



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 _____

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

Mailing Address Line 2 (Suite, Room, etc.) _____

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

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

Date of Accreditation (mm/dd/yyyy): _____

Name of Accrediting Body : _____

National Provider Identifier (NPI) : _____

CLIA Number for this Location (if applicable) : _____

Owners:

First Name		Middle Initial	Last Name
Social Security Number (Required)	Date of Birth (mm/dd/yyyy)		

First Name		Middle Initial	Last Name
Social Security Number (Required)	Date of Birth (mm/dd/yyyy)		

<i>First Name</i>	<i>Middle Initial</i>	<i>Last Name</i>
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<i>Social Security Number (Required)</i>	<i>Date of Birth (mm/dd/yyyy)</i>
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Administrator:

<i>First Name</i>	<i>Middle Initial</i>	<i>Last Name</i>
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<i>Social Security Number (Required)</i>	<i>Date of Birth (mm/dd/yyyy)</i>
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Alt. Administrator

<i>First Name</i>	<i>Middle Initial</i>	<i>Last Name</i>
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<i>Social Security Number (Required)</i>	<i>Date of Birth (mm/dd/yyyy)</i>
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DON:

<i>First Name</i>	<i>Middle Initial</i>	<i>Last Name</i>
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<i>Social Security Number (Required)</i>	<i>Date of Birth (mm/dd/yyyy)</i>
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ACCOUNTANT: (3 Years Budget)

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

twelve months of operation? _____

www.pnsystem.com 305.818.5940

Required documents:

Licenses, certifications and registrations required by Medicare or State law.

Federal, State, and/or local (city/county) business licenses, certifications and/or registrations required to operate a health care facility.

Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name (e.g., IRS CP 575) provided in Section 2.

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