

OMB Approval No. 0938-0685

**SECTION 2: PRACTITIONER IDENTIFICATION**

**A. Personal Information** – The information furnished in this section will allow us to uniquely identify you in the Medicare program. Check the box “Change” only if you are reporting a change to existing information in this section. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

1. Provide your full name.
2. If you previously used another name(s), including a maiden name, supply that under “Other Name.”
3. Provide your date, State, and country of birth.
4. Indicate your gender.
5. Furnish the name of the medical school or other health care training institution you attended for the Medical Specialty you will check in Section 2E1 or Section 2E2 and your year of graduation or certification.

**B. Correspondence Address** - This section will assist us in contacting you with any questions we have concerning your business relationship with the Medicare program.

Check the box “Change” only if you are reporting a change to existing information in this section. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

- **You must provide an address and telephone number where we can contact you directly to resolve any issues that may arise as a result of your enrollment in the Medicare program.** It also may be necessary to send you important changes/information concerning the Medicare program that directly impacts you and/or your Medicare payments. Therefore, this address cannot be that of your billing agency, management service organization, or staffing company. You may furnish your home address and telephone number if you choose.

**C. Residency Status** - Your responses to the questions in this section will assist us in determining your eligibility to bill Medicare for the services you render to Medicare patients.

Check the box “Change” only if you are reporting a change to existing information in this section. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

1. Check to identify if you are currently a resident, intern, or fellow at a health care facility.
  - If “Yes,” provide the name of the facility where you serve as a resident/intern/fellow.
  - If “No,” skip to Section 2D (Business Information).
2. State whether the services you render in the facility shown in Question 1 are part of your requirements for graduation from a formal residency program.
3. Indicate if you also render services at other facilities or practice locations.
  - If “Yes,” you **must** report these other practice locations in Section 4 (Current Practice Location(s)).
4. Indicate if any services that you render, at any practice location you report in Section 4, are required for graduation from a formal residency program.
  - If “Yes,” indicate if the teaching hospital has agreed to incur all or substantially all costs of the training in the other facility or practice location.

**D. Business Information (if applicable)** - Complete this section if you operate your practice as a business under a name different from your individual name. For instance, you must complete this section if your business is setup as a corporation. This information is needed to correctly report to the IRS all Medicare payments you receive and the tax identification number under which these payments are made.

Check the box “Change” only if you are reporting a change to existing information in this section. Provide the new information, the effective date of the change, and sign and date the certification statement. Otherwise:

1. If this section does not apply to you, check the box provided and skip to Section 2E (Medical Specialty(s)).
2. Provide the legal business name you use when reporting tax information to the IRS. Supply your tax identification number as issued by the IRS and a copy of the IRS CP 575 or other documentation that confirms the reported TIN.

**NOTE:** If your business **is a corporation**, you will need to complete three applications. The 1<sup>st</sup> application (CMS 855I) is required to establish you as an individual practitioner with the Medicare program. The 2<sup>nd</sup> application (CMS 855B) is required to enroll your business. Once you complete the applications identifying yourself and your business, you must also complete a CMS 855R to reassign benefits payable to you as an individual practitioner to your business, which will be submitting claims for the services you have rendered. In addition, any other practitioners who render services for your business, who will be reassigning their benefits to the business, must also complete a CMS 855R.