

OMB Approval No. 0938-0685

SECTION 2: PROVIDER IDENTIFICATION**A. Type of Provider**

1. Type of provider - Check the appropriate box to identify the type of provider for which this application is being submitted. Only one provider type may be checked per application. If the provider functions as two or more provider types, a separate CMS 855A must be submitted for each type. If the provider changes the type of services it provides (becomes a different provider type), a new CMS 855A must be completed and submitted (except for hospitals changing the type of hospital services provided – see #2 below).

NOTE: The only Medicare-eligible provider types are those listed. If this provider believes it meets Medicare eligibility requirements to participate in the Medicare program and its provider type is not listed, check the “Other” box and specify the type of service this provider will furnish to Medicare beneficiaries. Before checking “Other,” be certain that this provider is an organizational provider type that would submit claims to a Medicare Fiscal Intermediary. Some medical organizations may own or control supplier types that are only eligible to submit claims to a Medicare carrier. These suppliers must complete the CMS 855B and submit it to their local carrier.

2. If “Hospital” was checked in Section 2A1, check all applicable types of services this hospital furnishes. If the hospital is reporting a change in the types of services it provides, check the change box and check all current types of provided services.
3. If “Hospital” was checked in Section 2A1:

Check the appropriate box to indicate if the hospital wants one Medicare Part B services billing number, multiple Part B services billing numbers for each department (e.g., cardiology, pathology, radiology), or if this section is not applicable. If a combination of both separate billing numbers for some departments and combined billing numbers for groups of other departments are requested, furnish all details in Section 2G. If multiple numbers are being requested, each department to be issued a Part B Medicare billing number must be reported here.

NOTE: Hospitals must complete and submit the form CMS 855B to the local Medicare carrier to obtain a Part B Medicare billing number.

4. If this hospital has a compliance plan which states that the hospital checks all managing employees against the exclusion/debarment lists of both the HHS Office of the Inspector General (OIG) and the General Services Administration (GSA), check “Yes” in the box provided. Otherwise, check “No.” At any time, CMS or its Medicare contractor may request a copy of the compliance plan.

The licenses, certifications and registrations which must be submitted with this application are those required by Medicare or the State to function as the provider type for which this provider is enrolling. Local licenses/permits that are not of a medical nature are not required but any business license required to operate as a health care facility must be submitted. 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.

B. Provider Identification Information - Check the box “Change” only if reporting a change to existing information. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

1. Furnish the legal business name for this provider as reported to the IRS for tax purposes. This may be the same name as that of the owner of this provider.
2. Provide any “doing business as” name this provider uses. The “doing business as” name is the name the provider is generally known by to the public.
3. Check the appropriate box to indicate the organizational structure of this provider. Check “Corporation” if the provider is such, regardless of whether the provider is “for-profit” or “non-profit.” “Partnership” should be checked for all “General” or “Limited” partnerships. All other providers should check “Other,” and specify the type of organizational structure (e.g., limited liability company).
4. Furnish this provider’s “Medicare Year-End Cost Report Date.” This date will determine when cost reports and audits are due for this provider. This date may be the same as the provider’s “fiscal year-end date.”