

**2. Practitioner Identification (Continued)****E. Medical Specialty(s)****1. Physician Specialty**☐ **Change****Effective Date:** \_\_\_\_\_a) Designate your primary specialty and all secondary specialty(s) below using: **P=Primary** **S=Secondary**

<input type="checkbox"/> Addiction medicine	<input type="checkbox"/> Hematology/Oncology	<input type="checkbox"/> Otolaryngology
<input type="checkbox"/> Allergy/Immunology	<input type="checkbox"/> Infectious disease	<input type="checkbox"/> Pathology
<input type="checkbox"/> Anesthesiology	<input type="checkbox"/> Internal medicine	<input type="checkbox"/> Pediatric medicine
<input type="checkbox"/> Cardiac surgery	<input type="checkbox"/> Interventional Pain Management	<input type="checkbox"/> Peripheral vascular disease
<input type="checkbox"/> Cardiovascular disease (Cardiology)	<input type="checkbox"/> Interventional radiology	<input type="checkbox"/> Physical medicine and rehabilitation
<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Maxillofacial surgery	<input type="checkbox"/> Plastic and reconstructive surgery
<input type="checkbox"/> Colorectal surgery (Proctology)	<input type="checkbox"/> Medical oncology	<input type="checkbox"/> Podiatry
<input type="checkbox"/> Critical care (Intensivists)	<input type="checkbox"/> Nephrology	<input type="checkbox"/> Preventive medicine
<input type="checkbox"/> Dermatology	<input type="checkbox"/> Neurology	<input type="checkbox"/> Psychiatry
<input type="checkbox"/> Diagnostic radiology** (see note)	<input type="checkbox"/> Neuropsychiatry	<input type="checkbox"/> Pulmonary disease
<input type="checkbox"/> Emergency medicine	<input type="checkbox"/> Neurosurgery	<input type="checkbox"/> Radiation oncology
<input type="checkbox"/> Endocrinology	<input type="checkbox"/> Nuclear medicine	<input type="checkbox"/> Rheumatology
<input type="checkbox"/> Family practice	<input type="checkbox"/> Obstetrics/Gynecology	<input type="checkbox"/> Surgical oncology
<input type="checkbox"/> Gastroenterology	<input type="checkbox"/> Ophthalmology	<input type="checkbox"/> Thoracic surgery
<input type="checkbox"/> General practice	<input type="checkbox"/> Optometry	<input type="checkbox"/> Urology
<input type="checkbox"/> General surgery	<input type="checkbox"/> Oral surgery (Dentist only)	<input type="checkbox"/> Vascular surgery
<input type="checkbox"/> Geriatric medicine	<input type="checkbox"/> Orthopedic surgery	<input type="checkbox"/> Undefined physician type (Specify):
<input type="checkbox"/> Gynecological/Oncology	<input type="checkbox"/> Osteopathic manipulative treatment	_____
<input type="checkbox"/> Hand surgery		
<input type="checkbox"/> Hematology		

b) **Submit a copy of your State Physician License** and furnish the following information:

License Number	Issue/Effective Date (MM/DD/YYYY)	Expiration/Renewal Date (MM/DD/YYYY)
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**2. Non-Physician Specialty**☐ **Change****Effective Date:** \_\_\_\_\_

a) See instructions for specific non-physician requirements that must be met to enroll in the Medicare program and check the appropriate specialty below.

**Check only one:**

<input type="checkbox"/> Anesthesiology Assistant	<input type="checkbox"/> Nurse practitioner
<input type="checkbox"/> Audiologist	<input type="checkbox"/> Occupational therapist in private practice (see Sec. I)
<input type="checkbox"/> Certified nurse midwife	<input type="checkbox"/> Physical therapist in private practice (see Sec. I)
<input type="checkbox"/> Certified registered nurse anesthetist	<input type="checkbox"/> Physician assistant (see Sections F)
<input type="checkbox"/> Clinical nurse specialist	<input type="checkbox"/> Psychologist, Clinical (see Section G)
<input type="checkbox"/> Clinical social worker	<input type="checkbox"/> Psychologist billing independently (see Section H)
<input type="checkbox"/> Mass immunization roster biller	<input type="checkbox"/> Registered Dietitian or Nutrition Professional
	<input type="checkbox"/> Undefined non-physician type (Specify):
	_____

b) Submit documentation (e.g., copies of licenses, degrees) that confirms you have met the requirements for your specialty and furnish the following information:

License (or other) Number	Issue/Effective Date (MM/DD/YYYY)	Expiration/Renewal Date (MM/DD/YYYY)
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**F. Physician Assistants (PA) Only**☐ **Add**☐ **Delete****Effective Date:** \_\_\_\_\_

This section must be completed by all physician assistants to ensure correct claims coding when billing for your services. Since physician assistants cannot bill the Medicare program directly, they must report the Medicare billing number for all employers that bill Medicare for their services. All employers must be enrolled in the Medicare program.

Employer's NameMedicare Identification Number

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