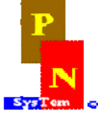

Any question call us at: 305-818-5940
Fax the form to: 305-819-4064 or e-mail to: info@pnsystem.com

MEDICARE/MEDICAID APPLICATION DATA

BUSINESS INFORMATION

Legal Business Name (not the "Doing Business As" name) as reported to the Internal Revenue Service

____

Tax Identification Number : ________________________________***Incorporation Date (mm/dd/yyyy) (if applicable)*** __________________

License Number: ______________________ *Effective Date*_________________*Expiration/Renewal Date* ________________

Medicare Provider #: _______________________ ***Effective Date:*** _____________________

Mailing Address Line 1 (Street Name and Number): ________________________________

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

City: _______________________ *State:* ___________ *Zip* ***Code +4*** __________________________ *(include the last 4 digits of the Zip Code)*

PHONE: ______________________ *FAX:* ___________________________

E-MAIL: ____

Is this provider accredited? ❏ YES ❏ NO If YES, complete the following:

Date of Accreditation ***(mm/dd/yyyy):*** ______________________ *Expiration Date:* ______________

Name of Accrediting Body : ____
Adverse legal action: ***❏ YES ❏ NO***

National Provider Identifier ***(NPI)*** *:*____

CLIA Number for this Location *(if applicable)* *:* ____

Owners:

First Name	*Middle Initial*	*Last Name*	*Title Corporation*

Social Security Number (Required)	*Date of Birth (mm/dd/yyyy)*	*State Birth*	*Country Birth*	*Date owner more than 5%*	*% ownership*

:

First Name	*Middle Initial*	*Last Name*	*Title Corporation*

Social Security Number (Required)	*Date of Birth (mm/dd/yyyy)*	*State Birth*	*Country Birth*	*Date owner more than 5%*	*% ownership*

First Name	*Middle Initial*	*Last Name*	*Title Corporation*

Social Security Number (Required)	*Date of Birth (mm/dd/yyyy)*	*State Birth*	*Country Birth*	*Date owner more than 5%*	*% ownership*

First Name	*Middle Initial*	*Last Name*	*Title Corporation*

Social Security Number (Required)	*Date of Birth (mm/dd/yyyy)*	*State Birth*	*Country Birth*	*Date owner more than 5%*	*% ownership*

MANGING CONTROL

Administrator:

First Name	*Middle Initial*	*Last Name*

Social Security Number (Required)	*Date of Birth (mm/dd/yyyy)*	*State Birth*	*Country Birth*	*Effective Date*	*% Control as officer*

Alt. Administrator

First Name	*Middle Initial*	*Last Name*

Social Security Number (Required)	*Date of Birth (mm/dd/yyyy)*	*State Birth*	*Country Birth*	*Effective Date*	*% Control as officer*

DON: *License:*

First Name	*Middle Initial*	*Last Name*

Social Security Number (Required)	*Date of Birth (mm/dd/yyyy)*	*State Birth*	*Country Birth*	*Effective Dat e*	*% Control as officer*

ACCOUNTANT: *(3 Years Budget)* ***ONLY MEDICARE APPLICATION (INITIAL)***

*How many visits does this HHA project it will make in the first: three months of operation?*__________________

twelve months of operation? __________________

BILLING AGENCY/INDIVIDUAL: ____

If Individual SS #: ______________________ ***Copr, Tax ID:*** ______________________

DBA: ______________________________________

Address: ______________________________________ ***ph:*** ______________

______________________________________ ***fax:*** ______________

Email: ____

Contact Person/Authorized Agent: ____

Required documents:

- ❑ ***Licenses, certifications and registrations required by Medicare or State law.***
- ❑ ***Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name (e.g., IRS CP 575) provided in Section 2.***
- ❑ ***Federal, State, and/or local (city/county) business licenses, certifications and/or registrations required to operate a health care facility. COPY of articules of corporation.***

- ❑ *Copy(s) of all documents that demonstrate meeting capitalization requirements (HHAs only). (ACCOUNTANT) (MEDICARE ONLY)*
- ❑ *Statement in writing from the bank. If Medicare payment due a provider of services is being sent to a bank (or similar financial institution) with whom the provider has a lending relationship (that is, any type of loan), then the provider 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.*
- ❑ *Copy(s) of all adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters).*

Bank Letter
Provider Letter (ONLY MEDICARE)
2 VOID CHECKS

DEPOSITORY INFORMATION (Financial Institution) (BANK INFO)

Depository Name____

Street Address ____

City ______________________________ State ______________ Zip Code __________

Depository Telephone Number ______________________________________

Depository Contact Person ______________________________________

Depository Routing Transit Number (nine digit) ___ ___ ___ ___ ___ ___ ___ ___ ___

Depositor Account Number ______________________________________

Type of Account (check one) ❑ Checking Account ❑ Savings Account

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