

15. Certification Statement

You **MUST** sign and date the certification statement below in order to be enrolled in the Medicare program. In doing so, you are attesting to meeting and maintaining the Medicare requirements stated below.

I, the undersigned, certify to the following:

- 1.) I have read the contents of this application, and the information contained herein is true, correct, and complete to the best of my knowledge. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare program contractor of this fact immediately.
- 2.) I authorize the Medicare contractor to verify the information contained herein. I agree to notify the Medicare contractor of any future changes to the information contained in this form within 90 days of the effective date of the change. I understand that any change in my status as an individual practitioner may require the submission of a new application.
- 3.) I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare billing privileges, and/or the imposition of fines, civil damages, and/or imprisonment.
- 4.) I agree to abide by the Medicare laws, regulations and program instructions that apply to me. The Medicare laws, regulations, and program instructions are available through the Medicare contractor.
- 5.) Neither I, nor any managing employee, is currently sanctioned, suspended, debarred, or excluded by the Medicare or Medicaid program, or any other Federal program, or is otherwise prohibited from providing services to Medicare or other Federal program beneficiaries.
- 6.) I agree that any existing or future overpayment made to me by the Medicare program may be recouped by Medicare through the withholding of future payments.
- 7.) I understand that the Medicare billing number issued to me can only be used by me or by a provider or supplier to whom I have reassigned my benefits under current Medicare regulations, when billing for services rendered by me.
- 8.) I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.
- 9.) I further certify that I am the individual practitioner who is applying for Medicare billing privileges.

Practitioner Name Print	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Practitioner Signature	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed	

16. Delegated Official**This Section Not Applicable****17. Attachments**

This section is a list of documents that, when applicable, should be submitted with this completed enrollment application.

Place a check next to each document (as applicable or required) that you are including with this completed application.

- ☐ Copy(s) of all Federal, State, and/or local (city/county) professional licenses, certifications and/or registrations specifically required to operate as a health care facility
- ☐ Copy(s) of all Federal, State, and/or local (city/county) business licenses, certifications and/or registrations specifically required to operate as a health care facility
- ☐ Copy(s) of all certificates or evidence of qualifying course work
- ☐ Copy(s) of all CLIA Certificates, FDA Mammography Certificates, and Diabetes Education Certificates
- ☐ Copy(s) of all adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters)
- ☐ Completed Form HCFA-460 – Medicare Participating Physician or Supplier Agreement
- ☐ Completed Form HCFA-588 - Authorization Agreement for Electronic Funds Transfer
- ☐ Completed Form CMS 855R – Individual Reassignment of Benefits
- ☐ IRS documentation confirming the Tax Identification Number with the Legal Business Name (e.g., CP 575)
- ☐ Any additional documentation or letters of explanation as needed