CAHABA GOVERNMENT BENEFIT ADMINISTRATORS, LLC

If your facility was selected for revalidation or is part of the HHA demonstration project, listed below are tips to help with the completion of the CMS 855A.

- Send a copy of the Cahaba GBA, LLC or CMS letter along with the completed CMS 855A form for appropriate handling.
- Complete the CMS 855A as your facility operates now. If you have submitted a CMS 855A in the past, please delete any information that is no longer applicable. Any information which does not match the information on file will be deleted.
- All letters and contacts will be directed to the person that completed Section 13 of the CMS 855A.
- It is helpful to identify, in Section 6, the person that acts as the Administrator of the agency. This is needed for a contact for all non enrollment type Medicare correspondence, i.e., Medicare cost reports.

Section 1: Basic Information

- 1A, this section must be completed to identify that you are revalidating your Medicare enrollment.

Section 2A: Type of Provider

- 2A1, identify the type of provider.
- 2A2, identify the subgroup, only needed if provider type in 2A1 is hospital.
- 2A3, answer the question regarding the compliance plan, only needed if provider type in 2A1 is hospital.

Section 2B: Business Information

- 2B1, identify the legal business name as reported to the IRS.
- 2B1, identify the tax identification number.
- 2B1, identify the Medicare year-end cost report date, it should be in mm/dd format, i.e. 12/31. Note: A change in your Medicare cost report date cannot be requested on the CMS 855A form. Please use the current approved Medicare year-end cost report date in this section.
- 2B1, identify the incorporation date.
- 2B1, identify the state where incorporated.
- 2B1, identify the other name and check the type of other name.
- 2B2, complete state license/certification information or mark the box that state license and/or certification is not applicable.
- 2B2, if your state requires a state license to operate, the state license information is applicable. Please complete the state license information in this section.
- 2B2, ensure this section is completed correctly. Note that this section is referring to state certification in lieu of licensure rather than Medicare certification.

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Section 2C: Correspondence Address

- Identify your mailing address, city, state, zip code + 4, telephone number, fax number, and e-mail address.
- The correspondence address must be one where the applicant can be contacted directly. It **cannot** be the address of a billing agency, management services organization, chain home office, or the provider's representative.
- The telephone number must be the applicant's. This should not be the contact person's and cannot be a cell phone.

Section 2D: Accreditation

- Identify whether your facility is accredited.
- If accredited, identify the date of accreditation, name of accrediting body, and type of accreditation or program.

Section 3: Adverse Legal Actions/Convictions

- This section is required to be completed. Identify in 3.1 whether the organization, under any current or former name or business entity, ever had an adverse action imposed against it. Refer to page 13 for a list of adverse legal actions that must be reported, including convictions, exclusions, revocations, and suspensions. These should be reported regardless of whether records were expunged or appeals are pending.
- Identify in 3.2 the specific actions, dates when it occurred, the Federal or State agency or court/administrative body that imposed the action, and the resolution, if any.

Section 4A: Practice Location Information

- Report all practice locations in this section.
- Identify the doing business as name, practice location address including street name and number, city, state, zip code + 4 digit extension, telephone number, fax number, e-mail address, Medicare identification number, NPI, CLIA number, and FDE/radiology certification number.
- The practice location address must be a specific street address as recorded by the United States Postal Service. This cannot be a P.O. Box.
- The practice location address must be able to be verified as being associated with the facilities name. Please provide documentation to support the affiliation between the practice location address and the facilities name (i.e., agency letterhead, business license, lease agreement, utility bill).
- The telephone number must be that of the practice location, not the contact person, parent organization, billing agent, management company, etc. This also cannot be a cell phone.
- For any HHA branches or other Hospital locations, identify the type of practice location.

Section 4B: Remittance Notice/Special Payments (AKA Pay-to Address)

- Check the box noting whether the address is the same as the practice location or different.
- If different, complete the special payments address, including PO box or street name and number, city, state, and zip code + 4.

Section 4C: Patient Medical Records Address

- This section only needs to be completed if medical records are stored at a location other than the practice location address. If this is the case, identify the patient medical records address, including street name and number, city, state, and zip code + 4. This address must be a specific street address as recorded by the United States Postal Service. This cannot be a P.O. box.

Section 4D: Base of Operations Address

- **HHA's only** - Check the box that indicates that the base of operations is the same as the practice location address or, if different than the practice location address, complete the base of operations address including street name and number, city, state, zip code + 4, telephone number, fax number, and e-mail address.

Section 4F: Geographic Location

- **HHA's only** - Complete Section 4F1 for initial reporting and/or additions. If you are reporting the entire state, check the box and note the state, or identify selected cities/towns, states, and zip codes. ***Do not list counties.**

Section 5: Ownership Interest and/or Managing Control Information (Organizations)

- Complete this section with information about all organizations that have 5% or more (direct or indirect) ownership interest of, any partnership interest in, and/or managing control of the provider. Please review the application instructions to complete this section appropriately.
- If there are no organizational owners, mark the box in Section 5A indicating that the entire section is not applicable.
- **Any organization previously reported in Section 2 does not need to be repeated in this section.** Pleas mark the box identifying this section as not applicable.
- If non-profit and operated and/or managed by a board of trustees or other governing body, the actual name of the board of trustees or other governing body should be reported in this section. While the organization is listed in Section 5, individual board members should be listed in Section 6.
- If you have a chain home office in Section 7, it must be included in this section.
- 5A, identify the legal business name as reported to the IRS and the doing business as name.
- 5A, identify the address, city, state, zip code, tax identification number, Medicare identification number, and NPI.
- 5B, complete documenting adverse legal history.
- 5B, the change box should only be marked in this section if there is a change to previously reported adverse legal history. If you are not changing previously reported information, remove the mark in the change box and the effective date. Only the question in 5B1 should be completed.

Section 6: Ownership Interest and/or Managing Control Information (Individuals)

- Complete this section with information about all individuals that have a 5% or greater direct or indirect ownership interest in the provider, all officers and directors of the provider, all managing employees of the provider and all individuals with a partnership interest in the provider. Please review the application instructions to complete this section appropriately.

  ***Note that the provider must have at least one managing employee.**
- As stated above, it is helpful to place a note on the Section 6 of the person that acts as the Administrator of the agency for all non enrollment type correspondence.

- The chain home office administrator in Section 7 must be included in this section.
- The contact person in Section 13 must be included in this section if he/she is a managing/directing employee.
- The authorized official(s) in Section 15 must be included in this section.
- The delegated official(s) in Section 16 must be included in this section.
- 6A1, identify the first name, **middle initial**, last name, jr., sr., etc., social security number, date of birth, individual's Medicare identification number, and individual's NPI.
- 6A1, this section should only include the Medicare identification number and NPI if the individuals have their own.
- 6A2, complete noting the individual's relationship to the provider.
- 6B, complete documenting adverse legal history. It is helpful if you go over this form with the person to ensure that you are aware of any adverse legal history and to ensure that you are answering this appropriately. It is helpful to go over the information in this section with them while completing.
- 6B, the change box should only be marked in this section if there is a change to previously reported adverse legal history. If you are not changing previously reported information, remove the mark in the change box and the effective date. Only the question in 6B1 should be completed.
- To ensure that we can verify the information, ensure that the first name, middle initial, last name, social security number, and date of birth, completed in this section match the information on file with the Social Security Administration.

Section 7: Chain Home Office Information

- Providers that are part of a chain organization that has a chain home office number must complete this section. If this section is not applicable, check the box identifying it as such.
- 7A, check the type of action reporting and the effective date.
- 7B, identify the home office administrator or CEO, including first name, **middle initial**, and last name, jr., sr, etc., title, social security number, and date of birth.
- 7C1, identify the home office name as reported to the IRS.
- 7C2, identify the home office address, city, state, zip code + 4, phone number, fax number, and e-mail address,
- 7C3, identify the home office tax identification number and cost report year end date, should be in mm/dd format.
- 7C4, identify the home office Medicare contractor, and home office chain number.
- 7D, identify the type of business structure.
- 7E, identify the provider's affiliation to the chain home office.

Section 8: Billing Agency Information

- This section should be completed with information on any billing agency the provider uses to process and submit their claims. If this section is not applicable, check the box identifying it as such.
- Identify the legal business name/individual name as reported to the IRS/Social Security Administration and the doing business as name.
- Identify the tax identification number or social security number, as appropriate.
- Identify the address, city, state, zip code + 4, phone number, fax number, e-mail address.

- Submit a copy of the applicant's **current signed** billing agreement. This should be in the provider's name and signed by the provider and the third party. This is required if the special payments address in 4B is billing agent's address.
- Ensure that the contract submitted meets the Medicare regulations that states that an agent's compensation cannot be related to the dollar amount billed or collected and/or the agent's compensation is dependent upon the actual collection of payment. If you have this type of agreement, it should be revised in accordance with Medicare regulations or withdrawn.

Section 12A: Capital Requirements for Home Health Agencies (HHAs)

- **HHA's only** - 12A1, check the appropriate box identifying if the HHA is non-profit or proprietary. The remainders of this section only need to be completed for provider's that are initially enrolling in the Medicare program.

Section 12B: Nursing Registries

- 12B, check the box indicating if the HHA contracts with a nursing registry. Furnish all information on the nursing registry if applicable. If applicable, identify the legal business name as reported to the IRS, the doing business as name, tax identification number, address, city, state, zip code + 4, telephone number, fax number, and e-mail address.

Section 13: Contact Person

- This section is required to be completed on all requests. Please complete. This will be the person that is contacted for all enrollment questions, including the letter stating the results of our review.
- If the authorized or delegated official is also the contact person, check the appropriate box.
- Identify the first name, **middle initial**, and last name, telephone number, fax number, address, city, state, zip code + 4, and e-mail address.

Section 15: Certification Statement

- Ensure the person designated as authorized official complies with CMS requirements. This person must have a Section 6 included and cannot be a contracted managing employee.
- During our review, if we note that there is a different authorized official on file, we will contact you to see if they are no longer the authorized official. If they are not, we will contact you to correct our records. No signature is required to delete anyone in this section.
- Complete the first name, **middle initial**, and last name, suffix, and telephone number.
- To demonstrate approval of the changes, the authorized official should re-sign **and** re-date a **new** certification statement. Do not add the signature to the existing page.
- The signatures must be an original.

Section 16: Delegated Official

- Ensure the person designated as delegated official complies with CMS requirements. This person must have a Section 6 included and cannot be a contracted managing employee.
- During our review, if we note that there is a different delegated official on file, we will contact you to see if they are no longer the delegated official. If they are not, we will contact you to correct our records. No signature is required to delete anyone in this section.
- Complete the first name, middle initial, and last name, suffix, and telephone number.
- If the delegated official is a W-2 employee, check the box.
- The signature of the delegated and authorized officials must be original.

Section 17: Attachments

- The state license is required to be submitted.
- Written confirmation from the IRS confirming your Tax Identification Number (TIN) with the Legal Business Name (e.g., IRS CP 575) provided in Section 2 is required to be submitted.
- If your organization is non-profit, a copy of the 501(c)(3) document or government affirmation letter verifying non-profit status is required.
- If the provider is not on EFT, the completed CMS-588, Authorization Agreement for Electronic Funds Transfer (EFT) is required to be submitted. This is available on the CMS Web site at http://www.cms.hhs.gov/cmsforms/downloads/CMS588.pdf. All supporting documents identified on this form are also required to be submitted. **The enrollment information will not be considered complete until the EFT documentation is submitted.**
- A copy of the National Provider Identifier (NPI) notification received from the National Plan and Provider Enumeration System (NPPES) is required to be submitted. If your provider has not yet applied for the NPI, please do so via the Web site instruction at https://nppes.cms.hhs.gov/NPPES/Welcome.do.
- **Note that the legal business name and TIN must match what is on the NPPES notification, CMS-855A application, and the IRS documentation. We cannot complete the processing of the enrollment information unless ALL of this information matches exactly.** If corrections to your NPI data are needed, please go to the NPPES website at https://nppes.cms.hhs.gov.
- Statement in writing from the bank that the bank has agreed to waive its right of offset for Medicare receivables. Refer to Section 17 of the application instructions to determine whether this applies to your organization.
- Copy of all adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters).
- Copy of delegated official's W-2 if you have designated one.
- An attestation for government entities is required. Refer to Section 5 of the application instructions for further detail on the submission of this statement.

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