

OMB Approval No. 0938-0685

2. Provider Identification (Continued)**C. Correspondence Address**☐ **Change****Effective Date:** _____**This must be an address and telephone number where Medicare can contact the provider directly.**

Mailing Address (Organization or Individual Name)

Mailing Address Line 1 (Street Name and Number)

Mailing Address Line 2 (Suite, Room, etc.)

City

State

ZIP Code + 4

Telephone Number

(Ext.)

Fax Number (if applicable)

E-mail Address (if applicable)

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Note: Sections 2D through 2F below require a "Yes," "No," or "Pending" response. If a specific question does not apply to this provider, check "No" and continue with the next question. If the response is "Yes" or "Pending," furnish the additional information requested in that section and continue with the next question.**D. Accreditation**☐ **Change****Effective Date:** _____

1. Is this provider accredited?

☐ YES ☐ NO**IF YES**, complete the following:☐ PENDING

2. Date of Accreditation (MM/DD/YYYY): _____

3. Name of Accrediting Body: _____

E. Federal Approval (FQHCs and OPOs only)☐ **Change****Effective Date:** _____

1. Is this provider Federally approved?

☐ YES ☐ NO**IF YES**, complete the following:☐ PENDING

2. Date of Approval (MM/DD/YYYY): _____

F. Prospective Payment System Exclusions☐ **Change****Effective Date:** _____

1. Does this provider have any "Prospective Payment System" (PPS) excluded units?

☐ YES ☐ NO**IF YES**, check the type(s) of excluded unit(s) below:

2. Type of unit(s) to be excluded:

☐ Psychiatric Unit☐ Rehabilitation Agency (unit)**G. Comments**

Use this section to explain any unique billing number requests or to clarify any other information furnished in this Section.