CONE HEALTH®

Please find enclosed applications for Medicare, Medicaid, and our managed care insurance companies. You will find instructions preceding each application section and a list of information we will need to process.

Separate from this DocuSign, we will also be requesting surrogacy access to your CMS account. This will give us access to complete any required Medicare enrollments and/or make any necessary updates to your NPPES/NPI registry. Please be on the lookout for an email from donotreply@cms.gov notifying you of a CMS I&A Connection Request. The link in this email will direct you to the Centers for Medicare and Medicaid Services (CMS) Identity & Access (I&A) System to approve this request.

Please note, if you will need medical staff privileges or membership, you will be or may have already received another privileging/credentialing packet from the Cone Health Medical Staff Services, which is different from the payor enrollment packet I am sending you.

Please refer to the following pages for documents required and any specific formats needed. Return all information as soon as possible via DocuSign. Failure to return a complete application will delay your credentialing/enrollment which may affect your start date.

If you have questions or need assistance, please feel free to email me or call me at 336-663-5227.

Thank you,

Shanon Petty

Shanon Petty, Payor Enrollment Specialist
Cone Health Medical Group
Phone: 336-663-5227
Fax: 336-663-5366
shanon.petty@conehealth.com

Personal Information

Full Name (as listed on your Social Security Card) – Attach a clear copy of your government ID that matches the name listed below. Please make sure that your professional license and DEA (if applicable) match this name exactly. **Upload Government ID**

First Name	
Middle Name	
Last Name	

Maiden or Other Names Used (if applicable)

Type of Previous Name	First Name	Middle Name	Last Name

Have you changed your name in the last 6 months or do you expect to be changing your name in the next 6 months? ◯ Yes ◯ No

If yes, please submit a copy of the legal document relating to the name change (marriage license, etc.) and a copy of your SS card with your new name. Please make sure all licenses, DEA, NPI registry, etc. are updated with your new name.

Social Security Number	
Date of Birth	
Gender Identity	◯ Male ◯ Female ◯
Preferred Pronouns	
Birth City/State/Country	
Languages Spoken	
NPI Number	

Professional IDs

Active Professional License – Upload a copy of each license. If additional uploads are needed, please use one of the miscellaneous attachment fields at the end of the application. **Please make sure that your professional license matches your full name on your application.** **Upload License**

License State	License Number	Issue Date	Expiration Date

DEA Registration Do you have a DEA? ◯ Yes ◯ No

If the address on your DEA is not in NC, please indicate when it will be changed to NC. **Please make sure that your DEA includes your full legal name as listed above, including full middle name.** **Upload DEA**

DEA Number	Issue Date	Expiration Date

Education/Training

Medical/Professional School - Please match your transcript dates as close as possible. You may receive a separate request for transcripts from NC Tracks for Medicaid enrollment.

Institution Name		
City/State		
Degree Earned (abr.)		**Upload Copy of Medical/Professional School Diploma**
Start Date (mm/dd/yyyy)		
End Date (mm/dd/yyyy)		

Do you have an Educational Commission for Foreign Medical Graduates (ECFMG) Number? If yes, please include a copy. ◯ Yes ◯ No

Internship - Did you complete an internship? ◯ Yes ◯ No

If yes, enter internship details below.

Institution Name		
City/State		
Degree Earned (abr.)		**Upload Copy of Internship Certificate of Completion**
Start Date (mm/dd/yyyy)		
End Date (mm/dd/yyyy)		

Residency - Did you complete a residency? ◯ Yes ◯ No

If yes, enter residency details below.

Institution Name		
City/State		
Degree Earned (abr.)		**Upload Copy of Residency Diploma/Certificate of Completion**
Start Date (mm/dd/yyyy)		
End Date (mm/dd/yyyy)		

Fellowship - Did you complete a fellowship? ◯ Yes ◯ No

If yes, enter fellowship details below.

Institution Name		
City/State		
Degree Earned (abr.)		**Upload Copy of Fellowship Diploma/Certificate of Completion**
Start Date (mm/dd/yyyy)		
End Date (mm/dd/yyyy)		

If you completed more than one internship/residency/fellowship, please use the fields below to detail this information.

Type of Education/Training		
Institution Name		
City/State		
Degree Earned (abr.)		**Upload Copy of Diploma/Certificate of Completion**
Start Date (mm/dd/yyyy)		
End Date (mm/dd/yyyy)		

Type of Education/Training		
Institution Name		
City/State		
Degree Earned (abr.)		**Upload Copy of Diploma/Certificate of Completion**
Start Date (mm/dd/yyyy)		
End Date (mm/dd/yyyy)		

Specialties

Please make sure the specialties below are all listed on your NPPES NPI Registry: npiregistry.cms.hhs.gov/. If your NPI registry needs to be updated, please login and update here: nppes.cms.hhs.gov/.

Primary Specialty	
Secondary Specialty	
Additional Specialties	

Are you board certified? ◯ Yes ◯ No **Upload Board Certificate(s)**

If yes, enter board details (Attach copies of each certificate)

	Name of Board	Board Specialty	Date Certified (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)
Primary				
Secondary				
Additional				
Additional				

If you have applied to a specialty board for examination, give the name of board and the date of scheduled examination.

Name of Board	Board Specialty	Date of Scheduled Examination

Work History

Upload CV/Resume

What is your estimated start date with Cone Health? _____

Are you leaving your current place of employment? ◯ Yes ◯ No

If yes, enter your estimated last date at your current employer (or current role if transferring within Cone Health) on the table below. If you are not leaving an employer/role, please use the end date "12/31/9999" on the table below. Including these accurate end dates will ensure we do not end date any companies that will remain active once you start with Cone Health.

List work history not included in your education/training.

Company Name	Job Title	City	State	Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)

Employment Gap

Please attest that you do not have any employment gaps over 60 days above. ◯ I attest there are no gaps in work history dates above.

◯ Yes, there is a gap that is not included in my education/training.

If yes, please explain the gap(s) below.

Gap Explanation	Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)

Disclosure Questions

Please review the following questions carefully and check yes or no for each one. Please complete the attached Supplemental Form for any questions to which you answer "yes".

1.	Has your license to practice in any jurisdiction ever been limited, restricted, reduced, suspended, voluntarily surrendered, revoked, denied or not renewed; have you ever been reprimanded by a state licensing agency; or are any of these actions pending with respect to your license; are you under investigation by any licensing or regulatory agency? (*If yes, please complete Supplemental Question No. 1*.)	**Y** ☐	**N** ☐
2.	Has your professional employment or membership in a professional organization ever been subject to disciplinary proceedings, denied, limited, restricted, reduced, suspended, revoked, not renewed, or voluntarily relinquished during or under threat of termination for any reason? (*If yes, please complete Supplemental Question No.2*.)	**Y** ☐	**N** ☐
3.	Has your Drug Enforcement Agency registration or other controlled substance authorization ever been limited, restricted, reduced, suspended, revoked, denied, not renewed, or have you voluntarily surrendered or limited your registration during or under the threat of an investigation or are any such actions pending? (*If yes, please complete Supplemental Question No.3*.)	**Y** ☐	**N** ☐
4.	Have you ever been sanctioned or suspended by Medicare or Medicaid? (*If yes, please complete Supplemental Question No.4*.)	**Y** ☐	**N** ☐
5.	To your knowledge, have you ever been reported to the National Practitioner Data Bank or the North/South Carolina Board of Medical Examiners? *(If yes, please complete Supplemental Question No.5*.)	**Y** ☐	**N** ☐
6.	Have you ever been convicted of a felony or misdemeanor, or are you under investigation with respect to such conduct? (*If yes, please complete Supplemental Question No.6*.)	**Y** ☐	**N** ☐
7.	Has a professional liability claim been assessed against you in the past five years, or are there any professional liability cases pending against you? (*If yes, please complete Supplemental Question No.7*.)	**Y** ☐	**N** ☐
8.	Has any liability insurance carrier canceled, refused coverage, or rated up because of unusual risk or have any procedures been excluded from your coverage? (*If yes, please complete Supplemental Question No. 8*.)	**Y** ☐	**N** ☐
9.	Have you ever practiced without liability coverage? (*If yes, please complete Supplemental Question No.9*.)	**Y** ☐	**N** ☐
10.	Do you currently have any medical, chemical dependency or psychiatric conditions that might adversely affect your ability to practice medicine or surgery or to perform the essential functions of your position? (*If yes, please complete Supplemental Question No.10*.)	**Y** ☐	**N** ☐
11.	Have your Hospital and/or Clinic privileges ever been limited, restricted, reduced, suspended, revoked, denied, not renewed, or have you voluntarily surrendered or limited your privileges during or under the threat of an investigation or are any such actions pending? (*If yes, please complete Supplemental Question No. 11*).	**Y** ☐	**N** ☐

SUPPLEMENTAL FORM

Provider Name:	***Provider ID#*** *(if applicable)*

1. License Limited, Reprimanded, etc.

List State(s) where action took place:
Date(s) License revoked, suspended, etc. From xx/xx/xxxx To xx/xx/xxxx
Please explain:

2. Employment/Membership Suspended, Limited, etc.

List State(s) where action took place:
List Professional Organization:
Please explain:

3. Drug Enforcement Agency (DEA) Explanation.

List State(s) where action took place:
Please explain:

SUPPLEMENTAL FORM

***Provider Name*:**	***Provider ID#*** *(if applicable)*

4. Medicare/Medicaid Sanction Disciplinary Action(s)

Disciplined Action(s):
List State(s):
Date(s) of action. From xx/xx/xxxx To xx/xx/xxxx
Please explain:

5. National Practitioner Data Bank Report(s)

Please explain the NPDB report (*if you have a copy please attach):*

6. Felony or Misdemeanor

Did you serve a sentence: Y ☐ N ☐ If YES, check how many years: 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ Other:
List State(s):
Please explain charge and verdict:

SUPPLEMENTAL FORM

Provider Name:	***Provider ID#*** *(if applicable)*

7. Named in Professional Liability Judgment, Settlement, etc.

Please explain, include dates & amounts:

8. Cancelled, Refused Coverage, etc.

Please list Insurance Carrier(s):
Please explain:

9. Practiced Without Liability Coverage

Please explain:

SUPPLEMENTAL FORM

Provider Name:	***Provider ID#*** *(if applicable)*

10. Medical, Chemical Dependency, or Psychiatric Conditions

Please explain in detail:

11. Hospital or Clinic Privileges Revoked, Restricted, etc.

List Hospital(s):
Date privileges revoked, suspended, etc. From xx/xx/xxxx To xx/xx/xxxx
Please explain:

ATTESTATION STATEMENT

Please sign the following form at the asterisk leaving all form fields blank in order to be used for multiple payors. This blank form is used in lieu of you signing a form for each of our managed care payors.

Do not date.

Attestation Statement

(IMPORTANT: Submit Original Only)

This application is to be signed by each individual provider submitting an application.

Fill in each space with the name of the Health Plan for which you are applying.

No Stamps or Copies Please

All information submitted by me in this application, as well as any attachments or supplemental information, is true, current, and complete to my best knowledge and belief as of the date of signature below. I fully understand that any significant misstatement in this application may constitute cause for denial of my application or termination of a resulting participation agreement.

By application for membership in _____, I signify my willingness to appear for interview in regard to my application. I authorize _____ to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on the questions in this application. Upon request, I will obtain and provide to _____ materials pertaining to my qualifications and competence, including, materials relating to complaints filed, any disciplinary action, suspension, or action to curtail my medical- surgical privileges. I further consent to the inspection by representatives of _____ of all documents that may be material to an evaluation of my professional qualifications and competence.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications. I release from liability all representatives of _____ for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability, all individuals and organizations that provide information to _____ in good faith and without malice concerning this application and I hereby consent to the release and verification of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to _____.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, _____, may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank. In the event I am accepted for participation in _____, I hereby consent to _____ for inspection of my patient records relating to _____ enrollees as necessary for its peer and utilization review purposes as permitted by state or federal law and regulation I further agree to notify _____ in a timely manner (not to exceed 30 days) of any changes to the information on the initial application.

_____

PRINT NAME OF PROVIDER

*

_____

SIGNATURE OF PROVIDER

_____

DATE

Please Sign and Complete this Application

NC MEDICAID PROVIDER EXCLUSION SANCTION INFORMATION

Please review questions A – K on the following pages carefully. Answering incorrectly will cause your Medicaid enrollment to be terminated.

For each exclusion sanction question answered yes, you must submit a complete copy of the applicable criminal complaint, Consent Order, documentation, and/or final disposition clearly indicating the final resolution in addition to a written explanation of the supporting documentation.

1. A thorough written explanation signed by the subject of the offense if an individual or by the provider's Office Administrator if the subject of the offense is an organization of the occurrence and dated within 6 months of the application date, by the provider's Office Administrator, an owner or managing employee of the occurrence including references to the infraction/conviction date(s) entered and the resolution.

2. All supporting documentation that relates to the incident.

Failure to submit all of the request information may result in the application being deemed incomplete.

Sign and date at the bottom of the fifth page to attest all questions are answered accurately.

Update to Documentation Requirements for Exclusion Sanction Questions

Effective Jan. 29, 2023, requirements for exclusion sanction question documentation will be updated. Currently, when an exclusion sanction question is answered 'yes,' providers must submit a complete copy of the applicable documentation **or** a written explanation of the supporting documentation. **With this update, both will be required**.

Please note the updated requirements below. *If these requirements are not met, an 'application incomplete' letter will be generated, prompting the provider to submit the proper documentation.**

Answering Exclusion Sanction Questions

Exclusion sanction questions will be required upon submission of every new application (manage change requests (MCRs), re-verification and re-enrollment applications).

Failure to disclose documentation related to an affirmative response will result in a denial of the application. Background checks are performed for all applications. If a provider answers affirmatively during their initial enrollment, they must continue to answer affirmatively and disclose all applicable adverse legal actions in subsequently submitted applications.

Documentation Required

Documentation clearly indicating the final resolution must be submitted with every application (initial enrollment, MCR, re-verification and re-enrollment application) regardless of the date last submitted.

Supporting documentation may include but is not limited to:

- Criminal complaint
- Consent Order
- Court documentation
- Final Disposition

Documentation must be provided for **every** exclusion sanction question answered yes; however, the documentation may be applicable to more than one sanction question. Documentation may be uploaded at the same time/as one file.

Written Explanation Signed and Dated by Responsible Party

A thorough written explanation for each question answered affirmatively must be **signed and dated by the responsible party** within six months of the application date.

- For individual applications, the provider must sign and date the explanation
- If the responsible party is an organization, the provider's office administrator must sign and date the explanation

The written explanation must include a reference to the reported adverse legal actions including date and the final resolution.

Date Congruency

All dates must align between the documentation provided and dates reported in the application. This includes the date listed on legal documentation, the written explanation and reported in the Exclusion Sanction section of the application.

During the background check process, all dates will be checked for accuracy. Dates that do not align will delay the application process.

Medicaid Exclusion Sanction Information

Please answer as the applicant.

IMPORTANT: If you answer "Yes" to any sanction question, you must attach supporting documentation that includes an explanation for each question as well as a complete copy of the applicable criminal complaint, consent order, documentation, and/or final disposition clearly indicating the final resolution. Submitting a written explanation in lieu of supporting documentation may result in the denial of this request.

A. Has the applicant, managing employees, owners, or agents ever been convicted of a felony, had adjudication withheld on a felony, pled no contest to a felony, or entered into a pre-trial agreement for a felony? Written Explanation Documentation

- ◯ Yes
- ◯ No

B. Has the applicant, managing employees, owners, or agents ever had disciplinary action taken against any business or professional license held in this or any other state, or has your license to practice ever been restricted, reduced, or revoked in this or any other state or been previously found by a licensing, certifying, or professional standards board or agency to have violated the standards or conditions relating to licensure or certification or the quality of services provided, or entered into a Consent Order issued by a licensing, certifying, or professional standards board or agency? Written Explanation Documentation

- ◯ Yes
- ◯ No

C. Has the applicant, managing employees, owners, or agents ever been denied enrollment, been suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, or any other government or private health care or health insurance program in any state, or been employed by a corporation, business, or professional association that has ever been suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, or any other government or private health care or health insurance program in any state? Written Explanation Documentation

- ◯ Yes
- ◯ No

D. Has the applicant, managing employees, owners, or agents ever had suspended payments from Medicare or Medicaid in any state, or been employed by a corporation, business, or professional association that ever had suspended payments from Medicare or Medicaid in any state? Written Explanation Documentation

- ◯ Yes
- ◯ No

E. Has the applicant, managing employees, owners, or agents ever had civil monetary penalties levied by Medicare, Medicaid, or other State or Federal Agency or Program, including the Division of Health Service Regulation (DHSR), even if the fine(s) have been paid in full? Written Explanation Documentation

- ◯ Yes
- ◯ No

F. Does the applicant, managing employees, owners, or agents owe money to Medicare or Medicaid that has not been paid? Written Explanation Documentation

- ◯ Yes
- ◯ No

G. Has the applicant, managing employees, owners, or agents ever been convicted under federal or state law of a criminal offense related to the neglect or abuse of a patient in connection with the delivery of any health care goods or services? Written Explanation Documentation

- ◯ Yes
- ◯ No

H. Has the applicant, managing employees, owners, or agents ever been convicted under federal or state law of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance? Written Explanation Documentation

- ◯ Yes
- ◯ No

I. Has the applicant, managing employees, owners, or agents ever been convicted of any criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct? Written Explanation Documentation

- ◯ Yes
- ◯ No

J. Has the applicant, managing employees, owners, or agents ever been found to have violated federal or state laws, rules, or regulations governing North Carolina's Medicaid program or any other state's Medicaid program or any other publicly funded federal or state health care or health insurance program and been sanctioned accordingly? Written Explanation Documentation

- ◯ Yes
- ◯ No

K. Has the applicant, managing employees, owners, or agents ever been convicted of an offense against the law other than a minor traffic violation? Written Explanation Documentation

- ◯ Yes
- ◯ No

L. Has the enrolling provider had any liability insurance carrier canceled, refused coverage, or rated up because of unusual risk or have any procedures been excluded from coverage?

Written Explanation Documentation

- ◯ Yes
- ◯ No

M. Has the enrolling provider ever practiced without liability coverage?

Written Explanation Documentation

- ◯ Yes
- ◯ No

N. Does the enrolling provider have any medical, chemical dependency or psychiatric conditions that might adversely affect your ability to practice medicine or surgery or to perform the essential functions of your position? Written Explanation Documentation

- ◯ Yes
- ◯ No

O. Has the enrolling provider's hospital and/or Clinic privileges ever been limited, restricted, reduced, suspended, revoked, denied, not renewed, or have you voluntarily surrendered or limited your privileges during or under the threat of an investigation or are any such actions pending?

Written Explanation Documentation

- ◯ Yes
- ◯ No

P. Has the enrolling provider had a professional liability claim assessed against them in the past five years or are there any professional liability cases pending against them? Written Explanation Documentation

- ◯ Yes
- ◯ No

_____ _____

Signature Date

MEDICARE APPLICATION

SECTION 3: READ AND ANSWER PAGE 10

SECTION 15: REVIEW AND SIGN THE CERTIFICATION STATEMENT.

SECTION 3: FINAL ADVERSE LEGAL ACTIONS

This section captures information regarding final adverse legal actions, such as convictions, exclusions, license revocations and license suspensions. All applicable final adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

NOTE: To satisfy the reporting requirement, section 3 must be filled out in its entirety, **and** all applicable attachments must be included.

A. FEDERAL AND STATE CONVICTIONS (CONVICTION AS DEFINED IN 42 C.F.R. SECTION 1001.2) WITHIN THE PRECEDING 10 YEARS

1. Any federal or state felony conviction(s) by the provider, supplier, or any owner or managing employee of the provider or supplier.
2. Any crime, under Federal or State law, where an individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld, or the criminal conduct has been expunged or otherwise removed, or there is a post-trial motion or appeal pending, or the court has made a finding of guilt or accepted a plea of guilty or nolo contendere.
3. 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.
4. Any misdemeanor conviction, under federal or state law, related to the theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
5. Any misdemeanor conviction, under federal or state law, related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.
6. Any misdemeanor conviction, under federal or state law, related to the interference with or obstruction of any investigation into any criminal offence described in 42 C.F.R. section 1001.101 or 1001.201.

B. EXCLUSIONS, REVOCATIONS OR SUSPENSIONS

1. Any current or past revocation, suspension, or voluntary surrender of a medical license in lieu of further disciplinary action.
2. Any current or past revocation or suspension of accreditation.
3. Any current or past suspension or exclusion imposed by the U.S. Department of Health and Human Service's Office of Inspector General (OIG).
4. Any current or past debarment from participation in any Federal Executive Branch procurement or non-procurement program.
5. Any other current or past Federal Sanctions (A penalty imposed by a Federal governing body (e.g. Civil Monetary Penalties (CMP))).
6. Any current or past Medicaid exclusion, revocation, or termination of any billing number.

C. FINAL ADVERSE LEGAL ACTION HISTORY

1. Have you, under any current or former name, had a final adverse legal action **listed above** imposed against you?

   ○ YES – continue below

   ○ NO – skip to section 4

2. If yes, report each final adverse legal action, when it occurred, and the federal or state agency or the court/ administrative body that imposed the action.

FINAL ADVERSE LEGAL ACTION	DATE	ACTION TAKEN BY

SECTION 15: CERTIFICATION STATEMENT AND SIGNATURE

As an individual practitioner, you are the only person who can sign this application. The authority to sign the application on your behalf may not be delegated to any other person.

The Certification Statement contains certain standards that must be met for initial and continuous enrollment in the Medicare program. Review these requirements carefully.

By signing this Certification Statement, you agree to adhere to all of the requirements listed therein and acknowledge that you may be denied entry into or have your billing privileges revoked from the Medicare program if any requirements are not met.

Title XVIII of the Social Security Act prohibits payment for services provided by an individual practitioner to be paid to another individual or organization/group unless the individual practitioner who provided the services specifically authorizes another individual or organization/group to receive said payments in accordance with 42 C.F.R. section 424.73 and 42 C.F.R. section 424.80. By signing this Certification Statement, you are authorizing the organization/group or individual identified in Section 4F to receive Medicare payments on your behalf. The signature(s) below authorize the reassignment of benefits, or the termination of a reassignment of benefits, between the individual practitioner shown in Section 2A and the organization/group or individual shown in Section 4F. The employment of, or contract between, the individual practitioner and organization/group or individual must be in compliance with CMS regulations and applicable Medicare program safeguard standards described in 42 C.F.R. section 424.80. These signatures also serve as an attestation and acknowledgment to the compliance with all laws and regulations pertaining to the reassignment of Medicare benefits. **NOTE: this language only applies if the application is submitted to establish, change or terminate a reassignment of benefits.**

A. CERTIFICATION STATEMENT

You **MUST** sign and date the certification statement below in order to be enrolled in the Medicare program. In doing so, you are attesting to meeting and maintaining the Medicare requirements stated below.

Under the penalty of perjury, I, the undersigned, certify to the following:

1. I have read the contents of this application, and the information contained herein is true, correct, and complete. If I become aware that any information in this application is not true, correct or complete, I agree to notify my designated Medicare Administrative Contractor of this fact in accordance with the time frames established in 42 C.F.R. section 424.516.
2. I authorize the Medicare Administrative Contractor to verify the information contained herein. I agree to notify the Medicare Administrative Contractor of any change in practice location, final adverse legal action, or any other changes to the information in this form in accordance with the timeframes established in 42 C.F.R. section 424.516. I understand that any change to my status as an individual practitioner may require the submission of a new application. I understand that any change in the business structure of my private practice may require the submission of a new application.
3. I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any alteration of any text on this application, may be punishable by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare billing privileges, and/or the imposition of fines, civil damages, and/or imprisonment.
4. I agree to abide by the Medicare laws, regulations and program instructions that apply to me or to the organization listed in section 4A of this application. The Medicare laws, regulations, and program instructions are available through the Medicare Administrative Contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations and program instructions (including, but not limited to, the Federal Anti-Kickback Statute, 42 U.S.C. section 1320a-7b(b) (section 1128B(b) of the Social Security Act) and the Physician Self-Referral Law (Stark Law), 42 U.S.C. section 1395nn (section 1877 of the Social Security Act)).
5. Neither I, nor any managing employee reported in this application, is currently sanctioned, suspended, debarred or excluded by Medicare or a State Health Care Program (e.g., Medicaid program), or any other Federal program, or is otherwise prohibited from providing services to Medicare or other federal program beneficiaries.

SECTION 15: CERTIFICATION STATEMENT AND SIGNATURE *(Continued)*

6. I agree that any existing or future overpayment made to me, or to my business as reported in section 4A, by the Medicare program, may be recouped by Medicare through the withholding of future payments.
7. I understand that the Medicare identification number (PTAN) issued to me can only be used by me or by a Medicare enrolled provider or supplier to whom I have reassigned my benefits under current Medicare regulations when billing for services rendered by me.
8. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.
9. I further certify that I am the individual practitioner who is applying for Medicare billing privileges and the signature below is my signature.

B. SIGNATURE AND DATE

First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.

Practitioner Signature ***(First, Middle, Last Name, Jr., Sr., M.D., etc.)***	**Date Signed** ***(mm/dd/yyyy)***

In order to process this application it MUST be signed and dated.

C. DELEGATED OR AUTHORIZED OFFICIAL OF INDIVIDUAL/ORGANIZATION/GROUP CERTIFICATION STATEMENT AND SIGNATURE

Only complete this section if you are a Delegated/Authorized Official of an organization/group or an individual practitioner receiving reassigned benefits and are accepting a new reassignment of Medicare benefits, terminating a reassignment of Medicare benefits, or making a change in reassignment of Medicare benefit information in Section 4F, between yourself and the individual practitioner listed in Section 2A.

Under penalty of perjury, I, the undersigned, certify that the above information is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me and/or the organization/group to liability under civil and criminal laws.

Delegated or Authorized Official's First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.

Delegated or Authorized Official's Signature ***(First, Middle, Last Name, Jr., Sr., M.D., etc.)***	**Date Signed** ***(mm/dd/yyyy)***

In order to process this application it MUST be signed and dated.