

# **Internet-based Provider Enrollment, Chain and Ownership System (PECOS)**

## **Enrollment Example**

# Disclaimer

- The Centers for Medicare & Medicaid Services (CMS) is providing this material as an informational reference for physicians and non-physician practitioners providers. Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of posting, the Medicare program is constantly changing, and it is the responsibility of each provider to remain abreast of the Medicare program requirements. Any regulations, policies and/or guidelines cited in this publication are subject to change without further notice. Current Medicare regulations can be found on the CMS Web site at <http://www.cms.hhs.gov>.
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## Before Getting Started

- Review the Internet-based PECOS “Getting Started Guide for physicians and non-physician practitioners” or “Getting Started Guide for Provider and Supplier Organizations.”
- Since Internet-based PECOS is a scenario-driven process, you will only see the enrollment screens necessary to complete your initial enrollment or your change of information action. The information collected using the Internet-based PECOS enrollment process is the same as the information collected through the paper application submission process.
- The screens following this page are intended to show a typical initial enrollment application for a physician. It takes approximately 20 minutes to complete an enrollment application via Internet-based PECOS.

## Welcome

### Notifications

Welcome to PECOS.

### Manage Medicare and Account Information


#### MY ENROLLMENTS


- Enroll in Medicare for the first time
- View and update existing Medicare information
- Continue working on saved applications

#### ACCOUNT MANAGEMENT

- Update your user account information, request or remove access to organizations
- Manage access to Medicare enrollments

## Help

 [User Account](#)

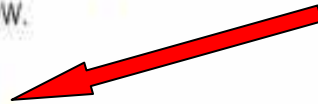
 [Manage Access](#)

## My Enrollments

### New Application

To enroll in the Medicare program for the first time or to create a new enrollment, please click the "New Application" button below.

**NEW APPLICATION** 



### Existing Associates


There are no Associates currently present for the details provided.

## Help

 [Medicare Part A Services](#)

 [Medicare Part B Services](#)

 [Legal Business Name](#)

 [National Provider Identifier \(NPI\)](#)

## Application Questionnaire

(\*) Red asterisk indicates a required field.

### Applicant Description

Please select the description that best matches the provider.\*

Sole Owner of a PA, PC or LLC

The applicant provides practitioner services through an incorporated business of which he/she is the only owner (the practitioner and business are legally distinct).

Self-Employed

The applicant provides healthcare services from a facility that he/she owns/leases/rents (the practitioner and business are legally the same).

Group Member Only

The applicant provides healthcare services only as an employee of another provider.

Group Member and is Self-Employed

The applicant is self-employed and provides healthcare services as an employee of another provider.

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## Help

[+ Sole Owner](#)

[+ Professional Corporation \(PC\)](#)

[+ Professional Association \(PA\)](#)

[+ Limited Liability Company \(LLC\)](#)

## Application Questionnaire

(\*) Red asterisk indicates a required field.

### Applicant Identification Information

First Name\*

John

Last Name\*

Doe

Social Security Number (SSN)\*

123-45-6789

123-45-6789

Date of Birth\*

mm/dd/yyyy

08/25/1962

[← PREVIOUS PAGE](#)

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## Application Questionnaire

(\*) Red asterisk indicates a required field.

State/Territory Where Healthcare Services Rendered

Please select a single state/territory where the applicant renders healthcare services.

State/Territory\*

NEW YORK



PREVIOUS PAGE

NEXT PAGE

CANCEL

## Application Questionnaire

(\*) Red asterisk indicates a required field.

### Primary Medicare Services Rendered

Please select the primary Medicare Services rendered by the applicant.\*

Note: A separate application is required for each primary healthcare service rendered.

#### Part B Physician Specialties\*

Internal Medicine

#### Part B Non-physician Specialties\*

Select Non-Physician Specialty

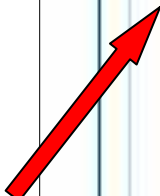
#### Part B Supplier Services\*

Select Supplier Type

#### Part A Provider Services\*

Select Provider Type

#### Undefined Type Specification\*



## Application Questionnaire

(\*) Red asterisk indicates a required field.

### Reassignment of Benefits

Is the applicant employed by a business or individual that will receive the practitioner's Medicare claims payments?\*

Yes

No

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NEXT PAGE 

## Confirm Reason for Application

### Medicare Part B Enrollment

Based on your responses, the following reason for application was identified.

- A Medicare Part B practitioner is enrolling in the Medicare program for the first time using their social security number (SSN). No reassignment of benefits exists with this application.

The application is for:

Name	Social Security Number (SSN)	Practitioner Specialty	State
John Doe	123-45-6789	Internal Medicine	New York

Clicking on the 'Start Application' button will create a Medicare application using the above information.

At the conclusion of this process:

- The application is submitted to the appropriate Medicare fee-for-service contractor(s) for processing
- The practitioner must sign a statement certifying the submitted information
- The certification statement, additional required signatures, and required attachments must be mailed to the identified fee-for-service contractor(s)

### Help

[+ Reassignment](#)

[+ Practitioner Specialty](#)

[+ Fee-for-Service Contractor](#)

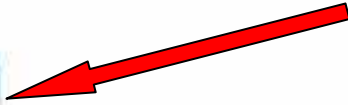
[+ Certification Statement](#)

## Personal Information

### Topic Summary

This topic requests personal and identification information about the applicant. [+ \(more information about Personal Information\)](#)


**ADD INFORMATION** 



### Personal Information

No Personal Information has been listed. Please click "Add Information" above.

## Help

 [Applicant](#)

 [RETURN TO TOPICS](#)

[NEXT TOPIC](#) 

## Personal Information

(\*) Red asterisk indicates a required field.

### Other Name for the Applicant

Does the applicant have any other name to supply?(e.g. former or maiden name, professional name, etc.)\*

Yes

No

Type of Other Name \*

Select Type

Other Type of Name

Other First Name \*

Other Middle Name

Other Last Name \*

Other Name Suffix

Select Suffix

Other Credentials (M.D., D.O., etc.)

## Help

+ [Other Name \(Individual\)](#)

[Home](#) > [My Enrollments](#) > [Initial Enrollment](#) > [Personal Information](#) > ADD

## Personal Information

(\*) Red asterisk indicates a required field.

### Birth Information

Country of Birth\*

United States

SELECT

State of Birth\*

Select State/Territory

PREVIOUS PAGE

NEXT PAGE

## Personal Information



### Medical/Professional School Information

(\*) Red asterisk indicates a required field.

Medical School or other Professional School \*

Select Medical School

Year of Graduation

yyyy

2002

PREVIOUS PAGE

SAVE



## Personal Information

### Topic Summary

This topic requests personal and identification information about the applicant. [+](#) [\(more information about Personal Information\)](#)

### Personal Information

XXXXXXXXXXXXXXXXXXXXXXXXXX

Date of Birth: 08/25/1962  
Social Security Number: 123-45-6789  
Gender: Male  
Drug Enforcement Agency (DEA) Number: XXXXXXXXX  
Country of Birth: United States  
State of Birth: NY  
Medical School or other Professional School:  
Year of Graduation: XXXX

[EDIT](#)



## Help

[+](#) [Applicant](#)

### Topic Summary

The practitioner specialty for this enrollment is listed below for your reference. This topic allows you to identify any secondary specialties for the practitioner. [+ \(more information about Practitioner Specialty\)](#)



#### Practitioner Specialty Information

##### Practitioner Specialties

Practitioner Type: Physician

Primary Physician Specialty  
INTERNAL MEDICINE

##### Secondary Physician Specialties

[ADD](#)

PULMONARY DISEASE

[DELETE](#)

CRITICAL CARE  
(INTENSIVISTS)

[DELETE](#)

#### Practitioner Specialty

[+ Practitioner Type](#)

[+ Primary Physician Specialty](#)

[+ Secondary Physician Specialties](#)

[PREVIOUS TOPIC](#)

[NEXT TOPIC](#)

[Home](#) > [My Enrollments](#) > [Initial Enrollment](#) > [License and Certification Information](#) > ADD

## License and Certification Information

(\*) Red asterisk indicates a required field.

### Type of Information

What type of information would you like to enter? \*

- License Information
- Certification Information



NEXT PAGE 

 CANCEL

## Residency/Fellowship Status

(\*) Red asterisk indicates a required field.

### Topic Summary

The topic requests information about the applicant's residency or fellowship status. [+ \(more information about Residency/Fellow Status\)](#)

Is the applicant currently in an approved training program as either a resident or a fellow?\*

Yes

No

[ADD INFORMATION](#) 

### Residency/Fellowship Status Information

No Residency or Fellowship Status has been listed. Please answer the question above.

### Help

[+ Residency](#)

[+ Fellowship](#)

## PAR Status

### Topic Summary

This topic requests information to determine if the applicant agrees to accept assignment for all covered services provided to Medicare patients. [+ \(more information about PAR Status\)](#)

#### PAR Status Information

Does the applicant agree to accept assignment for all covered services provided to Medicare patients? \*

Yes

No

#### PAR Status Information

No PAR Status Information has been listed. Please select the answer to the above question.

## Help

[+ PAR Status](#)

[+ Fee-for-Service Contractor](#)

## Correspondence Address

### Topic Summary

This topic requests information about the correspondence address for the applicant.

[+ \(more information about Correspondence Address\)](#)

**Note:** Do not use the contact information of a billing agency, staffing company, or managing organization as the contact information.

### Correspondence Address Information

Address: XX XXXXX XXX  
          XXXXX XXXXX xx 12345-6789

United States

Telephone: (XXX) XXX-XXXX

Fax: (XXX) XXX-XXXX

[EDIT](#)

[<< PREVIOUS TOPIC](#)

[NEXT TOPIC >>](#)

## Adverse Legal Actions

(\*) Red asterisk indicates a required field.

### Topic Summary

The topic requests information about adverse legal actions imposed against the applicant. [+](#)  
**(more information about Adverse Legal Actions)**

Has an adverse legal action ever been imposed against an applicant under any current or former name or business entity? \*

- Yes
- No

### Adverse Legal Actions That Must be Reported

#### Convictions

1. Any felony conviction under Federal or State law, regardless of whether it was health care related.
2. Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
5. Any misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

## Help

- [+ Adverse Legal Action](#)
- [+ Revocation](#)
- [+ Federal Non-Procurement Program](#)
- [+ Federal Procurement Program](#)

3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
5. Any misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations or Suspensions

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation or suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any current Medicare payment suspension under any Medicare billing number.

**ADD INFORMATION** 

**Adverse Legal Actions Information**

No adverse legal actions have been listed. Please answer the question above.

 **PREVIOUS TOPIC**

**NEXT TOPIC** 

## Physical Location and "Special Payments" Address

(\*) Red asterisk indicates a required field.

### National Provider Identifier (NPI)

Please provide the National Provider Identifier (NPI) that applies to the individual. If a National Provider Identifier (NPI) has been issued for the individual, it must be identified for this application.

### National Provider Identifier (NPI) \*

0123456789

[NEXT PAGE](#) 

## Help



[National Provider Identifier \(NPI\)](#)

## Physical Location and "Special Payments" Address

(\*) Red asterisk indicates a required field.

### Physical Location Address

Effective Date of Information \*

mm/dd/yyyy

Start Date at Practice Location

Location Name \*

John Doe MD

Address Line 1 \*

10 Oak St.

Address Line 2

City \*

Your Town

State/Territory:\* NY

ZIP Code+4 \*

5555

4444

[PREVIOUS PAGE](#)

[NEXT PAGE](#)

## Address Verification

(\*) Red asterisk indicates a required field.

### Address Verification

The address you have provided did not verify with the United States Postal Service (USPS) database. We have identified a verified, standardized address that corresponds to the address you provided.

Please select the address that you would like to submit: \*

**Verified USPS address:**

- 10 Oak St.  
Your Town, NY 55555 4444

**Address you entered:**

- 10 Oak St.  
Your Town, NY 55555 4444

[PREVIOUS PAGE](#)

[NEXT PAGE](#)

## Physical Location and "Special Payments" Address

(\*) Red asterisk indicates a required field.

### Physical Location Contact Information

**Telephone \***

(555) 555-5555    x Extension

**Fax**

(555) 555-5555

**E-mail Address**

[◀ PREVIOUS PAGE](#)

[NEXT PAGE ▶](#)

## Physical Location and "Special Payments" Address

(\*) Red asterisk indicates a required field.

You must resolve the following error(s) to continue

- The Telephone Number must be in the following format (555) 555-5555. Please re-enter the correct number.
- The Fax Number must be in the following format (555) 555-5555. Please re-enter the correct number.

### Physical Location Contact Information

Telephone \*

(555) 555-5555 x Extension

(123) 321-1234

Fax

(555) 555-5555

E-mail Address

PREVIOUS PAGE

NEXT PAGE

## Physical Location and "Special Payments" Address

### CLIA Numbers



Please provide any CLIA numbers that apply to this physical location.

CLIA Number

[ADD MORE](#) 

Note: Use the Add More button to add more than one CLIA number.

[PREVIOUS PAGE](#) 

[NEXT PAGE](#) 

## Help

- [+ Clinical Laboratory Improvement Amendments \(CLIA\) Number](#)

## Physical Location and "Special Payments" Address

### FDA Numbers



Please provide any FDA/Radiology (Mammography) Certification numbers that apply to this physical location.

FDA/Radiology (Mammography) Certification Number

**ADD MORE** 

**Note:** Use the Add More button to add more than one FDA/Radiology (Mammography) Certification number.

 **PREVIOUS PAGE**

**NEXT PAGE** 

### Help



[FDA/Radiology  
\(Mammography\)](#)

[Certification Number](#)

## Physical Location and "Special Payments" Address

(\*) Red asterisk indicates a required field.

### Practice Location Type

Is this practice location a: \*

-----Select Type----- ▼

-----Select Type-----

Private Practice Office Setting

Hospital

Retirement/Assisted living community

Other health care facility



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NEXT PAGE

### Physical Location and "Special Payments" Address

(\*) Red asterisk indicates a required field.

#### "Special Payments" Address (Domestic)

Country \*

United States

SELECT

Payment Location Name:

Effective Date of Information \*

mm/dd/yyyy

Date You Begin Receiving Payment at this Location

Address Line 1 \*

Address Line 2

City \*

State/Territory \*

----- Select State/Territory -----

ZIP Code+4 \*

PREVIOUS PAGE

SAVE

## Physical Location and "Special Payments" Address

### Topic Summary



This topic requests information about the Physical Location and "Special Payments" Address of the applicant's practice location and/or base of operations. [+ \(more information about Physical Location and "Special Payments" Address\)](#)

**ADD INFORMATION**

### Physical Location and "Special Payments" Address" Information

#### Identification Number(s)

National Provider Identifier(NPI):

**EDIT**

John Doe

Location Type: Practice Location

Physical Address:

10 Oak St  
Your Town, NY 55555 44444

Payment Address:

**EDIT**

**DELETE**

**EDIT**

**DELETE**

CLIA and FDA Certification Number(s):

**ADD**

### Help

[+ "Special Payments" Address](#)

CLIA and FDA Certification Number(s):

[ADD](#)

**NORTHERN WESTCHESTER HOSPITAL**

Location Type: Practice Location

Physical Address:

Payment Address:

[EDIT](#)

[DELETE](#)

[EDIT](#)

[DELETE](#)

CLIA and FDA Certification Number(s):

[ADD](#)

## Rendering Healthcare Services at the Patient's Home

(\*) Red asterisk indicates a required field.

### Topic Summary

This topic requests information about the locations where this applicant renders healthcare services in a patient's home. You may either list your locations individually by the cities or zip codes you service or you may identify the state. [+](#) [\(more information about Rendering Healthcare Services at the Patient's Home\)](#)

Does the applicant render health care services in patient's homes?\*

Yes

No

[ADD INFORMATION](#) 

### Rendering Healthcare Services at the Patient's Home

No locations have been listed. Please answer the question above.

## Individuals with Managing Control

(\*) Red asterisk indicates a required field.

### Topic Summary

This topic requests information about individuals with ownership interest in and/or managing control of the applicant.  
All managing employees for the practice locations listed on this enrollment must be reported.

[+ \(more information about Individuals with Managing Control\)](#)

Does the applicant have any individuals having managing control (managing employees) to report? \*

Yes

No

[ADD INFORMATION >>](#)

### Managing Employees Information

You have indicated that the applicant does not need to report an individual having managing control. Please click the "Next Topic" button or change the answer to the question above.

[<< PREVIOUS TOPIC](#)

[NEXT TOPIC >>](#)

### Help

[+ Limited Partnership](#)

[+ Five Percent \(5%\)  
or More Ownership  
Control](#)

[+ Partner](#)

[+ Managing Control](#)

## Patient Records Storage Location

(\*) Red asterisk indicates a required field.

### Topic Summary

This topic requests information about where patient medical records are stored. [+ \(more information about Record Storage Location\)](#)

Where are the patient's medical records stored (for current and former patients)? \*

At one of the Practice Locations or Base(s) of Operations reported on this enrollment

At a different location

[ADD INFORMATION](#) 

### Patient Records Storage Location Information

No patient records storage locations have been listed. Please answer the question above.

[PREVIOUS TOPIC](#) 

[NEXT TOPIC](#) 

## Help

[+ Practice Location](#)

[+ Base of Operations](#)

[+ Provider](#)

[+ Independent Diagnostic Testing Facilities \(IDTF\)](#)

[+ Mobile Facilities/ Portable Units](#)

## Contact Person

### Topic Summary



The topic requests information about the person or persons that the Medicare contractor should contact if any questions exist about the application. [+](#) [\(more information about Contact Person\)](#)

[ADD INFORMATION](#) 

### Contact Person Information

No contact person has been listed. Please click "Add Information" above.

[PREVIOUS TOPIC](#) 

[RETURN TO TOPICS](#) 

## Contact Person

### Topic Summary



The topic requests information about the person or persons that the Medicare contractor should contact if any questions exist about the application. [+](#) [\(more information about Contact Person\)](#)

[ADD INFORMATION](#)

### Contact Person Information

XXXXXXXXXXXXXXXXXXXX

Address: XXXXXXXXXXXXXXXX  
XXXXXXXXXXXX, NY XXXX-XXXX  
Telephone: (XXX) XXX-XXXX  
Fax: (XXX) XXX-XXXX  
E-mail Address: XXXX@XXX.com

[EDIT](#)

[DELETE](#)

[PREVIOUS TOPIC](#)

[RETURN TO TOPICS](#)

## Topics for this Enrollment

Enrollment ID: XXXXXXXXXXXXXXXX PacID: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

### Reason for Application

- Practitioner is Enrolling in Medicare for the First Time

### Topics








The data required for this enrollment application is grouped into topics. In order to electronically submit this enrollment application, you must complete all of the following topics.

You may view and print this enrollment application at any time during the enrollment process by clicking the View and Print button below.

This application is collecting the following topics:

#### Completed Topics

- ✓ [Personal Information](#)  more information about Personal Information
- ✓ [Practitioner Specialty](#)  more information about Practitioner Specialty
- ✓ [PAR Status Information](#)  more information about PAR Status Information
- ✓ [Physical Location and "Special Payments" Address](#)  more information about Physical Location and "Special Payments" Address
- ✓ [Rendering Healthcare Services at a Patient's Home](#)  more information about Rendering Healthcare Services at a Patient's Home

- ✓ [Practitioner Specialty](#)  more information about Practitioner Specialty

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- ✓ [PAR Status Information](#)  more information about PAR Status Information

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- ✓ [Physical Location and "Special Payments" Address](#)  more information about Physical Location and "Special Payments" Address

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- ✓ [Rendering Healthcare Services at a Patient's Home](#)  more information about Rendering Healthcare Services at a Patient's Home

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- ✓ [Resident/Fellow Status](#)  more information about Resident/Fellow Status

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- ✓ [Correspondence Address](#)  more information about Correspondence Address

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- ✓ [License and Certification Information](#)  more information about License and Certification Information

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- ✓ [Adverse Legal Actions](#)  more information about Adverse Legal Actions

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- ✓ [Individual Control](#)  more information about Individual Control

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- ✓ [Patient Records Storage Location](#)  more information about Patient Records Storage Location

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- ✓ [Billing Agency](#)  more information about Billing Agency

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- ✓ [Contact Person](#)  more information about Contact Person

## Submission Process

### Submission Process Overview



The following steps must be completed to submit this application:

- **Step 1. Error Check:** System checks for data errors or inconsistencies.
- **Step 2. Select Fee-For-Service Contractor:** Additional information is asked to help identify the Medicare Fee-For-Service Contractor who will process this application.
- **Step 3. Select Signatories:** The individuals required to sign this application will be identified.
- **Step 4. Printing and Mailing:** Review and print the forms required for or associated with this application.
- **Step 5. Submit:** Submit the application to electronically route it for processing.
- **Step 6. Print Receipt:** A receipt of the electronic submission is provided.

Click 'Next Page' to begin the Error Check.

[NEXT PAGE](#) >

<< [CANCEL](#)

[Home](#) > [My Enrollments](#) > [Initial Enrollment](#) > Submission Process

## Submission Process: Error Check

No Errors or Warnings Exist



No Errors or Warnings were found for this enrollment application. Please proceed with the submission process.

[NEXT PAGE](#) 

[CANCEL](#) 

## Medicare Fee-for-Service Contractor

(\*) Red asterisk indicates a required field.

### Medicare Fee-For-Service Contractor Selection

Please select a Fee-For-Service Contractor.

The Fee-For-Service Contractor will answer the applicant's questions, process the enrollment application, and pay the applicant's claims.

**Note:** It is recommended that the applicant select the Fee-For-Service Contractor of the Chain Home Office.

Fee-For-Service Contractor\*

NATIONAL GOVERNMENT SERVICES ▼



◀ PREVIOUS PAGE

NEXT PAGE ▶

⏪ CANCEL

## Help

+ [Fee-for-Service Contractor](#)

[Home](#) > [My Enrollments](#) > [Initial Enrollment](#) > Submission Process

## Submission Process

### Signatory for Individual Enrollment

The following individual practitioner must provide a signature:

- **John Doe**

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NEXT PAGE 

 CANCEL





## Submission Process

### Printing and Mailing Instructions


Each document listed below may be saved to your computer and/or printed for your personal records by clicking the "View and Print" link next to each document. Only the Certification / Authorization Statement(s) and the required supporting documentation must be printed and mailed to the Medicare contractor listed below. Please do not mail a copy of this application to the Medicare contractor if you are submitting it electronically.

1. **Print Submission Materials:** Print all required supporting documents. Click on the "View and Print" link next to "List of Supporting Documentation" below for a list of supporting documentation relevant to this application.
2. **Mail Items to Fee-For-Service Medicare Contractor:** The identified Medicare contractor is responsible for processing electronically submitted and mailed materials for this enrollment application. In order to complete the processing of your application, mail the Certification / Authorization Statement(s) and all required supporting documentation to the Medicare contractor listed below within 7 days of your electronic submission. Failure to do so may result in a rejection.



NATIONAL GOVERNMENT SERVICES  
P.O. BOX 4792  
SYRACUSE, NY 13221-4792

Action	Document Name
 <a href="#">View and Print</a>	Certification Statement for Individual Practitioners
 <a href="#">View and Print</a>	List of Supporting Documentation
 <a href="#">View and Print</a>	Copy of this Application (For your records only, please do not mail)
 <a href="#">View and Print</a>	CMS-460 Medicare Participating Physician or Supplier Agreement

NATIONAL GOVERNMENT SERVICES  
P.O. BOX 4792  
SYRACUSE, NY 13221-4792

Action	Document Name
 <a href="#">View and Print</a>	Certification Statement for Individual Practitioners
 <a href="#">View and Print</a>	List of Supporting Documentation
 <a href="#">View and Print</a>	Copy of this Application (For your records only, please do not mail)
 <a href="#">View and Print</a>	CMS-460 Medicare Participating Physician or Supplier Agreement

**Note:**

- For security reasons, Social Security Numbers and the year of birth in Date of Birth fields will not appear on the printed Medicare application. If you plan to mail your printed application to the Medicare contractor instead of submitting it electronically, please review the application and insert the Social Security Numbers and year of birth where they are required but not displayed.
- Documents in PDF format require the  [Adobe Acrobat Reader®](#). If you experience problems with PDF documents, please  [download the latest version of the Reader®](#).

 [PREVIOUS PAGE](#)

[NEXT PAGE](#) 

 [CANCEL](#)

## Supporting Documentation for Individual Practitioners

- Internet-based PECOS will list the supporting documentation that must be submitted with your signed and dated Certification Statement.
- The Medicare contractor may request, at any time during the enrollment process, documentation to support or validate information reported on the enrollment application.

## Submission Process

### Submit Electronically

You are now ready to submit this Medicare Application for processing. Please review the summary below to ensure this is the application and reason you wish to submit. Upon submission, the enrollment information is sent to a fee-for-service contractor for processing. Any corrections to this application must be coordinated through the Medicare contractor.

Applicant Name: **John Doe**

Tracking ID: **111222333444555**

#### Reason(s) for submission:

- A Medicare Part B practitioner is enrolling in the Medicare program for the first time to bill for Part B services. A reassignment of benefits may exist.

[PREVIOUS PAGE](#)

[SUBMIT](#)

## Help

[+ Fee-for-Service Contractor](#)

[+ Tracking ID](#)

## Submission Receipt

### Submission Complete



**You have successfully submitted your enrollment!**

**Remember:**

- You must have all certification statements and other documents requiring a signature signed by the individual displayed on each printed form
- You must mail all signed forms and supporting documentation to your Fee-For-Service contractor. An enrollment application cannot be fully processed until all these items have been received
- You should print this page for your records
- You may print additional copies of an enrollment, certification statement, or list of supporting documentation (these documents can be accessed from the My Enrollments page)

### Enrollment Tracking Information



**Applicant Name:**XXXX XXXXXXXX

**Tracking ID:**XXXXXXXXXXXXXXXXXXXX

**Submitted Date:** XX - JUNE - 2009

**Submitted By:** XXXXXX XXXXXXX

**Contact Email(s):**

XXXXXX@XXX.com

**Enrollment Tracking Information** ←

**Applicant Name:** XXXXX XXXXXXXX

**Tracking ID:** XXXXXXXXXXXXXXXXXXXX

**Submitted Date:** XX - JUNE - 2009

**Submitted By:** XXXXXXX XXXXXXX

**Contact Email(s):**

XXXXXXXX@XXXXXX.com

**Reason(s) for submission:**

- A Medicare Part B practitioner is enrolling in the Medicare program for the first time to bill for Part B services. A reassignment of benefits may exist.

**Medicare Contractor(s)**

**Medicare Contractor(s):**The identified contractors are responsible for processing electronically submitted and mailed materials for this enrollment application. If you have more than one contractor, you will need to submit all certification statements and supporting documentation to each contractor.

NATIONAL GOVERNMENT SERVICES  
P.O. BOX 4792  
SYRACUSE NY 13221-4792 ←

**PRINT** >>

**MY ENROLLMENTS** >>

# Final Step

- Print, sign and date the two-page Certification Statement and mail it along with all requested supporting documentation to the Medicare contractor. Note: you will need to sign the two-page Certification Statement for each application submitted. Thus, if you complete an initial application and a reassignment of benefits, you will need to print, sign, and date two separate Certification Statements.

Note: Do not mail the CMS-855 enrollment application that can be printed from Internet-based PECOS.

Retain this information for your records.