Medicare Enrollment Data Sheet
Individual Providers

Section A - Provider Information

items in **BOLD are mandatory*

First Name | Middle Initial | **Last Name** | Jr., Sr., M.D., etc.

List Other Name(s) Used (*if applicable*)

☐ Male ☐ Female / /

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

- -

Medical\Professional School | **Year of Graduation** | **SSN**

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

( ) - ( ) -

Individual NPI | **Phone #** | Fax # | Provider Email Address

Primary Specialty | Secondary Specialty(ies) | **Medicare Start Date**

Does Provider have any adverse actions, such as criminal convictions, exclusions, revocations or suspensions relating to Medicare, professional licensure or professional standing? ☐ **NO** ☐ **YES** *(if yes, please attach all details and documents)*

Section B – General Practice Information

Provider above is:

☐ Owns 100% of his/her incorporated practice (S-Corp/LLC) – ***Complete all applicable sections***

☐ Joining an established group and reassigning ALL Medicare benefits – ***Complete section B, skip to section G***

☐ Is in private practice, is not incorporated and will bill Medicare using his/her SSN

Practice Legal Name | **Tax ID** | **NPI**

/ /

Medicare # *(if issued)* | **Date of Incorporation** | **State of Incorporation**

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

Section C –Practice Location(s)

(duplicate this page as needed)

1)

Practice Name *(if different from Legal Name)*

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

( ) -	( ) -			/ /
Phone #	Fax #	NPI	Medicare #	**Effective Date**

CLIA #	FDA/Radiology Certificate #	Office Email Address

2)

Practice Name *(if different from Legal Name)*

Physical Address	Unit/Suite #	City	State	ZIP+4

( ) -	( ) -			/ /
Phone #	Fax #	NPI	Medicare #	Effective Date

CLIA #	FDA/Radiology Certificate #	Office Email Address

3)

Practice Name *(if different from Legal Name)*

Physical Address	Unit/Suite #	City	State	ZIP+4

( ) -	( ) -			/ /
Phone #	Fax #	NPI	Medicare #	Effective Date

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 –Reassignments

For providers reassigning ALL Medicare payments only

1) Name of Group/Organization	Medicare Number	Group NPI
2) Name of Group/Organization	Medicare Number	Group NPI
3) Name of Group/Organization	Medicare Number	Group NPI

Section H –Supporting Documents

- ☐ Copy of current Medical/Professional License
- ☐ Copy of current DEA certificate *(if applicable)*
- ☐ Copy of IRS Form CP 575 or 147-C*
- ☐ Copy of CLIA Certificate *(if applicable)**
- ☐ Copy of FDA/Radiology Certificate *(if applicable)**
- ☐ Copy of voided check*
- ☐ Copy of current certification (ARNP/PA Only)
- ☐ Copy of SSN Card

** 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.*

item not required for providers reassigning all payments to a group(s)

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

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.

THANK YOU FOR CHOOSING EXPRESS CREDENTIALING