Medicare Enrollment Data Sheet
Group & Entity Enrollment

Section A - Group Information

items in **BOLD are mandatory*

Legal Entity Name | **Tax ID** | **Group NPI**

/ /

Group Specialty *(urgent care, orthopedics, primary care etc.)* | **Date of Incorporation** | **State of Incorporation**

Org. Type: ☐ Corporation (C or S Corp) ☐ LLC ☐ Partnership ☐ Sole Proprietor ☐ Non-Profit

Check One ☐ Other:_____

Entity License # *(if applicable)* | State Issued | Effective Date | Expiration Date

Entity Certification # *(if applicable)* | State Issued | Effective Date | Expiration Date

Correspondence Address | Suite/Unit# | **City** | **State** | **ZIP+4**

( ) - ( ) -

Phone # | Fax # | Email Address

Is this Entity affiliated with a hospital in any way? ☐ **NO** ☐ **YES** *(if yes, please explain)*

Section B – Adverse Action

Has this Entity and/or any of its owners currently or previously been subject to any of the following: ☐ **NO** ☐ **YES**

(if yes, please attach all details and documents and indicate which owner(s) are involved in Section G)

1) Convicted, pled guilty or entered into pre-trial diversion for ANY felony offense in the past 10 years.
2) Convicted, pled guilty or entered into pre-trial diversion for a misdemeanor offense relating to any government healthcare program or involving abuse / neglect of a patient in connection with healthcare services; financial crimes such as embezzlement, fraud, theft or breach of fiduciary duty, relating to the delivery of health care services.
3) Convicted, pled guilty or entered into pre-trial diversion for any offense relating to the manufacture, distribution, prescription or dispensing of controlled substances.
4) Revocation, suspension or surrender pending disciplinary action of a professional health care license.
5) Suspension, exclusion or imposed sanction(s) by any federal or state healthcare program; suspension or revocation of any accreditation.
6) Revocation of any Medicare billing number or any current suspension of Medicare payments under any number.

Section C –Practice Location(s)

(duplicate this page as needed)

1)

Practice Name or d/b/a ***(if different from Legal Name)*** **Group NPI**

Physical Address Unit/Suite # **City** **State** **ZIP+4**

( ) - ( ) - / /

Phone # Fax # Medicare # *(if issued)* **Effective Date of Group**

CLIA # FDA/Radiology Certificate # Office Email Address

2)

Practice Name *(if different from Legal Name)* NPI

Physical Address Unit/Suite # City State ZIP+4

( ) - ( ) - / /

Phone # Fax # Medicare # *(if issued)* **Effective Date of Group**

CLIA # FDA/Radiology Certificate # Office Email Address

3)

Practice Name *(if different from Legal Name)* NPI

Physical Address Unit/Suite # City State ZIP+4

( ) - ( ) - / /

Phone # Fax # Medicare # *(if issued)* **Effective Date of Group**

CLIA # FDA/Radiology Certificate # Office Email Address

Section D –Special Payments

☐ *Check here if it's the same as the first location listed in Section C and skip to Section E*

Special Payment Address	Suite/Unit #	City	State	ZIP+4

Section E –Medical Record Storage

☐ *Check here if it's the same as the first location listed in Section C and skip to Section F*

Primary Storage Address	Suite/Unit #	City	State	ZIP+4

Secondary Storage Address *(if applicable)*	Suite/Unit#	City	State	ZIP+4

Section F –Outside Billing Agency

☐ *Check here if not applicable*

Billing Agency Name	d/b/a *(if applicable)*	Tax ID

( ) - ( ) -

Contact Person Name	**Phone #**	Fax #	Email Address

Section G –Ownership Control

All persons with 5% or greater ownership must be listed in this section along with anyone designated as an "Authorized Official" or "Delegated Official" of the Entity, regardless of ownership status.

First Name	**Middle Init.**	**Last Name**	Suffix (Jr, Sr, MD, etc.)	**Title/Role within Entity**

☐ Male ☐ Female / /

Gender	**Date of Birth**	**State of Birth**	**Country of Birth**

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SSN	**Medicare #** *(if issued)*	**NPI** *(if issued)*	**Date acquired ownership**

Has this owner been subjected to any item in Section B? ☐ **NO** ☐ **YES** *(if yes, please provide all documentation)*

 Duplicate this page as necessary for additional owner(s)/Official(s)

First Name	Middle Init.	Last Name	Suffix (Jr, Sr, MD, etc.)	Title/Role within Entity

☐ Male ☐ Female / /

Gender	Date of Birth	State of Birth	Country of Birth

- -

SSN	Medicare # *(if issued)*	NPI *(if issued)*	Date acquired ownership

Has this owner been subjected to any item in Section B? ☐ **NO** ☐ **YES** *(if yes, please ensure all documentation is provided)*

First Name	Middle Init.	Last Name	Suffix (Jr, Sr, MD, etc.)	Title/Role within Entity

☐ Male ☐ Female / /

Gender	Date of Birth	State of Birth	Country of Birth

- -

SSN	Medicare # *(if issued)*	NPI *(if issued)*	Date acquired ownership

Has this owner been subjected to any item in Section B? ☐ **NO** ☐ **YES** *(if yes, please ensure all documentation is provided)*

First Name	Middle Init.	Last Name	Suffix (Jr, Sr, MD, etc.)	Title/Role within Entity

☐ Male ☐ Female / /

Gender	Date of Birth	State of Birth	Country of Birth

- -

SSN	Medicare # *(if issued)*	NPI *(if issued)*	Date acquired ownership

Has this owner been subjected to any item in Section B? ☐ **NO** ☐ **YES** *(if yes, please ensure all documentation is provided)*

First Name	Middle Init.	Last Name	Suffix (Jr, Sr, MD, etc.)	Title/Role within Entity

☐ Male ☐ Female / /

Gender	Date of Birth	State of Birth	Country of Birth

- -

SSN	Medicare # *(if issued)*	NPI *(if issued)*	Date acquired ownership

Has this owner been subjected to any item in Section B? ☐ **NO** ☐ **YES** *(if yes, please ensure all documentation is provided)*

Section H –Authorized Official(s)

At least one (1) Authorized Official is required

(Must also be listed in Section G)

1) ( ) -

(required) Name **Contact Phone**

2) ( ) -

(optional) Name Contact Phone

Section I –Delegated Official(s)

(Must also be listed in Section G)

1) ( ) -

(optional) Name Contact Phone

2) ( ) -

(optional) Name Contact Phone

Section J – Linked Providers (reassignments)

If you are linking a provider(s) to the group or editing existing providers with a re-enrollment/revalidation, please provide the following information for each provider.

Action *(choose one)*	Provider Full Name	Degree *(MD, DO)*	NPI	SSN	Medicare ID	Effective Date
ADD REMOVE						
ADD REMOVE						
ADD REMOVE						
ADD REMOVE						
ADD REMOVE						
ADD REMOVE						

Supporting Documents

** if a voided check is not available, a letter on bank letterhead indicating the bank's routing number, your account number and the name as it appears on the account is also acceptable. The letter must include the bank officer's name and signature.*

- ☐ Copy of current License *(if applicable)*
- ☐ Copy of current certificate *(if applicable)*
- ☐ Copy of IRS Form CP 575 or 147-C
- ☐ Copy of CLIA Certificate(s) *(if applicable)*
- ☐ Copy of FDA/Radiology Certificate(s) *(if applicable)*
- ☐ Copy of voided check*
- ☐ Copy of SSN Card for **EACH PERSON** listed in this application

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Additional Enrollment Information

- The legal practice name as shown on IRS form CP-575 or 147-C must exactly match the name as it appears in the NPI registry (group) and on the bank account to which Medicare payments are deposited.
- Medicare requires documentation of Federal tax ID (EIN) to be made using form CP 575 or 147-C only. Other documents, regardless of whether they are from the IRS, are not acceptable. Form CP 575 is issued at the time a business first obtains their EIN. If this form is not available, form 147-C can be substituted in its place. To request a form 147-C be mailed or faxed, contact the IRS Business & Specialty Tax Line at (800) 829-4933.
- All names of owners, authorized officials and/or delegated officials MUST be listed as they appear on the person's social security card.
- Medicare applications must be submitted with original ink signatures. When your application(s) are complete, they will be sent to you electronically and will include detailed submission instructions.

IMPORTANT

If you have every been denied participation in Medicare for any reason and/or you have previously submitted an application(s) which was rejected for any reason, please include all copies of all correspondence you received from Medicare as well as a detailed explanation of your situation.

If you have any questions regarding Medicare enrollment, call our offices at (877) 918-9449 *(M-F 8:30a-5:00p EST)*

THANK YOU FOR CHOOSING EXPRESS CREDENTIALING