

**MEDICARE FEDERAL HEALTH CARE PRACTITIONER ENROLLMENT APPLICATION****Application for Individual Health Care Practitioners****General Instructions**

The Medicare Federal Health Care Practitioner Enrollment Application has been designed by the Centers for Medicare and Medicaid Services (CMS) to assist in the administration of the Medicare program and to ensure that the Medicare program is in compliance with all regulatory requirements. The information collected in this application will be used to ensure that payments made from the Medicare trust fund are only paid to qualified health care practitioners and that the amounts of the payments are correct. This information will also identify whether you are qualified to render health care services and/or supplies to Medicare beneficiaries. To accomplish this, Medicare must know basic identifying and qualifying information about you in order for you to be granted billing privileges in the Medicare program.

When completing this application to enroll and bill the Medicare program as an individual practitioner, you need to tell Medicare (1) who you are, (2) what qualifies you to render health care related services and/or supplies to Medicare beneficiaries, (3) where or how you intend to render these services and/or supplies, and (4) any individuals or organizations that manage your practice.

This application **MUST** be completed in its entirety, unless otherwise stated in these instructions. If a section does not apply to you, check (✓) the appropriate box in that section. Sections 7, 11, 12, and 16, have been deliberately omitted from this application because they are not applicable to the enrollment of individual health care practitioners.

<b>1. General Information</b>	
This section is to be completed with general information as to why you are submitting this application and whether you currently have a business relationship with Medicare. <b>To ensure timely processing of this application, Numbers 1, 2, and 3 below MUST ALWAYS be completed.</b>	
<b>A. Reason for Submittal of this Application</b>	
1. Check one: <input type="checkbox"/> Initial Enrollment <input type="checkbox"/> Reactivation <input type="checkbox"/> Revalidation <input type="checkbox"/> Change of Information - Check appropriate Section(s) below and furnish your Medicare Identification Number here: _____ <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 8 <input type="checkbox"/> 10 <input type="checkbox"/> 13 <input type="checkbox"/> Voluntary Deactivation of Billing Number—Effective Date (MM/DD/YYYY): _____ Medicare Identification Number to be Deactivated: _____	
2. Social Security Number: _____	
3. Are you currently enrolled in the Medicare program? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, furnish the following information about your current carrier: Current Carrier Name: _____ Current Medicare Identification Number or NPI: _____	
4. Check here <input type="checkbox"/> if you would like to submit claims electronically and are enrolling in Medicare for the first time.	