

additional public comment. Each revision has been based on comments received from our contractors, the health care industry, and new requirements imposed through legislation. All revisions are submitted to OMB and published in the **Federal Register** for public comment before approval and implementation.

The primary function of the CMS 855 is to gather information from a provider or supplier that tells us who it is, whether it meets certain qualifications to be a health care provider or supplier, where it practices or renders its services, the identity of the owners of the enrolling entity, and information necessary to establish the correct claims payment. The goal of evaluating and revising the CMS 855 is to simplify and clarify the information collection without jeopardizing our need to collect specific information. Listed below are the various sections of the CMS 855 and the information that each section collects. Not all sections apply to all provider and supplier types. For specific information collection requirements by provider or supplier type, review the applicable CMS 855 as mentioned earlier in this preamble.

1. Provider or Supplier Application

To ensure efficient processing of the CMS 855, this section requires the provider or supplier to give the reason for submission of the CMS 855 and to state whether it is currently known (enrolled) in Medicare and for any current Medicare identifiers (billing numbers or Medicare contractor name(s)).

2. General Identification Information

This section collects personal and business information to uniquely identify the provider or supplier with such information as type or specialty, name, business name, address, date of birth, SSN, EIN, correspondence address, and other similar information. This information is needed to uniquely identify the provider or supplier. Moreover, as detailed above, section 1124(a)(1) of the Act requires disclosure of both EINs and SSNs. See also section 31001(I) of the DCIA.

3. Adverse Legal Action(s) and Overpayment(s)

The information obtained in this section enables us to determine if an individual or entity should have its Medicare billing number denied or revoked. Table A in this section cites specific adverse legal actions which have a direct bearing on the individual's or entity's professional competence, professional performance, or financial

integrity that the provider or supplier must report to Medicare. These actions may serve as a basis for the Secretary, as set forth in section 1128 of the Act, to exclude an individual or entity from participation in Medicare and all other Federal health care programs.

4. Current Practice Location(s)

This section collects information to verify that the practice location where services are proposed to be or are being furnished by the enrolling provider or supplier meets Medicare requirements.

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

6. Ownership Interest and/or Managing Control Information (Individuals)

7. Chain Home Office Information

The information collected in the above three sections (5 through 7) is needed to ensure that all individuals and entities deriving financial benefit from the Medicare program are identified as required in sections 1124 and 1124A(a) of the Act, and in § 420.204. Those sections state that as a condition for approval or renewal of a contract or agreement, and for an entity to receive payment under Title XVIII, complete information as to the identity of each person and/or organization with an ownership or controlling interest of 5 percent or more and each managing employee as defined in section 1126(b) of the Act and § 420.201, must be disclosed.

8. Billing Agency

This section is needed to capture identifying information, such as legal business name and address, and to obtain information about the contract between the provider or supplier and the billing agency that submits bills or claims for Medicare payments on behalf of a Medicare provider or supplier. In addition, we need this information to verify that the biller has been authorized by the provider or supplier to submit bills or claims on the provider or supplier's behalf. We need to be able to monitor agreements made between billing and collection agents and providers and suppliers to ensure compliance with Medicare requirements found at 1842(b)(6) of the Act and §§ 424.73 and 424.80.

9. For Future Use

10. Staffing Company

This section is needed to capture identifying information, such as legal business name and address, and to obtain information about the contract between the provider or supplier and the staffing company that submits bills

or claims for Medicare payments on behalf of a Medicare provider or supplier. In addition, we need this information to verify that the biller has been authorized by the provider or supplier to submit bills or claims on the provider or supplier's behalf. We need to be able to monitor agreements made between staffing companies and providers and suppliers to ensure compliance with Medicare requirements found at section 1842(b)(6) of the Act and §§ 424.73 and 424.80.

11. Surety Bond Information

This section will be used on an "as needed" basis and would furnish us with information regarding certain providers and suppliers that are required to obtain a surety bond under section 4312 of the BBA (codified at sections 1834(a)(16), 1861(o)(7), 1861(p)(4)(A)(v) and 1861(cc)(2)(I)) of the Act. The BBA further grants the Secretary the authority, at his or her discretion, to impose the requirements on other Medicare providers or suppliers (other than physicians or other practitioners as defined in section 1842(b)(18)(C) of the Act). See also section 1834(a)(16) of the Act.

12. Capitalization Requirements for Home Health Agencies (HHAs)

This section collects information required by § 489.28, which requires all HHAs enrolling in Medicare for the first time to submit proof of sufficient operating funds.

13. Contact Person(s)

This information will allow a Medicare contractor to establish a direct point of contact to resolve issues pertaining to the completion and validation of the information furnished in the CMS 855.

14. Penalties for Falsifying Information on this Enrollment Application

This section is informational only. It cites various statutory references in the United States Code and the Social Security Act concerning actual knowledge, deliberate ignorance or reckless disregard of the truth or falsity of the information contained therein on an application to receive payment.

15. Certification Statement

The certification statement is being revised. Statement 3 on the CMS 855A, CMS 855B, and CMS 855S forms and statement 4 on the CMS 855I form have been changed to provide a better understanding of Medicare policy. An additional statement is also being added to the CMS 855A and CMS 855B forms for providers and suppliers that receive