

**MEDICARE FEDERAL HEALTH CARE PROVIDER/SUPPLIER ENROLLMENT APPLICATION****Application for Health Care Providers that will Bill Medicare Fiscal Intermediaries****General Instructions**

The Medicare Federal Health Care Provider/Supplier Enrollment Application has been designed by the Centers for Medicare and Medicaid Services (CMS) to assist in the administration of the Medicare program and to ensure that the Medicare program is in compliance with all regulatory requirements. The information collected in this application will be used to ensure that payments made from the Medicare trust fund are only paid to qualified health care providers, and that the amounts of the payments are correct. This information will also identify whether the provider is qualified to render health care services and/or furnish supplies to Medicare beneficiaries. To accomplish this, Medicare must know basic identifying and qualifying information about the health care provider that is seeking billing privileges in the Medicare program.

Medicare needs to know: (1) the type of health care provider enrolling, (2) what qualifies this provider as a health care related provider of services and/or supplies, (3) where this provider intends to render these services and/or furnish supplies, and (4) those persons or entities with an ownership interest, or managerial control, as defined in this application, over the provider.

This application **MUST** be completed in its entirety, unless the appropriate box is checked to indicate the section does not apply or when reporting a change to previously submitted information. If a section does not apply to this provider, check (✓) the appropriate box in that section and skip to the next section.

**1. General Application Information****A. Reason for Submittal of this Application**

This section is to be completed with general information as to why this application is being submitted and whether this provider currently has a business relationship with another Federal health care program.

**To ensure timely processing of this application, Numbers 1, 2 and 3 below MUST ALWAYS be completed.**

1. Check one: ☐ Initial Enrollment ☐ Revalidation
- ☐ Change of Information (Check appropriate Section(s) Being Changed)
- ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 10
- ☐ 11 ☐ 12 ☐ 13 ☐ 15 ☐ 16
- ☐ Voluntary Termination of Billing Number - Effective Date (MM/DD/YYYY): \_\_\_\_\_  
Billing Number to be Terminated: \_\_\_\_\_
- ☐ Change of Ownership (CHOW) - See Instructions and Complete Section 1B
- ☐ Acquisition/Merger (including the CHOW) - See Instructions and Complete Section 1C
- ☐ Consolidation (including the CHOW) - See Instructions and Complete Section 1D

2. Tax Identification Number: \_\_\_\_\_

3. Is this provider currently enrolled in the Medicare program? ☐ YES ☐ NO  
IF YES, furnish the following information about the current fiscal intermediary (FI):

Current FI Name: \_\_\_\_\_ Current Medicare Identification Number or NPI: \_\_\_\_\_

4. Fiscal Intermediary Preference:

- a) Check here ☐ if this provider is enrolling in the Medicare program for the first time. If known, furnish the name of the provider's fiscal intermediary preference in Section 1A4c below.
- b) Check here ☐ if this provider is currently enrolled in the Medicare program and is requesting a change of its fiscal intermediary as a result of a CHOW, acquisition/merger, or a consolidation, and furnish the name of the new preferred fiscal intermediary in Section 1A4c below.

c) Name of Preferred Fiscal Intermediary: \_\_\_\_\_

5. Check here ☐ if this provider would like to submit claims electronically and is enrolling in Medicare for the first time.