Medicare Application Data

Questions: 305-818-5940 / 786-514-9352 • Fax: 305-819-4064 • info@pnsystem.com

How to complete: save this document to your computer, type the information using Adobe Reader, then email it to us (use the **Email Form** button). **Please do not print or scan the form**, and use proper capitalization.

PECOS user: _____

Password: _____

☐ **$ 275.00**

1 BUSINESS INFORMATION

LEGAL BUSINESS NAME (NOT THE DBA) AS REPORTED TO THE IRS	DBA (DOING BUSINESS AS)
TAX IDENTIFICATION NUMBER	INCORPORATION DATE (MM/DD/YYYY) (IF APPLICABLE)

LICENSE NUMBER	LICENSE EFFECTIVE DATE	LICENSE EXPIRATION / RENEWAL DATE
MEDICARE PROVIDER #	MEDICARE EFFECTIVE DATE	NATIONAL PROVIDER IDENTIFIER (NPI)

ADDRESS (STREET, SUITE, CITY, STATE, ZIP+4 – INCLUDE THE LAST 4 DIGITS OF THE ZIP CODE)		
PHONE	FAX	E-MAIL
CLIA NUMBER FOR THIS LOCATION (IF APPLICABLE)		

Is this provider accredited? ☐ Yes ☐ No *If YES, complete the following:* **Adverse legal action?** ◯ Yes ◯ No

NAME OF ACCREDITING BODY	DATE OF ACCREDITATION (MM/DD/YYYY)	ACCREDITATION EXPIRATION DATE

2 OWNERS

Controlling interests – 5% or more

OWNER 1	FIRST NAME	MIDDLE INITIAL	LAST NAME	TITLE
	SSN (REQUIRED)	DOB (MM/DD/YYYY)	STATE / PROV. OF BIRTH	COUNTRY OF BIRTH	DATE OWNER (MORE THAN 5%)	% OWNERSHIP

OWNER 2	FIRST NAME	MIDDLE INITIAL	LAST NAME	TITLE
	SSN (REQUIRED)	DOB (MM/DD/YYYY)	STATE / PROV. OF BIRTH	COUNTRY OF BIRTH	DATE OWNER (MORE THAN 5%)	% OWNERSHIP

OWNER 3	FIRST NAME	MIDDLE INITIAL	LAST NAME	TITLE
	SSN (REQUIRED)	DOB (MM/DD/YYYY)	STATE / PROV. OF BIRTH	COUNTRY OF BIRTH	DATE OWNER (MORE THAN 5%)	% OWNERSHIP

OWNER 4	FIRST NAME	MIDDLE INITIAL	LAST NAME	TITLE
	SSN (REQUIRED)	DOB (MM/DD/YYYY)	STATE / PROV. OF BIRTH	COUNTRY OF BIRTH	DATE OWNER (MORE THAN 5%)	% OWNERSHIP

3 MANAGING CONTROL

ADMIN	FIRST NAME	MIDDLE INITIAL	LAST NAME
	SSN (REQUIRED)	DOB (MM/DD/YYYY)	STATE / PROV. OF BIRTH	COUNTRY OF BIRTH	EFFECTIVE DATE	% CONTROL AS OFFICER

ALT. ADM	FIRST NAME	MIDDLE INITIAL	LAST NAME
	SSN (REQUIRED)	DOB (MM/DD/YYYY)	STATE / PROV. OF BIRTH	COUNTRY OF BIRTH	EFFECTIVE DATE	% CONTROL AS OFFICER

DON License #: _____

DON	FIRST NAME	MIDDLE INITIAL	LAST NAME
	SSN (REQUIRED)	DOB (MM/DD/YYYY)	STATE / PROV. OF BIRTH	COUNTRY OF BIRTH	EFFECTIVE DATE	% CONTROL AS OFFICER

Medicare Application Data

Accountant • billing • required documents • bank information

4 ACCOUNTANT – 3-YEAR BUDGET

Only Medicare application (initial)

Projected number of visits this HHA will make in its first: **3 months of operation** _____ **12 months of operation** _____

5 BILLING AGENCY / INDIVIDUAL

BILLING AGENCY / INDIVIDUAL		DBA
IF INDIVIDUAL: SS #	CORP. TAX ID	CONTACT PERSON / AUTHORIZED AGENT
ADDRESS (STREET, SUITE, CITY, STATE, ZIP)		
PHONE	FAX	E-MAIL

6 REQUIRED DOCUMENTS

Email copies in PDF format

- Licenses (AHCA license, CLIA).
- Written confirmation from the IRS of your Tax ID with the Legal Business Name (e.g., IRS CP 575).
- Federal, state and/or local (city/county) business licenses, certifications and/or registrations required to operate a health care facility.
- Documents that demonstrate meeting capitalization requirements – Budget (Accountant; Medicare only): bank statement or bank letter.
- Written bank statement: if Medicare payments go to a bank with which the provider has a lending relationship (any type of loan), the bank must state in writing (in the loan agreement) that it waives its right of offset for Medicare receivables.
- Adverse legal action documentation (notifications, resolutions, reinstatement letters), if any.
- Accreditation report and certificate • Bank letter & statement • Provider letter • Voided check.

Full checklist *(email in PDF format)*

- ☐ Medicare Application Data (all questions answered)
- ☐ Budget (3 years, starting in current month)
  Visits: ~250 first 3 months; ~1,000 first 12 months • Daniel CPA 305-801-3929
- ☐ Provider Letter (follow format)
- ☐ Bank Letter (follow format)
- ☐ Business Licenses (City, County)
- ☐ AHCA License
- ☐ CLIA License
- ☐ Tax ID
- ☐ Accreditation report
- ☐ Organizational Chart
- ☐ Voided Check
- ☐ Form 1561 signed
- ☑ HHS-690 proof (done by us)
- ☐ Bank Statement

7 YOUR BANK INFORMATION (FINANCIAL INSTITUTION)

BANK NAME		BANK STREET ADDRESS, CITY, STATE, ZIP (NOT A PO BOX)
BANK TELEPHONE NUMBER	BANK CONTACT PERSON	
BANK ROUTING TRANSIT NUMBER (9 DIGITS)	BANK ACCOUNT NUMBER	TYPE OF ACCOUNT (CHECK ONE) ☐ Checking ☐ Savings

** The Medicare application fee of $750.00 will be paid electronically.*

Email Form | Clear Form



NEW SERVICE

Staff Digital IDs

✓ **Recognize your team**
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