

4. Current Practice Location(s)

This section is to be completed with information about where you currently render medical services to Medicare patients. You must complete this entire section beginning with Section 4A1 and carefully follow all instructions in each part. If you need additional space to report additional groups/organizations or if you have more than one private practice location, copy and complete this section as needed for each.

A. Group Practice Information

Beginning with Section 4A1, answer "Yes" or "No" to each question. When applicable, furnish the group/organization name and Medicare number for each group/organization to which you will reassign your benefits. In addition to identifying the group/organization to which you will reassign your benefits in this section, either you or each group/organization reported in this section must also complete and submit a CMS 855R (Individual Reassignment of Benefits) with this application. Reassigning benefits means that you are authorizing the group/organization to bill Medicare for the services you have rendered at the group/organization's practice location.

1. Will **all** of your services be rendered as part of a group(s) or organization(s) to which you will reassign your benefits? ☐ YES ☐ NO
IF YES, furnish the name and Medicare identification number of each group or organization below and skip to Sections 13 through 17.
IF NO, proceed to Question 2 below.

a) Name of Group/Organization	Group/Organization Medicare Number
b) Name of Group/Organization	Group/Organization Medicare Number
c) Name of Group/Organization	Group/Organization Medicare Number

2. Will **any** of your services be rendered as part of a group(s) or organization(s) to which you will reassign your benefits? ☐ YES ☐ NO
IF YES, furnish the name and Medicare identification number of each group or organization below and continue completing the rest of this application at Section 4B.
IF NO, continue with Section 4B below with information about your private practice.

a) Name of Group/Organization	Group/Organization Medicare Number
b) Name of Group/Organization	Group/Organization Medicare Number
c) Name of Group/Organization	Group/Organization Medicare Number

B. Practice Location Information ☐ Add ☐ Delete ☐ Change **Effective Date:** _____

1. Practice Location Name	Date You Started Rendering Services at this Location (MM/DD/YYYY)
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2. Practice Location Street Address Line 1 (Street Name and Number)

Practice Location Street Address Line 2 (Suite, Room, etc.)

City	County/Parish	State	ZIP Code + 4
Telephone Number () ()	(Ext.) ()	Fax Number (if applicable) ()	E-mail Address (if applicable)

3. Do you own/lease this practice location? ☐ YES ☐ NO

4. Is this practice location a:

private practice office setting?	<input type="checkbox"/> YES <input type="checkbox"/> NO
hospital?	<input type="checkbox"/> YES <input type="checkbox"/> NO
retirement/assisted living community?	<input type="checkbox"/> YES <input type="checkbox"/> NO
other health care facility? (Specify): _____	<input type="checkbox"/> YES <input type="checkbox"/> NO

5. CLIA Number for this location (if applicable)	FDA/Radiology (Mammography) Certification Number for this location (if applicable)
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