

* 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



MEDICARE APPLICATION DATA



\$ 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)

PHONE: _____ FAX: _____

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

**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*

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

<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: License:

<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>

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)

VOID CHECK (Email Copy)

Full Check List: (to be emailed PDF Format)

Medicare Application data (all questions answered)

Business Licenses (City, County)

AHCA License

Tax ID

Voided Check

CLIA License

YOUR BANK INFORMATION (Financial Institution)

BANK

Name _____

Street Address _____

City _____ State _____ Zip Code _____

Bank Telephone Number _____

Bank Contact Person _____

Bank Routing Transit Number (nine digit) _____

Bank Account Number _____

Type of Account (check one) Checking Account Savings Account

** application fee \$ 685.00 will be paid electronic*

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