

OMB Approval No. 0938-0685

SECTION 4: STATEMENT OF TERMINATION

This section is to be completed only if you are terminating your reassignment of benefits to the provider/supplier.

- Furnish the provider/supplier's name as reported to the IRS (the name must be the same as reported in Section 2).
- Complete, sign, and date the "Statement of Termination."

NOTE: All signatures must be original. Faxed, photocopied, or stamped signatures are not acceptable.

By his or her signature, the individual practitioner terminates the authority of the provider/supplier to claim or receive any fees or charges for the practitioner's services, and attests to the accuracy of the information provided on this form.

SECTION 5: REASSIGNMENT OF BENEFITS STATEMENT

The individual practitioner who will be reassigning benefits to the eligible provider/supplier must complete, sign, and date this Reassignment of Benefits Statement. Failure to do so will delay the processing of this application, thus limiting CMS's ability to make payments.

- Type or print the individual practitioner's full name.
- The individual practitioner must sign and date this section.

NOTE: All signatures must be original. Faxed, photocopied, or stamped signatures are not acceptable.

SECTION 6: ATTESTATION STATEMENT

Either the authorized official or a delegated official who has been identified on the provider/supplier's CMS 855B application must sign and date this Attestation Statement. By his or her signature, the authorized or delegated official attests to the accuracy of the information provided and certifies that the provider/supplier applying to receive or terminate payments is in fact eligible to receive or terminate reassigned benefits.

NOTE: All signatures must be original. Faxed, photocopied, or stamped signatures are not acceptable.

For further information on the requirements regarding the reassignment of benefits, contact the Medicare carrier.

SECTION 7: CONTACT PERSON

Provide the full name and telephone number of an individual who can be reached to answer questions regarding the information furnished in this application.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0685. The time required to complete this information collection is estimated at 60 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.