
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 issued)*: _____ NPI: _____

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

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 <i>(NOT "Doing Business As" Name)</i>		Tax Identification Number
1099 Mailing Address Line 1 <i>(Street Name and Number)</i>		Former Tax Identification Number <i>(if changed)</i>
1099 Mailing Address Line 2 <i>(Suite, Room, etc.)</i>		Medicaid Number <i>(if applicable)</i>
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 <i>(NOT your billing agent, staffing company, or managing organization)</i>		
Mailing Address Line 1 <i>(Street Name and Number)</i>		
Mailing Address Line 2 <i>(Suite, Room, etc.)</i>		
City/Town	State	ZIP Code + 4
Telephone Number	Fax Number <i>(if applicable)</i>	E-mail Address <i>(if applicable)</i>

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

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

City/Town	State	ZIP Code + 4
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Telephone Number	Fax Number (<i>if applicable</i>)	E-mail Address (<i>if applicable</i>)
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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	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> 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	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> 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	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> 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)
<input type="checkbox"/> 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)