UNM HOSPITALS

400 Tijeras Ave NW #450; Albuquerque, NM 87102
505-272-9642 phone; 719-580-6054 cell; 505-272-9991 fax

UNM Hospitals Billing Number Request Packet

Purpose: To request a unique billing number to be used for professional billing through UNM Hospitals.

Instructions:

1. Please complete lines 1-16 of the enclosed form: sign and date. This form will be used to complete repetitious data on subsequent forms.
2. Sign where indicated throughout the packet. Signature pages are included for both Medicare & Medicaid. Electronic applications will be submitted on your behalf on the following websites:

   Provider Enrollment, Chain, and Ownership System (PECOS) Application (Medicare)
   https://pecos.cms.hhs.gov/pecos/login.do#headingLv1

   New Mexico Medicaid Portal
   https://nmmedicaid.acsinc.com/webportal/enrollOnline

UNMH Coordinator Provider Enrollment
Attention: Yvonne Cordova
400 Tijeras Ave NW #450
Albuquerque, NM 87102
Phone: 505-272-9642
Fax: 505-272-9991

UNM | HOSPITALS

Please return completed forms to:
Attn: Yvonne Cordova
400 Tijeras Ave NW #450
Albuquerque, NM 87102
Phone: 505-272-9642
Cell: 719-580-6054

THIS ENTIRE PACKET MUST BE COMPLETED IN BLUE INK

Check one: ☐ Hospital Employee ☐ UNM Employee

1. Provider Name: _____
   Provider Legal / Birth Name: _____
2. Title: _____ Male ☐ Female ☐ Supervisor: _____
3. Start Date (Privilege Date): _____ Department: _____
4. Dept. Phone #: _____ Fax#: _____ Pager #: _____
5. Date of Birth: _____ Birth State: _____ Birth Country: _____
6. Social Security #: _____
7. DEA #: _____ DEA Expiration Date: _____
8. (BOP) Controlled Substance #: _____ Expiration Date: _____
9. Prof. License #: _____ Temporary ☐ Permanent ☐
10. Original Issue Date: _____ Expiration Date: _____
11. Certification Board: _____
12. Certification #: _____ Certification Date: _____
13. Medical/Prof. School: _____ Graduation Date: _____
14. Medicare PTAN #: _____
    New Mexico Medicaid #: _____
15. Home Address: _____
    _____
    Cell Phone #: _____
    Home Phone #: _____
16. Email Address: _____

Provider Signature: _____ Date: _____

Provider Billing/Dictation Number: _____ Date: _____

Assigned by UNM Hospital (Yvonne Cordova)

THE FOLLOWING INFORMATION IS REQUIRED BY PAYORS

PLEASE ATTACH COPIES

1. CNP, CNS : License, ANCC or NCC Card, Federal DEA, NM Board of Pharmacy, Diploma
2. PAC: License, NCCPA Card, Federal DEA, NM Board of Pharmacy, Diploma
3. CNM: RN License, CNM License, CNM Certification to Prescribe Dangerous Drugs, Federal DEA, NM Board of Pharmacy, Diploma
4. CRNA: RN License, CRNA Card, Diploma
5. PhD, PsyD, Audiologists, PharmD: License, Diploma/ Doctorate
6. LCSW, LPCC, LADC, LMFT, LPC, LMSW, LADAC, LPAT, LPC, LMHC License, Diploma

Medicaid

State of NM Medical Assistance Division – Provider Participation Agreement Application
Signature page

Use Blue Ink ONLY

Answer and initial questions A, B, C on page 10, print & sign & date where indicated in the middle of the page and initial bottom of page.

STATE OF NEW MEXICO
MEDICAL ASSISTANCE DIVISION
PROVIDER PARTICIPATION AGREEMENT
INDIVIDUAL APPLICANT WITHIN GROUP

Name of Individual	SSN	NPI

A) Have you ever had a license revoked, suspended or denied in any state? ☐ YES ☐ NO Initial_____

B) Have you ever been convicted of any criminal offense? ☐ YES ☐ NO Initial_____

C) Have you or any ever been excluded or suspended from participation in Title XVII (Medicare), Title XIX (Medicaid) or any other health care program? ☐ YES ☐ NO Initial_____

If YES to any of the above three questions, attach a brief statement of situation; date; city, county and professional association or court which handled the matter; any precinct case identification, and the adjudication or other result.

New Mexico Medicaid project staff may need to contact you regarding the completion of this form. Please list contact person and telephone number.

Contact Person: Yvonne Cordova *Telephone Number:* 505-272-9642

Whoever knowingly and willfully makes or causes to be made a false statement or representation of this statement, may be prosecuted under applicable federal or State laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or, where the entity already participates, a termination of its agreement or contract with the State agency.

Original signature required. Please use blue ink only.

INDIVIDUAL PROVIDER:

I understand that payment of claims will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state law.

Printed Name of Individual Practitioner: _____

Signature of Individual Practitioner: _____ Date _____

FOR STATE PURPOSES ONLY:

HUMAN SERVICES DEPARTMENT APPROVAL

☐ APPROVED ☐ NOT APPROVED

Reasons Not Approved:

Dates of Agreement: From: _____

Authorized Signature	Date

APPLICANT INITIAL HERE _____
CERTIFYING THE INFORMATION
ON THIS PAGE IS TRUE AND CORRECT

Medicare Application
855I & 855R

The following providers DO NOT complete the 855I or 855R
LPC, LPCC, LMFT, LADAC

Physician Assistants need to complete the 855I not the 855R

Everyone else must complete the 855I & 855R

Please sign signature pages in **Blue ink** only
855I
Section 3: answer yes or no, if yes follow the instructions

Section 15: Print – Sign – Date

Please sign signature pages in **Blue ink** only
855R
Section 6A: Print – Sign – Date

MEDICARE ENROLLMENT APPLICATION

PHYSICIANS AND NON-PHYSICIAN PRACTITIONERS

CMS-855I

SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION.

SEE PAGE 2 FOR INFORMATION ON WHERE TO MAIL THIS APPLICATION.

SEE PAGE 26 TO FIND THE LIST OF THE SUPPORTING DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

SECTION 3: FINAL ADVERSE LEGAL ACTIONS

This section captures information regarding final adverse legal actions, such as convictions, exclusions, license revocations and license suspensions. All applicable final adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

NOTE: To satisfy the reporting requirement, section 3 must be filled out in its entirety, **and** all applicable attachments must be included.

A. CONVICTIONS (AS DEFINED IN 42 C.F.R. SECTION 1001.2) WITHIN THE PRECEDING 10 YEARS

1. Any federal or state felony conviction(s).
2. Any misdemeanor conviction, under federal or state law, related to: (a) the delivery of an item or service under Medicare or a state health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
3. Any misdemeanor conviction, under federal or state law, related to the theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any misdemeanor conviction, under federal or state law, related to the interference with or obstruction of any investigation into any criminal offence described in 42 C.F.R. section 1001.101 or 1001.201.
5. Any misdemeanor conviction, under federal or state law, related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

B. EXCLUSIONS, REVOCATIONS OR SUSPENSIONS

1. Any current or past revocation or suspension of medical license.
2. Any current or past revocation or suspension of accreditation.
3. Any current or past suspension or exclusion imposed by the U.S. Department of Health and Human Service's Office of Inspector General (OIG).
4. Any current or past debarment from participation in any Federal Executive Branch procurement or non-procurement program.
5. Any other current or past Federal Sanctions.
6. Any Medicaid exclusion, revocation, or termination of any billing number.

C. FINAL ADVERSE LEGAL ACTION HISTORY

1. Have you, under any current or former name, ever had a final adverse legal action **listed above** imposed against you?

   ☐ YES – continue below

   ☐ NO – skip to section 4

2. If yes, report each final adverse legal action, when it occurred, and the federal or state agency or the court/ administrative body that imposed the action.

FINAL ADVERSE LEGAL ACTION	DATE	ACTION TAKEN BY

SECTION 15: CERTIFICATION STATEMENT AND SIGNATURE

As an individual practitioner, you are the only person who can sign this application. The authority to sign the application on your behalf may not be delegated to any other person.

The Certification Statement contains certain standards that must be met for initial and continuous enrollment in the Medicare program. Review these requirements carefully.

By signing this Certification Statement, you agree to adhere to all of the requirements listed therein and acknowledge that you may be denied entry into or have your billing privileges revoked from the Medicare program if any requirements are not met.

A. CERTIFICATION STATEMENT

You **MUST SIGN AND DATE** the certification statement below in order to be enrolled in the Medicare program. In doing so, you are attesting to meeting and maintaining the Medicare requirements stated below.

Under the penalty of perjury, I, the undersigned, certify to the following:

1. I have read the contents of this application, and the information contained herein is true, correct, and complete. If I become aware that any information in this application is not true, correct or complete, I agree to notify my designated Medicare Administrative Contractor of this fact in accordance with the time frames established in 42 C.F.R. section 424.516.
2. I authorize the Medicare Administrative Contractor to verify the information contained herein. I agree to notify the Medicare Administrative Contractor of any change in practice location, final adverse legal action, or any other changes to the information in this form in accordance with the timeframes established in 42 C.F.R. section 424.516. I understand that any change to my status as an individual practitioner may require the submission of a new application. I understand that any change in the business structure of my private practice may require the submission of a new application.
3. I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this application, may be punishable by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare billing privileges, and/or the imposition of fines, civil damages, and/or imprisonment.
4. I agree to abide by the Medicare laws, regulations and program instructions that apply to me or to the organization listed in section 4A of this application. The Medicare laws, regulations, and program instructions are available through the Medicare Administrative Contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations and program instructions (including, but not limited to, the Federal Anti-Kickback Statute, 42 U.S.C. section 1320a-7b(b) (section 1128B(b) of the Social Security Act) and the Physician Self-Referral Law (Stark Law), 42 U.S.C. section 1395nn (section 1877 of the Social Security Act)).
5. Neither I, nor any managing employee reported in this application, is currently sanctioned, suspended, debarred or excluded by Medicare or a State Health Care Program (e.g., Medicaid program), or any other Federal program, or is otherwise prohibited from providing services to Medicare or other federal program beneficiaries.
6. I agree that any existing or future overpayment made to me, or to my business as reported in section 4A, by the Medicare program, may be recouped by Medicare through the withholding of future payments.
7. I understand that the Medicare identification number (PTAN) issued to me can only be used by me or by a Medicare enrolled provider or supplier to whom I have reassigned my benefits under current Medicare regulations when billing for services rendered by me.
8. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.
9. I further certify that I am the individual practitioner who is applying for Medicare billing privileges and the signature below is my signature.

B. SIGNATURE AND DATE

First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.

Practitioner Signature *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*	Date Signed *(mm/dd/yyyy)*

In order to process this application it MUST be signed and dated.

MEDICARE ENROLLMENT APPLICATION

REASSIGNMENT OF MEDICARE BENEFITS

CMS-855R

SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION AND FOR INFORMATION ON WHERE TO MAIL THIS COMPLETED APPLICATION.

TO VIEW YOUR CURRENT MEDICARE REASSIGNMENTS GO TO:
HTTPS://PECOS.CMS.HHS.GOV

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SECTION 5: CONTACT PERSON INFORMATION (Optional)

If questions arise during the processing of this reassignment, the designated MAC will contact the individual indicated below. If a contact person is not furnished, the MAC will contact the individual practitioner is Section 3.

First Name	Middle Initial	Last Name	Jr., Sr., M.D., etc.
Yvonne		Cordova	

Contact Person Address Line 1 *(Street Name And Number)*
400 Tijeras Ave. NW

Contact Person Address Line 2 *(Suite, Room, Apt. #, etc.)*
Suite 450

City/Town	State	ZIP Code +4
Albuquerque	NM	87102

Telephone Number	Fax Number *(if applicable)*	Email Address *(if applicable)*
(505) 272-9642	(505) 272-9991	yjcordova@salud.unm.edu

Relationship or Affiliation to Individual or Organization/Group *(Spouse, Secretary, Attorney, Billing Agent, etc.)*
Delegated Official

NOTE: The Contact Person listed in this section will only be authorized to discuss issues concerning this reassignment. The designated MAC will not discuss any other Medicare issues about the organization/group or individual practitioner beyond this reassignment application with the above Contact Person.

SECTION 6: CERTIFICATION STATEMENTS AND SIGNATURES

Title XVIII of the Social Security Act prohibits payment for services provided by an individual practitioner to be paid to another individual or organization/group unless the individual practitioner who provided the services specifically authorizes another individual or organization/group to receive said payments in accordance with 42 CFR § 424.73 and 42 CFR § 424.80. All individual practitioners who allow another individual or organization/group to receive payment for their services must sign the Reassignment of Medicare Benefits Statement below. By signing this Reassignment of Medicare Benefits Statement, you are authorizing the organization/group or individual identified in Section 2 to receive Medicare payments on your behalf.

The signature(s) below authorize the reassignment of benefits, or the termination of a reassignment of benefits, between the individual practitioner shown in Section 3 and the organization/group shown in Section 2.

The employment of, or contract between, the individual practitioner and organization/group or individual must be in compliance with CMS regulations and applicable Medicare program safeguard standards described in 42 CFR § 424.80.

These signatures also serve as an attestation and acknowledgment to the compliance with all laws and regulations pertaining to the reassignment of Medicare benefits.

A. Individual Practitioner Certification Statement and Signature

Under penalty of perjury, I, the undersigned, certify that the above information is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws.

Individual Practitioner First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.

Individual Practitioner Signature *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*	Date Signed *(mm/dd/yyyy)*

B. Delegated or Authorized Official of Organization/Group Certification Statement and Signature

Under penalty of perjury, I, the undersigned, certify that the above information is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me and/or the organization/group to liability under civil and criminal laws.

Delegated or Authorized Official's First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.

Delegated or Authorized Official's Signature *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*	Date Signed *(mm/dd/yyyy)*

All signatures must be original and signed in blue ink. Applications with signatures deemed not original or not dated will not be processed. Stamped, faxed or copied signatures will not be accepted.

MEDICARE Enrollment Application 855I & 855R
I can work on your behalf.

SURROGATE

I will complete your Medicare PECOS Online Application for you but it requires your approval and electronic signature.
I will log onto Medicare PECOS I&A to request that I work on your behalf as surrogate. An email request will be sent to you to approve.

You will need to logon to the website using your NPI USER ID and PASSWORD so you can approve.
https://pecos.cms.hhs.gov/pecos/login.do#headingLv1
If you need assistance call the PECOS Help Desk @ 1-866-484-8049 options #1, #1,#2,#2,#2,#2.

As soon as you approve, please send me an email so I can logon. **Once I have completed the application you will receive another email asking you to logon & electronically sign.**

Please let me know if you have any questions.
Thank you.

9-22-17