



ATTACHMENT B - NOTIFICATION OF SPECIAL DOCUMENTATION

The following identifies the most common action/provider types. Click on the related link for a checklist that provides step-by-step instructions for completing the application. Also review the CMS-855A instructions on the CMS Web site at <http://www.cms.hhs.gov/MedicareProviderSupEnroll/> for additional instruction and data requirements.

- ✓ **Changing Existing Medicare Information – Currently Enrolled Providers**
(the steps in this checklist apply to each of the following 4 checklists)
 - **Additions, Deletions, and Changes of Address**
 - **Managing/Directing Employee Change**
 - **Authorized/Delegated Official Change**
 - **Transfer of Stock**
- ✓ **Full CMS-855s (Provider has not submitted an application since implementation of PECOS on July 29, 2002, Voluntary Submission, Reactivation)**
- ✓ **Converting Freestanding Rural Health Clinic to Provider-Based**
- ✓ **Initial Enrollment Resulting in Issuance of a Medicare Provider Number**
- ✓ **Home Health Agency Capitalization Requirements**
- ✓ **Voluntary Termination**
- ✓ **Changes of Ownership (old and new owner)**
- ✓ **Acquisitions and Mergers (acquiring and acquired owners)**
- ✓ **Consolidations (consolidating owners and newly created provider)**

Changing Existing Medicare Information – Currently Enrolled Providers

The following are the minimum requirements necessary in the submission of the CMS-855A application. This applies to all applications requesting to change existing Medicare enrollment information. Please note that if the provider is not in the CMS Provider Enrollment Chain and Ownership System (PECOS), a complete 855 is required. Follow the requirements for a full CMS-855A. If a full application is required but has not been submitted, the 855 will be returned.

- _____ Section 1A – check that you are changing your Medicare information.
- _____ Section 1A – Under billing number information, identify the Medicare identification number and National Provider Identifier (NPI).
- _____ Section 1B – Check all boxes that apply to the type of change that is being requested. For each box checked, refer to the corresponding “Required Sections” column for the specific sections that must be completed. Refer to the Checklists provided for some of the more frequent types of Change Requests.

- _____ Section 2B1 – complete this section with identification information. Ensure the legal business name and tax identification number matches the IRS documentation.
- _____ Section 2C – complete this section if this is the provider’s first 855.
- _____ Section 3 – identify if there are adverse legal actions. If yes, complete detail and submit the legal action documentation and resolution.
- _____ Section 4A – identify the NPI
- _____ Sections 4A and 4B – complete this section if this is the provider’s first 855.
- _____ Section 6 – complete for all Section 15 and 16 officials if this person is not already established for this provider via a prior approved CMS-855A application.
- _____ Section 13 – identify information for person who can be contacted with questions on the 855 application.
- _____ Section 15 (authorized official) or Section 16 (delegated official) – sign and date the 855. The signature must be an original, no faxes, stamps, or copies are accepted.
- _____ Section 17 - Submit the CMS-588 Authorization Agreement for EFT, if your provider is not currently on EFT, and the required support listed on the form. EFT is mandatory with the submission of the CMS-855A enrollment application. The application cannot be approved if the EFT requirement is not met. Refer to the CMS Web site at <http://www.cms.hhs.gov/cmsforms/downloads/CMS588.pdf> for the EFT form.
- _____ The CMS-588 EFT signature must match Section 15 of the CMS-855A.
- _____ Section 17 - Submit a copy of the delegated official’s W-2 if you have designated one in Section 16.
- _____ Section 17 – If Medicare payment due a provider of services is being sent to a bank (or similar financial institution) where the provider has a lending relationship (that is, any type of loan), then the provider must provide a statement in writing from the bank (which must be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.
- _____ For all sections, ensure all effective dates, middle initials, and credentials are included.
- _____ Submit a cover letter for any necessary clarifications or unique situations.

Additions, Deletions, and Changes of Address

- _____ Complete all steps noted under “Changing Existing Medicare Information – Currently Enrolled Providers”. Also complete the following:
- _____ Section 2C - identify the complete mailing address where correspondence should be sent. This should be the applicant’s address and telephone number, not the billing agency, management service organization, chain home office, or provider’s representative. No cell phones or personal phone numbers are allowed.
- _____ Section 4A – Check the box to identify if you are adding a new practice location to your provider, deleting/terminating an existing practice location, or changing an existing address due to a move to a new location. Also identify the effective date, i.e., mm/dd/yyyy.
- _____ Section 4A – if you have moved to a new address and have more than one practice location, also identify the location that has moved.

- _____ Section 4A – complete all fields to identify the practice location information. This must be an actual physical address where services are rendered. The address is as designated by the U.S. Postal Service, including street number and name, no P.O. or drop boxes, rural routes or highways are allowed.
- _____ Section 4A - the phone number must be the applicant’s, not that of the contact person, billing agent, or management service organization. This should be operational and answered by the provider. Cell phones are typically not allowed.
- _____ Section 4A – identify the National provider identifier. _____ Section 4A – if the fax number, e-mail address, CLIA number, or FDA/radiology number is blank, this indicates these fields do not apply to your provider.
- _____ Section 4A – Hospitals and HHAs need to identify the type of location. If blank, this indicates the location is the main location
- _____ Section 4B – Check the appropriate change, add or delete box following the Section 4A instruction. Note the effective date of the change.
- _____ Section 4B – Check the appropriate box indicating if the “special payments” (AKA pay-to) address is the same or different from the practice location in Section 4A.
- _____ Section 4B – Identify the special payments address if different from the practice location or if multiple practice locations are listed. Note that this must be the provider’s address. If it is a P.O. box, it must belong to the provider. For EFT, the provider must have control of the bank account.
- _____ Section 4C – Check the appropriate change, add or delete box following the Section 4A instruction. Note the effective date of the change.
- _____ Section 4C – Identify the patient medical records locations. This must be an actual physical location similar to the practice location as noted above.
- _____ Section 4D – HHAs and mobile or portable providers must complete this section
- _____ Section 4E – Complete this section only if the provider is mobile or portable.
- _____ Section 4F – HHAs must complete this section to identify the geographic location information where health care services will be rendered. Complete the appropriate section based on whether the change is an addition or deletion.
- _____ If this is a branch that is currently certified with an existing Medicare provider and requesting to be certified with another Medicare provider, a CMS-855A terminating the branch from the prior provider must also be submitted. Submit a cover letter with the application identifying the situation and provider number.
- _____ For requests to add provider-based locations, identify the parent provider name and Medicare number if not already on the application. Complete the provider-based attestation statement to receive formal approval for provider-based status. Refer to the Cahaba GBA, LLC Web site at https://www.cahabagba.com/part_a/enroll_update_your_records/enroll_provstatus.htm for further information on this status and the application. Although the attestation process is voluntary, Cahaba GBA, LLC strongly recommends its completion to ensure the clinic receives the appropriate designation.

Managing/Directing Employee Change

- _____ Complete all steps noted under “Changing Existing Medicare Information – Currently Enrolled Providers”. Also complete the following:

- _____ If the change is the result of a stock transfer, change of ownership, acquisition or merger, or consolidation, do not follow these procedures. Follow the appropriate procedures for the action type.
- _____ Section 6A – Check the box to identify if you are adding a new managing/directing employee to your provider, deleting/terminating an existing employee, or changing an existing employee. Also identify the effective date, i.e., mm/dd/yyyy.
- _____ Section 6A, complete the entire section (all fields) for each managing/directing employee being added, including middle names, credentials, and ownership relationships.
- _____ Identify the job title if this person should be listed as the contact in the intermediary’s system.
- _____ Section 6A, complete this section for each managing/directing employee being deleted.
- _____ Section 6B – ensure adverse legal history is completed for each individual.

Authorized/Delegated Official Changes

- _____ Complete all steps noted under “Changing Existing Medicare Information – Currently Enrolled Providers”. Also complete the following:
- _____ Section 6 - Complete the entire section (all fields) for each authorized and delegated official that is being added, if this person is not already established for this provider via a prior approved CMS-855A application. Include middle names, credentials, effective dates, and identify ownership relationships.
- _____ Section 6 - Complete this section for each authorized and delegated official being deleted, unless the person will remain with the provider as a managing employee.
- _____ Section 15 – Check the box to identify if you are adding, deleting, or changing the authorized official and note the effective date. Ensure the person that signs is authorized in accordance with the CMS-855A application instructions.
- _____ Section 15 – Complete first name, middle initial, last name, and suffix. Identify the telephone number. Sign and date. This must be an original. No faxes, stamps, or copies will be accepted. This step applies to the official being added and the one being deleted.
- _____ Section 16 – Check the box to identify if you are adding, deleting, or changing the delegated official and note the effective date.
- _____ Section 16 - Complete first name, middle initial, last name, and suffix. Identify the telephone number. Sign and date. This must be an original. No faxes, stamps, or copies will be accepted. This step applies to the official being added and the one being deleted.
- _____ Section 16 – Check the box if the delegated official is a W-2 employee. Note that this is a requirement for this official. The official cannot be a billing agent or contracted employee. Submit the W-2.
- _____ Section 16 – The authorized official that is assigning this delegation must also sign and date this section. This also must be an original. No faxes, stamps, or copies will be accepted.

Transfer of Stock

- _____ Complete all steps noted under “Changing Existing Medicare Information – Currently Enrolled Providers”. Also complete the following:

- _____ Section 1A – Under “Reason for Application”, note this is a stock transfer.
- _____ Section 5 – Check the box to identify if you are adding, deleting or changing the owning organization and identify the effective date of the change, i.e., mm/dd/yyyy.
- _____ Section 5A - complete this entire section (all fields) for each organization that is being added as a result of the stock transfer.
- _____ Section 5A – complete this section for each organization that is being deleted as a result of the stock transfer.
- _____ Section 5B – ensure adverse legal history is completed for each organization.
- _____ Section 6 – Check the box to identify if you are adding, deleting or changing the owning/controlling individual and identify the effective date of the change, i.e., mm/dd/yyyy.
- _____ Section 6A - complete this entire section (all fields) for each individual that is being added as a result of the stock transfer. Include middle names, credentials, and ownership relationships.
- _____ Section 6A - complete this section for each individual that is being deleted as a result of the stock transfer.
- _____ Section 6B – ensure adverse legal history is completed for each individual.
- _____ If the authorized or delegated officials have changed as a result of the stock transfer, follow the procedures above for this type of change.
- _____ Submit the final stock agreement or other legal document that identifies the transaction that has taken place and is final. Ensure the transaction is complete upon submission since approval cannot be recommended until the transfer has been finalized.
- _____ Submit the signed stock certificates evidencing that the transfer has occurred.

Full CMS-855s (Provider has not submitted an application since implementation of PECOS on July 29, 2002, Voluntary Submission, Reactivation)

If the provider is not in the CMS Provider Enrollment Chain and Ownership System (PECOS), a complete 855 is required, with all required support submitted. If the 855 has not been completed in its entirety and documentation is missing, the application will be returned.

- _____ **Complete all Sections of the CMS-855A** except 2F, 2G, and 2H. Follow the initial enrollment procedures below. The documentation to support HHA capitalization requirements are not required.

Converting a Free-Standing Rural Health Clinic (RHC) to Provider-Based

- _____ Section 1A – Check that you are a new enrollee in Medicare. Add a note in the “Reason for application” box that you converting a freestanding RHC to provider-based. Identify the freestanding Medicare provider number and the parent provider name and Medicare number.
- _____ **Complete all Sections of the CMS-855A** except 2F, 2G and 2H. Follow the initial enrollment procedures below.
- _____ Complete the provider-based attestation statement to receive formal approval for provider-based status. Refer to the Cahaba GBA, LLC Web site at https://www.cahabagba.com/part_a/enroll_update_your_records/enroll_provstatus.htm for further information on this status and the application. Although the attestation process is voluntary, Cahaba GBA, LLC strongly recommends its completion to ensure the clinic receives the appropriate designation.

Initial Enrollment Resulting in Issuance of a Medicare Provider Number

- _____ Section 1A – check that you are a new enrollee in Medicare.
- _____ **Complete all Sections of the CMS-855A** except 2F, 2G and 2H.
- _____ If this is a branch of an existing Medicare provider that is requesting a separate Medicare number, a CMS-855A terminating the branch from the existing provider must also be submitted. Submit a cover letter identifying the situation and provider number.
- _____ For provider-based entities, submit a cover letter identifying the parent provider name and Medicare number. Note that the 855 is processed by the audit intermediary of the parent.
- _____ Section 2A1 – identify the provider type.
- _____ Section 2A2 – If the provider is a hospital, check all applicable subunits.
- _____ Section 2A3 – If the provider is a hospital, answer regarding the compliance plan.
- _____ Section 2B1 – Complete all fields in this section.
 - _____ The legal business name should match IRS documentation.
 - _____ The tax identification number (TIN) should match IRS support.
 - _____ Ensure the type of organization is correctly identified. This most often is a corporation for Medicare Part A.
 - _____ The Medicare year end cost report date should include the month and day.
 - _____ The incorporation date and state where incorporated should be listed. If these fields are left blank, it indicates they do not apply to your provider.
 - _____ The doing business as (DBA) name needs to be listed as the “other name”
- _____ Section 2B2 – If the state license has been issued, identify the noted information. Note that the applicant should contact the state agency in advance of submitting the CMS-855A application. If the state license is required, this needs to be submitted with the application in order for it to be processed. In some states, a certificate of need (CON) is required. If the CON is not received prior to the 855 submission, this could result in denial of the application.
- _____ Section 2C - identify the complete mailing address where correspondence should be sent. This should be the applicant’s address and telephone number, not the billing agency, management service organization, chain home office, or provider’s representative. No cell phones or personal phone numbers are allowed.
- _____ Section 2D - note whether accredited. If yes, complete information.
- _____ Section 3 – identify whether the organization, under any current or former name or business entity, has ever had an adverse action. Refer to P. 13 of the 855 instructions for a listing of actions that must be reported. If actions exist, complete 3.2 and attach a copy of the adverse legal action documentation(s) and resolution(s).
- _____ Section 4A – complete all fields to identify the practice location information. This must be an actual physical address where services are rendered. The address is as designated by the U.S. Postal Service, including street number and name, no P.O. or drop boxes, rural routes or highways are allowed.
- _____ Section 4A - the phone number must be the applicant’s, not that of the contact person, billing agent, or management service organization. This should be operational and answered by the provider. Cell phones are typically not allowed.

- _____ Section 4A – identify the National provider identifier. _____ Section 4A – if the fax number, e-mail address, CLIA number, or FDA/radiology number is blank, this indicates these fields do not apply to your provider.
- _____ Section 4A – Hospitals and HHAs need to identify the type of location. If blank, this indicates the location is the main location
- _____ Section 4B – Check the appropriate box indicating if the “special payments” (AKA pay-to) address is the same or different from the practice location in Section 4A.
- _____ Section 4B – Identify the special payments address if different from the practice location or if multiple practice locations are listed. Note that this must be the provider’s address. If it is a P.O. box, it must belong to the provider. For EFT, the provider must have control of the bank account.
- _____ Section 4C – Identify the patient medical records locations. This must be an actual physical location similar to the practice location as noted above.
- _____ Section 4D – HHAs and mobile or portable providers must complete this section
- _____ Section 4E – Complete this section only if the provider is mobile or portable.
- _____ Section 4F – HHAs must complete this section to identify the geographic location information where health care services will be rendered.
- _____ Section 5 - complete the entire section (all fields) for each organization that has an ownership interest and/or managing control.
- _____ For unique or complex organizational structures, it is recommended that an organizational chart and/or explanation of the structure be submitted.
- _____ Section 5 – complete for the home office listed in Section 7.
- _____ Section 5B – ensure adverse legal history is completed for each organization.
- _____ If nonprofit, include the Board of Trustees or governing body in Section 5.
- _____ Submit the 501(c)(3) to support this status.
- _____ If Federal, State, county, city or other level of government, or an Indian tribe, will be legally and financially responsible for Medicare payments received, include an attestation signed by the authorized official as noted in the 855A instructions.
- _____ Section 6 - complete the entire section (all fields) for each individual that has an ownership interest and/or managing control. Include middle names and credentials and identify all relationships. This includes:
 - all persons with a 5 percent or greater direct or indirect ownership interest in the provider,
 - for corporations (whether for-profit or non-profit), all officers and directors
 - all managing employees of the providers
 - all individuals with a partnership interest in the provider, regardless of the percentage of ownership
 - all authorized and delegated officials
 - the home office administrator listed in Section 7.
- _____ Section 6B – ensure adverse legal history is completed for each individual.
- _____ Section 7 - complete Sections 7A through 7E (all fields) if the provider will be part of a chain home office.
- _____ Section 8 - complete all fields if the applicant contracts with a billing agency (either a company or individual) that will process and submit the claims. Please note that if a billing agency is used, you are responsible for the claims submitted on your behalf.

- _____ Section 8 - Submit the current signed billing agreement.
- _____ Section 12A – HHA providers only complete this section noting whether non-profit or for profit.
- _____ Section 12A - Identify the projected **total number of visits for all payor types** for the first 3 months and the first 12 months of operation. A capitalization amount cannot be computed without this information.
- _____ Section 12A - Submit bank statements, attestations, and other required documentation. Refer to “HHA Capitalization Requirements” for further detail.
- _____ Section 12B - check the box indicating if the HHA contracts with a nursing registry. Furnish all information on the nursing registry if applicable.
- _____ Section 13 - note contact(s) who are available to answer application questions. Identify their job titles. If managing/directing employees, include in Section 6.
- _____ Section 15 - The authorized official should review the certification statement. Complete **all** fields, sign and date. Submit the original statement. No faxes, copies, or stamps are accepted.
- _____ Section 16 - The delegated official(s) should review the certification statement. Complete **all** fields, sign and date. This official must be a W-2 employee, check the box and submit support. The authorized official must also sign and date. Submit the original statement. No faxes, copies, or stamps are accepted.
- _____ Section 17 - Submit the required license(s), refer to 2B2 above.
- _____ Section 17 - Submit the written confirmation from the IRS confirming your tax identification number with legal business name (e.g., IRS CP 575)
- _____ Section 17 - Submit the Form CMS-588 Authorization Agreement for Electronic Funds Transfer (EFT), and the required support listed on the form. EFT is mandatory. Note that the signature on the 588 must match the signature in Section 15 of the 855A.
- _____ Section 17 - Submit a copy of the delegated official’s W-2 if you have designated one in Section 16.
- _____ Section 17 – If Medicare payment due a provider of services is being sent to a bank (or similar financial institution) where the provider has a lending relationship (that is, any type of loan), then the provider must provide a statement in writing from the bank (which must be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.
- _____ Submit a cover letter for any necessary clarifications or unique situations.
- _____ Refer to the CMS 855A instructions for additional guidance.

Home Health Agency (HHA) Capitalization Requirements

[(Applies to HHA providers enrolling in the Medicare program for the first time or receiving a new Medicare provider number (e.g., conversion from branch to subunit)]

General capitalization requirements include:

- At least half (50 percent) of the funds must be the HHA’s own funds and not borrowed. The rest may be borrowed, including a secure line of credit or other lending source that are **unrelated** to the applicant. Credit cards are not acceptable.
- Acceptable funds include savings, checking, or other account(s) that contain the funds, cash and/or cash equivalents, i.e., short-term, highly liquid investments that are readily convertible to known amounts cash in the first three months of operation and present insignificant risk of changing in value (treasury bills, commercial paper, money market funds). Retirement accounts, including Roth IRAs, 529s, mutual funds, etc. are not considered a cash equivalent.

- In addition to the following checklist, see the 855A application instructions and the January 5, 1998, Federal Register, for further assistance.

Submit bank statements that demonstrate the HHA meets the capital requirement:

Current copies of bank, or other financial institution, statements containing the funds. At a minimum, this must show the HHA's name, address, account number and ending balance. Deposit slips and sweep accounts are not acceptable. If in the owner's name and it's a joint account, both spouses must be in Section 6 of the 855. If in a chain or parent's name, see below.

_____ Bank print offs are acceptable only if on bank letterhead or with a bank stamp. In either case, the print off must be signed and dated by an authorized bank representative.

_____ Borrowed funds, such as a **secure** line of credit, should be supported in the same manner as non-borrowed funds. If the borrowed funds are not in the same account(s) as the provider's own funds, the HHA needs to provide proof that the borrowed funds are available for use in operating the HHA by providing the following:

A copy of the statement(s) of the account(s) containing the borrowed funds. For a line of credit, this is in the form of a signed agreement between the HHA and financial institution, AKA a letter of credit. This should show the approved credit amount that is being borrowed and the amount available to borrow, net of any withdrawals. Credit cards are not acceptable.

Borrowed funds with a related lender are not acceptable. Related is defined as someone who has control or ownership, or a personal relationship to the borrowing organization. Funds from a person or entity that meets this definition do not qualify to meet the initial reserve operating funds requirement.

Additional Documentation for Chain Organizations and/or Provider-Based Facilities

_____ Funds of chain organizations or provider-based facilities are acceptable. However the HHA must submit an attestation statement or board approval on the parent or chain's letterhead, that specifically designates the funds for use by the HHA. This should identify the HHA name and location (i.e., practice location street address, city, state) and be signed by a board member or official designating the funds **and** if different, the authorized official. Both of these persons must be listed in Section 6 of the application. If the chain or parent uses the same checking account for all initial enrollment requests, the amount must be enough to cover the capital requirement for all facilities requesting approval that have not yet received certification.

Include an attestation statement from the financial institution(s):

_____ An officer of the bank or other financial institution, on bank letterhead, must certify/attest that the funds are in the account(s) and are immediately available for use. This should include the fund account balance and account number for each statement that is being used. This is required for borrowed and non-borrowed funds and should be submitted from each financial institution in which funds are being used to support capital. For borrowed funds, the institution

should note the actual amount available to borrow as of the date of the attestation, this amount should be any borrowings already made against the credit. The statement with the original signature should be submitted.

Include an attestation statement from the HHA:

_____ The HHAs authorized official must certify/attest on letterhead as to the portion of the required initial reserve operating funds that constitutes non-borrowed funds, this must be at least 50 percent of the total required funds. If true, the HHA should state that at least half the funds are the HHAs own funds and not borrowed. If funds are in the owner’s name rather than the HHA name, the official must also attest that the funds are specifically for use by the HHA.

Voluntary Termination

- _____ Section 1A – Check that you are voluntarily terminating your Medicare enrollment.
- _____ Section 1A – Under billing number information, identify the effective date of termination, Medicare identification number that is terminating, and National Provider Identifier (NPI) (if issued).
- _____ Section 1B - This section is only applicable if the provider is changing enrollment information in addition to requesting voluntary termination. Check all boxes that apply to the type of change that is being requested. For each box checked, refer to the corresponding “Required Sections” column for the specific sections that must be completed.
- _____ Section 2B1 – Identify the legal business name and tax identification number as reported to the IRS.
- _____ Section 6 – Complete the entire section (all fields) for the official in Section 15 or 16 if not included in a prior approved 855 application.
- _____ Section 13 – Identify the contact who is available to answer application questions
- _____ Section 15 (authorized official) or Section 16 (delegated official) – sign and date the 855. The signature must be an original, no faxes, stamps, or copies are accepted.
- _____ Submit a cover letter identifying any necessary clarifications or unique situations involved with this termination.

Changes of Ownership (CHOW)

A change of ownership typically occurs when a Medicare provider has been purchased (or leased) by another organization. The CHOW results in the transfer of the old owner’s identification number and provider agreement (including any Medicare outstanding debt of the old owner) to the new owner. The regulatory citation for CHOWs can be found at 42 CFR 489.18. If the purchaser (or lessee) elects not to accept a transfer of the provider agreement, then the old agreement should be terminated and the purchaser or lessee is considered a new applicant. **Separate CMS-855As need to be completed and submitted by the old and the new owner.** If the provider has provider-based facilities or subunits with separate Medicare agreements (e.g., rural health clinic, skilled nursing facility), a separate CMS-855A for the old and new owner is needed for each facility or subunit as well.

- CHOW - Old (Selling) Owner (transferor) – provider that is being purchased by another
- _____ Section 1A – Check the box indicating that there has been a CHOW of the Medicare-enrolled provider. Also check that you are the seller/former owner.
 - _____ Section 1A – Under billing number information, note the Medicare identification number, National Provider Identifier (NPI) (if issued), and the tax identification number of the old owner.
 - _____ Section 2F – Complete all fields identifying information on the old owner. Mark yes or no on the question asking if the new owner will be accepting assignment of the current “Provider Agreement”.
 - _____ Section 6 – Complete the entire section (all fields) for the official in Section 15 or 16 if not included in a prior approved 855 application.
 - _____ Section 13 – Identify the contact who is available to answer application questions
 - _____ Section 15 (authorized official) or Section 16 (delegated official) – sign and date the 855. The signature must be an original, no faxes, stamps, or copies are accepted.
 - _____ Section 17 - Submit a copy of the final sales agreement and a copy of the bill of sale. If this has not yet taken place, submit the interim documents. Note that the Contractor cannot recommend approval on the CHOW until the sale has been executed.
 - _____ Submit a cover letter identifying any necessary clarifications or unique situations involved with this termination.

- CHOW - New Owner (purchasing owner) – applicant that is purchasing another provider
- _____ Section 1A – Check the box indicating that there has been a CHOW of the Medicare-enrolled provider. Also check that you are the buyer/new owner.
 - _____ Section 1A – Under billing number information, note the Medicare identification number, National Provider Identifier (NPI), and the tax identification number of the new owner.
 - _____ If this request changes the facility from free-standing to provider-based, or vice versa, note this in a cover letter. For provider-based entities, also identify the parent provider name and Medicare number. Note that the 855 is processed by the audit intermediary of the parent.
 - _____ **Complete all Sections of the CMS-855A** except 2G and 2H.
 - _____ Section 2F – Complete all fields identifying information on the new owner. Mark yes or no on the question asking if the new owner will be accepting assignment of the current “Provider Agreement”.
 - _____ Section 2A1 – identify the provider type.
 - _____ Section 2A2 – If the provider is a hospital, check all applicable subunits.
 - _____ Section 2A3 – If the provider is a hospital, answer regarding the compliance plan.
 - _____ Section 2B1 – Complete all fields in this section.
 - _____ The legal business name should match IRS documentation.
 - _____ The tax identification number (TIN) should match IRS support.
 - _____ Ensure the type of organization is correctly identified. This most often is a corporation for Medicare Part A.
 - _____ The Medicare year end cost report date should include the month and day.
 - _____ The incorporation date and state where incorporated should be listed. If these fields are left blank, it indicates they do not apply to your provider.
 - _____ The doing business as (DBA) name needs to be listed as the “other name”

- _____ Section 2B2 – If the state license has been issued, identify the noted information. Note that the applicant should contact the state agency in advance of submitting the CMS-855A application. If the state license is required, this needs to be submitted with the application in order for it to be processed. In some states, a certificate of need (CON) is required. If the CON is not received prior to the 855 submission, this could result in denial of the application.
- _____ Section 2C - identify the complete mailing address where correspondence should be sent. This should be the applicant’s address and telephone number, not the billing agency, management service organization, chain home office, or provider’s representative. No cell phones or personal phone numbers are allowed.
- _____ Section 2D - note whether accredited. If yes, complete information.
- _____ Section 3 – identify whether the organization, under any current or former name or business entity, has ever had an adverse action. Refer to P. 13 of the 855 instructions for a listing of actions that must be reported. If actions exist, complete 3.2 and attach a copy of the adverse legal action documentation(s) and resolution(s).
- _____ Section 4A – complete all fields to identify the practice location information. Ensure all practice locations are included. This must be an actual physical address where services are rendered. The address is as designated by the U.S. Postal Service, including street number and name, no P.O. or drop boxes, rural routes or highways are allowed.
- _____ Section 4A - the phone number must be the applicant’s, not that of the contact person, billing agent, or management service organization. This should be operational and answered by the provider. Cell phones are typically not allowed.
- _____ Section 4A – identify the National provider identifier. Submit documentation.
- _____ Section 4A – if the fax number, e-mail address, CLIA number, or FDA/radiology number is blank, this indicates these fields do not apply to your provider.
- _____ Section 4A – Hospitals and HHAs need to identify the type of location. If blank, this indicates the location is the main location
- _____ Section 4B – Check the appropriate box indicating if the “special payments” (AKA pay-to) address is the same or different from the practice location in Section 4A.
- _____ Section 4B – Identify the special payments address if different from the practice Location or if multiple practice locations are listed. Note that this must be the provider’s address. If it is a P.O. box, it must belong to the provider. For EFT, the provider must have control of the bank account.
- _____ Section 4C – Identify the patient medical records locations. This must be an actual physical location similar to the practice location as noted above.
- _____ Section 4D – HHAs and mobile or portable providers must complete this section
- _____ Section 4E – Complete this section only if the provider is mobile or portable.
- _____ Section 4F – HHAs must complete this section to identify the geographic location information where health care services will be rendered.
- _____ Section 5 - complete the entire section (all fields) for each organization that has an ownership interest and/or managing control.
- _____ For unique or complex organizational structures, it is recommended that an organizational chart and/or explanation of the structure be submitted.
- _____ Section 5 – complete for the home office listed in Section 7.
- _____ Section 5B – ensure adverse legal history is completed for each organization.
- _____ If nonprofit, include the Board of Trustees or governing body in Section 5. Submit the 501(c)(3) to support this status.

- _____ If Federal, State, county, city or other level of government, or an Indian tribe, will be legally and financially responsible for Medicare payments received, include an attestation signed by the authorized official as noted in the 855A instructions.
- _____ Section 6 - complete the entire section (all fields) for each individual that has an ownership interest and/or managing control. Include middle names and credentials and identify all relationships. This includes:
 - all persons with a 5 percent or greater direct or indirect ownership interest in the provider,
 - for corporations (whether for-profit or non-profit), all officers and directors
 - all managing employees of the providers
 - all individuals with a partnership interest in the provider, regardless of the percentage of ownership
 - all authorized and delegated officials
 - the home office administrator listed in Section 7.
- _____ Identify the job title for the person that should be listed as contact in the Contractor's system, for the issuance of correspondence.
- _____ Section 6B – ensure adverse legal history is completed for each individual.
- _____ Section 7 - complete Sections 7A through 7E (all fields) if the provider will be part of a chain home office.
- _____ Section 8 - complete all fields if the applicant contracts with a billing agency (either a company or individual) that will process and submit the claims. Please note that if a billing agency is used, you are responsible for the claims submitted on your behalf.
- _____ Section 8 - Submit the current signed billing agreement.
- _____ Section 12A – HHA providers only - complete the portion of the section to note whether non-profit or for profit.
- _____ Section 12B - check the box indicating if the HHA contracts with a nursing registry. Furnish all information on the nursing registry if applicable._____
- _____ Section 13 - note contact(s) who are available to answer application questions. Identify their job titles. If managing/directing employees, include in Section 6.
- _____ Section 15 - The authorized official should review the certification statement. Complete **all** fields, sign and date. Submit the original statement. No faxes, copies, or stamps are accepted.
- _____ Section 16 - The delegated official(s) should review the certification statement. Complete **all** fields, sign and date. This official must be a W-2 employee, check the box and submit support. The authorized official must also sign and date. Submit the original statement. No faxes, copies, or stamps are accepted.
- _____ Section 17 - Submit the required license(s), refer to 2B2 above.
- _____ Section 17 - Submit the written confirmation from the IRS confirming your tax identification number with legal business name (e.g., IRS CP 575)
- _____ Section 17 - Submit the Form CMS-588 Authorization Agreement for Electronic Funds Transfer (EFT), and the required support listed on the form. EFT is mandatory. Note that the signature on the 588 must match the signature in Section 15 of the 855A.
- _____ Section 17 - Submit a copy of the final sales agreement and a copy of the bill of sale. If this has not yet taken place, submit the interim documents. If the CHOW is the result of an incorporation, also submit the articles of incorporation. Note that the Contractor cannot recommend approval on the CHOW until the sale has been executed.

- _____ Section 17 - Submit a copy of the delegated official's W-2 if you have designated one in Section 16.
- _____ Section 17 – If Medicare payment due a provider of services is being sent to a bank (or similar financial institution) where the provider has a lending relationship (that is, any type of loan), then the provider must provide a statement in writing from the bank (which must be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.
- _____ Submit a cover letter for any necessary clarifications or unique situations.
- _____ Refer to the CMS 855A instructions for additional guidance.

Acquisitions/Mergers

An acquisition/merger occurs when a currently enrolled Medicare provider is purchasing or has been purchased by another enrolled provider. Only the purchaser's provider number and tax identification number remains. Acquisitions/mergers are different from CHOWs in that the seller/former owner's provider number dissolves. In a CHOW, the seller/former owner's provider number typically remains intact and is transferred to the new owner. **Separate CMS-855As need to be completed and submitted by the old and the new owner.** If the provider has provider-based facilities or subunits with separate Medicare agreements (e.g., rural health clinic, skilled nursing facility), a separate CMS-855A for the old and new owner is needed for each facility or subunit as well.

Acquisition/Merger - Old Owner (Acquired Provider) – provider that is being acquired and will no longer retain its current Medicare provider number as a result of the acquisition.

- _____ Section 1A – Check the box indicating that the organization has taken part in an acquisition or merger. Also check that you are the seller/former owner.
- _____ Section 1A – Under billing number information, note the Medicare identification number, National Provider Identifier (NPI) (if issued), and the tax identification number of the old owner.
- _____ Section 2G – Identify the effective date of the acquisition.
- _____ Section 2G1 - Complete all fields identifying information on the provider being acquired.
- _____ Section 2G2 – Complete all fields identifying information on the organization that is acquiring the provider.
- _____ Section 6 – Complete the entire section (all fields) for the official in Section 15 or 16 if not included in a prior approved 855 application.
- _____ Section 13 – Identify the contact who is available to answer application questions
- _____ Section 15 (authorized official) or Section 16 (delegated official) – sign and date the 855. The signature must be an original, no faxes, stamps, or copies are accepted.
- _____ Section 17 - Submit a copy of the final sales agreement and a copy of the bill of sale. If this has not yet taken place, submit the interim documents. Note that the Contractor cannot recommend approval on the CHOW until the sale has been executed.
- _____ Submit a cover letter identifying any necessary clarifications or unique situations involved with this termination.

Acquisition/Merger - New owner (Acquiring Provider) – the organization acquiring the provider as a result of the acquisition.

- _____ Section 1A – Check the box indicating that the organization has taken part in an acquisition or merger. Also check that you are the buyer/new owner.
- _____ Section 1A – Under billing number information, note the Medicare identification number, National Provider Identifier (NPI), and the tax identification number of the new owner.
- _____ Section 1B - This section is only applicable if the provider is changing additional enrollment information as a result of the acquisition/merger. Check all boxes that apply to the type of change that is being requested. For each box checked, refer to the corresponding “Required Sections” column for the specific sections that must be completed.
- _____ Section 2G – Identify the effective date of the acquisition.
- _____ Section 2G1 - Complete all fields identifying information on the provider being acquired.
- _____ Section 2G2 – Complete all fields identifying information on the organization that is acquiring the provider.
- _____ Section 2G – Complete all fields identifying information on the new owner. Mark yes or no on the question asking if the new owner will be accepting assignment of the current “Provider Agreement”.
- _____ Section 4A – complete all fields to identify the practice location information. Ensure all practice locations are included. This must be an actual physical address where services are rendered. The address is as designated by the U.S. Postal Service, including street number and name, no P.O. or drop boxes, rural routes or highways are allowed.
- _____ Section 4A - the phone number must be the applicant’s, not that of the contact person, billing agent, or management service organization. This should be operational and answered by the provider. Cell phones are typically not allowed.
- _____ Section 4A – identify the National provider identifier. Submit documentation.
- _____ Section 4A – if the fax number, e-mail address, CLIA number, or FDA/radiology number is blank, this indicates these fields do not apply to your provider.
- _____ Section 4A – Hospitals and HHAs need to identify the type of location. If blank, this indicates the location is the main location
- _____ Section 4B – Check the appropriate box indicating if the “special payments” (AKA pay-to) address is the same or different from the practice location in Section 4A.
- _____ Section 4B – Identify the special payments address if different from the practice location or if multiple practice locations are listed. Note that this must be the provider’s address. If it is a P.O. box, it must belong to the provider. For EFT, the provider must have control of the bank account.
- _____ Section 4C – Identify the patient medical records locations. This must be an actual physical location similar to the practice location as noted above.
- _____ Section 4D – HHAs and mobile or portable providers must complete this section
- _____ Section 4E – Complete this section only if the provider is mobile or portable.
- _____ Section 4F – HHAs must complete this section to identify the geographic location information where health care services will be rendered.
- _____ Section 6 – Complete the entire section (all fields) for the official in Section 15 or 16 if not included in a prior approved 855 application.

- _____ Section 13 - note contact(s) who are available to answer application questions.
- _____ Section 15 - The authorized official should review the certification statement. Complete **all** fields, sign and date. Submit the original statement. No faxes, copies, or stamps are accepted.
- _____ Section 16 - The delegated official(s) should review the certification statement. Complete **all** fields, sign and date. This official must be a W-2 employee, check the box and submit support. The authorized official must also sign and date. Submit the original statement. No faxes, copies, or stamps are accepted.
- _____ Section 17 - Submit the Form CMS-588 Authorization Agreement for Electronic Funds Transfer (EFT), if your provider is not currently on EFT, and the required support listed on the form. EFT is mandatory. Note that the signature on the 588 must match the signature in Section 15 of the 855A.
- _____ Section 17 - Submit a copy of the final sales agreement and a copy of the bill of sale. If this has not yet taken place, submit the interim documents. Note that the Contractor cannot recommend approval on the transaction until the sale has been executed.
- _____ Section 17 - Submit a copy of the delegated official's W-2 if you have designated one in Section 16.
- _____ Section 17 – If Medicare payment due a provider of services is being sent to a bank (or similar financial institution) where the provider has a lending relationship (that is, any type of loan), then the provider must provide a statement in writing from the bank (which must be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.
- _____ Submit a cover letter for any necessary clarifications or unique situations.
- _____ Refer to the CMS 855A instructions for additional guidance.

Consolidations

A consolidation occurs two or more enrolled Medicare providers consolidate to form a new business entity. The tax identification numbers (TINs) and provider numbers of the consolidating entities dissolve and a new TIN and provider number are assigned to the new, consolidated entity. **Separate CMS-855As need to be completed and submitted by the old and the new owner.** If the provider has provider-based facilities or subunits with separate Medicare agreements (e.g., rural health clinic, skilled nursing facility), a separate CMS-855A for the old and new owner is needed for each facility or subunit as well.

Consolidation - Old Owner (Consolidating Provider) – provider that as a result of the consolidation, will no longer retain its current Medicare provider number

- _____ Section 1A – Check the box indicating that your organization has consolidated with another organization. Also, check that you are the former organization.
- _____ Section 1A – Under billing number information, note the Medicare identification number, National Provider Identifier (NPI) (if issued), and the tax identification number of the old owner.
- _____ Section 2H – Complete all fields in 2H1 identifying information on the first consolidating provider, all fields in 2H2 identifying information on the second consolidating provider, and all fields in 2H3 identifying information on the newly created provider.

- _____ Section 6 – Complete the entire section (all fields) for the official in Section 15 or 16 if not included in a prior approved 855 application.
- _____ Section 13 – Identify the contact who is available to answer application questions
- _____ Section 15 (authorized official) or Section 16 (delegated official) – sign and date the 855. The signature must be an original, no faxes, stamps, or copies are accepted.
- _____ Section 17 - Submit a copy of the final sales agreement and a copy of the bill of sale. If this has not yet taken place, submit the interim documents. Note that the Contractor cannot recommend approval on the CHOW until the sale has been executed.
- _____ Submit a cover letter identifying any necessary clarifications or unique situations involved with this termination.

Consolidation - New Owner (Newly Created Provider) – this is the newly created provider resulting from the consolidation.

- _____ Section 1A – Check the box indicating that your organization has consolidated with another organization. Also, check that you are the new organization.
- _____ Section 1A – Under billing number information, note the Medicare identification number, National Provider Identifier (NPI), and the tax identification number of the new owner.
- _____ **Complete all Sections of the CMS-855A** except 2F and 2G.
- _____ Section 2A1 – identify the provider type.
- _____ Section 2A2 – If the provider is a hospital, check all applicable subunits.
- _____ Section 2A3 – If the provider is a hospital, answer regarding the compliance plan.
- _____ Section 2B1 – Complete all fields in this section.
- _____ The legal business name should match IRS documentation.
- _____ The tax identification number (TIN) should match IRS support.
- _____ Ensure the type of organization is correctly identified. This most often is a corporation for Medicare Part A.
- _____ The Medicare year end cost report date should include the month and day.
- _____ The incorporation date and state where incorporated should be listed. If these fields are left blank, it indicates they do not apply to your provider.
- _____ The doing business as (DBA) name needs to be listed as the “other name”
- _____ Section 2B2 – If the state license has been issued, identify the noted information. Note that the applicant should contact the state agency in advance of submitting the CMS-855A application. If the state license is required, this needs to be submitted with the application in order for it to be processed. In some states, a certificate of need (CON) is required. If the CON is not received prior to the 855 submission, this could result in denial of the application.
- _____ Section 2C - identify the complete mailing address where correspondence should be sent. This should be the applicant’s address and telephone number, not the billing agency, management service organization, chain home office, or provider’s representative. No cell phones or personal phone numbers are allowed.
- _____ Section 2D - note whether accredited. If yes, complete information.
- _____ Section 2H – Complete all fields in 2H1 identifying information on the first consolidating provider, all fields in 2H2 identifying information on the second consolidating provider, and all fields in 2H3 identifying information on the newly created provider. Complete the legal business name and tax identifier for the new provider as reported to the IRS.

- _____ Section 3 – identify whether the organization, under any current or former name or business entity, has ever had an adverse action. Refer to P. 13 of the 855 instructions for a listing of actions that must be reported. If actions exist, complete 3.2 and attach a copy of the adverse legal action documentation(s) and resolution(s).
- _____ Section 4A – complete all fields to identify the practice location information. Ensure all practice locations are included. This must be an actual physical address where services are rendered. The address is as designated by the U.S. Postal Service, including street number and name, no P.O. or drop boxes, rural routes or highways are allowed.
- _____ Section 4A - the phone number must be the applicant’s, not that of the contact person, billing agent, or management service organization. This should be operational and answered by the provider. Cell phones are typically not allowed.
- _____ Section 4A – identify the National provider identifier. Submit documentation.
- _____ Section 4A – if the fax number, e-mail address, CLIA number, or FDA/radiology number is blank, this indicates these fields do not apply to your provider.
- _____ Section 4A – Hospitals and HHAs need to identify the type of location. If blank, this indicates the location is the main location
- _____ Section 4B – Check the appropriate box indicating if the “special payments” (AKA pay-to) address is the same or different from the practice location in Section 4A.
- _____ Section 4B – Identify the special payments address if different from the practice location or if multiple practice locations are listed. Note that this must be the provider’s address. If it is a P.O. box, it must belong to the provider. For EFT, the provider must have control of the bank account.
- _____ Section 4C – Identify the patient medical records locations. This must be an actual physical location similar to the practice location as noted above.
- _____ Section 4D – HHAs and mobile or portable providers must complete this section
- _____ Section 4E – Complete this section only if the provider is mobile or portable.
- _____ Section 4F – HHAs must complete this section to identify the geographic location information where health care services will be rendered.
- _____ Section 5 - complete the entire section (all fields) for each organization that has an ownership interest and/or managing control.
- _____ For unique or complex organizational structures, it is recommended that an organizational chart and/or explanation of the structure be submitted.
- _____ Section 5 – complete for the home office listed in Section 7.
- _____ Section 5B – ensure adverse legal history is completed for each organization.
- _____ If nonprofit, include the Board of Trustees or governing body in Section 5. Submit the 501(c)(3) to support this status.
- _____ If Federal, State, county, city or other level of government, or an Indian tribe, will be legally and financially responsible for Medicare payments received, include an attestation signed by the authorized official as noted in the 855A instructions.
- _____ Section 6 - complete the entire section (all fields) for each individual that has an ownership interest and/or managing control. Include middle names and credentials and identify all relationships. This includes:
 - all persons with a 5 percent or greater direct or indirect ownership interest in the provider,

- for corporations (whether for-profit or non-profit), all officers and directors all managing employees of the providers
 - all individuals with a partnership interest in the provider, regardless of the percentage of ownership
 - all authorized and delegated officials
 - the home office administrator listed in Section 7.
- _____ Section 6B – ensure adverse legal history is completed for each individual.
- _____ Section 7 - complete Sections 7A through 7E (all fields) if the provider will be part of a chain home office.
- _____ Section 8 - complete all fields if the applicant contracts with a billing agency (either a company or individual) that will process and submit the claims. Please note that if a billing agency is used, you are responsible for the claims submitted on your behalf.
- _____ Section 8 - Submit the current signed billing agreement.
- _____ Section 12A – HHA providers only complete this section noting whether non-profit or for profit.
- _____ Section 12A - Identify the projected **total number of visits for all payor types** for the first 3 months and the first 12 months of operation. A capitalization amount cannot be computed without this information.
- _____ Section 12A - Submit bank statements, attestations, and other required documentation. Refer to “HHA Capitalization Requirements” under initial enrollment for further detail. Since a new provider number will be issued, these requirements apply to the agency.
- _____ Section 12B - check the box indicating if the HHA contracts with a nursing registry. Furnish all information on the nursing registry if applicable.
- _____ Section 13 - note contact(s) who are available to answer application questions. Identify their job titles. If managing/directing employees, include in Section 6.
- _____ Section 15 - The authorized official should review the certification statement. Complete **all** fields, sign and date. Submit the original statement. No faxes, copies, or stamps are accepted.
- _____ Section 16 - The delegated official(s) should review the certification statement. Complete **all** fields, sign and date. This official must be a W-2 employee, check the box and submit support. The authorized official must also sign and date. Submit the original statement. No faxes, copies, or stamps are accepted.
- _____ Section 17 - Submit the required license(s), refer to 2B2 above.
- _____ Section 17 - Submit the written confirmation from the IRS confirming your tax identification number with legal business name (e.g., IRS CP 575)
- _____ Section 17 - Submit the Form CMS-588 Authorization Agreement for Electronic Funds Transfer (EFT), and the required support listed on the form. EFT is mandatory. Note that the signature on the 588 must match the signature in Section 15 of the 855A.
- _____ Section 17 - Submit a copy of the final sales agreement and a copy of the bill of sale. If this has not yet taken place, submit the interim documents. If the transaction is the result of an incorporation, also submit the articles of incorporation. Note that the Contractor cannot recommend approval on the transaction until the sale has been executed.
- _____ Section 17 - Submit a copy of the delegated official’s W-2 if you have designated one in Section 16.

- _____ Section 17 – If Medicare payment due a provider of services is being sent to a bank (or similar financial institution) where the provider has a lending relationship (that is, any type of loan), then the provider must provide a statement in writing from the bank (which must be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.
- _____ Submit a cover letter for any necessary clarifications or unique situations.
- _____ Refer to the CMS 855A instructions for additional guidance.