and Orthotics/Prosthetics personnel, must be W-2 employees of the enrolling supplier.

Type of Supplier (Check all that apply)

- ❑ Ambulatory Surgical Center
- ❑ Department Store
- ❑ Grocery Store
- ❑ Home Health Agency
- ❑ Hospital
- ❑ Indian Health Service
- ❑ Intermediate Care Nursing Facility
- ❑ Medical Supply Company
- ❑ Medical Supply Company with Orthotics Personnel
- ❑ Medical Supply Company with Pedorthic Personnel
- ❑ Medical Supply Company with Prosthetics Personnel
- ❑ Medical Supply Company with Prosthetic/Orthotic Personnel
- ❑ Medical Supply Company with Registered Pharmacist
- ❑ Medical Supply Company with Respiratory Therapist
- ❑ Nursing Facility (other)
- ❑ Occupational Therapist
- ❑ Optician
- ❑ Optometrist
- ❑ Orthotics Personnel
- ❑ Oxygen Supplier
- ❑ Pedorthic Personnel
- ❑ Pharmacy
- ❑ Physical Therapist
- ❑ Physician
- ❑ Prosthetics Personnel
- ❑ Prosthetic/Orthotic Personnel
- ❑ Rehabilitation Agency
- ❑ Skilled Nursing Facility
- ❑ Other_____

C. PRODUCTS AND SERVICES TO BE FURNISHED BY THIS SUPPLIER

Check all that apply. If you are a physician, skip to Section 2D. If you are adding/changing any supplies for which you plan to bill, you must notify the NSC. Failure to do so could result in revocation and/or overpayment collection.

If you check "Parenteral Nutrition" or "Drugs/Pharmaceuticals," a copy of the supplier's State pharmacy license must be submitted with this application.

- ❑ Accessories
- ❑ Commodes
- ❑ CPM Device
- ❑ Diabetic Equipment and Supplies
- ❑ Diabetic Footwear
- ❑ Dialysis Equipment and Supplies
- ❑ Drugs/Pharmaceuticals
- ❑ Durable Medical Equipment
- ❑ Enteral Nutrition
- ❑ Heat/Cold Applications
- ❑ Hemodialysis Equipment and Supplies
- ❑ Hospital Beds
  - ❑ Accessories
  - ❑ Electric
  - ❑ Manual
- ❑ Nebulizers
- ❑ Negative Pressure Wound
- ❑ Optician
- ❑ Orthotics – Custom Fabricated
- ❑ Orthotics – Non-customized
- ❑ Oxygen
- ❑ Parenteral Nutrition
- ❑ Patient Lifts and Seat Lift Mechanisms
- ❑ Power Mobility Devices (PMD)
  - ❑ Power Operated Vehicles (or scooters)
  - ❑ Power Wheelchairs
- ❑ Prosthetics
- ❑ Respiratory Equipment
  - ❑ Bi-level Positive Airway Pressure
  - ❑ Continuous Positive Airway Pressure
  - ❑ Intermittent Positive Pressure Breathing
  - ❑ Invasive Mechanical Ventilation
- ❑ Speech Generating Device
- ❑ Suction Pump
- ❑ Support Surfaces
  - ❑ For Beds
  - ❑ For Wheelchair/Power Mobility Devices
- ❑ Surgical Dressings
- ❑ Tens Units
- ❑ Traction Equipment
- ❑ Urinals/Bedpans
- ❑ Walkers, Canes and Crutches
- ❑ Wheelchairs – Manual
- ❑ Other (Specify):_____

SECTION 2D INSTRUCTIONS: LIABILITY INSURANCE INFORMATION

Consistent with DMEPOS supplier standard 10 on page 31, all DMEPOS suppliers enrolling in Medicare must have a comprehensive liability insurance policy in the amount of at least $300,000. The NSC must be listed on the policy as a Certificate Holder. The insurance policy must remain in force at all times and provide coverage of at least $300,000 per incident. Failure to maintain the required insurance at all times will result in revocation of the Medicare supplier billing number, retroactive to the date the insurance lapsed. Malpractice insurance policies do not demonstrate compliance with this requirement.

SECTION 3: ADVERSE LEGAL ACTIONS/CONVICTIONS

This section captures information regarding adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending. If you are uncertain as to whether a name reported on this application has an adverse legal action, query the Healthcare Integrity and Protection Data Bank. For information on how to access the Data Bank, call 1-800-767-6732 or visit *www.npdb-hipdb.com*. There is a charge for using this service.

ADVERSE LEGAL ACTIONS THAT MUST BE REPORTED

Convictions

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

   Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicare program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
2. Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
5. Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions

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

SECTION 3: ADVERSE LEGAL ACTIONS/CONVICTIONS (Continued)

ADVERSE LEGAL HISTORY

1. Have you or your organization, under any current or former name or business identity, ever had an adverse legal action listed on page 10 of this application imposed against you/it?

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

2. If yes, report each adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

   Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action	Date	Taken By	Resolution

SECTION 13: CONTACT PERSON

If questions arise during the processing of this application, the NSC will contact the individual shown below. If no one is listed below, we will contact you directly.

❑ Contact the Authorized Official listed in Section 15.
❑ Contact the Delegated Official listed in Section 16.

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

Address Line 1 *(Street Name and Number)*

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

City/Town	State	ZIP Code + 4

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

SECTION 15: CERTIFICATION STATEMENT (Continued)

A. ADDITIONAL REQUIREMENTS FOR MEDICARE ENROLLMENT

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

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

1. I agree to notify the NSC of any future changes to the information contained in this application within 30 days of the effective date of the change. I understand that any change in the business structure of this supplier may require the submission of a new application.

2. I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare identification number(s), and/or the imposition of fines, civil damages, and/or imprisonment.

3. I agree to abide by the Medicare laws, regulations and program instructions that apply to this supplier. The Medicare laws, regulations, and program instructions are available through the Medicare contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the supplier's compliance with all applicable conditions of participation in Medicare.

4. Neither this supplier, nor any five percent or greater owner, partner, officer, director, managing employee, authorized official, or delegated official thereof is currently sanctioned, suspended, debarred, or excluded by the Medicare or State Health Care Program, e.g., Medicaid program, or any other Federal program, or is otherwise prohibited from supplying services to Medicare or other Federal program beneficiaries.

5. I agree that any existing or future overpayment made to the supplier by the Medicare program may be recouped by Medicare through the withholding of future payments.

6. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

7. I authorize any national accrediting body whose standards are recognized by the Secretary as meeting the Medicare program participation requirements, to release to any authorized representative, employee, or agent of the Centers for Medicare & Medicaid Services (CMS) a copy of my most recent accreditation survey, together with any information related to the survey that CMS may require (including corrective action plans).

SECTION 15: CERTIFICATION STATEMENT (Continued)

B. 1ST AUTHORIZED OFFICIAL SIGNATURE

I have read the contents of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize the NSC to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the NSC of this fact immediately.

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

CHECK ONE	❑ CHANGE	❑ ADD	❑ DELETE
DATE (mm/dd/yyyy)			

Authorized Official's Information and Signature

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

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

C. 2ND AUTHORIZED OFFICIAL SIGNATURE

I have read the contents of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize the NSC to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the NSC of this fact immediately.

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

CHECK ONE	❑ CHANGE	❑ ADD	❑ DELETE
DATE (mm/dd/yyyy)			

Authorized Official's Information and Signature

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

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

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

SECTION 16: DELEGATED OFFICIAL(S) (OPTIONAL)

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

A. 1ST DELEGATED OFFICIAL SIGNATURE

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

CHECK ONE	❑ CHANGE	❑ ADD	❑ DELETE
DATE (mm/dd/yyyy)			

1. Delegated Official First Name **Print**	Middle Initial	Last Name	Suffix *(e.g., Jr., Sr.)*
Delegated Official *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)* **Signature**			Date Signed *(mm/dd/yyyy)*
❑ Check here if Delegated Official is a W-2 Employee		Telephone Number	
2. Authorized Official Assigning this Delegation *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)* **Signature**			Date Signed *(mm/dd/yyyy)*