

Any question call us at: 305-818-5940

Fax the form to: 305-819-4064 or e-mail to: info@pnssystem.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
<i>Social Security Number (Required)</i>	<i>Date of Birth (mm/dd/yyyy)</i>	<i>State Birth</i>	<i>Country Birth</i> <i>Date owner more than 5%</i> <i>% ownership</i>

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:

<i>First Name</i>	<i>Middle Initial</i>	<i>Last Name</i>	<i>Title Corporation</i>
<i>Social Security Number (Required)</i>	<i>Date of Birth (mm/dd/yyyy)</i>	<i>State Birth</i>	<i>Country Birth Date owner more than 5% % ownership</i>

:

<i>First Name</i>	<i>Middle Initial</i>	<i>Last Name</i>	<i>Title Corporation</i>
<i>Social Security Number (Required)</i>	<i>Date of Birth (mm/dd/yyyy)</i>	<i>State Birth</i>	<i>Country Birth Date owner more than 5% % ownership</i>

:

<i>First Name</i>	<i>Middle Initial</i>	<i>Last Name</i>	<i>Title Corporation</i>
<i>Social Security Number (Required)</i>	<i>Date of Birth (mm/dd/yyyy)</i>	<i>State Birth</i>	<i>Country Birth Date owner more than 5% % ownership</i>

:

MANGING CONTROL

Administrator:

<i>First Name</i>	<i>Middle Initial</i>	<i>Last Name</i>
<i>Social Security Number (Required)</i>	<i>Date of Birth (mm/dd/yyyy)</i>	<i>State Birth Country Birth Effective Date % Control as officer</i>

:

Alt. Administrator

<i>First Name</i>	<i>Middle Initial</i>	<i>Last Name</i>
<i>Social Security Number (Required)</i>	<i>Date of Birth (mm/dd/yyyy)</i>	<i>State Birth Country Birth Effective Date % Control as officer</i>

:

DON:

<i>First Name</i>	<i>Middle Initial</i>	<i>Last Name</i>
<i>Social Security Number (Required)</i>	<i>Date of Birth (mm/dd/yyyy)</i>	<i>State Birth Country Birth Effective Date % Control as officer</i>

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:

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.

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