MEDICARE FORM to be completed by the following specialties:

- Burn
- Cardiology
- Pathology
- Radiology
- Radiation Oncology
- Neonatology

To complete the form, please fill out:

- Section 1 – include effective date
- Section 2B
- Section 3
- Section 6A

Please return the completed form to:

Patricia Pearce
Business Office
Torrance Memorial Medical Center
3330 W. Lomita Blvd.
Torrance, CA 90505
(310) 784-3783
Patricia.Pearce@tmmc.com

MEDICARE ENROLLMENT APPLICATION

REASSIGNMENT OF MEDICARE BENEFITS

CMS-855R

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

SEE PAGE 2 FOR INFORMATION ON WHERE TO MAIL THIS COMPLETED APPLICATION.

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-1179
Expires: 01/2023

WHO SHOULD COMPLETE AND SUBMIT THIS APPLICATION

Complete this application if you are reassigning your right to bill the Medicare program and receive Medicare payments for some or all of the services you render to Medicare beneficiaries, or are terminating a currently established reassignment of benefits. Reassigning your Medicare benefits allows an eligible organization/group to submit claims and receive payment for Medicare Part B services that you have provided as a member of the organization/group. Such an eligible organization/group may be an individual, a clinic/group practice or other health care organization.

Physicians and non-physician practitioners, other than physician assistants, can reassign Medicare benefits or terminate a reassignment of Medicare benefits after enrollment in the Medicare program or make a change in their reassignment of Medicare benefit information using either:

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

Both the individual practitioner and the eligible organization/group must be currently enrolled (or concurrently enrolling via submission of the CMS-855B for the eligible organization/group and the CMS-855I for the individual practitioner) in the Medicare program before the reassignment can take effect. Generally, this application is completed by the organization/group, signed by the Delegated/Authorized Official of the organization/group and the individual practitioner, and submitted by the organization/group. When terminating a current reassignment, either the organization/group or the individual practitioner may submit this application with the appropriate sections completed and signed.

NOTE: A separate CMS-855R must be submitted for each organization/group where a reassignment is being established or terminated.

The individual or delegated/authorized official, by his/her signature, agrees to notify the Medicare Administrative Contractor (MAC) of any future changes to this reassignment in accordance with 42 C.F.R. section 424.516(d)(2).

NOTE: An individual does not need to reassign their benefits to a corporation, limited liability company, professional association, etc., when he/she is the sole owner. See the CMS-855I application for Physicians and Non- Physician Practitioners for more information.

NOTE: Physician Assistants: This application should not be used to report employment arrangements. Employment arrangements must be reported using the CMS-855I application.

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

INSTRUCTIONS FOR COMPLETING 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.
- Type or print all information so that it is legible. Do not use pencil.
- Ensure that the legal business name shown in Section 2 matches the name on the tax documents.
- Enter all NPIs in the applicable sections.
- Sign and date the certification statement(s) as appropriate.
- Keep a copy of your completed Medicare reassignment package for your own records.

ADDITIONAL INFORMATION

When establishing a new reassignment, Section 6A must be signed by the individual practitioner **and** Section 6B must be signed by a delegated or authorized official of the organization/group. If the reassignment is to an individual, that person must sign Section 6B. When terminating a reassignment, **either** Section 6A **or** Section 6B can be completed. Reassigned claims for services rendered by the individual will no longer be paid to the organization/group after the effective date of the termination.

- 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.

DEFINITIONS

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

Add: You are adding additional information to your existing information (e.g. practice locations).

Change: You are replacing existing information with new information (e.g. contact person) or updating existing information (e.g. change in suite #, telephone #).

Remove: You are removing existing 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

Reason for Submitting this Application
Check the applicable box and complete the required sections.

☑ You are enrolling or are currently enrolled in Medicare and will be reassigning your benefits	Effective Date *(mm/dd/yyyy)*:	**Complete all sections**
☐ You are an individual practitioner/organization changing information on a currently existing reassignment	Effective Date *(mm/dd/yyyy)*:	Complete sections 1, 2 or 3, as applicable, sections 4 and/or 5, as applicable, and section 6A or 6B, as applicable
☐ You are an individual practitioner terminating a reassignment with an organization/group	Effective Date *(mm/dd/yyyy)*:	Complete sections **1, 2, 3, 5,** and **6A**
☐ You are the organization/group terminating a reassignment with an individual	Effective Date *(mm/dd/yyyy)*:	Complete sections **1, 2, 3, 5,** and **6B**

SECTION 2: ORGANIZATION/GROUP RECEIVING THE REASSIGNED BENEFITS

A. Organization/Group Identification

Provide the information below for the organization/group to whom benefits are being reassigned, or a reassignment is being terminated. If the organization/group's initial enrollment application is being submitted concurrently with this reassignment application, write "pending" in the Medicare identification number block. The organization/group's name as reported to the IRS must be the same as reported on the organization/group's CMS-855B when it enrolled.

Organization/Group Legal Business Name *(as Reported to the Internal Revenue Service)*		
TORRANCE MEMORIAL MEDICAL CENTER		
Tax Identification Number (TIN)	Medicare Identification Number (PTAN) *(if issued)*	National Provider Identifier (NPI)
951644042	M050351	1477502797

B. Individual Practitioner Identification

Provide the information below for the individual to whom benefits are being reassigned, or a reassignment is being terminated. If the individual's initial enrollment application is being submitted concurrently with this reassignment application, write "pending" in the Medicare identification number block. The individual's name as reported to the Social Security Administration must be the same as reported on the individual's CMS-855I when the individual enrolled. If the individual is a sole proprietor with an Employee Identification Number (EIN), check the appropriate box and report the EIN.

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

☐ Social Security Number (SSN) (List number below if applicable)	☐ Employer Identification Number (EIN) (List number below if applicable)
Medicare Identification Number (PTAN) *(if issued)*	National Provider Identifier (NPI)

SECTION 3: INDIVIDUAL PRACTITIONER WHO IS REASSIGNING BENEFITS

Individual Practitioner Identification

Provide the information below for the individual practitioner who will be reassigning his/her benefits, or who will be terminating a reassignment. If the individual's initial enrollment application is being submitted concurrently with this reassignment application, write "pending" in the Medicare identification number field.

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

Social Security Number (SSN)	Medicare Identification Number (PTAN) *(if issued)*	National Provider Identifier (NPI)

SECTION 4: PRIMARY PRACTICE LOCATION(S) *(Optional)*

A. Primary Practice Location

Identify the primary practice location of the organization/group where the individual practitioner will render services most of the time. This practice location must be currently enrolled or enrolling in Medicare.

If you are changing information about a currently reported primary practice location or adding or removing primary 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)*

TORRANCE MEMORIAL MEDICAL CENTER

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

3330 LOMITA BLVD

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

City/Town	State	ZIP Code +4
TORRANCE	CA	90505

Medicare Identification Number for this location – PTAN (if issued)	National Provider Identifier (NPI)
M050351	1477502797

B. Secondary Practice Location

Identify additional practice location.

If you are changing information about a currently reported an additional practice location or adding or removing an additional 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)*

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

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

City/Town	State	ZIP Code +4

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

SECTION 5: CONTACT PERSON INFORMATION *(Optional)*

If questions arise during the processing of this reassignment, the designated MAC will contact the individual indicated below. If a contact person is not furnished, the MAC will contact the individual practitioner is Section 3.

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

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

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

Contact Person Address Line 1 *(Street Name And Number)*

3330 W LOMITA BLVD

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

ATTN: BUSINESS OFFICE

City/Town	State	ZIP Code +4
TORRANCE	CA	90505

Telephone Number	Fax Number *(if applicable)*	Email Address *(if applicable)*
(310) 784-3783	(310) 660-7425	PATRICIA.PEARCE@TMMC.COM

Relationship or Affiliation to Individual or Organization/Group *(Spouse, Secretary, Attorney, Billing Agent, etc.)*

HOSPITAL BASED PHYSICIAN BILLING MANAGER

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 6: CERTIFICATION STATEMENTS AND SIGNATURES

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. All individual practitioners who allow another individual or organization/ group to receive payment for their services must sign the Reassignment of Medicare Benefits Statement below. By signing this Reassignment of Medicare Benefits Statement, you are authorizing the organization/group or individual identified in Section 2 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 3 and the organization/group or individual shown in Section 2. 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.

A. Individual Practitioner Certification Statement and Signature

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 to liability under civil and criminal laws.

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

Individual 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.

B. Delegated or Authorized Official of Organization/Group Certification Statement and Signature

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.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1179 (Expires: 01/2023). The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

******CMS Disclosure**** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please visit http://www.cms.gov/MedicareProviderSupEnroll.**

MEDICARE SUPPLIER ENROLLMENT APPLICATION PRIVACY ACT STATEMENT

The Authority for maintenance of the system is given under provisions of sections 1102(a) (Title 42 U.S.C. 1302(a)), 1128 (42 U.S.C. 1320a–7), 1814(a)) (42 U.S.C. 1395f (a)(1), 1815(a) (42 U.S.C. 1395g(a)), 1833(e) (42 U.S.C. 1395I(3)),1871 (42 U.S.C. 1395hh), and 1886(d)(5)(F), (42 U.S.C. 1395ww(d)(5)(F) of the Social Security Act; 1842(r) (42 U.S.C.1395u(r)); section 1124(a)(1) (42 U.S.C. 1320a–3(a)(1), and 1124A (42 U.S.C. 1320a–3a), section 4313, as amended, of the BBA of 1997; and section 31001(i) (31 U.S.C. 7701) of the DCIA (Pub. L. 04–134), as amended.

The information collected here will be entered into the Provider Enrollment, Chain and Ownership System (PECOS).

PECOS will collect information provided by an applicant related to identity, qualifications, practice locations, ownership, billing agency information, reassignment of benefits, electronic funds transfer, the NPI and related organizations. PECOS will also maintain information on business owners, chain home offices and provider/chain associations, managing/ directing employees, partners, authorized and delegated officials, supervising physicians of the supplier, ambulance vehicle information, and/or interpreting physicians and related technicians. This system of records will contain the names, social security numbers (SSN), date of birth (DOB), and employer identification numbers (EIN) and NPI's for each disclosing entity, owners with 5 percent or more ownership or control interest, as well as managing/directing employees. Managing/directing employees include general manager, business managers, administrators, directors, and other individuals who exercise operational or managerial control over the provider/ supplier. The system will also contain Medicare identification numbers (i.e., CCN, PTAN and the NPI), demographic data, professional data, past and present history as well as information regarding any adverse legal actions such as exclusions, sanctions, and felonious behavior.

The Privacy Act permits CMS to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. Any such disclosure of data is known as a "routine use." The CMS will only release PECOS information that can be associated with an individual as provided for under Section III "Proposed Routine Use Disclosures of Data in the System." Both identifiable and non-identifiable data may be disclosed under a routine use. CMS will only collect the minimum personal data necessary to achieve the purpose of PECOS. Below is an abbreviated summary of the six routine uses. To view the routine uses in their entirety go to: **https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/Downloads/0532-PECOS.pdf**.

1. To support CMS contractors, consultants, or grantees, who have been engaged by CMS to assist in the performance of a service related to this collection and who need to have access to the records in order to perform the activity.
2. To assist another Federal or state agency, agency of a state government or its fiscal agent to:
   a. Contribute to the accuracy of CMS's proper payment of Medicare benefits,
   b. Enable such agency to administer a Federal health benefits program that implements a health benefits program funded in whole or in part with federal funds, and/or
   c. Evaluate and monitor the quality of home health care and contribute to the accuracy of health insurance operations.
3. To assist an individual or organization for research, evaluation or epidemiological projects related to the prevention of disease or disability, or the restoration or maintenance of health, and for payment related projects.
4. To support the Department of Justice (DOJ), court or adjudicatory body when:
   a. The agency or any component thereof, or
   b. Any employee of the agency in his or her official capacity, or
   c. Any employee of the agency in his or her individual capacity where the DOJ has agreed to represent the employee, or
   d. The United States Government, is a party to litigation and that the use of such records by the DOJ, court or adjudicatory body is compatible with the purpose for which CMS collected the records.
5. To assist a CMS contractor that assists in the administration of a CMS administered health benefits program, or to combat fraud, waste, or abuse in such program.
6. To assist another Federal agency to investigate potential fraud, waste, or abuse in, a health benefits program funded in whole or in part by Federal funds.

The applicant should be aware that the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503) amended the Privacy Act, 5 U.S.C. section 552a, to permit the government to verify information through computer matching.