

OMB Approval No. 0938-0685

## ATTACHMENT 1

<b>Ambulance Service Suppliers</b>			
This attachment is to be completed by all ambulance service suppliers enrolling in the Medicare program.			
<b>1. State License Information</b>			
This section is to be completed with information about the geographic area in which this company furnishes ambulance services. When applicable, State license information must be provided. In addition, a copy of the current State license must be submitted with this application.			
<b>A. Geographic Service Area</b> <input type="checkbox"/> Add <input type="checkbox"/> Delete           Effective Date: _____			
Furnish the county/parish, city, State and ZIP Code for all locations where this ambulance company renders service.			
<b>Note: If this ambulance company renders services in more than one State, and those States are serviced by different Medicare contractors, a separate CMS 855B enrollment application must be completed for each Medicare contractor jurisdiction.</b>			
<b>1. Initial Reporting and/or Additions:</b>			
County/Parish: _____ _____ _____ _____ _____ _____	City: _____ _____ _____ _____ _____ _____	State: _____ _____ _____ _____ _____ _____	ZIP Code(s): _____ _____ _____ _____ _____ _____
<b>2. Deletions:</b>			
County/Parish: _____ _____ _____	City: _____ _____ _____	State: _____ _____ _____	ZIP Code(s): _____ _____ _____
<b>B. State License Information</b> <input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change           Effective Date: _____			
<b>1.</b> Is this ambulance company licensed in the State where services are rendered and billed for? <input type="checkbox"/> YES <input type="checkbox"/> NO			
<b>2. IF NO, explain why:</b> _____ _____			
<b>7. IF YES, furnish the license information for the State where this ambulance service supplier will be rendering services and billing Medicare. Attach a copy of the current State license.</b>			
License Number	Issuing State (if applicable)	Issuing County/Parish (if applicable)	
Effective Date (MM/DD/YYYY)		Expiration Date (MM/DD/YYYY)	
<b>C. Paramedic Intercept Services Information</b> <input type="checkbox"/> Change           Effective Date: _____			
Does this ambulance company currently participate in a paramedic intercept services arrangement? <input type="checkbox"/> YES <input type="checkbox"/> NO			
<b>IF YES, submit a copy of the signed contractual agreement(s).</b>			