

**MEDICARE FEDERAL HEALTH CARE BENEFIT REASSIGNMENT APPLICATION****Application for the Reassignment of Medicare Benefits****General Instructions**

The Medicare Federal Health Care Benefit Reassignment 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 providers or suppliers with whom an individual practitioner has a valid reassignment of benefits on file with Medicare, and that the amount of the payments are correct. To accomplish this, Medicare must know basic identifying information about the individual practitioner and the provider/supplier who the individual practitioner is authorizing to receive payment on his or her behalf for services rendered to Medicare beneficiaries.

When completing this application, Medicare must know the name, social security number, and Medicare identification number of the individual practitioner reassigning his or her benefits and the name, tax identification number, and Medicare identification number of the provider/supplier receiving the individual practitioner's reassigned benefits.

This application must be completed any time an individual practitioner reassigns his or her benefits to an eligible provider/supplier. Both the individual practitioner and the eligible provider/supplier must be currently enrolled (or concurrently enrolling) in the Medicare program. Generally, this application will be completed by the provider/supplier, signed by the individual practitioner, and submitted by the provider/supplier. When deleting a current reassignment, either the provider/supplier or the individual practitioner may submit this application with the appropriate sections completed.

**1. General Information**

This section is to be completed with information as to why this reassignment of benefits application is being submitted.

**Reason for Submittal of this Application**

Check one:

- ☐ Add a New Reassignment – Effective Date: \_\_\_\_\_
- ☐ Terminate a Current Reassignment – Effective Date: \_\_\_\_\_
- ☐ Change Income Reporting Status - Effective Date (MM/DD/YYYY): \_\_\_\_\_
- ☐ Attesting to Current Reassignment

**2. Provider/Supplier Identification**

This section is to be completed with identifying information about the provider/supplier to which the individual practitioner is reassigning his or her benefits.

Legal Business Name of Provider/Supplier as Reported to IRS

Group Specialty

Tax Identification Number

Medicare Identification Number or NPI

**3. Individual Practitioner Identification**

This section is to be completed with identifying information about the individual practitioner who will be reassigning (or terminating the reassignment of) his or her benefits to the provider/supplier shown in Section 2 above.

Name First

Middle

Last

Jr., Sr., etc.

Social Security Number

Medicare Identification Number or NPI

Practitioner Specialty

What income reporting form does the individual practitioner receive from the supplier at the end of the calendar year based on his or her relationship with the provider/supplier shown in Section 2?

Check all that apply: ☐ W-2 ☐ 1099 ☐ 1065-K1 Other: \_\_\_\_\_