

OMB Approval No. 0938-0685

16. Delegated Official (Optional)

The signature of the authorized official below constitutes a legal delegation of authority to the official(s) named in this section to make changes and/or updates to this supplier's enrollment information. The signature(s) of the delegated official(s) shall have the same force and effect as that of the authorized official, and shall legally and financially bind the supplier to the laws, regulations, and program instructions of the Medicare program. By his or her signature, the delegated official certifies that he or she has read the Certification Statement in Section 15 and agrees to adhere to all of the stated requirements. The delegated official also certifies that he/she meets the definition of a delegated official. When making changes and/or updates to the supplier's enrollment information maintained by the Medicare program, the delegated official certifies that the information provided is true, correct, and complete to the best of his/her knowledge.

A. Check here ☐ if this supplier will not be assigning any delegated official(s) and skip to Section 17.

B. 1st Delegated Official Signature ☐ Add ☐ Delete ☐ Change **Effective Date:** _____

| | | | | |
|--|--|--------|------|-------------------|
| 1. Delegated Official Name | First | Middle | Last | Jr., Sr., etc. |
| Print | | | | |
| Delegated Official (First, Middle, Last, Jr., Sr., M.D., D.O., etc.) | | | | Date (MM/DD/YYYY) |
| Signature | | | | Signed |
| Title/Position | <input type="checkbox"/> Check here only if Delegated Official is a W-2 employee | | | |

2. **Signature** of Authorized Official (First, Middle, Last, Jr., Sr., M.D., D.O., etc.) Date (MM/DD/YYYY)
Assigning this Delegation Signed

C. 2nd Delegated Official Signature ☐ Add ☐ Delete ☐ Change **Effective Date:** _____

| | | | | |
|--|--|--------|------|-------------------|
| 3. Delegated Official Name | First | Middle | Last | Jr., Sr., etc. |
| Print | | | | |
| Delegated Official (First, Middle, Last, Jr., Sr., M.D., D.O., etc.) | | | | Date (MM/DD/YYYY) |
| Signature | | | | Signed |
| Title/Position | <input type="checkbox"/> Check here only if Delegated Official is a W-2 employee | | | |

4. **Signature** of Authorized Official (First, Middle, Last, Jr., Sr., M.D., D.O., etc.) Date (MM/DD/YYYY)
Assigning this Delegation Signed

D. 3rd Delegated Official Signature ☐ Add ☐ Delete ☐ Change **Effective Date:** _____

| | | | | |
|--|--|--------|------|-------------------|
| 5. Delegated Official Name | First | Middle | Last | Jr., Sr., etc. |
| Print | | | | |
| Delegated Official (First, Middle, Last, Jr., Sr., M.D., D.O., etc.) | | | | Date (MM/DD/YYYY) |
| Signature | | | | Signed |
| Title/Position | <input type="checkbox"/> Check here only if Delegated Official is a W-2 employee | | | |

6. **Signature** of Authorized Official (First, Middle, Last, Jr., Sr., M.D., D.O., etc.) Date (MM/DD/YYYY)
Assigning this Delegation Signed

17. Attachments

This section is a list of documents that, if applicable, should be submitted with this completed enrollment application.

Place a check next to each document (as applicable or required) from the list below that is being included with this completed application.

- ☐ Copy(s) of all Federal, State, and/or local (city/county) professional licenses, certifications and/or registrations specifically required to operate as a health care facility
- ☐ Copy(s) of all Federal, State, and/or local (city/county) business licenses, certifications and/or registrations specifically required to operate as a health care facility
- ☐ Copy(s) of all professional school degrees or certificates, or evidence of qualifying course work
- ☐ Copy(s) of all documentation verifying IDTF Supervisory Physician(s) proficiency
- ☐ Copy(s) of all CLIA Certificates, FDA Mammography Certificates, and Diabetes Education Certificates
- ☐ Copy(s) of all adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters)
- ☐ Completed Form HCFA-588 - Authorization Agreement for Electronic Funds Transfer
- ☐ Completed Form(s) CMS 855R - Individual Reassignment of Benefits
- ☐ IRS documents confirming the tax identification number and legal business name (e.g., CP 575)