

Solutions Medical Billing

8251 New Floyd Rd, Rome, N Y (315)865-4299 fax (315)865-6359

We will need the following info for the Medicare Credentialing:

For 855B Group App:

Name of Business: _____

Address:

Phone: _____

Fax: _____

Email: _____

Type of Practice (Specialty i.e. internal medicine, family practice):

NPI number for Group: _____

Tax ID#: _____

Is group a LLC, PC, Sole Proprietor (If Incorporated, need date):

Date Group became effective (date you want to start seeing MCR pts):

Has group ever had any adverse legal action taken? Yes _____ No _____

Correspondence address (If different from practice location):

Are Pt's medical records stored at practice location? _____

Services ever rendered in patient's homes? _____

What date will you/did you begin seeing Medicare patients? _____

Will you be using a billing service? Yes _____ No _____

If Yes we need the following 3 items - if No skip:

1. Name: _____

2. Address: _____

3. Tax ID: _____

Ownership:

Need name, date of birth, ss# of all persons with 5% or greater ownership and if that (those) person have any adverse legal history

**** MUST have at least ONE owner and/or managing employee.**

The following individuals must be reported:

- All persons who have a 5 percent or greater direct or indirect ownership interest in the supplier;
- 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

1. Name: _____

DOB: _____

SS#: _____

2. Name: _____

DOB: _____

SS#: _____

3. Name: _____

DOB: _____

SS#: _____

4. Name: _____

DOB: _____

SS#: _____

(if more spaces are needed, use a separate piece of paper)

For 855I Individual Provider Application: (for each provider)

Name: _____

Date of birth: _____

State of birth: _____

SS# : _____

Tax ID# (if you use one for billing): _____

Name on the Tax ID#: _____

Address of practice:

Correspondence address (if different):

Provider's Individual NPI # (If they already have one): _____

Name of Medical School: _____

Year of Graduation: _____

DEA # (if applicable): _____

CLIA # (if applicable): _____

FDA Mammography Certificate # (if applicable): _____

License #: _____

License state: _____

License eff date & expiration date: _____

Primary Specialty: _____

Date you will begin (or began) seeing Medicare patients: _____

Any adverse legal history: _____

Are you in a resident/fellowship program?

Yes _____ No _____

→ Also fax or email a copy of a VOIDED check for bank account that Medicare is to transfer any payments to. (Medicare requires electronic funds transfer for all providers.)

Charge for a group application is \$225. This includes the 855B, up to 4 855I's, 588EFT, 855R's and 460 Participating Provider agreement. If you require more than 4 individual apps there will be a \$50 charge for each additional provider.

Payment Information:

Credit Card:

Name on Card: _____

Exp Date: _____

Card#: _____

MC _____ VISA _____ AmEx _____

Solutions Medical Billing does not track the status of your application. Many carriers will send out a letter stating they have received your application and are working on it. If you have not heard anything, we recommend that you call you Medicare Part B carrier approximately 3 weeks after you mail the application to make sure it was received. We **do follow thru** on all applications if any corrections need to be made. If we receive any correspondence from Medicare regarding your application we will notify you.

Solutions Medical Billing Inc. 1-800-490-4299 www.solutions-medical-billing.com