Pecos User: _____

** Please save the document in your computer, using Adobe Reader type the info, and then email to us* Password:_____

Any question call us at: 305-818-5940 / 786-514-9352
Fax the form to: 305-819-4064 or e-mail to: info@pnsystem.com

Clear Form

MEDICARE APPLICATION DATA

CHAP Certified Consultant

☐ $ 245.00

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)*

**** do not not print or scan the form please***

PHONE: _____ *FAX:* _____

**please use proper capitalization*

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*

** Please save the document in your computer, using Adobe Reader type the info, and then email to us*

*** Please save the document in your computer, using Adobe Reader type the info, and then email to us***

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:

*** Please save the document in your computer, using Adobe Reader type the info, and then email to us***

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? __________________

** Please save the document in your computer, using Adobe Reader type the info, and then email to us*

BILLING AGENCY/INDIVIDUAL: _____
If Individual SS #: _____ ***Copr, Tax ID:*** _____
DBA: _____
Address: _____ ***ph:*** _____
_____ ***fax:*** _____
Email: _____

Contact Person/Authorized Agent: _____

Required documents:

❑***Licenses, (AHCA License, CLIA).*** *(Email Copy)*

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

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

❑ *Copy(s) of all documents that demonstrate meeting capitalization requirements (Budget)*
(ACCOUNTANT) (MEDICARE ONLY) *(Email Copy, Bank Statement or bank letter)*

❑ *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).*

Accreditation report, certificate *(Email Copy)*

Bank Letter & Statement *(Email Copy)*

Provider Letter 1 *(Email Copy)*

VOID CHECK *(Email Copy)*

Full Check List: *(to be emailed PDF Format)*

- ☐ Medicare Application data *(all questions answered)*
- ☐ Budget *(3 years, stating in current month must: total visits first 3 months about 250 visits, total visits first 12 months about 1000)*
- ☐ Provider Letter (follow format)
- ☐ Bank Letter (follow format)
- ☐ Business Licenses (City, County)
- ☐ AHCA License
- ☐ CLIA License
- ☐ Tax ID
- ☐ Accreditation report
- ☐ Organizational Chart
- ☐ Voided Check / Bank Statement

YOUR BANK INFORMATION (Financial Institution)

BANK

Name_____

Street Address _____

City _____State _____Zip Code _____

BankTelephone Number _____

Bank Contact Person _____

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

Bank Account Number _____

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

** application fee $ 585.00 will be paid electronic*

** Please save the document in your computer, using Adobe Reader type the info, and then email to us*

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Fax the form to: 305-819-4064 or e-mail to: info@pnsystem.com

ACHC PRODUCT CERTIFICATION

CHAP VERIFIED