

OMB Approval No. 0938-0685

**2. Provider Identification**

This section is to be completed with information specifically related to the provider submitting this application. Furnish the following information about the provider: (1) provider type, (2) provider name, (3) the mailing address and telephone number where Medicare can contact the provider directly, (4) whether the provider has been accredited or Federally approved, and (5) whether the provider has any "prospective payment system" (PPS) exclusions.

**A. Type of Provider**

Check the appropriate boxes below. The provider must meet all Medicare requirements for the type of provider checked. Submit copies of all required licenses, certifications, and registrations with this application.

**1. Type of Provider (Check one):**

- ☐ Religious Non-Medical Health Care Institution (RNHCI)  
☐ Community Mental Health Center  
☐ Comprehensive Outpatient Rehabilitation Facility  
☐ End-Stage Renal Disease Facility (ESRD)  
☐ Federally Qualified Health Center (FQHC)  
☐ Histocompatibility Laboratory  
☐ Home Health Agency  
☐ Home Health Agency (Sub-unit)  
☐ Hospice  
☐ Hospital (If checked, complete Sections 2A2 and 2A3)  
☐ Indian Health Services Facility  
☐ Multiple Hospital Component in a Medical Complex  
☐ Organ Procurement Organization (OPO)  
☐ Outpatient Physical Therapy/Occupational Therapy/  
 Speech Pathology Services  
☐ Psychiatric Unit (of Hospital)  
☐ Rehabilitation Agency (unit of a Hospital)  
☐ Rural Health Clinic  
☐ Skilled Nursing Facility  
☐ Other (Specify): \_\_\_\_\_

**2. If this provider is a hospital, check all applicable sub-groups listed below:**

- ☐ Hospital      ☐ Change      Effective Date: \_\_\_\_\_  
☐ Hospital—General  
☐ Hospital—Alcohol/Drug  
☐ Hospital—Acute Care  
☐ Hospital—Children's (excluded from PPS)  
☐ Hospital—Critical Access  
☐ Hospital—Critical Access (Swing-Bed unit)  
☐ Hospital—Long-Term (excluded from PPS)  
☐ Hospital—Long-Term (Swing-Bed unit)  
☐ Hospital—Psychiatric (excluded from PPS)  
☐ Hospital—Short-Term (General and Specialty)  
☐ Hospital—Short-Term (Swing-Bed unit)  
☐ Hospital—Rehabilitation (excluded from PPS)  
☐ Hospital—Rehabilitation (Swing-Bed unit)

☐ Other (Specify): \_\_\_\_\_

**3. Hospital Departments billing for Practitioner Services:**

If this provider is a hospital, check the appropriate box below. See instructions before completing this section.

- ☐ Not Applicable  
☐ Single billing number for all departments      ☐ Separate billing number for each department listed below

_____	_____	_____
_____	_____	_____
_____	_____	_____

**4. Does this hospital have a compliance plan stating that all managing employees are checked against the OIG exclusion and GSA debarment lists?**

☐ YES ☐ NO

**B. Provider Identification Information**

☐ Change

Effective Date: \_\_\_\_\_

Furnish the provider's legal business name (as reported to the IRS), "doing business as" name (name provider generally known by to the public), and the various operating dates and places of formal business registration and/or incorporation. If incorporated, the provider may be required to submit a copy of its "Articles of Incorporation" for validation purposes.

**1. Legal Business Name as Reported to the IRS****2. "Doing Business As" (DBA) Name (if applicable)****3. Identify the type of organizational structure for this provider (Check one):**

☐ Corporation      ☐ Partnership      ☐ Other (Specify): \_\_\_\_\_

**4. Medicare Year-End Cost Report Date (MM/DD)**