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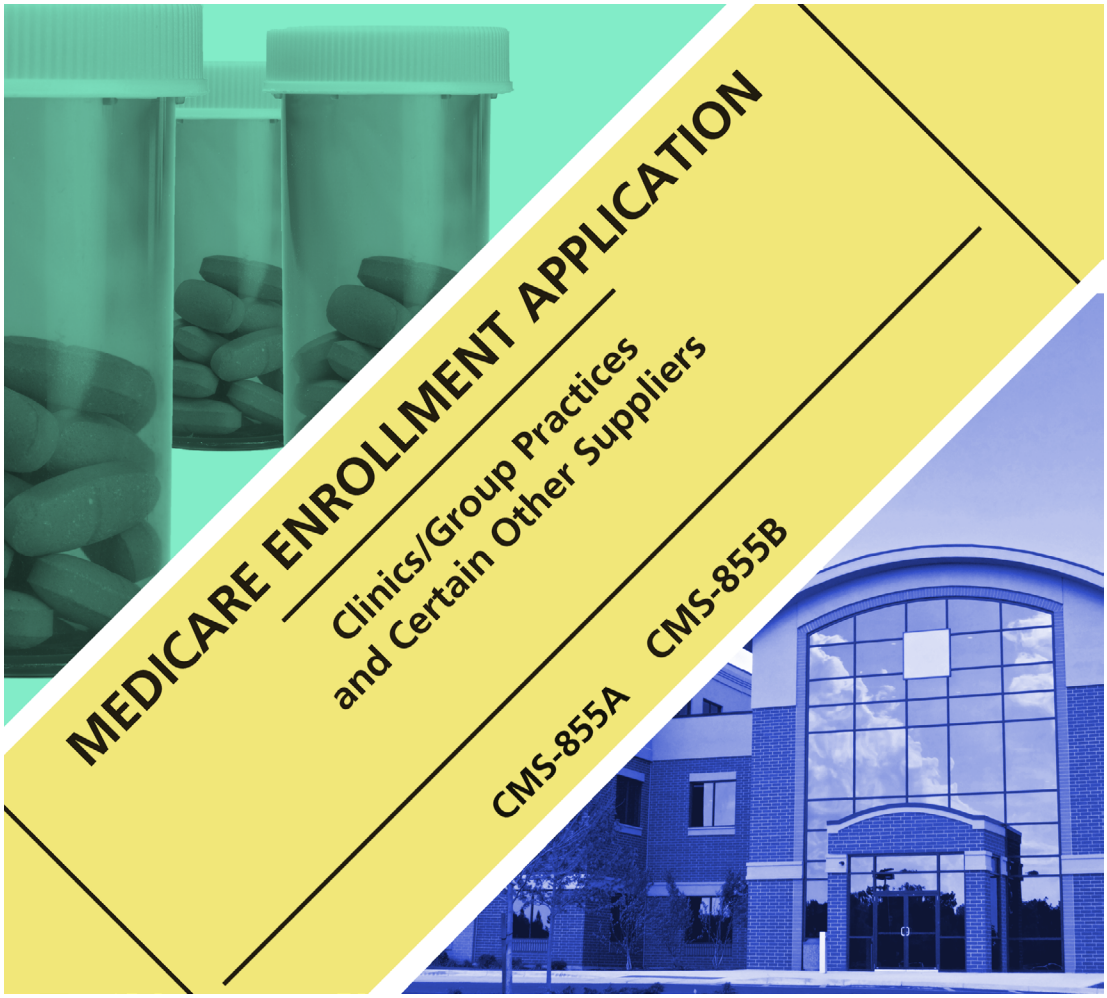
OPIOID TREATMENT PROGRAMS (OTPs) MEDICARE ENROLLMENT FACT SHEET



TARGET AUDIENCE

OTP Providers

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

TABLE OF CONTENTS

UPDATES

- Providers can now enroll via the CMS-855A application (pages 10-29)

INTRODUCTION

This fact sheet helps Opioid Treatment Providers (OTPs) understand how to enroll in Medicare. It includes enrollment tips and where to get help along the way. Visit the CMS Opioid Treatment Programs Center webpage for background on this new **Part B** benefit for Medicare beneficiaries with Opioid Use Disorder (OUD). You can print the enrollment checklist at the end of this document.

BACKGROUND

January 1, 2020, Medicare began paying Medicare-enrolled OTPs to deliver OUD treatment services to Medicare beneficiaries. To begin paying OTPs for services provided on or after January 1, 2020, the Centers for Medicare & Medicaid Services (CMS) began accepting and processing OTP enrollment applications. Your organization may enroll as an OTP provider if you meet certain criteria and applicable Medicare enrollment requirements.

Beginning January 1, 2021, Medicare Part B covers hospital outpatient Opioid Treatment Program services. Health care organizations may now apply on the Medicare Enrollment Application for Institutional Providers (CMS-855A) or through the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) (837I) when they enroll in the Medicare Program. These providers will submit claims using the CMS-1450.

As an OTP, you can be a Part **A** or a Part **B** provider.

To be eligible to enroll as an OTP service provider with Medicare, your program must have current, valid, and full certification by the Substance Abuse and Mental Health Services Administration (SAMHSA), and meet all the criteria required by SAMHSA including but not limited to: Drug Enforcement Administration (DEA) registration, State licensure, and accreditation.

Your Medicare Administrative Contractor (MAC) will verify your SAMHSA certification on the SAMHSA OTP directory. Please note that MACs **will not accept** applications without full SAMHSA certification and will deny applications for OTPs with "provisional" SAMHSA certification status. For information on SAMHSA certification visit: Apply for Opioid Treatment Program (OTP) Certification.

OVERVIEW OF THE OTP ENROLLMENT PROCESS

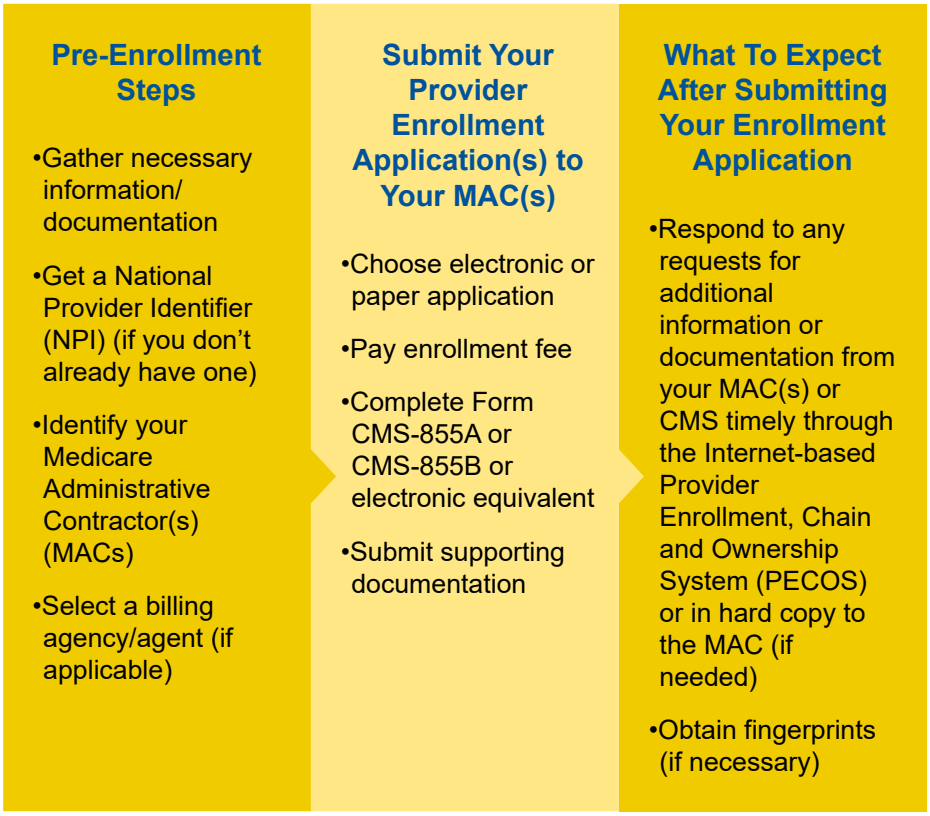


Figure 1: OTP Enrollment Process Diagram

PRE-ENROLLMENT STEPS

1 Gather Necessary Information/Documentation

Before you begin the application process, make sure you have all the necessary information and documentation you need, including:

- A detailed organizational chart (like the one you used for your SAMHSA certification)
- Names, contact information, and Tax Identification Numbers (TINs) and/or Social Security Numbers (SSNs) for all individuals or organizations with ownership interest in the OTP
- Addresses and phone numbers for all practice locations of the OTP
- Copies of legal record regarding any convictions, exclusions, revocations, and suspensions for any individual or entity with 5% or greater ownership and/or managing control associated with the OTP

Gathering this information before you begin the process will help you to complete your enrollment more quickly.

2 Get an NPI

You must have a National Provider Identifier (NPI) and include it in multiple sections of the enrollment application. Some OTPs will already have an NPI used in billing Medicaid or other health plans. If your OTP already has an NPI, you can skip to step 3 below. Your OTP clinicians must also get NPIs for enrollment screening, claim submission, and monitoring purposes. Get your NPI **before** beginning Medicare enrollment.

Apply for an NPI by one of the following three ways:

- **Electronically:** Visit the National Plan & Provider Enumeration System (NPPES) website. The link to the Identity & Access (I & A) Management System website on the right side of the NPPES log in page explains the steps to create a username and password. Once you get an I & A account, you can log in to NPPES and apply for an NPI and manage NPIs as well. You can use the same I & A account to access PECOS, the online enrollment system.

- **Paper Application:** Your OTP can complete, sign, and mail a paper application to the NPI Enumerator address on the form (Form-CMS10114, NPI Application/Update Form).

- **Via an EFIO:** You can also give permission to an Electronic File Interchange Organization (EFIO) to submit application data through the bulk enumeration process. In other words, rather than a provider or group of providers submitting a paper or web NPI application, the EFIO gets an NPI for him/her/them via the submission of an electronic file. For more information about EFIOs and submitting your NPI application through bulk enumeration, visit the EFI page on the CMS website.

Things to know about NPIs:

- An NPI is a unique 10-digit identification number issued to health care providers.
- NPPES is the fastest way to get an NPI.
- Review the paper NPI application before using NPPES to understand the NPI application requirements.
- When applying for an NPI, select a taxonomy code that best represents your organization.
- The NPI Enumerator processes NPI applications and helps health care providers with related questions.

3 Identify Your MACs

Medicare Administrative Contractors process Medicare Fee-For-Service (FFS) claims (also known as Medicare Part A and Part B claims) and enrollment applications on a jurisdiction-by-jurisdiction basis . As an OTP, you are a Part A or a Part B provider.

MACs also:

- Pay providers for Medicare FFS claims
- Answer providers inquiries
- Educate providers about Medicare FFS billing requirements

If your OTP offers services in more than one State and those States are in different MAC jurisdictions, complete a separate enrollment application (CMS-855A or CMS-855B) for each MAC jurisdiction. See the MAC Website List to find your contractor by State.

Contact your MAC if you have questions about enrolling in Medicare.

Some MACs have separate Part A and Part B provider enrollment phone numbers and other contact information. Opioid Treatment Programs should use the Part A contact information if you filed a CMS Form-855A and Part B contact information if you filed a CMS form-855B.

4 Select a billing agency/agent (if applicable)

Many providers use a billing agent to manage billing and claims processes on their behalf. If you use a billing agency/agent, you must include that information in Section 8 of the Form CMS-855B and CMS-855A Enrollment Application. You must choose the billing agency/agent before you submit the application. If you do not use a billing agency/agent, you will check the box to indicate that it does not apply and skip to the next section.

SUBMIT YOUR PROVIDER ENROLLMENT APPLICATION

Apply Electronically or By Paper Form

You must decide if you will apply online or with a paper application. You can apply:

1. Electronically through the Internet-based Provider Enrollment, Chain and Ownership System (PECOS). CMS recommends applying electronically, which will allow your application to be processed faster.

   PECOS is an online system that lets you complete most of your enrollment activities online, including submitting your enrollment application, changing existing Medicare enrollment record information, and other processes. It captures the same information as the paper application, but PECOS simplifies the enrollment process into short, easy-to-understand steps.

You must have Internet Explorer version 5.5 or higher and have the most recent version of Adobe Acrobat Reader before initiating an enrollment action using Internet-based PECOS.

There are advantages to using PECOS including:

- Enrolling faster than paper-based enrollment
- Providing a tailored application process in which you only give information relevant to YOUR application
- Offering more control over your enrollment information, including reassignments
- Making it easy to check and update your information for accuracy
- Requiring less staff time and administrative costs to complete and submit enrollment to Medicare

OR

2. By submitting a paper enrollment application to the MAC. Complete the paper-based applications using the Medicare Enrollment Application: Clinics/Group Practices and Certain Other Suppliers (Form CMS-855B) or the Medicare Enrollment Application: Institutional Providers (Form CMS-855A).

Pay the Enrollment Fee

The Medicare enrollment application fee applies to OTP providers. You must pay the enrollment fee upon initial enrollment and revalidation (every 5 years for OTP providers). CMS considers hardship exceptions on a case-by-case basis.

You can pay online through PECOS as you complete the electronic application or at the Medicare Enrollment for Providers and Suppliers website if you are completing a paper application.

To pay the fee you must include:

- Your NPI
- The OTP Legal Business Name
- Type of Tax Identification Information (TIN) to be provided (choose SSN or EIN from the drop down box in PECOS or checkbox on the paper application)
- The SSN or EIN (the actual number of the type indicated above)
- The State or Territory of the OTP (use the OTP primary practice location address)
- Your MAC (identified as your Fee-For-Service contractor)

COMPLETE THE FORM CMS-855A OR CMS-855B MEDICARE ENROLLMENT APPLICATION

Important Notes:

- OTPs may enroll (and be enrolled) in Medicare via the Form CMS-855A or the Form CMS-855B but not both.
- OTPs that are currently enrolled but are changing their OTP enrollment from a Form CMS-855B to a Form CMS-855A (or vice versa) must successfully complete the limited level of categorical screening under § 424.518(a) if the OTP has already completed, as applicable, the moderate or high level of categorical screening under § 424.518(b) or (c), respectively.
- If a Form CMS-855B-enrolled OTP changes to a Form CMS-855A enrollment (or vice versa) the effective date of billing that was established for the OTP's prior enrollment under § 424.520(d) and § 424.521(a) would be applied to the OTP's new enrollment.
- The application fee requirements apply to OTPs changing their enrollment from a Form CMS-855B to a Form CMS-855A (or vice versa).

As an OTP provider, you only need to fill out sections **1-6, 8, 13, 15, 16 (optional) and 17** of the application:

NOTE: The instructions are separated into the CMS-855A and CMS-855B enrollment applications. While many sections of both forms are the same, some sections of the CMS-855A have slightly different instructions. Choose the enrollment application that applies to you from the icons below to be automatically directed to the correct instructions.

Form CMS-855A **Form CMS-855B**

INSTRUCTIONS FOR THE FORM CMS-855A MEDICARE ENROLLMENT APPLICATION

Section 1: Basic Information

SECTION 1: BASIC INFORMATION *(Continued)*

A. Check one box and complete the required sections

REASON FOR APPLICATION	BILLING NUMBER INFORMATION	REQUIRED SECTIONS
☐ You are a **new enrollee** in Medicare	Enter your Medicare Identification Number (if issued) and the NPI you would like to link to this number in Section 4.	**Complete all applicable** sections except **2F, 2G,** and **2H**
☐ You are enrolling with another fee-for-service contractor's jurisdiction ☐ You are **reactivating** your Medicare enrollment	Enter your Medicare Identification Number (if issued) and the NPI you would like to link to this number in Section 4.	**Complete all applicable** sections except **2F, 2G,** and **2H**
☐ You are **voluntarily terminating** your Medicare enrollment	Effective Date of Termination: Medicare Identification Number(s) to Terminate *(if issued):* National Provider Identifier *(if issued):*	**Complete sections: 1, 2B1, 13,** and either **15** or **16**
☐ There has been a **Change of Ownership (CHOW)** of the Medicare-enrolled provider You are the: ☐ Seller/Former Owner ☐ Buyer/New Owner	Tax Identification Number:	**Seller/Former Owner: 1A, 2F, 13,** and either **15** or **16** **Buyer/New Owner: Complete all** sections except **2G** and **2H**

Figure 2: CMS Form-855A Section 1A

In **subsection A.** Check one box and complete the required section, select the reason for the application, depending on your status.

In **subsection B.** *Check all that apply and complete the required sections*, which are:

B. Check all that apply and complete the required sections:

	REQUIRED SECTIONS
☐ Identifying Information	**1, 2** (complete only those sections that are changing), **3, 13,** and either **15** (if you are the authorized official) **or 16** (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Adverse Legal Actions/Convictions	**1, 2B1, 3, 13,** and either **15** (if you are the authorized official) **or 16** (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Practice Location Information, Payment Address & Medical Record Storage Information	**1, 2B1, 3, 4** (complete only those sections that are changing), **13,** and either **15** (if you are the authorized official) **or 16** (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Ownership Interest and/or Managing Control Information (Organizations)	**1, 2B1, 3, 5, 13,** and either **15** (if you are the authorized official) **or 16** (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Ownership Interest and/or Managing Control Information (Individuals)	**1, 2B1, 3, 6, 13,** and either **15** (if you are the authorized official) **or 16** (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Chain Home Office Information	**1, 2B1, 3, 7, 13,** and either **15** (if you are the authorized official) **or 16** (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Billing Agency Information	**1, 2B1, 3, 8** (complete only those sections that are changing), **13,** and either **15** (if you are the authorized official) **or 16** (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Special Requirements for Home Health Agencies	**1, 2B1, 3, 12, 13,** and either **15** (if you are the authorized official) **or 16** (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Authorized Official(s)	**1, 2B1, 3, 6, 13,** and **15.**

Figure 3: CMS Form-855A Section 1B

- Identifying Information
- Final Adverse Actions/Convictions
- Practice Location Information, Payment Address & Medicare Record Storage Information
- Ownership Interest and/or Managing Control Information (Organizations)
- Ownership Interest and/or Managing Control Information (Individuals)
- Billing Agency Information
- Authorized Official(s)

Section 2: Identifying Information

In **subsection A.** *Type of Supplier*, check the box for Other and write "Opioid Treatment Provider" or "OTP" in the field for Specify.

SECTION 2: IDENTIFYING INFORMATION ***(Continued)***

A. Type of Provider

The provider must meet all Federal and State requirements for the type of provider checked. Check only one provider type. If the provider functions as two or more provider types, a separate enrollment application (CMS-855A) must be submitted for each type.

1. Type of Provider (other than Hospitals— See 2A2). Check only one:

☐ Community Mental Health Center
☐ Comprehensive Outpatient Rehabilitation Facility
☐ Critical Access Hospital
☐ End-Stage Renal Disease Facility
☐ Federally Qualified Health Center
☐ Histocompatibility Laboratory
☐ Home Health Agency
☐ Home Health Agency (Sub-unit)
☐ Hospice
☐ Indian Health Services Facility
☐ Organ Procurement Organization
☐ Outpatient Physical Therapy/Occupational Therapy/ Speech Pathology Services
☐ Religious Non-Medical Health Care Institution
☐ Rural Health Clinic
☐ Skilled Nursing Facility
☐ Other (Specify):_____

Figure 4: CMS Form-855A Section 2A

In **subsection B.** *Supplier Identification Information*:

- Add the required information for item 1. Business Information

B. Identification Information

1. BUSINESS INFORMATION

Legal Business Name (not the "Doing Business As" name) as reported to the Internal Revenue Service

Identify the type of organizational structure of this provider/supplier *(Check one)*

☐ Corporation ☐ Limited Liability Company ☐ Partnership

☐ Sole Proprietor ☐ Other *(Specify)*: _____

Tax Identification Number

Incorporation Date *(mm/dd/yyyy) (if applicable)*	State Where Incorporated *(if applicable)*

Other Name

Type of Other Name

☐ Former Legal Business Name ☐ Doing Business As Name ☐ Other *(Specify)*: _____

Identify how your business is registered with the IRS. (**NOTE:** If your business is a Federal and/or State government provider or supplier indicate "Non-Profit" below):

☐ Proprietary ☐ Non-Profit

NOTE: If a checkbox indicating Proprietaryship or non-profit status is not completed, the provider/supplier will be defaulted to "Proprietary."

What is the supplier's year end cost report date? *(mm/dd/yyyy)*

Is this supplier an Indian Health Facility enrolling with the designated Indian Health Service (IHS) Medicare Administrative Contractor (MAC)?

☐ Yes ☐ No

Figure 5: CMS Form-855A Section 2B.1

- Add the SAMHSA certification information for the OTP in item 2. State License Information/Certification Information Report the certification number, effective date, and expiration date in the same section
- Your Medicare Administrative Contractor (MAC) will verify that you are fully certified with SAMHSA and that your information has been entered correctly.

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

2. STATE LICENSE INFORMATION/CERTIFICATION INFORMATION

Provide the following information if the provider has a State license/certification to operate as the provider type for which you are enrolling.

☐ State License Not Applicable

License Number	State Where Issued
Effective Date *(mm/dd/yyyy)*	Expiration/Renewal Date *(mm/dd/yyyy)*

Certification Information

☐ Certification Not Applicable

Certification Number	State Where Issued
Effective Date *(mm/dd/yyyy)*	Expiration/Renewal Date *(mm/dd/yyyy)*

Figure 6: CMS Form-855A Section 2B.2

Include the correspondence address where we can contact you directly in subsection B.2.C. Correspondence Address. This address cannot be a billing agency's address.

C. Correspondence Address

Provide contact information for the entity listed in Section 2B1 of this section. Once enrolled, the information provided below will be used by the fee-for-service contractor if it needs to contact you directly. This address cannot be a billing agency's address.

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)*

Figure 7: CMS Form-855A Section 2C

If you are new to Medicare, you do not have to fill-out subsections E.through H.

Section 3: Final Adverse Legal Actions /Convictions

SECTION 3: FINAL ADVERSE ACTIONS/CONVICTIONS *(Continued)*

FINAL ADVERSE LEGAL HISTORY

1. Has your organization, under any current or former name or business identity, ever had a final adverse action listed on page 16 of this application imposed against it?

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

2. If yes, report each final adverse 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 final adverse action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

Figure 8: CMS Form-855A Section 3

Add information about any final adverse legal actions to Section 3.

You must report all applicable final adverse legal actions, regardless of whether any records were expunged or any appeals are pending.

If you report any adverse legal actions, send copies of related or supporting documentation including notifications, resolutions, and reinstatement.

What are Final Adverse Legal Actions?
Final adverse legal actions may include convictions, exclusions, revocations, and suspensions. Section 3 of the CMS-855A and CMS-855B applications includes more information about the specific actions that may constitute final adverse legal actions.

Section 4: Practice Location Information

In **subsection A.** *Practice Location Information*, you must:

SECTION 4: PRACTICE LOCATION INFORMATION ***(Continued)***

A. Practice Location Information

Report all practice locations where services will be furnished. If there is more than one location, copy and complete this section for each. Please list your primary practice location first.

To ensure that CMS establishes the correct associations between your Medicare legacy number (if issued) and your NPI, you must list a Medicare legacy number—NPI combination for each practice location. If you have multiple NPIs associated with both a single legacy number and a single practice location, please list below all NPIs and associated legacy numbers for that practice location.

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)*			

Practice Location Name *("Doing Business As" name if different from Legal Business Name)*

Practice Location Street Address Line 1 *(Street Name and Number – NOT a P.O. Box)*

Practice Location Street Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

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

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

CLIA Number for this location *(if applicable)*	FDA/Radiology (Mammography) Certification Number for this location *(if issued)*

Figure 9: CMS Form-855A Section 4A

If you see patients in more than one practice location, you will complete Section 4A for each location.

- Report all practice locations where services will be furnished
- List your primary location first
- List a Medicare legacy number/NPI combination for each practice location
- Leave the Medicare Identification Number blank (it is assigned after your enrollment application is approved)
- Check Other Hospital Practice Location and write in "Opioid Treatment Program" or "OTP"

If you are applying to Medicare for the first time, check Add for each location and include the following information specific to that location.

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

B. Where Do You Want Remittance Notices Or Special Payments Sent?
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)*			

Medicare will issue payments via electronic funds transfer (EFT). Since payment will be made by EFT, the "Special Payments" address will indicate where all other payment information (e.g., remittance notices, special payments) are sent.

☐ "Special Payments" address is the same as the practice location (only one address is listed in Section 4A). **Skip to Section 4C.**
☐ "Special Payments" address is different than that listed in Section 4A, or multiple locations are listed. **Provide address below.**

"Special Payments" Address Line 1 *(PO Box or Street Name and Number)*

"Special Payments" Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Figure 10: CMS Form-855A Section 4B

In **subsection B.** *Where do you want remittance notices or special payments sent?*, you must:

- Acknowledge that your payment address is the same as your practice location address, or
- Select Add to enter a location different from your practice location address
- Enter the address to which we should send remittance notices and special payments

In **subsection C.** *Where do you keep patients' medical records?*, you must:

C. Where Do You Keep Patients' Medical Records?

If you store patients' medical records (current and/or former patients) at a location other than the location in Section 4A or 4D, complete this section with the address of the storage location.

If this section is not complete, you are indicating that all records are stored at the practice locations reported in Section 4A or 4D. The records must be the provider's records, not the records of another provider. Post Office Boxes and drop boxes are not acceptable as physical addresses where patients' records are maintained.

For mobile facilities/portable units, the patients' medical records must be under the provider's control.

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

First Medical Record Storage Facility for Current and Former Patients

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

Storage Facility Address Line 1 *(Street Name and Number)*

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

City/Town	State	ZIP Code + 4

CMS-855A (07/11) 21

Figure 11: CMS Form-855A Section 4C

- Select Add
- Enter the effective date (the date you started seeing patients)
- Enter the address(es) of medical record storage facility(ies)

In **subsection D.** *Base of Operations Address for Mobile or Portable Providers (Location of Business Office or Dispatcher/Scheduler)*, you must:

D. Base of Operations Address for Mobile or Portable Providers (Location of Business Office or Dispatcher/Scheduler)

The base of operations is the location from where personnel are dispatched, where mobile/portable equipment is stored, and when applicable, where vehicles are parked when not in use.

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)*			

Check here ☐ and skip to Section 4E if the "Base of Operations" address is the same as the "Practice Location" listed in Section 4A.

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

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

City/Town	State	ZIP Code + 4

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

Figure 12: CMS Form-855A Section 4D

- Select Add
- Enter the effective date (date you started seeing patients)
- Enter the location (city, town, State, and ZIP) for the base of operations if it is different than the practice location listed in section 4A
- Check the box and skip to Section 4E if the "Base of Operations" address is the same as the "Practice Location" listed in Section 4A

F. Geographic Location For Mobile or Portable Providers where the Base of Operations and/or Vehicle Renders Services

For home health agencies (HHAs) and mobile/portable providers, furnish information identifying the geographic area(s) where health care services are rendered.

NOTE: If you provide mobile health care services in more than one State and those States are serviced by different Medicare fee-for-service contractors, complete a separate enrollment application (CMS-855A) for each Medicare fee-for-service contractor's jurisdiction.

1. INITIAL REPORTING AND/OR ADDITIONS

If you are reporting or adding an entire State, it is not necessary to report each city/town. Simply check the box below and specify the State.

☐ Entire State of _____

If services are provided in selected cities/towns, provide the locations below. Only list ZIP codes if you are not servicing the entire city/town.

CITY/TOWN	STATE	ZIP CODE

Figure 13: CMS Form-855A Section 4F

In **subsection F.** *Geographic Location For Mobile or Portable Providers where the Base of Operations and/or Vehicle Renders Services*, give the geographic area where services are rendered. You must:

- Enter the city/town, State, and ZIP code where health care services are rendered

If services are provided in home for an entire State, simply check the box for "Entire State of" and enter the name of the State.

Section 5: Ownership Interest and/or Managing Control Information (For Organizations)

SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS) ***(Continued)***

☐ Not Applicable

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)*			

A. Ownership/Managing Control Organization

1. IDENTIFYING INFORMATION

Legal Business Name as Reported to the Internal Revenue Service

"Doing Business As" Name *(if applicable)*

Address Line 1 *(Street Name and Number)*

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

City/Town	State	ZIP Code + 4

Tax Identification Number *(required)*

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

Figure 14: CMS Form-855A Section 5

Add information about any organizational ownership in Section 5.

- Report any organization that has a 5% or greater direct or indirect ownership of, a partnership interest in, and or managing control of the provider identified in Section 2
  - If there is more than one organization, copy and complete this section for each
  - Individuals should be reported in Section 6

Section 6: Ownership Interest and/or Managing Control Information (For Individuals)

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) ***(Continued)***

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)*			

A. Identifying Information

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

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

Social Security Number *(Required)*	Date of Birth *(mm/dd/yyyy)*	Place of Birth *(State)*	Country of Birth

Identify the type of ownership and/or managing control the individual identified above has in the provider identified in Section 2 of this application. Check all that apply. Complete all information for each type of ownership and/or managing control applicable.

☐ **5% or greater direct ownership interest**

Effective Date of 5% or greater direct ownership interest *(mm/dd/yyyy)*

Exact percentage of direct ownership this individual has in the provider

If this individual also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing, etc.).*

☐ **5% or greater indirect ownership interest**

Effective Date of 5% or greater indirect ownership interest *(mm/dd/yyyy)*

Exact percentage of indirect ownership this individual has in the provider

If this individual also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing, etc.).*

Figure 15: CMS Form-855A Section 6

Add information about individual ownership to Section 6.

- In **subsection A.** *Identifying Information*, add the full name, date and place of birth, Social Security Number (SSN), NPI, the type of ownership and/or managing control, effective date
- Add the officer, director, managing employer, effective date and exact percentage of control for owners with 5% or greater direct or indirect ownership
- In **subsection B.** *Final Adverse Legal Action History*, add the final adverse legal action history if an individual fits this category

Section 8: Billing Agency Information

SECTION 8: BILLING AGENCY INFORMATION

Applicants that use a billing agency must complete this section. A billing agency is a company or individual that you contract with to process and submit your claims. If you use a billing agency, you are responsible for the claims submitted on your behalf.

☐ **Check here if this section does not apply and skip to Section 12.**

BILLING AGENCY NAME AND ADDRESS

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)*			

Legal Business/Individual Name as Reported to the Social Security Administration or Internal Revenue Service

If Individual, Billing Agent Date of Birth *(mm/dd/yyyy)*

Tax Identification Number or Social Security Number *(required)*

"Doing Business As" Name *(if applicable)*

Billing Agency Address Line 1 *(Street Name and Number)*

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

City/Town	State	ZIP Code + 4

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

Figure 16: CMS Form-855A Section 8

If you choose to use one, you must include information about your billing agency or billing agent (if an individual) including:

- Legal business/individual name as reported to the Social Security Administration (SSA) or Internal Revenue Service (IRS)
- Date of birth (if individual)
- "Doing Business As" (DBA) name (if applicable)
- Tax Identification Number (TIN) or Social Security Number (SSN)
- Street address, city/town, State, Zip code +4
- Telephone number, fax number (if applicable), and e-mail address

If this section does not apply, check the box and skip to Section 12.

Section 12: Special Requirements for Home Health Agencies

All HHAs and HHA sub-units enrolling in the Medicare program must complete this section.
HHAs and HHA sub-units initially enrolling in Medicare, Medicaid, or both programs on or after January 1, 1998 are required to provide documentation supporting that they have sufficient initial reserve operating funds (capitalization) to operate for the first three months in the Medicare and/or Medicaid program(s). The capitalization requirement applies to all HHAs and HHA sub-units enrolling in the Medicare program, including HHAs or HHA sub-units currently participating in the Medicare program that, as a result of a change of ownership, will be issued a new provider number. The capitalization requirement does not apply to a branch of an HHA. Regulations found at 42 C.F.R. 489.28 require that the fee-for-service contractor determine the required amount of reserve operating funds needed for the enrolling HHA or HHA sub-unit by comparing the enrolling HHA or HHA sub-unit to at least three other new HHAs that it serves which are comparable to the enrolling HHA or HHA sub-unit. Factors to be considered are geographic location, number of visits, type of HHA or HHA sub-unit and business structure of the HHA or HHA sub-unit. The fee-for-service contractor then verifies that the enrolling HHA or HHA sub-unit has the required funds. To assist the fee-for-service contractor in determining the amount of funds necessary, the enrolling HHA or HHA sub-unit should complete this section.

Check here ☐ if this section does not apply and skip to Section 13.

A. Type of Home Health Agency

1. CHECK ONE:
☐ Non-Profit Agency ☐ Proprietary Agency

2. PROJECTED NUMBER OF VISITS BY THIS HOME HEALTH AGENCY
How many visits does this HHA project it will make in the first:
three months of operation?_____
twelve months of operation? _____

3. FINANCIAL DOCUMENTATION
A) In order to expedite the enrollment process, the HHA may attach a copy of its most current savings, checking, or other financial statement(s) that verifies the initial reserve operating funds, accompanied by:

1) An attestation from an officer of the bank or other financial institution stating that the funds are in the account(s) and are immediately available for the HHA's use, and

2) Certification from the HHA attesting that at least 50% of the reserve operating funds are non-borrowed funds.

B) Will the HHA be submitting the above documentation with this application? ☐ YES ☐ NO

NOTE: The fee-for-service contractor may require a subsequent attestation that the funds are still available. If the fee-for-service contractor determines that the HHA requires funds in addition to those indicated on the originally submitted account statement(s), it will require verification of the additional amount as well as a new attestation statement.

Figure 17: CMS Form-855A Section 12

All HHAs and HHA sub-units enrolling in the Medicare program must complete this section.

If this section does not apply to you, check the box and skip to Section 13.

Section 13: Contact Person

SECTION 13: CONTACT PERSON

If questions arise during the processing of this application, the fee-for-service contractor will contact the individual shown below. If the contact person is an authorized or delegated official, check the appropriate box below and skip to the section indicated.

☐ Contact an Authorized Official listed in Section 15

☐ Contact a Delegated Official listed in Section 16

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

Telephone Number	Fax Number *(if applicable)*

Address Line 1 *(Street Name and Number)*

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

City/Town	State	ZIP Code + 4

E-mail Address

Figure 18: CMS Form-855A Section 13

Add information about the Contact Person to Section 13. You must provide the contact person's full name, phone number, and address. Please note: only contact persons listed on the application will receive communication regarding application status from the MAC.

Section 15: Certification Statement

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 provider 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 Medicare fee-for-service contractor 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 Medicare fee-for-service contractor of this fact in accordance with the time frames established in 42 C.F.R. § 424.516(e).

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 provider 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 Medicare fee-for-service contractor 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 Medicare fee-for-service contractor of this fact in accordance with the time frames established in 42 C.F.R. § 424.516(e).

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)*			

Figure 19: CMS Form-855A Section 15

An Authorized Official (AO) can:

- Enroll the organization in the Medicare Program legally
- Commit the organization to abide by all Medicare Program statutes, regulations, and program instructions
- Can appoint Delegated Official(s) (DOs) (optional)

Add information for your selected AO(s) to Section 15. You must provide the full name, phone number, title/position, address, and signature of the officials.

Section 16: Delegated Official (Optional)

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 provider'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 provider to the laws, regulations, and program instructions of the Medicare program. By his or her signature, the 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 provider's enrollment information maintained by the Medicare program, the delegated official certifies that the information provided is true, correct, and complete.
- Delegated officials being deleted do not have to sign or date this application.
- Independent contractors are not considered "employed" by the provider and, therefore, cannot be delegated officials.
- The signature(s) of an authorized official in Section 16 constitutes a legal delegation of authority to any and 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)*			

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

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

☐ Check here if Delegated Official is a W-2 Employee	Telephone Number

Authorized Official Signature Assigning this Delegation *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

Figure 20: CMS Form-855A Section 16

A DO can't delegate their authority to another individual.

Add the information for your selected DO (optional). You must provide the full name, phone number, title/position, address, and signature of the officials.

Section 17: Supporting Documents

SECTION 17: SUPPORTING DOCUMENTS

This section lists the documents that, if applicable, must be submitted with this completed enrollment application. If you are newly enrolling, or are reactivating or revalidating your enrollment, you must provide all applicable documents. For changes, only submit documents that are applicable to that change. The enrolling provider may submit a notarized copy of a Certificate of Good Standing from the provider's State licensing/certification board or other medical associations in lieu of copies of the above-requested documents. This certification cannot be more than 30 days old.

The fee-for-service contractor may request, at any time during the enrollment process, documentation to support or validate information that you have reported in this application. The Medicare fee-for-service contractor may also request documents from you, other than those identified in this section 17, as are necessary to bill Medicare.

MANDATORY FOR ALL PROVIDER/SUPPLIER TYPES

Required documents that can only be obtained after a State survey are not required as part of the application submission but must be furnished within 30 days of the provider receiving them. The Medicare fee-for–service contractor will furnish specific licensing requirements for your provider type upon request.

- ☐ Licenses, certifications and registrations required by Medicare or State law.
- ☐ Federal, State, and/or local (city/county) business licenses, certifications and/or registrations required to operate a health care facility.
- ☐ Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name (e.g., IRS CP 575) provided in Section 2.
- ☐ Completed Form CMS-588, Authorization Agreement for Electronic Funds Transfer.
  NOTE: If a provider already receives payments electronically and is not making a change to its banking information, the CMS-588 is not required.

MANDATORY FOR SELECTED PROVIDER/SUPPLIER TYPES

- ☐ Copy(s) of all bills of sale or sales agreements (CHOWS, Acquisition/Mergers, and Consolidations only).
- ☐ Copy(s) of all documents that demonstrate meeting capitalization requirements (HHAs only).

MANDATORY, IF APPLICABLE

- ☐ Statement in writing from the bank. If Medicare payment due a provider of services is being sent to a bank (or similar financial institution) with whom the provider has a lending relationship (that is, any type of loan), then the provider must provide a statement in writing from the bank (which must be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.
- ☐ Copy(s) of all adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters).
- ☐ Copy of an attestation for government entities and tribal organizations
- ☐ Copy of HRSA Notice of Grant Award if that is a qualifying document for FQHC status
- ☐ Copy of IRS Determination Letter, if provider is registered with the IRS as non-profit
- ☐ Written confirmation from the IRS confirming your Limited Liability Company (LLC) is automatically classified as a Disregarded Entity. (e.g., Form 8832).
  NOTE: A disregarded entity is an eligible entity that is treated as an entity not separate from its single owner for income tax purposes.

Figure 21: CMS Form-855A Section 17

You must upload (in PECOS) or send (hard copy via mail with your application) the following supporting documentation:

- Licenses, certifications and registrations required by Medicare or State law. Federal, State , and/or local (city/county) business licenses, certifications and/or registrations required to operate a health care facility
- Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name (e.g., IRS CP 575) provided in Section 2
- Completed Form CMS-588, Authorization Agreement for Electronic Funds Transfer. NOTE: If a provider already receives payments electronically and is not making a change to its banking information, the CMS-588 is not required.
- An organizational chart that shows the name and title of key personnel of the OTP and the name of any central administration or larger organizational structure to which the program is responsible. The organizational chart shall report all managing employees, including the medical director and program sponsor. This can the same chart you used to get SAMHSA certification.
- A Form CMS-1561 Provider Agreement signed and dated by an authorized or delegated official of the OTP with a handwritten or digitally signed signature.
- Statement in writing from the bank. If Medicare payment due a provider of services is being sent to a bank (or similar financial institution) with whom the provider has a lending relationship (that is, any type of loan), then the provider must a written statement in writing from the bank that the bank has agreed to waive its right of offset for Medicare receivables.
- Copy(s) of all final adverse action documentation (e.g., notifications, resolutions, and reinstatement letters.)
- Copy of an attestation for government entities and tribal organizations.
- Copy of HRSA Notice of Grant Award if that is a qualifying document for FQHC status.
- Copy of IRS Determination Letter, if provider is registered with the IRS as non-profit.
- Written confirmation from the IRS confirming your Limited Liability Company (LLC) is automatically classified as a Disregarded Entity. (e.g., Form 8832) NOTE: A disregarded entity is an eligible entity that is treated as an entity not separate from its single owner for income tax purposes.

OTPs are mandatory participating providers and required under law to accept assignment for all services rendered to Medicare beneficiaries. Because assignment must be accepted, the automatic advantages of participation will be received.

Mandatory for All Providers

Mandatory for OTPs

Mandatory, If Applicable

INSTRUCTIONS FOR THE FORM CMS-855B MEDICARE ENROLLMENT APPLICATION

Section 1: Basic Information

SECTION 1: BASIC INFORMATION
ALL APPLICANTS MUST COMPLETE THIS SECTION ***(See instructions for details.)***

A. Check one box and complete the required sections.

REASON FOR APPLICATION	BILLING NUMBER INFORMATION	REQUIRED SECTIONS
☐ You are a **new enrollee** in Medicare	Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4.	**Complete all applicable sections** **Ambulance suppliers** must complete **Attachment 1** **IDTF suppliers** must complete **Attachment 2**
☐ You are **enrolling in another fee-for-service contractor's jurisdiction**	Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4.	**Complete all applicable sections** **Ambulance suppliers** must complete **Attachment 1** **IDTF suppliers** must complete **Attachment 2**
☐ You are **reactivating** your Medicare enrollment	Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4. Medicare Identification Number(s) *(if issued):* National Provider Identifier *(if issued):*	**Complete all applicable sections** **Ambulance suppliers** must complete **Attachment 1** **IDTF suppliers** must complete **Attachment 2**
☐ You are **voluntarily terminating** your Medicare enrollment. (This is not the same as "opting out" of the program)	Effective Date of Termination: Medicare Identification Number(s) to Terminate *(if issued):* National Provider Identifier *(if issued):*	Sections **1, 2B1, 13,** and either **15 or 16** If you are terminating an employment arrangement with a physician assistant, complete Sections **1A, 2G, 13,** and either **15 or 16**

Figure 22: CMS Form-855B Section 1A

In **subsection A.** *Check one box and complete the required section*, select the reason for the application, depending on your status (new Medicare enrollee, reactivating, etc.)

SECTION 1: BASIC INFORMATION *(Continued)*

B. Check all that apply and complete the required sections:

	REQUIRED SECTIONS
☐ Identifying Information	**1, 2** (complete only those sections that are changing), **3, 13,** and either **15** (if you are an authorized official) **or 16** (if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier
☐ Final Adverse Actions/Convictions	**1, 2B1, 3, 13,** and either **15** (if you are an authorized official) **or 16** (if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier
☐ Practice Location Information, Payment Address & Medical Record Storage Information	**1, 2B1, 3, 4** (complete only those sections that are changing), **13,** and either **15** (if you are an authorized official) **or 16** (if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier
☐ Change of Ownership (Hospitals, Portable X-Ray Suppliers & Ambulatory Surgical Centers Only)	**Complete all sections and provide a copy of the sales agreement**
☐ Ownership Interest and/or Managing Control Information (Organizations)	**1, 2B1, 3, 5, 13,** and either **15** (if you are an authorized official) **or 16** (if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier
☐ Ownership Interest and/or Managing Control Information (Individuals)	**1, 2B1, 3, 6, 13,** and either **15** (if you are an authorized official) **or 16** (if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier
☐ Billing Agency Information	**1, 2B1, 3, 8** (complete only those sections that are changing), **13,** and either **15** (if you are an authorized official) **or 16** (if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier
☐ Authorized Official(s)	**1, 2B1, 3, 13, 15 or 16** (if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier

Figure 23: CMS Form-855B Section 1B

In **subsection B.** *Check all that apply and complete the required sections*, which are:

- Identifying Information
- Final Adverse Actions/Convictions
- Practice Location Information, Payment Address & Medicare Record Storage Information
- Ownership Interest and/or Managing Control Information (Organizations)
- Ownership Interest and/or Managing Control Information (Individuals)
- Billing Agency Information
- Authorized Official(s)

Section 2: Identifying Information

SECTION 2: IDENTIFYING INFORMATION

A. Type of Supplier

Check the appropriate box to identify the type of supplier you are enrolling as with Medicare. If you are more than one type of supplier, submit a separate application for each type. If you change the type of service that you provide (i.e., become a different supplier type), submit a new application.

Your organization must meet all Federal and State requirements for the type of supplier checked below.

TYPE OF SUPPLIER: ***(Check one only)***

- ☐ Ambulance Service Supplier
- ☐ Ambulatory Surgical Center
- ☐ Clinic/Group Practice
- ☐ Hospital Department(s)
- ☐ Independent Clinical Laboratory
- ☐ Independent Diagnostic Testing Facility
- ☐ Intensive Cardiac Rehabilitation
- ☐ Mammography Center
- ☐ Mass Immunization (Roster Biller Only)
- ☐ Pharmacy
- ☐ Physical/Occupational Therapy Group in Private Practice
- ☐ Portable X-ray Supplier
- ☐ Radiation Therapy Center
- ☐ Other *(Specify)*: _____

Figure 24: CMS Form-855B Section 2A

In **subsection A.** *Type of Supplier*, check the box for Other and write “Opioid Treatment Provider” or “OTP” in the field for Specify.

B. Supplier Identification Information

1. BUSINESS INFORMATION

Legal Business Name (not the “Doing Business As” name) as reported to the Internal Revenue Service

Tax Identification Number

Other Name	Type of Other Name
	☐ Former Legal Business Name ☐ Doing Business As Name ☐ Other *(Specify)*: _____

Identify how your business is registered with the IRS. (**NOTE:** If your business is a Federal and/or State government provider or supplier, indicate “Non-Profit” below.)

☐ Proprietary ☐ Non-Profit

NOTE: If a checkbox indicating Proprietary or non-profit status is not completed, the provider/supplier will be defaulted to “Proprietary.”

Identify the type of organizational structure of this provider/supplier *(Check one)*

☐ Corporation ☐ Limited Liability Company ☐ Partnership
☐ Sole Proprietor ☐ Other *(Specify)*: _____

Incorporation Date *(mm/dd/yyyy) (if applicable)*	State Where Incorporated *(if applicable)*

Is this supplier an Indian Health Facility enrolling with the designated Indian Health Service (IHS) Medicare Administrative Contractor (MAC)?

☐ Yes ☐ No

Figure 25: CMS Form-855B Section 2B

In **subsection B.** *Supplier Identification Information*:

- Add the required information for item *1. Business Information*

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

2. STATE LICENSE INFORMATION/CERTIFICATION INFORMATION

Provide the following information if the supplier has a State license/certification to operate as the supplier type for which you are enrolling.

☐ State License Not Applicable

License Number	State Where Issued
Effective Date *(mm/dd/yyyy)*	Expiration/Renewal Date *(mm/dd/yyyy)*

Certification Information

☐ Certification Not Applicable

Certification Number	State Where Issued
Effective Date *(mm/dd/yyyy)*	Expiration/Renewal Date *(mm/dd/yyyy)*

Figure 26: CMS Form-855B Section 2B.2

- add the SAMHSA certification information for the OTP in item *2. State License Information/Certification Information*
  - report the certification number, effective date, and expiration date in the same section

You must send documentation verifying certification status, including copies of:

- signed and dated SAMHSA renewal letter

3. CORRESPONDENCE ADDRESS

Provide contact information for the entity or person listed in Question 1 of this section. Once enrolled, the information provided below will be used by the fee-for-service contractor if it needs to contact you directly. This address cannot be a billing agency's address.

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)*	

Figure 27: CMS Form-855B Section 2B.3

Include the correspondence address where we can contact you directly in **subsection B.3.** *Correspondence Address*. This address cannot be a billing agency's address.

You do not have to fill-out subsections C through H; they don't apply to OTPs.

Section 3: Final Adverse Legal Actions/Convictions

SECTION 3: FINAL ADVERSE ACTIONS/CONVICTIONS *(Continued)*

FINAL ADVERSE HISTORY

1. Has your organization, under any current or former name or business identity, ever had any of the final adverse actions listed on page 13 of this application imposed against it?

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

2. If yes, report each final adverse 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 final adverse action documentation and resolution.

FINAL ADVERSE ACTION	DATE	TAKEN BY	RESOLUTION

Figure 28: CMS Form-855B Section 3

Add information about any final adverse legal actions to Section 3. You must report all applicable final adverse legal actions, regardless of whether any records were expunged or any appeals are pending.

If you report any adverse legal actions, send copies of related or supporting documentation including notifications, resolutions, and reinstatement.

What are Final Adverse Legal Actions?

Final adverse legal actions may include convictions, exclusions, revocations, and suspensions. Section 3 of the CMS-855A and CMS-855B applications includes more information about the specific actions that may constitute final adverse legal actions.

Section 4: Practice Location Information

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

A. Practice Location Information

If you see patients in more than one practice location, copy and complete Section 4A for each location.

To ensure that CMS establishes the correct association between your Medicare legacy number and your NPI, providers and suppliers must list a Medicare legacy number—NPI combination for each practice location. If you have multiple NPIs associated with both a single legacy number and a single practice location, please list below all NPIs and associated legacy numbers for that practice location.

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)*			

If you are enrolling for the first time, or if you are adding a new practice location, the date you provide should be the date you saw your first Medicare patient at this location.

Practice Location Name *("Doing Business As" name if different from Legal Business Name)*

Practice Location Street Address Line 1 *(Street Name and Number – NOT a P.O. Box)*

Practice Location Street Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

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

Date you saw your first Medicare patient at this practice location *(mm/dd/yyyy)*

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

Figure 29: CMS Form-855B Section 4A

In s**ubsection A.** *Practice Location Information*, you must:

- Add the Practice Location Name ("Doing Business As" name if different from Legal Business Name)
- Enter Street Address, telephone number and other applicable contact information of the practice location
- Enter your NPI
- Leave the Medicare Identification Number blank (the MAC assigns it after your enrollment application is approved)
- Check other health care facility and write in "Opioid Treatment Program" or "OTP"

If you see patients in more than one practice location, you will complete Section 4A for each location.

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

B. Where do you want remittance notices or special payments sent?
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)*			

Medicare will issue payments via electronic funds transfer (EFT). Since payments will be made by EFT, the "Special Payments" address should indicate where all other payment information (e.g., remittance notices, special payments) should be sent.

☐ "Special Payments" address is the same as the practice location (only one address is listed in Section 4A). Skip to Section 4C.

☐ "Special Payments" address is different than that listed in Section 4A, or multiple locations are listed. Provide address below.

"Special Payments" Address Line 1 *(PO Box or Street Name and Number)*

"Special Payments" Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Figure 30: CMS Form-855B Section 4B

In **subsection B.** *Where do you want remittance notices or special payments sent?*, you must:

- Select Add
- Enter the address to which we should send remittance notices and special payments

C. Where do you keep patients' medical records?
If you store patients' medical records (current and/or former patients) at a location other than the location in Section 4A or 4E, complete this section with the address of the storage location.

Post Office boxes and drop boxes are not acceptable as physical addresses where patients' records are maintained. For IDTFs and mobile facilities/portable units, the patients' medical records must be under the supplier's control. The records must be the supplier's records, not the records of another supplier. If this section is not completed, you are indicating that all records are stored at the practice locations reported in Section 4A or 4E.

Figure 31: CMS Form-855B Section 4C

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

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

First Medical Record Storage Facility (for current and former patients)

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

Storage Facility Address Line 1 *(Street Name and Number)*

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

City/Town	State	ZIP Code + 4

Second Medical Record Storage Facility (for current and former patients)

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

Storage Facility Address Line 1 *(Street Name and Number)*

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

City/Town	State	ZIP Code + 4

Figure 32: CMS Form-855B Section 4C

In **subsection C.** *Where do you keep patients' medical records?*, you must:

- Select Add
- Enter the effective date (this is the date you started seeing patients)
- Enter the address(es) of medical record storage facility(ies)

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

D. Rendering Services in Patients' Homes

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)*			

Furnish the city/town, State and ZIP code for all locations where health care services are rendered in patients' homes. If you provide health care services in more than one State and those States are serviced by different Medicare fee-for-service contractors, complete a separate CMS-855B enrollment application for each Medicare fee-for-service contractor's jurisdiction.

If you are adding or deleting an entire State, it is not necessary to report each city/town. Simply check the box below and specify the State.

☐ Entire State of _____

If you are providing services in selected cities/towns, furnish the locations below. Only list ZIP codes if you are not servicing the entire city/town.

CITY/TOWN	STATE	ZIP CODE

Figure 33: CMS Form-855B Section 4D

If applicable, in **subsection D.** *Rendering Services in Patients' Homes*, you will provide information for all locations where health care services are rendered in patients' homes. You must:

- Select Add
- Enter the effective date (the date you started seeing patients)
- Enter the city/town, State, and ZIP for all locations where services are rendered in patients' homes

If services are provided in home for an entire State, simply check the box for "Entire State of" and enter the name of the State.

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

E. Base of Operations Address for Mobile or Portable Suppliers (Location of Business Office or Dispatcher/Scheduler)

The base of operations is the location from where personnel are dispatched, where mobile/portable equipment is stored, and when applicable, where vehicles are parked when not in use.

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)*			

Check here ☐ and skip to Section 4F if the "Base of Operations" address is the same as the "Practice Location" listed in Section 4A.

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

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

City/Town	State	ZIP Code + 4

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

Figure 34: CMS Form-855B Section 4E

If applicable, in **subsection E.** *Base of operations address for Mobile or Portable Suppliers (Location of Business Office or Dispatcher/Scheduler)*, add information about the base of operations location from where personnel are dispatched, where mobile/portable equipment is stored, and when applicable, where vehicles are parked when not in use. You must:

- Select Add
- Enter the effective date (this is the date you started seeing patients)
- Add the address of the location

If the Base of Operations address is the same as the Practice Location listed in Section 4A, check the box to skip to section 4F.

F. Vehicle Information

If the mobile health care services are rendered inside a vehicle, such as a mobile home or trailer, furnish the following vehicle information. Do not provide information about vehicles that are used only to transport medical equipment (e.g., when the equipment is transported in a van but is used in a fixed setting, such as a doctor's office) or ambulance vehicles. If more than two vehicles are used, copy and complete this section as needed.

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 FOR EACH VEHICLE	TYPE OF VEHICLE *(van, mobile home, trailer, etc.)*	VEHICLE IDENTIFICATION NUMBER
☐ CHANGE ☐ ADD ☐ DELETE		
Effective Date:		
☐ CHANGE ☐ ADD ☐ DELETE		
Effective Date:		

For each vehicle, submit a copy of all health care related permits/licenses/registrations.

Figure 35: CMS Form-855B Section 4F

If applicable, in **subsection F.** *Vehicle Information*, give information about any vehicles in which mobile health care services are rendered. You must:

- Select Add
- Enter the effective date (the date you started seeing patients)
- Identify the type of vehicle
- Enter the Vehicle Identification Number (VIN)

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

G. Geographic Location for Mobile Or Portable Suppliers Where the Base of Operations and/or Vehicle Renders Services

Provide the city/town, State, and ZIP Code for all locations where mobile and/or portable services are rendered.

NOTE: If you provide mobile or portable health care services in more than one State and those States are serviced by different Medicare fee-for-service contractors, complete a separate enrollment application (CMS-855B) for each Medicare fee-for-service contractor's jurisdiction.

INITIAL REPORTING AND/OR ADDITIONS

If you are reporting or adding an entire State, it is not necessary to report each city/town. Simply check the box below and specify the State.

☐ Entire State of _____

If services are provided in selected cities/towns, provide the locations below. Only list ZIP codes if you are not servicing the entire city/town.

CITY/TOWN	STATE	ZIP CODE

Figure 36: CMS Form-855B Section 4G

If applicable, in **subsection G.** *Geographic Location for Mobile or Portable Suppliers Where the Base of Operations and/or Vehicle Renders Services*, provide the city/town, State, and ZIP Code for all locations where mobile and/or portable services are rendered. You must:

- Enter the city/town, State, and ZIP code for all locations

If services are provided for an entire State, simply check the box for "Entire State of" and enter the name of the State.

Sections 5: Ownership Interest and/or Managing Control Information (For Organizations)

Report all organizations with ownership and managing control of the OTP in Section 5.

A. Organization with Ownership Interest and/or Managing Control—Identification Information

☐ Not Applicable

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)*			

Check all that apply:

☐ 5 Percent or More Ownership Interest ☐ Partner ☐ Managing Control

Legal Business Name as Reported to the Internal Revenue Service

"Doing Business As" Name *(if applicable)*

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)*

NPI *(if issued)*	Tax Identification Number *(Required)*	Medicare Identification Number(s) *(if issued)*

What is the effective date this owner acquired ownership of the provider identified in Section 2B1 of this application? *(mm/dd/yyyy)* _____

What is the effective date this organization acquired managing control of the provider identified in Section 2B1 of this application? *(mm/dd/yyyy)* _____

NOTE: Furnish both dates if applicable.

CMS-855B (07/11) 22

Figure 37: CMS Form-855B Section 5A

- In **subsection A.** *Organization with Ownership Interest and/or Managing Control – Identification Information*, add the legal business name, address, phone number, TIN, NPI, effective date

SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS) ***(Continued)***

B. Final Adverse Legal Action History

If reporting a change to existing information, check "Change," provide the effective date of the change, and complete the appropriate fields in this section.

☐ Change
Effective Date:_____

1. Has this individual in Section 5A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 13 of this application imposed against him/her?

   ☐ YES–Continue Below ☐ NO–Skip to Section 6

2. If YES, report each final 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 final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

Figure 38: CMS Form-855B Section 5B

- In **subsection B.** *Final Adverse Legal Action History*, add any final adverse legal action history if your organization fits this category

Section 6: Ownership Interesting and/or Managing Control Information (For Individuals)

Add information about individual ownership to Section 6.

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) ***(Continued)***

A. Individuals with Ownership Interest and/or Managing Control—Identification Information
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)*			

The name, date of birth, and social security number of each person listed in this Section must coincide with the individual's information as listed with the Social Security Administration.

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

Date of Birth *(mm/dd/yyyy)*	Place of Birth *(State)*	Country of Birth

Social Security Number *(Required)*	Medicare Identification Number *(if issued)*	NPI *(if issued)*

What is the above individual's relationship with the supplier in Section 2B1? *(Check all that apply.)*

☐ 5 Percent or Greater Direct/Indirect Owner
☐ Authorized Official
☐ Delegated Official
☐ Partner
☐ Director/Officer
☐ Contracted Managing Employee
☐ Managing Employee (W-2)

What is the effective date this owner acquired ownership of the provider identified in Section 2B1 of this application? *(mm/dd/yyyy)* _____

What is the effective date this individual acquired managing control of the provider identified in Section 2B1 of this application? *(mm/dd/yyyy)* _____

NOTE: Furnish both dates if applicable.

Figure 39: CMS Form-855B Section 6A

- In **subsection A.** *Individuals with Ownership Interest and/or Managing Control – Identification Information:*
  - add the full name, date and place of birth, Social Security Number (SSN), NPI
  - add relationship with supplier, effective date

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) ***(Continued)***

B. Final Adverse Legal Action History

Complete this section for the individual reported in Section 6A above. If reporting a change to existing information, check "change," provide the effective date of the change and complete the appropriate fields in this section.

☐ Change
Effective Date:_____

1. Has this individual in Section 6A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 13 of this application imposed against him/her?

   ☐ YES–Continue Below ☐ NO–Skip to Section 8

2. If YES, report each final 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 final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

Figure 40: CMS Form-855B Section 6B

In **subsection B.** *Final Adverse Legal Action History,* add final adverse legal action history if an **individual** fits this category.

Section 8: Billing Agency Information

SECTION 8: BILLING AGENCY INFORMATION

A billing agency is a company or individual that you contract with to prepare and submit your claims. If you use a billing agency, you are responsible for the claims submitted on your behalf.

☐ **Check here if this section does not apply and skip to Section 13.**

BILLING AGENCY NAME AND ADDRESS

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)*			

Legal Business/Individual Name as Reported to the Social Security Administration or the Internal Revenue Service	If Individual, Billing Agent Date of Birth *(mm/dd/yyyy)*
"Doing Business As" Name *(if applicable)*	Tax Identification/Social Security Number *(required)*
Billing Agency Street Address Line 1 *(Street Name and Number)*	
Billing Agency Street Address Line 2 *(Suite, Room, etc.)*	

City/Town	State	ZIP Code + 4

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

Figure 41: CMS Form-855B Section 8

If you choose to use one, you must include information about your billing agency or billing agent (if an individual) including:

- Legal business/individual name as reported to the Social Security Administration (SSA) or Internal Revenue Service (IRS)
- Date of birth (if individual)
- "Doing Business As" (DBA) name (if applicable)
- Tax Identification Number (TIN) or Social Security Number (SSN)
- Street address, city/town, State, ZIP code +4
- telephone number, fax number (if applicable), and email address

If you do not use a billing agency/agent, check the box to indicate that it does not apply and skip to the next section.

Section 13: Contact Person

SECTION 13: CONTACT PERSON

If questions arise during the processing of this application, the fee-for-service contractor will contact the individual shown below. If the contact person is either an authorized or delegated official, check the appropriate box below.

☐ Contact an Authorized Official listed in Section 15.

☐ Contact a Delegated Official listed in Section 16.

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

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

Address Line 1 *(Street Name and Number)*

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

City/Town	State	ZIP Code + 4

Figure 42: CMS Form-855B Section 13

Add information about the Contact Person to Section 13. You must provide the contact person's full name, phone number, and address.

Section 15 Certification Statement

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 Medicare fee-for-service contractor 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 Medicare fee-for-service contractor of this fact in accordance with the time frames established in 42 CFR § 424.516.

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)*

Figure 43: CMS Form-855B Section 15

An **Authorized Official (AO)** can:

- Enroll the organization in the Medicare Program legally
- Commit the organization to abide by all Medicare Program statutes, regulations, and program instructions
- Can appoint **Delegated Official(s) (DOs)** (optional)

Add information for your selected AO(s) to Section 15. You must provide the full name, phone number, title/position, address, and signature of the officials.

Section 16: Delegated Official (Optional)

SECTION 16: DELEGATED OFFICIAL (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, the 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. A 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, a delegated official certifies that the information provided is true, correct, and complete.
- Delegated officials being deleted do not have to sign or date this application.
- Independent contractors are not considered "employed" by the supplier, and therefore cannot be delegated officials.
- The signature(s) 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)*			

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

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

☐ Check here if Delegated Official is a W-2 Employee	Telephone Number

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

Figure 44: CMS Form-855B Section 16

A DO can't delegate their authority to another individual.

Add the information for your selected DO (optional). You must provide the full name, phone number, title/position, address, and signature of the officials.

Section 17: Supporting Documents

SECTION 17: SUPPORTING DOCUMENTS

This section lists the documents that, if applicable, must be submitted with this enrollment application. If you are newly enrolling, or are reactivating or revalidating your enrollment, you must provide all applicable documents. For changes, only submit documents that are applicable to that change.

The fee-for-service contractor may request, at any time during the enrollment process, documentation to support or validate information reported on the application. The Medicare fee-for-service contractor may also request documents from you, other than those identified in this Section 17, as are necessary to bill Medicare.

MANDATORY FOR ALL PROVIDER/SUPPLIER TYPES

- ☐ Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name (e.g., IRS form CP 575) provided in Section 2.
  (**NOTE:** This information is needed if the applicant is enrolling their professional corporation, professional association, or limited liability corporation with this application or enrolling as a sole proprietor using an Employer Identification Number.)"
- ☐ Completed Form CMS-588, for Electronic Funds Transfer Authorization Agreement.
  (**NOTE:** If a supplier already receives payments electronically and is not making a change to its banking information, the CMS-588 is not required.)

MANDATORY FOR SELECTED PROVIDER/SUPPLIER TYPES

- ☐ Copy(s) of all documentation verifying IDTF Supervisory Physician(s) proficiency and/or State licenses or certification for IDTF non-physician personnel.
- ☐ Copy(s) of all documentation verifying the State licenses or certifications of the laboratory Director or non-physician practitioner personnel of an independent clinical laboratory.

MANDATORY, IF APPLICABLE

- ☐ Copy of IRS Determination Letter, if supplier is registered with the IRS as non-profit.
- ☐ Written confirmation from the IRS confirming your Limited Liability Company (LLC) is automatically classified as a Disregarded Entity. (e.g., Form 8832).
  (**NOTE:** A disregarded entity is an eligible entity that is treated as an entity not separate from its single owner for income tax purposes.
- ☐ Statement in writing from the bank. If Medicare payment due a supplier of services is being sent to a bank (or similar financial institution) with whom the supplier has a lending relationship (that is, any type of loan), then the supplier must provide a statement in writing from the bank (which must be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.
- ☐ Copy(s) of all final adverse action documentation (e.g., notifications, resolutions, and reinstatement letters).
- ☐ Completed Form(s) CMS 855R, Reassignment of Medicare Benefits.
- ☐ Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement.
- ☐ Copy of an attestation for government entities and tribal organizations.
- ☐ Copy of FAA 135 certificate (air ambulance suppliers).
- ☐ Copy(s) of comprehensive liability insurance policy (IDTFs only).

Figure 45: CMS Form-855B Section 17

You must upload (in PECOS) or send (hard copy via mail with your application) the following supporting documentation:

- Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name (e.g., IRS form CP 575) provided in Section 2. (NOTE: This information is needed if the applicant is enrolling their professional corporation, professional association, or limited liability corporation with this application or enrolling as a sole proprietor using an Employer Identification Number.)
- Completed Form CMS-588, for Electronic Funds Transfer Authorization Agreement. (NOTE: If a supplier already receives payments electronically and is not making a change to its banking information, the CMS-588 is not required.)
- An organizational chart that shows the name and title of key personnel of the OTP and the name of any central administration or larger organizational structure to which the program is responsible. The organizational chart shall report all managing employees, including the medical director and program sponsor. This may be the same chart you used to get SAMHSA certification.
- A Form CMS-1561 Provider Agreement signed and dated by an authorized or delegated official of the OTP.
  - The signature must be handwritten or digitally signed.
- Copy of IRS Determination Letter, if provider is registered with the IRS as non-profit.
- Written confirmation from the IRS confirming your Limited Liability Company (LLC) is automatically classified as a Disregarded Entity. (e.g., Form 8832). (NOTE: A disregarded entity is an eligible entity that is treated as an entity not separate from its single owner for income tax purposes.)
- Statement in writing from the bank. If Medicare payment due a supplier of services is being sent to a bank (or similar financial institution) with whom the supplier has a lending relationship (that is, any type of loan), then the supplier must provide a statement in writing from the bank (which must be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.
- Copy(s) of all final adverse action documentation (e.g., notifications, resolutions, and reinstatement letters).
- Copy of an attestation for government entities and tribal organizations.

Mandatory for All Providers

Mandatory for OTPs

Mandatory, If Applicable

Help with Submitting

CMS has an External User Services (EUS) help desk (visit the EUS Customer Portal). This resource supports people with I & A, PECOS, and other system questions. Keep in mind, the help desk may not be able to give specific information about the Opioid Treatment Program.

WHAT TO EXPECT AFTER SUBMITTING YOUR ENROLLMENT APPLICATION

MAC Review of Enrollment Application

MACs take approximately 45 days to review submitted applications, but it may take longer if you use the paper application. Additionally, MACs may send development requests when they need more information or need you to take action. MACs may ask you to submit fingerprints for individuals who have a 5% or greater direct/indirect ownership, as a partner of an OTP provider when:

- Initially enrolling
- Substance Abuse and Mental Health Services Administration (SAMHSA) certified after October 23, 2018

You should reply quickly to avoid enrollment delay or denial. To avoid these development requests and additional delays, make sure you complete all information and requirements before you submit your application.

CMS will initiate an observational site visit for initial enrollment, revalidation, and when you add a practice location.

Approval and Billing

Your MAC will notify you when they approve or deny your application. The MAC will send you a copy of the provider agreement (also signed by CMS), along with the enrollment approval letter. Once your MAC approves your enrollment application, your billing effective date is the later of the date the MAC got your application or the date you began delivering services at a new practice location. You can get a retrospective billing date for up to 30 days prior to the effective date.

Your MAC will also issue your OTP a Provider Transaction Access Number (PTAN). A PTAN is a Medicare-only number issued to providers by MACs upon enrollment to Medicare. When a MAC approves enrollment and issues an approval letter, the letter will include your assigned PTAN.

- You must use your NPI to bill the Medicare program and your PTAN to authenticate your OTP to use your MAC's self-help tools such as the Interactive Voice Response (IVR) phone system, internet portal, and on-line application status
- You should generally only use your PTAN with your MAC

The NPI and the PTAN are related to each other for Medicare purposes. If you have relationships with one or more medical groups or practices or with multiple Medicare contractors, MACs usually assign separate PTANS. Together, the NPI and PTAN identify your OTP in the Medicare Program. CMS maintains both the NPI and PTAN in PECOS, the national provider and supplier enrollment system.

Denied Enrollment

- If your MAC denies your enrollment due to non-compliance, you can submit a corrective action plan (CAP) within 30 days
- MACs determine if the CAP sufficiently addresses the issue

Changes to Your Application

- You must update any changes in ownership and/or adverse legal action history within 30 days of the change
- You must make all other changes within 90 days of the change

Identify Your EDI Contractor

In preparation for billing, you should identify the contractor responsible for your Electronic Data Interchange (EDI) connectivity. For further information on the level of support available by the contractor to entities that exchange Medicare Health Insurance Portability and Accountability Act (HIPAA) EDI transactions, refer to the Medicare Parts A/B and DME EDI Help Lines. You must have this information before you begin billing Medicare.

EDI is the automated transfer of data in a specific format following specific data content rules between a health care provider and Medicare, or between Medicare and another health care plan. In some cases, that transfer may take place with the help of a clearinghouse or billing service that represents a provider of health care or another payer.

OTP ENROLLMENT PROCESS CHECKLIST

Before beginning the enrollment process, ensure your OTP has FULL certification with SAMHSA. MACs will deny Medicare provider enrollment applications for OTPs with provisional SAMHSA certification or in the process of obtaining certification.

Pre-Enrollment Steps:

- ☐ Gather necessary information/documentation
- ☐ Get an NPI (unless OTP already uses NPI for Medicaid billing)
- ☐ Identify your MAC(s)
- ☐ Select a billing agency/agent (if applicable)

Submitting Your Provider Enrollment Application:

- ☐ Choose electronic (recommended) or paper-based enrollment
- ☐ Pay the enrollment fee
- ☐ Complete the Form CMS-855A or Form CMS-855B electronic equivalent via PECOS, or the form in hard copy for all appropriate MAC jurisdictions
- ☐ Send supporting documentation

What to Expect After Submitting Your Enrollment Application:

- ☐ Allow at least 45 days for your MAC(s) to review the application(s)
- ☐ Reply quickly to any requests for additional information or documentation
- ☐ If approved, begin furnishing and billing OTP services starting on the billing effective date. The billing effective date is the later of: the date the MAC received your application OR the date you began delivering services at new location
- ☐ If you are switching your enrollment form a CMS-855B enrollment to a CMS-855A enrollment, or vice versa, the effective date of billing privileges that was established for the OTP's prior enrollment applies to your new enrollment. Your old enrollment must be deactivated and claim submission verified as you cannot duplicate billing. If you have submitted claims with your initial enrollment, the MAC will make your effective date for your new enrollment the day after the last claim was filed for the old enrollment
- ☐ If denied, submit a corrective action plan within 30 days
- ☐ Update any changes in ownership and/or adverse legal action history within 30 days, and all other changes within 90 days
- ☐ Identify your EDI contractor

RESOURCES

- A/B MAC Jurisdictions
- Apply for Opioid Treatment Program (OTP) Certification
- Certification of Opioid Treatment Programs (OTPs)
- CMS Fingerprinting Instruction Website
- CMS Opioid Program Treatment Centers
- CMS PECOS Information
- Contact Your MAC
- Electronic Billing & EDI Transactions
- Electronic File Interchange (EFI)
- External User Services (EUS) for Medicare Providers
- Form CMS-588 Electronic Funds Transfer (EFT) Authorization Agreement
- Form CMS-855A Enrollment Application
- Form CMS-855B Enrollment Application
- Form CMS-1561 Provider Agreement
- Identity & Access (I & A) Management System
- I & A System Quick Reference Guide
- Internet-based Provider Enrollment, Chain and Ownership System (PECOS)
- MAC Website List
- Medicare Enrollment Application Fee
- Medicare Parts A/B and DME EDI Help Lines
- National Provider Identifier (NPI) Application/Update Form
- National Plan & Provider Enumeration System (NPPES)
- NPPES FAQs
- NPPES Help
- OTP FAQs
- PECOS FAQs
- PECOS Main Page
- SAMSHA
- SAMSHA OTP Directory
- What is a MAC?
- Who are the MACs?
- "Who Should I Call?" CMS Provider/supplier Enrollment Assistance Guide

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