

## OMB Approval No. 0938-0685

**C. Correspondence Address** - 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:

- **Furnish a name, address, and telephone number where Medicare or the Medicare fiscal intermediary can directly get in touch with the enrolling provider.**

This section will assist us in contacting the provider with any questions we have concerning its business relationship with the Medicare program. The provider must furnish a name, address, and telephone number where Medicare or the fiscal intermediary can directly contact it to resolve any personal or business issues that arise as a result of its enrollment in the Medicare program. This data will also be used to furnish the provider with important changes or other information concerning the Medicare program that may directly affect the provider and/or its Medicare payments. This address cannot be that of the billing agency, management service organization, or staffing company. If we suspect that the provider's billing number is being misused, or if we have a legal question, we will contact the provider directly. This is to protect the provider as well as the Medicare program.

**D. Accreditation** - 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. Indicate whether this provider is accredited by any accrediting organization that Medicare has approved for acceptance in lieu of a State Survey.
2. If "Yes," furnish the date accreditation was received, and
3. Furnish the name of the Medicare-approved accrediting body or organization.

**E. Federal Approval (FQHCs and OPOs only)** - This section must be completed by all Federally Qualified Health Centers and Organ Procurement Organizations. To be eligible to enroll in the Medicare program, FQHCs and OPOs must receive federal approval to operate as a health care provider.

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. Indicate if this FQHC or OPO has received federal approval. If "Yes,"
2. Furnish the date of approval and submit a copy of the approval certificate with this application.

**F. Prospective Payment System Exclusions** - 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. Indicate if this provider has any "Prospective Payment System Exclusions." This section is primarily for hospitals that have psychiatric units or rehabilitation agencies (units).
2. If "Yes," indicate the type of unit to be excluded by checking one or both boxes provided.

**G. Comments** - This section is to be used as an opportunity to explain any unique billing number requests or to clarify any other information furnished in this section (Section 2 - Provider Identification).