

OMB Approval No. 0938-0685

2. Supplier Identification

This section is to be completed with information specifically related to the supplier submitting this application. Furnish the following information about the supplier: (1) supplier type, (2) supplier name, and (3) the mailing address and telephone number where Medicare can contact the supplier directly.

A. Type of Supplier ☐ **Change** **Effective Date:** _____

The supplier must meet all Medicare requirements for the type of supplier checked below. If this supplier is a single specialty clinic/group practice, the specialty must be reported. Submit copies of all required licenses, certifications, and registrations with this application.

1. Type of Supplier (Check one):

- ☐ Ambulance Service Supplier
☐ Ambulatory Surgical Center
☐ Diagnostic Radiology Group Practice/Clinic
☐ Hospital or other provider type which is also enrolled with a fiscal intermediary (complete 2E on page 11)
☐ Independent Clinical Laboratory (CLIA)
☐ Independent Diagnostic Testing Facility (IDTF)
☐ Mammography Screening Center
☐ Managed Care Plan (non-Medicare + Choice)
☐ Mass Immunization Roster Biller Only
☐ Medicare +Choice Organization
☐ Medical Faculty Practice Plan:
 See instructions for specific documentation requirements
☐ Multi-Specialty Clinic or Group Practice

- ☐ Occupational Therapy Group (complete 2A2 below)
☐ Other Medical Care Group
☐ Physical Therapy Group (complete 2A2 below)
☐ Portable X-ray Facility
☐ Public Health/Welfare Agency
☐ Radiation Therapy Center
☐ Slide Preparation Facility
☐ Voluntary Health/Charitable Agency
☐ *Single-Specialty Clinic/Group Practice:
*Specify group/clinic specialty below:

☐ Other (Specify): _____

2. Will this supplier be receiving reassigned benefits from individual practitioners? ☐ YES ☐ NO
IF YES, submit a CMS 855R for each individual practitioner who will be reassigning benefits to this supplier.

3. PT/OT Groups ONLY - All occupational and physical therapy groups must answer the following questions:

- a)** Are all of the group's PT/OT services only rendered in patients' homes? ☐ YES ☐ NO
b) Does this group maintain private office space? ☐ YES ☐ NO
c) Does this group own, lease, or rent its private office space? ☐ YES ☐ NO
d) Is this private office space used exclusively for the group's private practice? ☐ YES ☐ NO
e) Does this group furnish PT/OT services outside of its office and/or patients' homes? ☐ YES ☐ NO
IF YES, provide a copy of the lease agreement that gives the group exclusive use of the facility for PT/OT services.

B. Supplier Identification Information ☐ **Change** **Effective Date:** _____

Furnish the supplier's legal business name (as reported to the IRS), "doing business as" name (name supplier generally known by to the public), and organizational structure.

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 supplier (Check one):

☐ Corporation ☐ Partnership ☐ Other (Specify): _____

C. Correspondence Address ☐ **Change** **Effective Date:** _____

This must be an address and telephone number where Medicare can contact this supplier 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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