Fremont County Board of Commissioners

615 Macon Ave., Room 105 - Cañon City, Colorado 81212
Phone (719) 276-7300 - Fax (719) 276-7412

Kevin Grantham	Debbie Bell	Dwayne McFall
District 1	District 2	District 3

August 7, 2024

CMS
PO Box 3095
Mechanicsburg, PA 17055-1813

Re: Medicare Enrollment Application
CMS 855

To Whom It May Concern:

Be advised that Fremont County Government, a political subdivision of the State of Colorado, is the "Owner" of the Fremont County Department of Public Health and Environment, the Public Health Agency for Fremont County, Colorado, the Provider of health care services on this Application. Fremont County will be legally and financially responsible for Medicare payments received (including any potential overpayments). In accordance with the instructions for Governmental/Tribal Organizations, the Board of Commissioners for the County of Fremont, State of Colorado, hereby attests that Fremont County will be legally and financially responsible in the event that there is any outstanding debt owed to CMS. The undersigned has the authority to legally and financially bind Fremont County to the laws, regulations, and program instructions of Medicare.

Sincerely Yours,

Dwayne McFall, Chairman
Board of Commissioners for Fremont County

MEDICARE ENROLLMENT APPLICATION

Clinics/Group Practices and Other Suppliers

CMS-855B

SEE PAGE 1–2 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION.

SEE PAGE 3 FOR INFORMATION ON WHERE TO MAIL THIS COMPLETED APPLICATION.

SEE SECTION 12 FOR A LIST OF SUPPORTING DOCUMENTATION TO BE SUBMITTED WITH THIS APPLICATION.

TO VIEW YOUR CURRENT MEDICARE ENROLLMENT RECORD GO TO: HTTPS://PECOS.CMS.HHS.GOV

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-1377
Expires: 03/2024

WHO SHOULD SUBMIT THIS APPLICATION

Clinics, group practices, and other suppliers must complete this application to enroll in the Medicare program and receive a Medicare billing number.

Clinics, group practices, and other suppliers can apply for enrollment in the Medicare program or make a change in their enrollment information using either:

- The Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or
- The paper CMS-855B enrollment application. Be sure you are using the most current version.

For additional information regarding the Medicare enrollment process, including Internet-based PECOS and to get the current version of the CMS-855B, go to **http://www.cms.gov/MedicareProviderSupEnroll**.

NOTE: Applicants using this application require a Type 2 NPI. See below for more information.

NOTE: For the purposes of this application, the word "supplier" is used universally and includes any providers or suppliers who are required to complete the CMS-855B application.

Complete and submit this application if you are an organization/group or other supplier that plans to bill Medicare and you are:

- Enrolling in the Medicare program for the first time with this Medicare Administrative Contractor (MAC) under this tax identification number.
- Currently enrolled in Medicare but have a new tax identification number. If you are reporting a change to your current Medicare enrollment to your tax identification number, you must complete a new application.
- Currently enrolled in Medicare and need to enroll in another Medicare Administrative Contractor's (MAC's) jurisdiction (e.g., you have opened a practice location in a geographic territory serviced by another MAC).
- Revalidating your Medicare enrollment. CMS may require you to submit or update your enrollment information. The MAC will notify you when it is time for you to revalidate your enrollment information. Do not submit a revalidation application until you have been contacted by your MAC.
- Previously enrolled in Medicare and you need to reactivate your Medicare billing number to resume billing. Prior to being reactivated, you must meet all current requirements for your supplier type before reactivation may occur.
- Currently enrolled in Medicare and need to make changes to your enrollment information (e.g., you have added or changed a practice location). Changes must be reported in accordance with the timeframes established in 42 C.F.R. section 424.516. (IDTF changes of information must be reported in accordance with 42 C.F.R. section 410.33.)
- A hospital, hospital department, or other medical practice or clinic that may bill for Medicare Part A services but will also bill for Medicare Part B practitioner services or provide purchased laboratory tests to other entities that will bill Medicare Part B.
- A certified Medicare Part B provider (i.e. Ambulatory Surgery Center, Portable X-ray Supplier) intending to report a CHOW. A CHOW 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 Medicare Identification Number and provider agreement (including any outstanding Medicare debt of the old owner) to the new owner. The regulatory citation for CHOWs can be found at 42 C.F.R. 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 and must initially enroll in Medicare.
- A medical practice, group/clinic or other supplier that will bill for Medicare Part B services (e.g., group practices, clinics, independent laboratories, portable x-ray suppliers).
- Terminating a Physician Assistant (PA) employer relationship.
- Terminating an employer or individual relationship with an Independent Diagnostic Testing Facility (IDTF).
- Voluntary terminating your Medicare billing privileges. A supplier should voluntarily terminate its Medicare enrollment when it:
  - Will no longer be rendering services to Medicare patients, or
  - Is planning to cease (or has ceased) operations.

NOTE: For the purposes of this section of this application, an entity is defined as a group/clinic, other supplier, or any organization to which you will reassign your Medicare benefits.

BILLING NUMBER AND NATIONAL PROVIDER IDENTIFIER INFORMATION

The Provider Transaction Access Number (PTAN), often referred to as a Medicare Supplier Number or Medicare Billing Number, is a generic term for any number other than the National Provider Identifier (NPI) that is used by a supplier bill the Medicare program.

The NPI is the standard unique health identifier for health care providers and suppliers and is assigned by the National Plan and Provider Enumeration System (NPPES). To enroll in Medicare, you must obtain an NPI and furnish it on this application prior to enrolling in Medicare or when submitting a change to your existing Medicare enrollment information. Applying for the NPI is a process separate from Medicare enrollment. As a supplier, it is your responsibility to determine if you have "subparts." A subpart is a component of an organization (supplier) that furnishes healthcare and is not itself a legal entity. If you do have subparts, you must determine if they should obtain their own unique NPIs. Before you complete this enrollment application, you need to make those determinations and obtain NPI(s) accordingly. To obtain an NPI, you may apply online at **https://NPPES.cms.hhs.gov**. For more information about NPI enumeration, visit **www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/enumeration**.

NOTE: The Legal Business Name (LBN) and Tax Identification Number (TIN) that you furnish in section 2A must be the same LBN and TIN you used to obtain your NPI. Once this information is entered into PECOS from this application, your LBN, TIN and NPI **must** match exactly in both PECOS and NPPES.

Organizational Health Care Providers (Entity Type 2): Organizational health care providers are eligible for an Entity Type 2 NPI (Organizations). Organizational health care providers may have a single employee or thousands of employees. Examples of organizational providers include hospitals, home health agencies, groups/clinics, nursing homes, ambulance companies, health care provider corporations formed by groups/individuals, and single member LLCs with an EIN, **not** individual health care providers.

Important: For NPI purposes, sole proprietors and sole proprietorships are considered to be "Type 1" providers. Organizations (e.g., corporations, partnerships) are treated as "Type 2" entities. When reporting the NPI of a sole proprietor on this application, therefore, the individual's Type 1 NPI should be reported; for organizations, the Type 2 NPI should be furnished.

To obtain an NPI, you may apply online at **https://NPPES.cms.hhs.gov**.

INSTRUCTIONS FOR COMPLETING AND SUBMITTING THIS APPLICATION

All information on this form is required with the exception of those fields specifically marked as "optional." Any field marked as optional is not required to be completed nor does it need to be updated or reported as a "change of information" as required in 42 C.F.R. section 424.516. However, it is highly recommended that if reported, these fields be kept up-to-date.

- This form must be typed. It may not be handwritten. If portions of this form are handwritten, the application may be returned to you by your MAC.
- When necessary to report additional information, copy and complete the applicable section as needed.
- Attach all required supporting documentation.
- Keep a copy of your completed Medicare enrollment package for your own records.

TIPS TO AVOID DELAYS IN YOUR ENROLLMENT

To avoid delays in the enrollment process, you should:

- Complete all required sections, as shown in section 1.
- Ensure that the legal business name shown in section 2 matches the name on the tax documents.
- Ensure that the correspondence address shown in section 2 is the supplier's address.
- Enter your NPI(s) in the applicable section(s).
- Include the Electronic Funds Transfer (EFT) Authorization Agreement (when applicable) with your enrollment application with a voided check or bank letter.
- Sign and date section 15.
- Ensure all supporting documents are sent to your designated MAC.
- The supplier pays the required application fee (via **https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do**) upon initial enrollment, the addition of a new business location, revalidation and, if requested, reactivation PRIOR to completing and submitting this application to the MAC.

ADDITIONAL INFORMATION

- You may visit our website to learn more about the enrollment process via the Internet-Based Provider Enrollment Chain and Ownership System (PECOS) at: **https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/InternetbasedPECOS.html**. Also, all of the CMS-855 applications are all located on the CMS webpage: **https://www.cms.gov/medicare/cms-forms/cms-forms/cms-forms-list.html**. Simply enter "855" in the "Filter On:" box on this page and only the application forms will be displayed to choose from.
- The MAC may request additional documentation to support and validate information reported on this application. You are responsible for providing this documentation within 30 days of the request per 42 C.F.R. section 424.525(a)(1).
- The information you provide on this form is protected under 5 U.S.C. section 552(b)(4) and/or (b)(6), respectively. For more information, see the last page of this application to read the Privacy Act Statement.

ACRONYMS COMMONLY USED IN THIS APPLICATION

C.F.R.: Code of Federal Regulations
EFT: Electronic Funds Transfer
EIN: Employer Identification Number
IHS: Indian Health Service
IRS: Internal Revenue Service
LBN: Legal Business Name
LLC: Limited Liability Corporation
MAC: Medicare Administrative Contractor
NPI: National Provider Identifier
NPPES: National Plan and Provider Enumeration System
OTP: Opioid Treatment Program
PTAN: Provider Transaction Access Number also referred to as the Medicare Identification Number
SSN: Social Security Number
TIN: Tax Identification Number

DEFINITIONS

NOTE: For the purposes of this CMS-855B application, the following definitions apply:

- **Add:** You are adding additional enrollment information to your existing information (e.g. practice locations).
- **Change:** You are replacing existing information with new information (e.g. billing agency, managing employee) or updating existing information (e.g. change in suite #, telephone #).
- **Remove:** You are removing existing enrollment information.

WHERE TO MAIL YOUR APPLICATION

Send this completed application with original signatures and all required documentation to your designated MAC. The MAC that services your State is responsible for processing your enrollment application. To locate the mailing address for your designated MAC, go to **www.cms.gov/MedicareProviderSupEnroll**.

SECTION 1: BASIC INFORMATION

ALL APPLICANTS MUST COMPLETE THIS SECTION

A. REASON FOR SUBMITTING THIS APPLICATION

Check one box and complete the required sections of this application as indicated.

☐ You are a new enrollee in Medicare	Complete all applicable sections **Ambulance suppliers** must complete **Attachment 1** **IDTF suppliers** must complete **Attachment 2** **OTPs** must complete **Attachment 3**
☐ You are enrolling with another Medicare Administrative Contractor (MAC)	Complete all applicable sections **Ambulance suppliers** must complete **Attachment 1** **IDTF suppliers** must complete **Attachment 2** **OTPs** must complete **Attachment 3**
☒ You are revalidating your Medicare enrollment	Complete all applicable sections **Ambulance suppliers** must complete **Attachment 1** **IDTF suppliers** must complete **Attachment 2** **OTPs** must complete **Attachment 3**
☐ You are reactivating your Medicare enrollment	Complete all applicable sections **Ambulance suppliers** must complete **Attachment 1** **IDTF suppliers** must complete **Attachment 2** **OTPs** must complete **Attachment 3**
☐ You are reporting a change to your Medicare enrollment information	Go to section 1B below
☐ You are voluntarily terminating your Medicare enrollment Effective date of termination *(mm/dd/yyyy)*: _____ Medicare Identification Number: _____	Section 1, 2A1, 13 (optional), and 15 Employers terminating Physician Assistants must complete sections 1, 2A1, 2F, 13 (optional), and 15

SECTION 1: BASIC INFORMATION *(Continued)*

B. WHAT INFORMATION IS CHANGING?

Check all that apply and complete the required sections.

Please note: When reporting ANY information, sections **1, 2A1, 3, and 15** MUST always be completed in addition to the information that is changing within the required section.

Changing Information	Required Sections
☐ Business Identifying Information	**1, 2A1, 3, 12, 13 (optional)** and **15** and **6** for the signer if that authorized or delegated official has not been established for this supplier
☐ Final Adverse Legal Actions	**1, 2A1, 3, 12, 13 (optional)** and **15** and **6** for the signer if that authorized or delegated official has not been established for this supplier
☐ Medical Specialty Information	**1, 2A, 2B, 3, 4, 12, 13 (optional),** and **15** and **6** for the signer if that authorized or delegated official has not been established for this supplier
☐ Supplier Specific Information	**1, 2A1, 2A2-2A4, 2B–2F (as applicable), 3, 12,13 (optional),** and **15** and **6** for the signer if that authorized or delegated official has not been established for this supplier
☐ Physician Assistant Employment Terminations	**1, 2A1, 2F, 3, 13 (optional)** and **15** and **6** for the signer if that authorized or delegated official has not been established for this supplier
☐ Private Practice Business Information	**1, 2A, 3, 4A, 12, 13 (optional)** and **15** and **6** for the signer if that authorized or delegated official has not been established for this supplier
☐ Change of Ownership (Hospitals, Hospital Departments, Portable X-Ray Suppliers and Ambulatory Surgical Centers Only)	**Complete all sections and provide a copy of the sales agreement**
☐ Ownership Interest and/or Managing Control Information (Organizations)	**1, 2A1, 3, 5, 13,** and **15,** and **6** for the signer if that authorized or delegated official has not been established for this supplier
☐ Ownership Interest and/or Managing Control Information (Individuals)	**1, 2A1, 3, 6, 13, and 15,** and another **6** for the signer if that authorized or delegated official has not been established for this supplier
☒ Managing Employee Information	**1, 2A1, 3, 6, 12, 13 (optional),** and **15** and **6** for the signer if that authorized or delegated official has not been established for this supplier

SECTION 1: BASIC INFORMATION *(Continued)*

Changing Information	Required Sections
☐ Address Information ☐ Correspondence Mailing Address ☐ Medicare Beneficiary Medical Records Storage Address ☐ Practice Location Address ☐ Remittance Notices/Special Payment Mailing Address ☐ Base of Operations Address for Mobile or Portable Suppliers (location of Business Office or Dispatcher/ Scheduler)	**1, 2A, 3, 12, 13 (optional)** and **15 AND sections 2A3, 2A4, 4A, 4B, 4C,** and/or **4E** as applicable for the address that is being changed and **6** for the signer if that authorized or delegated official has not been established for this supplier
☐ Billing Agency Information	**1, 2A1, 3, 8, 13 (optional)** and **15** and **6** for the signer if that authorized or delegated official has not been established for this supplier
☒ Authorized Official(s) and/or Delegated Official(s)	**1, 2A1, 3, 13, 15A1** (if you are an Authorized Official) or **15B1** (if you are a delegated official), and another **6** for the signer if that authorized or delegated official has not been established for this supplier
☐ Any other information not specified above	**1, 2A1, 3, 12 (if applicable), 13 (optional)** and **15** and the applicable section or sub-section that is changing and **6** for the signer if that authorized or delegated official has not been established for this supplier

ATTACHMENT 1: AMBULANCE SERVICE SUPPLIERS (ONLY)

Changing Information	Required Sections
☐ Ambulance Supplier Transport Type	**1, 2A, 3, 12, 13 (optional)** and 15 and **6** for the signer if that authorized or delegated official has not been established for this supplier **Attachment 1(A)**
☐ Geographic Area	**1, 2A, 3, 12, 13 (optional)** and **15** and **6** for the signer if that authorized or delegated official has not been established for this supplier **Attachment 1(B)**
☐ State License Information	**1, 2A, 3, 12, 13 (optional)** and **15** and **6** for the signer if that authorized or delegated official has not been established for this supplier **Attachment 1(C)**
☐ Vehicle Information	1, 2A, 3, 12, 13 (optional) and 15 and **6** for the signer if that authorized or delegated official has not been established for this supplier **Attachment 1(D)**

SECTION 1: BASIC INFORMATION *(Continued)*

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (ONLY)

Changing Information	Required Sections
☐ CPT-4 and HCPCS Codes	**1, 2A, 3, 12, 13 (optional)** and 15 and **6** for the signer if that authorized or delegated official has not been established for this supplier **Attachment 2(B)**
☐ Interpreting Physician Information	**1, 2A, 3, 12, 13 (optional)** and **15** and **6** for the signer if that authorized or delegated official has not been established for this supplier **Attachment 2(C)**
☐ Personnel (Technicians) Who Perform Tests	**1, 2A, 3, 12, 13 (optional)** and **15** and **6** for the signer if that authorized or delegated official has not been established for this supplier **Attachment 2(D)**
☐ Supervising Physicians	1, 2A, 3, 12, 13 (optional) and 15 and 6 for the signer if that authorized or delegated official has not been established for this supplier **Attachment 2(E)**

ATTACHMENT 3: OPIOID TREATMENT PROGRAMS (ONLY)

Changing Information	Required Sections
☐ Opioid Treatment Program Personnel – Ordering Personnel Identification	**1, 2A1, 3, 12, 13 (optional)** and **15** and **6** for the signer if that authorized or delegated official has not been established for this supplier **Attachment 3A**
☐ Opioid Treatment Program Personnel – Dispensing Personnel Identification	**1, 2A1, 3, 12, 13 (optional)** and **15** and **6** for the signer if that authorized or delegated official has not been established for this supplier **Attachment 3B**

SECTION 2: IDENTIFYING INFORMATION

A. SUPPLIER IDENTIFICATION INFORMATION

1. BUSINESS INFORMATION

Legal Business Name as Reported to the Internal Revenue Service	Tax Identification Number (TIN)
County of Fremont	84-6000765

Medicare Identification Number (PTAN) *(if issued)*	National Provider Identifier (NPI)
COB5228	1013917921

Other Name *(if applicable)*

Type of Other Name *(if applicable)*. Check box indicating Type of Other Name:

☐ Former Legal Business Name

☐ Doing Business As Name

☐ Other *(Describe)*: _____

Business Structure information
Identify how your business is registered with the IRS. (NOTE: If your business is a Federal and/or State government supplier, indicate "Non-Profit" below. In addition, government-owned entities do not need to provide an IRS Form 501(c)(3)).

☐ Proprietary

☒ Non-Profit (Submit IRS Form 501(c)(3)

☐ Disregarded Entity (Submit IRS Form 8832)

NOTE: If a checkbox identifying how the business is registered with the IRS is not completed, the supplier will be defaulted to "Proprietary."

Identify the type of organizational structure of this supplier: *(Check one)*

☐ Corporation

☐ Limited Liability Company

☐ Partnership

☐ Sole Proprietor

☒ Other *(Specify)*: County Government

Is this supplier an Indian Health Service (IHS) Facility? ..... ○ Yes ◉ No

2. LICENSE/CERTIFICATION/REGISTRATION INFORMATION

Complete the appropriate subsection(s) below for your supplier type as you will report in section 2B. If no subsection is associated with your supplier type, check the box stating the information is not applicable.

a. Active License Information

☐ License Not Applicable

License Number	Effective Date (mm/dd/yyyy)	State Where Issued

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

b. Active Certification Information

Complete the appropriate subsection(s) below for your supplier type as you will report in section 2B. If no subsection is associated with your supplier type, check the box stating the information is not applicable. ***If you are certified by a national entity, put the word "all" in the "State Where Issued" data field.**

☐ Certification Not Applicable

Certification Number	Effective Date (mm/dd/yyyy)	State Where Issued*

Certifying Entity (Specialty Board, State, Other)

3. CORRESPONDENCE MAILING ADDRESS

This is the address where correspondence will be sent to the supplier listed in section 2A1 by your designated MAC. This address cannot be a billing agent or agency's address or a medical management company address.

If you are reporting a change to your Correspondence Mailing Address, check the box below. This will replace any current Correspondence Mailing Address on file.

☐ **Change** **Effective Date** *(mm/dd/yyyy)*: _____

Attention *(optional)*

Correspondence Mailing Address Line 1 *(P.O. Box or Street Name and Number)*
201 N. Sixth Street

Correspondence Mailing Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4
Canon City	CO	81212-3303

Telephone Number *(if applicable)*	Fax Number *(if applicable)*	E-mail Address *(if applicable)*
(719) 276-7450	(719) 276-7451	fcdphe@fremontco.com

4. MEDICAL RECORD CORRESPONDENCE ADDRESS

This is the address where the medical record correspondence will be sent to the supplier listed in section 2A1 by your designated MAC. This information would be used for any medical record review requests.

☐ Check here if your Medical Record Correspondence Address should be mailed to your Correspondence Address in section 2A3 (above) and skip this section.

If you are reporting a change to your Medical Record Correspondence Address, check the box below. This will replace any current Medical Record Correspondence Address on file.

☐ **Change** **Effective Date** *(mm/dd/yyyy)*: _____

Attention *(optional)*

Medical Record Correspondence Mailing Address Line 1 *(P.O. Box or Street Name and Number)*

Medical Record Correspondence Mailing Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number *(if applicable)*	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

B. TYPE OF SUPPLIER

Check the appropriate box to identify the type of supplier you are enrolling as with Medicare. If you are more than one type of supplier, submit a separate application for each type. If you change the type of service that you provide (i.e., become a different supplier type), submit a new application.

Your organization must meet all Federal and State requirements for the type of supplier checked below.

Type of Supplier: *(Check one only)*

- ☐ Ambulance Service Supplier
- ☐ Ambulatory Surgical Center
- ☐ Clinic/Group Practice
- ☐ Hospital Department(s)
- ☐ Independent Clinical Laboratory
- ☐ Independent Diagnostic Testing Facility
- ☐ Intensive Cardiac Rehabilitation
- ☐ Mammography Center
- ☐ Mass Immunization (Roster Biller Only)
- ☐ Opioid Treatment Program
- ☐ Pharmacy
- ☐ Physical/Occupational Therapy Group in Private Practice
- ☐ Portable X-ray Supplier
- ☐ Radiation Therapy Center
- ☐ Other *(Specify)*: _____

Note: Only use "other" checkbox if your supplier type is eligible to enroll and bill the Medicare program but is not reflected in the list of suppliers. If you are unsure if you are eligible to enroll contact your designated MAC before you submit this application.

C. HOSPITALS ONLY

This section should only be completed by hospitals that are currently enrolled or enrolling with a MAC (the Part A Medicare contractor), and will be billing a MAC for Medicare Part B services, as follows:

- Hospitals requiring a Part B billing number to provide pathology services.
- Hospitals requiring a Medicare Part B billing number to provide purchased tests to other Medicare Part B billers.
- If the hospital requires more than one departmental Part B billing number to bill for Part B practitioner services, list each department needing a number.

If your organization is not a hospital, and believes it will need a Part B billing number, contact the designated MAC to determine if this form should be submitted.

NOTE: Only complete this section if the clinic/hospital department is located within the hospital. If your hospital is enrolling a clinic that is not located within the hospital, do not complete this section.

Check "Clinic/Group Practice" in section 2B and complete this entire application for the clinic/group practice.

1. Are you going to:
   - ☐ bill for the entire hospital with one billing number? (If yes, continue to section 2D.)
   - ☐ separately bill for each hospital department? (If yes, answer question 2.)

2. List the hospital departments for which you plan to bill separately:

DEPARTMENT	MEDICARE IDENTIFICATION NUMBER	NPI

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

D. PHYSICAL THERAPY (PT) AND OCCUPATIONAL THERAPY (OT) GROUPS ONLY

1. Does this group ONLY render PT/OT services in patients' homes? ..... ○ Yes ○ No
2. Does this group maintain private office space? ..... ○ Yes ○ No
3. Does this group own, lease, or rent its private office space? ..... ○ Yes ○ No
4. Is this private office space used exclusively for the group's private practice? ..... ○ Yes ○ No
5. Does this group provide PT/OT services outside of its office and/or patients' homes? ..... ○ Yes ○ No

If you responded YES to questions 2, 3, or 4 above, you must have and attach a copy of any written agreement that gives the group exclusive use of the office space for PT/OT services.

E. ACCREDITATION FOR AMBULATORY SURGICAL CENTERS (ASCs) ONLY

NOTE: Copy and complete this section if more than one accreditation needs to be reported.

Check one of the following and furnish any additional information as requested:

☐ The enrolling ASC supplier is accredited.

☐ The enrolling ASC supplier is not accredited (includes exempt suppliers).

Name of Accrediting Organization

Effective Date of Current Accreditation *(mm/dd/yyyy)*	Expiration of Current Accreditation *(mm/dd/yyyy)*

F. EMPLOYER TERMINATING EMPLOYMENT ARRANGEMENT WITH ONE OR MORE PHYSICIAN ASSISTANTS

Complete this section if you are a health care provider corporation and you are discontinuing the employment arrangement of a PA(s). Health care provider corporations must also complete section 2A1 with your organizational information.

PA'S NAME	EFFECTIVE DATE OF DEPARTURE	PA'S MEDICARE IDENTIFICATION NUMBER	PA'S NPI

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, which received a sentence of deferred adjudication, adjudication withheld, stay of adjudication, withholding of judgment, or order of deferral — regardless of whether the court dismissed the case upon completion of probation, and regardless of whether the felony was reduced to a misdemeanor.
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 Medicaid exclusion, enrollment suspension, payment suspension, revocation, or termination of any billing number.

C. FINAL ADVERSE LEGAL ACTION HISTORY

1. Has your organization, under any current or former name or business identity, ever had a final adverse legal action listed above imposed against it?

   ○ **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 4: PRACTICE LOCATION INFORMATION

INSTRUCTIONS

This section captures information about the physical location(s) where you currently provide health care services. If you operate a mobile facility or portable unit, provide the address for the "Base of Operations," as well as vehicle information and the geographic area serviced by these facilities or units.

MOBILE FACILITY AND/OR PORTABLE UNIT

A "mobile facility" is generally a mobile home, trailer, or other large vehicle that has been converted, equipped, and licensed to render health care services. These vehicles usually travel to local shopping centers or community centers to see and treat patients inside the vehicle.

A "portable unit" is when the supplier transports medical equipment to a fixed location (e.g., physician's office, nursing home) to render services to the patient.

The most common types of mobile facilities/portable units are mobile IDTFs, portable X-ray suppliers, portable mammography, and mobile clinics. Physicians and non-physician practitioners (e.g., nurse practitioners, physician assistants) who perform services at multiple locations (e.g., house calls, assisted living facilities) are not considered to be mobile facilities/portable units.

A. PRACTICE LOCATION INFORMATION

Complete this section for each of your practice locations where you render services to Medicare beneficiaries. This includes all locations you will disclose on claims forms for reimbursement. If you have and see patients at more than one private practice location or health care facility, **copy and complete this section for each location.**

All reported practice location addresses must be a specific street address as recorded by the United States Postal Service. Your practice location must be the physical location where you render services to Medicare beneficiaries. Your practice location address cannot be a Post Office (P.O.) Box.

If you render services in a hospital, retirement or assisted living community, and/or other health care facilities, furnish the name, address and telephone number for those facilities.

If you only render services in patients' homes (house calls only), you may supply your home address in this section if you do not have a separate office. In section 4D3 explain that this address is for administrative purposes only and that all services are rendered in patients' homes. You must then also complete section 4D1 as appropriate.

Only report those practice locations that are within the jurisdiction of the designated MAC to which you will be submitting this application. If you have to report practice locations outside the jurisdiction of the designated MAC to which you are submitting this application you must submit a separate CMS-855B Enrollment Application to the MAC that has jurisdiction for those locations. If you are enrolling for the first time, or if you are adding a new practice location, the date you provide should be the date you saw your first Medicare patient at this location.

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

A. PRACTICE LOCATION INFORMATION *(Continued)*

If you are changing information about a currently reported practice location or adding or removing practice location information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ **Change** ☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

Practice Location Name *("Doing Business As" Name, if applicable)*

Practice Location Street Address Line 1 *(Street Name and Number – NOT a P.O. Box)*

Practice Location Street Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number *(if applicable)*	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

Medicare Identification Number for this location – PTAN *(if issued)*	National Provider Identifier (NPI)

Is this your primary practice location? ○ Yes ○ No	Date you saw or will see your first Medicare patient at this practice location *(mm/dd/yyyy)*

Is your private practice location reported above located in a:

☐ Ambulatory Surgical Center
☐ Group Practice Office/Clinic
☐ Home/Business Office for Administrative Use Only
☐ Hospital or Hospital Department
☐ Indian Health Services (IHS) or Tribal Facility Community
☐ Retirement or Assisted Living
☐ Skilled Nursing Facility or Other Nursing Facility
☐ Other Health Care Facility *(Specify)*: _____

CLIA Number for this location *(if applicable)*

Attach a copy of the most current CLIA certifications for each practice location(s) reported on this application.

FDA/Radiology (Mammography) Certification Number for this location *(if issued)*

Attach a copy of the most current FDA certifications for each practice location(s) reported on this application.

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

B. REMITTANCE NOTICES/SPECIAL PAYMENTS MAILING ADDRESS

Furnish an address where remittance notices and special payments should be sent for services rendered at the practice location(s) reported in section 4A. Please note that payments will be made in your name or, if a business is reported in section 4A, payments will be made in the name of the business.

Medicare will issue all routine payments via electronic funds transfer (EFT). Since payments will be made by EFT, the special payments address below should indicate where all other payment information (e.g., remittance notices, non-routine special payments) should be sent.

☐ Check here if your Remittance Notice/Special Payments should be mailed to your Primary Practice Location Address in section 4A above and skip this section, OR

☐ Check here if your Remittance Notice/Special Payments should be mailed to your Correspondence Address in section 2A3 and skip this section.

If you are reporting a change to your Remittance Notice/Special Payments Mailing Address, check the box below and furnish the effective date.

☐ **Change** **Effective Date** *(mm/dd/yyyy)*: _____

Special Payments Address Line 1 (P.O. Box or Street Name and Number)

Special Payments Address Line 2 (Suite, Room, Apt. #, etc.)

City/Town	State	ZIP Code + 4

C. MEDICARE BENEFICIARY MEDICAL RECORDS STORAGE ADDRESS

If your Medicare beneficiaries' medical records are stored at a location other than the Practice Location Address shown in section 4A complete this section with the name and address of the storage location. This includes the records for both current and former Medicare beneficiaries.

Post office boxes and drop boxes are not acceptable as a physical address where Medicare beneficiaries' records are maintained. The records must be your records and not the records of another practitioner. For IDTFs and mobile facilities/portable units, the patients' medical records must be under the supplier's control. If all records are stored at the Practice Location reported in section 4A, check the box below and skip this section.

☐ Records are stored at the Practice Location reported in section 4A.

If you are adding or removing a storage location, check the applicable box below and furnish the effective date.

☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

1. Paper Storage

Name of Storage Facility

Storage Facility Address Line 1 *(Street Name and Number)*

Storage Facility Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

2. Electronic Storage

Do you store your patient medical records electronically? ..... ○ YES ○ NO

If yes, identify where/how these records are stored below. This can be a website, URL, in-house software program, online service, vendor, etc. This must be an electronic storage site that can be accessed by CMS or its designees if necessary.

Site where electronic records are stored

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

D. RENDERING SERVICES IN PATIENTS' HOMES

List the city/town, county, state/territory, or ZIP code for all locations where you render health care services in patients' homes or, if previously reported, where you no longer render health care services in patients' homes.

If you provide health care services in more than one state/territory and those states/territories are serviced by different MACs, complete a separate CMS-855B enrollment application for each MAC's jurisdiction.

1. Initial Reporting and/or Additions

If you are reporting or adding an entire state/territory, check the box below and specify the state/territory.

☐ Entire State/Territory of _____

If services are only provided in selected cities/towns or counties, provide the locations below. Only list ZIP codes if you are not servicing the entire city/town or county.

CITY/TOWN	COUNTY	STATE/ TERRITORY	ZIP CODE

2. Deletions

If you are deleting an entire state/territory, check the box below and specify the state/territory.

☐ Entire State/Territory of _____

If services are no longer provided in selected cities/towns or counties, provide the locations below. Only list ZIP codes if you are not deleting service in the entire city/town or county.

CITY/TOWN	COUNTY	STATE/ TERRITORY	ZIP CODE

3. Comments/Special Circumstances

Explain any unique circumstances concerning your practice location(s) or the method by which you render health care services (e.g., practice on certain days of the week).

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

E. Base of Operations Address for Mobile or Portable Suppliers (Location of Business Office or Dispatcher/ Scheduler)

The base of operations is the location from where personnel are dispatched, where mobile/portable equipment is stored, and when applicable, where vehicles are parked when not in use.

NOTE: When necessary to report more than one base of operations, copy and complete this section for each base of operations.

If you are changing information about currently reported information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section

☐ **Change** ☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

☐ Check here and skip to section 4F if the "Base of Operations" address is the same as the "Practice Location" listed in section 4A.

Base of Operations Street Address Line 1 *(Street Name and Number)*

Base of Operations Street Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number *(if applicable)*	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

F. Vehicle Information

If the mobile health care services are rendered inside a vehicle, such as a mobile home or trailer, furnish the following vehicle information below. Do not provide information about vehicles that are used only to transport medical equipment (e.g., when the equipment is transported in a van but is used in a fixed setting, such as a doctor's office) or ambulance vehicles. If more than four vehicles are used, copy and complete this section as needed.

For each vehicle, submit a copy of all health care related permits/licenses/registrations.

If you are adding or removing information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE FOR EACH VEHICLE	TYPE OF VEHICLE *(van, mobile home, trailer, etc.)*	VEHICLE IDENTIFICATION NUMBER
○ ADD ○ REMOVE Effective Date *(mm/dd/yyyy):*		
○ ADD ○ REMOVE Effective Date *(mm/dd/yyyy):*		
○ ADD ○ REMOVE Effective Date *(mm/dd/yyyy):*		
○ ADD ○ REMOVE Effective Date *(mm/dd/yyyy):*		

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

G. Geographic Location for Mobile OR Portable Suppliers Where the Base of Operations and/or Vehicle Renders Services

Provide the city/town, county, state/territory, and zip code for all locations where mobile and/or portable services are rendered.

NOTE: If you provide mobile or portable health care services in more than one state/territory and those states/territories are serviced by different MACs, complete a separate CMS-855B enrollment application for each MAC's jurisdiction.

1. Initial Reporting and/or Additions

If you are reporting or adding an entire state/territory, check the box below and specify the state/territory.

☐ Entire State/Territory of _____

If services are only provided in selected cities/towns or counties, provide the locations below. Only list ZIP codes if you are not servicing the entire city/town or county.

CITY/TOWN	COUNTY	STATE/ TERRITORY	ZIP CODE

2. Deletions

If you are deleting an entire state/territory, check the box below and specify the state/territory.

☐ Entire State/Territory of _____

If services are no longer provided in selected cities/towns or counties, provide the locations below. Only list ZIP codes if you are not deleting service in the entire city/town or county.

CITY/TOWN	COUNTY	STATE/ TERRITORY	ZIP CODE

SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS)

NOTE: Only report organizations in this section. Individuals must be reported in section 6.

Complete this section with information about all organizations that have 5 percent or more (direct or indirect) ownership interest of, any partnership interest in, and/or managing control of, the supplier identified in Section 2, as well as information on any adverse legal actions that have been imposed against that organization. For examples of organizations that should be reported here, visit our Web site: www.cms.hhs.gov/MedicareProviderSupEnroll. If there is more than one organization that should be reported, copy and complete this section for each.

NOTE: It is not necessary for the organization reported in 2A1 to report itself in this section.

The supplier must submit an organizational structure diagram/flowchart identifying all the entities listed in section 5 and their relationships with the supplier and each other.

MANAGING CONTROL (ORGANIZATIONS)

Any organization that exercises operational or managerial control over the supplier, or conducts the day-to-day operations of the supplier, is a managing organization and must be reported. The organization need not have an ownership interest in the supplier in order to qualify as a managing organization.

Report the entity under the role of "managing control" if, for instance, an entity:

a. has direct responsibility for the performance of your organization AND

b. is capable of changing the leadership, allocation of resources, or other processes of your organization to improve performance.

Suppliers should also report any managing relationship with a management services organization under contract with the supplier to furnish management services for the business.

Faculty practice plans, university-based health systems, hospital outpatient departments, medical foundations, and groups that primarily treat enrollees of group model HMOs should review this definition of managing control (organizations) carefully to determine if it applies

SPECIAL TYPES OF ORGANIZATIONS

Governmental/Tribal Organizations
If a federal, state, county, city or other level of government, or an Indian tribe, will be legally and financially responsible for Medicare payments received (including any potential overpayments), the name of that government or Indian tribe should be reported as an owner. The supplier must submit a letter on the letterhead of the responsible government (e.g., government agency) or tribal organization that attests that the government or tribal organization will be legally and financially responsible in the event that there is any outstanding debt owed to CMS. This letter must be signed by an appointed or elected official of the government or tribal organization who has the authority to legally and financially bind the government or tribal organization to the laws, regulations, and program instructions of the Medicare program.

Non-Profit, Charitable and Religious Organizations
Many non-profit organizations are charitable or religious in nature, and are operated and/or managed by a board of trustees or other governing body. The actual name of the board of trustees or other governing body should be reported in this section. While the organization should be listed in section 5, individual board members should be listed in section 6. Each non-profit organization should submit a copy of a 501(c)(3) document verifying its non-profit status.

SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS) *(Continued)*

NOTE: All organizations that complete this section must also complete section 5B.

All organizations that have any of the following must be reported in section 5:

- 5 percent or more ownership of the supplier,
- Managing control of the supplier, or
- A partnership interest in the supplier, regardless of the percentage of ownership the partner has.
- A management services organization under contract with the supplier to furnish management services for the business

Owning/Managing organizations are generally one of the following types:

- Corporations (including non-profit corporations)
- Partnerships and Limited Partnerships (as indicated above)
- Limited Liability Companies
- Charitable and/or Religious organizations
- Governmental and/or Tribal organizations

A. ORGANIZATION WITH OWNERSHIP INTEREST AND/OR MANAGING CONTROL—IDENTIFICATION INFORMATION

☐ Not Applicable

If you are changing information about your current ownership interest and/or managing control information for this organization, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ **Change** ☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

Check all that apply:

☐ 5 Percent or More Ownership Interest ☐ Partner ☐ Managing Control

Legal Business Name as Reported to the Internal Revenue Service

"Doing Business As" Name *(if applicable)*

Address Line 1 *(Street Name and Number)*

Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number *(if applicable)*	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

National Provider Identifier (NPI)	Tax Identification Number *(Required)*	Medicare Identification Number for this location – PTAN *(if issued)*

What is the effective date this owner acquired ownership of the supplier identified in section 2A1 of this application? *(mm/dd/yyyy)*

What is the effective date this organization acquired managing control of the supplier identified in section 2A1 of this application? *(mm/dd/yyyy)*

NOTE: Furnish both dates if applicable.

SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS) *(Continued)*

B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for the organization reported in section 5A above. If you need additional information regarding what to report, please refer to section 3 of this application.

NOTE: If reporting more than one organization, copy and complete sections 5A and 5B for each organization reported.

1. Has this organization in section 5A above, under any current or former name or business identity, ever had a final adverse legal action listed in section 3 of this application imposed against it?

   ○ **YES** – continue below ○ **NO** – skip to section 6

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.

NOTE: To satisfy the reporting requirement, section 5B2 must be filled out in its entirety, and all applicable attachments must be included.

FINAL ADVERSE LEGAL ACTION	DATE	ACTION TAKEN BY

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS)

NOTE: Only report individuals in this section. Organizations must be reported in section 5.

NOTE: A supplier MUST have at least ONE organizational or individual owner, ONE managing employee and ONE Authorized Official. In addition, all Authorized Officials and/or Delegated Officials must complete this section, as well as the individuals listed below.

The following individuals must be reported in section 6A:

- All persons who have a 5 percent or greater direct or indirect ownership interest in the supplier (For more information on "direct" and "indirect" owners, go to www.cms.hhs.gov/MedicareProviderSupEnroll.);
- If (and only if) the supplier is a corporation (whether for-profit or non-profit), all officers and directors of the supplier;
- All managing employees of the supplier;
- All individuals with a partnership interest in the supplier, regardless of the percentage of ownership the partner has; and
- Authorized and delegated officials. All Authorized Officials must identify one other relationship of 5% or greater direct/indirect owner, Partner or Director/Officer. All Delegated Officials must identify one other relationship but can select managing employee as other relationship. **NOTE:** If you need additional information regarding who to report, please refer to section 15 of this application.

Example: A supplier is 100 percent owned by Company C, which itself is 100 percent owned by Individual D. Assume that Company C is reported in section 5A as an owner of the supplier. Assume further that Individual D, as an indirect owner of the supplier, is reported in section 6A. Based on this example, the supplier would check the "5 percent or Greater Direct/Indirect Owner" box in section 6A.

NOTE: All partners within a partnership must be reported on this application. This applies to both "General" and "Limited" partnerships. For instance, if a limited partnership has several limited partners and each of them only has a 1 percent interest in the supplier, each limited partner must be reported on this application, even though each owns less than 5 percent. The 5 percent threshold primarily applies to corporations and other organizations that are not partnerships.

Non-Profit, Charitable or Religious Organizations: If you are a non-profit charitable or religious organization that has no organizational or individual owners (only board members, directors or managers), you should complete this section and submit a 501(c)(3) document verifying non-profit status with your application.

For purposes of this application, the terms "officer," "director," and "managing employee" are defined as follows:

- **Officer** is any person whose position is listed as being that of an officer in the supplier's "articles of incorporation" or "corporate bylaws," or anyone who is appointed by the board of directors as an officer in accordance with the supplier's corporate bylaws.
- **Director** is a member of the supplier's "board of directors." It does not necessarily include a person who may have the word "director" in his/her job title (e.g., departmental director, director of operations). Moreover, where a supplier has a governing body that does not use the term "board of directors," the members of that governing body will still be considered "directors." Thus, if the supplier has a governing body titled "board of trustees" (as opposed to "board of directors"), the individual trustees are considered "directors" for Medicare enrollment purposes.
- **Managing Employee** means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operations of the supplier, either under contract or through some other arrangement, regardless of whether the individual is a W-2 employee of the supplier.

NOTE: If a governmental or tribal organization will be legally and financially responsible for Medicare payments received (per the instructions for Governmental/Tribal Organizations in section 5), the supplier is only required to report its managing employees in section 6. Owners, partners, officers, and directors do not need to be reported, except those who are listed as authorized or delegated officials on this application.

Any information on final adverse actions that have been imposed against the individuals reported in section 6A must be furnished. If there is more than one individual, copy and complete this section for each individual.

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) *(Continued)*

A. INDIVIDUALS WITH OWNERSHIP INTEREST AND/OR MANAGING CONTROL—IDENTIFICATION INFORMATION

If you are changing information about your current ownership interest and/or managing control information for this individual, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☒ **Change** ☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: 08/07/2024

The name, date of birth, and social security number of each person listed in this section must coincide with the individual's information as listed with the Social Security Administration. IRS issues Individual Tax Identification Numbers (ITINs) to foreign nationals and others who have federal tax reporting or filing requirements and are not eligible to obtain a Social Security Number (SSN) from the Social Security Administration (SSA). Please report your ITIN in this section, if applicable.

First Name	Middle Initial	Last Name	Jr., Sr.,M.D., etc.
Paula	L	Buser	

Title	Date of Birth *(mm/dd/yyyy)*
Director	06/27/1961

Social Security Number (SSN) or Individual Tax Identification Number (ITIN)
203-46-9637

What is the above individual's relationship with the supplier in section 2A1?

☐ 5 Percent or Greater Direct/Indirect Owner
☐ Authorized Official
☒ Delegated Official
☐ Partner
☐ Director/Officer
☐ Contracted Managing Employee
☒ W-2 Managing Employee

What is the effective date this owner acquired ownership of the supplier identified in section 2A1 of this application? *(mm/dd/yyyy)* _____

What is the effective date this individual acquired managing control of the supplier identified in section 2A1 of this application? *(mm/dd/yyyy)* 08/07/2024

NOTE: Furnish both dates if applicable.

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) *(Continued)*

B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for the individual reported in section 6A above. If you need additional information regarding what to report, please refer to section 3 of this application.

NOTE: If reporting more than one individual, copy and complete sections 6A and 6B for each individual reported.

1. Has the individual in section 6A above, under any current or former name or business identity, ever had a final adverse legal action listed in section 3 of this application imposed against him/her?

   ○ **YES** – continue below ◉ **NO** – skip to section 8

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.

NOTE: To satisfy the reporting requirement, section 6B2 must be filled out in its entirety, and all applicable attachments must be included.

FINAL ADVERSE LEGAL ACTION	DATE	ACTION TAKEN BY

SECTION 7: THIS SECTION INTENTIONALLY LEFT BLANK

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) *(Continued)*

A. INDIVIDUALS WITH OWNERSHIP INTEREST AND/OR MANAGING CONTROL—IDENTIFICATION INFORMATION

If you are changing information about your current ownership interest and/or managing control information for this individual, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☒ **Change** ☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: 08/07/2024

The name, date of birth, and social security number of each person listed in this section must coincide with the individual's information as listed with the Social Security Administration. IRS issues Individual Tax Identification Numbers (ITINs) to foreign nationals and others who have federal tax reporting or filing requirements and are not eligible to obtain a Social Security Number (SSN) from the Social Security Administration (SSA). Please report your ITIN in this section, if applicable.

First Name	Middle Initial	Last Name	Jr., Sr.,M.D., etc.
Traci	A	Dever	

Title	Date of Birth *(mm/dd/yyyy)*
Office Administrator	06/28/0969

Social Security Number (SSN) or Individual Tax Identification Number (ITIN)
524375499

What is the above individual's relationship with the supplier in section 2A1?

☐ 5 Percent or Greater Direct/Indirect Owner
☐ Authorized Official
☒ Delegated Official
☐ Partner
☐ Director/Officer
☐ Contracted Managing Employee
☒ W-2 Managing Employee

What is the effective date this owner acquired ownership of the supplier identified in section 2A1 of this application? *(mm/dd/yyyy)* _____

What is the effective date this individual acquired managing control of the supplier identified in section 2A1 of this application? *(mm/dd/yyyy)* 08/07/2024

NOTE: Furnish both dates if applicable.

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) *(Continued)*

B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for the individual reported in section 6A above. If you need additional information regarding what to report, please refer to section 3 of this application.

NOTE: If reporting more than one individual, copy and complete sections 6A and 6B for each individual reported.

1. Has the individual in section 6A above, under any current or former name or business identity, ever had a final adverse legal action listed in section 3 of this application imposed against him/her?

   ○ **YES** – continue below ◉ **NO** – skip to section 8

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.

NOTE: To satisfy the reporting requirement, section 6B2 must be filled out in its entirety, and all applicable attachments must be included.

FINAL ADVERSE LEGAL ACTION	DATE	ACTION TAKEN BY

SECTION 7: THIS SECTION INTENTIONALLY LEFT BLANK

SECTION 8: BILLING AGENCY/AGENT INFORMATION

A billing agency/agent is a company or individual that you contract with to prepare and submit your claims. If you use a billing agency/agent you must complete this section. Even if you use a billing agency/agent, you remain responsible for the accuracy of the claims submitted on your behalf.

NOTE: The billing agency/agent address cannot be the correspondence mailing address completed in section 2A3 of this application.

☐ Check here if this section does not apply and skip to section 12.

If you are changing information about your current billing agency/agent or adding or removing billing agency/agent information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ **Change** ☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

BILLING AGENCY/AGENT NAME AND ADDRESS

Legal Business as reported to the Internal Revenue Service or Individual Name as Reported to the Social Security Administration

If Billing Agent: Date of Birth *(mm/dd/yyyy)*

Billing Agency Tax Identification Number or Billing Agent Social Security Number *(required)*

Billing Agency/Agent "Doing Business As" Name *(if applicable)*

Billing Agency/Agent Address Line 1 *(Street Name and Number)*

Billing Agency/Agent Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town		State	ZIP Code + 4
Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*	

SECTION 9: THIS SECTION INTENTIONALLY LEFT BLANK

SECTION 10: THIS SECTION INTENTIONALLY LEFT BLANK

SECTION 11: THIS SECTION INTENTIONALLY LEFT BLANK

SECTION 12: SUPPORTING DOCUMENTATION INFORMATION

This section lists the documents that, if applicable, must be submitted with this completed enrollment application. If you are enrolling for the first time, or reactivating or revalidating your enrollment you must submit applicable documents. When reporting a change of information, only submit documents that apply to the change reported. Your designated Medicare Administrative Contractor (MAC) may request, at any time during the enrollment process, documentation to support or validate information reported on this application. In addition, your designated MAC may also request documents from you other than those identified in this section as are necessary to ensure correct billing of Medicare.

☐ Completed Form CMS-855R, Individual Reassignment of Medicare Benefits, for the individual practitioner(s) if you will be submitting claims and receiving payments for the individual practitioner(s) who will be rendering services as part of your group/clinic or other health care organization. A CMS-855I is necessary if the individual practitioner does not have a current Medicare enrollment in the state.

☐ Copy(s) of all final adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters).

☐ Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement.

NOTE: The CMS-460 must be submitted for all initial enrollments or reactivations only if you want to be a participating supplier in Medicare.

☐ Completed Form CMS-588, Electronic Funds Transfer Authorization Agreement. Include a voided check or bank letter.

NOTE: If you currently receive payments electronically and are not making a change to your banking information, the CMS-588 is not required.

☐ If Medicare payments due to you are being sent to a bank (or similar financial institution) where you have a lending relationship (that is, any type of loan), you 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.

☒ Written confirmation from the IRS confirming your Tax Identification Number and Legal Business Name provided in section 2A (e.g., IRS form CP-575).

NOTE: This information is needed if the applicant is enrolling their professional corporation, professional association, or limited liability corporation with this application or enrolling as a sole proprietor using an Employer Identification Number.

☐ Written confirmation from the IRS if your business is registered as a Limited Liability Company (LLC), including single member LLCs, confirming your LLC is automatically classified as a Disregarded Entity (e.g., IRS Form 8832).

NOTE: A Disregarded Entity is an eligible entity that is not treated as a separate entity from its single owner for income tax purposes.

☐ Copy of IRS Determination Letter if you are registered with the IRS as non-profit (e.g., IRS Form 501(c)(3)).

NOTE: Government-owned entities do not need to provide an IRS Form 501(c)(3).

☐ The provider must submit an organizational structure diagram/flowchart identifying all of the entities listed in section 5 and their relationships with the provider and each other.

☒ Copy of an attestation for government entities and tribal organizations.

☐ Copy of all ambulances' licenses (NOTE: required for all application submissions, including a change of information).

☐ Copy of all mobile vehicle registrations (all mobile services including ambulance vehicles).

☐ Copy of FAA 135 Certificate (air ambulance suppliers).

☐ Copy(s) of comprehensive liability insurance policy (IDTFs only).

☐ Copy(s) of all documentation verifying IDTF Supervisory Physician(s) proficiency and/or state licenses or certifications for IDTF non-physician personnel.

☐ Copy(s) of all documentation verifying the state licenses or certifications of the laboratory Director or non-physician practitioner personnel of an independent clinical laboratory.

☐ Copy of the Opioid Treatment Program approval letter.

☐ Copy of the Opioid Treatment Program's operating certificate.

SECTION 13: CONTACT PERSON INFORMATION *(Optional)*

If questions arise during the processing of this application, your designated MAC will contact the individual reported below.

☒ **Change** ☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: 08/07/2024

First Name	Middle Initial	Last Name	Jr., Sr.,M.D., etc.
Autumn		Dever	

Contact Person Address Line 1 *(Street Name and Number)*
201 N Sixth Street

Contact Person Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4
Canon City	CO	81212-3303

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*
(719) 276-7448	(719) 276-7451	autumn.dever@fremontco.com

NOTE: The Contact Person listed in this section will only be authorized to discuss issues concerning this or any other enrollment application. Your designated MAC will not discuss any other Medicare issues about you with the above Contact Person.

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION ON THIS APPLICATION

This section explains the penalties for deliberately furnishing false information in this application to gain or maintain enrollment in the Medicare program.

1. 18 U.S.C. section 1001 authorizes criminal penalties against an individual who, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious, or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000 (18 U.S.C. section 3571). Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.
2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against any individual who, "knowingly and willfully," makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a federal health care program. The offender is subject to fines of up to $25,000 and/or imprisonment for up to five years.
3. The Civil False Claims Act, 31 U.S.C. Section 3729, imposes civil liability, in part, on any person who, with actual knowledge, deliberate ignorance or reckless disregard of truth or falsity (a) presents or causes to be presented to the United States Government or its contractor or agent a false or fraudulent claim for payment or approval; (b) uses or causes to be used a false record or statement material either to a false or fraudulent claim or to an obligation to pay the Government; (c) conceals or improperly avoids or decreases an obligation to pay or transmit money or property to the Government; or (d) conspires to violate any provision of the False Claims Act. The False Claims Act imposes a civil penalty of between $5,000 and $10,000 per violation, as adjusted for inflation by the Federal Civil Penalties Inflation Adjustment Act, 28 U.S.C. 2461, plus three times the amount of damages sustained by the Government.
4. Section 1128A(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any state agency...a claim...that the Secretary determines is for a medical or other item or service that the person knows or should know:

   a. was not provided as claimed; and/or

   b. the claim is false or fraudulent.

   This provision authorizes a civil monetary penalty of up to $10,000 for each item or service, an assessment of up to three times the amount claimed, and exclusion from participation in the Medicare program and state health care programs.
5. 18 U.S.C. 1035 authorizes criminal penalties against individuals in any matter involving a health care benefit program who knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact; or makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items or services. The individual shall be fined or imprisoned up to 5 years or both.
6. 18 U.S.C. 1347 authorizes criminal penalties against individuals who knowing and willfully execute, or attempt, to execute a scheme or artifice to defraud any health care benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by or under the control of any, health care benefit program in connection with the delivery of or payment for health care benefits, items, or services. Individuals shall be fined or imprisoned up to 10 years or both. If the violation results in serious bodily injury, an individual will be fined or imprisoned up to 20 years, or both. If the violation results in death, the individual shall be fined or imprisoned for any term of years or for life, or both.
7. The United States Government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment." Remedies include compensatory and punitive damages, restitution, and recovery of the amount of the unjust profit.

SECTION 15: CERTIFICATION STATEMENT

An **Authorized Official** is defined as an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program.

A **Delegated Official** is defined as an individual who is delegated by an authorized official the authority to report changes and updates to the supplier's enrollment record. A delegated official must be an individual with an "ownership or control interest" in (as that term is defined in section 1124(a)(3) of the Social Security Act), or be a W-2 managing employee of the supplier.

Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the supplier's Medicare status. Even when delegated officials are reported in this application, an authorized official retains the authority to make any such changes and/or updates by providing his or her printed name, signature, and date of signature as required in section 15B.

NOTE: Authorized officials and delegated officials must be reported in section 6, either on this application or on a previous application to this same MAC. If this is the first time an authorized and/or delegated official has been reported on the CMS-855B, you must complete section 6 for that individual and that individual must sign section 15.

By his/her signature(s), an authorized official binds the supplier to all of the requirements listed in the Certification Statement and acknowledges that the supplier may be denied entry to or revoked from the Medicare program if any requirements are not met.

Only an authorized official has the authority to sign (1) the initial enrollment application on behalf of the supplier and (2) add or remove additional authorized officials and delegated officials. Once the delegation of authority has been established all other enrollment application submissions can be signed by either an authorized official or delegated official.

By signing this application, an authorized official agrees to immediately notify the MAC if any information furnished on this application is not true, correct, or complete. In addition, an authorized official, by his/her signature, agrees to notify the MAC of any future changes to the information contained in this form, after the supplier is enrolled in Medicare, in accordance with the timeframes established in 42 C.F.R. 424.516. (IDTF changes of information must be reported in accordance with 42 C.F.R. 410.33.)

The supplier can have as many authorized officials as it wants. If the supplier has more than two authorized officials, it should copy and complete this section as needed.

EACH AUTHORIZED AND DELEGATED OFFICIAL MUST HAVE AND DISCLOSE HIS/HER SOCIAL SECURITY NUMBER.

SECTION 15: CERTIFICATION STATEMENT *(Continued)*

A. Additional Requirements for Medicare Enrollment for Authorized Officials

These are additional requirements that the supplier must meet and maintain in order to bill the Medicare program. Read these requirements carefully. By signing, the supplier is attesting to having read the requirements and understanding them.

By his/her signature(s), the authorized official(s) named below and the delegated official(s) named in section 15D agree to adhere to the following requirements stated in this Certification Statement:

1. I authorize the Medicare contractor to verify the information contained herein. I agree to notify the Medicare contractor of any future changes to the information contained in this application in accordance with the timeframes established in 42 C.F.R. section 424.516. I understand that any change in the business structure of this supplier may require the submission of a new application.
2. I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this application form, may be punished 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.
3. I agree to abide by the Medicare laws, regulations and program instructions that apply to me or to the organization listed in section 2A1 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)).
4. Neither this supplier, nor any five percent or greater owner, partner, officer, director, managing employee, authorized official, or delegated official thereof is currently sanctioned, suspended, debarred, or excluded by the Medicare or State Health Care Program, e.g., Medicaid program, or any other Federal program, or is otherwise prohibited from supplying services to Medicare or other Federal program beneficiaries.
5. I agree that any existing or future overpayment made to the supplier by the Medicare program may be recouped by Medicare through the withholding of future payments.
6. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and I will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.
7. I authorize any national accrediting body whose standards are recognized by the Secretary as meeting the Medicare program participation requirements, to release to any authorized representative, employee, or agent of the Centers for Medicare & Medicaid Services (CMS), a copy of my most recent accreditation survey, together with any information related to the survey that CMS may require (including corrective action plans).

SECTION 15: CERTIFICATION STATEMENT *(Continued)*

B. AUTHORIZED OFFICIAL SIGNATURE(S)

1. 1ST AUTHORIZED OFFICIAL SIGNATURE

I have read the contents of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete and I authorize the MAC to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the MAC of this fact in accordance with the time frames established in 42 C.F.R. section 424.516.

If you are adding or removing an authorized official, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☒ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: 08/07/2024

Authorized Official's Information and Signature

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

Telephone Number	Title/Position
(719) 276-7303	Board of County Commissioners, Chair

Authorized Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*	**Date Signed** *(mm/dd/yyyy)*
	08/07/2024

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

2. 2ND AUTHORIZED OFFICIAL SIGNATURE *(if applicable)*

I have read the contents of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete and I authorize the MAC to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the MAC of this fact in accordance with the time frames established in 42 C.F.R. section 424.516.

If you are adding or removing an authorized official, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

Authorized Official's Information and Signature

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

Telephone Number	Title/Position

Authorized Official 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.

SECTION 15: CERTIFICATION STATEMENT *(Continued)*

C. ADDITIONAL REQUIREMENTS FOR MEDICARE ENROLLMENT FOR DELEGATED OFFICIALS

NOTE: Delegated Officials are optional.

1. You are not required to have a delegated official. However, if no delegated official is assigned, the authorized official(s) will be the only person(s) who can make changes and/or updates to the supplier's status in the Medicare program.
2. The signature of a delegated official shall have the same force and effect as that of an authorized official, and shall legally and financially bind the supplier to the laws, regulations, and program instructions of the Medicare program. By his or her signature, the delegated official certifies that he or she has read the Certification Statement in section 15 and agrees to adhere to all of the stated requirements. A delegated official also certifies that he/she meets the definition of a delegated official. When making changes and/or updates to the supplier's enrollment information maintained by the Medicare program, a delegated official certifies that the information provided is true, correct, and complete.
3. Delegated officials being removed do not have to sign or date this application.
4. Independent contractors are not considered "employed" by the supplier, and therefore cannot be delegated officials.
5. The signature(s) of an authorized official in section 15B constitutes a legal delegation of authority to all delegated official(s) assigned in section 15D.
6. If there are more than two individuals, copy and complete this section for each individual.

SECTION 15: CERTIFICATION STATEMENT *(Continued)*

D. DELEGATED OFFICIAL SIGNATURE(S)

1. 1ST DELEGATED OFFICIAL SIGNATURE

If you are adding or removing a delegated official, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☒ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: 08/07/2024

Delegated Official's Information and Signature

Delegated Official First Name	Middle Initial	Last Name	*Jr., Sr., M.D., etc.*
Paula	L	Buser	

Delegated Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*	Date Signed *(mm/dd/yyyy)*
Paula L Buser	08/07/2024

☒ Check here if Delegated Official is a W-2 Employee	Telephone Number
	(719) 276-7449

Authorized Official's Signature Assigning this Delegation *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*	Date Signed *(mm/dd/yyyy)*
	08/07/2024

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

2. 2ND DELEGATED OFFICIAL SIGNATURE

If you are adding or removing a delegated official, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☒ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

Delegated Official's Information and Signature

Delegated Official First Name	Middle Initial	Last Name	*Jr., Sr., M.D., etc.*
Traci	A	Dever	

Delegated Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*	Date Signed *(mm/dd/yyyy)*
Traci Autumn Dever	08/07/2024

☒ Check here if Delegated Official is a W-2 Employee	Telephone Number
	(719) 276-7448

Authorized Official's Signature Assigning this Delegation *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*	Date Signed *(mm/dd/yyyy)*
	08/07/2024

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

Department of the Treasury
Internal Revenue Service
P.O. Box 24033
Fresno, CA 93779-4033

In reply refer to: 8958008717
September 17, 2001
84-6000765 000

County Of Fremont
% Finance Office
615 Macon Ave Ste 102
Canyon City, CO 81212-3390 272

Taxpayer Identification Number: 84-6000765

Form(s):

Dear County Of Fremont

This is to verify that the Employer Identification Number, 84-6000765, has been assigned to the above entity:

County of Fremont
% Finance Office
615 Macon Ave Ste 102
Canyon City, Co. 81212

Sincerely,

Mr. Rodriguez
8901490
Customer Service Representative