

11th Hour Accreditation and Surety Bond Decisions

Reasonable questions for an unreasonable situation

To speak with a representative please call 785-783-8480

Or

Attend the 11th Hour Accreditation and Surety Bond Webinar

Space is limited.

Reserve your Webinar seat now at:

<https://www2.gotomeeting.com/register/770517011>

**MANDATORY
ACCREDITATION
ALL EXISTING PROVIDERS**

by

September 30, 2009

(apply by 1/31/09 to guarantee)

Application Submitted after 3/1/2008
Accredited Before Application

DEEMED ORGANIZATIONS

- Accreditation Commission for Healthcare (ACHC)
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO) – Now Joint Commission (JC)
- Community Health Accreditation Program (CHAP)
- Healthcare Quality Association on Accreditation (HQAA)
- The Compliance Team, Inc.
- National Association of Boards of Pharmacy
- National Board of Accreditation for Orthotic Suppliers
- Board for Orthotist/Prosthetist Certification
- Commission on Accreditation of Rehabilitation Facilities
- American Board for Certification in Orthotics and Prosthetics

EXEMPTIONS

Physicians, including dentists

Orthotists / Prosthetists

Opticians / Optometrists

Audiologists

Occupational Therapists

Physical Therapists

Podiatrists

Pedorthists, mastectomy fitters, orthopedic fitters / technicians and athletic trainers shall require accreditation to obtain/maintain Medicare billing privileges.

SURETY BONDS

SURETY BONDS

- **EFFECTIVE** October 2, 2009
- \$50,000 Surety Bond **REQUIRED** / NPI assigned
 - Multi-site bonds available for multiple locations
- Approximate Cost = **Varies widely (\$200-\$4000)**
- http://www.fms.treas.gov/c570/c570_a-z.html
- Elevated Amount if “Final Adverse Action(s)” = **“HIGH RISK Providers”**
- Additional \$50,000 per occurrence

FINAL ADVERSE ACTIONS

- Within last 10 years since enrollment, revalidation or reenrollment:
 - A Medicare imposed revocation of any Medicare billing privileges
 - Suspension or revocation of a license to provide health care by any State licensing authority
 - Revocation or suspension by an accreditation organization
 - A conviction of a Federal or State felony offense (as defined in 42 CFR 424.535(a)(3)(i)(A)) within the last 10 years preceding enrollment, revalidation, or reenrollment
 - An exclusion or debarment from participation in a Federal or State health care program.

THE 855-S

**FAILURE TO SUBMIT AN
855-S TO THE NATIONAL
SUPPLIER
CLEARINGHOUSE (NSC) BY
SEPTEMBER 30, 2009 WILL
RESULT IN TERMINATION
OF YOUR PART B BILLING
PRIVILEGES FOR 1 YEAR!**

855-S CHOICES

- **DO NOTHING – LOSE PART B PRIVILEGES FOR 1 YEAR**
- **VOLUNTARILY TERMINATE**
- **ACCREDITATION AND SURETY BOND – BUSINESS AS USUAL FOR ALL ACCREDITED PRODUCTS**
- **PHARMACEUTICALS ONLY – SURETY BOND ONLY**

CHOICE 1 – DO NOTHING

- Disconnect from this webinar / hang up the phone – Medicare will automatically revoke your Part B billing privileges October 1, 2009
- **GAME OVER!** You will not be able to get them back for 1 year!
- BUT.....

CHOICE 2

VOLUNTARILY TERMINATE

- Medicare will automatically revoke your Part B billing privileges October 1, 2009
- You will be able to get them back once you are accredited **AND** you have your Surety Bond!
- NO 12 month waiting period!



MEDICARE ENROLLMENT APPLICATION

**Durable Medical Equipment, Prosthetics, Orthotics,
and Supplies (DMEPOS) Suppliers**

CMS-855S

SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION.

SEE PAGE 2 FOR INFORMATION ON WHERE TO MAIL THIS APPLICATION.

SEE PAGE 35 FOR A LIST OF SUPPORTING DOCUMENTS THAT MUST BE SUBMITTED WITH THIS APPLICATION.

SEE PAGE 36 FOR A LIST OF THE DMEPOS SUPPLIER STANDARDS. EVERY APPLICANT MUST MEET AND MAINTAIN THESE ENROLLMENT STANDARDS.



Download the 855-S at:

<http://www.cms.hhs.gov/cmsforms/downloads/cms855s.pdf>

SECTION 1: BASIC INFORMATION

A. Provide the two-letter State Code (e.g., TX for Texas) where your business is located **B. Check one box and provide the necessary information where requested**

DMEPOS suppliers must furnish their Medicare Identification Number, often referred to as a supplier number, and their NPI below. Note: Unless enrolling as a sole proprietorship with multiple locations, each enrolled supplier of DMEPOS must obtain an NPI for each practice location.

However, if the applicant is the sole owner of more than one incorporated DMEPOS supplier location (i.e., a sole proprietor with multiple locations) only one NPI will be issued.

Medicare Identification Number (if issued): 1234560001 NPI: 1234567890

<input type="checkbox"/> You are a new enrollee in Medicare or are enrolling a new location with a tax identification number not previously enrolled with the NSC	Complete all sections
<input type="checkbox"/> You are adding a new business location using a tax identification number already enrolled with the NSC	1A, 1B, 2, 4, 6 (for managing/directing employee only), 12, 13, 15, 16 (if applicable)
<input type="checkbox"/> You are reactivating your Medicare Supplier Billing Number	Complete all sections
<input type="checkbox"/> You are reenrolling	Complete all sections
<input checked="" type="checkbox"/> You are voluntarily terminating your Medicare enrollment. Effective date of termination: <u>October 1, 2009</u>	1B, 4A (page 15 only), 13, and either 15 or 16
<input type="checkbox"/> You are changing your Medicare information	Go to Section 1C

SECTION 4: CURRENT BUSINESS LOCATION

A. BUSINESS LOCATION INFORMATION

This section captures information regarding your business location.

- A separate application must be submitted for each physical business location that intends to bill Medicare for items sold to Medicare beneficiaries from that location. Locations that serve only as warehouses or repair facilities should not be reported.
- The address must be a specific street address as recorded by the United States Postal Service. Do not furnish a P.O. Box. If you are in a hospital and/or other health care facility and you provide services to patients at that facility, furnish the name and address of the hospital or facility.
- A change to the business location address requires submission of professional and business licenses for the new address, and proof of insurance covering the new address.

NOTE: You must separately enroll each Medicare DMEPOS supplier business location.

If you are making a change in this section, please check the box and list effective date below.

<input type="checkbox"/> CHANGE	DATE (mm/dd/yyyy) _____
--	--------------------------------

Business Location Name/Doing Business As Name *(NOT your billing agent, staffing company, or managing organization)*

XYZ Retail Pharmacy, Incorporated

Business Location Address Line 1 *(Street Name and Number)*

1500 Main Street

Business Location Address Line 2 *(Suite, Room, etc.)*

Suite A

City/Town

Denver

State

Colorado

ZIP Code + 4

80123-7676

Telephone Number

(303) 666-8888

Fax Number *(if applicable)*

(303) 666-9999

E-mail Address *(if applicable)*

bpill@yahoo.com

Date this Business Started at this Location *(mm/dd/yyyy)*

04/01/1956

Date this Business Terminated at this Location *(if applicable) (mm/dd/yyyy)*

List your posted hours of operation as shown at your business location.

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
8AM-5PM	8AM-5PM	8AM-5PM	8AM-5PM	8AM-5PM

SATURDAY	SUNDAY	TOTAL HOURS AVAILABLE TO THE PUBLIC
8AM-6PM	CLOSED	55

SECTION 13: CONTACT PERSON

If questions arise during the processing of this application, the NSC will contact the individual shown below. If no one is listed below, we will contact you directly.

- Contact the Authorized Official listed in Section 15. **OR**
 Contact the Delegated Official listed in Section 16.

First Name William	Middle Initial R	Last Name Pharmacist	Jr., Sr., etc.
Address Line 1 (<i>Street Name and Number</i>) 5678 Pillcounter Drive			
Address Line 2 (<i>Suite, Room, etc.</i>)			
City/Town Elizabeth		State Colorado	ZIP Code + 4 80107-5555
Telephone Number (303) 666-8888	Fax Number (<i>if applicable</i>) (303) 666-9999	E-mail Address (<i>if applicable</i>) bpill@yahoo.com	

SECTION 15: CERTIFICATION STATEMENT (Continued)

B. 1ST AUTHORIZED OFFICIAL SIGNATURE

I have read the contents of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize the NSC to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the NSC of this fact immediately.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

NOTE: Authorized officials must be reported in Section 6 of this application.

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			

Authorized Official's Information and Signature

First Name William	Middle Initial R	Last Name Pharmacist	Suffix (e.g., Jr., Sr.)
Telephone Number 303-666-8888	E-mail Address bpill@yahoo.com	Title/Position President	
Authorized Official Signature (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.) Sign Here		Date Signed (mm/dd/yyyy) 09/01/2009	

C. 2ND AUTHORIZED OFFICIAL SIGNATURE IF APPLICABLE

I have read the contents of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize the NSC to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the NSC of this fact immediately.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

NOTE: Authorized officials must be reported in Section 6 of this application.

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			

Authorized Official's Information and Signature

First Name	Middle Initial	Last Name	Suffix (e.g., Jr., Sr.)
Telephone Number	E-mail Address	Title/Position	
Authorized Official Signature (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)		Date Signed (mm/dd/yyyy)	

All signatures must be original and signed in ink. Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

OR

SECTION 16: DELEGATED OFFICIAL(S) (OPTIONAL)

- You are not required to have a delegated official. However, if no delegated official is assigned, the authorized official(s) will be the only person(s) who can make changes and/or updates to the supplier’s status in the Medicare program.
- The signature of a delegated official shall have the same force and effect as that of an authorized official, and shall legally and financially bind the supplier to the laws, regulations, and program instructions of the Medicare program. By his or her signature, a delegated official certifies that he or she has read the Certification Statement in Section 15 and agrees to adhere to all of the stated requirements. The delegated official also certifies that he/she meets the definition of a delegated official. When making changes and/or updates to the supplier’s enrollment information maintained by the Medicare program, the delegated official certifies that the information provided is true, correct, and complete.
- A delegated official who is being deleted does not have to sign or date this application.
- Independent contractors are not considered “employed” by the supplier. Therefore, an independent contractor cannot be a delegated official.
- The signature of an authorized official in Section 16 constitutes a legal delegation of authority to all delegated official(s) assigned in Section 16.
- If there are more than two individuals, copy and complete this section for each individual.
- Delegated officials must be reported in section 6 of this application.

A. 1ST DELEGATED OFFICIAL SIGNATURE

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

NOTE: Delegated officials must be reported in Section 6 of this application.

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			

Delegated Official First Name William	Middle Initial R	Last Name Pharmacist	Suffix (e.g., Jr., Sr.) Jr.
Delegated Official Signature (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.) Sign Here			Date Signed (mm/dd/yyyy) 09/01/2009
Telephone Number 303-555-1212		E-mail Address bpilljr@yahoo.com	
Authorized Official’s Signature Assigning this Delegation (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.) Sign Here			Date Signed (mm/dd/yyyy) 09/01/2009

Check here if Delegated Official is a W-2 Employee

CHOICE 3

ACCREDITATION & SURETY BOND

- Even though your Accreditation Organization (AO) will report your accreditation status to NSC, **STILL** inform them yourself on the 855-S
- You **MUST** inform the NSC you have your Surety Bond!
- Result = **NO** interruption in billing!

SECTION 1: BASIC INFORMATION

A. Provide the two-letter State Code (e.g., TX for Texas) where your business is located

B. Check one box and provide the necessary information where requested

DMEPOS suppliers must furnish their Medicare Identification Number, often referred to as a supplier number, and their NPI below. Note: Unless enrolling as a sole proprietorship with multiple locations, each enrolled supplier of DMEPOS must obtain an NPI for each practice location.

However, if the applicant is the sole owner of more than one incorporated DMEPOS supplier location (i.e., a sole proprietor with multiple locations) only one NPI will be issued.

Medicare Identification Number (if issued): 1234560001 NPI: 1234567890

<input type="checkbox"/> You are a new enrollee in Medicare or are enrolling a new location with a tax identification number not previously enrolled with the NSC	Complete all sections
<input type="checkbox"/> You are adding a new business location using a tax identification number already enrolled with the NSC	1A, 1B, 2, 4, 6 (for managing/directing employee only), 12, 13, 15, 16 (if applicable)
<input type="checkbox"/> You are reactivating your Medicare Supplier Billing Number	Complete all sections
<input type="checkbox"/> You are reenrolling	Complete all sections
<input type="checkbox"/> You are voluntarily terminating your Medicare enrollment. Effective date of termination: _____	1B, 4A (page 15 only), 13, and either 15 or 16
<input checked="" type="checkbox"/> You are changing your Medicare information	Go to Section 1C

SECTION 1: BASIC INFORMATION (Continued)

C. Check the item(s) listed that is changing and complete the applicable sections

MARK ALL THAT APPLY

REQUIRED SECTIONS

<input type="checkbox"/> Supplier Type (submit licensure if applicable) <input type="checkbox"/> Products and Services (submit accreditation if applicable)	1C, 2 (complete 2A1 and those data elements that are changing), 3, 13 , and either 15 (if you are the authorized official) or 16 (if you are the delegated official), and 6 for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
<input checked="" type="checkbox"/> Accreditation Information	1C, 2A1, 2G, 3, 13 , and either 15 (if you are the authorized official), or 16 (if you are the delegated official), and 6 for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
<input checked="" type="checkbox"/> Surety Bond Information	1C, 2A1, 3, 12, 13 , and either 15 (if you are the authorized official), or 16 (if you are the delegated official), and 6 for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
<input type="checkbox"/> Final Adverse Actions/Convictions	1C, 2A1, 3, 13 , and either 15 (if you are the authorized official) or 16 (if you are the delegated official), and 6 for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
<input type="checkbox"/> Current Business Location	1C, 2A1, 3, 4, 12, 13 , and either 15 (if you are the authorized official) or 16 (if you are the delegated official), and 6 for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
<input type="checkbox"/> Ownership and/or Managing Control Information (Organizations)	1C, 2A1, 3, 5, 13 , and either 15 (if you are the authorized official) or 16 (if you are the delegated official), and 6 for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
<input type="checkbox"/> Ownership and/or Managing Control Information (Individuals)	1C, 2A1, 3, 6, 13 , and either 15 (if you are the authorized official) or 16 (if you are the delegated official), and 6 for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
<input type="checkbox"/> Billing Agency Information	1, 2A1, 3, 8 (complete only those data elements that are changing), 13 , and either 15 (if you are the authorized official) or 16 (if you are the delegated official), and 6 for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
<input type="checkbox"/> Authorized Official	1C, 2A1, 3, 6, 13 and 15
<input type="checkbox"/> Delegated Official	1C, 2A1, 3, 6, 13, 15 and 16

SECTION 2: IDENTIFYING INFORMATION

SECTION 2A1 INSTRUCTIONS

A. SUPPLIER IDENTIFICATION

All applicants new to Medicare or suppliers that are making changes to their Medicare information must complete this section. DO NOT PROVIDE BILLING AGENT INFORMATION HERE.

1. Where should we mail your 1099?

Organizational Suppliers (e.g., Corporations, Partnerships, LLCs, Sub-Chapter S)

If you are an organizational supplier, furnish the supplier's legal name (as reported to the IRS) and TIN. Furnish 1099 mailing address information where indicated. A copy of the IRS CP-575 or other correspondence issued by the IRS showing the TIN for this business MUST be submitted. Complete only item A on this page.

Sole Proprietors

If you are a sole proprietor (only owner of a business that is not incorporated) list your Social Security Number (SSN) and the full legal name associated with the SSN as reported to the IRS in the appropriate fields. If you want your Medicare payments reported under your Employer Identification Number (EIN) furnish it in the appropriate space below. Furnish 1099 mailing address information where indicated. Complete only item B on this page.

NOTE: Sole Proprietors: If you furnish an EIN in Section B, payment will be made to your EIN. If you do not furnish an EIN in Section B, payment will be made to your SSN. You can not use both an SSN and EIN. You can only use one number to bill Medicare. If furnishing an EIN, a copy of the IRS CP-575 or other correspondence issued by the IRS showing the EIN for this business MUST be submitted.

A. Organizational Suppliers (e.g., Corporations, Partnerships, LLCs, Sub-Chapter S)

Legal Name as Reported to the IRS XYZ Retail Pharmacy, Incorporated		Tax Identification Number 20-3579123
1099 Mailing Address Line 1 (Street Name and Number) 1500 Main Street		Former Tax Identification Number (if changed)
1099 Mailing Address Line 2 (Suite, Room, etc.) Suite A		Medicaid Number (if applicable) 43734067046
1099 Mailing Address City Denver	1099 Mailing Address State Colorado	1099 Mailing Address ZIP Code + 4 80123-7676

OR

B. Sole Proprietors

Social Security Number 555-33-9999	Full Legal Name Associated with this Social Security Number XYZ Retail Pharmacy	
Employer Identification Number 20-3579123		
1099 Mailing Address Line 1 (Street Name and Number) 1500 Main Street		Former Tax Identification Number (if changed)
1099 Mailing Address Line 2 (Suite, Room, etc.) Suite A		Medicaid Number (if applicable) 43734067046
1099 Mailing Address City Denver	1099 Mailing Address State Colorado	1099 Mailing Address ZIP Code + 4 80123-7676

SECTION 2: IDENTIFYING INFORMATION (Continued)

E. LIABILITY INSURANCE INFORMATION

All DMEPOS suppliers must have liability insurance and must submit a complete copy of their liability insurance policy or evidence of self-insurance with this application. You must provide the name and telephone number for both your insurance agent and your underwriter. The underwriter is with the company providing your insurance coverage. This contact information is necessary for the NSC to verify your policy. We will not verify this information with your insurance agent.

Name of Insurance Company _____

Insurance Policy Number	Date Policy Issued (mm/dd/yyyy)	Expiration Date of Policy (mm/dd/yyyy)	
Insurance Agent's First Name	Middle Initial	Last Name	Jr., Sr., etc.
Agent's Telephone Number	Agent's Fax Number (if applicable)	Agent's E-mail Address (if applicable).	
Underwriter's Agent's First Name	Middle Initial	Last Name	Jr., Sr., etc.
Underwriter's Telephone Number	Underwriter's Fax Number (if applicable)	Underwriter's E-mail Address (if applicable)	

Is the insurance agent also the underwriter for this policy?

- Yes (Submit written proof from the insurance company attesting the agent is also the underwriter.)
- No

F. ORGANIZATIONAL STRUCTURE

Identify the type of organizational structure for this supplier (Check one):

- ~~Not~~ Publically Traded Corporation (regardless of whether supplier is "for-profit" or "non-profit")
- Publically Traded Corporation (regardless of whether supplier is "for-profit" or "non-profit")
- Partnership ("general" or "limited")
- Sole Proprietor/Sole Proprietorship
- Other (Specify) _____

G. ACCREDITATION INFORMATION

Note: Copy and complete this section if more than one accreditation needs to be reported.

Check one of the following and furnish any additional information as requested:

- The enrolling supplier, including the business location in Section 4A, is accredited.
- The enrolling supplier is not accredited (includes exempt suppliers).

Name of Accrediting Organization
Accreditation Commission for HealthCare

Effective Date of Current Accreditation June 1, 2009	Expiration of Current Accreditation May 31, 2012
---	---

SECTION 3: FINAL ADVERSE ACTIONS/CONVICTIONS (Continued)

FINAL ADVERSE ACTION HISTORY

1. Have you or your organization, under any current or former name or business identity, ever had a final adverse action listed on page 13 of this application imposed against you/it?

YES—Continue Below NO—Skip to Section 4

2. If yes, report each final adverse action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the final adverse action documentation(s) and resolution(s).

Final Adverse Action	Date	Taken By	Resolution
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SECTION 12: SURETY BOND INFORMATION

This section is to be completed by DMEPOS suppliers mandated by law to obtain a surety bond in order to enroll in and bill the Medicare program. Furnish all requested information about the supplier's insurance agent, surety company, and the surety bond. The surety bond must be a continuous bond. A copy of the original surety bond must be submitted with this application.

A. Check Box: Check the box if this DMEPOS supplier believes it is not required to obtain a surety bond for Medicare enrollment. Information on supplier types exempt from getting a surety bond can be found at www.palmettogba.com/nsc or by calling the NSC customer service line at (866) 238-9652.

B. Name and Address of Surety Bond Company: If reporting a change to existing information, check "Change;" provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. Furnish the legal business name and tax identification number of the surety bond company liable for this bond.
2. Furnish the complete business address, telephone number and e-mail address of the surety bond company.

C. Name and Address of Insurance Agency/Broker: If reporting a change to existing information, check "Change;" provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. Provide the legal business name of the agency that issued the bond.
2. Provide the name of the individual agent who issued the bond for the bond agency.
3. Furnish the complete business address, telephone number and e-mail address of the agency.

D. Surety Bond Information: If reporting a change to existing information, check "Change;" provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise, complete this section with specific information about the bond as follows:

1. State the dollar amount of the bond and the bond number.
2. Furnish the effective date of the bond. If reporting a new bond or new surety bond company, furnish the expiration date of the current bond.

SECTION 12: SURETY BOND INFORMATION (Continued)

This section is to be completed by all DMEPOS suppliers required by regulation (see 424.57 (c)(26) and 42 C.F.R. § 424.57 (d)) to obtain a surety bond in order to enroll and maintain Medicare billing privileges. Furnish all requested information about the supplier's insurance agent, surety company, and the surety bond.

A. Check here if this supplier is not required to obtain a surety bond for Medicare enrollment and skip to Section 13. See instructions for surety bond requirements.

B. Name and Address of Surety Bond Company Change **Effective Date:** _____

Legal Business Name of Surety Bond Company as Reported to the IRS Pharmacists Mutual		Tax Identification Number 20-1234567
Business Address Line 1 (Street Name and Number) 808 US Highway 18 West		
Business Address Line 2 (Suite, Room, etc.)		
City Algona		State Iowa
ZIP Code + 4 50511-1111		
Telephone Number (Ext.) (515) 295-2461	Fax Number (if applicable) (515) 295-9306	E-mail Address (if applicable) bbrothis@phmic.com

C. Name and Address of Insurance Agency/Broker Change **Effective Date:** _____

Legal Business Name of Agency/Broker as Reported to the IRS Henderson Insurance Group		Tax Identification Number 20-9876543
Name of Individual Agent Brent Mings		
Business Address Line 1 (Street Name and Number) 12345 Orchard Road		
Business Address Line 2 (Suite, Room, etc.) Suite 150		
City Englewood		State Colorado
ZIP Code + 4 80333-9999		
Telephone Number (Ext.) (303) 888-9999	Fax Number (if applicable) (303) 888-8888	E-mail Address (if applicable) bmings@henderson.com

D. Surety Bond Information Change **Effective Date:** _____

Amount of Surety Bond \$ 50,000.00	Surety Bond Number 43324-23325-1424-4-999
Effective Date of Surety Bond (mm/dd/yyyy) 10/01/2009	If reporting a new bond, give cancellation date of the current bond (mm/dd/yyyy)

SECTION 13: CONTACT PERSON

If questions arise during the processing of this application, the NSC will contact the individual shown below. If no one is listed below, we will contact you directly.

- Contact the Authorized Official listed in Section 15. **OR**
 Contact the Delegated Official listed in Section 16.

First Name William	Middle Initial R	Last Name Pharmacist	Jr., Sr., etc.
Address Line 1 (<i>Street Name and Number</i>) 5678 Pillcounter Drive			
Address Line 2 (<i>Suite, Room, etc.</i>)			
City/Town Elizabeth		State Colorado	ZIP Code + 4 80107-5555
Telephone Number (303) 666-8888	Fax Number (<i>if applicable</i>) (303) 666-9999	E-mail Address (<i>if applicable</i>) bpill@yahoo.com	

SECTION 15: CERTIFICATION STATEMENT (Continued)

B. 1ST AUTHORIZED OFFICIAL SIGNATURE

I have read the contents of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize the NSC to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the NSC of this fact immediately.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

NOTE: Authorized officials must be reported in Section 6 of this application.

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			

Authorized Official's Information and Signature

First Name William	Middle Initial R	Last Name Pharmacist	Suffix (e.g., Jr., Sr.)
Telephone Number 303-666-8888	E-mail Address bpill@yahoo.com	Title/Position President	
Authorized Official Signature (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.) Sign Here		Date Signed (mm/dd/yyyy) 09/01/2009	

C. 2ND AUTHORIZED OFFICIAL SIGNATURE IF APPLICABLE

I have read the contents of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize the NSC to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the NSC of this fact immediately.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

NOTE: Authorized officials must be reported in Section 6 of this application.

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			

Authorized Official's Information and Signature

First Name	Middle Initial	Last Name	Suffix (e.g., Jr., Sr.)
Telephone Number	E-mail Address	Title/Position	
Authorized Official Signature (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)		Date Signed (mm/dd/yyyy)	

All signatures must be original and signed in ink. Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

OR

SECTION 16: DELEGATED OFFICIAL(S) (OPTIONAL)

- You are not required to have a delegated official. However, if no delegated official is assigned, the authorized official(s) will be the only person(s) who can make changes and/or updates to the supplier’s status in the Medicare program.
- The signature of a delegated official shall have the same force and effect as that of an authorized official, and shall legally and financially bind the supplier to the laws, regulations, and program instructions of the Medicare program. By his or her signature, a delegated official certifies that he or she has read the Certification Statement in Section 15 and agrees to adhere to all of the stated requirements. The delegated official also certifies that he/she meets the definition of a delegated official. When making changes and/or updates to the supplier’s enrollment information maintained by the Medicare program, the delegated official certifies that the information provided is true, correct, and complete.
- A delegated official who is being deleted does not have to sign or date this application.
- Independent contractors are not considered “employed” by the supplier. Therefore, an independent contractor cannot be a delegated official.
- The signature of an authorized official in Section 16 constitutes a legal delegation of authority to all delegated official(s) assigned in Section 16.
- If there are more than two individuals, copy and complete this section for each individual.
- Delegated officials must be reported in section 6 of this application.

A. 1ST DELEGATED OFFICIAL SIGNATURE

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

NOTE: Delegated officials must be reported in Section 6 of this application.

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			

Delegated Official First Name William	Middle Initial R	Last Name Pharmacist	Suffix (e.g., Jr., Sr.) Jr.
Delegated Official Signature (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.) Sign Here			Date Signed (mm/dd/yyyy) 09/01/2009
Telephone Number 303-555-1212		E-mail Address bpilljr@yahoo.com	
Authorized Official’s Signature Assigning this Delegation (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.) Sign Here			Date Signed (mm/dd/yyyy) 09/01/2009

Check here if Delegated Official is a W-2 Employee

SECTION 1: BASIC INFORMATION (Continued)

C. Check the item(s) listed that is changing and complete the applicable sections

MARK ALL THAT APPLY

REQUIRED SECTIONS

<input checked="" type="checkbox"/> Supplier Type (submit licensure if applicable) <input checked="" type="checkbox"/> Products and Services (submit accreditation if applicable)	1C, 2 (complete 2A1 and those data elements that are changing), 3, 13 , and either 15 (if you are the authorized official) or 16 (if you are the delegated official), and 6 for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
<input checked="" type="checkbox"/> Accreditation Information	1C, 2A1, 2G, 3, 13 , and either 15 (if you are the authorized official), or 16 (if you are the delegated official), and 6 for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
<input checked="" type="checkbox"/> Surety Bond Information	1C, 2A1, 3, 12, 13 , and either 15 (if you are the authorized official), or 16 (if you are the delegated official), and 6 for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
<input type="checkbox"/> Final Adverse Actions/Convictions	1C, 2A1, 3, 13 , and either 15 (if you are the authorized official) or 16 (if you are the delegated official), and 6 for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
<input type="checkbox"/> Current Business Location	1C, 2A1, 3, 4, 12, 13 , and either 15 (if you are the authorized official) or 16 (if you are the delegated official), and 6 for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
<input type="checkbox"/> Ownership and/or Managing Control Information (Organizations)	1C, 2A1, 3, 5, 13 , and either 15 (if you are the authorized official) or 16 (if you are the delegated official), and 6 for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
<input type="checkbox"/> Ownership and/or Managing Control Information (Individuals)	1C, 2A1, 3, 6, 13 , and either 15 (if you are the authorized official) or 16 (if you are the delegated official), and 6 for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
<input type="checkbox"/> Billing Agency Information	1, 2A1, 3, 8 (complete only those data elements that are changing), 13 , and either 15 (if you are the authorized official) or 16 (if you are the delegated official), and 6 for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
<input type="checkbox"/> Authorized Official	1C, 2A1, 3, 6, 13 and 15
<input type="checkbox"/> Delegated Official	1C, 2A1, 3, 6, 13, 15 and 16

SECTION 2: IDENTIFYING INFORMATION (Continued)

3. Where should we mail your reenrollment request package if different from Section 2A2 above?

This is the address to which the NSC will send your reenrollment request package.

Business Location Name *(NOT your billing agent, staffing company, or managing organization)*

Mailing Address Line 1 *(Street Name and Number)*

Mailing Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4
Telephone Number	Fax Number <i>(if applicable)</i>	E-mail Address <i>(if applicable)</i>

4. Is this supplier currently enrolled in the Medicare program other than as a DMEPOS supplier?

YES NO

If yes, please provide the following for each enrolled supplier:

Medicare Contractor Name	Provider/Supplier Type	NPI
--------------------------	------------------------	-----

B. TYPE OF SUPPLIER

The supplier must meet all Medicare requirements for the DMEPOS supplier type checked. Any specialty personnel including, but not limited to, Respiratory Therapists, and Orthotics/Prosthetics personnel, must be W-2 employees of the enrolling supplier.

Type of supplier (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Ambulatory Surgical Center | <input type="checkbox"/> Medical Supply Company with Respiratory Therapist |
| <input type="checkbox"/> Department Store | <input type="checkbox"/> Nursing Facility (other) |
| <input type="checkbox"/> Grocery Store | <input type="checkbox"/> Occupational Therapist |
| <input type="checkbox"/> Home Health Agency | <input type="checkbox"/> Optician |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Orthotics Personnel |
| <input type="checkbox"/> Indian Health Service | <input type="checkbox"/> Oxygen and/or Oxygen Related Equipment Supplier |
| <input type="checkbox"/> Intermediate Care Nursing Facility | <input type="checkbox"/> Pedorthic Personnel |
| <input type="checkbox"/> Medical Supply Company | <input checked="" type="checkbox"/> Pharmacy |
| <input type="checkbox"/> Medical Supply Company with Orthotics Personnel | <input type="checkbox"/> Physical Therapist |
| <input type="checkbox"/> Medical Supply Company with Pedorthic Personnel | <input type="checkbox"/> Physica/Dentist |
| <input type="checkbox"/> Medical Supply Company with Prosthetics Personnel | <input type="checkbox"/> Physician, other than Optometrist or Dentist |
| <input type="checkbox"/> Medical Supply Company with Prosthetic/Orthotic Personnel | <input type="checkbox"/> Physician/Optometrist |
| <input checked="" type="checkbox"/> Medical Supply Company with Registered Pharmacist | <input type="checkbox"/> Prosthetics Personnel |
| | <input type="checkbox"/> Prosthetic/Orthotic Personnel |
| | <input type="checkbox"/> Rehabilitation Agency |
| | <input type="checkbox"/> Skilled Nursing Facility |
| | <input type="checkbox"/> Other _____ |

SECTION 2: IDENTIFYING INFORMATION (Continued)

C. NON ACCREDITED PRODUCTS

Check all that apply.

- Epoetin
- Immunosuppressive Drugs
- Infusion Drugs
- Nebulizer Drugs
- Oral Anticancer Drugs
- Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)
- Check here if the supplier does not furnish any of the products and/or services listed in Section 2D and provides one or more of the products shown below. If checked, skip Section 2D and continue to Section 2E (Liability Insurance Information).

If you are adding/changing any supplies for which you plan to bill, you must notify the NSC. Consistent with 42 CFR § 424.57 (c)(2), a supplier has not made or caused to be made, any false statement or misrepresentation of a material fact on its application for billing privileges. (The supplier must provide complete and accurate information in response to questions on its application for billing privileges. The supplier must report to CMS any changes in information supplied on the application within 30 days of the change.) Failure to do so could result in revocation and/or overpayment collection.

SECTION 2: IDENTIFYING INFORMATION (Continued)**MUST MATCH AO LIST!!!!****D. PRODUCTS AND SERVICES TO BE FURNISHED BY THIS SUPPLIER**

Check all that apply. If you are adding/changing any supplies for which you plan to bill, you must notify the NSC. Consistent with 42 CFR § 424.57 (c)(2), a supplier has not made or caused to be made, any false statement or misrepresentation of a material fact on its application for billing privileges. (The supplier must provide complete and accurate information in response to questions on its application for billing privileges. The supplier must report to CMS any changes in information supplied on the application within 30 days of the change.) Failure to do so could result in revocation and/or overpayment collection.

If you are unsure of the licensure and/or certification and/or accreditation requirements for your product(s), services(s), and/or State, check the NSC website at www.palmettogba.com/nsc. Failure to attach applicable licensure and/or certification could result in denial or revocation of your Medicare billing number and/or overpayment collection.

- | | |
|--|---|
| <input type="checkbox"/> Automatic External Defibrillators (AEDs) and/or Supplies | <input type="checkbox"/> Orthoses: Prefabricated (non-custom fabricated) |
| <input type="checkbox"/> Blood Glucose Monitors and/or Supplies (mail order) | <input type="checkbox"/> Orthoses: Off-the-Shelf |
| <input type="checkbox"/> Blood Glucose Monitors and/or Supplies (non-mail order) | <input type="checkbox"/> Osteogenesis Stimulators |
| <input type="checkbox"/> Breast Prostheses and/or Accessories | <input type="checkbox"/> Ostomy Supplies |
| <input type="checkbox"/> Canes and/or Crutches | <input type="checkbox"/> Oxygen Equipment and/or Supplies |
| <input type="checkbox"/> Cochlear Implants | <input type="checkbox"/> Parenteral Nutrients, Equipment and/or Supplies |
| <input type="checkbox"/> Commodes/Urinals/Bedpans | <input type="checkbox"/> Patient Lifts |
| <input type="checkbox"/> Continuous Passive Motion (CPM) Devices | <input type="checkbox"/> Pneumatic Compression Devices and/or Supplies |
| <input type="checkbox"/> Continuous Positive Airway Pressure (CPAP) Devices and/or Supplies | <input type="checkbox"/> Power Operated Vehicles (Scooters) |
| <input type="checkbox"/> Contracture Treatment Devices: Dynamic Splint | <input type="checkbox"/> Prosthetic Lenses: Conventional Contact Lenses |
| <input type="checkbox"/> Diabetic Shoes/Inserts | <input type="checkbox"/> Prosthetic Lenses: Conventional Eyeglasses |
| <input type="checkbox"/> Diabetic Shoes/Inserts—Custom | <input type="checkbox"/> Prosthetic Lenses: Prosthetic Cataract Lenses |
| <input type="checkbox"/> Enteral Nutrients, Equipment and/or Supplies | <input type="checkbox"/> Respiratory Assist Devices |
| <input type="checkbox"/> External Infusion Pumps and/or Supplies | <input type="checkbox"/> Respiratory Suction Pumps |
| <input type="checkbox"/> Eye Prostheses | <input type="checkbox"/> Seat Lift Mechanisms |
| <input type="checkbox"/> Facial Prostheses | <input type="checkbox"/> Somatic Prostheses |
| <input type="checkbox"/> Gastric Suction Pumps | <input type="checkbox"/> Speech Generating Devices |
| <input type="checkbox"/> Heat & Cold Applications | <input type="checkbox"/> Support Surfaces: Pressure Reducing Beds/Mattresses/Overlays/Pads |
| <input type="checkbox"/> Hemodialysis Equipment and/or Supplies | <input type="checkbox"/> Surgical Dressings |
| <input type="checkbox"/> High Frequency Chest Wall Oscillation (HFCWO) Devices and/or Supplies | <input type="checkbox"/> Tracheostomy Supplies |
| <input type="checkbox"/> Home Dialysis Equipment and/or Supplies | <input type="checkbox"/> Traction Equipment |
| <input type="checkbox"/> Hospital Beds—Electric | <input type="checkbox"/> Transcutaneous Electrical Nerve Stimulators (TENS) and/or Supplies |
| <input type="checkbox"/> Hospital Beds—Manual | <input type="checkbox"/> Ultraviolet Light Devices and/or Supplies |
| <input type="checkbox"/> Implanted Infusion Pumps and/or Supplies | <input type="checkbox"/> Urological Supplies |
| <input type="checkbox"/> Infrared Heating Pad Systems and/or Supplies | <input type="checkbox"/> Ventilators Accessories and/or Supplies |
| <input type="checkbox"/> Insulin Infusion Pumps and/or Supplies | <input type="checkbox"/> Voice Prosthetics |
| <input type="checkbox"/> Intermittent Positive Pressure Breathing (IPPB) Devices | <input type="checkbox"/> Walkers |
| <input type="checkbox"/> Intrapulmonary Percussive Ventilation Devices | <input type="checkbox"/> Wheelchair Seating/Cushions |
| <input type="checkbox"/> Invasive Mechanical Ventilation Devices | <input type="checkbox"/> Wheelchairs—Complex Rehabilitative Manual Wheelchairs |
| <input type="checkbox"/> Limb Prostheses | <input type="checkbox"/> Wheelchairs—Complex Rehabilitative Manual Wheelchair Related Accessories |
| <input type="checkbox"/> Mechanical In-Exsufflation Devices | <input type="checkbox"/> Wheelchairs—Complex Rehabilitative Power Wheelchairs |
| <input type="checkbox"/> Nebulizer Equipment and/or Supplies | <input type="checkbox"/> Wheelchairs—Complex Rehabilitative Power Wheelchair Related Accessories |
| <input type="checkbox"/> Negative Pressure Wound Therapy Pumps and/or Supplies | <input type="checkbox"/> Wheelchairs—Standard Manual |
| <input type="checkbox"/> Neuromuscular Electrical Stimulators (NMES) and/or Supplies | <input type="checkbox"/> Wheelchairs—Standard Manual Related Accessories |
| <input type="checkbox"/> Neurostimulators and/or Supplies | <input type="checkbox"/> Wheelchairs—Standard Power |
| <input type="checkbox"/> Ocular Prostheses | <input type="checkbox"/> Wheelchairs—Standard Power Related Accessories |
| <input type="checkbox"/> Orthoses: Custom Fabricated | |

CHOICE 4

PHARMACEUTICALS ONLY

- Allows for billing of PART B DRUGS ONLY
- NO OTHER HME including diabetic supplies, nebulizers, etc.....
- Requires a Surety Bond
- Result = NO suspension of Part B number & NO interruption in billing!

SECTION 1: BASIC INFORMATION

A. Provide the two-letter State Code (e.g., TX for Texas) where your business is located **B. Check one box and provide the necessary information where requested**

DMEPOS suppliers must furnish their Medicare Identification Number, often referred to as a supplier number, and their NPI below. Note: Unless enrolling as a sole proprietorship with multiple locations, each enrolled supplier of DMEPOS must obtain an NPI for each practice location.

However, if the applicant is the sole owner of more than one incorporated DMEPOS supplier location (i.e., a sole proprietor with multiple locations) only one NPI will be issued.

Medicare Identification Number (if issued): 1234560001 NPI: 1234567890

<input type="checkbox"/> You are a new enrollee in Medicare or are enrolling a new location with a tax identification number not previously enrolled with the NSC	Complete all sections
<input type="checkbox"/> You are adding a new business location using a tax identification number already enrolled with the NSC	1A, 1B, 2, 4, 6 (for managing/directing employee only), 12, 13, 15, 16 (if applicable)
<input type="checkbox"/> You are reactivating your Medicare Supplier Billing Number	Complete all sections
<input type="checkbox"/> You are reenrolling	Complete all sections
<input type="checkbox"/> You are voluntarily terminating your Medicare enrollment. Effective date of termination: _____	1B, 4A (page 15 only), 13, and either 15 or 16
<input checked="" type="checkbox"/> You are changing your Medicare information	Go to Section 1C

SECTION 1: BASIC INFORMATION (Continued)

C. Check the item(s) listed that is changing and complete the applicable sections

MARK ALL THAT APPLY

REQUIRED SECTIONS

<input checked="" type="checkbox"/> Supplier Type (submit licensure if applicable) <input checked="" type="checkbox"/> Products and Services (submit accreditation if applicable)	1C, 2 (complete 2A1 and those data elements that are changing), 3, 13 , and either 15 (if you are the authorized official) or 16 (if you are the delegated official), and 6 for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
<input type="checkbox"/> Accreditation Information	1C, 2A1, 2G, 3, 13 , and either 15 (if you are the authorized official), or 16 (if you are the delegated official), and 6 for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
<input checked="" type="checkbox"/> Surety Bond Information	1C, 2A1, 3, 12, 13 , and either 15 (if you are the authorized official), or 16 (if you are the delegated official), and 6 for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
<input type="checkbox"/> Final Adverse Actions/Convictions	1C, 2A1, 3, 13 , and either 15 (if you are the authorized official) or 16 (if you are the delegated official), and 6 for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
<input type="checkbox"/> Current Business Location	1C, 2A1, 3, 4, 12, 13 , and either 15 (if you are the authorized official) or 16 (if you are the delegated official), and 6 for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
<input type="checkbox"/> Ownership and/or Managing Control Information (Organizations)	1C, 2A1, 3, 5, 13 , and either 15 (if you are the authorized official) or 16 (if you are the delegated official), and 6 for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
<input type="checkbox"/> Ownership and/or Managing Control Information (Individuals)	1C, 2A1, 3, 6, 13 , and either 15 (if you are the authorized official) or 16 (if you are the delegated official), and 6 for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
<input type="checkbox"/> Billing Agency Information	1, 2A1, 3, 8 (complete only those data elements that are changing), 13 , and either 15 (if you are the authorized official) or 16 (if you are the delegated official), and 6 for the signer if that authorized or delegated official has not been established for this DMEPOS supplier.
<input type="checkbox"/> Authorized Official	1C, 2A1, 3, 6, 13 and 15
<input type="checkbox"/> Delegated Official	1C, 2A1, 3, 6, 13, 15 and 16

SECTION 2: IDENTIFYING INFORMATION

SECTION 2A1 INSTRUCTIONS

A. SUPPLIER IDENTIFICATION

All applicants new to Medicare or suppliers that are making changes to their Medicare information must complete this section. DO NOT PROVIDE BILLING AGENT INFORMATION HERE.

1. Where should we mail your 1099?

Organizational Suppliers (e.g., Corporations, Partnerships, LLCs, Sub-Chapter S)

If you are an organizational supplier, furnish the supplier's legal name (as reported to the IRS) and TIN. Furnish 1099 mailing address information where indicated. A copy of the IRS CP-575 or other correspondence issued by the IRS showing the TIN for this business MUST be submitted. Complete only item A on this page.

Sole Proprietors

If you are a sole proprietor (only owner of a business that is not incorporated) list your Social Security Number (SSN) and the full legal name associated with the SSN as reported to the IRS in the appropriate fields. If you want your Medicare payments reported under your Employer Identification Number (EIN) furnish it in the appropriate space below. Furnish 1099 mailing address information where indicated. Complete only item B on this page.

NOTE: Sole Proprietors: If you furnish an EIN in Section B, payment will be made to your EIN. If you do not furnish an EIN in Section B, payment will be made to your SSN. You can not use both an SSN and EIN. You can only use one number to bill Medicare. If furnishing an EIN, a copy of the IRS CP-575 or other correspondence issued by the IRS showing the EIN for this business MUST be submitted.

A. Organizational Suppliers (e.g., Corporations, Partnerships, LLCs, Sub-Chapter S)

Legal Name as Reported to the IRS XYZ Retail Pharmacy, Incorporated		Tax Identification Number 20-3579123
1099 Mailing Address Line 1 (Street Name and Number) 1500 Main Street		Former Tax Identification Number (if changed)
1099 Mailing Address Line 2 (Suite, Room, etc.) Suite A		Medicaid Number (if applicable) 43734067046
1099 Mailing Address City Denver	1099 Mailing Address State Colorado	1099 Mailing Address ZIP Code + 4 80123-7676

OR

B. Sole Proprietors

Social Security Number 555-33-9999	Full Legal Name Associated with this Social Security Number XYZ Retail Pharmacy	
Employer Identification Number 20-3579123		
1099 Mailing Address Line 1 (Street Name and Number) 1500 Main Street		Former Tax Identification Number (if changed)
1099 Mailing Address Line 2 (Suite, Room, etc.) Suite A		Medicaid Number (if applicable) 43734067046
1099 Mailing Address City Denver	1099 Mailing Address State Colorado	1099 Mailing Address ZIP Code + 4 80123-7676

SECTION 2: IDENTIFYING INFORMATION (Continued)

3. Where should we mail your reenrollment request package if different from Section 2A2 above?

This is the address to which the NSC will send your reenrollment request package.

Business Location Name *(NOT your billing agent, staffing company, or managing organization)*

Mailing Address Line 1 *(Street Name and Number)*

Mailing Address Line 2 *(Suite, Room, etc.)*

City/Town

State

ZIP Code + 4

Telephone Number

Fax Number *(if applicable)*

E-mail Address *(if applicable)*

4. Is this supplier currently enrolled in the Medicare program other than as a DMEPOS supplier?

YES NO

If yes, please provide the following for each enrolled supplier:

Medicare Contractor Name

Provider/Supplier Type

NPI

B. TYPE OF SUPPLIER

The supplier must meet all Medicare requirements for the DMEPOS supplier type checked. Any specialty personnel including, but not limited to, Respiratory Therapists, and Orthotics/Prosthetics personnel, must be W-2 employees of the enrolling supplier.

Type of supplier (Check all that apply)

Ambulatory Surgical Center

Department Store

Grocery Store

Home Health Agency

Hospital

Indian Health Service

Intermediate Care Nursing Facility

Medical Supply Company

Medical Supply Company

with Orthotics Personnel

Medical Supply Company

with Pedorthic Personnel

Medical Supply Company

with Prosthetics Personnel

Medical Supply Company

with Prosthetic/Orthotic Personnel

Medical Supply Company

with Registered Pharmacist

Medical Supply Company

with Respiratory Therapist

Nursing Facility (other)

Occupational Therapist

Optician

Orthotics Personnel

Oxygen and/or Oxygen Related Equipment

Supplier

Pedorthic Personnel

Pharmacy

Physical Therapist

Physica/Dentist

Physician, other than Optometrist or Dentist

Physician/Optometrist

Prosthetics Personnel

Prosthetic/Orthotic Personnel

Rehabilitation Agency

Skilled Nursing Facility

Other _____

SECTION 2: IDENTIFYING INFORMATION (Continued)

C. NON ACCREDITED PRODUCTS

Check all that apply.

- Epoetin
- Immunosuppressive Drugs
- Infusion Drugs
- Nebulizer Drugs
- Oral Anticancer Drugs
- Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)
- Check here if the supplier does not furnish any of the products and/or services listed in Section 2D and provides one or more of the products shown below. If checked, skip Section 2D and continue to Section 2E (Liability Insurance Information).

If you are adding/changing any supplies for which you plan to bill, you must notify the NSC. Consistent with 42 CFR § 424.57 (c)(2), a supplier has not made or caused to be made, any false statement or misrepresentation of a material fact on its application for billing privileges. (The supplier must provide complete and accurate information in response to questions on its application for billing privileges. The supplier must report to CMS any changes in information supplied on the application within 30 days of the change.) Failure to do so could result in revocation and/or overpayment collection.

SECTION 2: IDENTIFYING INFORMATION (Continued)**LEAVE BLANK!!!!****D. PRODUCTS AND SERVICES TO BE FURNISHED BY THIS SUPPLIER**

Check all that apply. If you are adding/changing any supplies for which you plan to bill, you must notify the NSC. Consistent with 42 CFR § 424.57 (c)(2), a supplier has not made or caused to be made, any false statement or misrepresentation of a material fact on its application for billing privileges. (The supplier must provide complete and accurate information in response to questions on its application for billing privileges. The supplier must report to CMS any changes in information supplied on the application within 30 days of the change.) Failure to do so could result in revocation and/or overpayment collection.

If you are unsure of the licensure and/or certification and/or accreditation requirements for your product(s), services(s), and/or State, check the NSC website at www.palmettogba.com/nsc. Failure to attach applicable licensure and/or certification could result in denial or revocation of your Medicare billing number and/or overpayment collection.

- | | |
|--|---|
| <input type="checkbox"/> Automatic External Defibrillators (AEDs) and/or Supplies | <input type="checkbox"/> Orthoses: Prefabricated (non-custom fabricated) |
| <input type="checkbox"/> Blood Glucose Monitors and/or Supplies (mail order) | <input type="checkbox"/> Orthoses: Off-the-Shelf |
| <input type="checkbox"/> Blood Glucose Monitors and/or Supplies (non-mail order) | <input type="checkbox"/> Osteogenesis Stimulators |
| <input type="checkbox"/> Breast Prostheses and/or Accessories | <input type="checkbox"/> Ostomy Supplies |
| <input type="checkbox"/> Canes and/or Crutches | <input type="checkbox"/> Oxygen Equipment and/or Supplies |
| <input type="checkbox"/> Cochlear Implants | <input type="checkbox"/> Parenteral Nutrients, Equipment and/or Supplies |
| <input type="checkbox"/> Commodes/Urinals/Bedpans | <input type="checkbox"/> Patient Lifts |
| <input type="checkbox"/> Continuous Passive Motion (CPM) Devices | <input type="checkbox"/> Pneumatic Compression Devices and/or Supplies |
| <input type="checkbox"/> Continuous Positive Airway Pressure (CPAP) Devices and/or Supplies | <input type="checkbox"/> Power Operated Vehicles (Scooters) |
| <input type="checkbox"/> Contracture Treatment Devices: Dynamic Splint | <input type="checkbox"/> Prosthetic Lenses: Conventional Contact Lenses |
| <input type="checkbox"/> Diabetic Shoes/Inserts | <input type="checkbox"/> Prosthetic Lenses: Conventional Eyeglasses |
| <input type="checkbox"/> Diabetic Shoes/Inserts—Custom | <input type="checkbox"/> Prosthetic Lenses: Prosthetic Cataract Lenses |
| <input type="checkbox"/> Enteral Nutrients, Equipment and/or Supplies | <input type="checkbox"/> Respiratory Assist Devices |
| <input type="checkbox"/> External Infusion Pumps and/or Supplies | <input type="checkbox"/> Respiratory Suction Pumps |
| <input type="checkbox"/> Eye Prostheses | <input type="checkbox"/> Seat Lift Mechanisms |
| <input type="checkbox"/> Facial Prostheses | <input type="checkbox"/> Somatic Prostheses |
| <input type="checkbox"/> Gastric Suction Pumps | <input type="checkbox"/> Speech Generating Devices |
| <input type="checkbox"/> Heat & Cold Applications | <input type="checkbox"/> Support Surfaces: Pressure Reducing Beds/Mattresses/Overlays/Pads |
| <input type="checkbox"/> Hemodialysis Equipment and/or Supplies | <input type="checkbox"/> Surgical Dressings |
| <input type="checkbox"/> High Frequency Chest Wall Oscillation (HFCWO) Devices and/or Supplies | <input type="checkbox"/> Tracheostomy Supplies |
| <input type="checkbox"/> Home Dialysis Equipment and/or Supplies | <input type="checkbox"/> Traction Equipment |
| <input type="checkbox"/> Hospital Beds—Electric | <input type="checkbox"/> Transcutaneous Electrical Nerve Stimulators (TENS) and/or Supplies |
| <input type="checkbox"/> Hospital Beds—Manual | <input type="checkbox"/> Ultraviolet Light Devices and/or Supplies |
| <input type="checkbox"/> Implanted Infusion Pumps and/or Supplies | <input type="checkbox"/> Urological Supplies |
| <input type="checkbox"/> Infrared Heating Pad Systems and/or Supplies | <input type="checkbox"/> Ventilators Accessories and/or Supplies |
| <input type="checkbox"/> Insulin Infusion Pumps and/or Supplies | <input type="checkbox"/> Voice Prosthetics |
| <input type="checkbox"/> Intermittent Positive Pressure Breathing (IPPB) Devices | <input type="checkbox"/> Walkers |
| <input type="checkbox"/> Intrapulmonary Percussive Ventilation Devices | <input type="checkbox"/> Wheelchair Seating/Cushions |
| <input type="checkbox"/> Invasive Mechanical Ventilation Devices | <input type="checkbox"/> Wheelchairs—Complex Rehabilitative Manual Wheelchairs |
| <input type="checkbox"/> Limb Prostheses | <input type="checkbox"/> Wheelchairs—Complex Rehabilitative Manual Wheelchair Related Accessories |
| <input type="checkbox"/> Mechanical In-Exsufflation Devices | <input type="checkbox"/> Wheelchairs—Complex Rehabilitative Power Wheelchairs |
| <input type="checkbox"/> Nebulizer Equipment and/or Supplies | <input type="checkbox"/> Wheelchairs—Complex Rehabilitative Power Wheelchair Related Accessories |
| <input type="checkbox"/> Negative Pressure Wound Therapy Pumps and/or Supplies | <input type="checkbox"/> Wheelchairs—Standard Manual |
| <input type="checkbox"/> Neuromuscular Electrical Stimulators (NMES) and/or Supplies | <input type="checkbox"/> Wheelchairs—Standard Manual Related Accessories |
| <input type="checkbox"/> Neurostimulators and/or Supplies | <input type="checkbox"/> Wheelchairs—Standard Power |
| <input type="checkbox"/> Ocular Prostheses | <input type="checkbox"/> Wheelchairs—Standard Power Related Accessories |
| <input type="checkbox"/> Orthoses: Custom Fabricated | |

SECTION 3: FINAL ADVERSE ACTIONS/CONVICTIONS (Continued)

FINAL ADVERSE ACTION HISTORY

1. Have you or your organization, under any current or former name or business identity, ever had a final adverse action listed on page 13 of this application imposed against you/it?

YES—Continue Below NO—Skip to Section 4

2. If yes, report each final adverse action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the final adverse action documentation(s) and resolution(s).

Final Adverse Action	Date	Taken By	Resolution
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SECTION 12: SURETY BOND INFORMATION

This section is to be completed by DMEPOS suppliers mandated by law to obtain a surety bond in order to enroll in and bill the Medicare program. Furnish all requested information about the supplier's insurance agent, surety company, and the surety bond. The surety bond must be a continuous bond. A copy of the original surety bond must be submitted with this application.

A. Check Box: Check the box if this DMEPOS supplier believes it is not required to obtain a surety bond for Medicare enrollment. Information on supplier types exempt from getting a surety bond can be found at www.palmettogba.com/nsc or by calling the NSC customer service line at (866) 238-9652.

B. Name and Address of Surety Bond Company: If reporting a change to existing information, check "Change;" provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. Furnish the legal business name and tax identification number of the surety bond company liable for this bond.
2. Furnish the complete business address, telephone number and e-mail address of the surety bond company.

C. Name and Address of Insurance Agency/Broker: If reporting a change to existing information, check "Change;" provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. Provide the legal business name of the agency that issued the bond.
2. Provide the name of the individual agent who issued the bond for the bond agency.
3. Furnish the complete business address, telephone number and e-mail address of the agency.

D. Surety Bond Information: If reporting a change to existing information, check "Change;" provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise, complete this section with specific information about the bond as follows:

1. State the dollar amount of the bond and the bond number.
2. Furnish the effective date of the bond. If reporting a new bond or new surety bond company, furnish the expiration date of the current bond.

SECTION 12: SURETY BOND INFORMATION (Continued)

This section is to be completed by all DMEPOS suppliers required by regulation (see 424.57 (c)(26) and 42 C.F.R. § 424.57 (d)) to obtain a surety bond in order to enroll and maintain Medicare billing privileges. Furnish all requested information about the supplier's insurance agent, surety company, and the surety bond.

A. Check here if this supplier is not required to obtain a surety bond for Medicare enrollment and skip to Section 13. See instructions for surety bond requirements.

B. Name and Address of Surety Bond Company Change **Effective Date:** _____

Legal Business Name of Surety Bond Company as Reported to the IRS Pharmacists Mutual		Tax Identification Number 20-1234567
Business Address Line 1 (Street Name and Number) 808 US Highway 18 West		
Business Address Line 2 (Suite, Room, etc.)		
City Algona		State Iowa
ZIP Code + 4 50511-1111		
Telephone Number (Ext.) (515) 295-2461	Fax Number (if applicable) (515) 295-9306	E-mail Address (if applicable) bbrothis@phmic.com

C. Name and Address of Insurance Agency/Broker Change **Effective Date:** _____

Legal Business Name of Agency/Broker as Reported to the IRS Henderson Insurance Group		Tax Identification Number 20-9876543
Name of Individual Agent Brent Mings		
Business Address Line 1 (Street Name and Number) 12345 Orchard Road		
Business Address Line 2 (Suite, Room, etc.) Suite 150		
City Englewood		State Colorado
ZIP Code + 4 80333-9999		
Telephone Number (Ext.) (303) 888-9999	Fax Number (if applicable) (303) 888-8888	E-mail Address (if applicable) bmings@henderson.com

D. Surety Bond Information Change **Effective Date:** _____

Amount of Surety Bond \$ 50,000.00	Surety Bond Number 43324-23325-1424-4-999
Effective Date of Surety Bond (mm/dd/yyyy) 10/01/2009	If reporting a new bond, give cancellation date of the current bond (mm/dd/yyyy)

SECTION 13: CONTACT PERSON

If questions arise during the processing of this application, the NSC will contact the individual shown below. If no one is listed below, we will contact you directly.

- Contact the Authorized Official listed in Section 15. **OR**
 Contact the Delegated Official listed in Section 16.

First Name William	Middle Initial R	Last Name Pharmacist	Jr., Sr., etc.
Address Line 1 (<i>Street Name and Number</i>) 5678 Pillcounter Drive			
Address Line 2 (<i>Suite, Room, etc.</i>)			
City/Town Elizabeth		State Colorado	ZIP Code + 4 80107-5555
Telephone Number (303) 666-8888	Fax Number (<i>if applicable</i>) (303) 666-9999	E-mail Address (<i>if applicable</i>) bpill@yahoo.com	

SECTION 15: CERTIFICATION STATEMENT (Continued)

B. 1ST AUTHORIZED OFFICIAL SIGNATURE

I have read the contents of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize the NSC to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the NSC of this fact immediately.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

NOTE: Authorized officials must be reported in Section 6 of this application.

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			

Authorized Official's Information and Signature

First Name William	Middle Initial R	Last Name Pharmacist	Suffix (e.g., Jr., Sr.)
Telephone Number 303-666-8888	E-mail Address bpill@yahoo.com	Title/Position President	
Authorized Official Signature (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.) Sign Here		Date Signed (mm/dd/yyyy) 09/01/2009	

C. 2ND AUTHORIZED OFFICIAL SIGNATURE IF APPLICABLE

I have read the contents of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize the NSC to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the NSC of this fact immediately.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

NOTE: Authorized officials must be reported in Section 6 of this application.

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			

Authorized Official's Information and Signature

First Name	Middle Initial	Last Name	Suffix (e.g., Jr., Sr.)
Telephone Number	E-mail Address	Title/Position	
Authorized Official Signature (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)		Date Signed (mm/dd/yyyy)	

All signatures must be original and signed in ink. Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

OR

SECTION 16: DELEGATED OFFICIAL(S) (OPTIONAL)

- You are not required to have a delegated official. However, if no delegated official is assigned, the authorized official(s) will be the only person(s) who can make changes and/or updates to the supplier’s status in the Medicare program.
- The signature of a delegated official shall have the same force and effect as that of an authorized official, and shall legally and financially bind the supplier to the laws, regulations, and program instructions of the Medicare program. By his or her signature, a delegated official certifies that he or she has read the Certification Statement in Section 15 and agrees to adhere to all of the stated requirements. The delegated official also certifies that he/she meets the definition of a delegated official. When making changes and/or updates to the supplier’s enrollment information maintained by the Medicare program, the delegated official certifies that the information provided is true, correct, and complete.
- A delegated official who is being deleted does not have to sign or date this application.
- Independent contractors are not considered “employed” by the supplier. Therefore, an independent contractor cannot be a delegated official.
- The signature of an authorized official in Section 16 constitutes a legal delegation of authority to all delegated official(s) assigned in Section 16.
- If there are more than two individuals, copy and complete this section for each individual.
- Delegated officials must be reported in section 6 of this application.

A. 1ST DELEGATED OFFICIAL SIGNATURE

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

NOTE: Delegated officials must be reported in Section 6 of this application.

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			

Delegated Official First Name William	Middle Initial R	Last Name Pharmacist	Suffix (e.g., Jr., Sr.) Jr.
Delegated Official Signature (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.) Sign Here			Date Signed (mm/dd/yyyy) 09/01/2009
Telephone Number 303-555-1212		E-mail Address bpilljr@yahoo.com	
Authorized Official’s Signature Assigning this Delegation (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.) Sign Here			Date Signed (mm/dd/yyyy) 09/01/2009

Check here if Delegated Official is a W-2 Employee

Mailing 855-S to:

National Supplier Clearinghouse

PO Box 100142

Columbia, SC 29202-3142

1-866-238-9652 (9AM-5PM EST)

Overnight (non-USPS = UPS/FedEx)

National Supplier Clearinghouse

Palmetto GBA* AG-495

2300 Springdale Drive, Building 1

Camden, SC 29020