DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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Guidance on Completing the CMS-855A Enrollment Form

Note: This article was revised on July 6, 2013, to add a reference to MM8039 (http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM8039.pdf, to alert providers that for new enrollment or change of ownership enrollment applications, Medicare contractors may deny a Form CMS-855 enrollment application if the current owner of the provider or supplier has an existing overpayment that has not been repaid in full at the time an application for new enrollment or change of ownership is filed. All other information remains the same.

Provider Types Affected

This MLN Matters® Special Edition Article is intended for hospitals and other providers that complete the CMS-855A enrollment application. Specifically, this article applies to the following health care organizations:

- Community Mental Health Centers;
- Comprehensive Outpatient Rehabilitation Facilities;
- Critical Access Hospitals;

- End-Stage Renal Disease Facilities;
- Federally Qualified Health Centers;
- Histocompatibility Laboratories;
- Home Health Agencies;
- Hospices;
- Hospitals;
- Indian Health Services Facilities;
- Organ Procurement Organizations;
- Outpatient Physical Therapy/Occupational Therapy /Speech Pathology Services;
- Religious Non-Medical Health Care Institutions;
- Rural Health Clinics; and
- Skilled Nursing Facilities.

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) is issuing this article solely as an educational guide to improve compliance with documentation requirements for the Medicare Enrollment Application for Institutional Providers, Form CMS-855A (07/11). This article presents a brief guide that you may use when completing the CMS-855A application. Please note that use of this guide is not mandatory and does not ensure Medicare enrollment.

Background

Getting Started

What do I need to have to fill out the CMS-855A?

You should have the following before you start to fill out the application:

- Your Internal Revenue Service (IRS) document confirming your Employer Identification Number (EIN) - also known as the Federal Tax Identification Number (TIN) - and your Legal Business Name;
- Your National Provider Identifier (NPI) document confirming your NPI number; Note: If you do not have an NPI, you may apply online at https://nppes.cms.hhs.gov/NPPES/Welcome.do on the CMS website;

- Your completed Electronic Funds Transfer Agreement (EFT) including your Bank Account Information (check or bank confirmation letter) or voided check with the legal business name matching the LBN on your IRS documentation (counter checks are not accepted); and,
- A copy of your organizational chart that details all of your direct and indirect owners.

Where can I get a copy of the CMS-855A application?

You may download and view the application at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855a.pdf on the CMS website.

What are the sections of the application?

Below are the sections and brief explanations on filling them out.

Section 1 –Basic Information

Section 1A – Reason for Application

This section identifies the purpose of the application submission. Only one reason should be selected. Here is a description of the possible submission reasons:

- New Enrollee
- Enrolling with another Fee-For-Service (FFS) Medicare contractor;
- Reactivating a prior enrollment;
- Change of Ownership (CHOW)
- Acquisition/Merger or Consolidation
- Changing Medicare enrollment information -- Must include Provider Transaction Access Number (PTAN) or CMS Certification Number (CCN) and NPI; or
- Revalidating Medicare enrollment information.

Section 1B – Check all that apply

If Section 1A reports a change in Medicare enrollment information, indicate the sections in which the information is changing. Please remember that you are responsible for disclosing changes timely.

Section 2 – Identifying Information

Section 2A – Type of Provider

Indicate the type of provider enrolling/enrolled.

- You should make only one selection in Section 2A1 and you should not check "Other";
- You must submit separate enrollment applications if multiple provider types are indicated in Section 2A1; and,
- If you indicate that the provider type is a hospital, be sure to check all applicable subgroups and units in Section 2A2; and answer the questions in Section 2A3 and 2A4.
- If you indicate that the provider type is a Hospital—Swing-Bed approved; Hospital - Psychiatric Unit or a Hospital — Rehabilitation Unit and it is initially enrolling, a separate enrollment application is not needed. The applicant may simply list these units in Section 4A of the hopspital's application and check the applicable box in that section.

Section 2B – Identification Information

In this section, you should do the following:

- Enter the Legal Business Name (LBN) as reported to the IRS (Note: Review your IRS documents to ensure that the correct name is indicated);
- Identify the type of organizational structure, as defined by the IRS. You may select from the following: Corporation, Limited Liability Company, Partnership, Sole Proprietor or Other. If Other is indicated, please specify the type of organization;
- Enter the Tax Identification Number (TIN) on file with the IRS;
- For corporations, provide the Incorporation Date and State where Incorporated;
- If applicable, specify any "other" name as noted in this section;
- Identify how your business is registered with the IRS by checking either Proprietary or Non-Profit. If a selection is not made on the application, you will be listed in the system as Proprietary;
- Enter your year-end cost report date;
- Indicate whether you are an Indian Health Facility enrolling with the designated Indian Health Service (IHS) MAC by checking yes or no;

- If State licensure information applies and is known at the time of enrollment, please provide the license number, State where issued, effective date, and expiration/renewal date. Otherwise, mark “Not Applicable”;

- If certification information applies and is known at the time of enrollment, please provide the certification number, State where issued, effective date and expiration/renewal date; otherwise, mark “Not Applicable”.

Section 2C – Correspondence Address

Provide an address where the applicant can be contacted directly. Be sure to include the entire ZIP code (ZIP Code + 4). This address cannot be the address of a billing agency, provider’s representative or the chain home office.

Section 2D – Accreditation

Indicate whether the facility is accredited. If accredited, provide the date of accreditation, name of accrediting body, and type of accreditation or accreditation program.

Section 2E – Comments

Provide any comments, if needed, to clarify a unique enrollment situation.

Section 2F – Change of Ownership (CHOW) Information

You should complete this section if the type of CHOW transaction described in the instructions on page 4 of the CMS-855A has occurred. The information provided in this section should be that of the seller/former owner.

- Provide the Legal Business Name (LBN), Doing Business As name, Provider Transaction Access Number (PTAN) or CMS Certification Number (CCN), and NPI of the Seller/Former Owner;

- Indicate the effective date of transfer. This date can be a future date and must match the date on the final bill of sale.

- Indicate the name of the Medicare contractor for the Seller/Former Owner.

- Indicate if the new owner will be accepting assignment of the current Provider Agreement. If the answer is no, the application should not be completed as if a CHOW has occurred. The new owner should refer to the instructions in section 1A to apply as a New Enrollee.

Section 2G – Acquisitions/Mergers

You should complete this section only if an acquisition/merger – as that term is described in the instructions on page 5 of the CMS-855A - has occurred.

- Provide the effective date of acquisition.
- Indicate in Section 2G1 the Legal Business Name and Medicare contractor name of the provider being acquired.
- If the provider being acquired has separate Medicare PTANs/CCNs for any units or branches, be sure to provider the name/department, PTAN/CCN, and NPI of those units/branches.
- Indicate in Section 2G2 the LBN, PTAN/CCN, Medicare contractor name, and NPI of the acquiring provider.

Section 2H – Consolidations

Complete this section only if a consolidation – as that term is described in the instructions on page 5 of the CMS-855A – has occurred.

- In Sections 2H1 - 3, as applicable, provide the LBN, Medicare Contractor name, and effective date of consolidation for each consolidating provider organization. If the provider has separate Medicare PTANs/CCNs for any units or branches, be sure to provider the name/department, PTAN/CCN, and NPI of those units/branches.
- Indicate in Section 2H3 the LBN and TIN of the newly created provider.

Section 3 – Final Adverse Actions/Convictions

Final adverse actions include, but are not limited to, felony convictions, licensure suspensions or revocations, or exclusions from participation in a federal or state health care program. A complete list of reportable adverse actions can be found on page 16 of the CMS-855A application. (You may download and view the CMS-855A at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855a.pdf on the CMS website.)

- If the provider, under any current or former name or business identity, has had a reportable adverse action, mark Yes;
- Identify the final adverse action, date of action, federal or state agency or the court or administrative body that imposed the action and the resolution, if any, in this section;

- If no final adverse action exists, be sure to mark No. (Note: Do not indicate that this section is Not Applicable.)

Section 4 – Practice Location Information

Section 4A – Practice Location Information

All practice locations must be disclosed in this section. Please list the primary practice location first, and list the PTAN or CCN (if assigned) and NPI combination for each practice location. If a location has multiple NPIs, list each of the NPIs for the location in this section.

- The box labeled Change should only be marked if the information for a current practice location is changing. (Note: The change, add and delete boxes are for the practice location, not for the application itself). If the physical location of your facility has changed, please complete one section as an Add and one section as a Delete to ensure your Medicare records are appropriately updated.
- Provide the practice location name (indicate the Doing Business As name if it is different from the Legal Business Name).
- Include the practice location street, any building identifiers (e.g., suites numbers), city, state and the entire ZIP code (ZIP Code + 4).
- Provide the telephone number, fax number (if applicable) and e-mail address (if applicable).

Identify the type of practice location for Hospitals and Home Health Agencies (HHAs); for Hospitals this includes provider types such as Swing-Bed Unit; Hospital - Psychiatric Unit or a Hospital — Rehabilitation Unit.

Section 4B – Where do you want Remittance Notices or Specials Payments Sent?

Medicare will issue payments via Electronic Funds Transfer (EFT). Therefore, this address will be used for all other payment information (i.e., remittance notices, special payments).

- The Change box should be marked only if the information for a current special payments location is changing. (Note: The change, add and delete boxes are for the special payments location, not for the application itself)
- If you list only one address in Section 4A, and you will use that address as the Special Payments address, check the first block in Section 4B, write same in the address section and skip to Section 4C;
- If there are multiple addresses in Section 4A or the special payments address will be different from the address in Section 4A, check the second box in Section 4B and enter the special payments location street, any building identifiers (e.g., suites numbers), city, state and entire ZIP code (ZIP Code + 4).

Section 4C – Where do you keep patients' medical records?

This section captures any address in which patient medical records are stored. If this section is not competed, you are indicating that all records are stored at the practice locations reported in Sections 4A or 4D.

- The Change box should only be marked if the information for the medical records location is changing. (Note: The change, add and delete boxes are for the medical records location, not the application itself)
- If you store medical records at a location other than the addresses listed in sections 4A or 4D, provide the storage facility location street, any building identifiers (e.g., suites number), city, state and entire ZIP code (ZIP Code + 4).

Section 4D – Base of Operations Address for Mobile or Portable Providers

This section captures the location, if applicable, where personnel are dispatched, where mobile/portable equipment is stored, and where vehicles are parked when not in use.

- The Change box should only be marked if the information for the base of operations location is changing. (Note: The change, add and delete boxes are for the base of operations location, not the application itself);
- If applicable, provide the base of operations street address, any building identifiers (e.g., suites numbers), city, state and entire ZIP code (ZIP Code + 4);
- Provide the telephone number, fax number (if applicable) and e-mail address (if applicable).

Section 4E – Vehicle Information

This section captures vehicle information, if applicable, for mobile health care services that are rendered inside the vehicle, like a van, mobile home, or trailer.

- The Change box should only be marked if the information for the base of operations location is changing. (Note: The change, add and delete boxes are for the practice location, not the application itself)
- Provide the type of vehicle and Vehicle Identification Number (VIN) for each vehicle.
- Submit copies of all health care related permits, licenses, and registrations for each vehicle.

Section 4F – Geographic Location for Mobile or Portable Providers where the Base of Operations and/or Vehicle Renders Services

For Home Health Agencies (HHAs) and mobile or portable providers, this section captures geographic areas where health care services are rendered.

- For Section 4F1, Initial Reporting and/or Additions: If you are rendering services throughout the entire state, mark the box Entire State Of and provide the name of the state. If you are providing services in selected cities/towns, provide the locations areas (i.e., city/town, state, ZIP code).

- For Section 4F2, Deletions: If you are deleting previously disclosed services throughout the entire state, mark the box Entire State Of and provide the name of the state. If you are deleting previously disclosed services in selected cities/towns, provide the location areas (i.e., city/town, state, ZIP code).

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

Check the box Not Applicable if Section 5 does not apply to the provider listed in Section 2.

Section 5A – Organization with Ownership Interest and/or Managing Control – Identification Information

If the provider identified in Section 2 is owned and/or operated by another organization, please provide identifying information and check type of organization in Sections 5A1 and 5A2.

Section 5A – Ownership/Managing Control Identification Information

You must report all organizations that have any of the following interests in the enrolling provider. Check the types of interest that the entity has in the provider and complete all information for each type of ownership and/or managing control applicable:

- 5% or greater direct ownership interest;
- 5% or greater indirect ownership interest;
- 5% or greater mortgage or security interest;
- All general partnership interests, regardless of the percentage. This includes: (1) all interests in a non-limited partnership, and (2) all general partnership interests in a limited partnership;
- Limited partnership interests if the interest in the partnership is at least 10%; and
- Managing control.

For each organization, be sure to:

- Indicate the Legal Business Name (LBN) that is displayed on the IRS document.
- Provide the street address, any building identifiers (e.g., suites numbers), city, state and entire ZIP code (ZIP Code + 4).

If a federal, state, county, city, or other level of government or Indian tribe will be legally and financially responsible for Medicare payments received, the name of that agency or organization must be listed as an owner and an attestation statement signed by an authorized official (as indicated in Section 15 of the CMS-855A) must be submitted.

If the provider is a non-profit, charitable or religious entity and is operated and/or managed by a Board of Trustees or governing body, the name of the Board of Trustees or governing body should be reported in this section. The organization is listed in Section 5. The individuals on the Board or governing body are listed in Section 6.

If applicable, the chain home office must be listed in Section 5 as well as in Section 7.

Note that the following data elements in Section 5 need not be completed:

- "Exact percentage of operational/managerial control this organization has in the provider"

- "Other ownership or control/interest" if the organization/individual does not have an ownership, partnership, mortgage, security, or other quantifiable interest in the provider. (Otherwise, this data element must be completed.)

Section 5B – Adverse Legal History

Final adverse actions include, but are not limited to, felony convictions, licensure suspensions or revocations, or exclusions from participation in a federal or state health care program. A complete list of reportable final adverse actions can be found on page 16 of the CMS-855A application. (You may view the CMS-855A at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855a.pdf on the CMS website.)

- Check the box Change in Section 5B only if there is a change to the entity's final adverse action history.
- If the organization identified in Section 5A, under any current or former name or business identity, has had a reportable final adverse action, mark the box Yes and enter the final adverse action, date of action, the federal or state agency or

the court or administrative body that took the action and the resolution in Section 5B.

- If no final legal adverse action exists, be sure to mark the box No. Do not indicate that this section is not applicable.

Section 6 – Ownership Interest and/or Managing Control information (Individuals)

Section 6A – Individuals with Ownership Interest and/or Managing Control – Identification Information

This section captures information on individuals with ownership interest and/or managing control of the provider.

- At least one managing employee must be listed in this section.
- The box Change should be marked only if the specific information related to the individual is changing (i.e., last name, relationship to provider).
- The name and date of birth of the individual must match what has been reported to the Social Security Administration (SSA).
- A middle initial must be supplied, or the individual should provide evidence that a middle name does not exist.
- Be sure to mark all relationship types in Section 6A. The box Other Ownership or Control/interest cannot be the only box checked.
- The box Partner should be marked only if the provider's organizational structure in Section 2B1 is Partnership.
- If the provider is a corporation, the provider's officers and directors must be reported in this section.
- If the provider is a non-profit, charitable or religious entity and is operated and/or managed by a Board of Trustees or governing body, the names of the individual board members should be reported in this section. The individuals are listed in Section 6 and the organization is listed in Section 5.
- Authorized and delegated officials must be reported in this section.
- Authorized and delegated officials cannot be Contracted Managing Employees.
- The Chain Home Office administrator (if any) must be reported in this section.

Note that the following data elements in Section 6 need not be completed:

- "Exact percentage of control as an Officer this individual has in the provider"
- "Exact percentage of control as a Director this individual has in the provider"
- "Exact percentage of management control this individual has in the provider" (under the "W-2 Managing Employee" heading)

- "Exact percentage of this contracted managing employee's control in the provider"

- "Exact percentage of operational/managerial control this individual has in the provider"

- "Other ownership or control/interest" if the organization/individual does not have an ownership, partnership, mortgage, security, or other quantifiable interest in the provider. (Otherwise, this data element must be completed.)

Section 6B – Adverse Legal History

Final adverse actions include, but are not limited to, felony convictions, licensure suspensions or revocations, and exclusions from participation in a federal or state health care program. A complete list of reportable final adverse actions can be found on page 16 of the CMS 855A application.

- If the individual identified in Section 6A, under any current or former name or business identity, has had a reportable final adverse action, mark the box Yes and enter the final adverse action, date of action, the federal or state agency or the court or administrative body that took the action and the resolution. .
- If no final adverse action exists, mark the box No. Do not indicate that this section is not applicable.
- Check the box Change in Section 6B only if there is a change to the entity's final adverse action history.

Section 7 – Chain Home Office Information

This section applies to providers that are part of a chain organization. It should be completed in its entirety for providers enrolling in a chain, disassociating from a current chain or changing from one chain to another.

- Check the box Not Applicable if this does not apply to you.
- A middle initial for the administrator must be supplied, or the individual should provide evidence that a middle name does not exist.
- Enter the LBN that is displayed on the IRS document.
- Be sure to include the entire ZIP code (ZIP Code + 4).
- All home office information needs to be furnished in its entirety. .

Section 8 – Billing Agency Information

A billing agency is a company or individual that will process and submit claims on your behalf.

- Check the box Not Applicable if this section does not apply to you.
- Indicate the Legal Business Name (LBN) that is displayed on the IRS document.

- Be sure to include the entire ZIP code (ZIP Code + 4).

Section 12 – Special Requirements for Home Health Agencies (HHAs)

Check the box Not Applicable if this section does not apply to you.

Section 13 – Contact Person

This is the only person with whom the Medicare contractor can discuss this application, with the exception of the authorized or the delegated official. Multiple individuals can be listed in this section.

Section 15 – Certification Statement

This section is signed by the authorized official of the organization. Authorized officials must be identified in Section 6 of the application. A provider can have as many authorized officials as it desires, but must have at least one.

- Mark the box Change only if the information for the authorized official is changing. (Note: The change, add, and delete boxes are for the authorized official, not the application itself.)
- The name and date of birth of the individual must match what has been reported to the Social Security Administration (SSA).
- A middle initial must be supplied, or the individual should provide evidence that a middle name does not exist.
- There must be at least one original signature for each authorized official who signs an application.

Section 16 – Delegated Official(s) (Optional)

(Note: Authorized and delegated officials must be identified in Section 6 of the application.)

- Mark the box Change only if the information for the delegated official is changing. (Note: The change, add, and delete boxes are for the delegated official, not the application itself.)
- The name and date of birth of the individual must match what has been reported to the Social Security Administration (SSA).
- A middle initial must be supplied, or the individual should provide evidence that a middle name does not exist.
- There must be at least one original signature for each delegated official that signs an application.

Section 17 – Supporting Documents

Certain documents must be submitted with your application:

- An IRS document must be submitted for initial applications, revalidations, CHOWs (new owner). The Authorization Agreement for Electronic Funds Transfer, Form CMS-588, must be submitted with original signatures if you are not currently receiving funds electronically.
- Submit a written statement from the bank listed on the EFT if you have a lending relationship with them, stating that the bank has agreed to waive its right of offset for Medicare receivables.
- Submit a copy of the state license for complete applications or if updates to the licensure information are made.
- If the provider is a non-profit, charitable, or religious entity and there are no owners, the 501(c)(3) must be submitted.

What are some tips for completing the EFT Authorization Agreement - Form CMS-588?

Below are some tips for completing the CMS-588. You may download and view this form at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS588.pdf on the CMS website.

- Part II - The LBN should match your IRS documentation and be on the Provider/Supplier Legal Business Name line.
- Part V - The EFT form must be signed by an approved authorized or delegated official as identified in Section 15 or 16 of the CMS-855A. An original signature is required.
- An original, preprinted, voided check, or confirmation of account information on bank letterhead must be submitted with the EFT. The letter from the bank should confirm the name on the account, electronic routing transit number, account number and type, and the bank officer's name and signature. Ensure that the bank information completed on the CMS-588 form matches the information on the voided check or bank confirmation. (Note: The name on the bank account must match the provider's Legal Business Name or the chain home office's Legal Business Name; payment to the owning organization's bank account is not acceptable).
- A deposit slip cannot be accepted, as the routing number is sometimes incorrect.
- If payment is being made to the chain home office, a letter authorizing payment to the chain home office must be submitted. This letter must be signed by both the provider's authorized official (as identified in Section 15 of the CMS-855A) and by the Home Office's CEO/Administrator.

Additional Information

For more information about Medicare enrollment, visit the Medicare Provider-Supplier Enrollment webpage at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html on the CMS website.

You may want to review MM8019 (http:/www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8019.pdf) which alerts providers to a manual update regarding provider and supplier enrollment responsibilities.

If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.