GLENN SOLOMON (*pro hac vice*)
CHRISTOPHER CHARLES JEW (*pro hac vice*)
WILLIAM MAVITY (*pro hac vice*)
KING & SPALDING LLP
633 West Fifth Street, Suite 1600
Los Angeles, CA 90071
Telephone: (213) 443-4355
Facsimile: (213) 443-4310
Email: gsolomon@kslaw.com
cjew@kslaw.com

SARA BRINKMANN (*pro hac vice*)
KING & SPALDING LLP
1100 Louisiana Street, Suite 4100
Houston, TX 77002-5213
Telephone: (713) 751-3200
Facsimile: (713) 751-3290
Email: sbrinkmann@kslaw.com

CONNOR R. BREWER (SBN 040378)
KING & SPALDING LLP
2601 Olive Street, Suite 2300
Dallas, TX 75201
Telephone: (214) 764-4420
Facsimile: (214) 764-4601
Email: cbrewer@kslaw.com

Attorneys for Defendants
Radiology Partners, Inc.; Sonoran Radiology, Ltd.

UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

PHOENIX DIVISION

United Healthcare Services, Inc.; UnitedHealthcare Insurance Company; and UMR, Inc.,

Plaintiffs,

v.

Radiology Partners, Inc.; and Sonoran Radiology, Ltd.,

Defendants.

Case No. 2:25-cv-02862-PHX-GMS

DEFENDANTS RADIOLOGY PARTNERS, INC. AND SONORAN RADIOLOGY, LTD.'S REQUEST FOR JUDICIAL NOTICE IN SUPPORT OF MOTION TO TRANSFER, OR IN THE ALTERNATIVE, DISMISS AND OR STAY

NOW INTO THE COURT, through undersigned counsel, comes Defendants Radiology Partners, Inc. ("RP") and Sonoran Radiology, Ltd. ("Sonoran") (collectively, "Defendants"), which respectfully request that this Court take judicial notice of Exhibits 1 – 27 attached hereto, filed in support of Defendant's Motion to Transfer, Stay, or Dismiss Under the First-to-File Rule, or Alternatively, Dismiss Pursuant to F. R. C. P. 12(b)(6).

DATED: November 3, 2025

Respectfully submitted,

KING & SPALDING LLP

By: */s/ Glenn Solomom*
Glenn Solomon
Sara Brinkmann
Christopher Charles Jew
Connor R. Brewer
William Mavity

Attorneys for Defendants
Radiology Partners, Inc.
Sonoran Radiology, Ltd.

MEMORANDUM OF POINTS AND AUTHORITIES

Pursuant to Fed. R. Evid. 201, Defendants Radiology Partners, Inc. ("RP") and Sonoran Radiology, Ltd. ("Sonoran") (collectively "Defendants") respectfully request that the Court take judicial notice ("RJN") of the attached Exhibits 1 - 27 in connection with Defendants' concurrently filed Motion to Transfer, or in the alternative, Dismiss or Stay.

Defendants are not requesting judicial notice of the Exhibits for the truth of the matters asserted therein. Rather, judicial notice is only sought for the respective relevance of each document to the issues raised in the concurrently filed motion. Namely, Defendants seek to have this Court transfer, or in the alternative dismiss and/or stay, United's complaint based on the First to File rule. This Request asks this Court to take notice of publicly available documents from Federal Court in the Central District of California ("CD CA") and Texas State Court, which will show that United has a previously filed and still pending interrelated lawsuit alleging substantially similar core wrongdoing against RP.

Defendants also seek to have this Court take judicial notice of publicly available government information regarding 1) the employment statuses and affiliations of the radiologists at issue in this lawsuit and 2) trade names for Sonoran.

I. Applicable Law

"When ruling on a Rule 12(b)(6) Motion to Dismiss… [courts may] consider certain materials— documents attached to the complaint, documents incorporated by reference in the complaint, or matters of judicial notice—without converting the motion to dismiss into a motion for summary judgment." *United States v. Ritchie*, 342 F.3d 903, 908 (9th Cir. 2003); *Shaw v. Hahn*, 56 F.3d 1128, 1129 (9th Cir. 1995) ("In deciding whether to dismiss a claim under Fed.R.Civ.P. 12(b)(6), a court may look beyond the plaintiff's complaint to matters of public record.")

Facts properly subject to judicial notice are those that are "not subject to reasonable dispute," because they are "generally known within the trial court's territorial jurisdiction; or "can be accurately and readily determined from sources whose accuracy cannot reasonably be questioned." Fed. R. Evid. 201(b)(1)-(2).

Such documents include publicly available government documents such as those prepared

by government agencies or available on state Secretary of State websites. *See*, e.g., *Advanced Reimbursement Solutions LLC v. Aetna Life Insurance Company* (D. Ariz., Mar. 25, 2022, No. CV-19-05395-PHX-DLR) 2022 WL 889058, at *4) (holding that "[t]he Court also can consider the Medicare Claims Processing Manual because it is a publicly available document produced by a federal agency, the content of which is not subject to reasonable dispute."); *Gerritsen v. Warner Bros. Ent. Inc.*, 112 F. Supp. 3d 1011, 1033 (C.D. Cal. 2015) ("Under Rule 201, the court can take judicial notice of "[p]ublic records and government documents available from reliable sources on the Internet," such as websites run by governmental agencies."); *Applied Underwriters, Inc. v. Lara*, 530 F. Supp. 3d 914, 924 (E.D. Cal. 2021), aff'd on other grounds, 37 F.4th 579 (9th Cir. 2022) ("the court further takes judicial notice of Exhibits 8 and 9 to defendants' Request for Judicial Notice, which are business entity profiles for plaintiffs Applied and ARS, retrieved from the Nebraska Secretary of State website, and thus matters of public record not subject to reasonable dispute.")

These also include documents filed in other Court proceedings. *See*, *Jiangmen Kinwai Furniture Decoration Co. Ltd v. Int'l Mkt. Centers, Inc.,* 719 F. App'x 556, 558 (9th Cir. 2017) (Nevada District Court was entitled to consider records from Northern District of CA case when ruling on motion to dismiss pursuant to first-to-file rule, noting "district courts are permitted to take judicial notice of other courts' proceedings, particularly where, "those proceedings have a direct relation to matters at issue."); See also, *Hansen v. Musk*, 653 F. Supp. 3d 832, 837 (D. Nev. 2023), aff'd, 122 F.4th 1162 (9th Cir. 2024), *cert. denied sub nom. Hansen v. Tesla, Inc.*, 145 S. Ct. 2850 (2025) (taking judicial notice of publicly filed arbitration award for use in preclusion analysis in ruling on motion to dismiss)

II. The Court May Take Judicial Notice of Court Records Showing Chronology of Lawsuits, Similarity of Parties and Issues for a First to File Analysis

A. Exhibits 1 – 6: CD Cal Lawsuit Materials

The first-to-file rule is a "generally recognized doctrine of federal comity which permits a district court to decline jurisdiction over an action when a complaint involving the same parties and issues has already been filed in another district." *Winters v. Quicken Loans Inc.*, 2021 WL

948767, at *2 (D. Ariz. Mar. 12, 2021) (quoting *Pacesetter Sys., Inc. v. Medtronic, Inc.*, 678 F.2d 93, 94–95 (9th Cir. 1982)).

"When deciding whether to apply the first to file rule, district courts look to three factors: (**1) chronology of the lawsuits; (2) similarity of the parties; and (3) similarity of the issues."** *Paparella v. Plume Design Inc.*, 2023 WL 2463778, at *2–3 (D. Ariz. Mar. 10, 2023). RP and Sonoran asks this Court to Judicially Notice show that this lawsuit involves all three factors and support dismissing, transferring or staying.

Because the "First to File" rule contemplates a court considering the parties and arguments present in prior proceedings, Courts often grant judicial notice of documents from those prior proceedings when ruling on such motions. The following Exhibits demonstrate why United's complaint should be dismissed, transferred, or stayed.

Exhibits 1 and **2**, attached hereto, show that United filed the CA Lawsuit in 2023, more than two years before filing this lawsuit. Following RP's Motion to Compel Arbitration, the court in the CA Lawsuit stayed the action pending the resolution of arbitration. See Ex. 3. This was in order to avoid the potential for inconsistent results in Court versus arbitration on the underlying core issues, among other things.

Here, as in the CD CA Lawsuit, United Healthcare Services, Inc., is a plaintiff and RP is a defendant. The other parties that United has added to this matter are subsidiaries and/or affiliates of each of them. Both complaints show that the allegations asserted by United in the CA lawsuit include many that are substantially similar to those asserted here, including among others, the core alleged issue of whether Sonoran is the group providing the services for which it bills – i.e., United's bogus pass-through billing argument.

1. **UnitedHealthcare of Texas, Inc. and United Healthcare Services, Inc.'s Complaint against Radiology Partners, Inc., filed on April 14, 2023 [ECF No. 1]; Case No. 2:23-cv-02825**

Relevant Excerpts include:

Paragraph 3: "Since as early as 2014, Radiology Partners has engaged in a classic form of healthcare fraud called pass-through billing. Simply put, Radiology Partners, caused its affiliated medical groups to bill for services that they did not perform."

Paragraph 92: "On information and belief, Radiology Partners' pass-through billing of claims through the Agreement with United is just one example of Radiology Partners' use of United contracts to pass-through bill."

2. United Healthcare Services, Inc.'s First Amended Complaint against Radiology Partners, Inc., filed on August 2, 2023 [ECF No. 38]; Case No. 2:23-cv-02825

Relevant Excerpts include:

Paragraph 3: "Since as early as 2014, Radiology Partners has engaged in a classic form of healthcare fraud called pass-through billing. Simply put, Radiology Partners, caused its affiliated medical groups to bill for services that they did not perform."

Paragraph 56: "… The examples provided below [related to RP affiliated medical groups in Texas, Florida, and North Carolina] are merely examples, and are not intended to limit the scope of this case or the resulting damages incurred by United and its customers and members."

Paragraph 88: "On information and belief Radiology Partners engaged in its fraudulent billing scheme in **several states across the country**. The following are just a few examples of Radiology Partners' scheme."

Paragraph 173: "**Radiology Partners acquired medical groups across the country** so that it had control over how the claims for services performed by providers affiliated with those medical groups could be billed."

3. Order of Hon. Michael W. Fitzgerald, Granting Defendant's Motion to Compel Arbitration, September 27, 2023 [ECF. No. 90], Case No. 2:23-cv-02825

Relevant Excerpts include:

p. 9: "Accordingly, the Motion is **GRANTED**. Plaintiff is **ORDERED** to submit its claims to arbitration as provided by the Arbitration Provision. 9 U.S.C. § 4…. the Court **STAYS** this action pending completion of the arbitration. *See* 9 U.S.C. § 3. The parties shall file a joint status report every 90 days apprising the Court of the status of the arbitration proceedings, with the first report due on **January 29, 2024**."

4. Application to Confirm Final Arbitration Award, August 1, 2025, Singleton Associates, P.A. v. United Healthcare of Texas, Inc., Case No. 2025-54399

Relevant Excerpts include:

Ex. A to Application, P. 6: "The Panel determines that United is not entitled to any recovery against Singleton."

5. **Agreed Final Judgment, September 5, 2025, Singleton Associates, P.A. v. United Healthcare of Texas, Inc., Case No. 2025-54399**

6. **Joint Status Report of United Healthcare Services, Inc. and Radiology Partners, Inc., filed on September 10, 2025 [ECF No. 144]; Case No. 2:23-cv-02825**

Relevant Excerpts include:

P. 2: "On August 8, 2025, United, through its subsidiaries, filed a complaint in the U.S. District Court for the District of Arizona, case no. 2:25-cv-02862, against Radiology Partners and another Radiology Partners' affiliated medical group, Sonoran Radiology, Ltd. ("Sonoran")."

III. The Court May Take Judicial Notice of Government Records and Publications

As noted above, the "Under Rule 201, the court can take judicial notice of "[p]ublic records and government documents available from reliable sources on the Internet," such as websites run by governmental agencies." *U.S. ex rel. Modglin v. DJO Glob. Inc.,* 48 F. Supp. 3d 1362, 1381 (C.D. Cal. 2014), *aff'd sub nom. United States v. DJO Glob., Inc.,* 678 F. App'x 594 (9th Cir. 2017)

A. Exhibits 7 – 10: Arizona Secretary of State Trade Names and Filings:

7. **AZ Secretary of State Trade Names and Trademarks Page**

Relevant Excerpts include:

Arizona's representation that "a trade name is similar to a "doing business as" ("DBA") name, and is not legally required but is an acceptable business practice."

8. **Sonoran Radiology Ltd. Arizona Secretary of State Profile**

9. **Arizona Corp Commission Trade Names for Sonoran**

This page shows that in 2019 Sonoran filed for and subsequently utilizes the following seven trade names: 1) Radiology Partners SMIL, (2) RP SMIL, (3) Radiology Partners Valley, (4) RP Valley, (5) Radiology Partners Saguaro, (6) RP Saguaro, and (7) RP Sol.

10. **Arizona Corp Commission Sun City Imaging Profile**

This page shows that Sun City Imaging, which United asserts "has its own TIN and, its own in-network contract with United dating back to 2005" no longer exists. (Complaint at ¶ 144). Thus, there is no separate Sun City Agreement that United could be utilizing instead.

B. ***Exhibit 11: NUCC 1500 Claim Form Reference:***

11. National Uniform Claim Committee ("NUCC") 1500 Claim Form Reference Instruction Manual

The National Uniform Claim Committee NUCC Manual instructs that the identity and NPI of the rendering provider, e.g., the radiologist, be identified in box 24J (Ex. 11. at 44) and the billing provider be identified by TIN in boxes 25 and 33 (*S*ee Ex. 11. at 49, 55).

Exhibits 12 – 27: CMS Revalidation Materials:

C. Exhibits 12 - 27: CMS Reassignment and Revalidation Materials:

Exhibits 12 – 18 explain that Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers/suppliers to "revalidate" or "renew" their Medicare enrollment information to maintain Medicare billing privileges. Generally, providers are required to perform this "revalidation" every three or five years. **See, Exs. 12, 13**. Revalidation occurs using the Provider Enrollment, Chain and Ownership System (PECOS). **Ex. 14 at p. 2.** ("This dataset is based on information gathered from the Provider Enrollment, Chain and Ownership System (PECOS).") Alternatively, Revalidation can be completed by paper using a CMS-855I or 855B forms. **See, Exs. 15, 16.**

Providers certify when submitting a CMS-855I form that "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." **Ex. 15 at p. 23.**

Among the information that providers must provide is information regarding "reassignments." PECOS states that "Reassignments" are "[a]n arrangement in which an individual assigns his/her benefits, and payment of those benefits, to a group, individual, or organization already enrolled or currently enrolling in the Medicare program. The individual is employed by or contracts with the group/organization to which benefits are reassigned." **Ex. 17 at p. 10.**

CMS provides "a searchable database that allows you to look up the revalidation due date

for Medicare providers who must revalidate their enrollment record information every three or five years. CMS sets every provider's revalidation due date at the end of a month and posts the revalidation due date six to seven months in advance." **Ex. 18**. This tool pulls from the Revalidation Due Date List dataset, The Revalidation Reassignment List, and the Revalidation Clinic Group practice Reassignment Datasets, all of which are gathered from PECOS. *Id.*

The Revalidation Due Date List dataset "contains revalidation due dates for Medicare providers who are due to revalidate in the following six months. If a provider's due date does not fall within the ensuing six months, the due date is marked 'TBD'. In addition, the dataset also includes subfiles with reassignment information for a given provider as well as due date listings for clinics and group practices and their providers. *Id.* CMS's database is updated monthly. (The data was updated as of November 3, 2025. The next refresh date will be December 1, 2025). *Id*.

Exhibits: 12 - 18

12. CMS Page: Additional Information on Revalidation

13. CMS Page: Revalidation Due Date List

14. CMS Page: Revalidation Reassignment List

15. CMS 855I Form

16. CMS 855B Form

17. Medicare Enrollment PECOS Glossary

18. CMS Page: Medicare Revalidation List

Exhibits: 19 – 27:

Exhibits 19 – 27 are reports pulled from CMS' revalidation database. The information contained therein is pulled from provider enrollment and revalidation through the PECOS system.

Defendants do not ask the court to notice these reports for the truth of the affiliations, but for the fact that the providers at issue have made these representations regarding their affiliation with radiology groups, and that this information was publicly available.

The revalidation reports show that the providers affiliated with Sonoran, including the five physicians specifically identified in United's complaint revalidated their enrollment with Medicare, and updated their information through PECOS showing which radiology groups that

they had reassigned their benefits and right to get paid to. Each of these physicians would have attested to the accuracy of what they submitted. Notably, each of the five providers identified in United's complaint note that they have reassigned their benefits to multiple providers.

A comparison between the numbers of providers associated with the various entities referenced in United's complaint (Sonoran Radiology Ltd, Associated Valley Radiologists, Southwest Diagnostic Imaging, LLC, and Evac LLC) shows that the numbers of providers associated with Sonoran, Associated Valley, Southwest Diagnostic Imaging, and Evac do not match with one another. This contradicts United's assertion Sonoran is a fictitious entity and that those groups overlap wholly with Sonoran.

The chart below summarizes the numbers of "reassigned providers" associated with Sonoran (as shown in **Exs. 19 – 22**)

Organization-Entity	**State**	**Reassigned Providers**
Sonoran Radiology Ltd, NPI: 1033745708	AL	6
Sonoran Radiology Ltd, NPI: 1033745708	AZ	426
Sonoran Radiology Ltd, NPI: 1033745708	CA	91
Sonoran Radiology Ltd, NPI: 1033745708	CO	52
Sonoran Radiology Ltd, NPI: 1033745708	CT	3
Sonoran Radiology Ltd, NPI: 1033745708	DC	6
Sonoran Radiology Ltd, NPI: 1033745708	DE	1
Sonoran Radiology Ltd, NPI: 1033745708	FL	48

Organization-Entity	State	Reassigned Providers
Sonoran Radiology Ltd, NPI: 1033745708	GA	12
Sonoran Radiology Ltd, NPI: 1033745708	HI	4
Sonoran Radiology Ltd, NPI: 1033745708	IA	2
Sonoran Radiology Ltd, NPI: 1033745708	ID	5
Sonoran Radiology Ltd, NPI: 1033745708	IL	20
Sonoran Radiology Ltd, NPI: 1033745708	IN	3
Sonoran Radiology Ltd, NPI: 1033745708	KS	4
Sonoran Radiology Ltd, NPI: 1033745708	KY	5
Sonoran Radiology Ltd, NPI: 1033745708	LA	6
Sonoran Radiology Ltd, NPI: 1033745708	MA	10
Sonoran Radiology Ltd, NPI: 1033745708	MD	5
Sonoran Radiology Ltd, NPI: 1033745708	ME	1
Sonoran Radiology Ltd, NPI: 1033745708	MI	9
Sonoran Radiology Ltd, NPI:	MN	5

Organization-Entity	State	Reassigned Providers
1033745708		
Sonoran Radiology Ltd, NPI: 1033745708	MO	3
Sonoran Radiology Ltd, NPI: 1033745708	MS	1
Sonoran Radiology Ltd, NPI: 1033745708	MT	2
Sonoran Radiology Ltd, NPI: 1033745708	NC	9
Sonoran Radiology Ltd, NPI: 1033745708	NE	0
Sonoran Radiology Ltd, NPI: 1033745708	NH	1
Sonoran Radiology Ltd, NPI: 1033745708	NJ	5
Sonoran Radiology Ltd, NPI: 1033745708	NM	12
Sonoran Radiology Ltd, NPI: 1033745708	NV	18
Sonoran Radiology Ltd, NPI: 1033745708	NY	7
Sonoran Radiology Ltd, NPI: 1033745708	OH	15
Sonoran Radiology Ltd, NPI: 1033745708	OK	5
Sonoran Radiology Ltd, NPI: 1033745708	OR	14

Organization-Entity	State	Reassigned Providers
Sonoran Radiology Ltd, NPI: 1033745708	PA	15
Sonoran Radiology Ltd, NPI: 1033745708	RI	2
Sonoran Radiology Ltd, NPI: 1033745708	SC	3
Sonoran Radiology Ltd, NPI: 1033745708	SD	1
Sonoran Radiology Ltd, NPI: 1033745708	TN	10
Sonoran Radiology Ltd, NPI: 1033745708	TX	132
Sonoran Radiology Ltd, NPI: 1033745708	UT	11
Sonoran Radiology Ltd, NPI: 1033745708	VA	5
Sonoran Radiology Ltd, NPI: 1033745708	WA	10
Sonoran Radiology Ltd, NPI: 1033745708	WI	8
Sonoran Radiology Ltd, NPI: 1033745708	WY	1
Total Number of Reassigned Providers Per Entity = 1,014		
Associated Valley Radiologists Ltd, NPI: 1932683257	AL	1
Associated Valley Radiologists Ltd, NPI: 1932683257	AZ	209

Organization-Entity	State	Reassigned Providers
Associated Valley Radiologists Ltd, NPI: 1932683257	CA	19
Associated Valley Radiologists Ltd, NPI: 1932683257	CO	1
Associated Valley Radiologists Ltd, NPI: 1932683257	DE	1
Associated Valley Radiologists Ltd, NPI: 1932683257	FL	9
Associated Valley Radiologists Ltd, NPI: 1932683257	GA	2
Associated Valley Radiologists Ltd, NPI: 1932683257	HI	1
Associated Valley Radiologists Ltd, NPI: 1932683257	IL	3
Associated Valley Radiologists Ltd, NPI: 1932683257	IN	1
Associated Valley Radiologists Ltd, NPI: 1932683257	KY	2
Associated Valley Radiologists Ltd, NPI: 1932683257	MT	1
Associated Valley Radiologists Ltd, NPI: 1932683257	NC	3
Associated Valley Radiologists Ltd, NPI: 1932683257	NV	8
Associated Valley Radiologists Ltd, NPI: 1932683257	OH	3
Associated Valley Radiologists	OR	2

Organization-Entity	State	Reassigned Providers
Ltd, NPI: 1932683257		
Associated Valley Radiologists Ltd, NPI: 1932683257	PA	4
Associated Valley Radiologists Ltd, NPI: 1932683257	TN	3
Associated Valley Radiologists Ltd, NPI: 1932683257	TX	18
Associated Valley Radiologists Ltd, NPI: 1932683257	UT	5
Associated Valley Radiologists Ltd, NPI: 1932683257	VA	4
Associated Valley Radiologists Ltd, NPI: 1932683257	WI	2
Associated Valley Radiologists Ltd, NPI: 1932683257	WV	1
Total Number of Reassigned Providers per Entity = 303		
Evac LLC, NPI: 1073772588	AZ	22
Total Number of Reassigned Providers per Entity = 22		
Southwest Diagnostic Imaging LLC, NPI: 1902896236	AL	1
Southwest Diagnostic Imaging LLC, NPI: 1902896236	AZ	163
Southwest Diagnostic Imaging LLC, NPI: 1902896236	CA	12
Southwest Diagnostic Imaging LLC, NPI: 1902896236	CO	4
Southwest Diagnostic Imaging	FL	8

Organization-Entity	State	Reassigned Providers
LLC, NPI: 1902896236		
Southwest Diagnostic Imaging LLC, NPI: 1902896236	GA	4
Southwest Diagnostic Imaging LLC, NPI: 1902896236	HI	2
Southwest Diagnostic Imaging LLC, NPI: 1902896236	IA	1
Southwest Diagnostic Imaging LLC, NPI: 1902896236	IL	1
Southwest Diagnostic Imaging LLC, NPI: 1902896236	LA	1
Southwest Diagnostic Imaging LLC, NPI: 1902896236	MA	2
Southwest Diagnostic Imaging LLC, NPI: 1902896236	MD	1
Southwest Diagnostic Imaging LLC, NPI: 1902896236	NE	1
Southwest Diagnostic Imaging LLC, NPI: 1902896236	NV	5
Southwest Diagnostic Imaging LLC, NPI: 1902896236	NY	2
Southwest Diagnostic Imaging LLC, NPI: 1902896236	OK	3
Southwest Diagnostic Imaging LLC, NPI: 1902896236	OR	1
Southwest Diagnostic Imaging LLC, NPI: 1902896236	PA	1

Organization-Entity	State	Reassigned Providers
Southwest Diagnostic Imaging LLC, NPI: 1902896236	TX	9
Southwest Diagnostic Imaging LLC, NPI: 1902896236	UT	6
Southwest Diagnostic Imaging LLC, NPI: 1902896236	VA	1
Southwest Diagnostic Imaging LLC, NPI: 1902896236	WA	1
Southwest Diagnostic Imaging LLC, NPI: 1902896236	WI	1
Total Number of Reassigned Providers per Entity = 231		

19. Sonoran Provider CMS Associated Providers

20. Associated Valley CMS Associated Providers

21. Southwest Diagnostic Imaging CMS Associated Providers

22. Evac LLC Associated Providers

23. Dr. Harvin Revalidation Page

Dr. Harvin's page shows that he has reassigned his benefits to both Sonoran Radiology Ltd. And Southwest Diagnostic Imaging LLC in his revalidations to CMS.

24. Dr. Slethaug Revalidation Page

Dr. Slethaug's page shows that he has reassigned his benefits to eighteen different radiology groups, including Associated Valley Radiologists, Ltd. and Sonoran Radiology Ltd. in his revalidations to CMS.

25. Dr. Lai Revalidation Page

Dr. Lai (Dubes)' page shows that she has reassigned her benefits to both Sonoran Radiology Ltd. And Southwest Diagnostic Imaging LLC in her revalidations to CMS.

26. Dr. Diegnan Revalidation Page

Dr. Diegnan's page shows that she has reassigned her benefits to four groups including

Associated Valley Radiologists Ltd, Sonoran Radiology Ltd. And Southwest Diagnostic Imaging LLC in her revalidations to CMS.

27. <u>Dr. Barclay-White Revalidation Page</u>

Dr. Barclay-White's page shows that he has reassigned his benefits to three groups including Associated Valley Radiologists Ltd, Sonoran Radiology Ltd. in his revalidations to CMS.

DATED: November 3, 2025

Respectfully submitted,

KING & SPALDING LLP

By: */s/Glenn Solomom*
Glenn Solomon
Sara Brinkmann
Christopher Charles Jew
Connor R. Brewer
William Mavity

Attorneys for Defendants
Radiology Partners, Inc.
Sonoran Radiology, Ltd.

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EXHIBIT 1

ROBINS, KAPLAN LLP
Roman Silberfeld, Bar No. 62783
RSilberfeld@RobinsKaplan.com
Tommy H. Du (CA Bar No. 305117)
TDu@robinskaplan.com
2121 Avenue of the Stars, Suite 2800
Los Angeles, CA 90067-5052
(310) 552-0130

Attorneys for UnitedHealthcare of Texas, Inc. and United Healthcare Services, Inc.

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

UNITEDHEALTHCARE OF TEXAS, INC. AND UNITED HEALTHCARE SERVICES, INC. Plaintiffs, v. RADIOLOGY PARTNERS, INC. Defendant.	Case No. **COMPLAINT**

Plaintiffs UnitedHealthcare of Texas, Inc., and United HealthCare Services, Inc. (collectively, "United") hereby state and allege as follows:

INTRODUCTION

1. Radiology Partners, Inc. ("Radiology Partners") is a rapidly growing physician-staffing company backed by billion-dollar private equity firms. In its unscrupulous pursuit of profits Radiology Partners orchestrated a pass-through billing scheme intended to defraud United, its customers, and its members of tens of millions of dollars. In addition to being unlawful, Radiology Partners' scheme unfairly drives up the cost of healthcare for patients and payors alike.

2. Since Radiology Partners was founded by former DaVita

ROBINS KAPLAN LLP

executives in 2012, it has acquired control over the practices of 3,300 radiologists across 35 different states.

3. Since as early as 2014, Radiology Partners has engaged in a classic form of healthcare fraud called pass-through billing. Simply put, Radiology Partners, caused its affiliated medical groups to bill for services that they did not perform.

4. Acting in concert with its affiliated medical groups, Radiology Partners deliberately caused thousands of claims to be improperly billed to United under network contracts, even though the in-network provider did not perform the underlying services being billed.

5. For example, one of Radiology Partners' affiliated radiology groups, Singleton Associates P.A. ("Singleton"), was a small radiology practice located in Houston, Texas that was contracted to practice at two local hospitals.

6. Singleton obtained particularly high reimbursement rates from United under a contract executed in 1998 (the "Agreement"). The Agreement made clear that Singleton was only entitled to reimbursement for services performed by its "Medical Group Physicians" who were "shareholders, partners or employees" of Singleton, prohibited Singleton from assigning its rights and responsibilities under the contract without written consent from United, and required Singleton to notify United of any changes in ownership or control.

7. For years, Singleton submitted claims for reimbursement under the Agreement without issue for services performed by its Medical Group Physicians located in the Houston area.

8. That changed in 2014 when Singleton was effectively acquired by Radiology Partners. Once Singleton was controlled by Radiology Partners, Radiology Partners caused Singleton to breach the Agreement by

submitting claims for services performed by providers who were not shareholders, partners, or employees of Singleton (the "Unauthorized Providers") and who were not performing services at hospitals where Singleton was contracted. Likewise, Radiology Partners caused Singleton to fraudulently bill United for services performed on individuals who were not Singleton's patients.

9. Radiology Partners directed and conspired with Singleton to engage in a fraudulent pass-through billing scheme to deceive United by submitting claims for services performed by Unauthorized Providers, many of whom were located outside of Houston, and in some cases, even outside of Texas. The sole purpose of the pass-through billing was to maximize Radiology Partners' profits for services performed by their affiliated medical groups.

10. The scheme grew over time. In 2013, before Radiology Partners took over Singleton, 70 unique providers performed services that were billed under the Agreement. That number increased to more than 150 unique providers in 2017; nearly 315 unique providers in 2018; more than 500 unique providers in 2019; and to more than ***1,000*** unique providers in 2022. Upon information and belief, most of the providers billing under Singleton's contract since at least 2017 were practicing with medical groups *other than* Singleton.

11. Radiology Partners' interference with Singleton's contracts with United and its conspiracy to defraud United has resulted in United paying tens of millions of dollars in reimbursements to which Radiology Partners and Singleton were not entitled.

12. All of this was done so that Radiology Partners' private equity investors could reap extraordinary profits.

13. United brings this action to recoup the amounts Radiology Partners unlawfully obtained from the United Plaintiffs and their plan sponsors.

PARTIES

14. Plaintiff UnitedHealthcare of Texas, Inc. is a corporation organized under the laws of Texas with a principal place of business in Texas.

15. Plaintiff United HealthCare Services, Inc. is a corporation organized under the laws of the State of Minnesota, with its principal place of business in the State of Minnesota.

16. Defendant Radiology Partners, Inc. is a Delaware Corporation with a principal place of business in the State of California.

JURISDICTION AND VENUE

17. This Court has subject matter jurisdiction over this action under 28 U.S.C. § 1332 because there is complete diversity between United and Radiology Partners and the amount in controversy exceeds $75,000.

18. This Court also has subject matter jurisdiction over this action under 28 U.S.C. § 1331 because it arises under the Constitution, laws, or treaties of the United States. Specifically, United asserts claims arising under the Federal Racketeer Influenced and Corrupt Organizations ("RICO") Act, 18 U.S.C. §§ 1961 *et seq.* and under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001, *et seq.* The Court likewise has subject matter jurisdiction over United's state and common-law claims, as those claims are so related to the federal claims that they form part of the same case or controversy. 28 U.S.C. § 1367.

19. This Court has general and specific personal jurisdiction over Radiology Partners in this action because Radiology Partners' principal place of business is in the State of California, it systematically and

continuously conducts business in California, and many of the activities giving rise to this action took place in and/or were directed by Radiology Partners from California.

20. Venue is proper in this district under 28 U.S.C. § 1391 because Radiology Partners resides in this district and a substantial part of the events giving rise to the claims in this action have occurred in this district. Specifically, from within this District, Radiology Partners devised and directed its unlawful pass-through billing scheme to cause Singleton to submit fraudulent claims for reimbursement for radiology services.

FACTUAL BACKGROUND

I. THE IMPACTED HEALTH BENEFIT PLANS

21. United is authorized to bring this action to recover overpayments caused by Radiology Partners' illegal and tortious conduct on behalf of United's fully insured and self-funded health plans.

22. United brings this action on its own behalf as the provider of fully-insured health plans through which individuals, employees, and employers pay United premiums in exchange for United agreeing to pay covered healthcare claims using United's money. A portion of the claims at issue in this case are fully insured claims. Thus, United was induced to pay its own funds as part of the fraudulent pass-through billing scheme between Radiology Partners and its affiliated practice groups.

23. United also brings this action as the claims administrator for self-funded, employer-established health plans. Those plans retain United as a third-party administrator to process employees' and their families' healthcare claims and pay those claims out of a pool of money comprised of funds contributed by employers and their employees. For these self-funded plans, United does not underwrite or insure the benefits being paid. Rather, claims covered under self-funded health plans are paid directly by

employers and employees using their own money. These are known as "administrative services only" or "ASO" plans. Accordingly, Radiology Partners profited as part of the improper billing scheme at the expense of the employers and employees, who fund these ASO health plans.

24. United provides claim administration services for the self-funded plans pursuant to Administrative Services Agreements ("ASAs"), which identify the rights and obligations of United and the plan sponsors.

25. The ASAs for the ASO plans at issue in this litigation confer on United the responsibility and discretion to administer claims under the plans.

26. Among other things, the ASAs give United the exclusive discretion and authority to monitor and pursue overpayments of plans funds. The ASAs state that the customers delegate to United the authority (but not the obligation) to recover overpayments resulting from fraud, waste, or abuse through litigation on behalf of the ASO plans.

27. United's ASAs typically state:

> Customer delegates to United the discretion and authority to develop and use standards and procedures for any recovery opportunity, including but not limited to whether or not to seek recovery, what steps to take if United decides to seek recovery, whether to initiate litigation or arbitration, the scope of such litigation or arbitration, which legal theories to pursue in such litigation or arbitration, and all decisions relating to such litigation or arbitration, including but not limited to, whether to compromise or settle any litigation or arbitration, and the circumstances under which a claim may be compromised or settled for less than the full

amount of the potential recovery. In all instances where United pursues recovery through litigation or arbitration, Customer, on behalf of itself and on behalf of its Plans, will be deemed to have granted United an assignment of all ownership, title, and legal rights and interests in and to any and all claims that are the subject matter of the litigation or arbitration.

28. The ERISA plans at issue in this litigation include this or substantially similar language. Beyond the authority entrusted to United under their ASAs with plan sponsors, United has a concrete business interest in paying only valid claims under the ASO plans it administers.

II. UNITED USES NETWORK AGREEMENTS TO MANAGE HEALTHCARE COSTS

29. United offers a broad range of integrated health care and related plans and services to its plan sponsors and member employees.

30. United's network of contracted medical care providers is a key component of United's efforts to ensure that healthcare benefits are affordable to its plan sponsors and member employees.

31. Through contracts with physicians and medical facilities, United can establish predictable rates of payment for medical care.

32. Health benefit plans encourage members to use in-network providers, an arrangement beneficial to both the provider, who enjoys certainty of payment, and the member, who receives appropriate healthcare services at a discounted cost.

33. When a United member receives in-network healthcare, the United member is responsible for the payment of a co-pay, deductible and/or co-insurance. Whether a member must pay more out of pocket can be impacted by the amounts allowed for a claim by United.

34. This participating provider network structure provides predictable costs to United, its plan sponsors, and their member employees to help keep their healthcare affordable.

III. RADIOLOGY PARTNERS' BLIND PURSUIT OF PROFIT

35. Radiology Partners is a physician-staffing company that affiliates with medical groups that provide radiology services at hospitals and other facilities. Formed in 2012, Radiology Partners describes itself as the "largest radiology practice" in the country. It operates in 35 states and at 3,000 sites, working with roughly 3,300 radiologists. At least two separate billion-dollar private equity firms, Starr Investment Holdings and New Enterprise Associates, have reportedly invested hundreds of millions of dollars in Radiology Partners since its creation.

36. Supported by these private equity firms, Radiology Partners has achieved its tremendous size and market position by seeking out and acquiring control of medical groups at a rapid pace.

37. While claiming that medical groups are "Locally Led," Radiology Partners carries out its operations through a web of subsidiaries and affiliates under the umbrella "RadPartners."

38. In some cases, medical groups are organized as professional associations. When Radiology Partners takes over, these professional associations become owned by physicians who are executives at Radiology Partners, thus giving Radiology Partners effective control over the medical group.

39. Radiology Partners controls various functions of these professional associations, including payor contracting and billing.

40. In exchange for these services, Radiology Partners siphons off large amounts of revenue from the medical groups. Indeed, on information and belief, the affiliated medical groups no longer retain any profits

resulting from the radiology services that they provide, and all profits are instead kept by Radiology Partners.

41. The dual desires to maximize revenue and profits to meet its private equity investors' goals, and to fund its rapid growth, have caused Radiology Partners to engage in the fraudulent practices at issue here in its dealings with insurers and claims administrators.

IV. RADIOLOGY PARTNERS' PASS-THROUGH BILLING SCHEME

42. This lawsuit concerns Radiology Partners' single-minded pursuit of profit obtained by causing its medical groups to violate the plain terms of their contracts with United.

43. As discussed in further detail below, Radiology Partners caused Singleton to bill United for services that Singleton did not perform in order to give Radiology Partners' other affiliated medical groups access to the high reimbursement rates provided in United's nearly 25-year-old contract with Singleton.

a. United's 1998 Network Contract with Singleton

44. Singleton and United entered into a Medical Group Participation Agreement effective January 1, 1998 (the "Agreement").

45. At the time, Singleton was a radiology group made up of individual radiologists or "Medical Group Physicians" that provided services in Houston at two facilities: St. Luke's Episcopal Hospital and Texas Children's Hospital.

46. Under the Agreement, United agreed to reimburse Singleton at a high rate of reimbursement totaling the "lesser of (1) Medical Group's Customary Charge, less any applicable Member Expenses, or (2) 80% of Medical Group's 1997 fee schedule as per the attached Payment Exhibit for such Health Services, less any applicable Member Expenses."

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47. Under this Agreement, Singleton was paid reimbursements equaling nearly 600% of what Medicare will pay for the same services. Stated another way, under the Agreement, United paid Singleton six times what Medicare would reimburse for the exact same services.

48. To ensure that Singleton was the *only* beneficiary of the high-reimbursement rates found in the Agreement, the parties included various provisions that set out which services were entitled to reimbursement under the terms of the contract.

49. The Agreement explicitly applies and provides for reimbursement only for services provided by a "Medical Group Physician," a term defined as M.D.'s or D.O.'s who "practice[] as a shareholder, partner or employee of [Singleton] and who has executed a Medical Group Physician Participation Addendum. "

50. The Agreement also states that Singleton "may assign any of its rights and responsibilities under the Agreement to any person or entity only upon the prior written consent" of United.

51. The Agreement also required that Singleton provide notice of any change in its name, ownership, or TIN.

52. The Agreement further stated that "[n]either party shall disclose to third parties any confidential or proprietary business information which it receives from the other party, including, but not limited to . . . specific rates. . . ."

b. Radiology Partners' Affiliation with Singleton

53. Recognizing the opportunity to exploit the healthcare system, Radiology Partners invested heavily to acquire this hospital-based physician practice groups.[1]

54. Funded by billion-dollar private equity firms, Radiology Partners is no stranger to this world of profiteering.

55. Before Radiology Partners became affiliated with Singleton, public filings show Singleton was a small radiology practice with approximately 30 radiologists who provided radiology services in and around Houston. Public filings also show that Singleton had officers, partners, and shareholders who were physicians that practiced as part of the Singleton medical group. That all changed after Singleton became affiliated with Radiology Partners.

56. In the fall of 2014, Singleton became affiliated with Radiology Partners. At the time the affiliation was announced in 2014, Singleton was described as having around "30 fellowship-trained, board-certified

[1] This phenomenon has led to state and federal legislation to combat the problem. *See* Surprise Medical Bills Cost Americans Millions. Congress Finally Banned Most of Them., The New York Times, December 22, 2020 (https://www.nytimes.com/2020/12/20/upshot/surprise-medical-bills-congress-ban.html); Surprise Billing Protections: Help Finally Arrives For Millions Of Americans, The Commonwealth Fund, December 17, 2020, https://www.commonwealthfund.org/blog/2020/surprise-billing-protections-cusp-becoming-law; Private Equity Is The Driving Force Behind Surprise Medical Billing, Americans for Financial Reform, March 30, 2020, https://ourfinancialsecurity.org/2020/03/fact-sheet-private-equity-driving-force-behind-surprise-medical-billing/; Investors' Deep-Pocket Push To Defend Surprise Medical Bills, Kaiser Health News, https://khn.org/news/investors-deep-pocket-push-to-defend-surprise-medical-bills/. This legislation has been opposed by the private investment firms using sham lobbying entities to hide their identities. *See* Mystery Solved: Private-Equity Backed Firms Are Behind Ad Blitz On 'Surprise Billing', The New York Times, September 16, 2019, https://www.nytimes.com/2019/09/13/upshot/surprise-billing-laws-ad-spending-doctor-patient-unity.html.

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radiologists serving six hospitals and over 20 total healthcare facilities throughout Houston, Texas and the surrounding metro area."[2]

57. On October 31, 2014, Singleton filed an Amended and Restated Certificate of Formation that changed Singleton's ownership and made Anthony Gabriel the only member, officer, or director of Singleton. In addition to becoming the sole member, Gabriel became the sole officer and director of Singleton.

58. No notice was ever provided to United of any change in Singleton's ownership.

59. Anthony Gabriel is a co-founder of Radiology Partners and its Chief Operating Officer.

60. By appointing Gabriel as the sole member and director of Singleton, Radiology Partners can exercise control over all actions taken by Singleton without formally owning it. Radiology Partners and Singleton structured their relationship to remain two separate entities.

c. Radiology Partners and Singleton's Scheme to Defraud United

61. Shortly after Radiology Partners and Singleton commenced their relationship, Radiology Partners caused Singleton to begin adding Unauthorized Providers, in breach of the Agreement. Those providers had no affiliation with Singleton but, instead, were affiliated with other medical groups that were controlled by Radiology Partners.

62. While the Agreement contemplated that providers could be added to the Singleton medical group subject to the other terms of those Agreement, only providers who were actually working for Singleton—and

[2] https://www.businesswire.com/news/home/20141110005131/en/Radiology-Partners-Expands-Radiology-Group-Practice-Through-Affiliation-with-Singleton-Associates; https://www.providenthp.com/expertise/singleton-associates/

providing services to Singleton patients—could be added to and have their services billed under that contract.

63. United has since learned that the vast majority of providers that Singleton, acting in concert with Radiology Partners, added to the Agreement were Unauthorized Providers. They were not employees, shareholders, or partners of Singleton and were not providing services to Singleton's patients (*i.e.*, at hospitals where Singleton was previously contracted to provide radiology services).

64. Indeed, many of the radiologists added to the Agreement starting in 2015 were employed by medical groups other than Singleton. Many of these groups had separate arrangements with Radiology Partners. And many of these other medical groups, that actually employed the providers Singleton was adding, had separate network contracts with United.

65. On information and belief, the sole reason for this contract manipulation is for Radiology Partners to increase profits by having its other affiliated medical groups reimbursed by United at Singleton's uniquely lucrative rates.

66. As a result, starting in 2015, Radiology Partners caused Singleton to add hundreds of providers to the Agreement so those providers services could be billed and reimbursed through that contract.

67. United has now discovered a consistent pattern: When Radiology Partners became affiliated with a new medical group, it would have the providers working for that new medical group added to the Agreement despite the fact that they were Unauthorized Providers.

68. Radiology Partners and Singleton accomplished this by conspiring to have an individual—representing themselves as acting on behalf of Singleton—make requests to United's operations team to link the

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"newly added providers" to the Singleton Tax Identification Number ("TIN") in United's systems.

69. When Singleton and/or Radiology Partners made these requests, they represented to United that the providers were Singleton providers as defined under the terms of the Agreement.

70. Relying on those representations, United then linked the new providers to Singleton's TIN, which allowed the new providers' claims to be reimbursed under the terms of Singleton's network agreement.

71. After linking those providers to Singleton's TIN, Singleton, at the direction of Radiology Partners, would then bill for services performed by those providers under the Agreement, despite the fact that Singleton was not entitled to reimbursement for services performed by Unauthorized Providers.

72. As a result of Radiology Partners and Singleton's scheme to have Singleton bill for services that were not payable under the terms of the Agreement with United, Radiology Partners and Singleton received tens of millions of dollars in reimbursements to which they were not entitled.

73. United has compared the professional identities of a sample of providers whose services were billed through the Agreement since 2014 with publicly available information about those providers and who they work for. The overwhelming majority of these providers were affiliated with Radiology Partners, but not with Singleton. Many are not local to Houston—which is where Singleton provides services—and some even reside outside the state of Texas.

74. The following are examples of Unauthorized Providers that Radiology Partners and Singleton caused to be improperly linked to the Singleton TIN and whose services Singleton, at the direction of Radiology Partners, fraudulently billed under the terms of the Agreement.

75. In 2015 United received claims for services performed by Matthew Clower, M.D., billed under the Singleton TIN and the terms of the Agreement. Dr. Clower's LinkedIn states that he was a radiologist for Radiology Partners from July 2015 to September 2019.[3] Prior to that, he worked for a radiology provider in Kentucky. During Dr. Clower's tenure at Radiology Partners, he was never listed as a provider on Singleton's website and his LinkedIn profile does not reflect that he ever worked for Singleton.[4]

76. Also in 2015, United began receiving claims for services performed by Nina Kottler, M.D., and billed by Singleton under the terms of the Agreement. Dr. Kottler describes herself as "the first radiologist to join Radiology Partners,"[5] which occurred when she assumed an executive role in April 2013. She is now the Associate Chief Medical Officer of Clinical Artificial Intelligence and Vice President of Clinical Operations at Radiology Partners.[6] In 2015, Dr. Kottler practiced at Eagle Imaging,[7] an Oklahoma-based provider that Radiology Partners partnered with in early 2013.[8] Dr. Kottler was part of Eagle Imaging's "Matrix" group, which provided "after hours" remote radiology services. Her status as a remote provider is consistent with her LinkedIn profile, which states she worked out of Huntington Beach, California. In 2015, Dr. Kottler was not a listed Singleton provider on Singleton's website.[9]

[3] https://www.linkedin.com/in/matthew-clower-m-d-651b9227/
[4] *See, e.g.*, https://web.archive.org/web/20160114103810/http://www.saparadiology.com/AdultServices/MeetOurPhysicians.aspx
[5] https://www.linkedin.com/in/radkottler/
[6] https://www.radpartners.com/about-us/our-team/
[7] https://web.archive.org/web/20160216090333/http://eagleimagingok.com/team/
[8] https://www.radpartners.com/2021/03/physician-spotlight-dr-byron-christie/
[9] https://web.archive.org/web/20150320225320/http://www.saparadiology.com:80/AdultServices/MeetOurPhysicians.aspx

77. Eagle Imaging—now "RP Eagle"—was Radiology Partners' first practice group and figures prominently in Radiology Partners' business. Many of Eagle Imaging's physicians have gone on to be executives at Radiology Partners. Dr. Kottler, above, is an example, as is Byron Christie, M.D., Radiology Partners' Associate Chief Medical Officer of Integration.

78. While Eagle Imaging had clinics in Texas in 2016, they were clustered around the Dallas-Fort Worth metropolitan area—250 miles from Houston. Nevertheless, in 2016 the services of at least ten Eagle Imaging providers were billed through the Agreement:[10]

Physician Name	**Physician NPI**	**Employer in 2016**[11]
Alexander, John E.	1194785022	Eagle Imaging / RP Eagle
Christie, Byron	1760434955	Eagle Imaging / RP Eagle
Eckard, Don	1548224322	Eagle Imaging / RP Eagle
Griggs, Thomas	1891743373	Eagle Imaging / RP Eagle
Jansen, Joshua	1952539629	Eagle Imaging / RP Eagle
Myers, Chuck	1801850193	Eagle Imaging / RP Eagle
Nelson, Brett	1700096435	Eagle Imaging / RP Eagle
Schucany, William G.	1114970910	Eagle Imaging / RP Eagle
Toppins, Anthony C.	1427001395	Eagle Imaging / RP Eagle
Whitley, Mark	1700840055	Eagle Imaging / RP Eagle

79. None of the physicians described in the previous paragraph were listed as Singleton providers in 2016.[12] Nor could they have been, given that none worked within 250 miles of Houston.

80. In 2017, United began receiving claims under the terms of the Agreement for services performed by providers at Consultants in Radiology P.A., or CIRPA, a Radiology Partners' affiliate since 2015. CIRPA is based on the Dallas-Fort Worth metropolitan area and provides remote radiology services. One of the CIRPA providers who billed through the Agreement, Narayana Mamillapalli, M.D., has worked at CIRPA since

[10] https://www.radpartners.com/about-us/our-team/

[11] Each of the physicians listed in this paragraph were listed on Eagle Imaging's website at that time. *See* https://web.archive.org/web/20160216090333/http://eagleimagingok.com/team/

[12] https://web.archive.org/web/20160314212539/http://www.saparadiology.com/AdultServices/MeetOurPhysicians.aspx

2016.[13] Another, Jeffrey Leitko, M.D., has been with CIRPA since 2007.[14] Neither Dr. Mamillapalli nor Dr. Leitko were listed as Singleton providers in 2017.[15]

81. Also in 2017, Radiology Partners billed claims through the Agreement for services by Mark Halsted, M.D., a "partner and member of [Radiology Partners'] remote reading team."[16] Dr. Halsted is based in Cincinnati, Ohio.

82. In 2018, another Radiology Partners' physician was billed through the Agreement: Arnold Saha, M.D., who worked for Radiology Partners in El Paso, Texas from September 2018 to April 2021.[17] Also in 2018, claims for services by Nadia Shah, M.D. were billed as if performed by Singleton. Dr. Shah has worked at Radiology Associates of North Texas in Fort Worth since 2013,[18] and was not listed as a Singleton provider in 2018.[19]

83. In 2019, Radiology Partners affiliated with a large radiology practice called Austin Radiological Associates ("ARA"), a group of 17 radiology clinics in and around Austin, Texas. Claims for ARA providers' services soon began to pour through the Agreement, including for: [20]

Physician Name	Physician NPI	Employer in 2019[21]
Alam, Tariq	1174642839	ARA
Aronoff, Michael D.	1457353625	ARA
Ben-Avi, Hillel	1841294790	ARA

[13] https://cirpa.com/portfolio-items/narayana-swamy-mamillapalli-md/
[14] https://cirpa.com/portfolio-items/jeffrey-k-leitko-md/
[15] https://web.archive.org/web/20171117000029/http://www.saparadiology.com:80/AdultServices/MeetOurPhysicians.aspx
[16] https://www.linkedin.com/in/mark-halsted-8367b86/
[17] https://www.linkedin.com/in/arnoldsahamd/
[18] https://www.linkedin.com/in/nadia-shah-a677aa67/
[19] https://web.archive.org/web/20180809110220/http://www.saparadiology.com:80/AdultServices/MeetOurPhysicians.aspx
[20] Each of the providers listed in this paragraph can be identified in an archived version of ARA's website from 2019. *See* https://web.archive.org/web/20191108155014/https://www.ausrad.com/our-doctors/.
[21] Each of the physicians listed in this paragraph were listed on ARA website at that time. *See* https://web.archive.org/web/20191108155014/https://www.ausrad.com/our-doctors/

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Contreras, Jaime	1245290469	ARA
Harper, Michael T.	1023058310	ARA
Jhaveri, Ravi	1215931027	ARA
Nguyen, Mike	1699006304	ARA
Price, Stephen B.	1316262330	ARA
Putnam, Russell	1639173263	ARA
Ranjithan, Murali	1962678490	ARA
Saravanan, Arthy[22]	1134412653	ARA
Shademan, Ashkan	1871814616	ARA
Sheneman, Jeffrey	1275588360	ARA
Trubek, Simon	1366446890	ARA
Winsett, Mary	1518961044	ARA

84. In 2020, Radiology Partners continued to bill new providers through the Agreement. Tong Maung, M.D., for example, a radiologist that works for RP Matrix out of San Diego,[23] and Jose L. Arjona, M.D., a Radiology Partners physician based in the Dallas-Fort Worth area, both had claims for their services submitted under the Agreement.[24] On information and belief, neither Dr. Maung or Dr. Arjona were listed as providers at Singleton.

85. From 2021 into 2022, Radiology Partners used the Agreement to bill for additions to its roster from its largest acquisition to date. Radiology Partners paid $885 million to acquire MEDNAX Radiology Solutions ("MEDNAX").[25] United has identified two notable radiology practice groups that were once owned by Mednax and were subsequently billed through the Agreement post-acquisition: Synergy Radiology Associates ("Synergy") and Virtual Radiologic (or "vRad").

86. Synergy is a Houston-based radiology practice that was acquired by MEDNAX in 2017.[26] Thus, Synergy became a part of Radiology

[22] Dr. Saravanan is the current Associate Chief Medical Officer for Recruitment at Radiology Partners. *See* https://www.radpartners.com/about-us/our-team/

[23] https://www.radpartners.com/rp-matrix-radiologists/

[24] https://www.linkedin.com/in/jose-l-arjona-md-236bb029/

[25] https://www.radpartners.com/2020/12/radiology-partners-completes-acquisition-of-mednax-radiology-solutions/

[26] https://synergyrad.org/mednax-announces-acquisition-of-leading-texas-radiology-practice-2/

Partners through the acquisition of MEDNAX. In 2021 and 2022, claims for at least five Synergy physicians were billed through the Agreement:

Physician Name	Physician NPI	Employer 2021-22[27]
Bacchav, Vrushali	1093030470	Synergy Radiology
Moore, Alaina	1952651325	Synergy Radiology
Rivera, Javier	1093030470	Synergy Radiology
Solomon, Eric	1164431565	Synergy Radiology
Telesmanich, Elizabeth	1912267626	Synergy Radiology

87. None of these physicians work at Singleton. To illustrate, both Drs. Moore[28] and Telesmanich[29] have worked at Synergy since at least 2018.[30]

88. vRad exclusively provides remote teleradiology services. It was acquired by MEDNAX in 2015,[31] and thus became part of Radiology Partners in late 2020. Following Radiology Partners' acquisition, claims for services performed by vRad radiologists began to flow through the Agreement. United was able to identify these radiologists' employer based on the address associated with their respective National Provider Identifiers. vRad is located at 11995 Singletree Lane, Suite 500, Eden Prairie, MN, and that address is registered to each provider's NPI. For example:

Physician Name	Physician NPI	Date Practice Address Last Updated in NPPES[32]
Gleason, Thomas R.	1811079437	January 9, 2020
Malik, Daewood	1336451673	June 25, 2021
Ngo, Lawrence	1457738072	July 21, 2020
Rex, David L.	1386608172	June 25, 2021
Tague, David F.	1841219508	June 25, 2021

[27] https://synergyrad.org/about-us/our-radiologists/
[28] https://www.linkedin.com/in/alaina-moore-a981a2125/
[29] https://www.linkedin.com/in/morgan-telesmanich-807b7510/
[30] *See, e.g.*, https://web.archive.org/web/20220521022948/https://baylorradiologists.com/our-physicians/
[31] https://www.vrad.com/wp-content/uploads/2021/12/vRadToBeAcquiredByMEDNAX_vRad_Press_Release_05_12_15.pdf
[32] Physicians in the United States register with the Centers for Medicare and Medicaid Services and receive a unique National Provider Identifier in return. These are maintained in the National Plan and Provider Enumeration System, searchable at https://npiregistry.cms.hhs.gov/search.

89. None of these providers mentioned above are listed as providers at Singleton.

90. Radiology Partners and Singleton each played different roles in their scheme to defraud United out of tens of millions of dollars. Singleton maintained the Agreement with United. Radiology Partners acquired medical groups all over Texas and across the United States and then conspired with Singleton to improperly cause United to link those providers to Singleton's TIN in United's contract and claims processing systems so that Radiology Partners could bill services performed by Unauthorized Providers through the Agreement.

91. Neither Radiology Partners nor Singleton could have effectuated their pass-through billing scheme without the other. Radiology Partners needed access to Singleton's Agreement with United. And Singleton needed Radiology Partners to acquire practices to become affiliated with Unauthorized Providers who were then linked to Singleton's TIN to accomplish the pass-through billing of claims for services performed by the Unauthorized Providers.

92. On information and belief, Radiology Partners' pass-through billing of claims through the Agreement with United is just one example of Radiology Partners' use of United contracts to pass-through bill.

93. On information and belief, Radiology Partners also caused Singleton and its other affiliates to bill claims in a manner that is fraudulent and inconsistent with industry standard billing practices through, for example, upcoding and miscoding claims.

94. Radiology Partners' pass-through billing scheme caused United tens of millions of dollars in damages.

95. United wrongfully paid these fraudulent claims for reimbursement to Singleton and other Radiology Partners affiliated medical

groups and, upon information and belief, those monies received then flowed upwards into Radiology Partners' coffers.

COUNT ONE

(TORTIOUS INTERFERENCE WITH CONTRACT)

107. United incorporates by reference as fully set forth herein the allegations in the preceding paragraphs.

108. The Agreement was a valid and enforceable contract between United and Singleton.

109. Radiology Partners was aware of the Agreement between United and Singleton and its provisions, including:

a. Radiology Partners knew that pursuant to Section 1 of the Agreement, the only providers defined as "Medical Group Physicians" were individuals who "practice as a shareholder, partner or employee of [Singleton] and who [have] executed a Medical Group Physician Participation Addendum."

b. Radiology Partners knew that the Agreement only provided for reimbursement of services rendered by Singleton and Singleton Medical Group Physicians.

c. Radiology Partners knew that the Agreement prohibited Singleton from assigning any of its rights and responsibilities under the Agreement without written consent of United.

d. Radiology Partners knew that Singleton was required to promptly notify United of any change in its name, ownership, or Federal Tax I.D. number (TIN).

e. Radiology Partners knew that the Agreement prohibited Singleton from disclosing to "third parties any confidential or proprietary business information which it receives from the other

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party, including, but not limited to . . . specific rates. . . ."

110. Radiology Partners improperly, wrongfully, willfully, and intentionally engaged in the scheme described in this Complaint. Radiology Partners' scheme was predicated upon the repeated breach of the Agreement.

111. By orchestrating and participating in the fraudulent scheme described herein, Radiology Partners caused Singleton to breach the Agreement with United, including the above provisions.

112. For instance, Radiology Partners caused Singleton to breach the Agreement by billing United for services performed by Unauthorized Providers using the Singleton TIN.

113. Likewise, Radiology Partners caused Singleton to breach the Agreement by failing to provide United with notice of its change in ownership or control after Radiology Partners installed its executive as the sole member, officer, and director.

114. Radiology Partners also requested that United link Unauthorized Providers to Singleton's TIN so that it could bill United for those services under the Agreement. In those requests, Radiology Partners represented to United that those providers were shareholders, partners, or employees of Singleton, when in fact most of them were not.

115. Radiology Partners also caused Singleton to breach the Agreement by making Singleton disclose confidential information, including the reimbursement rates provided under the Agreement, to Radiology Partners and its affiliates.

116. Radiology Partners' interference with the Agreement between Singleton and United was intentional, tortious, and without justification.

117. United has been damaged by Radiology Partners' acts of interference in an amount to be determined at trial.

COUNT TWO

(FRAUD)

118. United incorporates by reference as fully set forth herein the allegations in the preceding paragraphs.

119. Radiology Partners knowingly made material misrepresentations and omissions to United when requesting that Unauthorized Providers be linked to the Singleton TIN and on claims that Singleton and/or Radiology Partners submitted, or caused to be submitted, with the intent to induce United to rely on those misrepresentations and omissions to pay reimbursements on claims for services performed by Unauthorized Providers.

120. Each time that Radiology Partners made a request to United to link an Unauthorized Provider to Singleton's TIN, so that it could bill United for services performed by that provider, Radiology Partners represented to United that the provider was a Singleton provider, providing services on behalf of Singleton patients.

121. United relied on Radiology Partners' representations when linking the Unauthorized Providers to the Singleton TIN, which allowed it to bill (and receive reimbursements) services performed by the Unauthorized Providers.

122. Further, the submission of a claim to United constitutes a certification and representation that the information shown on the claim is true, accurate and complete, and that the submitted claims did not knowingly or recklessly disregard or misrepresent or conceal material facts.

123. Each time Radiology Partners submitted a claim, or caused a claim to be submitted by Singleton, it represented that the provider who performed the service was entitled to bill under the Agreement for those services.

124. Likewise, each time Radiology Partners submitted a claim, or caused a claim to be submitted by Singleton, it represented that it had performed the services being billed and thus was entitled to reimbursements for those services.

125. Yet many of the providers billing under the Agreement were not authorized to bill under the Agreement. They were not Singleton providers as defined under the Agreement, and they were not providing services to Singleton patients, as required under the Agreement.

126. The fact that the providers linked to Singleton's TIN and whose services Singleton and Radiology Partners were billing for were Unauthorized Providers, and that Radiology Partners had planned the scheme in concert with Singleton, was information material to United's determination of whether claims billed by those providers were payable.

127. Radiology Partners made the aforementioned misrepresentations and omissions with the intent to wrongfully induce United to make payment on the claims under the Agreement.

128. United reasonably relied on the aforementioned misrepresentations and omissions by Radiology Partners and paid the claims submitted for services performed by Unauthorized Providers.

129. Because United processes over one million claims per day, the vast majority are automatically adjudicated by United's claim-processing systems. Due to the volume of claims that United processes, United cannot review the medical records underlying each and every claim for accuracy before making the decision to pay a claim—doing so would grind the healthcare system to a halt. Instead, United relied on Radiology Partners' representation that the information submitted in the claims was true, accurate and complete, and that Radiology Partners did not knowingly or recklessly disregard or misrepresent or conceal material facts.

130. As a direct and proximate result of Radiology Partners' misrepresentations and omissions, United has been damaged in an amount to be determined at trial.

COUNT THREE

(FRAUDULENT INDUCEMENT)

131. United incorporates by reference as fully set forth herein the allegations in the preceding and succeeding paragraphs.

132. Radiology Partners knowingly made the aforementioned misrepresentations and omissions to United when asking United to link Unauthorized Providers to Singleton's TIN and on claims that it submitted, or caused Singleton to submit, with the intent to induce United to rely on those misrepresentations and omissions to pay the claims, which it would not have otherwise done without Radiology Partners' misrepresentations.

133. United was injured by the payments that it was induced to make as a result of Radiology Partners' material misrepresentations.

134. As a direct and proximate result of Radiology Partners' misrepresentations and omissions, United has been damaged in an amount to be determined at trial.

COUNT FOUR

(NEGLIGENT MISREPRESENTATION)

135. United incorporates by reference as fully set forth herein the allegations in the preceding paragraphs.

136. Radiology Partners knowingly made the aforementioned material misrepresentations and omissions to United, made them without regard to their truth or falsity, made them under circumstances in which Radiology Partners ought to have known their falsity, or made them negligently and without the exercise of reasonable care or competence.

137. Radiology Partners intended and expected that United would

rely on its misrepresentations and omissions.

138. United justifiably relied on the aforementioned misrepresentations and omissions made by Radiology Partners, and paid the claims improperly billed by Singleton.

139. Radiology Partners had superior and special knowledge of its practice of submitting and causing Singleton to submit claims from Unauthorized Providers.

140. Radiology Partners had a duty to disclose to United information material to the claims that it submitted or caused Singleton to submit for reimbursement.

141. Radiology Partners understood that it had a special relationship of trust and confidence toward United that gave rise to a duty to speak and disclose material information regarding the claims being submitted.

142. As a direct and proximate result of Radiology Partners' misrepresentations and omissions, United has been damaged in an amount to be determined at trial.

COUNT FIVE

(MONEY HAD AND RECEIVED)

143. United incorporates by reference as fully set forth herein the allegations in the preceding paragraphs.

144. In addition, or in the alternative, Radiology Partners is liable under money had and received.

145. United has paid claims to Singleton and those funds were then funneled to Radiology Partners.

146. United would not have paid those claims but for the wrongful conduct of Radiology Partners, as described herein.

147. Singleton and Radiology Partners entered into a conspiracy to

bill unauthorized providers under the Agreement.

148. Without revealing to United the truth, Radiology Partners gouged United, its plan sponsors, and their member employees.

149. The excessive amounts paid by United should be returned to United in good conscience. Accordingly, United seeks the return of money had and received to compensate United, its plan sponsors, and their member employees.

COUNT SIX

(UNJUST ENRICHMENT)

150. United incorporates by reference as fully set forth herein the allegations in the preceding paragraphs.

151. In addition, or in the alternative, Radiology Partners is liable under the principle of unjust enrichment. United may recover based on unjust enrichment because Radiology Partners has used fraud to obtain a benefit to which it is not entitled.

152. Radiology Partners submitted and/or caused Singleton to submit claims to United that it would not have paid but for the wrongful conduct of Radiology Partners as described herein.

153. When United paid Singleton for services it was not obligated to cover, Radiology Partners received a benefit from United through its fraudulent billing practices. Specifically, Radiology Partners collected the sums wrongfully paid to Singleton by United as a result of this fraudulent scheme.

154. As a result, Radiology Partners has been unjustly enriched and United, its plan sponsors, and their member employees have been injured.

155. It would be inequitable for Radiology Partners to retain amounts United paid as a result of Radiology Partners' wrongful conduct alleged herein.

156. Accordingly, United seeks the return of that money to compensate United, its plan sponsors, and their member employees.

COUNT SEVEN

(VIOLATION OF CIVIL RICO, 18 U.S.C. § 1962(c))

157. United incorporates by reference as fully set forth herein the allegations in the preceding paragraphs.

158. Singleton and Radiology Partners are "persons" within the meaning of 18 U.S.C. § 1961(3) that conducted the affairs of an enterprise through a pattern of racketeering activity in violation of 18 U.S.C. § 1962(c).

159. Singleton and Radiology Partners entered into an association-in-fact enterprise (the "Enterprise") within the meaning of 18 U.S.C. § 1961(4). The Enterprise was an ongoing organization that functioned as a continuing unit. The Enterprise was created and/or used as a tool to effectuate a pattern of racketeering activity, and the Enterprise had the common purpose of doing the same. Singleton and Radiology Partners are each "persons" distinct from the Enterprise.

160. Radiology Partners and Singleton established the Enterprise in order to reap windfall profits from the United through a pattern of fraudulent pass-through billing. The Enterprise worked to deceive United into overpaying for radiology services by means of fraud perpetrated over the wires or by mail.

161. Each participant in the Enterprise played a distinct and indispensable role, and the participants joined as a group to execute the scheme and further the Enterprise's goals. Radiology Partners acquired medical groups across Texas and the country so that it had control over how the claims for services performed by providers affiliated with those medical groups could be billed. Singleton maintained the Agreement with United and made requests to United to link the Unauthorized Providers to

Singleton's TIN so that Singleton, at the direction of Radiology Partners, could bill and receive reimbursements for services performed by Unauthorized Providers under the terms of the Agreement. Singleton then billed United for services performed by the Unauthorized Providers and received reimbursements at rates United would not have paid had it know that the providers performing the services being billed were not Singleton providers and were not providing services to Singleton patients.

162. The Enterprise could not have succeeded, and its members could not have enjoyed the substantial financial benefits described above, absent their coordinated efforts. The members of the Enterprise functioned as a unit in pursuit of their common purpose.

163. The relationships between the members of the Enterprise extended beyond the unlawful predicate acts at issue in this case. In particular, Radiology Partners provided other legitimate services to Singleton as part of its relationship including clinical support, leadership education and development, IT infrastructure, data & analytics, and recruitment, credentialing and human resources support. The illegal scheme at issue in this litigation was and is distinct from any legitimate business activities undertaken by the members of the Enterprise.

164. Each participant in the Enterprise knew their scheme violated federal and state laws and breached the Agreement and acted with the specific intent to defraud the United.

165. The Enterprise engaged in and affected interstate commerce because, among other things, it fraudulently billed United for services performed by providers outside the state of Texas and because Radiology Partners is a California-based company.

166. Radiology Partners and Singleton conducted and participated in the affairs of the Enterprise through a pattern of racketeering activity that

includes acts indictable under 18 U.S.C. §§ 1341 (mail fraud), 1343 (wire fraud), and 1952 (use of interstate facilities to conduct unlawful activity).

167. Predicate acts of racketeering that Radiology Partners and Singleton engaged in include, but are not limited to:

a. The use of wires and mails to submit fraudulent claims to the United;

b. The use of wires and mails to request that United link Unauthorized Providers to the Singleton TIN; and

c. The use of the wires and mails to obtain payments from the United, and to distribute the proceeds of the scheme amongst its members.

168. The above-described acts reveal a sustained pattern of racketeering activity, in addition to the threat of continued racketeering activity.

a. As discussed above, the racketeering activity commenced in 2015 (at the latest) and continued for years thereafter to the present. During this period, the Enterprise operated continuously, requesting that United link Unauthorized Providers to the Singleton TIN numerous times during the course of the scheme described above.

b. Further, the Enterprise submitted claims for services performed by Unauthorized Providers under the Singleton TIN on nearly a daily basis since the Enterprise was formed in 2015.

c. The pattern and policy of linking Unauthorized Providers to the Singleton TIN and then billing United for services performed by the Unauthorized Providers under the terms of the Agreement has become the regular manner in which

Radiology Partners and Singleton conduct their business.

169. The purpose and effect of the Enterprise's racketeering activity was to defraud United out of substantial sums of money by deceiving them into significantly overpaying Singleton on claims for which Singleton was not entitled to reimbursement. The Enterprise caused this result by systematically submitting claims that deliberately misrepresented that the Unauthorized Providers were Singleton providers performing services on behalf of Singleton's patients.

170. United suffered injuries when it overpaid on fraudulent claims, losing many millions of dollars as a result of the Enterprise's racketeering activity.

171. United's injuries were directly and proximately caused by the racketeering activities as described above.

172. By virtue of these violations of 18 U.S.C. § 1962(c), Singleton and Radiology Partners are jointly and severally liable to United for three times the damages United sustained in an amount to be determined at trial, plus the cost of this suit, including reasonable attorneys' fees.

COUNT EIGHT

(CONSPIRACY TO VIOLATE CIVIL RICO, 18 U.S.C. § 1962(d))

173. United incorporates by reference as fully set forth herein the allegations in the preceding paragraphs.

174. 18 U.S.C. § 1962(d) provides that it "shall be unlawful for any person to conspire to violate any of the provisions of subsection (a), (b) or (c) of this section."

175. Radiology Partners and Singleton have violated 18 U.S.C. § 1962(d) by conspiring with each other to violate 18 U.S.C. § 1962(c). The object of this conspiracy has been and is to conduct or participate in, directly or indirectly, the conduct of the affairs of the Enterprise described

herein through a pattern of racketeering activity.

176. Radiology Partners and Singleton engaged in numerous overt and predicate fraudulent racketeering acts in furtherance of the conspiracy.

177. The nature of the above acts, material misrepresentations, and omissions in furtherance of the conspiracy gives rise to an inference that they not only agreed to the objective of an 18 U.S.C. § 1962(d) violation of RICO by conspiring to violate 18 U.S.C. § 1962(c), but also that they were aware that their ongoing acts have been and are part of an overall pattern of racketeering activity.

178. As a direct and proximate result of Radiology Partners and Singleton's overt acts and predicate acts in furtherance of violating 18 U.S.C. § 1962(d) by conspiring to violate 18 U.S.C. § 1962(c), United has been injured in its business and property as set forth more fully above.

179. The purpose and effect of the conspiracy was to defraud the United out of substantial sums of money by deceiving them into significantly overpaying Singleton on claims for which Singleton was not entitled to reimbursement. The Enterprise caused this result by systematically submitting claims that deliberately misrepresented that the Unauthorized Providers were Singleton providers performing services on behalf of Singleton's patients.

180. United suffered injuries when it overpaid on fraudulent claims, losing many millions of dollars as a result of the Enterprise's racketeering activity.

181. By virtue of these violations of 18 U.S.C. § 1962(d), Radiology Partners and Singleton are jointly and severally liable to United for three times the damages United sustained in an amount to be determined at trial, plus the cost of this suit, including reasonable attorneys' fees.

COUNT NINE

(UNFAIR COMPETITION, Cal. Bus. & Prof. Code §§ 17200, *et seq*.)

182. United incorporates by reference as fully set forth herein the allegations in the preceding paragraphs.

183. Radiology Partners has intentionally used deceit, trickery, and unfair methods to interfere with a central structure of United's business, damage United, and enrich itself.

184. Radiology Partners secretly, deceptively, and unfairly used Singleton as a conduit to wrongfully collect tens of millions of dollars in reimbursements from United.

185. As described herein, Radiology Partners took specific steps and measures to conceal from United that it was adding Unauthorized Providers to Singleton's TIN and causing Singleton to submit claims for services by Unauthorized Providers under the Agreement.

186. Radiology Partners engaged in this deceptive conduct to extract more favorable reimbursement rates for its providers in other medical groups aside Singleton across Texas and elsewhere.

187. California's Unfair Competition Law, Cal. Bus. & Prof. Code § 17200, *et seq*. (UCL), prohibits such unlawful, unfair, and fraudulent business practices.

188. Radiology Partners engaged in unlawful practices described above, including, but not limited to:

a. Radiology Partners orchestrated a fraudulent scheme with Singleton to breach the Agreement with United.

b. Radiology Partners caused Singleton to fraudulently bill United for services performed by Unauthorized Providers using the Singleton TIN.

c. Radiology Partners prevented United from being provided contractually required notice of change in ownership or

control with Singleton.

d. Purporting to act on Singleton's behalf, Radiology Partners requested that United link Unauthorized Providers to Singleton's TIN so that it could bill for United for those Unauthorized Providers' services under the Agreement. In those requests, Radiology Partners represented to United that those providers were shareholders, partners, or employees of Singleton, when in fact most of them were not.

f. Radiology Partners also forced Singleton disclose United's confidential and sensitive business information, including the reimbursement rates provided under the Agreement, to itself.

200. Radiology Partners' conduct has directly and proximately caused significant damages to United in the form of payments United made to Singleton, subsequent to and because of the foregoing breaches, which were not due and would not otherwise have been made had United known of Radiology Partners' and Singleton's concealed scheme.

201. By virtue of the foregoing, United is entitled to restitution of the amounts by which Singleton has been unjustly enriched, as well as an injunction prohibiting Radiology Partners from continuing to engage in the tortious conduct described above, and any other relief deemed just and proper.

COUNT TEN

(ERISA, 29 U.S.C. § 1132(a)(3))

202. United incorporates by reference as fully set forth herein the allegations in the preceding paragraphs.

203. United acts as a claims administrator for certain health benefit plans governed by ERISA, 29 U.S.C. § 1001, *et seq.* (the "ERISA Plans"). In

performing their duties as claims administrator, the United Plaintiffs act as ERISA fiduciaries for these plans as that term is defined in ERISA section 3(21).

204. ERISA Section 502(a)(3) permits fiduciaries to enjoin any acts or practices that violate any provisions of the ERISA Plans, and to obtain other appropriate relief to redress such violations or enforce provisions of the ERISA Plans.

205. Radiology Partners has engaged in the above-described scheme to defraud United into paying sums in excess of what was owed under the relevant ERISA plans by systematically and fraudulently submitting claims under the Agreement for services performed by Unauthorized Providers and for services performed on behalf of individuals who were not Singleton's patients.

206. Although the specific terms of the impacted ERISA Plans vary, the following example is reasonably representative and relevant to the conduct of Radiology Partners, as alleged herein:

> **Right to Recovery of Overpayments**. If the Claims Administrator determines that you or the provider have been overpaid, the Plan has the right to receive a refund from you or the provider of the difference between the amount paid and the amount that should have been paid. If you, or any other person or organization that was overpaid, do not promptly refund the full amount, the Plan may reduce the amount of future benefits up to the refund that is due. **The Plan may have additional other rights, such as suing to recover overpayments**, in addition to the right to reduce future benefits to receive

the refund.

207. United seeks equitable relief in the form of restitution, equitable liens, and a constructive trust on the amounts overpaid as a result of Radiology Partners' conduct and scheme.

208. Upon information and belief, the funds that Radiology Partners caused United to overpay remain in the possession or control of Radiology Partners, and are separately identifiable—even if commingled with other funds—through tracing methods including the "lowest intermediate balance" doctrine.

209. The funds that United seeks in restitution from Radiology Partners are "specific funds." For example, the Unauthorized Providers were wrongfully paid by United on a per-claim basis, and United seeks to recover the ill-gotten funds for those claims. Upon information and belief, records maintained by Radiology Partners will identify the specific funds sought by United.

210. The funds paid by United as a result of Radiology Partners' conduct and scheme, should, in equity and good conscience, be returned to United.

211. United also seeks recovery of reasonable and necessary attorney's fees and costs pursuant to ERISA Section 502(g)(1).

TOLLING

212. To the extent any limitations periods might apply to the claims above or that United may otherwise have against Radiology Partners, those limitations periods have not run because Radiology Partners has engaged in continuing, repetitive, tortious conduct, causing additional and ongoing injury to United. Because Radiology Partner's repetitive tortious conduct has not ceased, no limitations periods on United's claims have started to run.

213. Moreover, even if one or more limitations periods could apply, those limitations periods were tolled during the period before United uncovered Radiology Partner's systematic scheme. Radiology Partners concealed the central components of its scheme making it difficult to discover. Indeed, the very structure of Radiology Partner's control over Singleton is designed to be obscure. Radiology Partners' employees and agents also actively misrepresented Radiology Partners' affiliation with Singleton to United, making it difficult or impossible for United to ascertain.

214. Radiology Partners also knowingly made representations to United when requesting that Unauthorized Providers be linked to the Singleton TIN and on claims that Radiology Partners submitted or caused Singleton to submit to United. United justifiably relied on those representations and only recently learned that these representations were premised on materially false and/or misleading representations and omissions.

PRAYER FOR RELIEF

WHEREFORE, United respectfully requests a judgment in its favor granting the following relief:

a. An award of compensatory damages as requested herein;
b. Equitable relief as requested herein;
c. Declaratory relief as requested herein;
d. Injunctive relief as requested herein;
e. Treble damages as permitted under RICO and any other applicable state statutes;
f. Costs;
g. Reasonable attorney fees;
h. Prejudgment and post-judgment interest; and

i. An award of any other relief in law or equity that the Court deems just and proper.

DATED: April 14, 2023

ROBINS KAPLAN LLP

By: */s/Roman M. Silberfeld*

Roman M. Silberfeld (CA Bar No. 62783)
rsilberfeld@robinskaplan.com
Tommy H. Du (CA Bar No. 305117)
tdu@robinskaplan.com
2121 Avenue of the Stars, Suite 2800
Los Angeles, California 90067

Jamie R. Kurtz (*pro hac vice* to be filed)
jkurtz@robinskaplan.com
Marcus A. Guith (*pro hac vice* to be filed)
mguith@robinskaplan.com
Kyle D. Nelson (*pro hac vice* to be filed)
knelson@robinskaplan.com
Alexa R. Ely (*pro hac vice* to be filed)
aely@robinskaplan.com
800 LaSalle Ave., Suite 2800
Minneapolis, MN 55424

Paul D. Weller (*pro hac vice* to be filed)
pweller@robinskaplan.com
1325 Avenue of the Americas, Suite 2601
New York, New York 10019

Attorneys for UnitedHealthcare of Texas, Inc. and United Healthcare Services, Inc.

DEMAND FOR JURY TRIAL

Pursuant to Rule 38 of the Federal Rules of Civil Procedure, Plaintiffs demand a jury trial as to all matters so triable.

DATED: April 14, 2023

ROBINS KAPLAN LLP

By: */s/ Roman M. Silberfeld*

Attorney for UnitedHealthcare of Texas, Inc. and United Healthcare Services, Inc.

EXHIBIT 2

ROBINS, KAPLAN LLP
Roman Silberfeld, CA Bar No. 62783
RSilberfeld@RobinsKaplan.com
Tommy H. Du, CA Bar No. 305117
TDu@RobinsKaplan.com
2121 Avenue of the Stars, Suite 2800
Los Angeles, CA 90067-5052
(310) 552-0130

Attorneys for United Healthcare Services, Inc.

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

UNITED HEALTHCARE SERVICES, INC. Plaintiff, v. RADIOLOGY PARTNERS, INC. Defendant.	Case No. 2:23-cv-02825-MWF-AFM **FIRST AMENDED COMPLAINT**

Plaintiff United HealthCare Services, Inc. (hereinafter, "United") hereby states and alleges as follows:

INTRODUCTION

1. Radiology Partners, Inc. ("Radiology Partners") is a rapidly growing physician-staffing company backed by billion-dollar private equity firms. In its unscrupulous pursuit of profits, Radiology Partners orchestrated a pass-through billing scheme intended to defraud United, its customers, and its members of tens of millions of dollars. In addition to being unlawful, Radiology Partners' scheme unfairly drives up the cost of healthcare for patients and payors alike.

2. Since Radiology Partners was founded by former DaVita executives in 2012, it has acquired control over the practices of 3,300

radiologists across 35 different states.

3. Since as early as 2014, Radiology Partners has engaged in a classic form of healthcare fraud called pass-through billing. Simply put, Radiology Partners, caused its affiliated medical groups to bill for services that they did not perform.

4. Acting in concert with its affiliated medical groups, Radiology Partners deliberately caused tens of thousands of claims to be improperly billed to United even though the billing provider did not perform the underlying services being billed.

5. When a particular medical group bills United for services using its name and Tax Identification Number ("TIN"), it represents to United that it performed the services being billed.

6. However, United has discovered that several Radiology Partners affiliated radiology groups have systematically billed for services that they did not perform.

7. The reason that Radiology Partners engaged in this fraudulent billing behavior is pure greed—for itself, for its private-equity backers, and to cover the mounting debt from its rapid acquisition campaign.

8. To concoct this illicit scheme, Radiology Partners identified its affiliated medical groups that received the highest reimbursement rates in a particular state. Radiology Partners then caused its other affiliated medical groups in that state (and sometimes elsewhere) to fraudulently bill claims using the name and TIN of the groups receiving higher rates. Radiology Partners did this to maximize profits—to the detriment of United's customers and members.

9. For example, one of Radiology Partners' affiliated radiology groups, Singleton Associates P.A. ("Singleton"), was a small radiology

practice located in Houston, Texas that was contracted to practice at two local hospitals.

10. Singleton obtained particularly high reimbursement rates from United under a contract executed in 1998. The agreement made clear that Singleton was only entitled to reimbursement for services performed by its "Medical Group Physicians" who were "shareholders, partners or employees" of Singleton, prohibited Singleton from assigning its rights and responsibilities under the contract without written consent from United, and required Singleton to notify United of any changes in ownership or control.

11. For years, Singleton submitted claims for reimbursement under its TIN without issue because the claims were for services performed by physicians that it employed in the Houston area.

12. That changed in 2014 when Singleton was effectively acquired by Radiology Partners. Once Singleton was under the control of private equity backed Radiology Partners, Radiology Partners caused Singleton to submit claims for services performed by providers who were not Singleton Physicians and who were not performing services at hospitals where Singleton was contracted to perform services. Likewise, Radiology Partners caused Singleton to fraudulently bill United for services performed on individuals who were not Singleton's patients.

13. Radiology Partners directed and conspired with Singleton to engage in a fraudulent pass-through billing scheme to deceive United by submitting claims for services performed non-Singleton medical groups, many of whom were located outside of Houston, and in some cases, even outside of Texas. The sole purpose of the fraudulent billing was to maximize Radiology Partners' profits for services performed by its affiliated medical groups.

14. The scheme grew over time. In 2013, before Radiology Partners took over Singleton, 70 unique providers performed services that were billed under Singleton's TIN. That number increased to more than 150 unique providers in 2017; nearly 315 unique providers in 2018; more than 500 unique providers in 2019; and to more than ***1,000*** unique providers in 2022. Upon information and belief, most of the providers billing under Singleton's TIN since at least 2017 were practicing with medical groups *other than* Singleton.

15. Another example of Radiology Partners' fraudulent billing is located in Jacksonville, Florida. In October of 2018, Radiology Partners announced that it was entering into a "partnership" with a Jacksonville, Florida radiology group called Mori, Bean & Brooks PA ("MBB").

16. Still to this day, MBB advertises itself as a small radiology practice with less than 40 radiologists[1] offering services at several locations,[2] all of which are in and around Jacksonville, Florida.

17. However, as with Singleton, shortly after Radiology Partners effectively took over MBB, it caused MBB to begin billing United for services that were performed by other Radiology Partners' affiliated practices across Florida in order to obtain higher reimbursement rates.

18. Each time MBB, at the direction of Radiology Partners, billed United using its name and TIN for services performed by other medical groups, Radiology Partners caused MBB to misrepresent to United that it had performed the services being billed—when that was not the case.

19. On information and belief, Radiology Partners has engaged in similar fraudulent billing schemes in other states across the country including, at least, North Carolina.

[1] https://mbbradiology.wpengine.com/physicians/ (last accessed July 31, 2023)
[2] https://mbbradiology.com/locations/ (last accessed July 31, 2023).

20. Specifically, on information and belief, in North Carolina, Radiology Partners caused its affiliate, Greensboro Radiology, to bill for services performed by other North Carolina-based Radiology Partners affiliated medical groups, including Coastal Radiology Associates.

21. But for those misrepresentations caused by Radiology Partners, United would not have paid Singleton, MBB, Greensboro Radiology, or any other medical group for services that they did not perform (collectively Singleton, MBB, Greensboro Radiology, and any other Radiology Partners affiliated medical groups that billed for services that they did not perform are referred to herein as the "At-Issue Medical Groups").

22. Radiology Partners' conspiracy to defraud United has resulted in United paying tens of millions of dollars in reimbursements to which Radiology Partners and the At-Issue Medical Groups were not entitled.

23. All of this was done so that Radiology Partners' private equity investors could reap extraordinary profits.

24. United brings this action to recoup the amounts Radiology Partners unlawfully obtained from United and their plan sponsors.

PARTIES

25. Plaintiff United HealthCare Services, Inc. is a corporation organized under the laws of the State of Minnesota, with its principal place of business in the State of Minnesota.

26. Defendant Radiology Partners, Inc. is a Delaware Corporation with a principal place of business in the State of California.

JURISDICTION AND VENUE

27. This Court has subject matter jurisdiction over this action under 28 U.S.C. § 1332 because there is complete diversity between United and Radiology Partners and the amount in controversy exceeds $75,000.

28. This Court also has subject matter jurisdiction over this action under 28 U.S.C. § 1331 because it arises under the Constitution, laws, or treaties of the United States. Specifically, United asserts claims arising under the Federal Racketeer Influenced and Corrupt Organizations ("RICO") Act, 18 U.S.C. §§ 1961 *et seq.* and under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001, *et seq.* The Court likewise has subject matter jurisdiction over United's state and common-law claims, as those claims are so related to the federal claims that they form part of the same case or controversy. 28 U.S.C. § 1367.

29. This Court has general and specific personal jurisdiction over Radiology Partners in this action because Radiology Partners' principal place of business is in the State of California, it systematically and continuously conducts business in California, and many of the activities giving rise to this action took place in and/or were directed by Radiology Partners from California.

30. Venue is proper in this district under 28 U.S.C. § 1391 because Radiology Partners resides in this district and a substantial part of the events giving rise to the claims in this action have occurred in this district. Specifically, from within this district, Radiology Partners devised and directed its unlawful pass-through billing scheme to cause the At-Issue Medical Groups to submit fraudulent claims for reimbursement for radiology services.

FACTUAL BACKGROUND

I. THE IMPACTED HEALTH BENEFIT PLANS

31. United is authorized to bring this action to recover overpayments caused by Radiology Partners' illegal and tortious conduct on behalf of United's fully insured and self-funded health plans.

32. United brings this action on its own behalf as the provider of fully-insured health plans through which individuals, employees, and employers pay United premiums in exchange for United agreeing to pay covered healthcare claims using United's money. A portion of the claims at issue in this case are fully insured claims. Thus, United was induced to pay its own funds as part of the fraudulent pass-through billing scheme between Radiology Partners and the At-Issue Medical Groups.

33. United also brings this action as the claims administrator for self-funded, employer-established health plans. Those plans retain United as a third-party administrator to process employees' and their families' healthcare claims and pay those claims out of a pool of money comprised of funds contributed by employers and their employees. For these self-funded plans, United does not underwrite or insure the benefits being paid. Rather, claims covered under self-funded health plans are paid directly by employers and employees using their own money. These are known as "administrative services only" or "ASO" plans. Accordingly, Radiology Partners profited as part of the improper billing scheme at the expense of the employers and employees, who fund these ASO health plans.

34. United provides claim administration services for the self-funded plans pursuant to Administrative Services Agreements ("ASAs"), which identify the rights and obligations of United and the plan sponsors.

35. The ASAs for the ASO plans at issue in this litigation confer on United the responsibility and discretion to administer claims under the plans.

36. Among other things, the ASAs give United the exclusive discretion and authority to monitor and pursue overpayments of plans funds. The ASAs state that the customers delegate to United the authority

(but not the obligation) to recover overpayments resulting from fraud, waste, or abuse through litigation on behalf of the ASO plans.

37. United's ASAs typically state:

> Customer delegates to United the discretion and authority to develop and use standards and procedures for any recovery opportunity, including but not limited to whether or not to seek recovery, what steps to take if United decides to seek recovery, whether to initiate litigation or arbitration, the scope of such litigation or arbitration, which legal theories to pursue in such litigation or arbitration, and all decisions relating to such litigation or arbitration, including but not limited to, whether to compromise or settle any litigation or arbitration, and the circumstances under which a claim may be compromised or settled for less than the full amount of the potential recovery. In all instances where United pursues recovery through litigation or arbitration, Customer, on behalf of itself and on behalf of its Plans, will be deemed to have granted United an assignment of all ownership, title, and legal rights and interests in and to any and all claims that are the subject matter of the litigation or arbitration.

38. The ERISA plans at issue in this litigation include this or substantially similar language. Beyond the authority entrusted to United under their ASAs with plan sponsors, United has a concrete business interest in paying only valid claims under the ASO plans it administers.

II. RADIOLOGIST STAFFING AT HOSPITALS AND OTHER FACILITIES

39. Hospitals and other types of facilities, including inpatient, outpatient, and stand-alone imaging centers, can staff their radiology departments in several ways.

40. First, the facilities can hire radiologists directly such that the radiologists are employees of the facility. There is often increased overhead, and administrative burden associated with the facilities employing radiologists directly.

41. Second, the facilities can contract with stand-alone medical groups (also referred to herein as "radiology practices") who employ or contract with radiologists. The contracted medical groups are then responsible for staffing the facility's radiology department using the radiologists who are employed by or otherwise contracted with the medical group. In this model, the facility does not pay the radiologists directly and is not responsible for providing administrative oversight or other benefits to the radiologists. Instead, those administrative burdens are taken on by the medical group. This model is often more cost-effective and efficient for the facility.

42. Typically, a facility will contract with a single medical group to perform radiology services for that facility. A medical group can only perform services at a given facility if it is contracted by that facility to provide services.

43. When a medical group is contracted with a facility to provide radiology services, the medical group whose physicians performed the services bills insurance companies using the medical group's name and TIN.

44. When a medical group's physician performs the service, the medical group is the provider who rendered the service and can, thus, bill for that service.

III. RADIOLOGY PARTNERS' BLIND PURSUIT OF PROFIT

45. Radiology Partners is a physician-staffing company that "affiliates" with medical groups that provide radiology services at hospitals and other facilities. Formed in 2012, Radiology Partners describes itself as the "largest radiology practice" in the country. It operates in 35 states and at 3,000 sites, working with roughly 3,300 radiologists, and boasts annual revenues of over $2 billion.[3] Reports have indicated that, as of 2021, Radiology Partners manages the practices of over 7% of the radiologists in the entire country and is responsible for over 10% of the country's entire imaging volume.[4]

46. At least two separate billion-dollar private equity firms, Starr Investment Holdings and New Enterprise Associates, have reportedly invested hundreds of millions of dollars in Radiology Partners since its creation.

47. Supported by these private equity firms, Radiology Partners has achieved its tremendous size and market position by seeking out and acquiring control of medical groups at a rapid pace.

48. While claiming that medical groups are "Locally Led," Radiology Partners carries out its operations through a web of subsidiaries and affiliates under the umbrella "RadPartners."

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[3] Marty Stempniak, Radiology Business, *Radiology Partners' revenues reach more than $2B, a 13-fold increase in five years*, (March 17, 2022), Available at: https://radiologybusiness.com/topics/healthcare-management/mergers-and-acquisitions/radiology-partners-revenues-billion-sp-global

[4] Emily Hayes, Aunt Minnie, What's the endgame for private equity in radiology? (Dec. 14, 2021), available at: https://www.auntminnie.com/index.aspx?sec=ser&sub=def&pag=dis&ItemID=134532

49. In some cases, medical groups are organized as professional associations. When Radiology Partners takes over, these professional associations become owned by executives at Radiology Partners, thus giving Radiology Partners effective control over the medical group.

50. Radiology Partners controls various functions of these professional associations, including payor contracting and billing.

51. In exchange for these services, Radiology Partners siphons off large amounts of revenue from the medical groups. Indeed, on information and belief, the affiliated medical group physicians no longer retain any profits resulting from the radiology services that they provide, and all profits are instead kept by Radiology Partners.

52. The desires to maximize profits, to meet its private equity investors' goals, and to fund its rapid growth have caused Radiology Partners to engage in the fraudulent practices at issue here in its dealings with insurers and claims administrators.

IV. RADIOLOGY PARTNERS' FRAUDULENT BILLING SCHEME

53. This lawsuit concerns Radiology Partners' single-minded pursuit of profit obtained by causing certain of its affiliated medical groups to bill United for services that they did not perform in order to defraud United into paying more for those services than they otherwise should.

54. As discussed in further detail below, Radiology Partners caused the At-Issue Medical Groups to bill United for services that they did not perform to induce United to pay more for those services than United would have paid had the medical groups that provided the services billed the claims directly.

55. United pays different medical groups different rates depending on a variety of factors including, but not limited to, where the provider is located, the size of the provider, and the duration of United's relationship

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with the provider. Radiology Partners exploited these differences by misrepresenting to United that higher-reimbursed medical groups performed the services being billed to United when that was not the case. This is a classic type of healthcare fraud.

56. On information and belief this exploiting these differences is a common business practice of Radiology Partners. However, given the covert nature of this scheme, United is unable to identify every instance in which Radiology Partners engaged in the fraudulent billing scheme. The examples provided below are merely examples, and are not intended to limit the scope of this case or the resulting damages incurred by United and its customers and members.

a. Radiology Partners' Affiliation with the At-Issue Medical Groups

57. Recognizing the opportunity to exploit the healthcare system, Radiology Partners invested heavily to acquire hospital-based physician practice groups.[5]

58. Before Radiology Partners became affiliated with the At-Issue Medical Groups, public filings show that Singleton, MBB, and Greensboro Radiology were all small radiology practices who provided services across

[5] This phenomenon has led to state and federal legislation to combat the problem. *See* Surprise Medical Bills Cost Americans Millions. Congress Finally Banned Most of Them., The New York Times, December 22, 2020 (https://www.nytimes.com/2020/12/20/upshot/surprise-medical-bills-congress-ban.html); Surprise Billing Protections: Help Finally Arrives For Millions Of Americans, The Commonwealth Fund, December 17, 2020, https://www.commonwealthfund.org/blog/2020/surprise-billing-protections-cusp-becoming-law; Private Equity Is The Driving Force Behind Surprise Medical Billing, Americans for Financial Reform, March 30, 2020, https://ourfinancialsecurity.org/2020/03/fact-sheet-private-equity-driving-force-behind-surprise-medical-billing/; Investors' Deep-Pocket Push To Defend Surprise Medical Bills, Kaiser Health News, https://khn.org/news/investors-deep-pocket-push-to-defend-surprise-medical-bills/. This legislation has been opposed by the private investment firms using sham lobbying entities to hide their identities. *See* Mystery Solved: Private-Equity Backed Firms Are Behind Ad Blitz On 'Surprise Billing', The New York Times, September 16, 2019, https://www.nytimes.com/2019/09/13/upshot/surprise-billing-laws-ad-spending-doctor-patient-unity.html.

relatively small geographic areas. As shown below, this changed after these practices became "affiliated" with Radiology Partners.

*i. **Singleton***

59. Before affiliating with Radiology Partners, Singleton was a small radiology practice with approximately 30 radiologists who provided radiology services in and around Houston, Texas. Even today, Singleton, which has since become known as "Baylor Radiologists," continues to be a relatively small radiology practice comprised of 25 radiologists[6] and offers services exclusively in the Houston area, specifically at inpatient and outpatient locations within the CHI St. Luke's Health System.[7]

60. Public filings also show that, before affiliating with Radiology Partners, Singleton had officers, partners, and shareholders who were physicians that practiced as part of the Singleton medical group. That all changed after Singleton became affiliated with Radiology Partners.

61. In the fall of 2014, Singleton became affiliated with Radiology Partners. At the time the affiliation was announced in 2014, Singleton was described as having around "30 fellowship-trained, board-certified radiologists serving six hospitals and over 20 total healthcare facilities throughout Houston, Texas and the surrounding metro area."[8]

62. On October 31, 2014, Singleton filed an Amended and Restated Certificate of Formation that changed Singleton's ownership and made Anthony Gabriel the sole member, officer, or director of Singleton.

63. No notice was ever provided to United of any change in Singleton's ownership.

[6] https://baylorradiologists.com/our-physicians/
[7] https://baylorradiologists.com/contact-us/
[8] https://www.businesswire.com/news/home/20141110005131/en/Radiology-Partners-Expands-Radiology-Group-Practice-Through-Affiliation-with-Singleton-Associates; https://www.providenthp.com/expertise/singleton-associates/

64. Anthony Gabriel is a co-founder of Radiology Partners and its Chief Operating Officer.

65. By appointing Gabriel as the sole member and director of Singleton, Radiology Partners can exercise control over all actions taken by Singleton without formally owning it. Radiology Partners and Singleton structured their relationship to remain two separate entities.

ii. Mori, Bean & Brooks

66. Like Singleton, MBB is a small radiology practice that offers services in Jacksonville, Florida. According to MBB's website, it is comprised of less than 40 radiologists offering a variety of types of radiology services around Jacksonville.[9]

67. In the fall of 2018, MBB announced its partnership with Radiology Partners.

68. As with Singleton, when Radiology Partners affiliated with MBB, the existing officers and directors (who were primarily MBB radiologists) were all removed and replaced with employees of Radiology Partners including Steve Tumbarello (Chief Financial Officer of Radiology Partners), David Gutierrez (Controller for Radiology Partners), Jay Bronner (former President and Chief Medical Officer of Radiology Partners)[10] and Basak Ertan (Chief Revenue Officer at Radiology Partners).

69. By appointing Radiology Partners executives as the officers of MBB, Radiology Partners can exercise control over all actions taken by MBB without formally owning it. Radiology Partners and MBB structured their relationship to remain two separate entities.

[9] https://mbbradiology.wpengine.com/physicians/

[10] Dr. Bronner has since left Radiology Partners and was replaced as an MBB officer by Nina Kottler, Associate Chief Medical Officer, Clinical AI at Radiology Partners.

70. No notice was ever provided to United of MBB's change in ownership and control.

iii. Greensboro Radiology

71. Greensboro Radiology is a radiology practice comprised of just over 60 physicians[11] that provide radiology services at hospitals and imaging centers in North Carolina.[12]

72. In May of 2019, Radiology Partners announced that it had entered into a partnership with Greensboro Radiology.

73. Upon its affiliation with Radiology Partners, the single shareholder of Greensboro Radiology became Nina Kottler, Associate Chief Medical Officer, Clinical AI at Radiology Partners. Similarly, Anthony Gabriel, co-founder of Radiology Partners, became the COO/Secretary of Greensboro Radiology.

74. On information and belief, Radiology Partners structured its acquisition such that Radiology Partners was able to exercise control over all of Greensboro Radiology's actions.

75. No notice was ever provided to United of Greensboro Radiology's change in ownership or control.

b. Radiology Partners' Scheme to Defraud United

76. Shortly after Radiology Partners commenced its relationship with each of the At-Issue Medical Groups as described above, Radiology Partners began to cause the At-Issue Medical Groups to bill for services performed by *other* Radiology Partners-affiliated medical groups.

77. Specifically, as Radiology Partners continued to expand and form partnerships with new medical groups across the country, it began to

[11] https://www.greensbororadiology.com/About/AboutUs.aspx
[12] https://www.greensbororadiology.com/About/Locations.aspx

look for ways to maximize its revenue and cover the mounting debt from its acquisition campaign.

78. One way that Radiology Partners did this was by "leveraging" its affiliated radiology practices that had the most favorable reimbursement rates in a given state. Radiology Partners "leveraged" its affiliated radiology practices by causing the medical group with the most favorable reimbursement rates to bill for services performed by other Radiology Partners-affiliated practices in that same state.

79. In doing so, Radiology Partners caused the At-Issue Medical Groups to bill claims for services under that practice's name and TIN even though different medical groups performed the services and/or the services were performed on behalf of another medical group's patients. When Radiology Partners caused an At-Issue Medical Group to bill claims using its own name and TIN—rather than the name and TIN of the medical group who performed the services—it represented to United that the At-Issue Medical Group performed the service being billed.

80. Relying on the representations that the At-Issue Medical Group performed the services being billed, United and other payors paid the At-Issue Medical Group for services that it did not perform at much higher reimbursement rates than if the medical group who performed the service had billed the claims directly.

81. Radiology Partners' scheme to cause certain of its affiliated practices to bill for services they did not perform was directed by Keegan Scanlon (VP Integrations, Strategic Projects and Communications at Radiology Partners), Basak Ertan (Chief Revenue Officer at Radiology Partners), Anthony Gabriel (President and Co-Founder at Radiology Partners), and Fredricka Richards (Sr. Vice President, Payor Strategy and Contracting), among others.

82. Radiology Partners effectuated its scheme by causing United, and other payors, to link the unique National Provider Identifier (NPI) for specific physicians to the TIN of the At-Issue Medical Group that Radiology Partners wanted to bill the services under—even though those physicians were not affiliated with the At-Issue Medical Group and were not performing services on behalf of patients of the At-Issue Medical Group.

83. In order to hide its fraudulent conduct, Radiology Partners had a policy of linking only a few NPIs to an At-Issue Medical Group's TIN at a time so that United would not catch on to Radiology Partners' billing scheme. It was not suspicious for a medical group to add a few providers here and there. It would have been very suspicious if a small practice group began to add dozens of providers at a time.

84. By linking the NPIs to the At-Issue Medical Group's TIN, the At-Issue Medical Group was able to bill for services provided by those physicians even though those physicians were not affiliated with the At-Issue Medical Group and were not performing services for patients of the At-Issue Medical Group.

85. Each time an At-Issue Medical Group billed a claim for services rendered by other medical groups' physicians or for services performed for patients who were not patients of the At-Issue Medical Group, it was a misrepresentation that the At-Issue Medical Group performed the services at issue.

86. As a result of the misrepresentations made to United, United paid the At-Issue Medical Group for services it did not perform. Had United known that the At-Issue Medical Group did not perform the services or that the services were not performed on behalf of the At-Issue Medical Group's patients, United would have never paid the At-Issue Medical Group for the services.

87. Further, because of the misrepresentations, United paid much more for services than it would have paid, had the medical group that actually performed the services billed for them.

88. On information and belief Radiology Partners engaged in its fraudulent billing scheme in several states across the country. The following are just a few examples of Radiology Partners' scheme.

i. Radiology Partners' Scheme Using Singleton

89. Sometime after Radiology Partners and Singleton commenced their relationship, Radiology Partners began linking physicians who worked for other Radiology Partners affiliated practices with Singleton's TIN so that Singleton could bill United for services provided by those non-Singleton physicians. United has since learned that the vast majority of providers who performed the services billed by Singleton were not employees, shareholders, or partners of Singleton and were not providing services to Singleton's patients (*i.e.*, at hospitals where Singleton was previously contracted to provide radiology services).

90. Indeed, many of the radiologists who performed the services billed by Singleton were employed by other Radiology Partners-affiliated medical groups.

91. On information and belief, the sole reason that Radiology Partners caused Singleton to bill for services performed by physicians affiliated with other radiology practices at hospitals where Singleton was not authorized to perform services is for Radiology Partners to increase profits by having its other affiliated medical groups reimbursed by United at Singleton's uniquely lucrative rates.

92. As a result, starting in 2015, Radiology Partners caused Singleton to systematically add hundreds of providers to its TIN so that

those providers' services could be billed and reimbursed through Singleton's contract with United.

93. United has now discovered a consistent pattern: When Radiology Partners became affiliated with a new medical group, it would have the providers working for that new medical group linked to the Singleton TIN—even though they were not employees of Singleton and were not performing services at hospitals where Singleton was contracted to perform those services.

94. Radiology Partners and Singleton accomplished this by conspiring to have an individual—representing themselves as acting on behalf of Singleton—make requests to United's operations team to link the "newly added providers" to Singleton's TIN in United's systems.

95. When Singleton and/or Radiology Partners made these requests, they represented to United that the providers were Singleton providers, as defined under the terms of the parties' agreement and as understood in the industry.

96. Relying on those representations, United then linked the new providers to Singleton's TIN, which allowed the new providers' claims to be reimbursed under the terms of Singleton's network agreement.

97. After linking those providers to Singleton's TIN, Singleton, at the direction of Radiology Partners, would then bill for services performed by those providers, despite the fact that Singleton was not entitled to reimbursement for services performed by physicians who were not employees of Singleton and who were not performing services on behalf of Singleton.

98. As a result of Radiology Partners and Singleton's scheme to have Singleton bill for services that were not payable to Singleton,

Radiology Partners and Singleton received tens of millions of dollars in reimbursements to which they were not entitled.

99. United has compared the professional identities of a sample of providers whose services were billed through Singleton's TIN since 2014 with publicly available information about those providers and who they work for. The overwhelming majority of these providers were affiliated with other Radiology Partners medical groups, but not with Singleton. Many are not local to Houston—which is where Singleton provides services—and some even reside outside the state of Texas.

100. The following are examples of providers that Radiology Partners and Singleton caused to be improperly linked to the Singleton TIN and whose services Singleton, at the direction of Radiology Partners, fraudulently billed to United as if Singleton had performed the services at issue.

101. In 2015, United received claims for services performed by Matthew Clower, M.D., billed under the Singleton TIN. Dr. Clower's LinkedIn states that he was a radiologist for Radiology Partners from July 2015 to September 2019.[13] Prior to that, he worked for a radiology provider in Kentucky. During Dr. Clower's tenure at Radiology Partners, he was never listed as a provider on Singleton's website and his LinkedIn profile does not reflect that he ever worked for Singleton.[14]

102. Also in 2015, United began receiving claims for services performed by Nina Kottler, M.D., and billed under Singleton's TIN. Dr. Kottler describes herself as "the first radiologist to join Radiology

[13] https://www.linkedin.com/in/matthew-clower-m-d-651b9227/

[14] *See, e.g.*, https://web.archive.org/web/20160114103810/http://www.saparadiology.com/AdultServices/MeetOurPhysicians.aspx

Partners,"[15] which occurred when she assumed an executive role in April 2013. She is now the Associate Chief Medical Officer of Clinical Artificial Intelligence and Vice President of Clinical Operations at Radiology Partners.[16] In 2015, Dr. Kottler practiced at Eagle Imaging,[17] an Oklahoma-based provider that Radiology Partners partnered with in early 2013.[18] Dr. Kottler was part of Eagle Imaging's "Matrix" group, which provided "after hours" remote radiology services. Her status as a remote provider is consistent with her LinkedIn profile, which states she worked out of Huntington Beach, California. In 2015, Dr. Kottler was not a listed Singleton provider on Singleton's website.[19]

103. Eagle Imaging—now "RP Eagle"—was Radiology Partners' first practice group and figures prominently in Radiology Partners' business. Many of Eagle Imaging's physicians have gone on to be executives at Radiology Partners. Dr. Kottler, above, is an example, as is Byron Christie, M.D., Radiology Partners' Associate Chief Medical Officer of Integration.

104. While Eagle Imaging had clinics in Texas in 2016, they were clustered around the Dallas-Fort Worth metropolitan area—250 miles from Houston. Nevertheless, in 2016 the services of at least ten Eagle Imaging providers were billed under Singleton's TIN:[20]

Provider Name	**Provider NPI**	**Employer in 2016**[21]
Alexander, John E.	1194785022	Eagle Imaging / RP Eagle
Christie, Byron	1760434955	Eagle Imaging / RP Eagle
Eckard, Don	1548224322	Eagle Imaging / RP Eagle
Griggs, Thomas	1891743373	Eagle Imaging / RP Eagle
Jansen, Joshua	1952539629	Eagle Imaging / RP Eagle

[15] https://www.linkedin.com/in/radkottler/
[16] https://www.radpartners.com/about-us/our-team/
[17] https://web.archive.org/web/20160216090333/http://eagleimagingok.com/team/
[18] https://www.radpartners.com/2021/03/physician-spotlight-dr-byron-christie/
[19] https://web.archive.org/web/20150320225320/http://www.saparadiology.com:80/AdultServices/MeetOurPhysicians.aspx
[20] https://www.radpartners.com/about-us/our-team/
[21] Each of the physicians listed in this paragraph were listed on Eagle Imaging's website at that time. *See* https://web.archive.org/web/20160216090333/http://eagleimagingok.com/team/

Myers, Chuck	1801850193	Eagle Imaging / RP Eagle
Nelson, Brett	1700096435	Eagle Imaging / RP Eagle
Schucany, William G.	1114970910	Eagle Imaging / RP Eagle
Toppins, Anthony C.	1427001395	Eagle Imaging / RP Eagle
Whitley, Mark	1700840055	Eagle Imaging / RP Eagle

105. None of the physicians described in the previous paragraph were listed as Singleton providers in 2016.[22] Nor could they have been, given that none worked within 250 miles of Houston.

106. In 2017, United began receiving claims under Singleton's TIN for services performed by providers at Consultants in Radiology P.A., or CIRPA, a Radiology Partners' affiliate since 2015. CIRPA is based on the Dallas-Fort Worth metropolitan area and provides remote radiology services. One of the CIRPA providers who billed through Singleton's TIN, Narayana Mamillapalli, M.D., has worked at CIRPA since 2016.[23] Another, Jeffrey Leitko, M.D., has been with CIRPA since 2007.[24] Neither Dr. Mamillapalli nor Dr. Leitko were listed as Singleton providers in 2017.[25]

107. Also in 2017, Radiology Partners billed claims under Singleton's TIN for services by Mark Halsted, M.D., a "partner and member of [Radiology Partners'] remote reading team."[26] Dr. Halsted is based in Cincinnati, Ohio.

108. In 2018, another Radiology Partners' physician was billed under Singleton's TIN: Arnold Saha, M.D., who worked for Radiology Partners in El Paso, Texas from September 2018 to April 2021.[27] Also in 2018, claims for services by Nadia Shah, M.D. were billed as if performed by Singleton. Dr.

[22] https://web.archive.org/web/20160314212539/http://www.saparadiology.com/AdultServices/MeetOurPhysicians.aspx
[23] https://cirpa.com/portfolio-items/narayana-swamy-mamillapalli-md/
[24] https://cirpa.com/portfolio-items/jeffrey-k-leitko-md/
[25] https://web.archive.org/web/20171117000029/http://www.saparadiology.com:80/AdultServices/MeetOurPhysicians.aspx
[26] https://www.linkedin.com/in/mark-halsted-8367b86/
[27] https://www.linkedin.com/in/arnoldsahamd/

Shah has worked at Radiology Associates of North Texas in Fort Worth since 2013,[28] and was not listed as a Singleton provider in 2018.[29]

109. In 2019, Radiology Partners affiliated with a large radiology practice called Austin Radiological Associates ("ARA"), a group of 17 radiology clinics in and around Austin, Texas. Claims for ARA providers' services soon began to pour through under Singleton's TIN, including for: [30]

Provider Name	Provider NPI	Employer in 2019[31]
Alam, Tariq	1174642839	ARA
Aronoff, Michael D.	1457353625	ARA
Ben-Avi, Hillel	1841294790	ARA
Contreras, Jaime	1245290469	ARA
Harper, Michael T.	1023058310	ARA
Jhaveri, Ravi	1215931027	ARA
Nguyen, Mike	1699006304	ARA
Price, Stephen B.	1316262330	ARA
Putnam, Russell	1639173263	ARA
Ranjithan, Murali	1962678490	ARA
Saravanan, Arthy[32]	1134412653	ARA
Shademan, Ashkan	1871814616	ARA
Sheneman, Jeffrey	1275588360	ARA
Trubek, Simon	1366446890	ARA
Winsett, Mary	1518961044	ARA

110. In 2020, Radiology Partners continued to bill new providers under Singleton's TIN. Tong Maung, M.D., for example, a radiologist that works for RP Matrix out of San Diego,[33] and Jose L. Arjona, M.D., a Radiology Partners physician based in the Dallas-Fort Worth area, both had claims for their services submitted under Singleton's TIN.[34] On information

[28] https://www.linkedin.com/in/nadia-shah-a677aa67/

[29] https://web.archive.org/web/20180809110220/http://www.saparadiology.com:80/AdultServices/MeetOurPhysicians.aspx

[30] Each of the providers listed in this paragraph can be identified in an archived version of ARA's website from 2019. *See* https://web.archive.org/web/20191108155014/https://www.ausrad.com/our-doctors/.

[31] Each of the physicians listed in this paragraph were listed on ARA website at that time. *See* https://web.archive.org/web/20191108155014/https://www.ausrad.com/our-doctors/

[32] Dr. Saravanan is the current Associate Chief Medical Officer for Recruitment at Radiology Partners. *See* https://www.radpartners.com/about-us/our-team/

[33] https://www.radpartners.com/rp-matrix-radiologists/

[34] https://www.linkedin.com/in/jose-l-arjona-md-236bb029/

and belief, neither Dr. Maung nor Dr. Arjona were listed as providers at Singleton.

111. From 2021 into 2022, Radiology Partners used Singleton's TIN to bill for additions to its roster from its largest acquisition to date. Radiology Partners paid $885 million to acquire MEDNAX Radiology Solutions ("MEDNAX").[35] United has identified two notable radiology practice groups that were once owned by Mednax and were subsequently billed through Singleton's TIN post-acquisition: Synergy Radiology Associates ("Synergy") and Virtual Radiologic (or "vRad").

112. Synergy is a Houston-based radiology practice that was acquired by MEDNAX in 2017.[36] Thus, Synergy became a part of Radiology Partners through the acquisition of MEDNAX. In 2021 and 2022, claims for at least five Synergy physicians were billed under Singleton's TIN:

Provider Name	**Provider NPI**	**Employer 2021-22**[37]
Bacchav, Vrushali	1093030470	Synergy Radiology
Moore, Alaina	1952651325	Synergy Radiology
Rivera, Javier	1093030470	Synergy Radiology
Solomon, Eric	1164431565	Synergy Radiology
Telesmanich, Elizabeth	1912267626	Synergy Radiology

113. None of these physicians work for Singleton; both Drs. Moore[38] and Telesmanich[39] have worked at Synergy since at least 2018.[40]

114. vRad exclusively provides remote teleradiology services. It was acquired by MEDNAX in 2015,[41] and thus became part of Radiology Partners in late 2020. Following Radiology Partners' acquisition, claims for

[35] https://www.radpartners.com/2020/12/radiology-partners-completes-acquisition-of-mednax-radiology-solutions/
[36] https://synergyrad.org/mednax-announces-acquisition-of-leading-texas-radiology-practice-2/
[37] https://synergyrad.org/about-us/our-radiologists/
[38] https://www.linkedin.com/in/alaina-moore-a981a2125/
[39] https://www.linkedin.com/in/morgan-telesmanich-807b7510/
[40] *See, e.g.*, https://web.archive.org/web/20220521022948/https://baylorradiologists.com/our-physicians/
[41] https://www.vrad.com/wp-content/uploads/2021/12/vRadToBeAcquiredByMEDNAX_vRad_Press_Release_05_12_15.pdf

services performed by vRad radiologists began to flow through Singleton's TIN. United was able to identify these radiologists' employer based on the address associated with their respective National Provider Identifiers. vRad is located at 11995 Singletree Lane, Suite 500, Eden Prairie, MN, and that address is registered to each provider's NPI. For example:

Provider Name	Provider NPI	Date Practice Address Last Updated in NPPES[42]
Gleason, Thomas R.	1811079437	January 9, 2020
Malik, Daewood	1336451673	June 25, 2021
Ngo, Lawrence	1457738072	July 21, 2020
Rex, David L.	1386608172	June 25, 2021
Tague, David F.	1841219508	June 25, 2021

115. None of these providers mentioned above are listed as providers at Singleton.

116. Radiology Partners and Singleton each played different roles in their scheme to defraud United out of tens of millions of dollars. Singleton used its name and TIN to bill United. Radiology Partners acquired medical groups all over Texas and across the United States and then conspired with Singleton to improperly cause United to link those providers to Singleton's TIN so that Radiology Partners could bill services performed by non-Singleton providers using Singleton's TIN in order to get paid at higher rates.

117. Neither Radiology Partners nor Singleton could have effectuated their pass-through billing scheme without the other.

ii. Radiology Partners' Scheme Using MBB

118. As with Singleton, after Radiology Partners affiliated with MBB, it began linking physicians working for Radiology Partners' other Florida-based medical groups to MBB's TIN so that MBB could bill United for

[42] Physicians in the United States register with the Centers for Medicare and Medicaid Services and receive a unique National Provider Identifier in return. These are maintained in the National Plan and Provider Enumeration System, searchable at https://npiregistry.cms.hhs.gov/search.

services performed by Radiology Partners' other Florida-based medical groups.

119. In addition to MBB, Radiology Partners is affiliated with several other Florida-based medical groups including Bethesda Radiology Group ("Bethesda") and Radiology Associates of South Florida ("RASF").

120. After Radiology Partners affiliated with MBB, United began receiving claims for services performed by physicians employed by Bethesda and RASF under MBB's TIN.

121. The following are examples of physicians employed by other medical groups whose services were billed under MBB's name and TIN:

Provider Name	Provider NPI	Employer
Adami, Carol	1154395119	Bethesda Radiology Associates
Alvarez, Ariana, B.	1265406201	Bethesda Radiology Associates
Dacosta, Darlene	1801053756	Bethesda Radiology Associates
Deyoe, Lane, A.	1972577856	Bethesda Radiology Associates
Edelstein, Richard	1295709152	Bethesda Radiology Associates
Fergenson, Jon	1609840453	Bethesda Radiology Associates
Figueroa, Nicholas	1457791295	Bethesda Radiology Associates
Jalens, Lori, J.	1588638449	Bethesda Radiology Associates
Naveed, Nausheen	1508182742	Bethesda Radiology Associates
Oconnor, David, K.	1801860655	Bethesda Radiology Associates
Sani, Farhad, W.	1235337072	Bethesda Radiology Associates
Abrams, Kevin, J.	1700869633	Radiology Associates of South Florida
Adler, Leon	1982687802	Radiology Associates of South Florida
Aguiar, Aimee, M.	1841273760	Radiology Associates of South Florida
Amaro, Angie	1043563976	Radiology Associates of South Florida
Balkissoon, Avinash R, A.	1528041449	Radiology Associates of South Florida
Baquero, Julio	1760465389	Radiology Associates of South Florida
Batlle, Juan, C.	1538130588	Radiology Associates of South Florida
Behairy, Moataz	1801215868	Radiology Associates of South Florida
Cantor-Thorpe, Amy, M.	1467434530	Radiology Associates of South Florida
Carbonell, Marlene	1528068715	Radiology Associates of South Florida
Careaga-Hernandez, Arleene	1568977643	Radiology Associates of South Florida
Chaneles, Margaret, C.	1245212315	Radiology Associates of South Florida

Chundru, Surya, N.	1265766893	Radiology Associates of South Florida
Cury, Ricardo, C.	1871575589	Radiology Associates of South Florida
Diez, Juan, C.	1689657504	Radiology Associates of South Florida
Dorio, Paul, J.	1407825912	Radiology Associates of South Florida
Elgarresta, Lawrence, F.	1942282017	Radiology Associates of South Florida
Extein, Jason, E.	1962797076	Radiology Associates of South Florida
Faridad, Derek, J.	1871537209	Radiology Associates of South Florida
Fazekas, Jessica	1609938281	Radiology Associates of South Florida
Fernandez, Pedro, L.	1790767283	Radiology Associates of South Florida
Fields, Jonathan	1437131919	Radiology Associates of South Florida
Freeman, Louis	1831130699	Radiology Associates of South Florida
Fukuma, Brett Craig	1235573684	Radiology Associates of South Florida
Gandhi, Ripal, T.	1417150764	Radiology Associates of South Florida
Geronemus, Adam	1275585192	Radiology Associates of South Florida
Groves, Arthur, C.	1821065459	Radiology Associates of South Florida
Inzinna, Joseph, D.	1396733721	Radiology Associates of South Florida
Iparraguirre, Maria, D.	1780666859	Radiology Associates of South Florida
Keedy, Jennifer	1447265897	Radiology Associates of South Florida
Lafosse-Marin, Stephane, G.	1154303220	Radiology Associates of South Florida
Lampen-Sachar, Katharine	1326200197	Radiology Associates of South Florida
Luedemann, Kirsten, A.	1902858392	Radiology Associates of South Florida
Malavevidal, Ivan	1346222411	Radiology Associates of South Florida
Maroules, Christopher, D	1285861708	Radiology Associates of South Florida
Martinez, Ariane	1326466814	Radiology Associates of South Florida
Martinez, Maria, P.	1730161217	Radiology Associates of South Florida
Messinger, Jonathan, M	1972586832	Radiology Associates of South Florida
Mosca, Heather, A.	1104146646	Radiology Associates of South Florida
Narayanan, Govindarajan	1699794297	Radiology Associates of South Florida
Niekamp, Andrew	1437576626	Radiology Associates of South Florida
Nouri, Navid	1134381551	Radiology Associates of South Florida
Oliveira, George, R.	1285895318	Radiology Associates of South Florida
Parrilla, Victor	1376525436	Radiology Associates of South Florida
Pena, Constantino, S.	1821070301	Radiology Associates of South Florida
Podrasky, Ann	1336122233	Radiology Associates of South Florida
Powell, Alex	1770566697	Radiology Associates of South Florida
Prasuna, Inampudi	1265414338	Radiology Associates of South Florida
Rabassa, Antonio	1427030584	Radiology Associates of South Florida
Rafael, Justin, M.	1003115155	Radiology Associates of South Florida

Robinson, Lamar, E.	1700013356	Radiology Associates of South Florida
Rubin, Jonathan, S.	1275515751	Radiology Associates of South Florida
Sayegh, Karl	1285981191	Radiology Associates of South Florida
Schiro, Brian, J.	1588867188	Radiology Associates of South Florida
Scortegagna, Eduardo	1164778056	Radiology Associates of South Florida
Sidani, Charif	1265676910	Radiology Associates of South Florida
Singer, Daniel	1033101571	Radiology Associates of South Florida
Smock, David, E.	1922090463	Radiology Associates of South Florida
Souza, Frederico, D.	1356587125	Radiology Associates of South Florida
Teitelbaum, Philip	1104012715	Radiology Associates of South Florida
Tewfik, Joanna, N.	1124183199	Radiology Associates of South Florida
Toro Pape, Franz, W.	1417381211	Radiology Associates of South Florida
Valderrabano, Carmen, V	1073508925	Radiology Associates of South Florida
Vega, Onelis	1487025425	Radiology Associates of South Florida
Villalobos, Eduardo, E.	1043329303	Radiology Associates of South Florida
Vuong, Hao, V.	1003899923	Radiology Associates of South Florida
Whitley, Amy, B.	1811970528	Radiology Associates of South Florida
Williams, Lorna, S.	1740256304	Radiology Associates of South Florida
Ziffer, Jack	1952383440	Radiology Associates of South Florida

122. Both Bethesda and RASF are located in Miami, Florida—approximately 350 miles from MBB's locations.

123. In addition, Radiology Partners caused MBB to bill for services using its name and TIN that were performed by vRAD, a Radiology Partners' teleradiology company.

124. The following are examples of vRAD physicians whose claims were billed under MBB's name and TIN:

Provider Name	**Provider NPI**	**Employer**
Aikawa, Taro	1144265455	VRAD
Albrektson, Joshua, R.	1104155258	VRAD
Allen, Michael, S.	1083662654	VRAD
Alvi, Fozail, I.	1184891962	VRAD
Beeson, Donn, K.	1740495654	VRAD
Bloss, Michael, F.	1801854732	VRAD
Bogan, Jennifer, K.	1720058001	VRAD
Briggs, Lawrence, J.	1679553671	VRAD

Browning, Jared, C.	1720174238	VRAD
Bryant, Jennifer, E.	1396751426	VRAD
Cobb, Michael, L.	1932170131	VRAD
Conway, Deborah, J.	1982777033	VRAD
Curtis, Bernadette, R.	1407858970	VRAD
Davae, Ketan, C.	1700838620	VRAD
Delavallade, Dawn	1750445086	VRAD
Edson, Steven, B.	1881656692	VRAD
Faliszek, James, E.	1467568261	VRAD
Foral, Jonathan, M.	1477576064	VRAD
Fox, Stephen, G.	1023094737	VRAD
Gaurilof-Rothenberg, Jane	1154377117	VRAD
Giovannetti, Mark, J.	1730123191	VRAD
Green, Adam, S.	1649226804	VRAD
Ivy, Cathleen, A.	1851394944	VRAD
Kartha, Krishnan	1144325952	VRAD
Kennedy, Keiron, T.	1740221944	VRAD
Kessler, Larry, S	1033197652	VRAD
Lamoureux, Christine, A.	1275578593	VRAD
Lawton, Christopher, S.	1285673293	VRAD
Losasso, Carl, J.	1508881442	VRAD
Manjikian, Viken	1225094683	VRAD
Morais, Joshua, D.	1669674651	VRAD
Nicell, Donald, T.	1689679631	VRAD
Ramas, Carla, V.	1356676431	VRAD
Reckson, Mark, W.	1588710487	VRAD
Rickards, James, S.	1730211046	VRAD
Robinette, Alison, M.	1649444761	VRAD
Rozell, Joseph, M.	1629368519	VRAD
Schultze, Dietrich	1922192459	VRAD
Shapoval, Anton	1245529536	VRAD
Slone, Richard, M.	1346225166	VRAD
Spirer, David, J.	1780876177	VRAD
Staib, Neil, E.	1225021413	VRAD
Thaler, Bruce, J.	1477572865	VRAD

Tievsky, Andrew, L.	1861458788	VRAD
Tobon, Sandra, P.	1306874581	VRAD
Vrla, Rolf, F.	1396734430	VRAD
Zimmer, Wendy	1568420149	VRAD

iii. Radiology Partners' Scheme Using Greensboro Radiology

125. As with Singleton and MBB, after Radiology Partners affiliated with Greensboro Radiology, it began linking physicians working for Radiology Partners' other North Carolina-based medical groups, Coastal Radiology Associates, to Greensboro Radiology's TIN so that Greensboro Radiology could bill United for services performed by Radiology Partners' other North Carolina-based medical group.

126. The following are examples of physicians employed by other Coastal Radiology Associates whose services were billed under Greensboro Radiology's name and TIN:

Provider Name	**Provider NPI**	**Employer**
Baggett, Rebecca, M.	1285894576	Coastal Radiology Associates
Lorentzen, James, C.	1205818226	Coastal Radiology Associates,
Rodriguez, Enrique	1093058620	Coastal Radiology Associates,
Blackmon, Floriece	1992834949	Coastal Radiology Associates,
Desmond, Timothy, P.	1528000775	Coastal Radiology Associates,
Sloan, Timothy, C.	1306828207	Coastal Radiology Associates,
Wehrung, Kristin Mary	1295780948	Coastal Radiology Associates,

* * * *

127. In addition to the above, on information and belief, Radiology Partners also caused the At-Issue Medical Groups to bill claims in a manner that is fraudulent and inconsistent with industry standard billing practices through, for example, upcoding and miscoding claims.

128. Radiology Partners' fraudulent billing scheme caused United tens of millions of dollars in damages.

129. United wrongfully paid these fraudulent claims for reimbursement to the At-Issue Medical Groups and, upon information and belief, those monies received then flowed upwards into Radiology Partners' coffers.

COUNT ONE

(FRAUD)

130. United incorporates by reference as fully set forth herein the allegations in the preceding paragraphs.

131. Radiology Partners knowingly made material misrepresentations and omissions to United when requesting that United link physicians to the TIN's of the At-Issue Medical Groups even though the physicians being linked to the At-Issue Medical Groups were affiliated with other radiology practices and were performing services on behalf of patients of other radiology practices and on claims that the At-Issue Medical Groups and/or Radiology Partners submitted, or caused to be submitted, with the intent to induce United to rely on those misrepresentations and omissions to pay reimbursements on claims for services that were not performed by the At-Issue Medical Groups.

132. Each time that Radiology Partners made a request to United to link a physician to one of the At-Issue Medical Group's TINs, so that the At-Issue Medical Group could bill United for services performed by that provider, Radiology Partners represented to United that the claim was for a service performed by the At-Issue Medical Group on behalf of one of the At-Issue Medical Group's patients .

133. United relied on Radiology Partners' representations when

linking the providers to the At-Issue Medical Groups' TINs, which allowed the At-Issue Medical Groups to bill (and receive reimbursements) for services performed by physicians who were affiliated with a medical group other than the At-Issue Medical Groups.

134. Further, the submission of a claim to United constitutes a certification and representation that the information shown on the claim is true, accurate and complete, and that the submitted claims did not knowingly or recklessly disregard or misrepresent or conceal material facts.

135. Each time Radiology Partners submitted a claim, or caused a claim to be submitted by one of the At-Issue Medical Groups, it represented that the provider who performed the service did so on behalf of the At-Issue Medical Group and was performing services on patients of the At-Issue Medical Group.

136. Likewise, each time Radiology Partners submitted a claim, or caused a claim to be submitted by one of the At-Issue Medical Groups, it represented that it was the practice that performed the services being billed and, thus, was entitled to reimbursements for those services.

137. Yet many of the physicians who performed the services being billed were affiliated with medical groups other than the At-Issue Medical Groups and were not providing services to patients of the At-Issue Medical Group.

138. The aforementioned representations were material to United's determination of whether claims submitted and billed by the At-Issue Medical Groups were payable.

139. Radiology Partners made the aforementioned misrepresentations and omissions with the intent to wrongfully induce United to make payment on the claims to the At-Issue Medical Groups at higher rates than United would have paid had the medical group that

performed the service billed it directly.

140. United reasonably relied on the aforementioned misrepresentations and omissions by Radiology Partners and paid the claims submitted for services performed by medical groups other than the At-Issue Medical Groups.

141. Because United processes over one million claims per day, the vast majority are automatically adjudicated by United's claim-processing systems. Due to the volume of claims that United processes, United cannot review the medical records underlying each and every claim for accuracy before making the decision to pay a claim—doing so would grind the healthcare system to a halt. Instead, United relied on Radiology Partners' representation that the information submitted in the claims was true, accurate and complete, and that Radiology Partners did not knowingly or recklessly disregard or misrepresent or conceal material facts.

142. As a direct and proximate result of Radiology Partners' misrepresentations and omissions, United has been damaged in an amount to be determined at trial.

COUNT TWO

(FRAUDULENT INDUCEMENT)

143. United incorporates by reference as fully set forth herein the allegations in the preceding and succeeding paragraphs.

144. Radiology Partners knowingly made the aforementioned misrepresentations and omissions to United when asking United to link physicians to the At-Issue Medical Groups' TINs and on claims that it submitted, or caused the At-Issue Medical Groups to submit, with the intent to induce United to rely on those misrepresentations and omissions to pay the claims, which it would not have otherwise done without Radiology Partners' misrepresentations.

145. United was injured by the payments that it was induced to make as a result of Radiology Partners' material misrepresentations.

146. As a direct and proximate result of Radiology Partners' misrepresentations and omissions, United has been damaged in an amount to be determined at trial.

COUNT THREE

(NEGLIGENT MISREPRESENTATION)

147. United incorporates by reference as fully set forth herein the allegations in the preceding paragraphs.

148. Radiology Partners knowingly made the aforementioned material misrepresentations and omissions to United, made them without regard to their truth or falsity, made them under circumstances in which Radiology Partners ought to have known their falsity, or made them negligently and without the exercise of reasonable care or competence.

149. Radiology Partners intended and expected that United would rely on its misrepresentations and omissions.

150. United justifiably relied on the aforementioned misrepresentations and omissions made by Radiology Partners, and paid the claims improperly billed by the At-Issue Medical Groups.

151. Radiology Partners had superior and special knowledge of its practice of submitting and causing the At-Issue Medical Groups to submit claims for services performed by physicians affiliated with medical groups other than the At-Issue Medical Groups and/or for services performed on patients of medical groups other than the At-Issue Medical Groups.

152. Radiology Partners had a duty to disclose to United information material to the claims that it submitted or caused the At-Issue Medical Groups to submit for reimbursement.

153. Radiology Partners understood that it had a special relationship

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of trust and confidence toward United that gave rise to a duty to speak and disclose material information regarding the claims being submitted.

154. As a direct and proximate result of Radiology Partners' misrepresentations and omissions, United has been damaged in an amount to be determined at trial.

COUNT FOUR

(MONEY HAD AND RECEIVED)

155. United incorporates by reference as fully set forth herein the allegations in the preceding paragraphs.

156. In addition, or in the alternative, Radiology Partners is liable under money had and received.

157. United has paid claims to the At-Issue Medical Groups and those funds were then funneled to Radiology Partners.

158. United would not have paid those claims but for the wrongful conduct of Radiology Partners, as described herein.

159. The At-Issue Medical Groups and Radiology Partners entered into a conspiracy to bill for services not performed by the At-Issue Medical Groups and/or for individuals that are not patients of the At-Issue Medical Groups.

160. Without revealing to United the truth, Radiology Partners gouged United, its plan sponsors, and their member employees.

161. The excessive amounts paid by United should be returned to United in good conscience. Accordingly, United seeks the return of money had and received to compensate United, its plan sponsors, and their member employees.

COUNT FIVE

(UNJUST ENRICHMENT)

162. United incorporates by reference as fully set forth herein the allegations in the preceding paragraphs.

163. In addition, or in the alternative, Radiology Partners is liable under the principle of unjust enrichment. United may recover based on unjust enrichment because Radiology Partners has used fraud to obtain a benefit to which it is not entitled.

164. Radiology Partners submitted and/or caused the At-Issue Medical Groups to submit claims to United that it would not have paid but for the wrongful conduct of Radiology Partners as described herein.

165. When United paid Singleton for services it was not obligated to cover, Radiology Partners received a benefit from United through its fraudulent billing practices. Specifically, Radiology Partners collected the sums wrongfully paid to the At-Issue Medical Groups by United as a result of this fraudulent scheme.

166. As a result, Radiology Partners has been unjustly enriched and United, its plan sponsors, and their member employees have been injured.

167. It would be inequitable for Radiology Partners to retain amounts United paid as a result of Radiology Partners' wrongful conduct alleged herein.

168. Accordingly, United seeks the return of that money to compensate United, its plan sponsors, and their member employees.

COUNT SIX

(VIOLATION OF CIVIL RICO, 18 U.S.C. § 1962(c))

169. United incorporates by reference as fully set forth herein the allegations in the preceding paragraphs.

170. The At-Issue Medical Groups and Radiology Partners are "persons" within the meaning of 18 U.S.C. § 1961(3) that conducted the affairs of an enterprise through a pattern of racketeering activity in

violation of 18 U.S.C. § 1962(c).

171. Each of the At-Issue Medical Groups and Radiology Partners entered into separate association-in-fact enterprises (the "Enterprise") within the meaning of 18 U.S.C. § 1961(4). Each separate Enterprise consisted of Radiology Partners and one of the At-Issue Medical Groups. The Enterprises are ongoing organizations that functioned as continuing units. The Enterprises were created and/or used as a tool to effectuate a pattern of racketeering activity, and the Enterprises had the common purpose of doing the same. The At-Issue Medical Groups and Radiology Partners are each "persons" distinct from the Enterprise.

172. Radiology Partners and the At-Issue Medical Groups established the Enterprises in order to reap windfall profits from the United through a pattern of fraudulent pass-through billing. The Enterprises worked to deceive United into overpaying for radiology services by means of fraud perpetrated over the wires or by mail.

173. Each participant in the Enterprises played a distinct and indispensable role, and the participants joined as a group to execute the scheme and further the Enterprise's goals. Radiology Partners acquired medical groups across the country so that it had control over how the claims for services performed by providers affiliated with those medical groups could be billed. The At-Issue Medical Groups made requests to United to link the physicians affiliated with other medical groups to the At-Issue Medical Groups' TINs so that the At-Issue Medical Groups, at the direction of Radiology Partners, could bill and receive reimbursements for services performed by medical groups other than the At-Issue Medical Groups. The At-Issue Medical Groups then billed United for services performed by the medical groups other than the At-Issue Medical Groups and received reimbursements at rates United would not have paid had it

know that the physicians performing the services being billed were not the At-Issue Medical Groups' physicians and were not providing services to patients of the At-Issue Medical Groups.

174. The Enterprises could not have succeeded, and its members could not have enjoyed the substantial financial benefits described above, absent their coordinated efforts. The members of the Enterprises functioned as a unit in pursuit of their common purpose.

175. The relationships between the members of the Enterprise extended beyond the unlawful predicate acts at issue in this case. In particular, Radiology Partners provided other legitimate services to Singleton as part of its relationship including clinical support, leadership education and development, IT infrastructure, data & analytics, and recruitment, credentialing and human resources support. The illegal scheme at issue in this litigation was and is distinct from any legitimate business activities undertaken by the members of the Enterprises.

176. Each participant in the Enterprises knew their scheme violated federal and state laws and acted with the specific intent to defraud the United.

177. The Enterprises engaged in and affected interstate commerce because, among other things, it fraudulently billed United for services performed by physicians in Texas, Florida, and North Carolina, and because Radiology Partners is a California-based company.

178. Radiology Partners and the At-Issue Medical Groups conducted and participated in the affairs of the Enterprises through a pattern of racketeering activity that includes acts indictable under 18 U.S.C. §§ 1341 (mail fraud), 1343 (wire fraud), and 1952 (use of interstate facilities to conduct unlawful activity).

179. Predicate acts of racketeering that Radiology Partners and

Singleton engaged in include, but are not limited to:

a. The use of wires and mails to submit fraudulent claims to the United;

b. The use of wires and mails to request that United link physicians who were not physicians of the At-Issue Medical Group to the At-Issue Medical Groups' TINs; and

c. The use of the wires and mails to obtain payments from the United, and to distribute the proceeds of the scheme amongst its members.

180. The above-described acts reveal a sustained pattern of racketeering activity, in addition to the threat of continued racketeering activity.

a. As discussed above, the racketeering activity commenced in 2015 for Singleton, 2018 for MBB, and 2019 for Greensboro Radiology and continued for years thereafter to the present. During this period, the Enterprises operated continuously, requesting that United link physicians to the At-Issue Medical Groups' TINs even though those physicians were physicians of other medical groups numerous times during the course of the scheme described above.

b. Further, the Enterprises submitted claims for services performed by other medical groups under the At-Issue Medical Groups' TINs almost daily since the time that each of the Enterprises were formed.

c. The pattern and policy of linking physicians to the At-Issue Medical Groups' TINs and then billing United for services performed other medical groups as if the At-Issue Medical Groups had performed the services on behalf of the At-Issue

Medical Groups' TINs has become the regular manner in which Radiology Partners and the At-Issue Medical Groups conduct their business.

181. The purpose and effect of the Enterprise's racketeering activities was to defraud United out of substantial sums of money by deceiving them into significantly overpaying the At-Issue Medical Groups on claims for which the At-Issue Medical Groups were not entitled to reimbursement. The Enterprises caused this result by systematically submitting claims that deliberately misrepresented that physicians linked to the At-Issue Medical Groups' TINS were the At-Issue Medical Groups' physicians performing services on behalf of the At-Issue Medical Groups' patients.

182. United suffered injuries when it overpaid on fraudulent claims, losing many millions of dollars as a result of the Enterprise's racketeering activity.

183. United's injuries were directly and proximately caused by the racketeering activities as described above.

184. By virtue of these violations of 18 U.S.C. § 1962(c), Radiology Partners is liable to United for three times the damages United sustained in an amount to be determined at trial, plus the cost of this suit, including reasonable attorneys' fees.

COUNT SEVEN

(CONSPIRACY TO VIOLATE CIVIL RICO, 18 U.S.C. § 1962(d))

185. United incorporates by reference as fully set forth herein the allegations in the preceding paragraphs.

186. 18 U.S.C. § 1962(d) provides that it "shall be unlawful for any person to conspire to violate any of the provisions of subsection (a), (b) or (c) of this section."

187. Radiology Partners and the At-Issue Medical Groups have

violated 18 U.S.C. § 1962(d) by conspiring with each other to violate 18 U.S.C. § 1962(c). The object of this conspiracy has been and is to conduct or participate in, directly or indirectly, the conduct of the affairs of the Enterprise described herein through a pattern of racketeering activity.

188. Radiology Partners and the At-Issue Medical Groups engaged in numerous overt and predicate fraudulent racketeering acts in furtherance of the conspiracy.

189. The nature of the above acts, material misrepresentations, and omissions in furtherance of the conspiracy gives rise to an inference that they not only agreed to the objective of an 18 U.S.C. § 1962(d) violation of RICO by conspiring to violate 18 U.S.C. § 1962(c), but also that they were aware that their ongoing acts have been and are part of an overall pattern of racketeering activity.

190. As a direct and proximate result of Radiology Partners and At-Issue Medical Groups' overt acts and predicate acts in furtherance of violating 18 U.S.C. § 1962(d) by conspiring to violate 18 U.S.C. § 1962(c), United has been injured in its business and property as set forth more fully above.

191. The purpose and effect of the conspiracy was to defraud the United out of substantial sums of money by deceiving them into significantly overpaying the At-Issue Medical Groups on claims for which the At-Issue Medical Groups were not entitled to reimbursement. The Enterprise caused this result by systematically submitting claims that deliberately misrepresented that the physicians performing the services at issue were the At-Issue Medical Groups' physicians providing services on behalf of the At-Issue Medical Groups' patients.

192. United suffered injuries when it overpaid on fraudulent claims, losing many millions of dollars as a result of the Enterprise's racketeering

activity.

193. By virtue of these violations of 18 U.S.C. § 1962(d), Radiology Partners is liable to United for three times the damages United sustained in an amount to be determined at trial, plus the cost of this suit, including reasonable attorneys' fees.

COUNT EIGHT

(UNFAIR COMPETITION, Cal. Bus. & Prof. Code §§ 17200, *et seq*.)

194. United incorporates by reference as fully set forth herein the allegations in the preceding paragraphs.

195. Radiology Partners has intentionally used deceit, trickery, and unfair methods to interfere with a central structure of United's business, damage United, and enrich itself.

196. Radiology Partners secretly, deceptively, and unfairly used the At-Issue Medical Groups as a conduit to wrongfully collect tens of millions of dollars in reimbursements from United.

197. As described herein, Radiology Partners took specific steps and measures to conceal from United that it was adding physicians to At-Issue Medical Groups' TINs even though they were the physicians of other medical groups and causing the Billing Providers to submit claims for services performed by other medical groups for patients of other medical groups.

198. Radiology Partners engaged in this deceptive conduct to extract more favorable reimbursement rates.

199. California's Unfair Competition Law, Cal. Bus. & Prof. Code § 17200, *et seq*. (UCL), prohibits such unlawful, unfair, and fraudulent business practices.

200. Radiology Partners engaged in unlawful practices described above, including, but not limited to:

a. Radiology Partners caused the At-Issue Medical Groups to fraudulently bill United for services performed by other medical groups using the At-Issue Medical Groups' TINs.

b. Purporting to act on the At-Issue Medical Groups' behalf, Radiology Partners requested that United link other medical groups physicians to the At-Issue Medical Groups' TINs so that the At-Issue Medical Groups could bill for services performed by other medical groups' physicians on behalf of other medical groups' patients.

200. Radiology Partners' conduct has directly and proximately caused significant damages to United in the form of payments United made to the At-Issue Medical Groups, which were not due and would not otherwise have been made had United known of Radiology Partners' and the At-Issue Medical Group's concealed scheme.

201. By virtue of the foregoing, United is entitled to restitution of the amounts by which Radiology Partners has been unjustly enriched, as well as an injunction prohibiting Radiology Partners from continuing to engage in the tortious conduct described above, and any other relief deemed just and proper.

COUNT NINE

(ERISA, 29 U.S.C. § 1132(a)(3))

202. United incorporates by reference as fully set forth herein the allegations in the preceding paragraphs.

203. United acts as a claims administrator for certain health benefit plans governed by ERISA, 29 U.S.C. § 1001, *et seq.* (the "ERISA Plans"). In performing their duties as claims administrator, United acts as ERISA fiduciaries for these plans as that term is defined in ERISA section 3(21).

204. ERISA Section 502(a)(3) permits fiduciaries to enjoin any acts or

practices that violate any provisions of the ERISA Plans, and to obtain other appropriate relief to redress such violations or enforce provisions of the ERISA Plans.

205. Radiology Partners has engaged in the above-described scheme to defraud United into paying sums in excess of what was owed under the relevant ERISA plans by systematically and fraudulently submitting claims for services performed by medical groups other than the At-Issue Medical Groups for patients of medical groups other than the At-Issue Medical Groups.

206. Although the specific terms of the impacted ERISA Plans vary, the following example is reasonably representative and relevant to the conduct of Radiology Partners, as alleged herein:

> **Right to Recovery of Overpayments**. If the Claims Administrator determines that you or the provider have been overpaid, the Plan has the right to receive a refund from you or the provider of the difference between the amount paid and the amount that should have been paid. If you, or any other person or organization that was overpaid, do not promptly refund the full amount, the Plan may reduce the amount of future benefits up to the refund that is due. **The Plan may have additional other rights, such as suing to recover overpayments**, in addition to the right to reduce future benefits to receive the refund.

207. United seeks equitable relief in the form of restitution, equitable liens, and a constructive trust on the amounts overpaid as a result of Radiology Partners' conduct and scheme.

208. Upon information and belief, the funds that Radiology Partners caused United to overpay remain in the possession or control of Radiology Partners, and are separately identifiable—even if commingled with other funds—through tracing methods including the "lowest intermediate balance" doctrine.

209. The funds that United seeks in restitution from Radiology Partners are "specific funds." For example, the Unauthorized Providers were wrongfully paid by United on a per-claim basis, and United seeks to recover the ill-gotten funds for those claims. Upon information and belief, records maintained by Radiology Partners will identify the specific funds sought by United.

210. The funds paid by United as a result of Radiology Partners' conduct and scheme, should, in equity and good conscience, be returned to United.

211. United also seeks recovery of reasonable and necessary attorney's fees and costs pursuant to ERISA Section 502(g)(1).

TOLLING

212. To the extent any limitations periods might apply to the claims above or that United may otherwise have against Radiology Partners, those limitations periods have not run because Radiology Partners has engaged in continuing, repetitive, tortious conduct, causing additional and ongoing injury to United. Because Radiology Partner's repetitive tortious conduct has not ceased, no limitations periods on United's claims have started to run.

213. Moreover, even if one or more limitations periods could apply, those limitations periods were tolled during the period before United uncovered Radiology Partner's systematic scheme. Radiology Partners concealed the central components of its scheme making it difficult to

discover. Indeed, the very structure of Radiology Partner's control over the At-Issue Medical Groups is designed to be obscure. Radiology Partners' employees and agents also actively misrepresented Radiology Partners' affiliation with the At-Issue Medical Groups to United, making it difficult or impossible for United to ascertain.

214. Radiology Partners also knowingly made representations to United when requesting that other medical groups' physicians be linked to the At-Issue Medical Groups' TINS and on claims that Radiology Partners submitted or caused the At-Issue Medical Groups to submit to United. United justifiably relied on those representations and only recently learned that these representations were premised on materially false and/or misleading representations and omissions.

PRAYER FOR RELIEF

WHEREFORE, United respectfully requests a judgment in its favor granting the following relief:

a. An award of compensatory damages as requested herein;
b. Equitable relief as requested herein;
c. Declaratory relief as requested herein;
d. Injunctive relief as requested herein;
e. Treble damages as permitted under RICO and any other applicable state statutes;
f. Costs;
g. Reasonable attorney fees;
h. Prejudgment and post-judgment interest; and
i. An award of any other relief in law or equity that the Court deems just and proper.

[*signature page to follow*]

DATED: August 2, 2023

ROBINS KAPLAN LLP

By: /s/ Jamie R. Kurtz

Roman M. Silberfeld (CA Bar No. 62783)
rsilberfeld@robinskaplan.com
Tommy H. Du (CA Bar No. 305117)
tdu@robinskaplan.com
2121 Avenue of the Stars, Suite 2800
Los Angeles, California 90067

Jamie R. Kurtz (admitted *pro hac vice*)
jkurtz@robinskaplan.com
Marcus A. Guith (admitted *pro hac vice*)
mguith@robinskaplan.com
Kyle D. Nelson (admitted *pro hac vice*)
knelson@robinskaplan.com
Alexa R. Ely (admitted *pro hac vice*)
aely@robinskaplan.com
800 LaSalle Ave., Suite 2800
Minneapolis, MN 55424

Paul D. Weller (admitted *pro hac vice*)
pweller@robinskaplan.com
1325 Avenue of the Americas, Suite 2601
New York, New York 10019

Attorneys for United Healthcare Services, Inc.

ROBINS KAPLAN LLP

DEMAND FOR JURY TRIAL

Pursuant to Rule 38 of the Federal Rules of Civil Procedure, Plaintiff demands a jury trial as to all matters so triable.

DATED: August 2, 2023

ROBINS KAPLAN LLP

By: /s/ Jamie R. Kurtz

Attorney for United Healthcare Services, Inc.

EXHIBIT 3

STAY

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CIVIL MINUTES—GENERAL

Case No. CV 23-02825-MWF (JPRx) **Date: September 27, 2023**
Title: UnitedHealthcare of Texas, Inc. et al v. Radiology Partners, Inc.

Present: The Honorable MICHAEL W. FITZGERALD, U.S. District Judge

Deputy Clerk:	Court Reporter:
Rita Sanchez	Not Reported
Attorneys Present for Plaintiff:	**Attorneys Present for Defendant:**
None Present	None Present

Proceedings (In Chambers): ORDER GRANTING DEFENDANT'S MOTION TO COMPEL ARBITRATION [69]

Before the Court is Defendant Radiology Partners, Inc.'s Motion to Compel Arbitration (the "Motion"), filed on August 18, 2023. (Docket No. 69). Plaintiff United HealthCare Services, Inc. filed an Opposition on September 5, 2023. (Docket No. 76). Defendant filed a Reply on September 12, 2023. (Docket No. 80).

The Court has read and considered the Motion and held a hearing on **September 25, 2023**.

The Motion is **GRANTED** and the action is **STAYED** pending the arbitration proceedings.

I. BACKGROUND

Plaintiff is a Minnesota corporation and one of the largest health plans in the United States. (First Amended Complaint ("FAC") (Docket No. 38) ¶ 25; Motion at 5). Plaintiff executed contracts ("Participation Agreements") with radiology practices (the "Practices") which entitled the Practices to receive reimbursements for services performed by "Medical Group Physicians" as defined in the Participation Agreements. (*Id.* ¶¶ 9–10). The Participation Agreements also stated that the Practices could not assign their rights and responsibilities under the agreement without Plaintiff's written consent and also required the Practices to notify Plaintiff if there were a change in ownership or control of the Practices. (*Id.*¶ 10).

STAY

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CIVIL MINUTES—GENERAL

Case No. CV 23-02825-MWF (JPRx) **Date: September 27, 2023**
Title: UnitedHealthcare of Texas, Inc. et al v. Radiology Partners, Inc.

On April 8, 2022, one of the Practices, Singleton Associates, P.A. ("Singleton"), filed an arbitration demand against United Healthcare of Texas ("UHCTX") — a former party to this case and wholly-owned subsidiary of Plaintiff — for reduced reimbursement rates pursuant to the parties Participation Agreement. (Motion at 1, 7). Singleton and UHCTX both agreed to arbitration. (*Id.*at 7). On March 10, 2023, UHCTX sought a continuance requesting to file counterclaims (the "Counterclaims") in Arbitration, but the arbitration panel (the "Panel") denied the continuance motion. (*Id.* at 8). However, after discovery including document productions, depositions, and evidentiary hearings, the Panel granted UHCTX leave for the Counterclaims and deemed them filed in the Arbitration on April 2, 2023. (*Id.* at 8–9). On April 14, 2023, the plaintiffs in this case, UHCTX and United HealthCare Services, Inc., filed the Original Complaint. (*Id.* at 10; *see also* Original Complaint (Docket No. 1)). But additional discovery, which included more document production and depositions, in the Arbitration was still being held for the Counterclaims. (*Id.* at 9). On June 30, 2023, Singleton filed a Motion for Summary Disposition for the Counterclaims. (*Id.* at 10).

In the FAC, Plaintiff alleges that Defendant, a physician-staffing company, became affiliated with the Practices and began to submit claims for services performed by providers who were not authorized Medical Group Physicians under the Participation Agreements. (*Id.*¶¶ 12, 17, 20, 45, 61, 68, 72). Plaintiff seeks to recover alleged overpayments caused by Defendant and asserts the following claims: fraud; fraud inducement; negligent misrepresentation; money had and received; unjust enrichment; violation of civil RICO, 18 U.S.C. § 1962(c); conspiracy to violate civil RICO, 18 U.S.C. § 1962(d); unfair competition under California Business & Professions Code sections 17200, et seq.; and ERISA, 29 U.S.C. § 1132(a)(3).

The Participation Agreements included the following arbitration clauses:

Texas Practice Group:

> Plan or Payor and Medical Group will work together in good faith to resolve any disputes about their business relationship. If the parties are

STAY

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

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> unc1ble to resolve the dispute within 30 days following the date one party sent written notice of the dispute to the other party, and if Plan, Medical Group, or any Payor that has consent in writing to binding arbitration, wishes to pursue the dispute, it shall be submitted to binding arbitration in accordance with the rules of the American Arbitration Association. . . .

(Docket No. 68-4 at 6)

Florida Practice Group:

> The parties will work together in good faith to resolve any and all disputes between them (hereinafter referred to as "Disputes") including but not limited to all questions of arbitrability, the existence, validity, scope or termination of the Agreement or any term thereof.
>
> If the parties are unable to resolve any such Dispute within 60 days following the date one party sent written notice of the Dispute to the other party, and if either party wishes to pursue the Dispute, it shall thereafter be submitted to binding arbitration in accordance with the Commercial Dispute Procedures of the American Arbitration Association, as they may be amended from time to time (see http://www.adr.org). . . .

(Docket No. 68-5 at 5)

North Carolina:

> The parties will work together in good faith to resolve any and all disputes between them (hereinafter referred to as "Disputes") including but not limited to all questions of arbitrability, the existence, validity, scope or termination of the Agreement or any term thereof.
>
> If the parties are unable to resolve any such Dispute within 60 days following the date one party sent written notice of the Dispute to the other party, and if either party wishes to pursue the Dispute, it shall thereafter

> be submitted to binding arbitration in accordance with the Commercial Dispute Procedures of the American Arbitration Association, as they may be amended from time to time (see http://www.adr.org). . . .

(Docket No. 68-6 at 6)

Defendant now moves to compel arbitration, arguing that Plaintiff's claims are subject to mandatory arbitration pursuant to the arbitration clauses in the Participation Agreements. (*See* Motion).

II. LEGAL STANDARD

The Federal Arbitration Act ("FAA") requires district courts to compel arbitration on all claims subject to arbitration agreements. *See Dean Witter Reynolds, Inc. v. Byrd*, 470 U.S. 213, 218 (1985) (citing 9 U.S.C. §§ 3, 4). The FAA creates a general presumption in favor of arbitration. *Gilmer v. Interstate/Johnson Lane Corp.*, 500 U.S. 20, 24–25 (1991). Under the FAA, a party moving to compel arbitration must show "(1) the existence of a valid, written agreement to arbitrate; and, if it exists, (2) that the agreement to arbitrate encompasses the dispute at issue." *Ashbey v. Archstone Prop. Mgmt., Inc.*, 785 F.3d 1320, 1323 (9th Cir. 2015).

"In determining whether a valid arbitration agreement exists, federal courts 'apply ordinary state law principles that govern the formation of contracts.'" *Nguyen*, 763 F.3d at 1175 (quoting *First Options of Chicago, Inc. v. Kaplan*, 514 U.S. 938, 944 (1995)). "Federal courts sitting in diversity look to the law of the forum state — here, California — when making choice of law determinations." *Id*. (citation omitted).

III. DISCUSSION

Even though Defendant is a non-signatory to the Participation Agreements, it argues that the doctrines of agency and equitable estoppel support compelling arbitration. (Motion at 1).

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CIVIL MINUTES—GENERAL

Case No. CV 23-02825-MWF (JPRx) **Date: September 27, 2023**
Title: UnitedHealthcare of Texas, Inc. et al v. Radiology Partners, Inc.

A. Agency Theory

Defendant argues that Plaintiff is bound to the Arbitration Clause under the principles of agency. (Motion at 1). Plaintiff argues that Defendant cannot compel arbitration under agency theory because Defendant is a principal and not an agent. (Opp. at 9). In response, Defendant argues that the Practices authorized it to be their agent through management services agreements. (Reply at 10).

Under California's choice-of-law analysis, the Court would only apply the laws of the state of each of the Practices – Texas, Florida, and North Carolina – if the law in those states "materially differs from the law of California." *In re Henson*, 869 F.3d 1052, 1059–60 (9th Cir. 2017) (citing *Washington Mut. Bank, FA v. Superior Court*, 24 Cal. 4th 906, 919, 103 Cal. Rptr. 2d 320 (2001)) (internal quotations omitted). The parties do not dispute that California laws apply due to a lack of material differences between the laws of the state of each of the Practices.

Under California law, "agency is the fiduciary relationship that arises when one [party] (a 'principal') manifests assent to another [party] (an 'agent') that the agent shall act on the principal's behalf and subject to the principal's control, and the agent manifests assent or otherwise consents so to act." *Mavrix Photographs, LLC v. LiveJournal, Inc.*, 873 F.3d 1045, 1054 (9th Cir. 2017) (as amended) (quoting Restatement (Third) of Agency § 1.01 (Am. Law Inst. 2006)). "Courts have generally applied the agency principle to prevent parties from evading arbitration obligations by suing a signatory's agents instead of the principal." *Soto v. Am. Honda Motor Co.*, 946 F. Supp. 2d 949, 956 (N.D. Cal. 2012) (citation omitted).

Defendant argues that the management services agreements of each Practice designated Defendant as its agent to manage day to day operations. (Motion at 19–20 (citing Exs. D, F, G (Docket Nos. 68-7, 68-8, 68-10)). However, Plaintiff argues that Defendant is acting as the principal because Defendant's executives and employees seized control of the Practices by appointing themselves as sole officers and directors of the Practices. (See FAC ¶¶ 65, 69, 74; Opp. at 10–11 (citing Exs. E-Q (Docket Nos. 76-6–76-18)). Defendant argues that sharing employees or officers does not "render

one entity the agent of another" and that individuals not Defendant are the Practices' principals. (Reply at 9–10 (citing *Harris Rutsky & Co. Ins. Services, Inc. v. Bell & Clements Ltd.*, 328 F.3d 1122, 1135 (9th Cir. 2003))).

"In considering a motion to compel arbitration, the court applies a standard similar to that under Federal Rule of Civil Procedure 56 on summary judgment." *Smith v. H.F.D. No. 55, Inc.*, No. 2:15-cv-01293, 2016 WL 881134, at *4 (E.D. Cal. Mar. 8, 2016). Defendant, "as the party seeking to compel arbitration, must prove the existence of a valid agreement by a preponderance of the evidence." *Wilson v. Huuuge, Inc.*, 944 F.3d 1212, 1219 (9th Cir. 2019) (citation omitted). However, neither side has presented sufficient evidence demonstrating which company has control of the other. "[O]nly when no genuine disputes of material fact surround the arbitration agreement's existence and applicability may the court compel arbitration." *Smith*, 2016 WL 881134, at *4 (citing *Three Valleys Mun. Water Dist. v. E.F. Hutton & Co.*, 925 F.2d 1136, 1141 (9th Cir. 1991)). Because this is a clear dispute of fact, the Court will not compel arbitration based on agency principles.

B. Equitable Estoppel

California law permits non-signatories to invoke arbitration clauses under the doctrine of equitable estoppel only in limited circumstances. *See In re Henson*, 869 F.3d 1052 (9th Cir. 2017). The two circumstances are:

> (1) when a signatory must rely on the terms of the written agreement in asserting its claims against the "nonsignatory or the claims are intimately founded in and intertwined with the underlying contract, and
>
> (2) when the signatory alleges substantially interdependent and concerted misconduct by the nonsignatory and another signatory and the allegations of interdependent misconduct are founded in or intimately connected with the obligations of the underlying agreement.

UNITED STATES DISTRICT COURT
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Murphy v. DirecTV, Inc., 724 F.3d at 1218, 1229 (9th Cir. 2013) (internal quotation omitted). Defendant argues the first circumstance — that the FAC is intertwined with and dependent on the Participation Agreements. (Motion at 16).

Plaintiff argues that there is a material difference in the equitable estoppel laws of each state, but the Court is not persuaded that the authorities cited in the Opposition for Florida and North Carolina support that proposition. *Compare Kroma Makeup EU, LLC v. Boldface Licensing + Branding, Inc.*, 845 F.3d 1351 (11th Cir. 2017) (applying Florida law), *and Smith Jamison Constr. v. APAC-Atl., Inc.*, 257 N.C. App. 714, 811 S.E.2d 635 (2018) (applying North Carolina law) *with Murphy*, 724 F.3d at 1229. "[A] party contend[ing] that some other law should apply to an issue . . . has the burden to show that the [other] law . . . rather than California law, should apply." *Lemmon v. Snap, Inc.*, No. 19-cv-4504, 2022 WL 1407936, at *2 (C.D. Cal. Mar. 31, 2022) (citation and internal quotations omitted).

Plaintiff argues that Texas does not recognize the first circumstance under *Murphy*. (See Opp. at 21). While Texas Supreme Court has acknowledged the existence of the first circumstance under *Murphy*, it has not decided its validity in Texas. *See V3 Constr. Co., LLC v. Butler*, No. 02-20-00171-cv, 2021 WL 519912 (Tex. App. Feb. 11, 2021). The Fifth Circuit has, however, "predicted" that Texas "would adopt this estoppel formulation." *Jody James Farms, JV v. Altman Grp., Inc.*, 547 S.W.3d 624, 639 (Tex. 2018) (citing *Hays v. HCA Holdings, Inc.*, 838 F.3d 605, 612 (5th Cir. 2016)). Therefore, this Court will adopt the predictions of the Fifth Circuit and because there is no material difference between California and Texas law, the Court will analyze the first circumstance under California law.

Plaintiff argues that the real issue is that the Practices through Defendant fraudulently billed claims for services that the Practices did not perform under the Practices' name and Tax Identification Number. (Opp. at 17). The Court agrees with Plaintiff's argument that if one looked only at the cleverly amended text of the FAC, it would seem that the Court does not need to interpret the Participation Agreements. However, the Court also agrees with Defendant that "it is the substance of Plaintiff's

claim that counts, and not the form of its pleading." (Reply at 13 (quoting *Franklin v. Cmty. Reg'l Med. Ctr.*, 998 F.3d 867, 875 (9th Cir. 2021)).

Equitable estoppel applies to a written agreement containing an arbitration clause when a party must rely on the terms of the written agreement in asserting its claims. *Comer v. Micor, Inc.*, 436 F.3d 1098, 1101 (9th Cir. 2006) ("Equitable estoppel 'precludes a party from claiming the benefits of a contract while simultaneously attempting to avoid the burdens that contract imposes.'") (citing *Wash. Mut. Fin. Group, LLC v. Bailey*, 364 F.3d 260, 267 (5th Cir. 2004)). Additionally, while the FAC is the operative pleading, "[a] prior pleading . . .may be admissible in evidence against the pleader; e.g., as an admission or prior inconsistent statement by the pleader." *Robinson v. Salazar*, 885 F. Supp. 2d 1002, 1025 (E.D. Cal. 2012), *aff'd sub nom. Robinson v. Jewell*, 790 F.3d 910 (9th Cir. 2015).

The Original Complaint against Defendant significantly overlaps with the Arbitration Counterclaims. (*See* Redline of Original Complaint and Counterclaims, Docket no. 69-8). When it filed the FAC, Plaintiff removed UHCTX as a party and the tortious interference with contract claim, and added almost parallel allegations against two other practices affiliated with Defendant. (*Compare* Original Complaint *with* the FAC). Defendant alleges that the FAC still references Singleton 136 times and contains 59 paragraphs that are almost verbatim from the Counterclaims. (Motion at 11).

This issue, of course, was extensively addressed at the hearing. Ultimately, the Court agrees with Defendant that it is impossible to understand why the alleged fraud is indeed a "lie" – as Plaintiff's counsel argued – without understanding the relationship between the parties as set forth in the Participation Agreements. Without the context and framework of the Participation Agreements, Plaintiff's allegations do not make sense.

Duplicative litigation undermines the major purpose of the FAA, which is "the efficient and expeditious resolution of claims." *Sink v. Aden Enters., Inc.*, 352 F.3d 1197, 1201 (9th Cir. 2003) (citations omitted). When evaluating estoppel, the Court

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

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cannot turn a blind eye to the Counterclaims in arbitration, the similarities between the Counterclaims and the Original Complaint, nor the changes between the Original Complaint and the FAC. The Court finds that Defendant, by its own admission, is relying on the Participation Agreements containing arbitration clauses as the basis for its claims.

C. Scope of the Arbitration Provision

In addition to showing the existence of an enforceable arbitration provision, the moving party must show that the parties' dispute falls within the scope of the provision. Here, neither party disputes that Plaintiff's claims are within the scope of the Arbitration Provision and the Court agrees.

Accordingly, the Motion is **GRANTED**. Plaintiff is **ORDERED** to submit its claims to arbitration as provided by the Arbitration Provision. 9 U.S.C. § 4.

"A district court may either stay the action or dismiss it outright when, as here, the court determines that all of the claims raised in the action are subject to arbitration." *Johnmohammadi v. Bloomingdale's, Inc.*, 755 F.3d 1072, 1074 (9th Cir. 2014). Notwithstanding this discretion, the Ninth Circuit's preference is for district courts to "stay[ ] an action pending arbitration rather than dismissing it." *MediVas, LLC v. Marubeni Corp.*, 741 F.3d 4, 9 (9th Cir. 2014). The parties proffer no reason here for the Court to depart from the Ninth Circuit's preference.

Accordingly, the Court **STAYS** this action pending completion of the arbitration. *See* 9 U.S.C. § 3. The parties shall file a joint status report every 90 days apprising the Court of the status of the arbitration proceedings, with the first report due on **January 29, 2024**.

IT IS SO ORDERED.

EXHIBIT 4

8/1/2025 6:48 AM
Marilyn Burgess - District Clerk Harris County
Envelope No. 103853231
By: Brianna Janel Denmon
Filed: 8/1/2025 6:48 AM

CAUSE NO. _____

SINGLETON ASSOCIATES, P.A.,	)	**IN THE DISTRICT COUIRT OF**
	)	
Plaintiff,	)	
	)	
v.	)	**HARRIS COUNTY, TEXAS**
	)	
UNITED HEALTHCARE OF TEXAS, INC.,	)	
	)	
	)	
Defendant.	)	**____ JUDICIAL DISTRICT**

APPLICATION TO CONFIRM FINAL ARBITRATION AWARD

Plaintiff Singleton Associates, P.A. ("Singleton" or "Plaintiff"), pursuant to the Federal Arbitration Act ("FAA"), 9 U.S.C. § 9, and the Texas General Arbitration Act ("TGAA"), Tex. Civ. Prac. & Rem. Code §§ 171.087 and 171.092(a), hereby applies to the court for a judgment confirming the arbitration award, dated August 7, 2024, and rendered in *Singleton Associates, P.A., v. United Healthcare of Texas, Inc.*, Case Number 01-22-0001-4956, before the American Arbitration Association ("AAA"), Commercial Arbitration Panel. Singleton would show as follows:

PRELIMINARY STATEMENT

On August 7, 2024, a panel of arbitrators (the "Panel") entered a Final Award (the "Final Award") in Phase III of the above-captioned arbitration (the "Arbitration"). Singleton now seeks to have this Court confirm the Final Award and enter judgment in accordance with the Final Award.

PARTIES

1. Singleton Associates, P.A. is a Texas-based medical group with employed and contracted hospital-based radiologists, with its principal business office located in Houston, Texas.

2. Defendant United HealthCare of Texas, Inc. ("United" or "Defendant"), is a Texas corporation with its principal business office located in Dallas, Texas. Defendant may be served with process by and through its registered agent, CT Corporation System, 350 North St. Paul Street, Dallas, Texas 75201, or through its counsel of record in the arbitration.

JURISDICTION AND VENUE

3. The relief sought is within the jurisdictional limits of the Court. Pursuant to Tex. R. Civ. P. 47(c)(5), Singleton seeks only non-monetary relief, namely confirmation of the Final Award.

4. Jurisdiction is proper in this Court because the matter relates to the confirmation of an arbitration award arising out of an arbitration agreement that provided for arbitration in Harris County, Texas. *See* Tex. Civ. Prac. & Rem. Code § 171.081.

5. This Court has personal jurisdiction over Defendant pursuant to the dispute resolution provision in the Agreement (defined below), which provides in relevant part, that any proceeding under the applicable agreement between the parties "shall be conducted in Harris County, Texas." Defendant also purposefully availed itself of the jurisdiction of Harris County, Texas, through its participation in the Arbitration, which occurred in Harris County, Texas.

6. Venue is proper in Harris County, Texas pursuant to Tex. Civ. Prac. & Rem. Code § 171.096(c) because the arbitration hearing was held in Haris County, Texas. Venue is also proper in Harris County under the Agreement, in which the parties agreed that disputes would be arbitrated in Harris County, Texas.

STATEMENT OF FACTS

7. Singleton filed a demand for arbitration on April 8, 2022 claiming that Defendant had breached the 1998 United Healthcare of Texas, Inc. Medical Group Participation Agreement

(the "Agreement"), seeking all remedies available under law, equity, contract, tort, and AAA rules, to the full extent available, and as deemed just and proper by the Arbitrators, for any causes of action available and proven at the hearing, including damages, exemplary and/or punitive damages, interest, declaratory relief, injunctive relief, penalties, attorneys' fees, and costs.

8. United answered the demand and asserted general and specific denials and affirmative defenses.

9. Section 8 of the Agreement contains the applicable dispute resolution provision in the Agreement, which provides as follows:

> Plan Or Payor and Medical Group will work together in good faith to resolve any disputes about their business relationship. If the parties are unable to resolve the dispute within 30 days following the date one party sent written notice of the dispute to the other party, and if Plan, Medical Group, or any Payor that has consented in writing to binding arbitration, wishes to pursue the dispute, it shall be submitted to binding arbitration in accordance with the rules of the American Arbitration Association. In no event may arbitration be initiated more than one year following the sending of written notice of the dispute. Any arbitration proceeding under this Agreement shall be conducted in Harris County, Texas. The arbitrators may construe or interpret but shall not vary or ignore the terms of this Agreement, shall have no authority to award any punitive or exemplary damages, and shall be bound by controlling law. If the dispute pertains to a matter which is generally administered by certain Plan procedures, such as a credentialing or quality improvement plan, the procedures set forth in that plan must be fully exhausted by Medical Group before Medical Group may invoke its right to arbitration under this section. The parties acknowledge that because this Agreement affects interstate commerce the Federal Arbitration Act applies.

10. The Arbitration was conducted in three Phases. Phase I decided which contract was the operative agreement that governed the parties' dispute. Phase II decided whether Singleton had been paid all amounts due under the Agreement and, if not, the amount of any underpayment owed by United.

11. On or about March 10, 2023, ten days before the Phase I evidentiary hearing, United moved for leave to assert belated counterclaims, attaching to that motion the counterclaims it sought to bring, including among other things, several alleged breach of contract and tort theories.

12. On April 2, 2023, the Panel issued its Phase I Order, finding Singleton was correct about the controlling contract, stating that "The Panel finds the 1998 contract to be the operative agreement between the parties", and that United's alleged replacement contract never became effective. The Panel also allowed United to assert its counterclaims and set those counterclaims to be heard during a Phase III.

13. Singleton denied United's counterclaims.

14. The Panel issued its Phase II Order on September 26, 2023, finding that United underpaid Singleton on the Agreement.

15. In a separate matter, *Singleton Associates, P.A. v. United Healthcare of Texas, Inc.*, No. 20223-71562, in the 281st Judicial District of Harris County, Texas (the "Related Case"), Singleton applied to have the Phase I and II interim awards confirmed. United opposed confirmation of those awards.

16. Due to changes in Panel membership, the decision rendered in Phase II of the Arbitration was reconsidered, and the Panel requested the parties to present additional evidence during Phase III on the question of how damages should be calculated. During Phase III, the Panel heard testimony and considered evidence regarding United's counterclaims and Singleton's defenses. The Panel also heard testimony and considered evidence regarding how to calculate the underpayment amount found in Phase II.

17. Following nine days of testimony from May 13 through May 23, 2024, post-hearing briefing, and closing arguments on July 29, 2024, the Panel issued the Final Award.

18. After the Final Award was issued, Singleton moved to dismiss the Related Case, which the Court granted.

19. Attached hereto as Exhibit A is a true and correct copy of the Final Award. Among other things, the Final Award reflects that the Panel: (1) confirmed its finding that, "the 1998 contract to be the operative agreement between the parties;" and (2) found that neither Singleton nor United was entitled to any money or relief to either party.

FIRST CLAIM:
CONFIRMATION OF FINAL AWARD

20. Plaintiff repeats and realleges the allegations set forth in the foregoing Paragraphs above as if set forth more fully herein.

21. Plaintiff has timely filed this petition to confirm the Final Award.

22. The TGAA provides that a trial court "shall confirm" an arbitration award unless a party opposing confirmation offers grounds for vacating, modifying, or correcting the award. Tex. Civ. Prac. & Rem. Code § 171.087. The TGAA provides that when a trial court grants "an order that confirms, modifies, or corrects an award, the court *shall* enter a judgment or decree conforming to the order." *Id*. § 171.092(a) (emphasis added). The statute further provides that the "judgment or decree may be enforced in the same manner as any other judgment or decree." *Id.*

23. Similarly, the FAA provides that when a party moves for an order confirming an arbitration award, "the court *must* grant such an order unless the award is vacated, modified, or corrected . . . ." 9 U.S.C. § 9 (emphasis added). "The [FAA] requires the court to enter judgment basis upon which it was reached." *Chiron Corp. v. Ortho Diagnostic Sys., Inc.*, 207 F.3d 1126, 1133 (9th Cir. 2000).

24. "[A]n award of arbitrators upon matters submitted to them is given the same effect as the judgment of a court of last resort. All reasonable presumptions are indulged in favor of the

award, and none against it." *CVN Group, Inc. v. Delgado*, 95 S.W.3d 234, 238 (Tex. 2002) (quotation omitted). An arbitration award "is presumed valid and entitled to great deference." *Cambridge Legacy Grp., Inc. v. Jain*, 407 S.W.3d 443, 447 (Tex. App.—Dallas 2013, pet. denied). "When reviewing an arbitration award, [the Court] may not substitute [its] judgment for that of the arbitrators merely because [it] would have reached a different decision." *Id.*

25. The Final Award has not been vacated or modified pursuant to Tex. Civ. Prac. & Rem. Code § 171.088.

26. No party opposing confirmation of the Final Award has offered grounds for vacating, modifying, or correcting the Final Award.

27. By reason of the foregoing, to the Court should enter an order confirming the Final Award pursuant to Tex. Civ. Prac. & Rem. Code § 171.087 and enter judgment thereon pursuant to Tex. Civ. Prac. & Rem. Code § 171.092.

FOR THESE REASONS, Plaintiff Singleton Associates, P.A. respectfully requests that this Court confirm the Final Award and enter judgment as follows:

1. Enter an Order, pursuant to Tex. Civ. Prac. & Rem. Code § 171.087, confirming the Final Award, dated August 7, 2024;

2. Enter a final judgment, pursuant to Tex. Civ. Prac. & Rem. Code § 171.092, conforming to the Final Award; and

3. Award Singleton such other relief as the Court deems equitable and just.

Date: August 1, 2025

Respectfully submitted,

By: */s/ Sara Brinkmann*

KING & SPALDING LLP
Sara Brinkmann
Tex. Bar No. 24069919
J. Robert Sheppard, III
Tex. Bar No. 24107910
1100 Louisiana Street
Suite 4100
Houston, Texas 77002
(Tel): 713-751-3200
(Fax): 713-751-3900
sbrinkmann@kslaw.com
rsheppard@kslaw.com

Glenn Solomon (PHV forthcoming)
Christopher Jew (PHV forthcoming)
gsolomon@kslaw.com
cjew@kslaw.com

ATTORNEYS FOR SINGLETON ASSOCIATES, P.A

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing instrument was served pursuant to Rules 21 and 21a of the Texas Rules of Civil Procedure on August 1, 2025 upon all counsel of record.

/s/ J. Robert Sheppard, III
J. Robert Sheppard, III

EXHIBIT A

AMERICAN ARBITRATION ASSOCIATION
Commercial Arbitration Panel

Singleton Associates, P.A., Claimant/Counterclaim Respondent, v. United Healthcare of Texas, Inc., Respondent/Counterclaimant	Case Number: 01-22-0001-4956 Arbitrators Hon. Daniel Naranjo Edward "Trey" Bergman III Marshall A. Bennett, Jr. (Chair)

FINAL AWARD

{¶1} We, the undersigned Arbitrators, having been designated in accordance with the arbitration agreement entered into between the above-named parties with an effective date of January 1, 1998, and having been duly sworn, and having duly heard the proofs and allegations of the Parties, hereby AWARD as follows:

THE PLEADINGS

{¶2} Singleton filed a demand for arbitration on April 8, 2022. Singleton's demand seeks all remedies available under law, equity, contract, tort, and AAA rules, to the full extent available, as deemed just and proper by the Arbitrators, for any causes of action available and proven at the hearing. Singleton's demand seeks to recover more than $27,000,000. It also seeks the following remedies: damages, interest, declaratory relief, injunctive relief, penalties, attorneys' fees, costs, exemplary/punitive, etc.

{¶3} On May 26, 2022, United filed an answering statement asserting general and specific denials and affirmative defenses.

{¶4} On February 27, 2023, United filed an amended answering statement, once again asserting general and specific denials and affirmative defenses.

{¶5} On March 10, 2023, United filed a motion for leave to file counterclaims against Singleton. United's proposed counterclaims were attached to its motion. On April 2, 2023, the Panel granted United's motion and its counterclaims were received into the record. United counterclaims for breach of contract, fraud, fraudulent inducement, negligent misrepresentation, money had and received, unjust enrichment, violation of civil RICO, and conspiracy to violate civil RICO. United seeks an award of compensatory damages, equitable relief, declaratory relief, injunctive relief, treble damages, costs, reasonable attorney fees, pre-judgment and post-judgment interest, and any other relief in law or equity that the Panel deems just and proper. No specific dollar recovery amount was demanded.

{¶6} On April 24, 2023, Singleton filed the Claimants' Answering Statement And Counterclaim To United's Phase 3 Counterclaim. Singleton's pleading asserts a general denial of United's claims. It also asserts counterclaims for estoppel by law and quasi-estoppel precluding United's counterclaims, for permanent injunction, unjust enrichment, and a class action seeking injunctive relief for itself and the other members of the proposed class,

{¶7} On May 2, 2023, the Panel entered an order severing Singleton's class claim and referring it to the AAA for further proceedings in accordance with the Association's rules.

{¶8} On May 23, 2023, United filed its Answering Statement To Singleton Associates, P.A.'s Phase III Counterclaims, generally denying Singleton's claims and asserting affirmative defenses.

THE ARBITRATION AGREEMENT

{¶9} The governing contract entered into by the Parties includes the following arbitration agreement:

> Plan Or Payor and Medical Group will work together in good faith to resolve any disputes about their business relationship. If the parties are unable to resolve the

> dispute within 30 days following the date one party sent written notice of the dispute to the other party, and if Plan, Medical Group, or any Payor that has consented in writing to binding arbitration, wishes to pursue the dispute, it shall be submitted to binding arbitration in accordance with the rules of the American Arbitration Association. In no event may arbitration be initiated more than one year following the sending of written notice of the dispute. Any arbitration proceeding under this Agreement shall be conducted in Harris County, Texas. The arbitrators may construe or interpret but shall not vary or ignore the terms of this Agreement, shall have no authority to award any punitive or exemplary damages, and shall be bound by controlling law. If the dispute pertains to a matter which is generally administered by certain Plan procedures, such as a credentialing or quality improvement plan, the procedures set forth in that plan must be fully exhausted by Medical Group before Medical Group may invoke its right to arbitration under this section. The parties acknowledge that because this Agreement affects interstate commerce the Federal Arbitration Act applies.

Under this provision, the substantive law of the State of Texas is controlling, the Federal Arbitration Act applies, and the Panel has no authority to award punitive or exemplary damages

{¶10} The Panel determines that the arbitration agreement gives the Arbitrators full authority, power, and jurisdiction to hear and determine all of the Parties' claims, counterclaims, defenses, and requests for relief in this arbitration. The Parties have not raised an objection to the current membership of the Panel.

PHASES I AND II

{¶11} This arbitration has been conducted in three phases. During Phase I, the Panel heard testimony regarding which contract controlled the Parties' relationship. During Phase II, the Panel heard testimony regarding whether Singleton had been paid all amounts due under the applicable agreement and, if not, the amount of any underpayment. During Phase III, the Panel heard testimony regarding United's counterclaims and Singleton's counterclaims thereto. The Panel also received testimony regarding calculating the underpayment amount found in Phase II.

{¶12} Following the conclusion of Phase I, the Panel decided that the contract, effective January 1, 1998 ("the 1998 Agreement"), controlled the relationship of the Parties. Due to

changes in Panel membership, this decision was reconsidered and reaffirmed on two separate occasions.

{¶13} Following the conclusion of Phase II, the Panel decided that Singleton had not been paid the total amount due under the 1998 Agreement and that the underpayment totaled $134,327,505.00. Due to changes in Panel membership, this decision was reconsidered, and the Panel asked the parties to present additional evidence during Phase III on the question of whether the amount of the underpayment should be calculated at 100% of billed charges or 80% of billed charges.

PHASE III

{¶14} The Panel conducted the final hearing in this matter, starting on Monday, May 13, 2024, in Houston, Texas. The arbitrators, Hon. Daniel Naranjo, Edward "Trey" Bergman, III, Esq., and Marshall A. Bennett, Jr., Esq., were present throughout the final hearing. Also present throughout the hearing were lead counsel for United Healthcare of Texas, Inc. ("United"), Munir Meghjee, Esq., and Jamie R. Kurtz, Esq., of the Robins Kaplan, LLP law firm, and their co-counsel, and lead counsel for Singleton Associates, P.A. ("Singleton"), Kevin Leyendecker, Esq., of the Ahmad Zavitsanos Mensing law firm, and Sara Brinkmann, Esq. of the King & Spalding LLP law firm, and their co-counsel.

{¶15} The Panel took nine full days of the testimony, adjourning on Thursday, May 23, 2024. After that, Panel members separately viewed several hours of admitted deposition testimony.

{¶16} The Parties submitted opening post-hearing briefs and replies thereto.

{¶17} By mutual agreement of the Parties, the closing arguments took place on Monday, July 29, 2024, in Minneapolis, Minnesota. Once again, all members of the Panel were present

and all parties appeared through counsel. At the conclusion of the closing arguments, the Parties confirmed that they did not wish to submit additional evidence or argument, and the Panel closed the final hearing.

{¶18} The Panel proceeded immediately to deliberate, and it now issues this Award.

FINDINGS

{¶19} At the original scheduling conference on December 29, 2022, the Parties agreed that they wished the Panel to issue a Standard Award and the Panel so ordered in its initial scheduling Orders #1 and #2. Such an award is the default form of award under Rule 48 of the Commercial Arbitration Rules. Thereafter United requested that the Panel issue a reasoned award. Singleton did not agree to this request. Pursuant to Rule 48, the Panel determines that a Standard form of award is appropriate in this matter.

{¶20} In the Phase I Decision entered on April 2, 2023, the Panel made the following finding: "The Panel finds the 1998 contract to be the operative agreement between the parties." The Panel confirms this finding.

{¶21} In Phase II the Panel entered the Interim Award On Singleton's Arbitration Demand on September 26, 2023. The Panel now vacates that Interim Award.

{¶22} The difference between the amount United paid on claims pursuant to the rates specified in the 2020 Agreement and the amount it would have paid pursuant to the rates specified in the 1998 Agreement is $94,275,324.00. United's underpayment of Singleton's claims at the rate specified in the 2020 Agreement was a breach of the 1998 Agreement.

{¶23} Because of its breaches of the 1998 Agreement and its other acts and omissions, Singleton is not entitled to recover this difference and underpayment or any other relief against United. Because of its breaches of the 1998 Agreement and its other acts and omissions, United

is not entitled to any other relief against Singleton. The Panel determines that the evidence fully supports these decisions at law and in equity.

AWARD

{¶24} The Panel determines that Singleton is not entitled to any recovery against United.

{¶25} The Panel determines that United is not entitled to any recovery against Singleton.

{¶26} The Panel determines that both parties shall bear their own attorney fees and expenses.

{¶27} The Panel determines that the AAA fees and expenses totaling $72,300.00 and Arbitrator fees and expenses totaling $1,359,345.62 shall be borne as incurred.

{¶28} The Panel denies all other claims, counterclaims, defenses, and requests for relief asserted by the Parties. All relief not granted in this Award is hereby denied.

{¶29} This Final Award is issued in Houston, Texas.

{¶30} BY PANEL DECISION IT IS SO ORDERED.

Date: August 7, 2024

Arbitrator Hon. Daniel Naranjo

Arbitrator Edward "Trey" Bergman

Arbitrator Marshall A. Bennett, Jr., Chair

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Yadir Rodriguez on behalf of Sara Brinkmann
Bar No. 24069919
yrodriguez@kslaw.com
Envelope ID: 103853231
Filing Code Description: Petition
Filing Description: Application to Confirm Final Arbitration Award
Status as of 8/1/2025 11:28 AM CST

Case Contacts

Name	BarNumber	Email	TimestampSubmitted	Status
Robert Sheppard		rsheppard@kslaw.com	8/1/2025 6:48:54 AM	SENT
Sara Brinkmann		sbrinkmann@kslaw.com	8/1/2025 6:48:54 AM	SENT
Christopher Jew		cjew@kslaw.com	8/1/2025 6:48:54 AM	SENT
Glenn Solomon		gsolomon@kslaw.com	8/1/2025 6:48:54 AM	SENT
Yadir Rodriguez		yrodriguez@kslaw.com	8/1/2025 6:48:54 AM	SENT

EXHIBIT 5

9/5/2025 2:14 PM
Marilyn Burgess - District Clerk Harris County
Envelope No. 105266513
By: Shanelle Taylor
Filed: 9/5/2025 2:14 PM

CAUSE NO. 2025-54399

SINGLETON ASSOCIATES, P.A.	§	IN THE DISTRICT COURT OF
Plaintiff,	§	
	§	
v.	§	HARRIS COUNTY, TEXAS
	§	
UNITED HEALTHCARE OF TEXAS, INC.	§	
	§	
Defendant.	§	129th JUDICIAL DISTRICT

AGREED FINAL JUDGMENT

Upon the stipulation of Plaintiff Singleton Associates, P.A. and Defendant United Healthcare of Texas, Inc., the arbitration award dated August 7, 2024, rendered in *Singleton Associates,. P.A., v. United Healthcare of Texas, Inc.*, Case No., 01-22-0001-4956, before the American Arbitration Association is CONFIRMED.

Each party shall bear its own costs.

This is a FINAL JUDGMENT.

All relief not granted herein is DENIED.

SO ORDERED on _____, 2025.

Signed:
9/9/2025

HON. MICHAEL GOMEZ
JUDGE PRESIDING

Unofficial Copy Office of Marilyn Burgess District Clerk

AGREED AS TO FORM AND SUBSTANCE
AND ENTRY RESPECTFULLY REQUESTED:

HICKS THOMAS LLP

By: */s/ Paul L. Mitchell*
Robin L. Harrison
Texas Bar No. 09120700
Paul L. Mitchell
Texas Bar No. 14217920
700 Louisiana, Suite 2300
Houston, Texas 77002
Telephone: (713) 547-9100
Facsimile: (713) 547-9150
rharrison@hicksthomas.com
pmitchell@hicks-thomas.com

ATTORNEYS FOR DEFENDANT
UNITED HEALTHCARE OF TEXAS, INC.

KING & SPALDING LLP

By: */s/ Sara Brinkmann*
Sara Brinkman
Tex. Bar No. 24069919
J. Robert Sheppard, III
Tex. Bar No. 24107910
1100 Louisiana Street, Suite 4100
Houston, Texas 77002
(Tel): 713-751-3200
(Fax): 713-751-3900
sbrinkmann@kslaw.com
rsheppard@kslaw.com

Glenn Solomon
Tex. Bar No. 24135614
Christopher Jew (*PHV*)
gsolomon@kslaw.com
cjew@kslaw.com

ATTORNEYS FOR PLAINTIFF
SINGLETON ASSOCIATES, P.A

Unofficial Copy Office of Marilyn Burgess, District Clerk

Automated Certificate of eService

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Jackie Marlowe on behalf of Robin Harrison
Bar No. 9120700
jmarlowe@hicks-thomas.com
Envelope ID: 105266513
Filing Code Description: No Fee Documents
Filing Description: Agreed Final Judgment
Status as of 9/5/2025 2:35 PM CST

Case Contacts

Name	BarNumber	Email	TimestampSubmitted	Status
Robert Sheppard		rsheppard@kslaw.com	9/5/2025 2:14:09 PM	SENT
Yadir Rodriguez		yrodriguez@kslaw.com	9/5/2025 2:14:09 PM	SENT
Sara Brinkmann		sbrinkmann@kslaw.com	9/5/2025 2:14:09 PM	SENT
Christopher Jew		cjew@kslaw.com	9/5/2025 2:14:09 PM	SENT
Glenn Solomon		gsolomon@kslaw.com	9/5/2025 2:14:09 PM	SENT
Paul Mitchell		pmitchell@hicks-thomas.com	9/5/2025 2:14:09 PM	SENT
Robin Harrison		rharrison@hicks-thomas.com	9/5/2025 2:14:09 PM	SENT

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EXHIBIT 6

ROBINS KAPLAN LLP
Roman M. Silberfeld, CA Bar No. 62783
RSilberfeld@RobinsKaplan.com
Tommy H. Du, CA Bar No. 305117
TDu@RobinsKaplan.com
2121 Avenue of the Stars, Suite 2800
Los Angeles, California 90067
T: (310) 552-0130
F: (310) 229-5800

Jamie R. Kurtz (admitted *pro hac vice*)
JKurtz@RobinsKaplan.com
Marcus A. Guith (admitted *pro hac vice*)
MGuith@RobinsKaplan.com
Kyle D. Nelson (admitted *pro hac vice*)
KNelson@RobinsKaplan.com
Alexa R. Ely (admitted *pro hac vice*)
AEly@RobinsKaplan.com
800 LaSalle Avenue, Suite 2800
Minneapolis, Minnesota 55402
T: (612) 349-8500
F: (612) 339-4181

Paul D. Weller (admitted *pro hac vice*)
PWeller@RobinsKaplan.com
1325 Avenue of the Americas, Suite 2601
New York, New York 10019
T: (212) 980-7400
F: (212) 980-7499

Attorneys for Plaintiff
United Healthcare Services, Inc.

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

UNITED HEALTHCARE SERVICES, INC.,

Plaintiff,

v.

RADIOLOGY PARTNERS, INC.,

Defendant.

Case No. 2:23-cv-2825-MWF-AFM

Hon. Michael W. Fitzgerald

JOINT STATUS REPORT

ROBINS KAPLAN LLP
ATTORNEYS AT LAW
LOS ANGELES

United Healthcare Services, Inc. ("United") and Radiology Partners, Inc. ("Radiology Partners") (collectively, the "Parties") submit this joint status report in accordance with the Court's orders dated September 27, 2023 and February 27, 2025. (Dkt. Nos. 90 and 111) .

The arbitrations involving United and its subsidiaries, Mori, Bean and Brooks, Inc. ("MBB"), and Greensboro Radiology, P.A. ("Greensboro") are still underway and currently in discovery. In the arbitration involving MBB, the matter is set for a final hearing starting on January 12, 2026. As for the arbitration involving Greensboro, the matter is set for a final hearing starting on August 17, 2026.

On June 25, 2025, United, through its subsidiaries, initiated an arbitration matter against Radiology Partners and another Radiology Partners' affiliated medical group in Colorado, Mountain Radiology, Inc. ("Mountain").

On August 8, 2025, United, through its subsidiaries, filed a complaint in the U.S. District Court for the District of Arizona, case no. 2:25-cv-02862, against Radiology Partners and another Radiology Partners' affiliated medical group, Sonoran Radiology, Ltd. ("Sonoran"). Radiology Partners and Sonoran's responsive pleading deadline is October 15, 2025.

[*Signatures to follow*]

ROBINS KAPLAN LLP
ATTORNEYS AT LAW
LOS ANGELES

Dated: September 10, 2025

ROBINS KAPLAN LLP

By: */s/ Jamie R. Kurtz*

Roman M. Silberfeld (CA Bar No. 62783)
RSilberfeld@RobinsKaplan.com
Tommy H. Du (CA Bar No. 305117)
TDu@RobinsKaplan.com
2121 Avenue of the Stars, Suite 2800
Los Angeles, California 90067

Jamie R. Kurtz (admitted *pro hac vice*)
JKurtz@RobinsKaplan.com
Marcus A. Guith (admitted *pro hac vice*)
MGuith@RobinsKaplan.com
Kyle D. Nelson (admitted *pro hac vice*)
KNelson@RobinsKaplan.com
Alexa R. Ely (admitted *pro hac vice*)
AEly@RobinsKaplan.com
800 LaSalle Ave., Suite 2800
Minneapolis, MN 55424

Paul D. Weller (admitted *pro hac vice*)
PWeller@RobinsKaplan.com
1325 Avenue of the Americas, Suite 2601
New York, New York 10019

Attorneys for Plaintiff
United Healthcare Services, Inc.

Dated: September 10, 2025

KING AND SPALDING LLP

By: */s/ Christopher C. Jew*

Glenn E. Solomon (CA Bar No. 155674)
gsolomon@kslaw.com
Peter A. Strotz (CA Bar No. 129904)
pstrotz@kslaw.com
Christopher C. Jew (CA Bar No. 302193)
cjew@kslaw.com

633 West Fifth Street, Suite 1600
Los Angeles, CA 90071
Telephone: +1 213 443 4355
Facsimile: +1 213 443 4310

Sara Brinkmann (admitted *pro hac vice*)
sbrinkmann@kslaw.com
1100 Louisiana Street, Suite 4100
Houston, TX 77002-5213
Telephone: +1 713 751 3200
Facsimile: +1 713 751 3290

AHMAD ZAVITSANOS & MENSING PPLC

P. Kevin Leyendecker (admitted *pro hac vice*)
kleyendecker@azalaw.com
Michael Killingsworth (admitted *pro hac vice*)
mkillingsworth@azalaw.com
Daryl Moore (admitted *pro hac vice*)
dmoore@azalaw.com
John Zavitsanos (admitted *pro hac vice*)
jzavitsanos@azalaw.com
1221 McKinney, Suite 2500
Houston, TX 77010
Telephone: +1 713 600 4961
Facsimile: +1 713 655 0062

Attorneys for Defendant Radiology Partners, Inc.

ROBINS KAPLAN LLP
ATTORNEYS AT LAW
LOS ANGELES

EXHIBIT 7

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Trade Names and Trademarks

TM

Trade Names and Trademarks

» English » Español

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Filing a trademark registers a logo or slogan to be displayed on goods or services for public record. Trademarks also are referred to as service marks. These, too, are not required to be filed, but is an acceptable business practice.

These filings are only applicable in Arizona and are not substitutes for national filings. If you want to file nationwide, you may want to consult the U.S. Patent and Trademark Office or the State Library of Arizona; a branch of the Arizona State Library, Archives and Public Records, a division of the Secretary of State; as it is a U.S. Patent and Trademark Resource Center.

Check filing guidelines and tips in our Trade Name and Trademark Handbook. Our office strongly suggests that customers perform extensive, independent research before registering a trade name. We cannot guarantee that chosen names will not conflict with existing business names.

+ Payment Information

+ Filing tips

+ Office Locations

Please Note - Online filing for Trade Names and Trademarks

Resources

- Online Trade Name & Trademark Forms
- Trade Name and Trademark Search
- Trade Name and Trademark Handbook(PDF)
- Popular Questions & Resources(PDF)
- Trademark Classification Number List(PDF)
- Trade Name, Trademark Public Information Request
- U.S. Patent Trademark Office
- Public Records Request

ARIZONA
BUSINESS ONE STOP

Arizona Business One Stop is an online portal that provides a single online location with personalized tools to plan, start, grow, move and close businesses in Arizona. It is a secure digital experience that does not require in-person interaction.

Disclaimer

This office is a filing agency, and we cannot provide legal advice or interpret statutes. Please refer to Arizona Revised Statutes or consult an attorney if you have questions regarding laws that apply to your specific filing.

Contact Business Services

Starting February 3, 2025, both the Phoenix and Tucson offices will be open Monday through Friday (excluding Holidays) from 8 am to 5 pm.

Office of the Secretary of State
Business Services Division - Phoenix
1700 W Washington St, Fl 2
Phoenix AZ 85007-2808

602-542-6187

Office of the Secretary of State
Business Services Division - Tucson
400 West Congress Street, Suite 221
Tucson, AZ 85701

Contact Email Forms

- Business Services
- Trade Name and Trade Mark
- Notary
- Apostille

+ Tracking Pixel Disclaimer

EXHIBIT 8

Entity Information

Search Date and Time:
11/3/2025 7:49:09 PM

Entity Details

Entity Name:
SONORAN RADIOLOGY, LTD.

Entity ID:
23036060

Entity Type:
Domestic For-Profit (Business) Corporation

Entity Status:
Active

Formation Date:
11/8/2019

Reason for Status:
In Good Standing

Approval Date:
11/12/2019

Status Date:
12/15/2022

Original Incorporation Date:
11/8/2019

Life Period:
Perpetual

Business Type:
Other - Other - Transaction of any lawful business for which corporations may be incorporated in the state of Arizona

Last Annual Report Filed:
2025

Domicile State:
Arizona

Annual Report Due Date:
11/8/2026

Years Due:

Original Publish Date:

Statutory Agent Information

Name:

Corporation Service Company

Appointed Status:

Active 11/16/2020

Attention:

Corporation Service Company

Address:

7955 S Priest Dr., Suite 102, TEMPE, AZ 85284, USA

Agent Last Updated:

9/24/2025

E-mail:

Attention:

Mailing Address:

County:

Maricopa

Principal Information

Title	Name	Attention	Address	Date of Taking Office	Last Updated
Director	Richard Whitney		12554 Riata Vista Circle, AUSTIN, TX, 78727, USA		8/8/2025
President	Richard Whitney		12554 Riata Vista Circle, AUSTIN, TX, 78727, USA		8/8/2025
Secretary	John Pantazis		12554 Riata Vista Circle, AUSTIN, TX, 78727, USA		8/8/2025
Treasurer	Jamie Larsen		12554 Riata Vista Circle, AUSTIN, TX, 78727, USA		8/8/2025

Page 1 of 1, records 1 to 4 of 4

Entity Known Place of Business

Attention:

Address: 2323 W. Rose Garden Lane, PHOENIX, AZ, 85027, USA

County: Maricopa

Last Updated: 9/24/2025

Entity Principal Office Address

Attention:

Address:

County:

Last Updated:

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Document History | Name/Restructuring History | Pending Documents | Microfilm History

EXHIBIT 9

ARIZONA SECRETARY OF STATE
(https://azsos.gov)

Entity Search

Search for the entity you would like to find:

○ **Name:** Trade name, trademark or partnership description (e.g. Fred's Bar, Grill and Watch Sales)

○ **File Number:** Trade name, trademark or partnership file numbe

◉ **Owner or Agent:** Sonoran Radiology, Ltd

Search for Owner or Agent Sonoran Radiology, Ltd found 7 results.
Please click the filing number link below to select the entity you wish to see.
Please click the arrow to the left of the filing number if you would prefer to check a quick preview of the entity.

9132436	Radiology Partners Saguaro	Trade Name
9291337	Radiology Partners SMIL	Trade Name
9319355	Radiology Partners Valley	Trade Name
9132645	RP Saguaro	Trade Name
9291352	RP SMIL	Trade Name
9212352	RP Sol	Trade Name
9319353	RP Valley	Trade Name

1 | 8 items per page | 1 - 7 of 7 items

Search

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EXHIBIT 10

Entity Information

Search Date and Time:
11/3/2025 7:56:25 PM

Entity Details

Entity Name:
SUN CITY IMAGING, LTD.

Entity ID:
07128793

Entity Type:
Domestic Professional Corporation

Entity Status:
Inactive

Formation Date:
3/1/1994

Reason for Status:
Merged to/with other entity

Approval Date:
3/1/1994

Status Date:
2/16/2024

Original Incorporation Date:
3/1/1994

Life Period:
Perpetual

Business Type:
Any legal purpose

Last Annual Report Filed:
2023

Domicile State:
Arizona

Annual Report Due Date:

Years Due:

Original Publish Date:

Statutory Agent Information

Name:

CORPORATION SERVICE COMPANY

Appointed Status:

Active 10/15/2018

Attention:

Address:

8825 N 23RD AVE SUITE 100, PHOENIX, AZ 85021, USA

Agent Last Updated:

10/17/2023

E-mail:

Attention:

Mailing Address:

County:

Maricopa

Principal Information

Title	Name	Attention	Address	Date of Taking Office	Last Updated
Secretary	Anthony Gabriel MD		2330 Utah Ave, El Segundo, CA, 90245, USA		10/17/2023
Director	Richard Whitney		2330 Utah Avenue, El Segundo, CA, 90245, USA		10/17/2023
President	Richard Whitney		2330 Utah Avenue, El Segundo, CA, 90245, USA		10/17/2023
Treasurer	Steve Tumbarello		2330 Utah Avenue, El Segundo, CA, 90245, USA		10/17/2023

Page 1 of 1, records 1 to 4 of 4

Entity Known Place of Business

Attention:

Address: 8825 N AVENIDA DEL SOL, PARADISE VALLEY, AZ, 85253, USA

County: Maricopa

Last Updated: 10/17/2023

Entity Principal Office Address

Attention:

Address:

County:

Last Updated:

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EXHIBIT 11

National Uniform Claim Committee

NUCC™
National Uniform Claim Committee

1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12

July 2024

Version 12.0 7/24

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The 1500 Health Insurance Claim Form (1500 Claim Form) is in the public domain.

The NUCC has developed this general instructions document for completing the 1500 Claim Form. This document is intended to be a guide for completing the 1500 Claim Form and not definitive instructions for this purpose. Any user of this document should refer to the most current federal, state, or other payer instructions for specific requirements applicable to using the 1500 Claim Form.

The NUCC Reference Instruction Manual must remain intact. Any payer-specific instructions for completion of the 1500 Claim Form need to be maintained in a separate document.

The information provided here is for reference use only and does not constitute the rendering of legal, financial, or other professional advice or recommendations by the AMA or the NUCC. You should consult with an appropriate professional if you need legal or other advice. The listing of an organization or the provision of a link to a Web site does not imply any endorsement by the AMA or the NUCC or by any of its members for the products, services, and/or Internet sites listed.

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1500 Claim Form Citation
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BACKGROUND INFORMATION

The 1500 Health Insurance Claim Form (1500 Claim Form) answers the needs of many health care payers. It is the basic paper claim form prescribed by many payers for claims submitted by physicians, other providers, and suppliers, and in some cases, for ambulance services.

In the 1960s, there were a number of different claim forms and coding systems required by third-party payers to communicate information regarding procedures and services to agencies concerned with insurance claims. There was, however, no standardized form for physicians and other health care providers to report health care services. Therefore, the American Medical Association (AMA) embraced an assignment in the 1980s to work with the Centers for Medicare & Medicaid Services (CMS; formerly known as HCFA), and many other payer organizations through a group called the Uniform Claim Form Task Force to standardize and promote the use of a universal health claim form. As a result of this joint effort, the 1500 Claim Form is accepted nationwide by most insurance entities as the standard claim form/attending physician statement for submission of medical claims.

The Uniform Claim Form Task Force was replaced by the National Uniform Claim Committee (NUCC) in the mid 1990s. The NUCC's goal was to develop the NUCC Data Set (NUCC-DS), a standardized data set for use in an electronic environment, but applicable to and consistent with evolving paper claim form standards. The NUCC continues to be responsible for the maintenance of the 1500 Claim Form. Although many providers now submit electronic claims, many of their software/hardware systems depend on the existing 1500 Claim Form in its current image.

SCOPE OF INSTRUCTIONS

This NUCC Reference Instruction Manual provides specific instructions on how to complete the 1500 Claim Form. Instructions and information provided align with the Accredited Standards Committee X12 (ASC X12) Health Care Claim: Professional (837), 005010X222 Technical Report Type 3 (5010) and 005010X222A1 Technical Report Type 3 (5010A1). 5010 and 5010A1 are collectively referred to as "5010A1" in this manual.

The 1500 Claim Form instructions were initially approved by the NUCC in November 2005. The NUCC continues to research the type of data that are typically reported, as well as the required data elements that may apply to public and private payers. Therefore, the instructions have and will continue to evolve. Updated versions of this instruction manual are released each July. The ultimate goal of the NUCC is to develop standardized national instructions. The end result may require additional changes to the 1500 Claim Form in the future.

The instructions in this manual are not specific to any applicable public or private payer. Refer to specific instructions issued by your payer, clearinghouse, and/or vendor for further clarification of reporting requirements.

The 1500 Claim Form may also be used to report patient encounter data to federal, state, and/or other public health agencies. Refer to instructions issued by these agencies for further clarification of reporting requirements.

ONLINE RESOURCES

The NUCC Reference Instruction Manual, Change Log, and a form to request changes to the manual are available at: www.nucc.org.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

OVERALL INSTRUCTIONS

Each Item Number includes the title, instructions, description, field specifications, and example. The examples provided in the instructions are demonstrating how to enter the data in the field. They are not providing instruction on how to bill for certain services.

PUNCTUATION

The use of punctuation is noted in the instructions section of each Item Number.

MULTIPLE PAGE CLAIMS

When reporting line item services on multiple page claims, only the diagnosis code(s) reported on the first page may be used and must be repeated on subsequent pages. If more than 12 diagnoses are required to report the line services, the claim must be split and the services related to the additional diagnoses must be billed as a separate claim. If there are more than 50 service lines, the claim must be split.

NOTE 1: Form images throughout this manual may not be to scale.

NOTE 2: Data content entered into fields may not fill all allotted space.

FIELD SPECIFIC INSTRUCTIONS

CARRIER BLOCK

The carrier block is located in the upper center and right margin of the form. In order to distinguish this version of the form from previous versions, the Quick Response (QR) code symbol and the date approved by the NUCC have been added to the top, left-hand margin.

INSTRUCTIONS: Enter in the white, open carrier area the name and address of the payer to whom this claim is being sent. Enter the name and address information in the following format:

1st Line – Name
2nd Line – First line of address
3rd Line – Second line of address, if necessary
4th Line – City, State (2 characters) and ZIP code

Line	Descriptor	Type	Bytes	Columns
4	Payer Name	A/N	41	38-78
5	Payer Address 1	A/N	41	38-78
6	Payer Address 2	A/N	41	38-78
7	Payer City State and ZIP	A/N	41	38-78

For an address with three lines, enter it in the following format:

1st Line – Name
2nd Line – Line of address
3rd Line – Leave blank
4th Line – City, State (2 characters) and ZIP code

Line	Descriptor	Type	Bytes	Columns
4	Payer Name	A/N	41	38-78
5	Payer Address	A/N	41	38-78
6	Leave blank			
7	Payer City State and ZIP	A/N	41	38-78

Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Report a 5 or 9-digit ZIP code. Enter the 9-digit ZIP code without the hyphen.

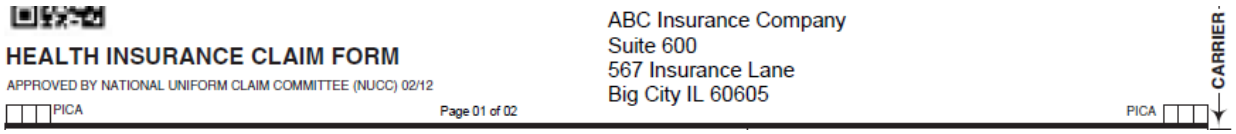
When printing page numbers on multiple page claims (generally done by clearinghouses when converting 5010A1 to the 1500 Claim Form), print the page numbers in the Carrier Block on Line 8 beginning at column 32. Page numbers are to be printed as:

Page XX of YY

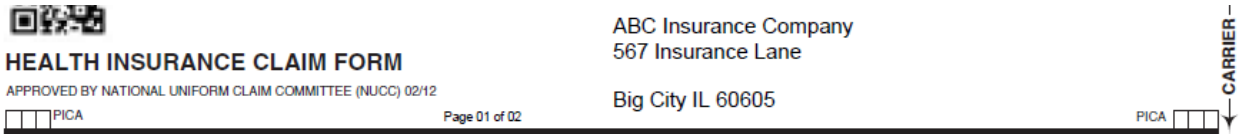
DESCRIPTION: The payer is the carrier, health plan, third-party administrator, or other payer that will handle the claim. This information directs the claim to the appropriate payer.

EXAMPLES:

Four line address:



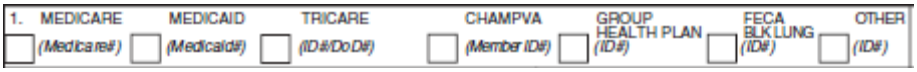
Three line address:



ITEMS 1–13: PATIENT AND INSURED INFORMATION

Note: If the patient can be identified by a unique Member Identification Number, the patient is considered to be the "insured". The patient is reported as the insured in the insured data fields and not in the patient fields.

ITEM NUMBER 1



TITLE: Medicare, Medicaid, TRICARE, CHAMPVA, Group Health Plan, FECA, Black Lung, Other

INSTRUCTIONS: Indicate the type of health insurance coverage applicable to this claim by placing an X in the appropriate box. Only one box can be marked.

DESCRIPTION: "Medicare, Medicaid, TRICARE, CHAMPVA, Group Health Plan, FECA, Black Lung, Other" means the insurance type to which the claim is being submitted. "Other" indicates health insurance including HMOs, commercial insurance, automobile accident, liability, or workers' compensation. This information directs the claim to the correct program and may establish primary liability.

FIELD SPECIFICATION: This field allows for entry of 1 character in any box within the field.

EXAMPLE:

ITEM NUMBER 1a

TITLE: Insured's ID Number

INSTRUCTIONS: Enter the insured's ID number as shown on insured's ID card for the payer to which the claim is being submitted. If the patient has a unique Member Identification Number assigned by the payer, then enter that number in this field.

FOR TRICARE: Enter the DoD Benefits Number (DBN 11-digit number) from the back of the ID card.

FOR WORKERS COMPENSATION CLAIMS: Enter the appropriate identifier of the employee.

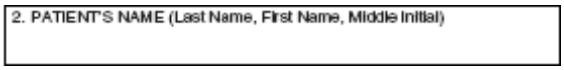
FOR OTHER PROPERTY AND CASUALTY CLAIMS: Enter the appropriate identifier of the insured person or entity, such as property and casualty Claim Number or Claim ID.

DESCRIPTION: The "Insured's ID Number" is the identification number of the insured. This information identifies the insured to the payer.

FIELD SPECIFICATION: This field allows for entry of 29 characters.

EXAMPLE:

ITEM NUMBER 2



TITLE: Patient's Name

INSTRUCTIONS: Enter the patient's full last name, first name, and middle initial. If the patient uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name.

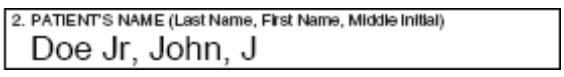
Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.

If the patient's name is the same as the insured's name (i.e., the patient is the insured), then it is not necessary to report the patient's name.

DESCRIPTION: The "Patient's Name" is the name of the person who received the treatment or supplies.

FIELD SPECIFICATION: This field allows for the entry of 28 characters.

EXAMPLE:



ITEM NUMBER 3

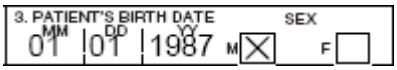
TITLE: Patient's Birth Date, Sex

INSTRUCTIONS: Enter the patient's 8-digit birth date (MM | DD | YYYY). Enter an X in the correct box to indicate sex (gender) of the patient. Only one box can be marked. If sex is unknown, leave blank.

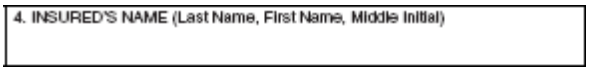
DESCRIPTION: The "Patient's Birth Date, Sex" is information that will identify the patient and it distinguishes persons with similar names.

FIELD SPECIFICATION: This field allows for the entry of the following: 2 digits under MM, 2 digits under DD, 4 digits under YY, and 1 character in either box.

EXAMPLE:



ITEM NUMBER 4



TITLE: Insured's Name

INSTRUCTIONS: Enter the insured's full last name, first name, and middle initial. If the insured uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name.

Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.

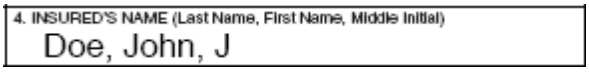
FOR WORKERS COMPENSATION CLAIMS: Enter the name of the Employer.

FOR OTHER PROPERTY & CASUALTY CLAIMS: Enter the name of the insured person or entity.

DESCRIPTION: The "Insured's Name" identifies the person who holds the policy, which would be the employee for employer-provided health insurance.

FIELD SPECIFICATION: This field allows for the entry of 29 characters.

EXAMPLE:



ITEM NUMBER 5

5. PATIENT'S ADDRESS (No., Street)	
CITY	STATE
ZIP CODE	TELEPHONE (Include Area Code) ( )

TITLE: Patient's Address (multiple fields)

INSTRUCTIONS: Enter the patient's address. The first line is for the street address; the second line, the city and state; the third line, the ZIP code.

Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Report a 5 or 9-digit ZIP code. Enter the 9-digit ZIP code without the hyphen.

If reporting a foreign address, contact payer for specific reporting instructions.

If the patient's address is the same as the insured's address, then it is not necessary to report the patient's address.

"Patient's Telephone" does not exist in 5010A1. The NUCC recommends that the phone number not be reported. Phone extensions are not supported.

FOR WORKERS' COMPENSATION AND OTHER PROPERTY AND CASUALTY CLAIMS: If required by a payer to report a telephone number, do not use a hyphen or space as a separator within the telephone number.

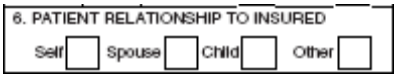
DESCRIPTION: The "Patient's Address" is the patient's permanent residence. A temporary address or school address should not be used.

FIELD SPECIFICATION: This field allows for the entry of the following: 28 characters for street address, 24 characters for city, 3 characters for state, 12 digits for ZIP code, 3 digits for area code, and 10 digits for phone number.

EXAMPLE:
With phone number, if required.

5. PATIENT'S ADDRESS (No., Street) 123 Main Street	
CITY Anytown	STATE IL
ZIP CODE 60610	TELEPHONE (Include Area Code) (312) 5551212

ITEM NUMBER 6



TITLE: Patient Relationship to Insured

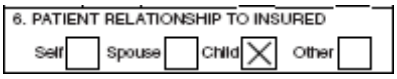
INSTRUCTIONS: Enter an X in the correct box to indicate the patient's relationship to insured when Item Number 4 is completed. Only one box can be marked.

If the patient is a dependent, but has a unique Member Identification Number and the payer requires the identification number be reported on the claim, then report "Self", since the patient is reported as the insured.

DESCRIPTION: The "Patient Relationship to Insured" indicates how the patient is related to the insured. "Self" would indicate that the insured is the patient. "Spouse" would indicate that the patient is the husband or wife or qualified partner, as defined by the insured's plan. "Child" would indicate that the patient is the minor dependent, as defined by the insured's plan. "Other" would indicate that the patient is other than the self, spouse, or child, which may include employee, ward, or dependent, as defined by the insured's plan.

FIELD SPECIFICATION: This field allows for entry of 1 character in any box within the field.

EXAMPLE:



ITEM NUMBER 7

7. INSURED'S ADDRESS (No., Street)	
CITY	STATE
ZIP CODE	TELEPHONE (Include Area Code) ( )

TITLE: Insured's Address (multiple fields)

INSTRUCTIONS: Enter the insured's address. If Item Number 4 is completed, then this field should be completed. The first line is for the street address; the second line, the city and state; the third line, the ZIP code.

Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Report a 5 or 9-digit ZIP code. Enter the 9-digit ZIP code without the hyphen.

If reporting a foreign address, contact payer for specific reporting instructions.

"Insured's Telephone" does not exist in 5010A1. The NUCC recommends that the phone number not be reported. Phone extensions are not supported.

FOR WORKERS COMPENSATION CLAIMS: Enter the address of the Employer.

FOR OTHER PROPERTY AND CASUALTY CLAIMS: Enter the address of the insured noted in Item Number 4.

FOR WORKERS' COMPENSATION AND OTHER PROPERTY AND CASUALTY CLAIMS: If required by a payer to report a telephone number, do not use a hyphen or space as a separator within the telephone number.

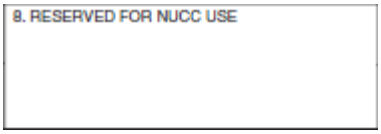
DESCRIPTION: The "Insured's Address" is the insured's permanent residence, which may be different from the patient's address in Item Number 5.

FIELD SPECIFICATION: This field allows for the entry of the following: 29 characters for street address, 23 characters for city, 4 characters for state, 12 digits for ZIP code, 3 digits for area code, and 10 digits for phone number.

EXAMPLE:

7. INSURED'S ADDRESS (No., Street) 123 N Main Street	
CITY Anytown	STATE IL
ZIP CODE 60610	TELEPHONE (Include Area Code) (312) 5551212

ITEM NUMBER 8



TITLE: Reserved for NUCC Use

INSTRUCTIONS: This field was previously used to report “Patient Status.” “Patient Status” does not exist in 5010A1, so this field has been eliminated.

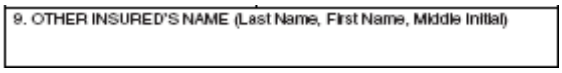
This field is reserved for NUCC use. The NUCC will provide instructions for any use of this field.

DESCRIPTION: This field is reserved for NUCC use.

FIELD SPECIFICATION: None

EXAMPLE: None

ITEM NUMBER 9



TITLE: Other Insured’s Name

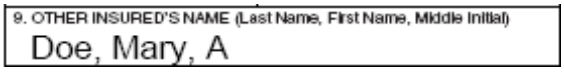
Instructions: If Item Number 11d is marked, complete fields 9, 9a, and 9d, otherwise leave blank. When additional group health coverage exists, enter other insured’s full last name, first name, and middle initial of the enrollee in another health plan if it is different from that shown in Item Number 2. If the insured uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name.

Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.

DESCRIPTION: The “Other Insured’s Name” indicates that there is a holder of another policy that may cover the patient.

FIELD SPECIFICATION: This field allows for the entry of 28 characters.

EXAMPLE:



ITEM NUMBER 9a

TITLE: Other Insured's Policy or Group Number

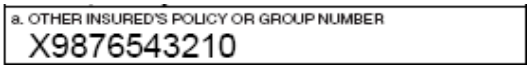
INSTRUCTIONS: Enter the policy or group number of the other insured.

Do not use a hyphen or space as a separator within the policy or group number.

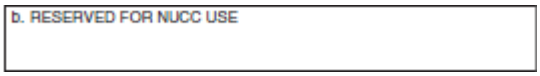
DESCRIPTION: The "Other Insured's Policy or Group Number" identifies the policy or group number for coverage of the insured as indicated in Item Number 9.

FIELD SPECIFICATION: This field allows for the entry of 28 characters.

EXAMPLE:



ITEM NUMBER 9b



TITLE: Reserved for NUCC Use

INSTRUCTIONS: This field was previously used to report "Other Insured's Date of Birth, Sex." "Other Insured's Date of Birth, Sex" does not exist in 5010A1, so this field has been eliminated.

This field is reserved for NUCC use. The NUCC will provide instructions for any use of this field.

DESCRIPTION: This field is reserved for NUCC use.

FIELD SPECIFICATION: None

EXAMPLE: None

ITEM NUMBER 9c

TITLE: Reserved for NUCC Use

INSTRUCTIONS: This field was previously used to report “Employer’s Name or School Name.” “Employer’s Name or School Name” does not exist in 5010A1, so this field has been eliminated.

This field is reserved for NUCC use. The NUCC will provide instructions for any use of this field.

DESCRIPTION: This field is reserved for NUCC use.

FIELD SPECIFICATION: None

EXAMPLE: None

ITEM NUMBER 9d

TITLE: Insurance Plan Name or Program Name

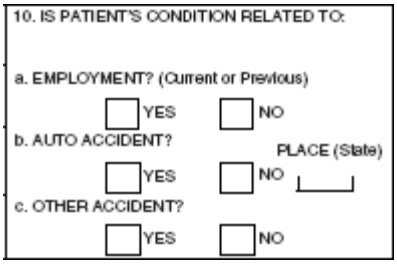
INSTRUCTIONS: Enter the other insured’s insurance plan or program name.

DESCRIPTION: The “Insurance Plan Name or Program Name” identifies the name of the plan or program of the other insured as indicated in Item Number 9.

FIELD SPECIFICATION: This field allows for the entry of 28 characters.

EXAMPLE:

ITEM NUMBERS 10a–10c



TITLE: Is Patient's Condition Related To:

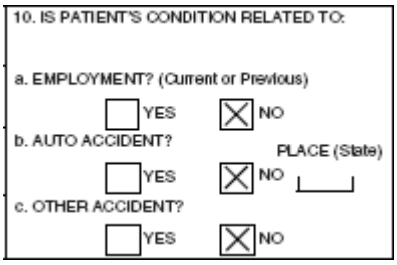
INSTRUCTIONS: When appropriate, enter an X in the correct box to indicate whether one or more of the services described in Item Number 24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. Only one box on each line can be marked.

The state postal code where the accident occurred must be reported if "YES" is marked in 10b for "Auto Accident." Any item marked "YES" indicates there may be other applicable insurance coverage that would be primary, such as automobile liability insurance. Primary insurance information must then be shown in Item Number 11.

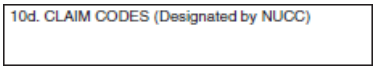
DESCRIPTION: This information indicates whether the patient's illness or injury is related to employment, auto accident, or other accident. "Employment (current or previous)" would indicate that the condition is related to the patient's job or workplace. "Auto accident" would indicate that the condition is the result of an automobile accident. "Other accident" would indicate that the condition is the result of any other type of accident.

FIELD SPECIFICATION: This field allows for the entry of the following: 1 character in either box per each line and 2 characters in the Place/State field.

EXAMPLE:



ITEM NUMBER 10d



TITLE: Claim Codes (Designated by NUCC)

INSTRUCTIONS: When applicable, use to report appropriate claim codes. Applicable claim codes are designated by the NUCC. Please refer to the most current instructions from the public or private payer regarding the need to report claim codes.

When required by payers to provide the sub-set of Condition Codes approved by the NUCC, enter the Condition Code in this field. The Condition Codes approved for use on the 1500 Claim Form are available at www.nucc.org under Code Sets.

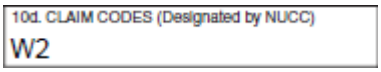
When reporting more than one code, enter three blank spaces and then the next code.

FOR WORKERS COMPENSATION CLAIMS: Condition Codes are required when submitting a bill that is a duplicate or an appeal. (Original Reference Number must be entered in Box 22 for these situations). Note: Do not use Condition Codes when submitting a revised or corrected bill.

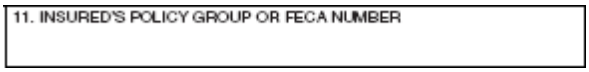
DESCRIPTION: The "Claim Codes" identify additional information about the patient's condition or the claim.

FIELD SPECIFICATION: This field allows for the entry of 19 characters.

EXAMPLE:



ITEM NUMBER 11



TITLE: Insured's Policy, Group, or FECA Number

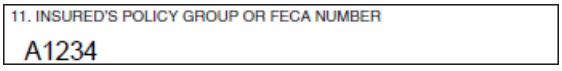
INSTRUCTIONS: Enter the insured's policy or group number as it appears on the insured's health care identification card. If Item Number 4 is completed, then this field should be completed.

Do not use a hyphen or space as a separator within the policy or group number.

DESCRIPTION: The "Insured's Policy, Group, or FECA Number" is the alphanumeric identifier for the health, auto, or other insurance plan coverage. The FECA number is the 9-character alphanumeric identifier assigned to a patient claiming work-related condition(s) under the Federal Employees Compensation Act 5 USC 8101.

FIELD SPECIFICATION: This field allows for the entry of 29 characters.

EXAMPLE:



ITEM NUMBER 11a

TITLE: Insured's Date of Birth, Sex

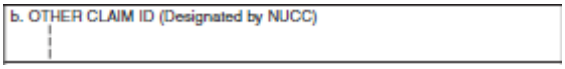
INSTRUCTIONS: Enter the 8-digit date of birth (MM|DD|YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.

DESCRIPTION: The "Insured's Date of Birth, Sex" is the birth date and gender of the insured as indicated in Item Number 1a.

FIELD SPECIFICATION: This field allows for the entry of the following: 2 digits under MM, 2 digits under DD, 4 digits under YY, and 1 character in either box.

EXAMPLE:

ITEM NUMBER 11b



TITLE: Other Claim ID (Designated by NUCC)

INSTRUCTIONS: Enter the "Other Claim ID." Applicable claim identifiers are designated by the NUCC.

When submitting to Property and Casualty payers, e.g. Automobile, Homeowner's, or Workers' Compensation insurers and related entities, the following qualifier and accompanying identifier has been designated for use:

Y4 Agency Claim Number (Property Casualty Claim Number)

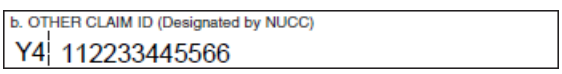
Enter the qualifier to the left of the vertical, dotted line. Enter the identifier number to the right of the vertical, dotted line.

FOR WORKERS' COMPENSATION OR PROPERTY & CASUALTY: Required if known. Enter the claim number assigned by the payer.

DESCRIPTION: The "Other Claim ID" is another identifier applicable to the claim.

FIELD SPECIFICATION: This field allows for the entry of the following: 2 characters to the left of the vertical, dotted line and 28 characters to the right of the dotted line.

EXAMPLE:



ITEM NUMBER 11c

TITLE: Insurance Plan Name or Program Name

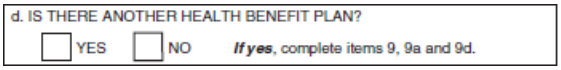
INSTRUCTIONS: Enter the name of the insurance plan or program of the insured. Some payers require an identification number of the primary insurer rather than the name in this field.

DESCRIPTION: The "Insurance Plan Name or Program Name" is the name of the plan or program of the insured as indicated in Item Number 1a.

FIELD SPECIFICATION: This field allows for the entry of 29 characters.

EXAMPLE:

ITEM NUMBER 11d



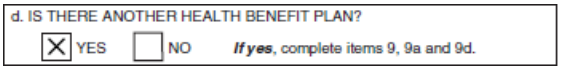
TITLE: Is there another Health Benefit Plan?

INSTRUCTIONS: When appropriate, enter an X in the correct box. If marked "YES", complete 9, 9a, and 9d. Only one box can be marked.

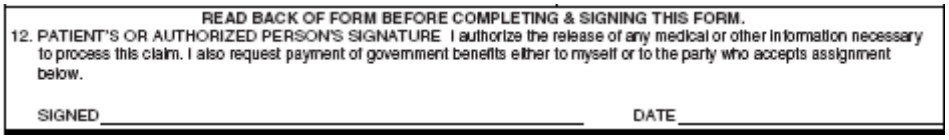
DESCRIPTION: "Is there another health benefit plan" indicates that the patient has insurance coverage other than the plan indicated in Item Number 1.

FIELD SPECIFICATION: This field allows for the entry of 1 character in either box.

EXAMPLE:



ITEM NUMBER 12


READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED _____ DATE _____

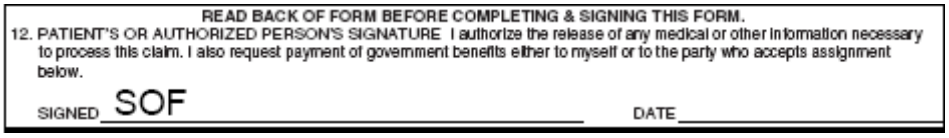
TITLE: Patient's or Authorized Person's Signature

INSTRUCTIONS: Enter "Signature on File," "SOF," or legal signature. When legal signature, enter date signed in 6-digit (MM|DD|YY) or 8-digit format (MM|DD|YYYY) format. If there is no signature on file, leave blank or enter "No Signature on File."

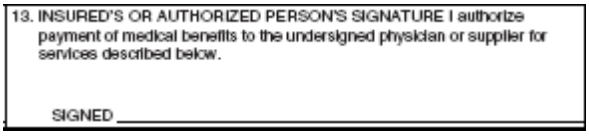
DESCRIPTION: The "Patient's or Authorized Person's Signature" indicates there is an authorization on file for the release of any medical or other information necessary to process and/or adjudicate the claim.

FIELD SPECIFICATION: Use the space available to enter signature/information and date.

EXAMPLE:


READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SOF DATE _____

ITEM NUMBER 13


13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____

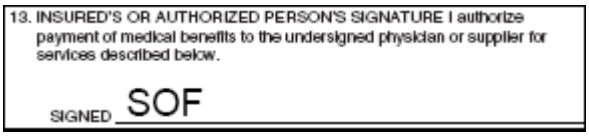
TITLE: Insured's or Authorized Person's Signature

INSTRUCTIONS: Enter "Signature on File," "SOF," or legal signature. If there is no signature on file, leave blank or enter "No Signature on File."

DESCRIPTION: The "Insured's or Authorized Person's Signature" indicates that there is a signature on file authorizing payment of medical benefits.

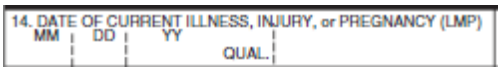
FIELD SPECIFICATION: Use the space available to enter signature/information.

EXAMPLE:


13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SOF

ITEMS 14–33: PHYSICIAN OR SUPPLIER INFORMATION

ITEM NUMBER 14



TITLE: Date of Current Illness, Injury, or Pregnancy (LMP)

INSTRUCTIONS: Enter the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date.

Enter the applicable qualifier to identify which date is being reported.

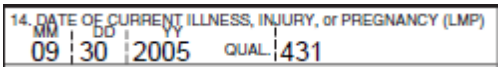
431	Onset of Current Symptoms or Illness
484	Last Menstrual Period

Enter the qualifier to the right of the vertical, dotted line.

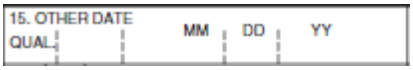
DESCRIPTION: The “Date of Current Illness, Injury, or Pregnancy” identifies the first date of onset of illness, the actual date of injury, or the LMP for pregnancy.

FIELD SPECIFICATION: This field allows for the entry of the following: 2 digits under MM, 2 digits under DD, 4 digits under YY, and 3 characters to the right of the vertical, dotted line.

EXAMPLE:



ITEM NUMBER 15



TITLE: Other Date

INSTRUCTIONS: Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) format.

Enter the applicable qualifier to identify which date is being reported.

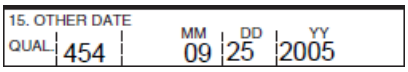
454	Initial Treatment
304	Latest Visit or Consultation
453	Acute Manifestation of a Chronic Condition
439	Accident
455	Last X-ray
471	Prescription
090	Report Start (Assumed Care Date)
091	Report End (Relinquished Care Date)
444	First Visit or Consultation

Enter the qualifier between the left-hand set of vertical, dotted lines.

DESCRIPTION: The "Other Date" identifies additional date information about the patient's condition or treatment.

FIELD SPECIFICATION: This field allows for the entry of the following: 3 characters between the vertical, dotted lines, 2 digits under MM, 2 digits under DD, and 4 digits under YY.

EXAMPLE:



ITEM NUMBER 16

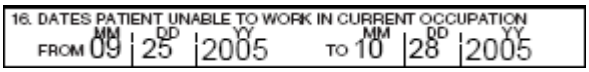
TITLE: Dates Patient Unable to Work in Current Occupation

INSTRUCTIONS: If the patient is employed and is unable to work in current occupation, a 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) date must be shown for the "from–to" dates that the patient is unable to work. An entry in this field may indicate employment-related insurance coverage.

DESCRIPTION: "Dates Patient Unable to Work in Current Occupation" is the time span the patient is or was unable to work.

FIELD SPECIFICATION: This field allows for the entry of the following in each of the date fields: 2 digits under MM, 2 digits under DD, and 4 digits under YY.

EXAMPLE:



ITEM NUMBER 17

TITLE: Name of Referring Provider or Other Source

INSTRUCTIONS: Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim.

If multiple providers are involved, enter one provider using the following priority order:

1. Referring Provider
2. Ordering Provider
3. Supervising Provider

Do not use periods or commas. A hyphen can be used for hyphenated names.

Enter the applicable qualifier to identify which provider is being reported.

DN	Referring Provider
DK	Ordering Provider
DQ	Supervising Provider

Enter the qualifier to the left of the vertical, dotted line.

DESCRIPTION: The name entered is the referring provider, ordering provider, or supervising provider who referred, ordered, or supervised the service(s) or supply(ies) on the claim. The qualifier indicates the role of the provider being reported.

FIELD SPECIFICATION: This field allows for the entry of 2 characters to the left of the vertical, dotted line and 24 characters to the right of the dotted line.

EXAMPLE:

ITEM NUMBER 17a AND 17b (Split Field)

17a.		
17b.	NPI	

TITLE 17a: Other ID#

INSTRUCTIONS 17a: The Other ID number of the referring, ordering, or supervising provider is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a.

The NUCC defines the following qualifiers used in 5010A1:

0B	State License Number
1G	Provider UPIN Number
G2	Provider Commercial Number
LU	Location Number (This qualifier is used for Supervising Provider only.)

DESCRIPTION: The non-NPI ID number of the referring, ordering, or supervising provider is the unique identifier of the professional.

FIELD SPECIFICATION: This field allows for the entry of 2 characters in the qualifier field and 17 characters in the Other ID# field.

TITLE 17b: NPI #

INSTRUCTIONS 17b: Enter the NPI number of the referring, ordering, or supervising provider in Item Number 17b.

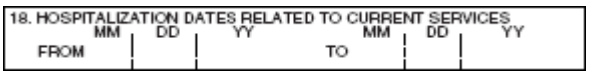
DESCRIPTION: The NPI number refers to the HIPAA National Provider Identifier number.

FIELD SPECIFICATION: This field allows for the entry of a 10-digit NPI number.

EXAMPLE:

17a.	G2	ABC1234567890
17b.	NPI	0123456789

ITEM NUMBER 18



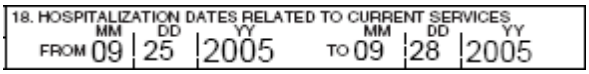
TITLE: Hospitalization Dates Related to Current Services

INSTRUCTIONS: Enter the inpatient 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) hospital admission date followed by the discharge date (if discharge has occurred). If not discharged, leave discharge date blank. This date is when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

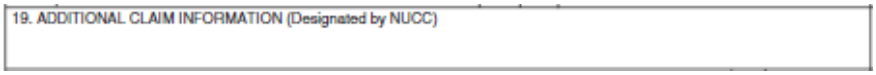
DESCRIPTION: The "Hospitalization Dates Related to Current Services" refers to an inpatient stay and indicates the admission and discharge dates associated with the service(s) on the claim.

FIELD SPECIFICATION: This field allows for the entry of the following in each of the date fields: 2 digits under MM, 2 digits under DD, and 4 digits under YY.

EXAMPLE:



ITEM NUMBER 19



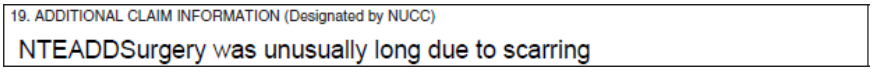
TITLE: Additional Claim Information (Designated by NUCC)

INSTRUCTIONS: Please refer to the most current instructions from the public or private payer regarding the use of this field. Report the appropriate qualifier, when available, for the information being entered. Do not enter a space, hyphen, or other separator between the qualifier and the information.

For the Claim Information (NTE), the following are the qualifiers in 5010A1. Enter the qualifier "NTE", followed by the appropriate qualifier, then the information. Do not enter spaces between the qualifier and the first word of the information. After the qualifier, use spaces to separate any words.

ADD Additional Information
CER Certification Narrative
DCP Goals, Rehabilitation Potential, or Discharge Plans
DGN Diagnosis Description
TPO Third Party Organization Notes

EXAMPLE:



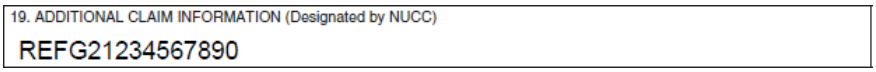
For additional identifiers (REFs), the following are the qualifiers in 5010A1. Enter the qualifier "REF", followed by the qualifier, then the identifier. Do not enter spaces between the qualifier and identifier.

0B	State License Number
1G	Provider UPIN Number
G2	Provider Commercial Number
LU	Location Number (This qualifier is used for Supervising Provider only.)
N5	Provider Plan Network Identification Number
SY	Social Security Number (The social security number may not be used for Medicare.)
X5	State Industrial Accident Provider Number
ZZ	Provider Taxonomy (The qualifier in the 5010A1 for Provider Taxonomy is PXC, but ZZ will remain the qualifier for the 1500 Claim Form.)

The above list contains both provider identifiers, as well as the provider taxonomy code. The provider identifiers are assigned to the provider either by a specific payer or by a third party in order to uniquely identify the provider. The taxonomy code is designated by the provider in order to identify his/her provider grouping, classification, or area of specialization. Both, provider identifiers and provider taxonomy may be used in this field.

Taxonomy codes or other identifiers reported in this field must not be reportable in other fields, i.e., Item Numbers 17, 24J, 32, or 33.

EXAMPLE:



For Supplemental Claim Information (PWK), the following are the qualifiers in the 5010A1. Enter the qualifier "PWK", followed by the appropriate Report Type Code, the appropriate Transmission Type Code, then the Attachment Control Number. Do not enter spaces between the qualifiers and data.

REPORT TYPE CODES

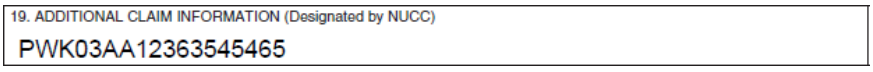
03	Report Justifying Treatment Beyond Utilization
04	Drugs Administered
05	Treatment Diagnosis
06	Initial Assessment
07	Functional Goals
08	Plan of Treatment
09	Progress Report
10	Continued Treatment
11	Chemical Analysis
13	Certified Test Report
15	Justification for Admission
21	Recovery Plan
A3	Allergies/Sensitivities Document
A4	Autopsy Report
AM	Ambulance Certification
AS	Admission Summary
B2	Prescription
B3	Physician Order
B4	Referral Form
BR	Benchmark Testing Results

BS	Baseline
BT	Blanket Test Results
CB	Chiropractic Justification
CK	Consent Form(s)
CT	Certification
D2	Drug Profile Document
DA	Dental Models
DB	Durable Medical Equipment Prescription
DG	Diagnostic Report
DJ	Discharge Monitoring Report
DS	Discharge Summary
EB	Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payor)
HC	Health Certificate
HR	Health Clinic Records
I5	Immunization Record
IR	State School Immunization Records
LA	Laboratory Results
M1	Medical Record Attachment
MT	Models
NN	Nursing Notes
OB	Operative Note
OC	Oxygen Content Averaging Report
OD	Orders and Treatments Document
OE	Objective Physical Examination (including vital signs) Document
OX	Oxygen Therapy Certification
OZ	Support Data for Claim
P4	Pathology Report
P5	Patient Medical History Document
PE	Parenteral or Enteral Certification
PN	Physical Therapy Notes
PO	Prosthetics or Orthotic Certification
PQ	Paramedical Results
PY	Physician's Report
PZ	Physical Therapy Certification
RB	Radiology Films
RR	Radiology Reports
RT	Report of Tests and Analysis Report
RX	Renewable Oxygen Content Averaging Report
SG	Symptoms Document
V5	Death Notification
XP	Photographs

TRANSMISSION TYPE CODES

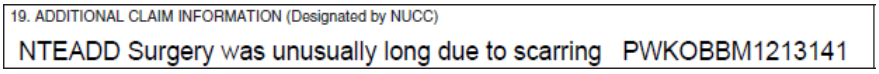
AA	Available on Request at Provider Site
BM	By Mail

EXAMPLE:



When reporting multiple separate items, enter three blank spaces and then the next qualifier and followed by the information

EXAMPLE:



DESCRIPTION: "Additional Claim Information" identifies additional information about the patient's condition or the claim.

FIELD SPECIFICATION: This field allows for the entry of 71 characters.

ITEM NUMBER 20

TITLE: Outside Lab? $Charges

INSTRUCTIONS: Complete this field when billing for purchased services by entering an X in "YES." A "YES" mark indicates that the reported service was provided by an entity other than the billing provider (for example, services subject to Medicare's anti-markup rule). A "NO" mark or blank indicates that no purchased services are included on the claim.

If "YES" is marked, enter the purchase price under "$Charges" and complete Item Number 32. Each purchased service must be reported on a separate claim form as only one charge can be entered.

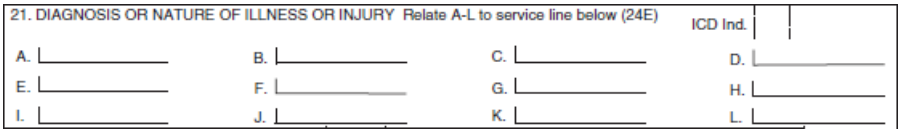
When entering the charge amount, enter the amount in the field to the left of the vertical line. Enter number right justified to the left of the vertical line. Enter 00 for cents if the amount is a whole number. Do not use dollar signs, commas, or a decimal point when reporting amounts. Negative dollar amounts are not allowed. Leave the right-hand field blank.

DESCRIPTION: "Outside lab? $Charges" indicates that services have been rendered by an independent provider as indicated in Item Number 32 and the related costs.

FIELD SPECIFICATION: This field allows for the entry of the following: 1 character in either box in the Outside Lab area and 8 characters to the left of the vertical line in the $Charges area.

EXAMPLE:

ITEM NUMBER 21



TITLE: Diagnosis or Nature of Illness or Injury

INSTRUCTIONS: Enter the applicable ICD indicator to identify which version of ICD codes is being reported.

9	ICD-9-CM
0	ICD-10-CM

Enter the indicator between the vertical, dotted lines in the upper right-hand area of the field.

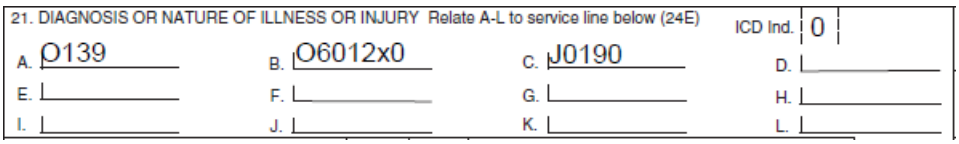
Enter the codes left justified on each line to identify the patient's diagnosis or condition. Do not include the decimal point in the diagnosis code, because it is implied. List no more than 12 ICD-10-CM or ICD-9-CM diagnosis codes. Relate lines A - L to the lines of service in 24E by the letter of the line. Use the greatest level of specificity. Do not provide narrative description in this field.

DESCRIPTION: The "ICD Indicator" identifies the version of the ICD code set being reported. The "Diagnosis or Nature of Illness or Injury" is the sign, symptom, complaint, or condition of the patient relating to the service(s) on the claim.

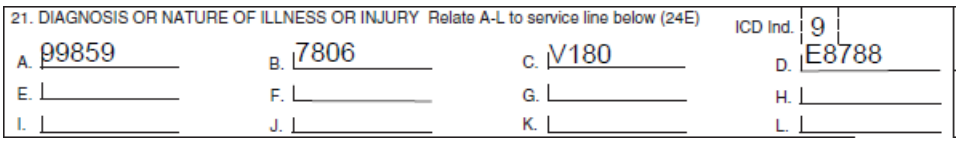
FIELD SPECIFICATION: This field allows for the entry a 1 digit indicator and 12 diagnosis codes at a maximum of 7 characters in length.

EXAMPLE:

ICD-10-CM:



ICD-9-CM:



ITEM NUMBER 22

TITLE: Resubmission and/or Original Reference Number

INSTRUCTIONS: List the original reference number for resubmitted claims. Please refer to the most current instructions from the public or private payer regarding the use of this field.

When resubmitting a claim, enter the appropriate bill frequency code left justified in the left-hand side of the field.

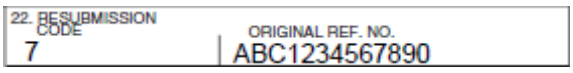
7	Replacement of prior claim
8	Void/cancel of prior claim

This Item Number is not intended for use for original claim submissions.

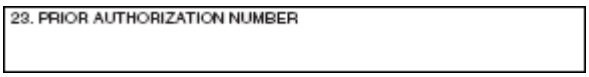
DESCRIPTION: "Resubmission" means the code and original reference number assigned by the destination payer or receiver to indicate a previously submitted claim or encounter.

FIELD SPECIFICATION: This field allows for the entry of 11 characters in the Code area and 18 characters in the Original Ref. No. area.

EXAMPLE:



ITEM NUMBER 23



TITLE: Prior Authorization Number

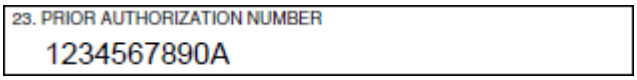
INSTRUCTIONS: Enter any of the following: prior authorization number, referral number, mammography certification number, or Clinical Laboratory Improvement Amendments (CLIA) number, as assigned by the payer for the current service.

Do not enter hyphens or spaces within the number.

DESCRIPTION: The "Prior Authorization Number" is the payer assigned number authorizing the service(s).

FIELD SPECIFICATION: This field allows for the entry of 29 characters.

EXAMPLE:



SECTION 24

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1															NPI	
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

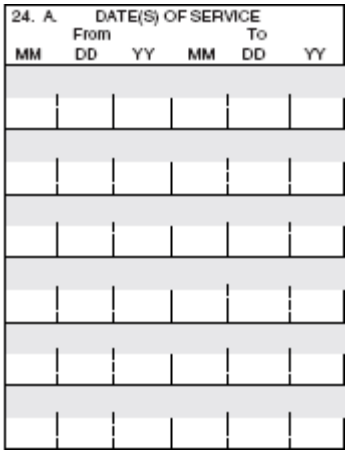
INSTRUCTIONS: Supplemental information can only be entered with a corresponding, completed service line. The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and another/proprietary identifier and to accommodate the submission of supplemental information to support the billed service. The top area of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service.

The supplemental information is to be placed in the shaded section of 24A through 24G as defined in each Item Number. Providers must verify requirements for this supplemental information with the payer.

See page 45 for further instructions and examples of how to enter supplemental information.

FIELD SPECIFICATION: The shaded area of lines 1 through 6 allow for the entry of 61 characters from the beginning of 24A to the end of 24G.

ITEM NUMBER 24A



TITLE: Date(s) of Service [lines 1–6]

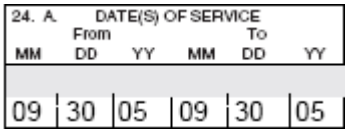
INSTRUCTIONS: Enter date(s) of service, both the "From" and "To" dates. If there is only one date of service, enter that date under "From." Leave "To" blank or re-enter "From" date. If grouping services, the place of service, procedure code, charges, and individual provider for each line must be identical for that service line. Grouping is allowed only for services on consecutive days. The number of days must correspond to the number of units in 24G.

When required by payers to provide additional narrative description of an unspecified code, NDC, contract rate, or tooth numbers and areas of the oral cavity enter the applicable qualifier and number/code/information starting with the first space in the shaded line of this field. Do not enter a space, hyphen, or other separator between the qualifier and the number/code/ information. The information may extend to 24G. Further instructions on entering supplemental information with qualifiers, including examples, are on page 45.

DESCRIPTION: "Date(s) of Service" indicates the actual month, day, and year the service(s) was provided. Grouping services refers to a charge for a series of identical services without listing each date of service.

FIELD SPECIFICATION: This field allows for the entry of the following in each of the unshaded date fields: 2 digits under MM, 2 digits under DD, and 2 digits under YY.

EXAMPLE:



ITEM NUMBER 24B

TITLE: Place of Service [lines 1–6]

INSTRUCTIONS: In 24B, enter the appropriate two-digit code from the Place of Service Code list for each item used or service performed. The Place of Service Codes are available at: www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html.

DESCRIPTION: The "Place of Service" Code identifies the location where the service was rendered.

FIELD SPECIFICATION: This field allows for the entry of 2 digits in the unshaded area.

EXAMPLE:

ITEM NUMBER 24C

TITLE: EMG [lines 1–6]

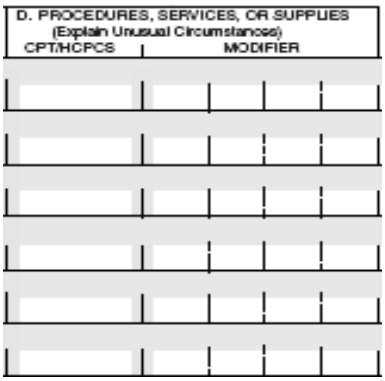
INSTRUCTIONS: Check with payer to determine if this information (emergency indicator) is necessary. If required, enter Y for "YES" or leave blank if "NO" in the bottom, unshaded area of the field. The definition of emergency would be either defined by federal or state regulations or programs, payer contracts, or as defined in 5010A1.

DESCRIPTION: "EMG" identifies if the service was an emergency.

FIELD SPECIFICATION: This field allows for the entry of 2 characters in the unshaded area.

EXAMPLE:

ITEM NUMBER 24D



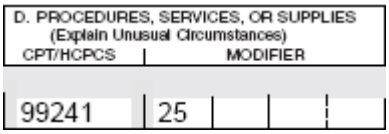
TITLE: Procedures, Services, or Supplies [lines 1–6]

INSTRUCTIONS: Enter the CPT or HCPCS code(s) and modifier(s) (if applicable) from the appropriate code set in effect on the date of service. This field accommodates the entry of up to four 2-character modifiers. The specific procedure code(s) must be shown without a narrative description.

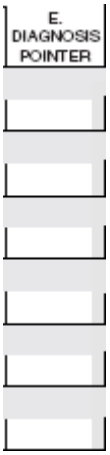
DESCRIPTION: "Procedures, Services or Supplies" identify the medical services and procedures provided to the patient.

FIELD SPECIFICATION: This field allows for the entry of the following: 6 characters in the unshaded area of the CPT/HCPCS field and four sets of 2 characters in the Modifier area.

EXAMPLE:



ITEM NUMBER 24E



TITLE: Diagnosis Pointer [lines 1–6]

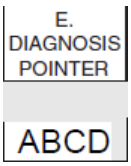
INSTRUCTIONS: In 24E, enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference letter(s) should be A – L or multiple letters as applicable. ICD-10-CM or ICD-9-CM diagnosis codes must be entered in Item Number 21. Do not enter them in 24E.

Enter letters left justified in the field. Do not use commas between the letters.

DESCRIPTION: The “Diagnosis Pointer” is the line letter from Item Number 21 that relates to the reason the service(s) was performed.

FIELD SPECIFICATION: This field allows for the entry of 4 characters in the unshaded area.

EXAMPLE:



ITEM NUMBER 24F

TITLE: $Charges [lines 1–6]

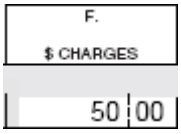
INSTRUCTIONS: Enter the charge amount for each listed service.

Enter the number right justified in the left-hand area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the right-hand area of the field if the amount is a whole number.

DESCRIPTION: "$Charges" is the total billed amount for each service line.

FIELD SPECIFICATION: This field allows for the entry of 6 digits to the left of the vertical line and 2 digits to the right of the vertical line in the unshaded area.

EXAMPLE:



ITEM NUMBER 24G

TITLE: Days or Units [lines 1–6]

INSTRUCTIONS: Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia units or minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.

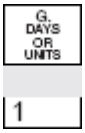
Enter numbers left justified in the field. No leading zeros are required. If reporting a fraction of a unit, use the decimal point.

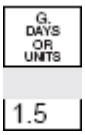
Anesthesia services must be reported as minutes. Units may only be reported for anesthesia services when the code description includes a time period (such as “daily management”).

DESCRIPTION: “Days or Units” is the number of days corresponding to the dates entered in 24A or units as defined in CPT or HCPCS coding manual(s).

FIELD SPECIFICATION: This field allows for the entry of 3 digits in the unshaded area.

EXAMPLES:





ITEM NUMBER 24H

TITLE: EPSDT/Family Plan [lines 1–6]

INSTRUCTIONS: For reporting of Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) and Family Planning services, refer to specific payer instructions.

EPSDT
When EPSDT services are reported on this claim, identify the status of the referral by entering one of the following reason codes right justified in the shaded area of the field.

The following codes for EPSDT are used in 5010A1:

AV	Available – Not Used (Patient refused referral.)
S2	Under Treatment (Patient is currently under treatment for referred diagnostic or corrective health problem.)
ST	New Service Requested (Referral to another provider for diagnostic or corrective treatment/scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service, not including dental referrals.)
NU	Not Used (Used when no EPSDT patient referral was given.)

Family Planning
When there is a requirement to report this is a Family Planning service, enter Y for "YES" in the unshaded area of the field.

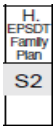
When there is no requirement to report this is a Family Planning service, leave the field blank.

DESCRIPTION: The "EPSDT/Family Plan" identifies certain services that may be covered under some state plans.

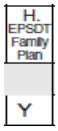
FIELD SPECIFICATION: This field allows for the entry of 1 character in the unshaded area and 2 characters right justified in the shaded area.

EXAMPLES

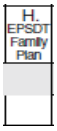
EPSDT:



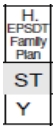
Family Planning – Yes:



Family Planning – No:



EPSDT and Family Planning:



ITEM NUMBER 24I

TITLE: ID Qualifier [lines 1–6]

INSTRUCTIONS: Enter in the shaded area of 24I the qualifier identifying if the number is a non-NPI. The Other ID# of the rendering provider should be reported in 24J in the shaded area.

The NUCC defines the following qualifiers used in 5010A1:

0B	State License Number
1G	Provider UPIN Number
G2	Provider Commercial Number
LU	Location Number
ZZ	Provider Taxonomy (The qualifier in the 5010A1 for Provider Taxonomy is PXC, but ZZ will remain the qualifier for the 1500 Claim Form.)

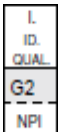
The above list contains both provider identifiers, as well as the provider taxonomy code. The provider identifiers are assigned to the provider either by a specific payer or by a third party in order to uniquely identify the provider. The taxonomy code is designated by the provider in order to identify his/her provider grouping, classification, or area of specialization. Both, provider identifiers and provider taxonomy may be used in this field.

The Rendering Provider is the person or company (laboratory or other facility) who rendered or supervised the care. In the case where a substitute provider (locum tenens) was used, enter that provider's information here. Report the Identification Number in Items 24I and 24J only when different from data recorded in items 33a and 33b.

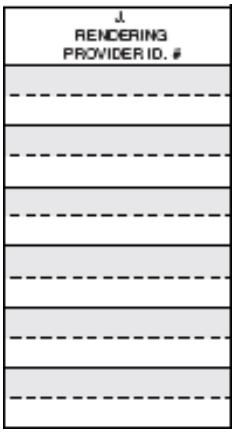
DESCRIPTION: If the provider does not have an NPI number, enter the appropriate qualifier and identifying number in the shaded area. There will always be providers who do not have an NPI and will need to report non-NPI identifiers on their claim forms. The qualifiers will indicate the non-NPI number being reported.

FIELD SPECIFICATION: This field allows for the entry of a 2 character qualifier in the shaded area.

EXAMPLE:



ITEM NUMBER 24J



TITLE: Rendering Provider ID # [lines 1–6]

INSTRUCTIONS: The individual rendering the service is reported in 24J. Enter the non-NPI ID number in the shaded area of the field. Enter the NPI number in the unshaded area of the field.

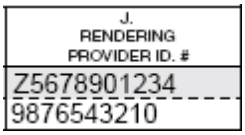
The Rendering Provider is the person or company (laboratory or other facility) who rendered or supervised the care. In the case where a substitute provider (locum tenens) was used, enter that provider's information here. Report the Identification Number in Items 24I and 24J only when different from data recorded in items 33a and 33b.

Enter numbers left justified in the field.

DESCRIPTION: The individual performing/rendering the service should be reported in 24J and the qualifier indicating if the number is a non-NPI is reported in 24I. The non-NPI ID number of the rendering provider refers to the payer assigned unique identifier of the professional.

FIELD SPECIFICATION: This field allows for the entry of 11 characters in the shaded area and entry of a 10-digit NPI number of the unshaded area.

EXAMPLE:



INSTRUCTIONS AND EXAMPLES OF SUPPLEMENTAL INFORMATION IN ITEM NUMBER 24

The following are types of supplemental information that can be entered in the shaded areas of Item Number 24:

- Narrative description of unspecified codes
- National Drug Codes (NDC) for drugs
- Device Identifier of the Unique Device Identifier for supplies
- Contract rate
- Tooth numbers and areas of the oral cavity

The following qualifiers are to be used when reporting these services.

ZZ	Narrative description of unspecified code
N4	National Drug Codes (NDC)
DI	Device Identifier of the Unique Device Identifier (UDI)
CTR	Contract rate
JP	Universal/National Tooth Designation System
JO	ANSI/ADA/ISO Specification No. 3950-1984 Dentistry Designation System for Tooth and Areas of the Oral Cavity

If required to report other supplemental information not listed above, follow payer instructions for the use of a qualifier for the information being reported. When reporting a service that does not have a qualifier, enter two blank spaces before entering the information.

To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code.

More than one supplemental item can be reported in the shaded lines of Item Number 24. Enter the first qualifier and number/code/information at 24A. After the first item, enter three blank spaces and then the next qualifier and number/code/information.

When reporting dollar amounts in the shaded area, always enter dollar amount, a decimal point, and cents. Use 00 for the cents if the amount is a whole number. Do not use commas. Do not enter dollar signs.

Examples: 1000.00
123.45

<u>Additional Information for Reporting NDC</u>

When entering supplemental information for NDC, add in the following order: qualifier, NDC code, one space, unit/basis of measurement qualifier, quantity. The number of digits for the quantity is limited to eight digits before the decimal and three digits after the decimal. If entering a whole number, do not use a decimal. Do not use commas.

Examples: 1234.56
2
99999999.999

When a dollar amount is being reported, enter the following after the quantity: one space, dollar amount. Do not enter a dollar sign.

The following qualifiers are to be used when reporting NDC unit/basis of measurement:

F2	International Unit	ME	Milligram	UN	Unit
GR	Gram	ML	Milliliter		

When reporting compound drugs, a statement of ingredients may be required to be attached to the claim.

When required to report both the repackaged NDC and original NDC of a drug, use the shaded area of 24. Report the information in the following order: qualifier (N4), NDC code, one space, unit/basis of measurement qualifier, quantity, one space, ORIG, qualifier (N4), NDC code.

UDI Replacement of NDC for Supplies

National Health Related Items Code (NHRIC) and National Drug Code (NDC) numbers assigned to some supplies/devices are being replaced with a Unique Device Identifier (UDI). When required to report a supply and that supply's NHRIC/NDC has been replaced by a UDI, report the Device Identifier (DI) portion of the UDI.

Medical and Surgical Supplies

The following qualifiers are to be used when regulations mandate the use of the Universal Product Number (UPN) for reporting medical and surgical supplies:

EN EAN/UCC - 13
EO EAN/UCC - 8
HI HIBC (Health Care Industry Bar Code)

Supplier Labeling Standard Primary Data Message
UK GTIM 14 - digit data structure
UP UCC - 12

Additional Information for Reporting Tooth Numbers and Areas of the Oral Cavity

When reporting tooth numbers, add in the following order: qualifier, tooth number, e.g., JP16. When reporting an area of the oral cavity, enter in the following order: qualifier, area of oral cavity code, e.g., JO10.

When reporting multiple tooth numbers for one procedure, add in the following order: qualifier, tooth number, blank space, tooth number, blank space, tooth number, etc., e.g., JP1 16 17 32.

When reporting multiple tooth numbers for one procedure, the number of units reported in 24G is the number of teeth involved in the procedure.

When reporting multiple areas of the oral cavity for one procedure, add in the following order: qualifier, oral cavity code, blank space, oral cavity code, etc., e.g., JO10 20.

When reporting multiple areas of the oral cavity for one procedure, the number of units reported in 24G is the number of areas of the oral cavity involved in the procedure.

The following are the codes for tooth numbers, reported with the JP qualifier:

1 – 32	Permanent dentition
51 – 82	Permanent supernumerary dentition
A – T	Primary dentition
AS – TS	Primary supernumerary dentition

The following are the codes for areas of the oral cavity, reported with the JO qualifier:

00	Entire oral cavity
01	Maxillary arch
02	Mandibular arch
10	Upper right quadrant
20	Upper left quadrant
30	Lower left quadrant
40	Lower right quadrant

For further information on these codes, refer to the Current Dental Terminology (CDT) Manual available from the American Dental Association.

EXAMPLES

Please note: The following examples are of how to enter different types of supplemental information in 24. These examples demonstrate how the data are to be entered into the fields and are not meant to provide direction on how to code for certain services.

UNSPECIFIED CODE:

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
ZZ Kaye Walker													N	G2	12345678901
10	01	05	10	01	05	11		E1399		AB	165 00	1	N	NPI	0123456789

NDC CODE:

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N459148001665 UN1													N	G2	12345678901
10	01	05	10	01	05	11		J0400		A	500 00	1	N	NPI	0123456789

REPACKAGED NDC:

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N455289047590 UN30 ORIGN400025152531													N	G2	12345678901
10	01	05	10	01	05	11		J3490		A	500 00	30	N	NPI	0123456789

UDI REPLACEMENT OF NDC:

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
DI12345678912345678912345678912345678 9													N	G2	12345678901
10	01	05	10	01	05	11		E0110		A	200 00	1	N	NPI	0123456789

TOOTH NUMBER:

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
JP1													N	G2	12345678901
10	01	05	10	01	05	11		D7240		A	500 00	1	N	NPI	0123456789

MULTIPLE TOOTH NUMBERS:

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
JP1 16 17 32													N	G2	12345678901
10	01	05	10	01	05	11		D7240		A	500 00	4	N	NPI	0123456789

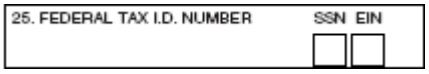
AREA OF ORAL CAVITY:

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
JO10													N	G2	12345678901
10	01	05	10	01	05	11		41820		A	500 00	1	N	NPI	0123456789

MULTIPLE AREAS OF ORAL CAVITY:

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
JO10 20													N	G2	12345678901
10	01	05	10	01	05	11		D7310		A	500 00	2	N	NPI	0123456789

ITEM NUMBER 25



TITLE: Federal Tax ID Number

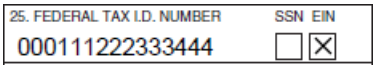
INSTRUCTIONS: Enter the "Federal Tax ID Number" (employer ID number or SSN) of the Billing Provider identified in Item Number 33. This is the tax ID number intended to be used for 1099 reporting purposes. Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked.

Do not enter hyphens with numbers. Enter numbers left justified in the field.

DESCRIPTION: The "Federal Tax ID Number" is the unique identifier assigned by a federal or state agency.

FIELD SPECIFICATION: This field allows for the entry of 15 characters for the "Federal Tax ID Number" and 1 character in either box.

EXAMPLE:



ITEM NUMBER 26

TITLE: Patient's Account No.

INSTRUCTIONS: Enter the patient's account number assigned by the provider of service's or supplier's accounting system.

Do not enter hyphens with numbers. Enter numbers left justified in the field.

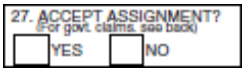
Note: While the patient's account number is a required data element in the 837P claim transaction, it is strongly encouraged but not required on a paper claim. Payers or their vendors may choose to enter a default into the field if no number is reported by the provider for reporting in the 835 remittance. If no default number is used within the internal processing system, payers would report a single zero on an 835 remittance per the 835 TR3.

DESCRIPTION: The "Patient's Account No." is the identifier assigned by the provider.

FIELD SPECIFICATION: This field allows for the entry of 14 characters.

EXAMPLE:

ITEM NUMBER 27



TITLE: Accept Assignment?

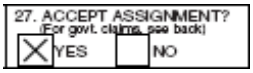
INSTRUCTIONS: Enter an X in the correct box. Only one box can be marked.

Report “Accept Assignment?” for all payers.

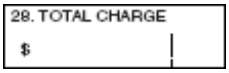
DESCRIPTION: The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer’s program.

FIELD SPECIFICATION: This field allows for the entry of 1 character in either box.

EXAMPLE:



ITEM NUMBER 28



TITLE: Total Charge

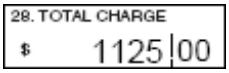
INSTRUCTIONS: Enter total charges for the services (i.e., total of all charges in 24F).

Enter the amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.

DESCRIPTION: The “Total Charge” is the total billed amount for all services entered in 24F (lines 1–6).

FIELD SPECIFICATION: This field allows for the entry of 7 digits to the left of the vertical line and 2 digits to the right of the vertical line.

EXAMPLE:



ITEM NUMBER 29

TITLE: Amount Paid

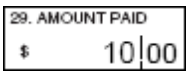
INSTRUCTIONS: Enter total amount the patient and/or other payers paid on the covered services only.

Enter the amount right justified in the left-hand area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the right-hand area if the amount is a whole number.

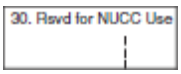
DESCRIPTION: The “Amount Paid” is the payment received from the patient or other payers.

FIELD SPECIFICATION: This field allows for the entry of 6 digits to the left of the vertical line and 2 digits to the right of the vertical line.

EXAMPLE:



ITEM NUMBER 30



TITLE: Reserved for NUCC Use

INSTRUCTIONS: This field was previously used to report “Balance Due.” “Balance Due” does not exist in 5010A1, so this field has been eliminated.

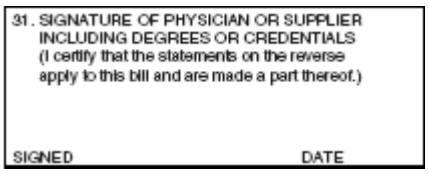
This field is reserved for NUCC use. The NUCC will provide instructions for any use of this field.

DESCRIPTION: This field is reserved for NUCC use.

FIELD SPECIFICATION: None

EXAMPLE: None

ITEM NUMBER 31



TITLE: Signature of Physician or Supplier Including Degrees or Credentials

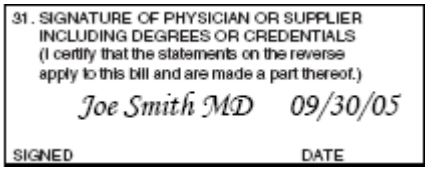
INSTRUCTIONS: "Signature of Physician or Supplier Including Degrees or Credential" does not exist in 5010A1.

Enter the legal signature of the practitioner or supplier, signature of the practitioner or supplier representative, "Signature on File," or "SOF." Enter either the 6-digit date (MM|DD|YY), 8-digit date (MM|DD|YYYY), or alphanumeric date (e.g., January 1, 2003) the form was signed.

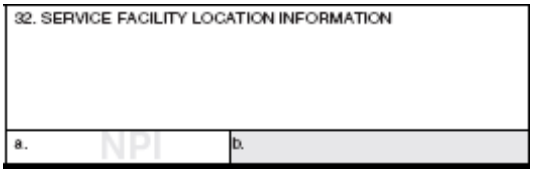
DESCRIPTION: The "Signature of the Physician or Supplier Including Degrees or Credentials" refers to the authorized or accountable person and the degree, credentials, or title.

FIELD SPECIFICATION: Use the space available to enter signature and date.

EXAMPLE:



ITEM NUMBER 32, 32a, AND 32b



TITLE 32: Service Facility Location Information

INSTRUCTIONS: Enter the name, address, city, state, and ZIP code of the location where the services were rendered. Providers of service (namely physicians) must identify the supplier's name, address, ZIP code, and NPI number when billing for purchased diagnostic tests. When more than one supplier is used, a separate 1500 Claim Form should be used to bill for each supplier.

If the "Service Facility Location" is a component or subpart of the Billing Provider and they have their own NPI that is reported on the claim, then the subpart is reported as the Billing Provider and "Service Facility Location" is not used. When reporting an NPI in the "Service Facility Location," the entity must be an external organization to the Billing Provider.

Enter the name and address information in the following format:

1st Line – Name
2nd Line – Address
3rd Line – City, State and ZIP code

Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Enter a space between town name and state code; do not include a comma. Report a 9-digit ZIP code. Enter the 9-digit ZIP code without the hyphen.

If reporting a foreign address, contact payer for specific reporting instructions.

DESCRIPTION: The name and address of facility where services were rendered identifies the site where service(s) were provided.

FIELD SPECIFICATION: This field allows for the entry of three lines of 26 characters each in the Service Facility Location Information area.

TITLE 32a: NPI#

INSTRUCTIONS: Enter the NPI number of the service facility location in 32a.

Only report a Service Facility Location NPI when the NPI is different from the Billing Provider NPI.

DESCRIPTION: The NPI number refers to the HIPAA National Provider Identifier number.

FIELD SPECIFICATION: This field allows for the entry of a 10-digit NPI number.

TITLE 32b: Other ID#

INSTRUCTIONS: Enter the qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.

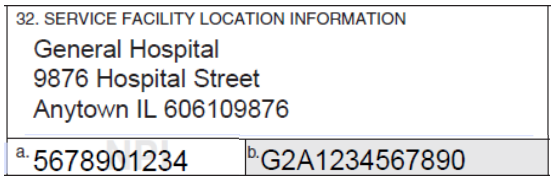
The NUCC defines the following qualifiers used in 5010A1:

0B	State License Number
G2	Provider Commercial Number
LU	Location Number

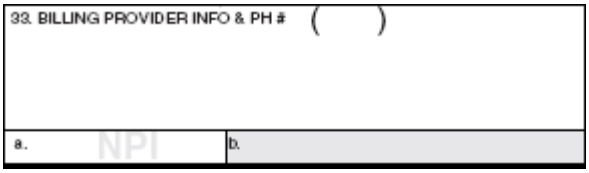
DESCRIPTION: The non-NPI ID number of the service facility is the payer assigned unique identifier of the facility.

FIELD SPECIFICATION: This field allows for the entry of 14 characters in 32b.

EXAMPLE:



ITEM NUMBER 33, 33a, AND 33b



TITLE 33: Billing Provider Info & Ph #

INSTRUCTIONS: Enter the provider's or supplier's billing name, address, ZIP code, and phone number. The phone number is to be entered in the area to the right of the field title. Enter the name and address information in the following format:

1st Line – Name
2nd Line – Address
3rd Line – City, State and ZIP code

Item 33 identifies the provider that is requesting to be paid for the services rendered and should always be completed.

Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Enter a space between town name and state code; do not include a comma. Report a 9-digit ZIP code. Enter the 9-digit ZIP code without the hyphen. Do not use a hyphen or space as a separator within the telephone number.

If reporting a foreign address, contact payer for specific reporting instructions.

5010A1 requires the "Billing Provider Address" be a street address or physical location. The NUCC recommends that the same requirements be applied here.

DESCRIPTION: The billing provider's or supplier's billing name, address, ZIP code, and phone number is the billing office location and telephone number of the provider or supplier.

FIELD SPECIFICATION: This field allows for the entry of the following: 3 characters for area code, 9 characters for phone number, and 3 lines of 29 characters in the Billing Provider Info area.

TITLE 33a: NPI#

INSTRUCTIONS: Enter the NPI number of the billing provider in 33a.

DESCRIPTION: The NPI number refers to the HIPAA National Provider Identifier number.

FIELD SPECIFICATION: This field allows for the entry of a 10-digit NPI number.

TITLE 33b: Other ID#

INSTRUCTIONS: Enter the qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.

The NUCC defines the following qualifiers used in 5010A1:

0B	State License Number
G2	Provider Commercial Number
ZZ	Provider Taxonomy (The qualifier in the 5010A1 for Provider Taxonomy is PXC, but ZZ will remain the qualifier for the 1500 Claim Form.)

The above list contains both provider identifiers, as well as the provider taxonomy code. The provider identifiers are assigned to the provider either by a specific payer or by a third party in order to uniquely identify the provider. The taxonomy code is designated by the provider in order to identify his/her provider grouping, classification, or area of specialization. Both, provider identifiers and provider taxonomy may be used in this field.

DESCRIPTION: The non-NPI ID number of the billing provider refers to the payer assigned unique identifier of the professional.

FIELD SPECIFICATION: This field allows for the entry of 17 characters in 33b.

EXAMPLE:

33. BILLING PROVIDER INFO & PH # ( )	
Physician Practice Inc 1234 Healthcare Street Anytown IL 606101234	
a. 9876543210	b. G2Z5678901234

REFERENCES

Accredited Standards Committee X12, Insurance Subcommittee, ASC X12N. Health Care Claim: Professional (837), 005010X222. Washington Publishing Company, May 2006. <http:www.wpc-edi.com>.

Accredited Standards Committee X12, Insurance Subcommittee, ASC X12N. Type 1 Errata to Health Care Claim: Professional (837), 005010X222A1. Washington Publishing Company, June 2010. <http:www.wpc-edi.com>.

APPENDIX A: DEFINITIONS

The following definitions apply to terms used on the 1500 Claim Form.

PROVIDER TERMS

Referring Provider
The Referring Provider is the individual who directed the patient for care to the provider rendering the services being reported.

Examples include, but are not limited to, primary care provider referring to a specialist; orthodontist referring to an oral and maxillofacial surgeon; physician referring to a physical therapist; provider referring to a home health agency.

Ordering Provider
The Ordering Provider is the individual who requested the services or items being reported on this service line.

Examples include, but are not limited to, provider ordering diagnostic tests and medical equipment or supplies.

Rendering Provider
5010A1 837P
The Rendering Provider is the person or company (laboratory or other facility) who rendered the care. In the case where a substitute provider (locum tenens) was used, enter that provider's information here.

Future Versions of 837P
The Rendering Provider is the individual who provided the care. In the case where a substitute provider (locum tenens) was used, that individual is considered the Rendering Provider.

The Rendering Provider does not include individuals performing services in support roles, such as lab technicians or radiology technicians.

Supervising Provider
The Supervising Provider is the individual who provided oversight of the Rendering Provider and the care being reported.

An example includes, but is not limited to, supervision of a resident physician.

Purchased Service Provider
A Purchased Service Provider is an individual or entity that performs a service on a contractual or reassignment basis for a separate provider who is billing for the service.

Examples of services include, but are not limited to: (a) processing a laboratory specimen; (b) grinding eyeglass lenses to the specifications of the Rendering Provider; or (c) performing diagnostic testing services (excluding clinical laboratory testing) subject to Medicare's anti-markup rule. In the case where a substitute provider (a locum tenens physician) is used, that individual is not considered a Purchased Service Provider.

INDIVIDUAL TERMS

Patient
An individual who has received, is receiving, or intends to receive health care services. (Health care services as defined by federal and state regulations.)

Dependent
An individual who has insurance coverage under the policy of another individual.

Subscriber
An individual or entity that is the holder of an insurance policy (including health, property and casualty, auto, workers' compensation, or other liability) for the purposes of health care services.

Insured
An individual or entity that has insurance coverage.

APPENDIX B: ABBREVIATIONS

AMA – American Medical Association

BLK Lung – Black Lung

CHAMPVA – Civilian Health and Medical Program of the Department of Veterans Affairs

CLIA – Clinical Laboratory Improvement Amendments

CMS – Centers for Medicare & Medicaid Services, formerly HCFA

COB – Coordination of Benefits

CPT® – Current Procedural Terminology, 4th Edition

DD – Day, indicates entry of two digits for the day

DME – Durable Medical Equipment

EIN – Employer Identification Number

EMG – Emergency

EPSDT – Early & Periodic Screening, Diagnosis, and Treatment

F – Female

FECA – Federal Employees' Compensation Act

GTIN – Global Trade Item Number

HCFA – Health Care Financing Administration, currently CMS

HCPCS – HCFA Common Procedural Coding System

HIBCC – Health Industry Business Communications Council

HIPAA – Health Insurance Portability and Accountability Act of 1996

HMO – Health Maintenance Organization

ICD-9-CM – Internal Classification of Disease, Revision 9, Clinical Modification

ICD-10-CM - Internal Classification of Disease, Revision 10, Clinical Modification

I.D. or ID – Identification

I.D. # or ID# – Identification Number

INFO – Information

LMP – Last Menstrual Period

M – Male

MM – Month, indicates entry of two digits for the month

NDC – National Drug Codes

No. – Number

NUCC – National Uniform Claim Committee

NUCC-DS – National Uniform Claim Committee Data Set

NPI – National Provider Identifier

OMB – Office of Management and Budget

OZ – Product number Health Care Uniform Code Council

PH # – Phone Number

QUAL. – Qualifier

REF. – Reference

SOF – Signature on File

SSN – Social Security Number

UPC – Universal Product Code

UPIN – Unique Physician Identification Number

USIN – Unique Supplier Identification Number

VP – Vendor Product Number

YY – Year, indicates entry of two digits for the year

YYYY – Year, indicates entry of four digits for the year (YYYY)

APPENDIX C: GUIDELINES FOR MODIFYING THE 1500 (02/12) CLAIM FORM

The following are the National Uniform Claim Committee's (NUCC) recommended guidelines for making modifications to the 1500 (02/12) Claim Form.

PRINTER-SPECIFIC/SUPPLIER-SPECIFIC INFORMATION
Any printer-specific/supplier-specific information (e.g., logo, reorder number, phone number) that is preprinted on the form must be placed in a manner in which it will not interfere with the data content of the form. Data content includes the carrier information at the top of the page and any other pre-printed text in the margins. (See the instructions for the location of the carrier information within the carrier block of the form.)

TRACKING INFORMATION ADDED BY CLEARINGHOUSES, PAYERS, OR OTHER PROCESSORS
Any tracking information (e.g., time stamp, tracking number) that is added by clearinghouses, payers, or other claims processors must be placed in a manner in which it will not interfere with the data content of the form. Data content includes the carrier information at the top of the page. (See the instructions for the location of the carrier information within the carrier block of the form.)

BARCODES
Any barcodes added to the form, either pre-printed or during processing, must be placed in a manner in which it will not interfere with the data content of the form. Data content includes the carrier information at the top of the page. (See the instructions for the location of the carrier information within the carrier block of the form.)

ADDITIONAL DATA ELEMENTS
The NUCC strongly discourages required or optional reporting of any data elements in addition to the data content fields on the form.

APPENDIX D: CHANGE REQUEST FORM FOR 1500 CLAIM FORM AND INSTRUCTIONS

PLEASE REVIEW THE 1500 CLAIM FORM AND INSTRUCTIONS CRITERIA IN ITS ENTIRETY BEFORE COMPLETING THE REQUEST FORM.

Questions about the 1500 Claim Form and 1500 Reference Instruction Manual can be emailed to nuccinfo@nucc.org. The request form is not needed to ask questions.

1500 CLAIM FORM REQUEST CRITERIA

The following criteria are used by the NUCC when considering requests for changes to the 1500 Claim Form.

Note: Revisions to the 1500 Claim Form occur infrequently (e.g., every 5 – 10 years) if at all due to the impact on the industry to implement a revised form. Requests for changes to the form will be reviewed and held until the next potential revision. In addition, form space constraints limit the ability to accommodate requests for revision.

- Data being requested has been added to the X12 Health Care Claim: Professional (837P) electronic transaction.
- The need to report the data is national and not local or state specific.
- The change to the form will not significantly impact current users.
- The request includes specific information on how the current form is negatively impacting claims processing or adjudication.
- The proposed change is within the scope of work being done to revise the form. (The NUCC may limit the scope of changes it will consider during a revision of the form, based on industry feedback of the impact of implementing the changes.)

1500 INSTRUCTIONS REQUEST CRITERIA

The following criteria are used by the NUCC when considering requests for changes to the 1500 Reference Instruction Manual.

- The instruction for reporting the data aligns with data reported in the X12 Health Care Claim: Professional (837P) electronic transaction.
- The need for the instruction is national and not local or state specific.
- The change to the instructions will not significantly impact current users of the instructions.
- The request includes specific information on how the current instructions are negatively impacting claims processing or adjudication.
- The request is to clarify current instructions.

NUCC REVIEW OF REQUESTS

The applicant is responsible for submitting appropriate information and documentation that demonstrates the need for the change to the 1500 form or instructions. During its review, the NUCC may, but is not required to, complete independent research, which it may share with the requester.

ADDITIONAL INFORMATION

- Updated versions of the 1500 Claim Form Reference Instruction Manual are released yearly on July 1.
- Any changes, clarifications, and errata for the instructions are posted to the NUCC website, at www.nucc.org under the 1500 Claim Form tab, with the issue and effective date of the change.
- Revision of the 1500 Claim Form is done infrequently (e.g., every 5 – 10 years) due to the impact on the industry to implement a revised form. Information will be posted on the NUCC website when the form is under review for revision.
- If a request for a change is denied, the requester may not submit a new request for the same or substantially similar change for a period of one (1) year from the date of denial.

INSTRUCTIONS FOR SUBMITTING REQUESTS

1. After reading the 1500 Claim Form and Instructions Criteria, complete all sections of the form and be as thorough as possible explaining the request.
2. Include specific information and documentation that supports the need for the change and how the criteria are met. Requests lacking supporting information or documentation will be returned to the requester and will not be reviewed by the NUCC until the necessary information or documentation, as the case may be, is provided.
3. **Submit completed forms to nuccinfo@nucc.org.**

Change Request Form for 1500 Claim Form and Instructions

Date:	
Requester Name or Organization:	Requester Contact Information:
Is the request for a change to the form or instructions? _____ Form _____ Instructions	
Describe the change being requested. Include information that explains how the change will: • Align with the X12 Health Care Claim: Professional (837P) electronic transaction (instruction revisions), Or Align with new data added to the X12 Health Care Claim: Professional (837P) electronic transaction (Form revisions), • Meet a national need and not local or state specific need, • Not significantly impact current users of the form or instructions, or • Not impact current claims processing or adjudication.	
Explain the reason for the request, such as why the current form or instruction is inadequate or what new item needs to be accommodated.	
Provide proposed language for the instruction change.	

EXHIBIT 12

An official website of the United States government Here's how you know

Methodology

Additional Information on Revalidation

Download

Page last modified
October 30, 2024

Associated data products (4)

Overview
Overview
Associated Products

Overview

Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers/suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria. CMS has completed its initial round of revalidations and will be resuming regular revalidation cycles in accordance with 42 CFR §424.515. In an effort to streamline the revalidation process and reduce provider/supplier burden, CMS has implemented several revalidation processing improvements one of which is established due dates by which Providers must revalidate.

Medicare Providers must validate their enrollment record every three or five years. CMS sets every Provider's Revalidation due date at the end of a month and posts the upcoming six to seven months of due dates online. A due date of 'TBD' means that CMS has not set the due date yet.

Revalidation Due Date Lists are posted on data.cms.gov which are downloadable by Providers.

These lists are refreshed every two months and two months' worth of due dates are appended to the list

Associated data products

Showing **1-3** of **4** total

Dataset

Revalidation Clinic Group Practice Reassignment

Page last modified
Nov 3, 2025

Dataset

Revalidation Reassignment List

Page last modified
Nov 3, 2025

Dataset

Contact us

Didn't find the answer you were looking for?

Email Support

A federal government website managed and paid for by the U.S. Centers for Medicare & Medicaid Services.

Our Headquarters

7500 Security Boulevard,
Baltimore, MD 21244

EXHIBIT 13

An official website of the United States government Here's how you know

Revalidation Due Date List

Information on revalidation due dates for Medicare providers.

Data update frequency
Monthly

Latest data available
November 2025

Data source
Centers for Medicare & Medicaid Services

View Data Access API Download

The Revalidation Due Date List dataset contains revalidation due dates for Medicare providers who are due to revalidate in the following six months. If a provider's due date does not fall within the ensuing six months, the due date is marked 'TBD'. In addition the dataset also includes subfiles with reassignment information for a given provider as well as due date listings for clinics and group practices and their providers.

Looking for quick insights?

Try out our Medicare Revalidation List tool to look up the due date for Medicare providers who must revalidate their enrollment record information.

Launch Tool

Back to Top

Resources for Using and Understanding the Data

This dataset is based on information gathered from the Provider Enrollment, Chain and Ownership System (PECOS).

Resources
Summary
Resources
Details
Related
Contact

The COVID-19 public health emergency (PHE) ended at 11:50 p.m. on May 11, 2023. Providers and suppliers that established temporary Medicare billing privileges via the Medicare Provider Enrollment Hotline during the PHE are required to submit a complete CMS-855 enrollment application in order to establish full Medicare billing privileges. Medicare Administrative Contractors (MACs) began issuing letters on June 1, 2023. For a list of providers and suppliers with temporary billing privileges and issued a letter refer to the Temporary COVID Enrollments file. If you do not respond to the MAC's request, your temporary billing privileges will be deactivated.

Resources (5)

Featured Resource

Additional Information on Revalidation

View Methodology

Featured Resource

Revalidation Due Date List Data Dictionary

View Data Dictionary

Report	Temporary COVID Enrollments	Download Report
Related Link	Revalidation Reassignment List	View Resource
Related Link	Revalidation Clinic Group Practice Reassignment	View Resource

Page last modified

November 3, 2025

Date created

October 27, 2025

Contact email

ProviderEnrollmentDataRequests@cms.hhs.gov

Tags

Medicare | Original Medicare | Medicare Advantage | Provider Enrollment

Privacy level

Public Use File (Free)

Resources
Summary
Resources
Details
Related
Contact

All data available

November 2025 | October 2025
September 2025 | August 2025
July 2025 | June 2025

Show more

Related datasets in: Medicare Provider-Supplier Enrollment

View All

Dataset
Order and Referring
Page last modified
October 31, 2025

Dataset
Opt Out Affidavits
Page last modified
October 28, 2025

Dataset
Medicare Fee-For-Service Public Provider Enrollment
Page last modified
October 22, 2025

Recently updated in: Provider Characteristics

View All

Dataset
Revalidation Clinic Group Practice Reassignment
Page last modified

Dataset
Revalidation Reassignment List
Page last modified

Dataset
Fiscal Intermediary Shared System Attending and Rendering
Page last modified

November 3, 2025 November 3, 2025 October 31, 2025

Resources
Summary
Resources
Details
Related
Contact

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CMS Expert Help Desk

ProviderEnrollmentDataRequests@cms.hhs.gov

EXHIBIT 14

An official website of the United States government Here's how you know

Revalidation Reassignment List

Reassignments of Providers who are due for Revalidation.

Data update frequency
Monthly

Latest data available
November 2025

Data source
Centers for Medicare & Medicaid Services

View Data | Access API | Download

Summary
Summary
Resources
Details
Related
Contact

The Revalidation Reassignment List dataset provides information on reassignments of providers who are due for revalidation.

Looking for quick insights?

Try out our Medicare Revalidation List tool to look up the due date for Medicare providers who must revalidate their enrollment record information.

Launch Tool

Resources for Using and Understanding the Data

This dataset is based on information gathered from the Provider Enrollment, Chain and Ownership System (PECOS).

Resources (4)

Featured Resource

Additional Information on Revalidation

View Methodology

Featured Resource

Revalidation Reassignments List Data Dictionary

View Data Dictionary

Related Link

Revalidation Due Date List

View Resource

Related Link

Revalidation Clinic Group Practice Reassignment

View Resource

Page last modified

November 3, 2025

Date created

October 27, 2025

Contact email

ProviderEnrollmentDataRequests@cms.hhs.gov

Tags

States & Territories | ZIP Code | Medicare | Original Medicare | Medicare Advantage | Provider Enrollment

Privacy level

Public Use File (Free)

All data available

November 2025 | October 2025
September 2025 | August 2025
July 2025 | June 2025

Show more

Related datasets in:
Medicare Provider-Supplier Enrollment

View All

Dataset

Order and Referring

Page last modified
October 31, 2025

Dataset

Opt Out Affidavits

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October 28, 2025

Dataset

Medicare Fee-For-Service Public Provider Enrollment

Page last modified
October 22, 2025

Recently updated in:
Provider Characteristics

View All

Dataset

Revalidation Clinic Group Practice Reassignment

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November 3, 2025

Dataset

Revalidation Due Date List

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November 3, 2025

Dataset

Fiscal Intermediary Shared System Attending and Rendering

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October 31, 2025

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Data.CMS.gov

A federal government website managed and paid for by the U.S. Centers for Medicare & Medicaid Services.

Our Headquarters

7500 Security Boulevard,
Baltimore, MD 21244

Helpful Links

Contact

RSS Feeds

Get Email Updates

Site Map

CMS.gov Medicare.gov MyMedicare.gov Medicaid.gov InsureKidsNow.gov Healthcare.gov HHS.

v1.163.3

EXHIBIT 15

MEDICARE ENROLLMENT APPLICATION

PHYSICIANS AND NON-PHYSICIAN PRACTITIONERS

CMS-855I

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

SEE PAGE 3 FOR INFORMATION ON WHERE TO MAIL THIS COMPLETED APPLICATION.

SEE SECTION 12 FOR A LIST OF SUPPORTING DOCUMENTATION TO BE SUBMITTED WITH THIS APPLICATION.

TO VIEW YOUR CURRENT MEDICARE ENROLLMENT RECORD GO TO:
PECOS.CMS.HHS.GOV

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-1355
Expires: 05/26

WHO SHOULD SUBMIT THIS APPLICATION

All physicians, as well as all eligible professionals as defined in section 1848(k)(3)(B) of the Social Security Act must complete this application to enroll in the Medicare program and receive a Medicare billing number.

Physicians and non-physician practitioners can apply for enrollment in the Medicare program or make a change to their enrollment information (including adding or terminating a reassignment of benefits) using either:

- The Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or
- The paper CMS-855I enrollment application. Be sure you are using the most current version.

NOTE: All reassignment actions should now be reported via the CMS-855I. The CMS-855R (Reassignment of Medicare Benefits) form has been discontinued.

For additional information regarding the Medicare enrollment process (including Internet-based PECOS) and to get the current version of the CMS-855I, go to **CMS.gov/Medicare/Provider-Enrollment-and-Certification**.

Complete this application if you are an individual practitioner or eligible professional who plans to bill Medicare and you are:

- Currently enrolled in Medicare to order and certify and want to enroll as an individual practitioner to submit claims for services rendered.
- An individual practitioner or eligible professional who has formed a professional corporation, professional association, limited liability company, etc., of which you are the sole owner.
- Currently enrolled in Medicare and you received notice to revalidate your enrollment.
- Previously enrolled in Medicare and you need to reactivate your Medicare billing number to resume billing.
- Currently enrolled in Medicare and need to enroll in another Medicare Administrative Contractor's (MAC's) jurisdiction (e.g., you have opened a practice location in a geographic territory serviced by another MAC).
- Currently enrolled in Medicare and need to make changes to your enrollment information (e.g., you have added or changed a practice location).
- An individual practitioner (physician, physician assistant, nurse practitioner, or clinical nurse specialist) who furnishes acupuncture services.
- An individual practitioner, including physician assistant, who is reassigning Medicare benefits, terminating a reassignment of Medicare benefits after enrollment in the Medicare program, or making a change in their reassignment of Medicare benefits information. Reassigning your Medicare benefits allows an eligible organization/group to submit claims and receive payment for Medicare Part B services that you have provided as a member of the organization/group. Such an eligible organization/group may be an individual, a clinic/group practice or other health care organization.
- An organization/group who is accepting a new reassignment of Medicare benefits, terminating a reassignment of Medicare benefits, or making a change in reassignment of Medicare benefit information, between the organization/group and an individual practitioner.

  NOTE: Both the individual practitioner and the eligible organization/group must be currently enrolled (or concurrently enrolling via submission of the CMS-855B for the eligible organization/group and the CMS-855I for the individual practitioner) in the Medicare program before the reassignment can take effect.
- An individual practitioner voluntarily terminating your Medicare enrollment, including all reassignment of benefits.

NOTE: If you are a sole owner and intend to add an Authorized/Delegated Official to your Medicare enrollment, do not complete the CMS-855I application; rather, use the CMS-855B application.

BILLING NUMBER AND NATIONAL PROVIDER IDENTIFIER INFORMATION

The Provider Transaction Access Number (PTAN), often referred to as a Medicare Supplier Number or Medicare Billing Number is a generic term for any number other than the National Provider Identifier (NPI) that is used by a practitioner to bill the Medicare program.

The NPI is the standard unique health identifier for health care providers and suppliers and is assigned by the National Plan and Provider Enumeration System (NPPES). **To enroll in Medicare, you must obtain an NPI and furnish it on this application prior to enrolling in Medicare or when submitting a change to your existing Medicare enrollment information.** Applying for the NPI is a process separate from Medicare enrollment. To obtain an NPI, you may apply online at **NPPES.cms.hhs.gov**. For more information about NPI enumeration, visit **CMS.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand.**

Note: The Name and Social Security Number (SSN) that you furnish in section 2A and, if applicable, the Legal Business Name (LBN) and Tax Identification Number (TIN) you furnish in section 4A must be the same Name, SSN, LBN and TIN you used to obtain your NPI. Once this information is entered into PECOS from this application, your Name, SSN, LBN, TIN and NPI ***must*** match exactly in both PECOS and NPPES.

INSTRUCTIONS FOR COMPLETING AND SUBMITTING THIS APPLICATION

All information on this form is required with the exception of those fields specifically marked as "optional." Any field marked as optional is not required to be completed nor does it need to be updated or reported as a "change of information" as required in 42 C.F.R. section 424.516. However, it is highly recommended that if reported, these fields be kept up-to-date.

- This form must be typed. It may not be handwritten.
- When necessary to report additional information, copy and complete the applicable section as needed.
- Sign and date the certification statement(s) as appropriate.
- When establishing a new reassignment, Section 15B must be signed by the individual practitioner and Section 15C must be signed by a delegated/authorized official of the organization/group. If the reassignment is to an individual, that person must sign Section 15C.
- When terminating a reassignment or making changes to reassignment information, either the organization/group must sign Section 15C or the individual practitioner must sign Section 15B. In the case of termination, reassigned claims for services rendered by the individual will no longer be paid to the organization/group after the effective date of the termination.
- Generally, a new reassignment is established by the organization/group, signed by the Delegated/Authorized Official of the organization/group and the individual practitioner, and submitted by the organization/group. When terminating a current reassignment, you may submit this application with the appropriate sections completed and signed.
- Attach all required supporting documentation.
- Keep a copy of your completed Medicare enrollment package for your own records.

TIPS TO AVOID DELAYS IN YOUR ENROLLMENT

To avoid delays in the enrollment process, you should:

- Complete all required sections, as shown in section 1.
- Ensure that the Legal Business Name shown in section 4 matches the name on the tax documents.
- Ensure that the correspondence address shown in section 2 is the provider's address.
- Enter your NPI(s) in the applicable section(s).
- Include the Electronic Funds Transfer (EFT) Authorization Agreement (when applicable) with your enrollment application with a voided check or bank letter.
- Sign and date section 15.
- Ensure all supporting documents are sent to your designated MAC.

ADDITIONAL INFORMATION

- You may visit our website to learn more about the enrollment process via the Internet-Based Provider Enrollment Chain and Ownership System (PECOS) at: **CMS.gov/Medicare/Provider-Enrollment-and-Certification**. Also, all of the CMS-855 applications are located on the CMS webpage: **CMS.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List**. Simply enter "855" in the "Filter On:" box on this page and the application forms will be displayed to choose from.
- The MAC may request additional documentation to support and validate information reported on this application. You are responsible for providing this documentation within 30 days of the request per 42 C.F.R. section 424.525(a)(1) and (2).
- The information you provide on this form is protected under 5 U.S.C. section 552(b)(4) and/or (b)(6), respectively. For more information, see the last page of this application to read the Privacy Act Statement.

ACRONYMS COMMONLY USED IN THIS APPLICATION

- **C.F.R:** Code of Federal Regulations
- **EFT:** Electronic Funds Transfer
- **EIN:** Employer Identification Number
- **IHS:** Indian Health Service
- **IRS:** Internal Revenue Service
- **LBN:** Legal Business Name
- **LLC:** Limited Liability Corporation
- **MAC:** Medicare Administrative Contractor
- **NPI:** National Provider Identifier
- **NPPES:** National Plan and Provider Enumeration System
- **PTAN:** Provider Transaction Access Number also referred to as the Medicare Identification Number
- **SSN:** Social Security Number
- **TIN:** Tax Identification Number

DEFINITIONS

NOTE: For the purposes of this CMS-855I application, the following definitions apply:

- **Add:** You are adding additional enrollment information to your existing information (e.g. practice locations).
- **Change:** You are replacing existing information with new information (e.g. billing agency, managing employee) or updating existing information (e.g. change in suite #, telephone #).
- **Compact License:** A streamlined pathway to state licensure for qualified physicians and non-physician practitioners who wish to practice in multiple states. For more information on compact licenses, go to **CMS.gov/files/document/se20008.pdf**.
- **Reassignment of Medicare Benefits:** Authorization by an individual practitioner to allow an eligible organization/group to submit claims and receive payment for Medicare Part B services that the practitioner has provided as a member of the organization/group. Such an eligible organization/group may be an individual, a clinic/group practice or other health care organization.
- **Remove:** You are removing existing enrollment information

WHERE TO MAIL YOUR APPLICATION

Send this completed application with original signatures and all required documentation to your designated MAC. The MAC that services your State is responsible for processing your enrollment application. To locate the mailing address for your designated MAC, go to **CMS.gov/Medicare/Provider-Enrollment-and-Certification**.

SECTION 1: BASIC INFORMATION

A. REASON FOR SUBMITTING THIS APPLICATION

Check one box and complete the sections of this application as indicated.

☐ You are a **new enrollee** in Medicare	**Complete all applicable sections**
☐ You are **currently enrolled in Medicare to order and certify** and want to **enroll as an Individual Practitioner**	**Complete all applicable sections**
☐ You are **enrolling with another Medicare Administrative Contractor (MAC)**	**Complete all applicable sections**
☐ You are **revalidating** your Medicare enrollment	**Complete all applicable sections**
☐ You are **reactivating** your Medicare enrollment	**Complete all applicable sections**
☐ You are **reporting a change** to your Medicare enrollment information (includes establishing or terminating a reassignment)	**Go to section 1B below**
☐ You are **voluntarily terminating** your Medicare enrollment Effective date of termination *(mm/dd/yyyy)*: _____	**Sections 1A, 2A, 13 (optional), and 15**

B. WHAT INFORMATION IS CHANGING?

Check all that apply and complete the required sections.

Please note: When reporting ANY information, sections 1, 2A, 3 and 15 MUST always be completed in addition to the information that is changing within the required section.

☐ Personal Identifying Information	**1, 2A, 3, 12, 13 (optional)** and **15**
☐ Final Adverse Legal Actions	**1, 2A, 3, 12, 13 (optional)** and **15**
☐ Medical Specialty Information	**1, 2A, 2G or 2H, 3, 4, 12, 13 (optional),** and **15**
☐ Practitioner Specific Information	**1, 2A, 2B–2F, 2I–2K (as applicable), 3, 12, 13 (optional),** and **15**
☐ Reassignment of Benefits Information	**1, 2A, 4F, 12, 13 (optional)** and **15**
☐ Private Practice Business Information	**1, 2A, 3, 4A, 12, 13 (optional)** and **15**
☐ Managing Employee Information	**1, 2A, 3, 6, 12, 13 (optional),** and **15**
☐ Address Information ☐ Correspondence Mailing Address ☐ Medical Record Correspondence Mailing Address ☐ Remittance Notices/Special Payment Mailing Address ☐ Medicare Beneficiary Medical Records Storage Address ☐ Practice Location Address	**1, 2A, 3, 12, 13 (optional) and 15 AND sections 2D, 2E, 4B, 4C, and/or 4D as applicable for the address that is being changed**
☐ Billing Agency Information	**1, 2A, 3, 6, 8, 13 (optional)** and **15**
☐ Any other information not specified above	**1, 2A, 3, 13 (optional)** and **15 and the applicable section or sub-section that is changing**

SECTION 2: PERSONAL IDENTIFYING INFORMATION

A. INDIVIDUAL INFORMATION

The provider's Name, Date of Birth, and Social Security Number must match his/her social security record.

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

Type of Other Name

☐ Former or Maiden Name ☐ Professional Name ☐ Other *(Describe)*: _____

Social Security Number (SSN)	Date of Birth *(mm/dd/yyyy)*
Medical or other Professional School *(Training Institution, if non-MD)*	Year of Graduation *(yyyy)*

B. LICENSE/CERTIFICATION/REGISTRATION INFORMATION

Complete the appropriate subsection(s) below for your primary specialty type as you will report it in section 2G or 2H below, as applicable. If no subsection is associated with your primary specialty, report information relevant to your secondary specialty, as applicable. Report if you have a compact license. See definition on page 3.

1. Active License Information

☐ Active License ☐ Not Applicable

License Number	Effective Date *(mm/dd/yyyy)*	State Where Issued

Is this a compact license? ..... ○ Yes ○ No

2. Active Certification Information

NOTE: For physicians and non-physician practitioners with multiple certifications, report the active certification relating to your primary specialty as you report it in section 2G or 2H (below), as applicable. If no certification is associated with your primary specialty, report the certification(s) relevant to your secondary specialty, as applicable.

NOTE: If you are certified by a national entity, put the word "all" in the "State Where Issued" data field.

☐ Active Certification ☐ Not Applicable

Certification Number	Effective Date *(mm/dd/yyyy)*
Certifying Entity (Specialty Board, State, Other)	State Where Issued*

3. Drug Enforcement Agency (DEA) Registration Information

☐ Active DEA Registration ☐ Not Applicable

DEA Registration Number	Effective Date *(mm/dd/yyyy)*	State Where Issued

C. NEW PATIENT INFORMATION

Accepting New Patient Status: *(optional)*

Your response will be annotated in the Medicare Physician Compare Directory.

Are you currently accepting new Medicare patients? ..... ○ Yes ○ No

SECTION 2: PERSONAL IDENTIFYING INFORMATION *(Continued)*

D. CORRESPONDENCE MAILING ADDRESS

This is the address where correspondence will be sent directly to you by your designated MAC. This address cannot be a billing agent or agency's address or a medical management company address.

If you are reporting a change to your Correspondence Mailing Address, check the box below. This will replace any current Correspondence Mailing Address on file.

☐ **Change** **Effective Date *(mm/dd/yyyy)*:** _____

Attention *(optional)*

Correspondence Mailing Address Line 1 *(P.O. Box or Street Name and Number)*

Correspondence Mailing Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number *(if applicable)*	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

E. MEDICAL RECORD CORRESPONDENCE ADDRESS

This is the address where the medical record correspondence will be sent to the provider listed in section 2A by your designated MAC. This information would be used for any medical record review requests.

NOTE: This section is not applicable for providers who reassign all of their benefits to an organization/group.

☐ Check here if your Medical Record Correspondence should be mailed to your Correspondence Address in section 2D (above) and skip this section.

If you are reporting a change to your Medical Record Correspondence Address, check the box below. This will replace any current Medical Record Correspondence Address on file.

☐ **Change** **Effective Date *(mm/dd/yyyy)*:** _____

Attention *(optional)*

Medical Record Correspondence Address Line 1 *(P.O. Box or Street Name and Number)*

Medical Record Correspondence Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number *(if applicable)*	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

F. RESIDENT INFORMATION

NOTE: Resident is defined as an individual who participates in an approved medical residency program.

1. Provide the name and address of the hospital/facility where you are a resident.

Name of Hospital or Facility

Street Address

City/Town	State	ZIP Code + 4

2. Are the services that you render at the hospital/facility shown in section 2F1 part of your requirements for graduation from a formal residency or program? ..... ○ Yes ○ No

Date of Completion: *(mm/dd/yyyy)* _____

SECTION 2: PERSONAL IDENTIFYING INFORMATION *(Continued)*

F. RESIDENT INFORMATION *(Continued)*

3. Do you also render services at other facilities or practice locations? ○ Yes ○ No

If yes, you must report these practice locations in section 4B and/or section 4F.

4. Are the services that you render in any of the practice locations you will be reporting in section 4B and/or section 4F part of your requirements for graduation from a residency program? ○ Yes ○ No

If yes, has the teaching hospital/facility reported in section 2F1 above agreed to incur all or substantially all of the costs of your training in the non-hospital/facility location? ○ Yes ○ No

G. PHYSICIAN SPECIALTY

Designate your primary specialty and all secondary specialty(s) below using:

P=Primary S=Secondary

You can only select one primary specialty. If you have multiple primary specialties, you must complete and submit a separate CMS-855I application for each primary specialty. You may select multiple secondary specialties. A physician must meet all federal and state requirements for the type of specialty(s) checked.

- ☐ Addiction Medicine
- ☐ Adult Congenital Heart Disease
- ☐ Advanced Heart Failure and Transplant Cardiology
- ☐ Allergy/Immunology
- ☐ Anesthesiology
- ☐ Cardiac Electrophysiology
- ☐ Cardiac Surgery
- ☐ Cardiovascular Disease (Cardiology)
- ☐ Chiropractic
- ☐ Colorectal Surgery (Proctology)
- ☐ Critical Care (Intensivists)
- ☐ Dentist
- ☐ Dermatology
- ☐ Diagnostic Radiology
- ☐ Emergency Medicine
- ☐ Endocrinology
- ☐ Family Medicine
- ☐ Gastroenterology
- ☐ General Practice
- ☐ General Surgery
- ☐ Geriatric Medicine
- ☐ Geriatric Psychiatry
- ☐ Gynecological Oncology
- ☐ Hand Surgery
- ☐ Hematology
- ☐ Hematology/Oncology
- ☐ Hematopoietic Cell Transplantation and Cellular Therapy
- ☐ Hospice/Palliative Care
- ☐ Hospitalist
- ☐ Infectious Disease
- ☐ Internal Medicine
- ☐ Interventional Cardiology
- ☐ Interventional Pain Management
- ☐ Interventional Radiology
- ☐ Maxillofacial Surgery
- ☐ Medical Genetics and Genomics
- ☐ Medical Oncology
- ☐ Medical Toxicology
- ☐ Micrographic Dermatologic Surgery
- ☐ Nephrology
- ☐ Neurology
- ☐ Neuropsychiatry
- ☐ Neurosurgery
- ☐ Nuclear Medicine
- ☐ Obstetrics/Gynecology
- ☐ Ophthalmology
- ☐ Optometry
- ☐ Oral Surgery
- ☐ Orthopedic Surgery
- ☐ Osteopathic Manipulative Medicine
- ☐ Otolaryngology
- ☐ Pain Management
- ☐ Pathology
- ☐ Pediatric Medicine
- ☐ Peripheral Vascular Disease
- ☐ Physical Medicine and Rehabilitation
- ☐ Plastic and Reconstructive Surgery
- ☐ Podiatry
- ☐ Preventive Medicine
- ☐ Psychiatry
- ☐ Pulmonary Disease
- ☐ Radiation Oncology
- ☐ Rheumatology
- ☐ Sleep Medicine
- ☐ Sports Medicine
- ☐ Surgical Oncology
- ☐ Thoracic Surgery
- ☐ Undersea and Hyperbaric Medicine
- ☐ Urology
- ☐ Vascular Surgery
- ☐ Undefined Physician Specialty *(Specify)*:_____

1. Does the physician identified in section 2A provide acupuncture services and meet all state laws and requirements regarding such services? ○ Yes ○ No

SECTION 2: PERSONAL IDENTIFYING INFORMATION *(Continued)*

H. ELIGIBLE PROFESSIONAL OR OTHER NON-PHYSICIAN SPECIALTY TYPE

If you are an eligible professional, check the appropriate box below to indicate your specialty.

Check only one of the following: If you have multiple non-physician specialty types, you must complete and submit a separate CMS-855I application for each non-physician specialty type.

All individuals must meet specific licensing, educational, and work experience requirements. Include copies of educational and certification information with this application. If you need information concerning the specific requirements for your specialty, contact your designated MAC.

- ☐ Anesthesiology Assistant
- ☐ Certified Nurse Midwife (CNM)
- ☐ Certified Registered Nurse Anesthetist (CRNA)
- ☐ Clinical Nurse Specialist (CNS) (See section 2K)
- ☐ Clinical Social Worker
- ☐ Mass Immunization Roster Biller
- ☐ Nurse Practitioner (See section 2K)
- ☐ Occupational Therapist in Private Practice (See section 2J)
- ☐ Physical Therapist in Private Practice (See section 2J)
- ☐ Physician Assistant
- ☐ Psychologist, Clinical (See section 2I)
- ☐ Psychologist Billing Independently (See section 2I2)
- ☐ Qualified Audiologist
- ☐ Qualified Speech Language Pathologist
- ☐ Registered Dietitian or Nutrition Professional
- ☐ Undefined Non-Physician Practitioner Specialty *(Specify)*: _____

1. Does the physician assistant, nurse practitioner, or clinical nurse specialist identified in section 2A provide acupuncture services and have: ..... ○ Yes ○ No

- A masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and
- A current, full, active, and unrestricted license to practice acupuncture in a state, territory, or commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia.

If yes, provide a current copy of certification and proof of educational requirements.

I. PSYCHOLOGIST INFORMATION

1. Clinical Psychologists

Identify the type of your doctoral psychology degree (e.g., Ph.D., Ed.D., Psy. D.)_____

A copy of the degree may be requested by the MAC.

NOTE: Federal regulations at 42 C.F.R. section 410.71(d) state that to qualify as a clinical psychologist, a practitioner must hold a doctoral degree in psychology, and be licensed or certified, on the basis of the doctoral degree in psychology, by the state in which he or she practices, at the independent practice level of psychology, to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

2. Psychologists Billing Independently

NOTE: CMS requires that independently practicing psychologists have a more limited benefit under the Medicare program than clinical psychologists. With a degree starting at the master's level of psychology, independently practicing psychologists are authorized to bill the program directly solely for diagnostic psychological and neuropsychological tests that have been ordered by a physician, clinical psychologist or non-physician practitioner who is authorized to order diagnostic tests. Independently practicing psychologists are not authorized to supervise diagnostic psychological and neuropsychological tests. Any tests performed by an independently practicing psychologist must fall under the psychologist's state scope of practice. Additional information can be found in Pub. 100–02, the Medicare Benefits Policy Manual.

a. Do you render services of your own responsibility free from the administrative control of an employer such as a physician, institution, or agency? ..... ○ Yes ○ No

b. Do you treat your own patients? ..... ○ Yes ○ No

SECTION 2: PERSONAL IDENTIFYING INFORMATION *(Continued)*

c. Do you have the right to bill directly, and to collect and retain the fee for your services? ○ Yes ○ No

d. Is your private practice located in an institution or other facility? ○ Yes ○ No

If YES to question (d) above, answer questions 1 and 2 below.

1. If your private practice is located in an institution or other facility, is your office confined to a separately identified part of the institution/facility that is used solely as your office and cannot be construed as extending throughout the entire institution/facility? ○ Yes ○ No
2. If your private practice is located in an institution/facility, do you also render services to patients from outside the institution or facility where your office is located? ○ Yes ○ No

J. PHYSICAL/OCCUPATIONAL THERAPIST INFORMATION

Physical Therapists/Occupational Therapists in Private Practice (PT/OT)

The following questions only apply to your individual private practice. Do not complete this section if you are reassigning ***all*** of your benefits to a group/clinic/organization.

1. Do you **ONLY** render PT/OT services in the patients' homes? ○ Yes ○ No
2. Do you maintain private office space? ○ Yes ○ No
3. Do you own, lease, or rent your private office space? ○ Yes ○ No
4. Is this private office space used exclusively for your private practice? ○ Yes ○ No
5. Do you provide PT/OT services outside of your office and/or patients' homes? ○ Yes ○ No

If you responded YES to questions 2, 3 or 4 above, you must have and attach a copy of any written agreement that gives you exclusive use of the office space for PT/OT services.

K. CLINICAL NURSE SPECIALIST/NURSE PRACTITIONER INFORMATION

Clinical Nurse Specialists/Nurse Practitioners

Are you an employee of a skilled nursing facility (SNF) or of another entity that has an agreement to provide nursing services to a SNF? ○ Yes ○ No

If yes, furnish the SNF's name and address below.

Skilled Nursing Facility Name

Skilled Nursing Facility Street Address Line 1 *(Street Name and Number – Not a P.O. Box)*

Skilled Nursing Facility Street Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code +4

Tax Identification Number of SNF

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

NOTE: All individuals must meet specific licensing and educational requirements. Include copies of educational and certification information with this application.

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. FEDERAL AND STATE CONVICTIONS (CONVICTION AS DEFINED IN 42 C.F.R. SECTION 1001.2) WITHIN THE PRECEDING 10 YEARS

1. Any federal or state felony conviction(s) by the provider, supplier, or any owner or managing employee of the provider or supplier.
2. Any crime, under Federal or State law, where an individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld, or the criminal conduct has been expunged or otherwise removed, or there is a post-trial motion or appeal pending, or the court has made a finding of guilt or accepted a plea of guilty or nolo contendere.
3. 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.
4. 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.
5. Any misdemeanor conviction, under federal or state law, related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.
6. 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.

B. EXCLUSIONS, REVOCATIONS OR SUSPENSIONS

1. Any current or past revocation, suspension, or voluntary surrender of a medical license in lieu of further disciplinary action.
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 (A penalty imposed by a Federal governing body (e.g. Civil Monetary Penalties (CMP))).
6. Any current or past Medicaid exclusion, revocation, or termination of any billing number.

C. FINAL ADVERSE LEGAL ACTION HISTORY

1. Have you, under any current or former name, 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 4: BUSINESS INFORMATION

☐ If you do **NOT** have a private practice but you reassign **ALL** of your benefits to an organization/group or individual, check this box and only complete section 4F.

☐ If you **DO** have a private practice and you also reassign **ANY** of your benefits to an organization/group or individual, check this box and complete sections 4A – 4F.

☐ If you **DO** have a private practice and **ONLY** render services in your own private practice, check this box and complete sections 4A – 4E.

A. PRIVATE PRACTICE BUSINESS INFORMATION

Business Structure Information

Identify how your business is registered with the IRS:

☐ Proprietary ☐ Non-Profit (Submit IRS Form 501(c)(3) ☐ Disregarded Entity (Submit IRS Form 8832)

For the purposes of section 4A, if you are a:

- Professional Corporation, complete 4A1 and 4A2
- Professional Association, complete 4A1 and 4A2
- Limited Liability Company (LLC), including a single member LLC, complete 4A1 and 4A2
- Sole proprietor/Sole proprietorship, complete 4A3

1. Corporations, Associations and Limited Liability Company (LLC)

If your private practice is established as a professional corporation, professional association or limited liability company, including single member LLCs and you are the sole owner and will bill Medicare through this business entity, complete this section with information about your business entity.

NOTE: If you are filling out section 4A, you do not need to complete section 4F to reassign your benefits as a practitioner to your business entity.

NOTE: The LBN and TIN you furnish in section 4A must be the same LBN and TIN you used to obtain your NPI.

Legal Business Name as Reported to the Internal Revenue Service

Tax Identification Number	Medicare Identification Number (PTAN) *(if issued)*	NPI (Type 2 – Organization)

2. Final Adverse Legal Action History

Complete this section for your business as reported in section 4A1 above. If you need additional information regarding what to report, please refer to section 3 of this application.

NOTE: This section not required for Sole Proprietor/Sole Proprietorships.

a. Has your business, under any current or former name or business identity, had a final adverse legal action listed in section 3 of this application imposed against it?

○ YES – continue below

○ NO – skip to section 4

b. 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.

NOTE: To satisfy the reporting requirement, section 4A2 must be filled out in its entirety, **and** all applicable attachments must be included.

FINAL ADVERSE LEGAL ACTION	DATE	ACTION TAKEN BY

SECTION 4: BUSINESS INFORMATION *(Continued)*

3. Sole Proprietor/Sole Proprietorship

To qualify for this payment arrangement, you:

- Must be a sole proprietor;
- Must use **either** your EIN or SSN for all Medicare payments;
- Cannot reassign all of your Medicare payments, and
- Must submit a copy of your IRS Form CP-575 showing the LBN and EIN, if applicable.

☐ If you want your Medicare payments to be paid under your SSN, check this box and continue to section 4B.

☐ If you are a sole proprietor and want Medicare payments to be paid under your EIN, please check this box and fill in the EIN information below. Continue to section 4B.

Employer Identification Number (EIN)

B. PRACTICE LOCATION INFORMATION

NOTE: You do not need to complete this section if you are reassigning 100% of your Medicare benefits.

Complete this section for each of your practice locations where you render services to Medicare beneficiaries, including any distant site(s) where you render telehealth services. This includes all locations you will disclose on claims forms for reimbursement. If you have and see patients at more than one private practice location or health care facility, **copy and complete this section for each location.**

All reported practice location addresses must be a specific street address as recorded by the United States Postal Service. Your practice location must be the physical location where you render services to Medicare beneficiaries. Your practice location address cannot be a Post Office (P.O.) Box.

If you render services in a hospital, retirement or assisted living community, and/or other health care facilities, furnish the name, address and telephone number for those facilities.

If you only render services in patients' homes (house calls only), you may supply your home address in this section if you do not have a separate office. In section 4E3 explain that this address is for administrative purposes only and that all services are rendered in patients' homes. You must then also complete section 4E1 as appropriate.

Only report those practice locations that are within the jurisdiction of the designated MAC to which you will be submitting this application. If you have to report practice locations outside the jurisdiction of the designated MAC to which you are submitting this application you must submit a separate CMS-855I Enrollment Application to the MAC that has jurisdiction for those locations.

If you are changing information about a currently reported practice location or adding or removing practice location information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ **Change** ☐ **Add** ☐ **Remove** **Effective Date *(mm/dd/yyyy)*:** _____

Practice Location Name *("Doing Business As" Name)*

Practice Location Street Address Line 1 *(Street Name and Number – NOT a P.O. Box)*

Practice Location Street Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

Medicare Identification Number for this location – PTAN *(if issued)*	Date you saw or will see your first Medicare patient at this practice location *(mm/dd/yyyy)*

SECTION 4: BUSINESS INFORMATION *(Continued)*

B. PRACTICE LOCATION INFORMATION *(Continued)*

Is this your primary practice location?..... ○ Yes ○ No

Is your private practice location reported above located in a:

- ☐ Ambulatory Surgical Center
- ☐ Business Office for Administrative/Telehealth Use Only
- ☐ Home Office for Administrative/ Telehealth Use Only
- ☐ Hospital/Hospital Department
- ☐ Indian Health Services (IHS) or Tribal Facility
- ☐ Private Office Setting
- ☐ Retirement or Assisted Living Community
- ☐ Skilled Nursing Facility or Other Nursing Facility
- ☐ Other Health Care Facility (Specify):_____

C. REMITTANCE NOTICES/SPECIAL PAYMENTS MAILING ADDRESS

Furnish an address where remittance notices and special payments should be sent for services rendered at the practice location(s) reported in section 4B. Please note that payments will be made in your name or, if a business is reported in section 4A, payments will be made in the name of the business.

Medicare will issue all routine payments via electronic funds transfer (EFT). Since payments will be made by EFT, the special payments address below should indicate where all other payment information (e.g., remittance notices, non-routine special payments) should be sent, **OR**,

- ☐ Check here if your Remittance Notice/Special Payments should be mailed to your Practice Location Address in section 4B and skip this section, **OR**
- ☐ Check here if your Remittance Notice/Special Payments should be mailed to your Correspondence Address in section 2D and skip this section.

If you are reporting a change to your Remittance Notice/Special Payments Mailing Address, check the box below and furnish the effective date.

☐ **Change** **Effective Date (mm/dd/yyyy):** _____

Special Payments Address Line 1 *(P.O. Box or Street Name and Number)*

Special Payments Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

SECTION 4: BUSINESS INFORMATION *(Continued)*

D. MEDICARE BENEFICIARY MEDICAL RECORDS STORAGE ADDRESS

If your Medicare beneficiaries' medical records are stored at a location other than the Practice Location Address shown in section 4B complete this section with the name and address of the storage location. This includes the records for both current and former Medicare beneficiaries.

Post office boxes and drop boxes are not acceptable as a physical address where Medicare beneficiaries' records are maintained. The records must be your records and not the records of another practitioner. If all records are stored at the practice location reported in section 4B, check the box below and skip this section.

☐ Records are stored at the practice location reported in section 4B.

If you are adding or removing a storage location, check the applicable box below and furnish the effective date.

☐ **Add** ☐ **Remove** **Effective Date *(mm/dd/yyyy)*:** _____

1. Paper Storage

Do you store your patient medical records in a physical location? ..... ○ Yes ○ No

Name of Storage Facility

Storage Facility Address Line 1 *(Street Name and Number)*

Storage Facility Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

2. Electronic Storage

Do you store your patient medical records electronically? ..... ○ Yes ○ No

If yes, identify where/how these records are stored below. This can be a website, URL, in-house software program, online service, vendor, etc. This must be a site that can be accessed by CMS or its designees if necessary.

Site where electronic records are stored

SECTION 4: BUSINESS INFORMATION *(Continued)*

E. RENDERING SERVICES IN PATIENTS' HOMES

List the city/town, county, state, or ZIP code for all locations where you render health care services in patients' homes or, if previously reported, where you no longer render health care services in patients' homes.

☐ **Change** **Effective Date *(mm/dd/yyyy)*:** _____

1. Initial Reporting and/or Additions

If you are reporting or adding an entire state, check the box below and specify the state.

☐ Entire State of _____

If services are only provided in selected cities/towns or counties, provide the locations below. Only list ZIP codes if you are not servicing the entire city/town or county.

CITY/TOWN	COUNTY	STATE/TERRITORY	ZIP CODE

2. Deletions

If you are deleting an entire state, check the box below and specify the state.

☐ Entire State of _____

If services are no longer provided in selected cities/towns or counties, provide the locations below. Only list ZIP codes if you are not deleting service in the entire city/town or county.

CITY/TOWN	COUNTY	STATE/TERRITORY	ZIP CODE

3. Comments/Special Circumstances

Explain any unique circumstances concerning your practice location(s) or the method by which you render health care services (e.g., practice on certain days of the week).

SECTION 4: BUSINESS INFORMATION *(Continued)*

F. INDIVIDUAL/ORGANIZATION/GROUP RECEIVING THE REASSIGNED BENEFITS

NOTE: All reassignment actions should now be reported via the CMS-855I. The CMS-855R (Reassignment of Medicare Benefits) form has been discontinued.

Complete this section if you are:

1. An individual practitioner reassigning your right to bill the Medicare program and receive Medicare payments for some or all of the services you render to Medicare beneficiaries, terminating a currently established reassignment of benefits, making a change in reassignment of Medicare benefit information; or
2. An organization/group accepting a new reassignment of Medicare benefits from the individual practitioner identified in section 2A, terminating a currently established reassignment of benefits from the individual practitioner identified in section 2A, or making a change in reassignment of Medicare benefit information, between the organization/group and the individual practitioner identified in section 2A.

The individual or delegated/authorized official, by his/her signature, agrees to notify the Medicare Administrative Contractor (MAC) of any future changes to this reassignment in accordance with 42 C.F.R. section 424.516(d)(2).

Both the individual practitioner and the eligible organization/group must be currently enrolled (or concurrently enrolling via submission of the CMS-855B for the eligible organization/group and the CMS-855I for the individual practitioner) in the Medicare program before the reassignment can take effect.

If you reassign benefits to more than one organization/group, copy and complete this page as necessary.

NOTE: Revalidation applications must list all active reassignments.

1. Individual Practitioner Receiving Reassigned Benefits Identification

Provide the information below for the individual to whom benefits are being reassigned, or a reassignment is being terminated. If the individual's initial enrollment application is being submitted concurrently with this reassignment, write "pending" in the Medicare identification number block. The individual's name as reported to the Social Security Administration must be the same as reported on the individual's CMS-855I when the individual enrolled. If the individual is a sole proprietor with an Employee Identification Number (EIN), check the appropriate box and report the EIN.

☐ **Change** ☐ **Add** ☐ **Terminate** **Effective Date *(mm/dd/yyyy)*:** _____

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

☐ Social Security Number (SSN) (List number below if applicable)	☐ Employer Identification Number (EIN) (List number below if applicable)
Medicare Identification Number (PTAN) (if issued)	National Provider Identifier (NPI)

2. Organization/Group Receiving Reassigned Benefits Identification

Provide the information below for the organization/group to which benefits are being reassigned, or a reassignment is being terminated. If the organization/group's initial enrollment application is being submitted concurrently with this reassignment application, write "pending" in the Medicare identification number block. The organization/group's name as reported to the IRS must be the same as reported on the organization/group's CMS-855B when it enrolled.

☐ **Change** ☐ **Add** ☐ **Terminate** **Effective Date (*mm/dd/yyyy*):** _____

Organization/Group Legal Business Name (as Reported to the Internal Revenue Service)

Tax Identification Number (TIN)	Medicare Identification Number (PTAN) (if issued)	National Provider Identifier (NPI)

SECTION 4: BUSINESS INFORMATION *(Continued)*

3. Primary Practice Location(s) *(Optional)*

a. Primary Practice Location
Identify the primary practice location of the organization/group where the individual practitioner will render in-person services most of the time. This practice location must be currently enrolled or enrolling in Medicare.

If you are changing information about a currently reported primary practice location or adding or removing primary practice location information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ **Change** ☐ **Add** ☐ **Remove** **Effective Date *(mm/dd/yyyy)*:** _____

Practice Location Name *("Doing Business As" Name)*

Practice Location Street Address Line 1 *(Street Name and Number – NOT a P.O. Box)*

Practice Location Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

Medicare Identification Number for this location – PTAN *(if issued)*	National Provider Identifier (NPI)

b. Secondary Practice Location
Identify a secondary practice location of the organization/group where the individual practitioner will render in-person services most of the time. This practice location must be currently enrolled or enrolling in Medicare.

If you are changing information about a currently reported additional practice location or adding or removing an additional practice location information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ **Change** ☐ **Add** ☐ **Remove** **Effective Date *(mm/dd/yyyy)*:** _____

Practice Location Name *("Doing Business As" Name)*

Practice Location Street Address Line 1 *(Street Name and Number – NOT a P.O. Box)*

Practice Location Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

Medicare Identification Number for this location – PTAN *(if issued)*	National Provider Identifier (NPI)

SECTION 5: THIS SECTION INTENTIONALLY LEFT BLANK

SECTION 6: MANAGING EMPLOYEE INFORMATION

This section captures information about your managing employees. A managing employee means an individual who furnishes operational or managerial services, or who directly or indirectly conducts the day-to-day operations for your private practice, either as an employee or through some other arrangement.

NOTE: You do not need to complete this section if you are reassigning 100% of your Medicare benefits.

All managing employees at all of your practice locations reported in section 4 must be reported in this section. If there is more than one managing employee, copy and complete this section as needed.

NOTE: If you completed section 4 reporting that your private practice is established as a business entity, you must report at least one managing employee in accordance with Medicare policy for enrolling a business entity.

☐ I am the managing employee. Skip to section 8.

A. MANAGING EMPLOYEE IDENTIFYING INFORMATION

If you are changing information about your current managing employee or adding or removing a managing employee, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ **Change** ☐ **Add** ☐ **Remove** **Effective Date *(mm/dd/yyyy)*:** _____

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

Social Security Number	Date of Birth *(mm/dd/yyyy)*

Medicare Identification Number *(if issued)*	NPI *(if issued)*

Telephone Number	Fax Number *(if applicable)*	E-mail Address

1. What is the above individual's relationship with the practitioner in section 2A?

☐ Contracted Managing Employee

☐ W-2 Managing Employee

B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for the individual reported in section 6A above. If you need additional information regarding what to report, please refer to section 3 of this application.

1. Has this individual in section 6A above, under any current or former name, had a final adverse legal action listed in section 3 of this application imposed against him/her?

   ○ YES – continue below

   ○ NO – skip to section 8.

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.

NOTE: To satisfy the reporting requirement, section 6B2 must be filled out in its entirety, **and** all applicable attachments must be included.

FINAL ADVERSE LEGAL ACTION	DATE	ACTION TAKEN BY

SECTION 7: THIS SECTION INTENTIONALLY LEFT BLANK

SECTION 8: BILLING AGENCY/AGENT INFORMATION

A billing agency/agent is a company or individual that you contract with to prepare and submit your claims. If you use a billing agency/agent you must complete this section. Even if you use a billing agency/agent, you remain responsible for the accuracy of the claims submitted on your behalf.

NOTE: The billing agency/agent address cannot be the correspondence mailing address completed in section 2D of this application.

NOTE: You do not need to complete this section if you are reassigning 100% of your Medicare benefits.

☐ Check here if this section does not apply and skip to section 12.

If you are changing information about your current billing agency/agent or adding or removing a billing agency/agent information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ **Change** ☐ **Add** ☐ **Remove** **Effective Date *(mm/dd/yyyy)*:** _____

BILLING AGENCY/AGENT NAME AND ADDRESS

Legal Business Name as Reported to the Internal Revenue Service **or** Individual Name as reported to the Social Security Administration

If Individual Billing Agent: Date of Birth *(mm/dd/yyyy)*

Billing Agency Tax Identification Number **or** Billing Agent Social Security Number **(required)**

Billing Agency/Agent "Doing Business As" Name *(if applicable)*

Billing Agency/Agent Address Line 1 *(Street Name and Number)*

Billing Agency/Agent Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

SECTION 9: THIS SECTION INTENTIONALLY LEFT BLANK

SECTION 10: THIS SECTION INTENTIONALLY LEFT BLANK

SECTION 11: THIS SECTION INTENTIONALLY LEFT BLANK

SECTION 12: SUPPORTING DOCUMENTATION INFORMATION

This section lists the documents that, if applicable, must be submitted with this completed enrollment application. If you are enrolling for the first time, or reactivating or revalidating your enrollment you must submit applicable documents. When reporting a change of information, only submit documents that applicable the change reported. Your designated Medicare Administrative Contractor (MAC) may request, at any time during the enrollment process, documentation to support or validate information reported on this application. In addition, your designated MAC may also request documents from you other than those identified in this section as are necessary to ensure correct billing of Medicare.

☐ Copy(s) of all final adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters).

☐ Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement.

NOTE: The CMS-460 must be submitted for all initial enrollments or reactivations only if you want to be a Participating Practitioner in Medicare.

☐ Completed Form CMS-588, Electronic Funds Transfer Authorization Agreement. Include a voided check or bank letter.

NOTE: If you currently receive payments electronically and are not making a change to your banking information, the CMS-588 is not required. Physicians and non-physician practitioners who are reassigning all of their payments to a group/clinic or other health care organization are not required to submit the CMS-588.

☐ If Medicare payments due to you are being sent to a bank (or similar financial institution) where you have a lending relationship (that is, any type of loan), you 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.

☐ Written confirmation from the IRS confirming your Tax Identification Number and Legal Business Name provided in section 4A (e.g., IRS form CP-575).

NOTE: This information is needed if the applicant is enrolling their professional corporation, professional association, or limited liability corporation with this application or enrolling as a sole proprietor using an Employer Identification Number.

NOTE: Government-owned entities do not need to provide an IRS Form 501(c)(3).

☐ Written confirmation from the IRS if your business is registered as a Limited Liability Company (LLC), including single member LLCs, confirming your LLC is automatically classified as a Disregarded Entity (e.g., IRS Form 8832).

NOTE: A Disregarded Entity is an eligible entity that is not treated as a separate entity from its single owner for income tax purposes.

☐ Copy of IRS Determination Letter if you are registered with the IRS as non-profit (e.g., IRS Form 501(c)(3)).

NOTE: Government-owned entities do not need to provide an IRS Form 501(c)(3).

☐ Current copy of certification and proof of educational requirements for eligible professionals or other non-physician specialty types who provide acupuncture services.

SECTION 13: CONTACT PERSON INFORMATION *(Optional)*

If questions arise during the processing of this application, your designated MAC will contact the individual reported below.

☐ Assign the individual listed in section 2A of this application as the designated contact person.

☐ **Change** ☐ **Add** ☐ **Remove** **Effective Date *(mm/dd/yyyy)*:** _____

First Name	Middle Initial	Last Name	Jr., Sr., MD., etc.

Contact Person Address Line 1 *(Street Name and Number)*

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

City/Town	State	ZIP Code + 4

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

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

NOTE: The Contact Person listed in this section will only be authorized to discuss issues concerning this or any other enrollment application. Your designated MAC will not discuss any other Medicare issues about you with the above Contact Person.

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION ON THIS APPLICATION

This section explains the penalties for deliberately furnishing false information in this application to gain or maintain enrollment in the Medicare program.

1. 18 U.S.C. section 1001 authorizes criminal penalties against an individual who, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious, or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000 (18 U.S.C. section 3571). section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.
2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against any individual who, "knowingly and willfully," makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a federal health care program. The offender is subject to fines of up to $25,000 and/or imprisonment for up to five years.
3. The Civil False Claims Act, 31 U.S.C. § 3729, imposes civil liability, in part, on any person who, with actual knowledge, deliberate ignorance or reckless disregard of truth or falsity (a) presents or causes to be presented to the United States Government or its contractor or agent a false or fraudulent claim for payment or approval; (b) uses or causes to be used a false record or statement material either to a false or fraudulent claim or to an obligation to pay the Government; (c) conceals or improperly avoids or decreases an obligation to pay or transmit money or property to the Government; or (d) conspires to violate any provision of the False Claims Act. The False Claims Act imposes a civil penalty of between $5,000 and $10,000 per violation, as adjusted for inflation by the Federal Civil Penalties Inflation Adjustment Act, 28 U.S.C. 2461, plus three times the amount of damages sustained by the Government.
4. Section 1128A(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any state agency…a claim…that the Secretary determines is for a medical or other item or service that the person knows or should know:
   a) was not provided as claimed; and/or
   b) the claim is false or fraudulent.

   This provision authorizes a civil monetary penalty of up to $10,000 for each item or service, an assessment of up to three times the amount claimed, and exclusion from participation in the Medicare program and state health care programs.
5. 18 U.S.C. 1035 authorizes criminal penalties against individuals in any matter involving a health care benefit program who knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact; or makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items or services. The individual shall be fined or imprisoned up to 5 years or both.
6. 18 U.S.C. 1347 authorizes criminal penalties against individuals who knowing and willfully execute, or attempt, to executive a scheme or artifice to defraud any health care benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by or under the control of any, health care benefit program in connection with the delivery of or payment for health care benefits, items, or services. Individuals shall be fined or imprisoned up to 10 years or both. If the violation results in serious bodily injury, an individual will be fined or imprisoned up to 20 years, or both. If the violation results in death, the individual shall be fined or imprisoned for any term of years or for life, or both.
7. The United States Government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment."

   Remedies include compensatory and punitive damages, restitution, and recovery of the amount of the unjust profit.

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.

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 C.F.R. section 424.73 and 42 C.F.R. section 424.80. By signing this Certification Statement, you are authorizing the organization/group or individual identified in Section 4F 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 2A and the organization/group or individual shown in Section 4F. 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 C.F.R. section 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. **NOTE: this language only applies if the application is submitted to establish, change or terminate a reassignment of benefits.**

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 omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any 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.

SECTION 15: CERTIFICATION STATEMENT AND SIGNATURE *(Continued)*

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.

C. DELEGATED OR AUTHORIZED OFFICIAL OF INDIVIDUAL/ORGANIZATION/GROUP CERTIFICATION STATEMENT AND SIGNATURE

Only complete this section if you are a Delegated/Authorized Official of an organization/group or an individual practitioner receiving reassigned benefits and are accepting a new reassignment of Medicare benefits, terminating a reassignment of Medicare benefits, or making a change in reassignment of Medicare benefit information in Section 4F, between yourself and the individual practitioner listed in Section 2A.

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)***

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

MEDICARE SUPPLIER ENROLLMENT APPLICATION PRIVACY ACT STATEMENT

The Authority for maintenance of the system is given under provisions of sections 1102(a) (Title 42 U.S.C. 1302(a)), 1128 (42 U.S.C. 1320a–7), 1814(a)) (42 U.S.C. 1395f(a)(1), 1815(a) (42 U.S.C. 1395g(a)), 1833(e) (42 U.S.C. 1395l(3)), 1871 (42 U.S.C. 1395hh), and 1886(d)(5)(F), (42 U.S.C. 1395ww(d)(5)(F) of the Social Security Act; 1842(r) (42 U.S.C. 1395u(r)); section 1124(a)(1) (42 U.S.C. 1320a–3(a)(1), and 1124A (42 U.S.C. 1320a–3a), section 4313, as amended, of the BBA of 1997; and section 31001(i) (31 U.S.C. 7701) of the DCIA (Pub. L. 104–134), as amended.

The information collected here will be entered into the Provider Enrollment, Chain and Ownership System (PECOS).

PECOS will collect information provided by an applicant related to identity, qualifications, practice locations, ownership, billing agency information, reassignment of benefits, electronic funds transfer, the NPI and related organizations. PECOS will also maintain information on business owners, chain home offices and provider/chain associations, managing/directing employees, partners, authorized and delegated officials, supervising physicians of the supplier, ambulance vehicle information, and/or interpreting physicians and related technicians. This system of records will contain the names, social security numbers (SSN), date of birth (DOB), and employer identification numbers (EIN) and NPI's for each disclosing entity, owners with 5 percent or more ownership or control interest, as well as managing/directing employees. Managing/directing employees include general manager, business managers, administrators, directors, and other individuals who exercise operational or managerial control over the provider/ supplier. The system will also contain Medicare identification numbers (i.e., CCN, PTAN and the NPI), demographic data, professional data, past and present history as well as information regarding any adverse legal actions such as exclusions, sanctions, and felonious behavior.

The Privacy Act permits CMS to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. Any such disclosure of data is known as a "routine use." The CMS will only release PECOS information that can be associated with an individual as provided for under Section III "Proposed Routine Use Disclosures of Data in the System." Both identifiable and non-identifiable data may be disclosed under a routine use. CMS will only collect the minimum personal data necessary to achieve the purpose of PECOS. Below is an abbreviated summary of the six routine uses. To view the routine uses in their entirety go to: **CMS.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/Downloads/0532-PECOS.pdf**.

1. To support CMS contractors, consultants, or grantees, who have been engaged by CMS to assist in the performance of a service related to this collection and who need to have access to the records in order to perform the activity.
2. To assist another Federal or state agency, agency of a state government or its fiscal agent to:
   a. Contribute to the accuracy of CMS's proper payment of Medicare benefits,
   b. Enable such agency to administer a Federal health benefits program that implements a health benefits program funded in whole or in part with federal funds, and/or
   c. Evaluate and monitor the quality of home health care and contribute to the accuracy of health insurance operations.
3. To assist an individual or organization for research, evaluation or epidemiological projects related to the prevention of disease or disability, or the restoration or maintenance of health, and for payment related projects.
4. To support the Department of Justice (DOJ), court or adjudicatory body when:
   a. The agency or any component thereof, or
   b. Any employee of the agency in his or her official capacity, or
   c. Any employee of the agency in his or her individual capacity where the DOJ has agreed to represent the employee, or
   d. The United States Government, is a party to litigation and that the use of such records by the DOJ, court or adjudicatory body is compatible with the purpose for which CMS collected the records.
5. To assist a CMS contractor that assists in the administration of a CMS administered health benefits program, or to combat fraud, waste, or abuse in such program.
6. To assist another Federal agency to investigate potential fraud, waste, or abuse in, a health benefits program funded in whole or in part by Federal funds.

The applicant should be aware that the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503) amended the Privacy Act, 5 U.S.C. section 552a, to permit the government to verify information through computer matching.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1355 (Expires 05/2026). The time required to complete this information collection is estimated to average 0.5 – 3 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

******CMS Disclosure**** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please visit CMS.gov/Medicare/Provider-Enrollment-and-Certification.**

EXHIBIT 16

MEDICARE ENROLLMENT APPLICATION

Clinics/Group Practices and Other Suppliers

CMS-855B

SEE PAGE 1–2 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION.

SEE PAGE 3 FOR INFORMATION ON WHERE TO MAIL THIS COMPLETED APPLICATION.

SEE SECTION 12 FOR A LIST OF SUPPORTING DOCUMENTATION TO BE SUBMITTED WITH THIS APPLICATION.

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-1377
Expires: 03/2024

WHO SHOULD SUBMIT THIS APPLICATION

Clinics, group practices, and other suppliers must complete this application to enroll in the Medicare program and receive a Medicare billing number.

Clinics, group practices, and other suppliers can apply for enrollment in the Medicare program or make a change in their enrollment information using either:

- The Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or
- The paper CMS-855B enrollment application. Be sure you are using the most current version.

For additional information regarding the Medicare enrollment process, including Internet-based PECOS and to get the current version of the CMS-855B, go to **http://www.cms.gov/MedicareProviderSupEnroll**.

NOTE: Applicants using this application require a Type 2 NPI. See below for more information.

NOTE: For the purposes of this application, the word "supplier" is used universally and includes any providers or suppliers who are required to complete the CMS-855B application.

Complete and submit this application if you are an organization/group or other supplier that plans to bill Medicare and you are:

- Enrolling in the Medicare program for the first time with this Medicare Administrative Contractor (MAC) under this tax identification number.
- Currently enrolled in Medicare but have a new tax identification number. If you are reporting a change to your current Medicare enrollment to your tax identification number, you must complete a new application.
- Currently enrolled in Medicare and need to enroll in another Medicare Administrative Contractor's (MAC's) jurisdiction (e.g., you have opened a practice location in a geographic territory serviced by another MAC).
- Revalidating your Medicare enrollment. CMS may require you to submit or update your enrollment information. The MAC will notify you when it is time for you to revalidate your enrollment information. Do not submit a revalidation application until you have been contacted by your MAC.
- Previously enrolled in Medicare and you need to reactivate your Medicare billing number to resume billing. Prior to being reactivated, you must meet all current requirements for your supplier type before reactivation may occur.
- Currently enrolled in Medicare and need to make changes to your enrollment information (e.g., you have added or changed a practice location). Changes must be reported in accordance with the timeframes established in 42 C.F.R. section 424.516. (IDTF changes of information must be reported in accordance with 42 C.F.R. section 410.33.)
- A hospital, hospital department, or other medical practice or clinic that may bill for Medicare Part A services but will also bill for Medicare Part B practitioner services or provide purchased laboratory tests to other entities that will bill Medicare Part B.
- A certified Medicare Part B provider (i.e. Ambulatory Surgery Center, Portable X-ray Supplier) intending to report a CHOW. A CHOW typically occurs when a Medicare provider has been purchased (or leased) by another organization. The CHOW results in the transfer of the old owner's Medicare Identification Number and provider agreement (including any outstanding Medicare debt of the old owner) to the new owner. The regulatory citation for CHOWs can be found at 42 C.F.R. 489.18. If the purchaser (or lessee) elects not to accept a transfer of the provider agreement, then the old agreement should be terminated and the purchaser or lessee is considered a new applicant and must initially enroll in Medicare.
- A medical practice, group/clinic or other supplier that will bill for Medicare Part B services (e.g., group practices, clinics, independent laboratories, portable x-ray suppliers).
- Terminating a Physician Assistant (PA) employer relationship.
- Terminating an employer or individual relationship with an Independent Diagnostic Testing Facility (IDTF).
- Voluntary terminating your Medicare billing privileges. A supplier should voluntarily terminate its Medicare enrollment when it:
  - Will no longer be rendering services to Medicare patients, or
  - Is planning to cease (or has ceased) operations.

NOTE: For the purposes of this section of this application, an entity is defined as a group/clinic, other supplier, or any organization to which you will reassign your Medicare benefits.

BILLING NUMBER AND NATIONAL PROVIDER IDENTIFIER INFORMATION

The Provider Transaction Access Number (PTAN), often referred to as a Medicare Supplier Number or Medicare Billing Number, is a generic term for any number other than the National Provider Identifier (NPI) that is used by a supplier bill the Medicare program.

The NPI is the standard unique health identifier for health care providers and suppliers and is assigned by the National Plan and Provider Enumeration System (NPPES). To enroll in Medicare, you must obtain an NPI and furnish it on this application prior to enrolling in Medicare or when submitting a change to your existing Medicare enrollment information. Applying for the NPI is a process separate from Medicare enrollment. As a supplier, it is your responsibility to determine if you have "subparts." A subpart is a component of an organization (supplier) that furnishes healthcare and is not itself a legal entity. If you do have subparts, you must determine if they should obtain their own unique NPIs. Before you complete this enrollment application, you need to make those determinations and obtain NPI(s) accordingly. To obtain an NPI, you may apply online at **https://NPPES.cms.hhs.gov**. For more information about NPI enumeration, visit **www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/enumeration**.

NOTE: The Legal Business Name (LBN) and Tax Identification Number (TIN) that you furnish in section 2A must be the same LBN and TIN you used to obtain your NPI. Once this information is entered into PECOS from this application, your LBN, TIN and NPI **must** match exactly in both PECOS and NPPES.

Organizational Health Care Providers (Entity Type 2): Organizational health care providers are eligible for an Entity Type 2 NPI (Organizations). Organizational health care providers may have a single employee or thousands of employees. Examples of organizational providers include hospitals, home health agencies, groups/clinics, nursing homes, ambulance companies, health care provider corporations formed by groups/individuals, and single member LLCs with an EIN, **not** individual health care providers.

Important: For NPI purposes, sole proprietors and sole proprietorships are considered to be "Type 1" providers. Organizations (e.g., corporations, partnerships) are treated as "Type 2" entities. When reporting the NPI of a sole proprietor on this application, therefore, the individual's Type 1 NPI should be reported; for organizations, the Type 2 NPI should be furnished.

To obtain an NPI, you may apply online at **https://NPPES.cms.hhs.gov**.

INSTRUCTIONS FOR COMPLETING AND SUBMITTING THIS APPLICATION

All information on this form is required with the exception of those fields specifically marked as "optional." Any field marked as optional is not required to be completed nor does it need to be updated or reported as a "change of information" as required in 42 C.F.R. section 424.516. However, it is highly recommended that if reported, these fields be kept up-to-date.

- This form must be typed. It may not be handwritten. If portions of this form are handwritten, the application may be returned to you by your MAC.
- When necessary to report additional information, copy and complete the applicable section as needed.
- Attach all required supporting documentation.
- Keep a copy of your completed Medicare enrollment package for your own records.

TIPS TO AVOID DELAYS IN YOUR ENROLLMENT

To avoid delays in the enrollment process, you should:

- Complete all required sections, as shown in section 1.
- Ensure that the legal business name shown in section 2 matches the name on the tax documents.
- Ensure that the correspondence address shown in section 2 is the supplier's address.
- Enter your NPI(s) in the applicable section(s).
- Include the Electronic Funds Transfer (EFT) Authorization Agreement (when applicable) with your enrollment application with a voided check or bank letter.
- Sign and date section 15.
- Ensure all supporting documents are sent to your designated MAC.
- The supplier pays the required application fee (via **https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do**) upon initial enrollment, the addition of a new business location, revalidation and, if requested, reactivation PRIOR to completing and submitting this application to the MAC.

ADDITIONAL INFORMATION

- You may visit our website to learn more about the enrollment process via the Internet-Based Provider Enrollment Chain and Ownership System (PECOS) at: **https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/InternetbasedPECOS.html**. Also, all of the CMS-855 applications are all located on the CMS webpage: **https://www.cms.gov/medicare/cms-forms/cms-forms/cms-forms-list.html**. Simply enter "855" in the "Filter On:" box on this page and only the application forms will be displayed to choose from.
- The MAC may request additional documentation to support and validate information reported on this application. You are responsible for providing this documentation within 30 days of the request per 42 C.F.R. section 424.525(a)(1).
- The information you provide on this form is protected under 5 U.S.C. section 552(b)(4) and/or (b)(6), respectively. For more information, see the last page of this application to read the Privacy Act Statement.

ACRONYMS COMMONLY USED IN THIS APPLICATION

C.F.R.: Code of Federal Regulations
EFT: Electronic Funds Transfer
EIN: Employer Identification Number
IHS: Indian Health Service
IRS: Internal Revenue Service
LBN: Legal Business Name
LLC: Limited Liability Corporation
MAC: Medicare Administrative Contractor
NPI: National Provider Identifier
NPPES: National Plan and Provider Enumeration System
OTP: Opioid Treatment Program
PTAN: Provider Transaction Access Number also referred to as the Medicare Identification Number
SSN: Social Security Number
TIN: Tax Identification Number

DEFINITIONS

NOTE: For the purposes of this CMS-855B application, the following definitions apply:

- **Add:** You are adding additional enrollment information to your existing information (e.g. practice locations).
- **Change:** You are replacing existing information with new information (e.g. billing agency, managing employee) or updating existing information (e.g. change in suite #, telephone #).
- **Remove:** You are removing existing enrollment information.

WHERE TO MAIL YOUR APPLICATION

Send this completed application with original signatures and all required documentation to your designated MAC. The MAC that services your State is responsible for processing your enrollment application. To locate the mailing address for your designated MAC, go to **www.cms.gov/MedicareProviderSupEnroll**.

SECTION 1: BASIC INFORMATION

ALL APPLICANTS MUST COMPLETE THIS SECTION

A. REASON FOR SUBMITTING THIS APPLICATION

Check one box and complete the required sections of this application as indicated.

You are a new enrollee in Medicare	Complete all applicable sections **Ambulance suppliers** must complete **Attachment 1** **IDTF suppliers** must complete **Attachment 2** **OTPs** must complete **Attachment 3**
You are enrolling with another Medicare Administrative Contractor (MAC)	Complete all applicable sections **Ambulance suppliers** must complete **Attachment 1** **IDTF suppliers** must complete **Attachment 2** **OTPs** must complete **Attachment 3**
You are revalidating your Medicare enrollment	Complete all applicable sections **Ambulance suppliers** must complete **Attachment 1** **IDTF suppliers** must complete **Attachment 2** **OTPs** must complete **Attachment 3**
You are reactivating your Medicare enrollment	Complete all applicable sections **Ambulance suppliers** must complete **Attachment 1** **IDTF suppliers** must complete **Attachment 2** **OTPs** must complete **Attachment 3**
You are reporting a change to your Medicare enrollment information	Go to section 1B below
You are voluntarily terminating your Medicare enrollment Effective date of termination *(mm/dd/yyyy)*: _____ Medicare Identification Number: _____	Section 1, 2A1, 13 (optional), and 15 Employers terminating Physician Assistants must complete sections 1, 2A1, 2F, 13 (optional), and 15

SECTION 1: BASIC INFORMATION *(Continued)*

B. WHAT INFORMATION IS CHANGING?

Check all that apply and complete the required sections.

Please note: When reporting ANY information, sections **1, 2A1, 3, and 15** MUST always be completed in addition to the information that is changing within the required section.

Changing Information	Required Sections
Business Identifying Information	**1, 2A1, 3, 12, 13 (optional)** and **15** and **6** for the signer if that authorized or delegated official has not been established for this supplier
Final Adverse Legal Actions	**1, 2A1, 3, 12, 13 (optional)** and **15** and **6** for the signer if that authorized or delegated official has not been established for this supplier
Medical Specialty Information	**1, 2A, 2B, 3, 4, 12, 13 (optional)**, and **15** and **6** for the signer if that authorized or delegated official has not been established for this supplier
Supplier Specific Information	**1, 2A1, 2A2-2A4, 2B–2F (as applicable)**, **3**, **12,13 (optional)**, and **15** and **6** for the signer if that authorized or delegated official has not been established for this supplier
Physician Assistant Employment Terminations	**1, 2A1, 2F, 3, 13 (optional)** and **15** and **6** for the signer if that authorized or delegated official has not been established for this supplier
Private Practice Business Information	**1, 2A, 3, 4A, 12, 13 (optional)** and **15** and **6** for the signer if that authorized or delegated official has not been established for this supplier
Change of Ownership (Hospitals, Hospital Departments, Portable X-Ray Suppliers and Ambulatory Surgical Centers Only)	**Complete all sections and provide a copy of the sales agreement**
Ownership Interest and/or Managing Control Information (Organizations)	**1, 2A1, 3, 5, 13,** and **15**, and **6** for the signer if that authorized or delegated official has not been established for this supplier
Ownership Interest and/or Managing Control Information (Individuals)	**1, 2A1, 3, 6, 13, and 15**, and another **6** for the signer if that authorized or delegated official has not been established for this supplier
Managing Employee Information	**1, 2A1, 3, 6, 12, 13 (optional)**, and **15** and **6** for the signer if that authorized or delegated official has not been established for this supplier

SECTION 1: BASIC INFORMATION *(Continued)*

Changing Information	Required Sections
Address Information Correspondence Mailing Address Medicare Beneficiary Medical Records Storage Address Practice Location Address Remittance Notices/Special Payment Mailing Address Base of Operations Address for Mobile or Portable Suppliers (location of Business Office or Dispatcher/ Scheduler)	**1, 2A, 3, 12, 13 (optional)** and **15 AND sections 2A3, 2A4, 4A, 4B, 4C,** and/or **4E** as applicable for the address that is being changed and 6 for the signer if that authorized or delegated official has not been established for this supplier
Billing Agency Information	**1, 2A1, 3, 8, 13 (optional)** and **15** and 6 for the signer if that authorized or delegated official has not been established for this supplier
Authorized Official(s) and/or Delegated Official(s)	**1, 2A1, 3, 13, 15A1** (if you are an Authorized Official) or **15B1** (if you are a delegated official), and another **6** for the signer if that authorized or delegated official has not been established for this supplier
Any other information not specified above	**1, 2A1, 3, 12 (if applicable), 13 (optional)** and **15** and the applicable section or sub-section that is changing and **6** for the signer if that authorized or delegated official has not been established for this supplier

ATTACHMENT 1: AMBULANCE SERVICE SUPPLIERS (ONLY)

Changing Information	Required Sections
Ambulance Supplier Transport Type	**1, 2A, 3, 12, 13 (optional)** and 15 and **6** for the signer if that authorized or delegated official has not been established for this supplier **Attachment 1(A)**
Geographic Area	**1, 2A, 3, 12, 13 (optional)** and **15** and **6** for the signer if that authorized or delegated official has not been established for this supplier **Attachment 1(B)**
State License Information	**1, 2A, 3, 12, 13 (optional)** and **15** and **6** for the signer if that authorized or delegated official has not been established for this supplier **Attachment 1(C)**
Vehicle Information	1, 2A, 3, 12, 13 (optional) and 15 and 6 for the signer if that authorized or delegated official has not been established for this supplier **Attachment 1(D)**

SECTION 1: BASIC INFORMATION *(Continued)*

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (ONLY)

Changing Information	Required Sections
CPT-4 and HCPCS Codes	**1, 2A, 3, 12, 13 (optional)** and 15 and **6** for the signer if that authorized or delegated official has not been established for this supplier **Attachment 2(B)**
Interpreting Physician Information	**1, 2A, 3, 12, 13 (optional)** and **15** and **6** for the signer if that authorized or delegated official has not been established for this supplier **Attachment 2(C)**
Personnel (Technicians) Who Perform Tests	**1, 2A, 3, 12, 13 (optional)** and **15** and **6** for the signer if that authorized or delegated official has not been established for this supplier **Attachment 2(D)**
Supervising Physicians	1, 2A, 3, 12, 13 (optional) and 15 and 6 for the signer if that authorized or delegated official has not been established for this supplier **Attachment 2(E)**

ATTACHMENT 3: OPIOID TREATMENT PROGRAMS (ONLY)

Changing Information	Required Sections
Opioid Treatment Program Personnel – Ordering Personnel Identification	**1, 2A1, 3, 12, 13 (optional)** and **15** and **6** for the signer if that authorized or delegated official has not been established for this supplier **Attachment 3A**
Opioid Treatment Program Personnel – Dispensing Personnel Identification	**1, 2A1, 3, 12, 13 (optional)** and **15** and **6** for the signer if that authorized or delegated official has not been established for this supplier **Attachment 3B**

SECTION 2: IDENTIFYING INFORMATION

A. SUPPLIER IDENTIFICATION INFORMATION

1. BUSINESS INFORMATION

Legal Business Name as Reported to the Internal Revenue Service	Tax Identification Number (TIN)

Medicare Identification Number (PTAN) *(if issued)*	National Provider Identifier (NPI)

Other Name *(if applicable)*

Type of Other Name *(if applicable).* Check box indicating Type of Other Name:

- Former Legal Business Name
- Doing Business As Name
- Other *(Describe):* _____

Business Structure information
Identify how your business is registered with the IRS. (NOTE: If your business is a Federal and/or State government supplier, indicate "Non-Profit" below. In addition, government-owned entities do not need to provide an IRS Form 501(c)(3)).

- Proprietary
- Non-Profit (Submit IRS Form 501(c)(3)
- Disregarded Entity (Submit IRS Form 8832)

NOTE: If a checkbox identifying how the business is registered with the IRS is not completed, the supplier will be defaulted to "Proprietary."

Identify the type of organizational structure of this supplier: *(Check one)*

- Corporation
- Limited Liability Company
- Partnership
- Sole Proprietor
- Other *(Specify):* _____

Is this supplier an Indian Health Service (IHS) Facility? ..... Yes No

2. LICENSE/CERTIFICATION/REGISTRATION INFORMATION

Complete the appropriate subsection(s) below for your supplier type as you will report in section 2B. If no subsection is associated with your supplier type, check the box stating the information is not applicable.

a. Active License Information

- License Not Applicable

License Number	Effective Date (mm/dd/yyyy)	State Where Issued

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

b. Active Certification Information

Complete the appropriate subsection(s) below for your supplier type as you will report in section 2B. If no subsection is associated with your supplier type, check the box stating the information is not applicable. ***If you are certified by a national entity, put the word "all" in the "State Where Issued" data field.**

Certification Not Applicable

Certification Number	Effective Date (mm/dd/yyyy)	State Where Issued*

Certifying Entity (Specialty Board, State, Other)

3. CORRESPONDENCE MAILING ADDRESS

This is the address where correspondence will be sent to the supplier listed in section 2A1 by your designated MAC. This address cannot be a billing agent or agency's address or a medical management company address.

If you are reporting a change to your Correspondence Mailing Address, check the box below. This will replace any current Correspondence Mailing Address on file.

Change **Effective Date** *(mm/dd/yyyy)*: _____

Attention *(optional)*

Correspondence Mailing Address Line 1 *(P.O. Box or Street Name and Number)*

Correspondence Mailing Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number *(if applicable)*	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

4. MEDICAL RECORD CORRESPONDENCE ADDRESS

This is the address where the medical record correspondence will be sent to the supplier listed in section 2A1 by your designated MAC. This information would be used for any medical record review requests.

Check here if your Medical Record Correspondence Address should be mailed to your Correspondence Address in section 2A3 (above) and skip this section.

If you are reporting a change to your Medical Record Correspondence Address, check the box below. This will replace any current Medical Record Correspondence Address on file.

Change **Effective Date** *(mm/dd/yyyy)*: _____

Attention *(optional)*

Medical Record Correspondence Mailing Address Line 1 *(P.O. Box or Street Name and Number)*

Medical Record Correspondence Mailing Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number *(if applicable)*	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

B. TYPE OF SUPPLIER

Check the appropriate box to identify the type of supplier you are enrolling as with Medicare. If you are more than one type of supplier, submit a separate application for each type. If you change the type of service that you provide (i.e., become a different supplier type), submit a new application.

Your organization must meet all Federal and State requirements for the type of supplier checked below.

Type of Supplier: *(Check one only)*

- Ambulance Service Supplier
- Ambulatory Surgical Center
- Clinic/Group Practice
- Hospital Department(s)
- Independent Clinical Laboratory
- Independent Diagnostic Testing Facility
- Intensive Cardiac Rehabilitation
- Mammography Center
- Mass Immunization (Roster Biller Only)
- Opioid Treatment Program
- Pharmacy
- Physical/Occupational Therapy Group in Private Practice
- Portable X-ray Supplier
- Radiation Therapy Center
- Other *(Specify)*: _____

Note: Only use "other" checkbox if your supplier type is eligible to enroll and bill the Medicare program but is not reflected in the list of suppliers. If you are unsure if you are eligible to enroll contact your designated MAC before you submit this application.

C. HOSPITALS ONLY

This section should only be completed by hospitals that are currently enrolled or enrolling with a MAC (the Part A Medicare contractor), and will be billing a MAC for Medicare Part B services, as follows:

- Hospitals requiring a Part B billing number to provide pathology services.
- Hospitals requiring a Medicare Part B billing number to provide purchased tests to other Medicare Part B billers.
- If the hospital requires more than one departmental Part B billing number to bill for Part B practitioner services, list each department needing a number.

If your organization is not a hospital, and believes it will need a Part B billing number, contact the designated MAC to determine if this form should be submitted.

NOTE: Only complete this section if the clinic/hospital department is located within the hospital. If your hospital is enrolling a clinic that is not located within the hospital, do not complete this section.

Check "Clinic/Group Practice" in section 2B and complete this entire application for the clinic/group practice.

1. Are you going to:

   bill for the entire hospital with one billing number? (If yes, continue to section 2D.)

   separately bill for each hospital department? (If yes, answer question 2.)

2. List the hospital departments for which you plan to bill separately:

DEPARTMENT	MEDICARE IDENTIFICATION NUMBER	NPI

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

D. PHYSICAL THERAPY (PT) AND OCCUPATIONAL THERAPY (OT) GROUPS ONLY

1. Does this group ONLY render PT/OT services in patients' homes? ..... Yes No
2. Does this group maintain private office space? ..... Yes No
3. Does this group own, lease, or rent its private office space? ..... Yes No
4. Is this private office space used exclusively for the group's private practice? ..... Yes No
5. Does this group provide PT/OT services outside of its office and/or patients' homes? ..... Yes No

If you responded YES to questions 2, 3, or 4 above, you must have and attach a copy of any written agreement that gives the group exclusive use of the office space for PT/OT services.

E. ACCREDITATION FOR AMBULATORY SURGICAL CENTERS (ASCs) ONLY

NOTE: Copy and complete this section if more than one accreditation needs to be reported.

Check one of the following and furnish any additional information as requested:

The enrolling ASC supplier is accredited.

The enrolling ASC supplier is not accredited (includes exempt suppliers).

Name of Accrediting Organization	
Effective Date of Current Accreditation *(mm/dd/yyyy)*	Expiration of Current Accreditation *(mm/dd/yyyy)*

F. EMPLOYER TERMINATING EMPLOYMENT ARRANGEMENT WITH ONE OR MORE PHYSICIAN ASSISTANTS

Complete this section if you are a health care provider corporation and you are discontinuing the employment arrangement of a PA(s). Health care provider corporations must also complete section 2A1 with your organizational information.

PA'S NAME	EFFECTIVE DATE OF DEPARTURE	PA'S MEDICARE IDENTIFICATION NUMBER	PA'S NPI

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. FEDERAL AND STATE CONVICTIONS (Conviction as defined in 42 C.F.R. Section 1001.2) WITHIN THE PRECEDING 10 YEARS

1. Any federal or state felony conviction(s) by the provider, supplier, or any owner or managing employee of the provider or supplier.
2. Any crime, under Federal or State law, which received a sentence of deferred adjudication, adjudication withheld, stay of adjudication, withholding of judgment, or order of deferral — regardless of whether the court dismissed the case upon completion of probation, and regardless of whether the felony was reduced to a misdemeanor.
3. 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.
4. 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.
5. Any misdemeanor conviction, under federal or state law, related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.
6. 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.

B. EXCLUSIONS, REVOCATIONS OR SUSPENSIONS

1. Any current or past revocation, suspension, or voluntary surrender of a medical license in lieu of further disciplinary action.
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 (A penalty imposed by a Federal governing body (e.g. Civil Monetary Penalties (CMP)).
6. Any Medicaid exclusion, enrollment suspension, payment suspension, revocation, or termination of any billing number.

C. FINAL ADVERSE LEGAL ACTION HISTORY

1. Has your organization, under any current or former name or business identity, ever had a final adverse legal action listed above imposed against it?

   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 4: PRACTICE LOCATION INFORMATION

INSTRUCTIONS

This section captures information about the physical location(s) where you currently provide health care services. If you operate a mobile facility or portable unit, provide the address for the "Base of Operations," as well as vehicle information and the geographic area serviced by these facilities or units.

MOBILE FACILITY AND/OR PORTABLE UNIT

A "mobile facility" is generally a mobile home, trailer, or other large vehicle that has been converted, equipped, and licensed to render health care services. These vehicles usually travel to local shopping centers or community centers to see and treat patients inside the vehicle.

A "portable unit" is when the supplier transports medical equipment to a fixed location (e.g., physician's office, nursing home) to render services to the patient.

The most common types of mobile facilities/portable units are mobile IDTFs, portable X-ray suppliers, portable mammography, and mobile clinics. Physicians and non-physician practitioners (e.g., nurse practitioners, physician assistants) who perform services at multiple locations (e.g., house calls, assisted living facilities) are not considered to be mobile facilities/portable units.

A. PRACTICE LOCATION INFORMATION

Complete this section for each of your practice locations where you render services to Medicare beneficiaries. This includes all locations you will disclose on claims forms for reimbursement. If you have and see patients at more than one private practice location or health care facility, **copy and complete this section for each location**.

All reported practice location addresses must be a specific street address as recorded by the United States Postal Service. Your practice location must be the physical location where you render services to Medicare beneficiaries. Your practice location address cannot be a Post Office (P.O.) Box.

If you render services in a hospital, retirement or assisted living community, and/or other health care facilities, furnish the name, address and telephone number for those facilities.

If you only render services in patients' homes (house calls only), you may supply your home address in this section if you do not have a separate office. In section 4D3 explain that this address is for administrative purposes only and that all services are rendered in patients' homes. You must then also complete section 4D1 as appropriate.

Only report those practice locations that are within the jurisdiction of the designated MAC to which you will be submitting this application. If you have to report practice locations outside the jurisdiction of the designated MAC to which you are submitting this application you must submit a separate CMS-855B Enrollment Application to the MAC that has jurisdiction for those locations. If you are enrolling for the first time, or if you are adding a new practice location, the date you provide should be the date you saw your first Medicare patient at this location.

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

A. PRACTICE LOCATION INFORMATION *(Continued)*

If you are changing information about a currently reported practice location or adding or removing practice location information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

Change **Add** **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

Practice Location Name *("Doing Business As" Name, if applicable)*

Practice Location Street Address Line 1 *(Street Name and Number – NOT a P.O. Box)*

Practice Location Street Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number *(if applicable)*	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

Medicare Identification Number for this location – PTAN *(if issued)*	National Provider Identifier (NPI)

Is this your primary practice location? Yes No	Date you saw or will see your first Medicare patient at this practice location *(mm/dd/yyyy)*

Is your private practice location reported above located in a:

Ambulatory Surgical Center

Group Practice Office/Clinic

Home/Business Office for Administrative Use Only

Hospital or Hospital Department

Indian Health Services (IHS) or Tribal Facility Community

Retirement or Assisted Living

Skilled Nursing Facility or Other Nursing Facility

Other Health Care Facility *(Specify)*: _____

CLIA Number for this location *(if applicable)*

Attach a copy of the most current CLIA certifications for each practice location(s) reported on this application.

FDA/Radiology (Mammography) Certification Number for this location *(if issued)*

Attach a copy of the most current FDA certifications for each practice location(s) reported on this application.

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

B. REMITTANCE NOTICES/SPECIAL PAYMENTS MAILING ADDRESS

Furnish an address where remittance notices and special payments should be sent for services rendered at the practice location(s) reported in section 4A. Please note that payments will be made in your name or, if a business is reported in section 4A, payments will be made in the name of the business.

Medicare will issue all routine payments via electronic funds transfer (EFT). Since payments will be made by EFT, the special payments address below should indicate where all other payment information (e.g., remittance notices, non-routine special payments) should be sent.

Check here if your Remittance Notice/Special Payments should be mailed to your Primary Practice Location Address in section 4A above and skip this section, OR

Check here if your Remittance Notice/Special Payments should be mailed to your Correspondence Address in section 2A3 and skip this section.

If you are reporting a change to your Remittance Notice/Special Payments Mailing Address, check the box below and furnish the effective date.

Change **Effective Date** *(mm/dd/yyyy)*: _____

Special Payments Address Line 1 (P.O. Box or Street Name and Number)		
Special Payments Address Line 2 (Suite, Room, Apt. #, etc.)		
City/Town	State	ZIP Code + 4

C. MEDICARE BENEFICIARY MEDICAL RECORDS STORAGE ADDRESS

If your Medicare beneficiaries' medical records are stored at a location other than the Practice Location Address shown in section 4A complete this section with the name and address of the storage location. This includes the records for both current and former Medicare beneficiaries.

Post office boxes and drop boxes are not acceptable as a physical address where Medicare beneficiaries' records are maintained. The records must be your records and not the records of another practitioner. For IDTFs and mobile facilities/portable units, the patients' medical records must be under the supplier's control. If all records are stored at the Practice Location reported in section 4A, check the box below and skip this section.

Records are stored at the Practice Location reported in section 4A.

If you are adding or removing a storage location, check the applicable box below and furnish the effective date.

Add **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

1. Paper Storage

Name of Storage Facility		
Storage Facility Address Line 1 *(Street Name and Number)*		
Storage Facility Address Line 2 *(Suite, Room, Apt. #, etc.)*		
City/Town	State	ZIP Code + 4

2. Electronic Storage

Do you store your patient medical records electronically? ..... YES NO

If yes, identify where/how these records are stored below. This can be a website, URL, in-house software program, online service, vendor, etc. This must be an electronic storage site that can be accessed by CMS or its designees if necessary.

Site where electronic records are stored

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

D. RENDERING SERVICES IN PATIENTS' HOMES

List the city/town, county, state/territory, or ZIP code for all locations where you render health care services in patients' homes or, if previously reported, where you no longer render health care services in patients' homes.

If you provide health care services in more than one state/territory and those states/territories are serviced by different MACs, complete a separate CMS-855B enrollment application for each MAC's jurisdiction.

1. Initial Reporting and/or Additions
If you are reporting or adding an entire state/territory, check the box below and specify the state/territory.

Entire State/Territory of _____

If services are only provided in selected cities/towns or counties, provide the locations below. Only list ZIP codes if you are not servicing the entire city/town or county.

CITY/TOWN	COUNTY	STATE/ TERRITORY	ZIP CODE

2. Deletions
If you are deleting an entire state/territory, check the box below and specify the state/territory.

Entire State/Territory of _____

If services are no longer provided in selected cities/towns or counties, provide the locations below. Only list ZIP codes if you are not deleting service in the entire city/town or county.

CITY/TOWN	COUNTY	STATE/ TERRITORY	ZIP CODE

3. Comments/Special Circumstances
Explain any unique circumstances concerning your practice location(s) or the method by which you render health care services (e.g., practice on certain days of the week).

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

E. Base of Operations Address for Mobile or Portable Suppliers (Location of Business Office or Dispatcher/ Scheduler)

The base of operations is the location from where personnel are dispatched, where mobile/portable equipment is stored, and when applicable, where vehicles are parked when not in use.

NOTE: When necessary to report more than one base of operations, copy and complete this section for each base of operations.

If you are changing information about currently reported information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section

Change **Add** **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

Check here and skip to section 4F if the "Base of Operations" address is the same as the "Practice Location" listed in section 4A.

Base of Operations Street Address Line 1 *(Street Name and Number)*		
Base of Operations Street Address Line 2 *(Suite, Room, etc.)*		
City/Town	State	ZIP Code + 4
Telephone Number *(if applicable)*	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

F. Vehicle Information

If the mobile health care services are rendered inside a vehicle, such as a mobile home or trailer, furnish the following vehicle information below. Do not provide information about vehicles that are used only to transport medical equipment (e.g., when the equipment is transported in a van but is used in a fixed setting, such as a doctor's office) or ambulance vehicles. If more than four vehicles are used, copy and complete this section as needed.

For each vehicle, submit a copy of all health care related permits/licenses/registrations.

If you are adding or removing information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE FOR EACH VEHICLE	TYPE OF VEHICLE *(van, mobile home, trailer, etc.)*	VEHICLE IDENTIFICATION NUMBER
ADD REMOVE Effective Date *(mm/dd/yyyy):*		
ADD REMOVE Effective Date *(mm/dd/yyyy):*		
ADD REMOVE Effective Date *(mm/dd/yyyy):*		
ADD REMOVE Effective Date *(mm/dd/yyyy):*		

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

G. Geographic Location for Mobile OR Portable Suppliers Where the Base of Operations and/or Vehicle Renders Services

Provide the city/town, county, state/territory, and zip code for all locations where mobile and/or portable services are rendered.

NOTE: If you provide mobile or portable health care services in more than one state/territory and those states/territories are serviced by different MACs, complete a separate CMS-855B enrollment application for each MAC's jurisdiction.

1. Initial Reporting and/or Additions

If you are reporting or adding an entire state/territory, check the box below and specify the state/territory.

Entire State/Territory of _____

If services are only provided in selected cities/towns or counties, provide the locations below. Only list ZIP codes if you are not servicing the entire city/town or county.

CITY/TOWN	COUNTY	STATE/ TERRITORY	ZIP CODE

2. Deletions

If you are deleting an entire state/territory, check the box below and specify the state/territory.

Entire State/Territory of _____

If services are no longer provided in selected cities/towns or counties, provide the locations below. Only list ZIP codes if you are not deleting service in the entire city/town or county.

CITY/TOWN	COUNTY	STATE/ TERRITORY	ZIP CODE

SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS)

NOTE: Only report organizations in this section. Individuals must be reported in section 6.

Complete this section with information about all organizations that have 5 percent or more (direct or indirect) ownership interest of, any partnership interest in, and/or managing control of, the supplier identified in Section 2, as well as information on any adverse legal actions that have been imposed against that organization. For examples of organizations that should be reported here, visit our Web site: **www.cms.hhs.gov/MedicareProviderSupEnroll**. If there is more than one organization that should be reported, copy and complete this section for each.

NOTE: It is not necessary for the organization reported in 2A1 to report itself in this section.

The supplier must submit an organizational structure diagram/flowchart identifying all the entities listed in section 5 and their relationships with the supplier and each other.

MANAGING CONTROL (ORGANIZATIONS)

Any organization that exercises operational or managerial control over the supplier, or conducts the day-to-day operations of the supplier, is a managing organization and must be reported. The organization need not have an ownership interest in the supplier in order to qualify as a managing organization.

Report the entity under the role of "managing control" if, for instance, an entity:

a. has direct responsibility for the performance of your organization AND

b. is capable of changing the leadership, allocation of resources, or other processes of your organization to improve performance.

Suppliers should also report any managing relationship with a management services organization under contract with the supplier to furnish management services for the business.

Faculty practice plans, university-based health systems, hospital outpatient departments, medical foundations, and groups that primarily treat enrollees of group model HMOs should review this definition of managing control (organizations) carefully to determine if it applies

SPECIAL TYPES OF ORGANIZATIONS

Governmental/Tribal Organizations
If a federal, state, county, city or other level of government, or an Indian tribe, will be legally and financially responsible for Medicare payments received (including any potential overpayments), the name of that government or Indian tribe should be reported as an owner. The supplier must submit a letter on the letterhead of the responsible government (e.g., government agency) or tribal organization that attests that the government or tribal organization will be legally and financially responsible in the event that there is any outstanding debt owed to CMS. This letter must be signed by an appointed or elected official of the government or tribal organization who has the authority to legally and financially bind the government or tribal organization to the laws, regulations, and program instructions of the Medicare program.

Non-Profit, Charitable and Religious Organizations
Many non-profit organizations are charitable or religious in nature, and are operated and/or managed by a board of trustees or other governing body. The actual name of the board of trustees or other governing body should be reported in this section. While the organization should be listed in section 5, individual board members should be listed in section 6. Each non-profit organization should submit a copy of a 501(c)(3) document verifying its non-profit status.

SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS) *(Continued)*

NOTE: All organizations that complete this section must also complete section 5B.

All organizations that have any of the following must be reported in section 5:

- 5 percent or more ownership of the supplier,
- Managing control of the supplier, or
- A partnership interest in the supplier, regardless of the percentage of ownership the partner has.
- A management services organization under contract with the supplier to furnish management services for the business

Owning/Managing organizations are generally one of the following types:

- Corporations (including non-profit corporations)
- Partnerships and Limited Partnerships (as indicated above)
- Limited Liability Companies
- Charitable and/or Religious organizations
- Governmental and/or Tribal organizations

A. ORGANIZATION WITH OWNERSHIP INTEREST AND/OR MANAGING CONTROL—IDENTIFICATION INFORMATION

Not Applicable

If you are changing information about your current ownership interest and/or managing control information for this organization, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

Change **Add** **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

Check all that apply:

5 Percent or More Ownership Interest Partner Managing Control

Legal Business Name as Reported to the Internal Revenue Service

"Doing Business As" Name *(if applicable)*

Address Line 1 *(Street Name and Number)*

Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number *(if applicable)*	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

National Provider Identifier (NPI)	Tax Identification Number *(Required)*	Medicare Identification Number for this location – PTAN *(if issued)*

What is the effective date this owner acquired ownership of the supplier identified in section 2A1 of this application? *(mm/dd/yyyy)*

What is the effective date this organization acquired managing control of the supplier identified in section 2A1 of this application? *(mm/dd/yyyy)*

NOTE: Furnish both dates if applicable.

SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS) *(Continued)*

B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for the organization reported in section 5A above. If you need additional information regarding what to report, please refer to section 3 of this application.

NOTE: If reporting more than one organization, copy and complete sections 5A and 5B for each organization reported.

1. Has this organization in section 5A above, under any current or former name or business identity, ever had a final adverse legal action listed in section 3 of this application imposed against it?

   YES – continue below **NO** – skip to section 6

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.

NOTE: To satisfy the reporting requirement, section 5B2 must be filled out in its entirety, and all applicable attachments must be included.

FINAL ADVERSE LEGAL ACTION	DATE	ACTION TAKEN BY

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS)

NOTE: Only report individuals in this section. Organizations must be reported in section 5.

NOTE: A supplier MUST have at least ONE organizational or individual owner, ONE managing employee and ONE Authorized Official. In addition, all Authorized Officials and/or Delegated Officials must complete this section, as well as the individuals listed below.

The following individuals must be reported in section 6A:

- All persons who have a 5 percent or greater direct or indirect ownership interest in the supplier (For more information on "direct" and "indirect" owners, go to **www.cms.hhs.gov/MedicareProviderSupEnroll**.);
- If (and only if) the supplier is a corporation (whether for-profit or non-profit), all officers and directors of the supplier;
- All managing employees of the supplier;
- All individuals with a partnership interest in the supplier, regardless of the percentage of ownership the partner has; and
- Authorized and delegated officials. All Authorized Officials must identify one other relationship of 5% or greater direct/indirect owner, Partner or Director/Officer. All Delegated Officials must identify one other relationship but can select managing employee as other relationship. **NOTE:** If you need additional information regarding who to report, please refer to section 15 of this application.

Example: A supplier is 100 percent owned by Company C, which itself is 100 percent owned by Individual D. Assume that Company C is reported in section 5A as an owner of the supplier. Assume further that Individual D, as an indirect owner of the supplier, is reported in section 6A. Based on this example, the supplier would check the "5 percent or Greater Direct/Indirect Owner" box in section 6A.

NOTE: All partners within a partnership must be reported on this application. This applies to both "General" and "Limited" partnerships. For instance, if a limited partnership has several limited partners and each of them only has a 1 percent interest in the supplier, each limited partner must be reported on this application, even though each owns less than 5 percent. The 5 percent threshold primarily applies to corporations and other organizations that are not partnerships.

Non-Profit, Charitable or Religious Organizations: If you are a non-profit charitable or religious organization that has no organizational or individual owners (only board members, directors or managers), you should complete this section and submit a 501(c)(3) document verifying non-profit status with your application.

For purposes of this application, the terms "officer," "director," and "managing employee" are defined as follows:

- **Officer** is any person whose position is listed as being that of an officer in the supplier's "articles of incorporation" or "corporate bylaws," or anyone who is appointed by the board of directors as an officer in accordance with the supplier's corporate bylaws.
- **Director** is a member of the supplier's "board of directors." It does not necessarily include a person who may have the word "director" in his/her job title (e.g., departmental director, director of operations). Moreover, where a supplier has a governing body that does not use the term "board of directors," the members of that governing body will still be considered "directors." Thus, if the supplier has a governing body titled "board of trustees" (as opposed to "board of directors"), the individual trustees are considered "directors" for Medicare enrollment purposes.
- **Managing Employee** means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operations of the supplier, either under contract or through some other arrangement, regardless of whether the individual is a W-2 employee of the supplier.

NOTE: If a governmental or tribal organization will be legally and financially responsible for Medicare payments received (per the instructions for Governmental/Tribal Organizations in section 5), the supplier is only required to report its managing employees in section 6. Owners, partners, officers, and directors do not need to be reported, except those who are listed as authorized or delegated officials on this application.

Any information on final adverse actions that have been imposed against the individuals reported in section 6A must be furnished. If there is more than one individual, copy and complete this section for each individual.

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) *(Continued)*

A. INDIVIDUALS WITH OWNERSHIP INTEREST AND/OR MANAGING CONTROL—IDENTIFICATION INFORMATION

If you are changing information about your current ownership interest and/or managing control information for this individual, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

Change **Add** **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

The name, date of birth, and social security number of each person listed in this section must coincide with the individual's information as listed with the Social Security Administration. IRS issues Individual Tax Identification Numbers (ITINs) to foreign nationals and others who have federal tax reporting or filing requirements and are not eligible to obtain a Social Security Number (SSN) from the Social Security Administration (SSA). Please report your ITIN in this section, if applicable.

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

Title	Date of Birth *(mm/dd/yyyy)*

Social Security Number (SSN) or Individual Tax Identification Number (ITIN)

What is the above individual's relationship with the supplier in section 2A1?

- 5 Percent or Greater Direct/Indirect Owner
- Authorized Official
- Delegated Official
- Partner
- Director/Officer
- Contracted Managing Employee
- W-2 Managing Employee

What is the effective date this owner acquired ownership of the supplier identified in section 2A1 of this application? *(mm/dd/yyyy)* _____

What is the effective date this individual acquired managing control of the supplier identified in section 2A1 of this application? *(mm/dd/yyyy)* _____

NOTE: Furnish both dates if applicable.

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) *(Continued)*

B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for the individual reported in section 6A above. If you need additional information regarding what to report, please refer to section 3 of this application.

NOTE: If reporting more than one individual, copy and complete sections 6A and 6B for each individual reported.

1. Has the individual in section 6A above, under any current or former name or business identity, ever had a final adverse legal action listed in section 3 of this application imposed against him/her?

   YES – continue below **NO** – skip to section 8

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.

NOTE: To satisfy the reporting requirement, section 6B2 must be filled out in its entirety, and all applicable attachments must be included.

FINAL ADVERSE LEGAL ACTION	DATE	ACTION TAKEN BY

SECTION 7: THIS SECTION INTENTIONALLY LEFT BLANK

SECTION 8: BILLING AGENCY/AGENT INFORMATION

A billing agency/agent is a company or individual that you contract with to prepare and submit your claims. If you use a billing agency/agent you must complete this section. Even if you use a billing agency/agent, you remain responsible for the accuracy of the claims submitted on your behalf.

NOTE: The billing agency/agent address cannot be the correspondence mailing address completed in section 2A3 of this application.

Check here if this section does not apply and skip to section 12.

If you are changing information about your current billing agency/agent or adding or removing billing agency/agent information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

Change **Add** **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

BILLING AGENCY/AGENT NAME AND ADDRESS

Legal Business as reported to the Internal Revenue Service or Individual Name as Reported to the Social Security Administration

If Billing Agent: Date of Birth *(mm/dd/yyyy)*

Billing Agency Tax Identification Number or Billing Agent Social Security Number *(required)*

Billing Agency/Agent "Doing Business As" Name *(if applicable)*

Billing Agency/Agent Address Line 1 *(Street Name and Number)*

Billing Agency/Agent Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town		State	ZIP Code + 4
Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*	

SECTION 9: THIS SECTION INTENTIONALLY LEFT BLANK

SECTION 10: THIS SECTION INTENTIONALLY LEFT BLANK

SECTION 11: THIS SECTION INTENTIONALLY LEFT BLANK

SECTION 12: SUPPORTING DOCUMENTATION INFORMATION

This section lists the documents that, if applicable, must be submitted with this completed enrollment application. If you are enrolling for the first time, or reactivating or revalidating your enrollment you must submit applicable documents. When reporting a change of information, only submit documents that apply to the change reported. Your designated Medicare Administrative Contractor (MAC) may request, at any time during the enrollment process, documentation to support or validate information reported on this application. In addition, your designated MAC may also request documents from you other than those identified in this section as are necessary to ensure correct billing of Medicare.

Completed Form CMS-855R, Individual Reassignment of Medicare Benefits, for the individual practitioner(s) if you will be submitting claims and receiving payments for the individual practitioner(s) who will be rendering services as part of your group/clinic or other health care organization. A CMS-855I is necessary if the individual practitioner does not have a current Medicare enrollment in the state.

Copy(s) of all final adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters).

Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement.

NOTE: The CMS-460 must be submitted for all initial enrollments or reactivations only if you want to be a participating supplier in Medicare.

Completed Form CMS-588, Electronic Funds Transfer Authorization Agreement. Include a voided check or bank letter.

NOTE: If you currently receive payments electronically and are not making a change to your banking information, the CMS-588 is not required.

If Medicare payments due to you are being sent to a bank (or similar financial institution) where you have a lending relationship (that is, any type of loan), you 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.

Written confirmation from the IRS confirming your Tax Identification Number and Legal Business Name provided in section 2A (e.g., IRS form CP-575).

NOTE: This information is needed if the applicant is enrolling their professional corporation, professional association, or limited liability corporation with this application or enrolling as a sole proprietor using an Employer Identification Number.

Written confirmation from the IRS if your business is registered as a Limited Liability Company (LLC), including single member LLCs, confirming your LLC is automatically classified as a Disregarded Entity (e.g., IRS Form 8832).

NOTE: A Disregarded Entity is an eligible entity that is not treated as a separate entity from its single owner for income tax purposes.

Copy of IRS Determination Letter if you are registered with the IRS as non-profit (e.g., IRS Form 501(c)(3)).

NOTE: Government-owned entities do not need to provide an IRS Form 501(c)(3).

The provider must submit an organizational structure diagram/flowchart identifying all of the entities listed in section 5 and their relationships with the provider and each other.

Copy of an attestation for government entities and tribal organizations.

Copy of all ambulances' licenses (NOTE: required for all application submissions, including a change of information).

Copy of all mobile vehicle registrations (all mobile services including ambulance vehicles).

Copy of FAA 135 Certificate (air ambulance suppliers).

Copy(s) of comprehensive liability insurance policy (IDTFs only).

Copy(s) of all documentation verifying IDTF Supervisory Physician(s) proficiency and/or state licenses or certifications for IDTF non-physician personnel.

Copy(s) of all documentation verifying the state licenses or certifications of the laboratory Director or non-physician practitioner personnel of an independent clinical laboratory.

Copy of the Opioid Treatment Program approval letter.

Copy of the Opioid Treatment Program's operating certificate.

SECTION 13: CONTACT PERSON INFORMATION *(Optional)*

If questions arise during the processing of this application, your designated MAC will contact the individual reported below.

Change **Add** **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

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

Contact Person Address Line 1 *(Street Name and Number)*

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

City/Town	State	ZIP Code + 4

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

NOTE: The Contact Person listed in this section will only be authorized to discuss issues concerning this or any other enrollment application. Your designated MAC will not discuss any other Medicare issues about you with the above Contact Person.

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION ON THIS APPLICATION

This section explains the penalties for deliberately furnishing false information in this application to gain or maintain enrollment in the Medicare program.

1. 18 U.S.C. section 1001 authorizes criminal penalties against an individual who, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious, or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000 (18 U.S.C. section 3571). Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.
2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against any individual who, "knowingly and willfully," makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a federal health care program. The offender is subject to fines of up to $25,000 and/or imprisonment for up to five years.
3. The Civil False Claims Act, 31 U.S.C. Section 3729, imposes civil liability, in part, on any person who, with actual knowledge, deliberate ignorance or reckless disregard of truth or falsity (a) presents or causes to be presented to the United States Government or its contractor or agent a false or fraudulent claim for payment or approval; (b) uses or causes to be used a false record or statement material either to a false or fraudulent claim or to an obligation to pay the Government; (c) conceals or improperly avoids or decreases an obligation to pay or transmit money or property to the Government; or (d) conspires to violate any provision of the False Claims Act. The False Claims Act imposes a civil penalty of between $5,000 and $10,000 per violation, as adjusted for inflation by the Federal Civil Penalties Inflation Adjustment Act, 28 U.S.C. 2461, plus three times the amount of damages sustained by the Government.
4. Section 1128A(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any state agency…a claim…that the Secretary determines is for a medical or other item or service that the person knows or should know:

   a. was not provided as claimed; and/or

   b. the claim is false or fraudulent.

   This provision authorizes a civil monetary penalty of up to $10,000 for each item or service, an assessment of up to three times the amount claimed, and exclusion from participation in the Medicare program and state health care programs.
5. 18 U.S.C. 1035 authorizes criminal penalties against individuals in any matter involving a health care benefit program who knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact; or makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items or services. The individual shall be fined or imprisoned up to 5 years or both.
6. 18 U.S.C. 1347 authorizes criminal penalties against individuals who knowing and willfully execute, or attempt, to execute a scheme or artifice to defraud any health care benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by or under the control of any, health care benefit program in connection with the delivery of or payment for health care benefits, items, or services. Individuals shall be fined or imprisoned up to 10 years or both. If the violation results in serious bodily injury, an individual will be fined or imprisoned up to 20 years, or both. If the violation results in death, the individual shall be fined or imprisoned for any term of years or for life, or both.
7. The United States Government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment." Remedies include compensatory and punitive damages, restitution, and recovery of the amount of the unjust profit.

SECTION 15: CERTIFICATION STATEMENT

An **Authorized Official** is defined as an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program.

A **Delegated Official** is defined as an individual who is delegated by an authorized official the authority to report changes and updates to the supplier's enrollment record. A delegated official must be an individual with an "ownership or control interest" in (as that term is defined in section 1124(a)(3) of the Social Security Act), or be a W-2 managing employee of the supplier.

Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the supplier's Medicare status. Even when delegated officials are reported in this application, an authorized official retains the authority to make any such changes and/or updates by providing his or her printed name, signature, and date of signature as required in section 15B.

NOTE: Authorized officials and delegated officials must be reported in section 6, either on this application or on a previous application to this same MAC. If this is the first time an authorized and/or delegated official has been reported on the CMS-855B, you must complete section 6 for that individual and that individual must sign section 15.

By his/her signature(s), an authorized official binds the supplier to all of the requirements listed in the Certification Statement and acknowledges that the supplier may be denied entry to or revoked from the Medicare program if any requirements are not met.

Only an authorized official has the authority to sign (1) the initial enrollment application on behalf of the supplier and (2) add or remove additional authorized officials and delegated officials. Once the delegation of authority has been established all other enrollment application submissions can be signed by either an authorized official or delegated official.

By signing this application, an authorized official agrees to immediately notify the MAC if any information furnished on this application is not true, correct, or complete. In addition, an authorized official, by his/her signature, agrees to notify the MAC of any future changes to the information contained in this form, after the supplier is enrolled in Medicare, in accordance with the timeframes established in 42 C.F.R. 424.516. (IDTF changes of information must be reported in accordance with 42 C.F.R. 410.33.)

The supplier can have as many authorized officials as it wants. If the supplier has more than two authorized officials, it should copy and complete this section as needed.

EACH AUTHORIZED AND DELEGATED OFFICIAL MUST HAVE AND DISCLOSE HIS/HER SOCIAL SECURITY NUMBER.

SECTION 15: CERTIFICATION STATEMENT *(Continued)*

A. Additional Requirements for Medicare Enrollment for Authorized Officials

These are additional requirements that the supplier must meet and maintain in order to bill the Medicare program. Read these requirements carefully. By signing, the supplier is attesting to having read the requirements and understanding them.

By his/her signature(s), the authorized official(s) named below and the delegated official(s) named in section 15D agree to adhere to the following requirements stated in this Certification Statement:

1. I authorize the Medicare contractor to verify the information contained herein. I agree to notify the Medicare contractor of any future changes to the information contained in this application in accordance with the timeframes established in 42 C.F.R. section 424.516. I understand that any change in the business structure of this supplier may require the submission of a new application.
2. 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 form, may be punished 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.
3. I agree to abide by the Medicare laws, regulations and program instructions that apply to me or to the organization listed in section 2A1 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)).
4. Neither this supplier, nor any five percent or greater owner, partner, officer, director, managing employee, authorized official, or delegated official thereof is currently sanctioned, suspended, debarred, or excluded by the Medicare or State Health Care Program, e.g., Medicaid program, or any other Federal program, or is otherwise prohibited from supplying services to Medicare or other Federal program beneficiaries.
5. I agree that any existing or future overpayment made to the supplier by the Medicare program may be recouped by Medicare through the withholding of future payments.
6. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and I will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.
7. I authorize any national accrediting body whose standards are recognized by the Secretary as meeting the Medicare program participation requirements, to release to any authorized representative, employee, or agent of the Centers for Medicare & Medicaid Services (CMS), a copy of my most recent accreditation survey, together with any information related to the survey that CMS may require (including corrective action plans).

SECTION 15: CERTIFICATION STATEMENT *(Continued)*

B. AUTHORIZED OFFICIAL SIGNATURE(S)

1. 1ST AUTHORIZED OFFICIAL SIGNATURE

I have read the contents of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete and I authorize the MAC to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the MAC of this fact in accordance with the time frames established in 42 C.F.R. section 424.516.

If you are adding or removing an authorized official, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

Add **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

Authorized Official's Information and Signature

First Name	Middle Initial	Last Name	*Jr., Sr., M.D., etc.*
Telephone Number	Title/Position		
Authorized Official 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.

2. 2ND AUTHORIZED OFFICIAL SIGNATURE *(if applicable)*

I have read the contents of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete and I authorize the MAC to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the MAC of this fact in accordance with the time frames established in 42 C.F.R. section 424.516.

If you are adding or removing an authorized official, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

Add **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

Authorized Official's Information and Signature

First Name	Middle Initial	Last Name	*Jr., Sr., M.D., etc.*
Telephone Number	Title/Position		
Authorized Official 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.

SECTION 15: CERTIFICATION STATEMENT *(Continued)*

C. ADDITIONAL REQUIREMENTS FOR MEDICARE ENROLLMENT FOR DELEGATED OFFICIALS

NOTE: Delegated Officials are optional.

1. You are not required to have a delegated official. However, if no delegated official is assigned, the authorized official(s) will be the only person(s) who can make changes and/or updates to the supplier's status in the Medicare program.
2. The signature of a delegated official shall have the same force and effect as that of an authorized official, and shall legally and financially bind the supplier to the laws, regulations, and program instructions of the Medicare program. By his or her signature, the delegated official certifies that he or she has read the Certification Statement in section 15 and agrees to adhere to all of the stated requirements. A delegated official also certifies that he/she meets the definition of a delegated official. When making changes and/or updates to the supplier's enrollment information maintained by the Medicare program, a delegated official certifies that the information provided is true, correct, and complete.
3. Delegated officials being removed do not have to sign or date this application.
4. Independent contractors are not considered "employed" by the supplier, and therefore cannot be delegated officials.
5. The signature(s) of an authorized official in section 15B constitutes a legal delegation of authority to all delegated official(s) assigned in section 15D.
6. If there are more than two individuals, copy and complete this section for each individual.

SECTION 15: CERTIFICATION STATEMENT *(Continued)*

D. DELEGATED OFFICIAL SIGNATURE(S)

1. 1ST DELEGATED OFFICIAL SIGNATURE

If you are adding or removing a delegated official, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

Add **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

Delegated Official's Information and Signature

Delegated Official First Name	Middle Initial	Last Name	*Jr., Sr., M.D., etc.*
Delegated Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*			Date Signed *(mm/dd/yyyy)*
Check here if Delegated Official is a W-2 Employee		Telephone Number	
Authorized Official's Signature Assigning this Delegation *(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.

2. 2ND DELEGATED OFFICIAL SIGNATURE

If you are adding or removing a delegated official, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

Add **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

Delegated Official's Information and Signature

Delegated Official First Name	Middle Initial	Last Name	*Jr., Sr., M.D., etc.*
Delegated Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*			Date Signed *(mm/dd/yyyy)*
Check here if Delegated Official is a W-2 Employee		Telephone Number	
Authorized Official's Signature Assigning this Delegation *(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.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1377. The time required to complete this information collection is estimated to 0.5 to 3 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

DO NOT MAIL APPLICATIONS TO THIS ADDRESS. Mailing your application to this address will significantly delay application processing.

ATTACHMENT 1: AMBULANCE SERVICE SUPPLIERS

All ambulance service suppliers enrolling in the Medicare program must complete this attachment.

A. AMBULANCE SUPPLIER TRANSPORT TYPE

This section is to be completed to indicate which ambulance service(s) you intend to provide.

If you are reporting a change to your ambulance supplier transport type, check the box below. **This will replace any ambulance supplier transport type currently on file.**

Change **Effective Date** *(mm/dd/yyyy)*: _____

Are you enrolling as a:

Non-Emergency Ambulance

Emergency Ambulance

Both a Non-Emergency Ambulance and an Emergency Ambulance.

B. GEOGRAPHIC AREA

This section is to be completed with information about the geographic area in which this company provides ambulance services.

If you are changing, adding, or removing information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

Change **Add** **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

Provide the city/town, and/or county, state/territory, and ZIP code for all locations where this ambulance company renders services.

NOTE: If the ambulance company has vehicles garaged within a different Medicare contractor's jurisdiction, a separate CMS-855B enrollment application must be submitted to that Medicare Administrative Contractor (MAC).

1. Initial Reporting and/or Additions
If services are provided in selected cities/towns, and/or counties, provide the locations below. List ZIP codes only if they are not within the entire city/town.

CITY/TOWN	COUNTY	STATE/ TERRITORY	ZIP CODE

2. Deletions
If services are no longer provided in selected cities/towns, and/or counties, provide the locations below. List ZIP codes only if they are not within the entire city/town.

CITY/TOWN	COUNTY	STATE/ TERRITORY	ZIP CODE

ATTACHMENT 1: AMBULANCE SERVICE SUPPLIERS *(Continued)*

C. STATE LICENSE INFORMATION

If you are changing, adding, or removing information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

Change **Add** **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

Crew members must complete continuing education requirements in accordance with state and local licensing laws. Evidence of re-certification must be retained with the employer in case it is required by the MAC.

Is this ambulance company licensed in the state where services are rendered and billed for? ..... Yes No

If **NO**, explain why:

If **YES**, provide the license information for the state where this ambulance service supplier will be rendering services and billing Medicare. Attach a copy of the current state license.

License Number	Issuing State *(if applicable)*	Issuing City/Town *(if applicable)*

Effective Date *(mm/dd/yyyy)*	Expiration Date *(mm/dd/yyyy)*

ATTACHMENT 1: AMBULANCE SERVICE SUPPLIERS *(Continued)*

D. VEHICLE INFORMATION

Complete this section with information about the vehicles used by this ambulance company and the services they provide. If there is more than one vehicle, copy and complete this section as needed. Attach a copy of each vehicle registration.

To qualify as an air ambulance supplier, it is required that the air ambulance supplier has proof that the enrolling ambulance company, or the company leasing the air ambulance vehicle to the enrolling ambulance company, possesses a valid charter flight license (FAA 135 Certificate) for the aircraft being used as an air ambulance. If the enrolling ambulance company owns the aircraft, the owner's name on the FAA 135 Certificate must be the same as the enrolling ambulance company's name (or the ambulance company owner as reported in sections 5 or 6) in this application. If the enrolling ambulance company leases the aircraft from another company, a copy of the lease agreement must accompany this enrollment application.

If you are changing, adding, or removing information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

Change **Add** **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

Type (automobile, aircraft, boat, etc.)	Vehicle Identification Number	
Make (e.g., Ford)	Model (e.g., 350T)	Year (yyyy)

Does this vehicle provide:

Advanced life support (Level 1)	YES	NO
Advanced life support (Level 2)	YES	NO
Basic life support.....	YES	NO
Emergency runs.....	YES	NO
Non-emergency runs	YES	NO
Specialty care transport.....	YES	NO
Land ambulance.....	YES	NO
Air ambulance–fixed wing	YES	NO
Air ambulance–rotary wing.....	YES	NO
Marine ambulance	YES	NO

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (IDTFS)

INDEPENDENT DIAGNOSTIC TESTING FACILITY (IDTF) PERFORMANCE STANDARDS

Below is a list of the performance standards that an IDTF must meet in order to obtain or maintain their Medicare billing privileges. These standards, in their entirety, can be found in 42 C.F.R section 410.33(g).

1. Operate its business in compliance with all applicable Federal and State licensure and regulatory requirements for the health and safety of patients.
2. Provides complete and accurate information on its enrollment application. Changes in ownership, changes of location, changes in general supervision, and adverse legal actions must be reported to the Medicare Administrative Contractor (MAC) on the Medicare enrollment application within 30 calendar days of the change. All other changes to the enrollment application must be reported within 90 calendar days.
3. Maintain a physical facility on an appropriate site. For the purposes of this standard, a post office box, commercial mail box, hotel or motel is not considered an appropriate site.
   a. The physical facility, including mobile units, must contain space for equipment appropriate to the services designated on the enrollment application, facilities for hand washing, adequate patient privacy accommodations, and the storage of both business records and current medical records within the office setting of the IDTF, or IDTF home office, not within the actual mobile unit.
   b. IDTF suppliers that provide services remotely and do not see beneficiaries at their practice location are exempt from providing hand washing and adequate patient privacy accommodations.
4. Have all applicable diagnostic testing equipment available at the physical site excluding portable diagnostic testing equipment. A catalog of portable diagnostic equipment, including diagnostic testing equipment serial numbers, must be maintained at the physical site. In addition, portable diagnostic testing equipment must be available for inspection within two business days of a CMS inspection request. The IDTF must maintain a current inventory of the diagnostic testing equipment, including serial and registration numbers, provide this information to the MAC upon request, and notify the MAC of any changes in equipment within 90 days.
5. Maintain a primary business phone under the name of the designated business. The primary business phone must be located at the designated site of the business, or within the home office of the mobile IDTF units. The telephone number or toll free numbers must be available in a local directory and through directory assistance.
6. Have a comprehensive liability insurance policy of at least $300,000 per location that covers both the place of business and all customers and employees of the IDTF. The policy must be carried by a non-relative owned company. Failure to maintain required insurance at all times will result in revocation of the IDTF's billing privileges retroactive to the date the insurance lapsed. IDTF suppliers are responsible for providing the contact information for the issuing insurance agent and the underwriter. In addition, the IDTF must:
   a. Ensure that the insurance policy must remain in force at all times and provide coverage of at least $300,000 per incident; and
   b. Notify the CMS designated contractor in writing of any policy changes or cancellations.
7. Agree not to directly solicit patients, which include, but is not limited to, a prohibition on telephone, computer, or in-person contacts. The IDTF must accept only those patients referred for diagnostic testing by an attending physician, who is furnishing a consultation or treating a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Non-physician practitioners may order tests as set forth in section 410.32(a)(3).
8. Answer, document, and maintain documentation of a beneficiary's written clinical complaint at the physical site of the IDTF (for mobile IDTFs, this documentation would be stored at their home office.) This includes, but is not limited to, the following:
   a. The name, address, telephone number, and Medicare beneficiary identifier of the beneficiary.
   b. The date the complaint was received; the name of the person receiving the complaint; and a summary of actions taken to resolve the complaint.
   c. If an investigation was not conducted, the name of the person making the decision and the reason for the decision.

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (IDTFS) *(Continued)*

9. Openly post these standards for review by patients and the public.
10. Disclose to the government any person having ownership, financial, or control interest or any other legal interest in the supplier at the time of enrollment or within 30 days of a change.
11. Have its testing equipment calibrated and maintained per equipment instructions and in compliance with applicable manufacturers suggested maintenance and calibration standards.
12. Have technical staff on duty with the appropriate credentials to perform tests. The IDTF must be able to produce the applicable federal or state licenses or certifications of the individuals performing these services.
13. Have proper medical record storage and be able to retrieve medical records upon request from CMS or the MAC within 2 business days.
14. Permit CMS, including its agents, or its MACs, to conduct unannounced, on-site inspections to confirm the IDTF's compliance with these standards. The IDTF must be accessible during regular business hours to CMS and beneficiaries and must maintain a visible sign posting the normal business hours of the IDTF.
15. With the exception of hospital-based and mobile IDTFs, a fixed base IDTF does not include the following:
    a. Sharing a practice location with another Medicare-enrolled individual or organization.
    b. Leasing or subleasing its operations or its practice location to another Medicare enrolled individual or organization.
    c. Sharing diagnostic testing equipment using in the initial diagnostic test with another Medicare enrolled individual or organization.
16. Enrolls in Medicare for any diagnostic testing services that it furnishes to a Medicare beneficiary, regardless of whether the service is furnished in a mobile or fixed base location.
17. Bills for all mobile diagnostic services that are furnished to a Medicare beneficiary, unless the mobile diagnostic service is part of a service provided under arrangement as described in section 1861(w)(1) of the Act.

INSTRUCTIONS

If you perform diagnostic tests, other than clinical laboratory or pathology tests, and are required to enroll as an IDTF, you must complete this attachment. CMS requires the information in this attachment to determine whether the enrolling supplier meets all IDTF standards including, but not limited to, those listed above on this application. Not all suppliers that perform diagnostic tests are required to enroll as an IDTF.

If the IDTF is deleting an Interpreting Physician, a Technician who performs tests, or a Supervising Physician with this IDTF, complete section F of this attachment (below). Mail this attachment with original signatures to your designated MAC (**NOTE:** Supervising Physicians must sign section F). The MAC that services your State is responsible for processing your enrollment application information. To locate the mailing address for your designated MAC, go to **www.cms.gov/MedicareProviderSupEnroll**.

DIAGNOSTIC RADIOLOGY

Many diagnostic tests are radiological procedures that require the professional services of a radiologist. A radiologist's practice is generally different from those of other physicians because radiologists usually do not bill E&M codes or treat a patient's medical condition on an ongoing basis. A radiologist or group practice of radiologists is not necessarily required to enroll as an IDTF. If enrolling as a diagnostic radiology group practice or clinic and billing for the technical component of diagnostic radiological tests without enrolling as an IDTF (if the entity is a free standing diagnostic facility), it should contact the carrier to determine that it does not need to enroll as an IDTF.

A mobile IDTF that provides X-ray services is not classified as a portable X-ray supplier. Regulations governing IDTFs can be found at 42 C.F.R. 410.33.

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (IDTFS) *(Continued)*

CPT-4 AND HCPCS CODES

Report all CPT-4 and HCPCS codes for which this IDTF will bill Medicare. Include the following:

- Provide the CPT-4 or HCPCS codes for which this IDTF intends to bill Medicare,
- The name and type of equipment used to perform the reported procedure, and
- The model number of the reported equipment.

The IDTF should report all Current Procedural Terminology, Version 4 (CPT-4) codes, Healthcare Common Procedural Coding System codes (HCPCS), and types of equipment (including the model number), for which it will perform tests, supervise, interpret, and/or bill. All codes reported must be for diagnostic tests that an IDTF is allowed to perform. Diagnostic tests that are clearly surgical in nature, which must be performed in a hospital or ambulatory surgical center, should not be reported.

Consistent with IDTF supplier standard 6 on page 37 of this application, all IDTFs enrolling in Medicare must have a comprehensive liability insurance policy of at least $300,000 per location that covers both the place of business and all customers and employees of the IDTF. The policy must be carried by a non- relative owned company. Failure to maintain the required insurance at all times will result in revocation of the Medicare supplier billing number, retroactive to the date the insurance lapsed. Malpractice insurance policies do not demonstrate compliance with this requirement.

All IDTFs must submit a complete copy of the aforementioned liability insurance policy with this application.

A. STANDARDS QUALIFICATIONS

Provide the date this Independent Diagnostic Testing Facility met all current CMS standards *(mm/dd/yyyy)*

B. CPT-4 AND HCPCS CODES

If you are changing, adding, or removing information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

Change **Add** **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

All codes and modifiers (if applicable) reported here must be for diagnostic tests that an IDTF is allowed to perform. Diagnostic tests that are clearly surgical in nature, which must be performed in a hospital or ambulatory surgical center, should not be reported. Clinical laboratory and pathology codes should not be reported. This page may be copied for additional codes or equipment.

	CPT–4 OR HCPCS CODE	MODIFIER *(if applicable)*	EQUIPMENT	MODEL NUMBER
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (IDTFS) *(Continued)*

C. INTERPRETING PHYSICIAN INFORMATION

Check here if this section does not apply because the interpreting physician is enrolled in Medicare as an individual and will bill separately from the IDTF.

When a mobile unit of the IDTF performs a technical component of a diagnostic test and the interpretive physician is the same physician who ordered the test, the IDTF cannot bill for the interpretation. Therefore, these interpreting physicians should not be reported since the interpretive physician must submit his/her own claims for these tests.

All physicians whose interpretations will be billed by this IDTF with the technical component (TC) of the test (i.e., global billing) must be listed in this section. **If there are more than two physicians, copy and complete this section as needed.** All interpreting physicians must be currently enrolled in the Medicare program.

If you are billing for purchased interpretations, all requirements for purchased interpretations must be met.

1st Interpreting Physician Information

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

Change **Add** **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

First Name	Middle Initial	Last Name	Jr., Sr.,M.D., etc.
Social Security Number (SSN)		Date of Birth *(mm/dd/yyyy) (Required)*	
Medicare Identification Number *(if issued)*		NPI	

2nd Interpreting Physician Information

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

Change **Add** **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

First Name	Middle Initial	Last Name	Jr., Sr.,M.D., etc.
Social Security Number (SSN)		Date of Birth *(mm/dd/yyyy) (Required)*	
Medicare Identification Number *(if issued)*		NPI	

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (IDTFS) *(Continued)*

D. PERSONNEL (TECHNICIANS) WHO PERFORM TESTS

Complete this section with information about all non-physician personnel who perform tests for this IDTF.

NOTE: If there are more than two personnel (technicians), copy and complete this section as needed.

1st Personnel (Technician) Information

If you are changing, adding, or removing information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

Change **Add** **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

First Name	Middle Initial	Last Name	Jr., Sr.,M.D., etc.
Social Security Number (SSN)		Date of Birth *(mm/dd/yyyy) (Required)*	

Is this technician state licensed or state certified? *(see instructions for clarification)*..... YES NO

License/Certification Number *(if applicable)*	License/Certification Issue Date *(mm/dd/yyyy) (if applicable)*

Is this technician certified by a national credentialing organization?..... YES NO

Name of credentialing organization *(if applicable)*	Type of Credentials *(if applicable)*

2nd Personnel (Technician) Information

If you are changing, adding, or removing information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

Change **Add** **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

First Name	Middle Initial	Last Name	Jr., Sr.,M.D., etc.
Social Security Number (SSN)		Date of Birth *(mm/dd/yyyy) (Required)*	

Is this technician state licensed or state certified? *(see instructions for clarification)*..... YES NO

License/Certification Number *(if applicable)*	License/Certification Issue Date *(mm/dd/yyyy) (if applicable)*

Is this technician certified by a national credentialing organization?..... YES NO

Name of credentialing organization *(if applicable)*	Type of Credentials *(if applicable)*

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (IDTFS) *(Continued)*

E. SUPERVISING PHYSICIANS

Complete this section with identifying information about the physician(s) who supervise the operation of the IDTF and who provides the personal, direct, or general supervision per 42 C.F.R. 410.32(b)(3). The supervising physician must also attest to his/her supervising responsibilities for the enrolling IDTF.

Information concerning the type of supervision (personal, direct, or general) required for performance of specific IDTF tests can be obtained from your MAC. All IDTFs must report at least one supervisory physician, and at least one supervising physician must perform the supervision requirements stated in 42 C.F.R. 410.32(b)(3). All supervisory physician(s) must be currently enrolled in Medicare. Under 42 CFR section 410.33(b)(1), each supervising physician must be limited to providing general supervision at no more than three IDTF sites. This applies to both fixed sites and mobile units where three concurrent operations are capable of performing tests.

The type of supervision being performed by each physician who signs the attestation in this section of this application should be listed in this section.

NOTE: If there is more than one supervising physician, copy and complete this section for each.

Definitions of the types of supervision are as follows:

- **Personal Supervision** means a physician must be in attendance in the room during the performance of the procedure.
- **Direct Supervision** means the physician must be present in the office suite and immediately available to provide assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.
- **General Supervision** means the procedure is provided under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. General supervision also includes the responsibility that the non-physician personnel who perform the tests are qualified and properly trained and that the equipment is operated properly, maintained, calibrated and that necessary supplies are available.

If you are changing, adding, or removing information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

Change **Add** **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

First Name	Middle Initial	Last Name	Suffix *(e.g., Jr., Sr.)*

Social Security Number *(Required)*	Date of Birth *(mm/dd/yyyy) (Required)*

Medicare Identification Number *(if issued)*	NPI

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (IDTFS) *(Continued)*

TYPE OF SUPERVISION PROVIDED

Check the appropriate box below indicating the type of supervision provided by the physician reported above for the tests performed by the IDTF in accordance with 42 C.F.R. 410.32 (b)(3) (See instructions for definitions).

Personal Supervision Direct Supervision General Supervision

NOTE: Each supervising physician must be limited to providing general supervision to no more than three IDTF sites.

For each physician performing General Supervision, at least one of the three functions listed here must be checked. However, to meet the General Supervision requirement, in accordance with 42 C.F.R. 410.33(b), the enrolling IDTF must have at least one supervisory physician for each of the three functions. For example, two physicians may be responsible for function 1, a third physician may be responsible for function 2, and a fourth physician may be responsible for function 3. All four supervisory physicians must complete and sign the supervisory physician section of this application. Each physician should only check the function(s) he/she actually performs.

Assumes responsibility for the overall direction and control of the quality of testing performed.

Assumes responsibility for assuring that the non-physician personnel who actually perform the diagnostic procedures are properly trained and meet required qualifications.

Assumes responsibility for the proper maintenance and calibration of the equipment and supplies necessary to perform the diagnostic procedures.

OTHER SUPERVISION SITES

Does this supervising physician provide supervision at any other IDTF?..... YES NO

If yes, list all other IDTFs for which this physician provides supervision. For more than five, copy this sheet.

	NAME OF FACILITY	ADDRESS	TAX IDENTIFICATION NUMBER	LEVEL OF SUPERVISION
1.				
2.				
3.				
4.				
5.				

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (IDTFS) *(Continued)*

E. SUPERVISING PHYSICIANS *(Continued)*

ATTESTATION STATEMENT FOR SUPERVISING PHYSICIANS

All Supervising Physician(s) rendering supervisory services for this IDTF must sign and date this section. All signatures must be original.

1. I hereby acknowledge that I have agreed to provide (IDTF Name)_____with the Supervisory Physician services checked above for all CPT-4 and HCPCS codes and modifiers (if applicable) reported in this Attachment. (See number 2 below if all reported CPT-4 and HCPCS codes and modifiers (if applicable) do not apply). I also hereby certify that I have the required proficiency in the performance and interpretation of each type of diagnostic procedure, as reported by CPT-4 or HCPCS codes and modifiers (if applicable) in this Attachment (except for those CPT-4 or HCPCS codes and modifiers (if applicable) identified in number 2 below). I have read and understand the Penalties for Falsifying Information on this Enrollment Application, as stated in Section 14 of this application. I am aware that falsifying information may result in fines and/or imprisonment. If I undertake supervisory responsibility at any additional IDTFs, I understand that it is my responsibility to notify this IDTF at that time.
2. I am not acting as a Supervising Physician for the following CPT-4 and/or HCPCS codes reported in this Attachment.

CPT–4 OR HCPCS CODE	MODIFIER *(if applicable)*	CPT–4 OR HCPCS CODE	MODIFIER *(if applicable)*
3. Signature of Supervising Physician *(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)*			Date *(mm/dd/yyyy)*

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

ATTACHMENT 3: OPIOID TREATMENT PROGRAM PERSONNEL

All Opioid Treatment Programs enrolling in the Medicare program must complete this attachment.

Information for Individuals Legally Authorized to Order and/or Dispense Controlled Substances at OTP Facility

The OTP must include the following information for all employees, whether W-2 or not, and contracted staff, who are legally authorized to order and/or dispense controlled substances, *whether or not the individual is currently ordering and/or dispensing at the OTP facility*.

Ordering personnel

- First, Last Name, Middle Initial (if applicable)
- Date of Birth
- Social Security Number (SSN)
- Practitioner Type
- Active and Valid NPI
- License Number

Dispensing personnel

- First, Last Name, Middle Initial (if applicable)
- Date of Birth
- Social Security Number (SSN)
- Practitioner Type
- Active and Valid NPI
- License Number

Adverse History and Ineligibility

Under the OTP Standards in 42 C.F.R § 424.67, an OTP provider must not employ, as a W2 employee or not, or contract with anyone who meets any of the ineligibility criteria outlined below, whether or not the individual is currently ordering or dispensing at the OTP facility.

- Currently is revoked from Medicare under § 424.535 or any other applicable section in Title 42, and under an active reenrollment bar.
- Currently is on the preclusion list pursuant to 42 C.F.R. § 422.222 or § 423.120(c)(6).
- Currently is excluded by the Department of Health and Human Services (DHHS) Office of Inspector General (OIG).
- Has a prior action, including but not limited to a reprimand, fine, or restriction, by a state oversight board for professional misconduct issues relating to patient harm.

ATTACHMENT 3: OPIOID TREATMENT PROGRAM PERSONNEL *(Continued)*

A. ORDERING PERSONNEL IDENTIFICATION

Note: Copy and complete this section if more than three OTP ORDERING personnel need to be reported.

If you are changing information about currently reported OTP ordering personnel or adding or removing OTP personnel, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

Change **Add** **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

First Name of OTP Ordering Personnel	Middle Initial	Last Name of OTP Ordering Personnel	Suffix *(e.g., Jr., Sr., M.D., etc.)*
Social Security Number (SSN)		Date of Birth *(mm/dd/yyyy)*	
NPI		License Number	
Practitioner Type			

If you are changing information about currently reported OTP ordering personnel or adding or removing OTP personnel, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

Change **Add** **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

First Name of OTP Ordering Personnel	Middle Initial	Last Name of OTP Ordering Personnel	Suffix *(e.g., Jr., Sr., M.D., etc.)*
Social Security Number (SSN)		Date of Birth *(mm/dd/yyyy)*	
NPI		License Number	
Practitioner Type			

If you are changing information about currently reported OTP ordering personnel or adding or removing OTP personnel, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

Change **Add** **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

First Name of OTP Ordering Personnel	Middle Initial	Last Name of OTP Ordering Personnel	Suffix *(e.g., Jr., Sr., M.D., etc.)*
Social Security Number (SSN)		Date of Birth *(mm/dd/yyyy)*	
NPI		License Number	
Practitioner Type			

ATTACHMENT 3: OPIOID TREATMENT PROGRAM PERSONNEL *(Continued)*

B. DISPENSING PERSONNEL IDENTIFICATION

NOTE: Copy and complete this section if more than three OTP DISPENSING personnel need to be reported.

If you are changing information about currently reported OTP Dispensing personnel or adding or removing OTP personnel, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

Change **Add** **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

First Name of OTP Dispensing Personnel	Middle Initial	Last Name of OTP Dispensing Personnel	Suffix *(e.g., Jr., Sr., M.D., etc.)*
Social Security Number (SSN)		Date of Birth *(mm/dd/yyyy)*	
NPI		License Number	
Practitioner Type			

If you are changing information about currently reported OTP Dispensing personnel or adding or removing OTP personnel, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

Change **Add** **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

First Name of OTP Dispensing Personnel	Middle Initial	Last Name of OTP Dispensing Personnel	Suffix *(e.g., Jr., Sr., M.D., etc.)*
Social Security Number (SSN)		Date of Birth *(mm/dd/yyyy)*	
NPI		License Number	
Practitioner Type			

If you are changing information about currently reported OTP Dispensing personnel or adding or removing OTP personnel, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

Change **Add** **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

First Name of OTP Dispensing Personnel	Middle Initial	Last Name of OTP Dispensing Personnel	Suffix *(e.g., Jr., Sr., M.D., etc.)*
Social Security Number (SSN)		Date of Birth *(mm/dd/yyyy)*	
NPI		License Number	
Practitioner Type			

MEDICARE SUPPLIER ENROLLMENT APPLICATION PRIVACY ACT STATEMENT

The Authority for maintenance of the system is given under provisions of sections 1102(a) (Title 42 U.S.C. 1302(a)), 1128 (42 U.S.C. 1320a–7), 1814(a)) (42 U.S.C. 1395f (a)(1), 1815(a) (42 U.S.C. 1395g(a)), 1833(e) (42 U.S.C. 1395l(3)),1871 (42 U.S.C. 1395hh), and 1886(d)(5)(F), (42 U.S.C. 1395ww(d)(5)(F) of the Social Security Act; 1842(r) (42 U.S.C.1395u(r)); section 1124(a)(1) (42 U.S.C. 1320a–3(a)(1), and 1124A (42 U.S.C. 1320a–3a), section 4313, as amended, of the BBA of 1997; and section 31001(i) (31 U.S.C. 7701) of the DCIA (Pub. L. 04–134), as amended.

The information collected here will be entered into the Provider Enrollment, Chain and Ownership System (PECOS).

PECOS will collect information provided by an applicant related to identity, qualifications, practice locations, ownership, billing agency information, reassignment of benefits, electronic funds transfer, the NPI and related organizations. PECOS will also maintain information on business owners, chain home offices and provider/chain associations, managing/directing employees, partners, authorized and delegated officials, supervising physicians of the supplier, ambulance vehicle information, and/or interpreting physicians and related technicians. This system of records will contain the names, social security numbers (SSN), date of birth (DOB), and employer identification numbers (EIN) and NPI's for each disclosing entity, owners with 5 percent or more ownership or control interest, as well as managing/directing employees. Managing/directing employees include general manager, business managers, administrators, directors, and other individuals who exercise operational or managerial control over the provider/ supplier. The system will also contain Medicare identification numbers (i.e., CCN, PTAN and the NPI), demographic data, professional data, past and present history as well as information regarding any adverse legal actions such as exclusions, sanctions, and felonious behavior.

The Privacy Act permits CMS to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. Any such disclosure of data is known as a "routine use." The CMS will only release PECOS information that can be associated with an individual as provided for under Section III "Proposed Routine Use Disclosures of Data in the System." Both identifiable and non-identifiable data may be disclosed under a routine use. CMS will only collect the minimum personal data necessary to achieve the purpose of PECOS. Below is an abbreviated summary of the six routine uses. To view the routine uses in their entirety go to: **https://www.cms.gov/Research-Statistics-Data-and-Systems/ Computer-Data-and-Systems/Privacy/Downloads/0532-PECOS.pdf**.

1. To support CMS contractors, consultants, or grantees, who have been engaged by CMS to assist in the performance of a service related to this collection and who need to have access to the records in order to perform the activity.
2. To assist another Federal or state agency, agency of a state government or its fiscal agent to:
   a. Contribute to the accuracy of CMS's proper payment of Medicare benefits,
   b. Enable such agency to administer a Federal health benefits program that implements a health benefits program funded in whole or in part with federal funds, and/or
   c. Evaluate and monitor the quality of home health care and contribute to the accuracy of health insurance operations.
3. To assist an individual or organization for research, evaluation or epidemiological projects related to the prevention of disease or disability, or the restoration or maintenance of health, and for payment related projects.
4. To support the Department of Justice (DOJ), court or adjudicatory body when:
   a. The agency or any component thereof, or
   b. Any employee of the agency in his or her official capacity, or
   c. Any employee of the agency in his or her individual capacity where the DOJ has agreed to represent the employee, or
   d. The United States Government, is a party to litigation and that the use of such records by the DOJ, court or adjudicatory body is compatible with the purpose for which CMS collected the records.
5. To assist a CMS contractor that assists in the administration of a CMS administered health benefits program, or to combat fraud, waste, or abuse in such program.
6. To assist another Federal agency to investigate potential fraud, waste, or abuse in, a health benefits program funded in whole or in part by Federal funds.

The applicant should be aware that the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503) amended the Privacy Act, 5 U.S.C. section 552a, to permit the government to verify information through computer matching.

EXHIBIT 17

Medicare Enrollment
for Providers and Suppliers

Help

Glossary

The following list defines terms that are commonly used throughout the Medicare provider enrollment process in alphabetical order. Should further information be required about a term, please refer to the Links to More Information section of Help for an appropriate contact.

Please choose a letter to jump to the first term listed with that letter.

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

A

Account Address

The account holder's address, city, state and zip code.

Account Number

The depositor's account number appears on the bottom of the check or savings deposit slip after 9 digit routing number. This includes applicable leading zeros.

Accreditation

For more information on this term, please contact your Medicare contractor.

Accreditation Program

For more information on this term, please contact your Medicare contractor.

Accrediting Body

For more information on this term, please contact your Medicare contractor.

Acquisition/Merger

When a Medicare provider purchases or is purchased by another enrolled provider and only the purchaser's provider number and taxpayer identification number (TIN) remain.

Advanced Diagnostic Imaging

Section 135(a) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended section 1834(e) of the Social Security Act and required the Secretary to designate organizations to accredit suppliers, including but not limited to physicians, non-physician practitioners and Independent Diagnostic Testing Facilities, that furnish the technical component (TC) of advanced diagnostic imaging services.

Advanced Life Support (ALS)

For more information on this term, please contact your Medicare contractor.

Advanced Life Support (ALS) (Level 1)

For more information on this term, please contact your Medicare contractor.

Advanced Life Support (ALS) (Level 2)

For more information on this term, please contact your Medicare contractor.

Applicant

The individual or organization who is either applying for initial enrollment into the Medicare program or updating their existing enrollment information.

Assignment

For more information on this term, please contact your Medicare contractor.

Authorization Statement

For more information on this term, please contact your Medicare contractor.

Authorized Official

An appointed official (e.g., chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program. See 42 CFR 424.502 for additional information.

Authorized Signer

An authorized delegated official.

return to navigation

B

Base of Operations

The location from where personnel are dispatched, mobile/portable equipment is stored, and when applicable, where vehicles are parked when not in use.

Basic Life Support (BLS)

For more information on this term, please contact your Medicare contractor.

return to navigation

C

Capitalization Requirements

For more information on this term, please contact your Medicare contractor.

Carriers

Carriers process Medicare applications to pay Part B claims. Also known as Medicare fee-for-service contractors and Medicare Administrative Contractors (MACs).

Certification Statement

For more information on this term, please contact your Medicare contractor.

Chain Number

For more information on this term, please contact your Medicare contractor.

Change of Ownership (CHOW)

When a Medicare provider has been purchased or leased by another organization and the old owner's Medicare ID number is transferred to the new owner if the provider agreement is accepted.

A CHOW includes transfer of any Medicare outstanding debt of the old owner to the new owner. If the purchaser (or lessee) elects not to accept a transfer of the provider agreement, then the old agreement is terminated and the purchaser or lessee is considered a new applicant.

Because of the various situations in which a CHOW, acquisition/merger, or consolidation can occur, it is recommended that the provider contact its Medicare fee-for-service contractor or its CMS Regional Office if it is unsure as to whether such a transaction has occurred. The provider should also review the applicable federal regulation at 42 CFR 489.18 for additional guidance.

Clinical Laboratory Improvement Amendments (CLIA) Number

For more information on this term, please contact your Medicare contractor.

CMS Standards

For more information on this term, please contact your Medicare contractor.

Consolidation

When two or more enrolled Medicare providers consolidate and form a new business entity.

Contact Name for EFT

The name and title of the contact person for provider of EFT who can answer questions about the information submitted on this EFT section.

Correspondence Address

Once the provider is enrolled in Medicare, this is the address at which the contractor will contact the provider directly if necessary.

Cost Report

For more information on this term, please contact your Medicare contractor.

CP-575 Form

An Internal Revenue Service (IRS) document that identifies the taxpayer identification number and legal business name for an organization.

Credentials

For more information on this term, please contact your Medicare contractor.

return to navigation

D

Delegated Official

An individual who is delegated by the authorized official of the organization provider/supplier to report changes and updates to the enrollment record. The delegated official must be an individual with an ownership or control interest in, or be a W-2 managing employee of the provider or supplier. See 42 CFR 424.502 for additional information.

Director

A member of the provider's 'board of directors'.

A director does not necessarily include a person who may have the word 'director' in his/her job title (e.g., departmental director, director of operations). When a provider has a governing body that does not use the term 'board of directors', the members of that governing body will still be considered 'directors'. Thus, if the provider has a governing body titled 'board of trustees' (as opposed to 'board of directors'), the individual trustees are considered 'directors' for Medicare enrollment purposes.

Disregarded Entity

A disregarded entity is a business structure that chooses to be disregarded as separate from the business owner for federal tax purposes. The most common disregarded entity is a single-member limited liability company (LLC) that has chosen to be taxed as a sole proprietorship.

DME Supplier

A supplier who provides Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).

DME 1099 Mailing Address

This is the mailing address where the DMEPOS supplier will receive its Federal 1099 forms.

DME Hours of Operation

Business hours the DMEPOS supplier is open to the public.

DMEPOS

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) as defined in section 2B of the CMS-855S form.

DMEPOS Jurisdiction Area

Supplier jurisdiction area where majority of their claims are submitted. Claims submissions are based on where Medicare beneficiary resides.

Doing Business As Name

For more information on this term, please contact your Medicare contractor.

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E

Effective Date of Acquisition

For more information on this term, please contact your Medicare contractor.

Effective Date of Consolidation

For more information on this term, please contact your Medicare contractor.

Effective Date of Departure

For more information on this term, please contact your Medicare contractor.

Effective Date of Employment

For more information on this term, please contact your Medicare contractor.

Effective Date of this Practice Location

This is the Date you saw your first Medicare patient at this location. For more information on this term, please contact your Medicare contractor.

Effective Date of Transfer

For more information on this term, please contact your Medicare contractor.

Electronic Fund Transfer (EFT)

The mechanism by which providers and suppliers receive Medicare Part A and Part B payments directly into a designated bank account.

Electronic Funds Transfer Form CMS-588

EFT section will collect and store depository information. This will replace the CMS588 paper form. EFT information is required for initial enrollments.

Employer Identification Number (EIN)

Unique identifier the Internal Revenue Service (IRS) assigns to business entities. (A Taxpayer identification number (TIN) is an EIN, but an EIN is not always a TIN.)

Employer Organization

An employer organization is referred to as the organization that works on behalf of a provider organization who provides Medicare enrollment services in Internet-based PECOS. A user's employer and provider may or may not be the same organization entity when established in the PECOS Identity and Access Management (I&A) system.

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F

Facility Name

For more information on this term, please contact your Medicare contractor.

Facility Location Address

For more information on this term, please contact your Medicare contractor.

FDA/Radiology (Mammography) Certification Number

For more information on this term, please contact your Medicare contractor.

Federal Non-procurement Program

For more information on this term, please contact your Medicare contractor.

Federal Procurement Program

For more information on this term, please contact your Medicare contractor.

Fee-for-Service Contractor

These are entities known as Medicare administrative contractors, carriers, or fiscal intermediaries who manage enrollment and payment services related to Medicare Part A and Part B services.

Carriers have a contract with CMS to process Medicare applications to pay Part B claims.

Fiscal Intermediaries (FIs) have a contract with CMS to process Medicare applications to pay Part A and some Part B claims.

Medicare Administrative Contractors (MACs) have a contract with CMS to process Medicare applications to pay Part A and Part B claims.

The application generated by Internet-based PECOS and related materials are sent to the appropriate contractor who verifies the supplied information and processes the application.

Final Adverse Action

Convictions, exclusions, revocations, and suspensions. All applicable final adverse actions, under Federal or State law, against the applicant must be reported, regardless of whether any records were expunged or any appeals are pending.

Fiscal Intermediaries

Fiscal intermediaries (FIs) mainly process Medicare applications to pay Part A and some Part B claims.

Financial Institution

Financial Institution is the name of the bank or qualifying depository that will receive the funds.

Five Percent (5%) or More Ownership Control

Any individual/organization with five percent (5%) or more direct or indirect ownership in the organization.

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G

Geographic Service Area

The state, city, town, or zip code in which services are rendered to Medicare patients.

Group Member

For more information on this term, please contact your Medicare contractor.

See 'Reassignment' for additional information.

Group Member Only

The applicant provides healthcare services only as the employee of another provider.

Group Member and Self-Employed

The applicant is self-employed and provides healthcare services as an employee of another provider.

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H

Home Health Agency (HHA)

See 42 CFR Part 484.

All Home Health Agencies (HHA) or HHA subunits enrolling in the Medicare program will be issued a new provider number and are required to provide documentation demonstrating sufficient initial reserve operating funds (capitalization) to operate for the first three months of involvement in the Medicare program. They will also be required to provide capitalization documentation. The intermediary then determines the amount of funds required using the regulations found at 42 CFR 489.28.

Home Office Of Chain

Indicates if EFT payment will be made to the Chain Home Office.

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I

Incorporation Date

The date the organization named on this application became incorporated.

Independent Diagnostic Testing Facilities (IDTF)

A supervising physician can supervise at up to only three IDTF locations. See 42 CFR 410.33 or contact your local Medicare fee-for-service contractor for more information.

return to navigation

J

Joint Venture/Partnership

For more information on this term, please contact your Medicare contractor.

return to navigation

K

At this time there are no terms available for the letter you selected. Please select another letter.

return to navigation

L

Leased (Chain Home Office)

For more information on this term, please contact your Medicare contractor.

Legal Business Name

The name of the organization as reported to the Internal Revenue Service (IRS).

Liability Insurance

This is insurance required by Medicare for the DMEPOS supplier's business.

Liability Insurance Policy Number

This is the policy number for the applicant's liability insurance.

Limited Liability Company (LLC)

For more information on this term, please contact your Medicare contractor.

Limited Partnership

For more information on this term, please contact your Medicare contractor.

return to navigation

M

Managed (Chain Home Office)

For more information on this term, please contact your Medicare contractor.

Managing Control

Any organization or individual that exercises operational or managerial control over the provider, or conducts the day-to-day operations of the provider. The organization need not have an ownership interest in the provider in order to qualify as a managing organization.

Managing Employee

A general manager, business manager, administrator, director, or other individual that exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the provider or supplier, either under contract or through some other arrangement, whether or not the individual is a W-2 employee of the provider or supplier. For purposes of this definition, this includes a hospice or skilled nursing facility administrator and a hospice or skilled nursing facility medical director.

Medicaid Number

This is the number that a DMEPOS supplier uses to bill the Medicaid program.

Medicare Administrative Contractor (MAC)

MACs process Medicare applications to pay Part A and Part B claims.

Medicare Exclusion Database (MED)

The Medicare Exclusion Database (MED) includes information about excluded providers and organizations. The MED sanction information is read-only and the user cannot add, edit, or delete this information. Please contact your contractor for more information.

The Office of Inspector General (OIG), under Congressional mandate, established a program to exclude individuals and organizations affected by these various legal authorities, contained in sections 1128 and 1156 of the Social Security Act. The OIG also maintains a list of all currently excluded parties called the List of Excluded Individuals/Entities. The Medicare Exclusion Database (MED) receives excluded provider data from OIG each month. The data is formatted and verified, and then distributed to all CMS contractors in accordance with Sections 1128A & B and 1162(e) of the Social Security Act.

Medicare Identification Number (Medicare ID)

A generic term for the identifier assigned to the provider or supplier by the Medicare program. These identifiers are collectively known for Part A entities as CMS Certification Numbers (CCNs) (formerly called OSCAR Numbers), for Part B entities as Provider Transaction Access Numbers (PTANs). The type of CCN or PTAN varies by the type of provider/supplier. Part A certified providers include hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, community mental health facilities, end stage renal disease facilities, federally qualified health centers, home health agencies, hospices, rural health clinics, Indian Health Service facilities, outpatient physical therapy and speech language pathology facilities, religious non-medical health care Institutions, and histocompatibility laboratories. Part B suppliers to include physicians and other practitioners as well as medical groups have PINs (Provider Identification Numbers) and DMEPOS suppliers have NSC Numbers.

Medicare Part A Services

Per federal regulation 42 CFR 400.202, Part A services include inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

Medicare Part B Services

Part B services include doctors services, outpatient hospital care, durable medical equipment, and some medical services not covered by Medicare Part A.

Mobile Facilities/Portable Units

A vehicle in which medical services are rendered or that transports equipment for services across multiple locations within a geographic area. Examples include mobile independent diagnostic testing facilities, portable X-ray units, portable mammography units and mobile clinics.

Mobile Facilities/Portable Units

A vehicle in which medical services are rendered or that transports equipment for services across multiple locations within a geographic area. Examples include mobile independent diagnostic testing facilities, portable X-ray units, portable mammography units and mobile clinics.

Modality

A modality is the type of advanced diagnostic imaging procedures provided by the supplier or physician (including diagnostic magnetic resonance imaging (MRI), computed tomography (CT), nuclear medicine, and positron emission tomography (PET)).

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N

National Provider Identifier (NPI)

A standard, unique health identifier assigned upon application to entities that meet the regulatory definition of "health care provider" found at 45 CFR 160.103. NPIs are required by regulation to be used by health plans, health care clearinghouses, and health care providers who are "covered entities" under HIPAA to identify health care providers in HIPAA standard transactions. (Note: Medicare providers/suppliers are required to obtain NPIs, except those few that do not meet the "health care provider" definition.)

The NPI is a 10-digit numeric identifier (a check-digit is in the 10th position) assigned upon application to health care providers by the National Plan and Provider Enumeration System (NPPES).

National Provider Enrollment (NPE) DMEPOS Contractors

The NPE contractors are Novitas Solutions and Palmetto GBA. These contractors process Medicare enrollment applications for DMEPOS suppliers. Novitas Solutions will handle DMEPOS Supplier enrollment for the eastern states and Palmetto GBA will handle the western states. These contracts are referred to as National Provider Enrollment East (NPEAST) and National Provider Enrollment West (NPWEST).

Non-Accredited Products

Non-accredited products are products provided by a DMEPOS supplier that do not require the DMEPOS supplier to obtain accreditation from a CMS approved agency in order for the DMEPOS supplier to bill Medicare for that product.

Non-physician

For more information on this term, please contact your Medicare contractor.

Non-Physician Specialty

The primary health care service rendered by the non-physician applicant. Submitted claims to the Medicare program will be paid out under the terms and conditions associated with the chosen specialty. The applicant must supply the Medicare program with educational and/or training documentation showing the applicant's ability to render such services.

Non-profit Agency

For more information on this term, please contact your Medicare contractor.

NPPES Validation Letter, also known as NPI Notification

A notification sent by NPPES or by an EFI Organization to a provider who has been assigned an NPI. The NPI Notification informs the provider's Contact Person of the provider's NPI and contains other information about the enumerated provider. The NPI Notification can be used as a provider as proof of NPI assignment.

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O

Officer

Any person whose position is listed in either the provider's "articles of incorporation" or "corporate bylaws" as being that of an officer, or anyone who is appointed by the board of directors as an officer in accordance with the provider's corporate bylaws.

Operated (Chain Home Office)

For more information on this term, please contact your Medicare contractor.

Online Survey Certification and Reporting (OSCAR) Number

For more information on this term, please contact your Medicare contractor.

Other Name (Individual)

Another name by which the applicant as an individual may be known. Possible other names include Former Name, Maiden Name, or Professional Name.

Other Name (Organization)

Another name by which the applicant as an organization may be known. Possible other names include Former Legal Business Name or Doing Business As Name.

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P

PAR Status

An indication of whether or not a provider agrees to participate in the Medicare program and agrees to always accept the Medicare assignment for services rendered to Medicare beneficiaries.

Paramedic Intercept Services

An arrangement between a Basic Life Support (BLS) ambulance company and an Advanced Life Support (ALS) ambulance company whereby the latter provides the ALS services and the BLS ambulance company provides the transportation component.

Participating Provider

A participating provider agrees to always accept assignment of claims for all services furnished to Medicare beneficiaries. By agreeing to always accept assignment, the provider agrees to always accept Medicare-allowed amounts as payment in full and to not collect more than the Medicare deductible and coinsurance from the beneficiary.

Partner

For more information on this term, please contact your Medicare contractor.

Portable Units

A "portable unit" is when the provider transports medical equipment to a fixed location (e.g., a physician's office or nursing home) to render services to the patient.

Practice Location

A location owned/leased by the applicant where services are provided to patients. Out of office locations such as when services are rendered in a patients home or in mobile facilities should not be listed.

Practitioner Specialty

For more information on this term, please contact your Medicare contractor.

Practitioner Type

The primary physician or non-physician medical specialty for which the applicant meets all Federal and State requirements and practices the majority of the time. Claims for services rendered associated to this enrollment application will be processed according to the terms and conditions associated with the specialty.

Primary DME Supplier Type

The primary supplier type is the DMEPOS supplier applicant's primary place from where it furnishes DMEPOS or the type of DMEPOS it furnishes the most.

Primary Physician Specialty

For more information on this term, please contact your Medicare contractor.

Primary Practice Location

The physical location where the majority of services are rendered and/or the base of operations for mobile services.

Products and Services

Products and services are the items the DMEPOS Supplier furnishes to its customers and plans to bill Medicare for reimbursement.

Professional Association (PA)

An association of practitioners of a given profession.

Professional Corporation (PC)

A corporation formed by one or more licensed practitioners, esp. medical or legal, to operate their practices on a corporate plan.

Proprietary Agency

For more information on this term, please contact your Medicare contractor.

Prospective Payment System (PPS)

For more information on this term, please contact your Medicare contractor.

Provider

A hospital, a critical access hospital, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech pathology services, or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services. See 42 CFR 400.202 for more information.

Provider Agreement

For more information on this term, please contact your Medicare contractor.

Provider Identification Number (PIN)

A type of Medicare ID that is used as a Medicare billing number assigned to Part B suppliers and practitioners by the Medicare contractors.

Publicly Traded Corporation

A company issuing stocks, which are traded on the open market either on the stock exchange or on the over the counter market. Individual and institutional shareholders constitute the owners of a public company, in proportion to the amount of stock they own as a percentage of all outstanding stock. Shareholders have final say in all decisions taken by a public company and its managers.

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Q

At this time there are no terms available for the letter you selected. Please select another letter.

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R

Reactivation

When the Medicare billing privileges are made active again. The applicant must be able to submit a valid claim and meet all current requirements for the provider type before reactivation can occur.

Reassignment

An arrangement in which an individual assigns his/her benefits, and payment of those benefits, to a group, individual, or organization already enrolled or currently enrolling in the Medicare program. The individual is employed by or contracts with the group/organization to which benefits are reassigned.

Revalidation Package Mailing Address

This is the address where the DMEPOS Supplier wants the National Provider Enrollment (NPE) DMEPOS Contractor- Novitas Solutions for East or Palmetto GBA for West to mail the revalidation request to the DMEPOS supplier.

Regional Office

The CMS Regional Offices generally serve as the agency's main link to beneficiaries, health care providers, state and local governments as well as the general public.

Reserve Operating Funds

For more information on this term, please contact your Medicare contractor.

Residency

For more information on this term, please contact your Medicare contractor.

Resolution (Final Adverse Actions)

A brief description of how the final adverse action was resolved (e.g., license suspension).

Revalidation

When a Medicare fee-for-service contractor or CMS requires an update and submittal of enrollment information. If a DME Supplier has been contacted by the National Provider Enrollment (NPE) DMEPOS Contractor- Novitas Solutions for East or Palmetto GBA for West- to revalidate, the DME Supplier is required to either submit an updated enrollment application or certify to the accuracy of the enrollment information currently on file with their designated National Provider Enrollment (NPE) DMEPOS Contractor. Do not submit this application until you have been contacted by your designated National Provider Enrollment (NPE) DMEPOS Contractor.

Revocation

Termination of a provider or supplier's billing privileges specific to this enrollment application privileges.

Routing Number

The bank or financial institutional routing number is the first 9 digits located at the bottom left of your check or savings deposit slip. This includes applicable leading zeros.

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S

Secondary DME Supplier Type

The secondary supplier type is the DMEPOS supplier applicant's other place(s) from where it furnishes DMEPOS or the type(s) of DMEPOS it furnishes in addition to the primary supplier type.

Secondary Physician Specialties

For more information on this term, please contact your Medicare contractor.

Self-Employed

The applicant provides healthcare services from a facility that he/she owns/leases/rents (the practitioner and business are legally the same).

Skilled Nursing Facility (SNF)

For more information on this term, please contact your Medicare contractor.

Sole Owner of a PA, PC, LLC

A practitioner is the sole owner of an incorporated business that is legally distinct from its owner. Claims payments are received directly by the business using its tax identification number (TIN) for all services provided by the owning practitioner or other employees through a reassignment of benefits.

Sole Proprietor

For more information on this term, please contact your Medicare contractor.

"Special Payments" Address

The address where Medicare sends remittance notices and special payments to the applicant.

Specialty Care Transport

For more information on this term, please contact your Medicare contractor.

Sub-units

For more information on this term, please contact your Medicare contractor.

Subpart

A division of the organization that provides health care, but is not a separate legal entity.

Supplier

A physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare. See 42 CFR 400.202 for more information.

Surety Bond

A bond issued by an entity on behalf of a DMEPOS supplier, guaranteeing that the DMEPOS supplier will fulfill its obligations to the Medicare program. In the event that the obligations are not met, the Medicare program will recover its monetary losses via the bond.

Surety Bond Agency/Broker

The company or person who issued the applicant's surety bond.

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T

Taken By (Final Adverse Actions)

For more information on this term, please contact your Medicare contractor.

Tax Identification Number (TIN)

The identification number used by the Internal Revenue Service (IRS) for use on tax related documents. This number is an Employer Identification Number (EIN) or a Social Security Number (SSN).

Termination Date (of Advanced Diagnostic Service)

For more information on this term, please contact your Medicare contractor.

Termination Date (of Chain Home Office)

For more information on this term, please contact your Medicare contractor.

Termination Date (of "Special Payments" Address)

For more information on this term, please contact your Medicare contractor.

Termination Date (of Ambulance Service Supplier Geographic Service Area)

For more information on this term, please contact your Medicare contractor.

Termination Date (of Ambulance Service Supplier State License)

For more information on this term, please contact your Medicare contractor.

Termination Date (of Ambulance Service Supplier Vehicle)

For more information on this term, please contact your Medicare contractor.

Termination Date (of Billing Agency)

For more information on this term, please contact your Medicare contractor.

Termination Date (of CPT-4/HCPCS Codes)

For more information on this term, please contact your Medicare contractor.

Termination Date (of Electronic Funds Transfer)

For more information on this term, please contact your Medicare contractor.

Termination Date (of Geographic Location)

For more information on this term, please contact your Medicare contractor.

Termination Date (of HHA Type and Visit Information)

This is the date the applicant ended their HHA Type and Visit Information. For more information on this term, please contact your Medicare contractor.

Termination Date (of IDTF Interpreting Physician)

For more information on this term, please contact your Medicare contractor.

Termination Date (of IDTF Supervising Physician)

For more information on this term, please contact your Medicare contractor.

Termination Date (of IDTF Technician)

For more information on this term, please contact your Medicare contractor.

Termination Date (of Individual Control)

For more information on this term, please contact your Medicare contractor.

Termination Date (of Nursing Registry)

For more information on this term, please contact your Medicare contractor.

Termination Date (of Organization with Ownership Interest and/or Managing Control)

For more information on this term, please contact your Medicare contractor.

Termination Date (of Paramedic Intercept Services)

This is the date the applicant ended Paramedic Intercept Services for the enrollment.

Termination Date (of Patient Storage Records Location)

For more information on this term, please contact your Medicare contractor.

Termination Date (of Physical Location)

For more information on this term, please contact your Medicare contractor.

Termination Date (of Physician Employment Arrangement)

This is the date the applicant (Physician Assistant) terminated the relationship with an employer on this enrollment. For more information on this term, please contact your Medicare contractor.

Termination Date (of Primary DME Supplier Type)

The date the DMEPOS supplier stopped doing business in a primary supplier type place from where it was furnishing DMEPOS or stopped furnishing the type(s) of primary DMEPOS it was previously furnishing.

Termination Date (of Reassignment)

For more information on this term, please contact your Medicare contractor.

Termination Date (of Rendering Healthcare Services at a Patient's Home)

For more information on this term, please contact your Medicare contractor.

Termination Date (of this Practice Location)

This is the date the applicant termination dated at this practice location. For more information on this term, please contact your Medicare contractor.

Termination Date (of Secondary DME Supplier Type)

The date the DMEPOS supplier stopped doing business in a secondary supplier type place from where it was furnishing DMEPOS or stopped furnishing the type(s) of secondary DMEPOS it was previously furnishing.

Termination Date (of Surety Bond)

This is the date the surety bond was terminated by the DMEPOS supplier or the Surety Bond company.

Termination Date (of Surety Bond Company)

This is the date the DMEPOS supplier terminated its association with the surety bond company or the date the Surety Bond company terminated its association with the DMEPOS supplier.

Termination Date (of Surety Bond Insurance Agency/Broker)

This is the date the DMEPOS supplier terminated its association to its Surety Bond Agency/Broker or the Agency/Broker terminated its association with the DMEPOS supplier.

Termination Date (of Vehicle Information)

For more information on this term, please contact your Medicare contractor.

Termination Date (of Withdrawal)

For more information on this term, please contact your Medicare contractor.

Tracking ID

A unique identification number specific to an online enrollment application. This number is used to help track the application through all stages of the Medicare enrollment process.

Type of Vehicle

Describes the vehicle in which Medicare related services are rendered (e.g., van, trailer, helicopter, etc.).

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U

Underwriter

The name of the individual at the DMEPOS supplier's liability insurance company who can verify the DMEPOS supplier's liability insurance policy.

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V

Voluntary Termination

For more information on this term, please contact your Medicare contractor.

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W

Wholly Owned (Chain Home Office)

For more information on this term, please contact your Medicare contractor.

Withdrawal

For more information on this term, please contact your Medicare contractor.

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X

At this time there are no terms available for the letter you selected. Please select another letter.

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Y

Year End Cost Report Date

The provider may select any annual period for Medicare cost reporting purposes regardless of the reporting period it uses for other programs. Once a provider has made a selection and reported accordingly, it is required thereafter to report annually for periods ending as of the same date unless the contractor approves a change in the provider's reporting period. For more information on this term, please contact your Medicare contractor.

return to navigation

Z

At this time there are no terms available for the letter you selected. Please select another letter.

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EXHIBIT 18

An official website of the United States government Here's how you know

All Interactive Tools

Medicare Revalidation List

This tool is a searchable database that allows you to look up the revalidation due date for Medicare providers who must revalidate their enrollment record information every three or five years.

Latest data available: November 2025

Find a Provider:

Search by NPI: Enter NPI

Search for an organization: Enter organization name

Search for an individual: Enter provider first name | Enter provider last name

Location: State

Filter records (All, Due Dates Only, Specific Range): All records

Find Provider

Resources
Datasets

Information about the tool

UPDATES

This data was last refreshed on November 3, 2025. The next data refresh is on December 1, 2025.

Due Dates for April 2026 have been added on 11/03/2025.

No new due dates were issued for November 2024 - May 2025.

Any established due dates prior to July 2023 have been removed and replaced with TBD. CMS is reestablishing new due dates due to the impacts of the COVID-19 PHE.

Providers/suppliers should not submit their revalidation until they see the newly established Due Date on the tool.

CMS has extended the deadline for enrolled skilled nursing facilities (SNFs) to submit their revalidation to August 1, 2025. The revalidation look up tool and the revalidation list in PECOS will not be updated with the revised date. SNFs should refer to the Guidance for SNF Attachment on Form CMS-855A for this information.

This tool is a searchable database that allows you to look up the revalidation due date for Medicare providers who must revalidate their enrollment record information every three or five years. CMS sets every provider's revalidation due date at the end of a month and posts the revalidation due date six to seven months in advance.

A due date of "TBD" means that CMS has not set the due date yet.

- Affiliations now include reassignments as well as Physician Assistant (PA) employment relationships.
- All providers are identified on the downloadable file in a new column called "Enrollment Type" and are identified as follows:
  - 1-PartA
  - 2-DME
  - 3-PartB (Non-DME)

Resources (2)

Featured Resource
Additional Information on Revalidation
View Methodology

Featured Resource
Revalidation Due Date List Data Dictionary
View Data Dictionary

Information about associated datasets

The Revalidation Due Date List dataset contains revalidation due dates for Medicare providers who are due to revalidate in the following six months. If a provider's due date does not fall within the ensuing six months, the due date is marked 'TBD'. In addition, the dataset also includes subfiles with reassignment information for a given provider as well as due date listings for clinics and group practices and their providers.

The Revalidation Reassignment List dataset provides information on reassignments of providers who are due for revalidation.

The Revalidation Clinic Group Practice Reassignment dataset provides information between the physician and the group practice they reassign their billing to. It also includes individual employer association counts and the revalidation dates for the individual physician as well as the clinic group practice.

Related Datasets

Dataset
Revalidation Due Date List
Page last modified
November 3, 2025

Dataset
Revalidation Reassignment List
Page last modified
November 3, 2025

Dataset
Revalidation Clinic Group Practice Reassignment
Page last modified
November 3, 2025

Contact us

Didn't find the answer you were looking for?

Email Support

INDEX TO DEFENDANTS REQUEST FOR JUDICIAL NOTICE PART TWO	
Exhibit 19	Sonoran Assoc Providers

EXHIBIT 19

An official website of the United States government Here's how you know it ✓

Medicare Revalidation List

This tool is a searchable database that allows you to look up the revalidation due date for Medicare providers who will complete their enrollment record information every three or five years.

Latest data available: November 2025

Find a Provider:

Search by NPI | Search for an organization | Search for an individual

Location | Other Search Criteria

State | All records | Clear All | Find Provider

Displaying **1 - 50** of **All** records | Records per page: **100**

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: AL
Specialty: Clinic/Group Practice
Reassigned Providers: 4
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: AZ
Specialty: Clinic/Group Practice
Reassigned Providers: 426
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: 04/30/2026

State: FL
Specialty: Clinic/Group Practice
Reassigned Providers: 111
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: FM
Specialty: Clinic/Group Practice
Reassigned Providers: 52
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: FL
Specialty: Clinic/Group Practice
Reassigned Providers: 3
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: GA
Specialty: Clinic/Group Practice
Reassigned Providers: 4
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: FL
Specialty: Clinic/Group Practice
Reassigned Providers: 49
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: GA
Specialty: Clinic/Group Practice
Reassigned Providers: 14
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: 03/31/2026

State: IA
Specialty: Clinic/Group Practice
Reassigned Providers: 4
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: IA
Specialty: Clinic/Group Practice
Reassigned Providers: 3
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: ID
Specialty: Clinic/Group Practice
Reassigned Providers: 5
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: IL
Specialty: Clinic/Group Practice
Reassigned Providers: 20
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: IN
Specialty: Clinic/Group Practice
Reassigned Providers: 3
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: KS
Specialty: Clinic/Group Practice
Reassigned Providers: 3
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: KY
Specialty: Clinic/Group Practice
Reassigned Providers: 5
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: LA
Specialty: Clinic/Group Practice
Reassigned Providers: 3
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: MA
Specialty: Clinic/Group Practice
Reassigned Providers: 10
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: MD
Specialty: Clinic/Group Practice
Reassigned Providers: 3
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: ME
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: MI
Specialty: Clinic/Group Practice
Reassigned Providers: 4
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: MN
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: MO
Specialty: Clinic/Group Practice
Reassigned Providers: 3
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: MS
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: NC
Specialty: Clinic/Group Practice
Reassigned Providers: 11
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: NE
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: NH
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: NJ
Specialty: Clinic/Group Practice
Reassigned Providers: 3
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: NM
Specialty: Clinic/Group Practice
Reassigned Providers: 2
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: NV
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: NY
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: OH
Specialty: Clinic/Group Practice
Reassigned Providers: 10
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: OK
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: OR
Specialty: Clinic/Group Practice
Reassigned Providers: 2
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: PA
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: RI
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: SC
Specialty: Clinic/Group Practice
Reassigned Providers: 3
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: TN
Specialty: Clinic/Group Practice
Reassigned Providers: 10
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: TX
Specialty: Clinic/Group Practice
Reassigned Providers: 2
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: VA
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: VT
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: WA
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: WI
Specialty: Clinic/Group Practice
Reassigned Providers: 2
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: WV
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: WY
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: 01/31/2026

State: AL
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: 01/31/2026

State: AL
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: AR
Specialty: Clinic/Group Practice
Reassigned Providers: 14
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: AZ
Specialty: Clinic/Group Practice
Reassigned Providers: 15
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: CA
Specialty: Clinic/Group Practice
Reassigned Providers: 2
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: CO
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: CT
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: DC
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: DE
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: FL
Specialty: Clinic/Group Practice
Reassigned Providers: 78
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: GA
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: GU
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: HI
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: IA
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: ID
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: IL
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: IN
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: KS
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: KY
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: LA
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: MA
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: MD
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: ME
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: MI
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: MN
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: MO
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: MS
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: NC
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: NE
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: NH
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: NJ
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: NM
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: NV
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: NY
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: OH
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: OK
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: OR
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: PA
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: RI
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: SC
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: TN
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: TX
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: VA
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 9329074158

Due Date: TBD

State: VT
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

Resources | Datasets

Information about the tool

UPDATES

This data was last refreshed on November 3, 2025. The next data refresh is on December 1, 2025.

Due Dates for April 2026 have been added on 11/03/2025.

No new due dates were issued for November 2024 – May 2025.

Any established due dates prior to July 2023 have been removed and replaced with TBD. CMS is recalculating new due dates due to the impacts of the COVID-19 PHE.

Providers/suppliers should not submit their revalidation until they see the newly established due date in this tool.

CMS has extended the deadline for enrolled skilled nursing facilities (SNF) to submit their revalidation to August 1, 2025. The revalidation due up date and the revalidation due date at the end of a month are extended to the first day of the next month. Refer to the Guidance for SNF Attachment of a Form CMS-855A for this information.

This tool is a searchable database that allows you to look up the revalidation due date for Medicare providers who must revalidate their enrollment record information every three or five years. CMS sets every provider's revalidation due date at the end of a month and notifies each provider of their due date approximately 120 days prior.

A due date of "TBD" means that CMS has not set the due date yet.

- Revalidation due dates for participating hospitals as well as Physician Assistant (PA) enrollment are forthcoming.
- All providers are identified on the downloadable file in a new column called "Enrollment Type" and are identified as follows:
  - 1 = Part A
  - 2 = Part B
  - 3 = Part B (Non-DME)

Resources (2)

Featured Resource
Additional Information on Revalidation
View Methodology

Featured Resource
Revalidation Due Date List Data Dictionary
View Data Dictionary

Information about associated datasets

The Revalidation Due Date List dataset contains revalidation due dates for Medicare providers who are due to revalidate in the following six months. A provider's due date does not fall within the ensuing six months, the due date is marked "TBD". In addition, the dataset also includes information on provider name, address, and specialty as well as due date listings for clinics and group practices and their providers.

The Revalidation Reassignment List dataset provides information on reassignments of providers who are due for revalidation.

The Revalidation Clinic Group Practice Reassignment dataset provides information between the physician and the group practice they reassign their billing to. It also includes individual employer association counts and the revalidation dates for the individual physician as well as the entire group practice.

Related Datasets

Dataset
Revalidation Due Date List
Page last modified: November 3, 2025

Dataset
Revalidation Reassignment List
Page last modified: November 3, 2025

Dataset
Revalidation Clinic Group Practice Reassignment
Page last modified: November 3, 2025

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Update Your Mailing Address

Update Your Employment Info

Update Your Photo

Update Your Privacy Settings

Update Your Communication Preferences

Update Your Name

Update Your Primary Language

Update Your Time Zone

Update Your Display Preferences

Update Your Social Media Accounts

Update Your Member Directory Preferences

Update Your Professional Info

Update Your Education Info

Update Your Work Info

Update Your Volunteer Info

Update Your Publication Info

Update Your Speaking Info

Update Your Awards Info

Update Your Test Info

Update Your Honors Info

Update Your Organizations Info

Update Your Skills Info

Update Your Interests Info

Update Your Languages

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Exhibit 20	Associate Valley Assoc Providers

EXHIBIT 20

An official website of the United States government Here's how you know

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Medicare Revalidation List

This tool is a searchable database that allows you to look up the revalidation due date for Medicare providers who must revalidate their enrollment record information every three or five years.

Latest data available: November 2025

Find a Provider:

Search by NPI

Enter NPI

Search for an organization

associated valley

Search for an individual

Enter provider first name

Enter provider last name

Location

State

Filter records (All, Due Dates Only, Specific Range)

All records

Clear All

Find Provider

Displaying **1 - 23** of **23** records

Records per page: 100

ORGANIZATION
Associated Valley Radiologists Ltd
NPI: 1932683257
Due Date: TBD
State: AL
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Associated Valley Radiologists Ltd
NPI: 1932683257
Due Date: 01/31/2026
State: AZ
Specialty: Clinic/Group Practice
Reassigned Providers: 209
Enrollment Type: Non-DME Part B

ORGANIZATION
Associated Valley Radiologists Ltd
NPI: 1932683257
Due Date: 03/31/2026
State: CA
Specialty: Clinic/Group Practice
Reassigned Providers: 19
Enrollment Type: Non-DME Part B

ORGANIZATION
Associated Valley Radiologists Ltd
NPI: 1932683257
Due Date: TBD
State: CO
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Associated Valley Radiologists Ltd
NPI: 1932683257
Due Date: TBD
State: DE
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Associated Valley Radiologists Ltd
NPI: 1932683257
Due Date: TBD
State: FL
Specialty: Clinic/Group Practice
Reassigned Providers: 9
Enrollment Type: Non-DME Part B

ORGANIZATION
Associated Valley Radiologists Ltd
NPI: 1932683257
Due Date: TBD
State: GA
Specialty: Clinic/Group Practice
Reassigned Providers: 2
Enrollment Type: Non-DME Part B

ORGANIZATION
Associated Valley Radiologists Ltd
NPI: 1932683257
Due Date: TBD
State: HI
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Associated Valley Radiologists Ltd
NPI: 1932683257
Due Date: TBD
State: IL
Specialty: Clinic/Group Practice
Reassigned Providers: 3
Enrollment Type: Non-DME Part B

ORGANIZATION
Associated Valley Radiologists Ltd
NPI: 1932683257
Due Date: TBD
State: IN
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Associated Valley Radiologists Ltd
NPI: 1932683257
Due Date: TBD
State: KY
Specialty: Clinic/Group Practice
Reassigned Providers: 2
Enrollment Type: Non-DME Part B

ORGANIZATION
Associated Valley Radiologists Ltd
NPI: 1932683257
Due Date: TBD
State: MT
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

ORGANIZATION
Associated Valley Radiologists Ltd
NPI: 1932683257
Due Date: TBD
State: NC
Specialty: Clinic/Group Practice
Reassigned Providers: 5
Enrollment Type: Non-DME Part B

ORGANIZATION
Associated Valley Radiologists Ltd
NPI: 1932683257
Due Date: TBD
State: NV
Specialty: Clinic/Group Practice
Reassigned Providers: 8
Enrollment Type: Non-DME Part B

ORGANIZATION
Associated Valley Radiologists Ltd
NPI: 1932683257
Due Date: TBD
State: OH
Specialty: Clinic/Group Practice
Reassigned Providers: 3
Enrollment Type: Non-DME Part B

ORGANIZATION
Associated Valley Radiologists Ltd
NPI: 1932683257
Due Date: TBD
State: OR
Specialty: Clinic/Group Practice
Reassigned Providers: 2
Enrollment Type: Non-DME Part B

ORGANIZATION
Associated Valley Radiologists Ltd
NPI: 1932683257
Due Date: 04/30/2026
State: PA
Specialty: Clinic/Group Practice
Reassigned Providers: 4
Enrollment Type: Non-DME Part B

ORGANIZATION
Associated Valley Radiologists Ltd
NPI: 1932683257
Due Date: TBD
State: TN
Specialty: Clinic/Group Practice
Reassigned Providers: 3
Enrollment Type: Non-DME Part B

ORGANIZATION
Associated Valley Radiologists Ltd
NPI: 1932683257
Due Date: 02/28/2026
State: TX
Specialty: Clinic/Group Practice
Reassigned Providers: 10
Enrollment Type: Non-DME Part B

ORGANIZATION
Associated Valley Radiologists Ltd
NPI: 1932683257
Due Date: TBD
State: UT
Specialty: Clinic/Group Practice
Reassigned Providers: 5
Enrollment Type: Non-DME Part B

ORGANIZATION
Associated Valley Radiologists Ltd
NPI: 1932683257
Due Date: TBD
State: VA
Specialty: Clinic/Group Practice
Reassigned Providers: 4
Enrollment Type: Non-DME Part B

ORGANIZATION
Associated Valley Radiologists Ltd
NPI: 1932683257
Due Date: TBD
State: WI
Specialty: Clinic/Group Practice
Reassigned Providers: 2
Enrollment Type: Non-DME Part B

ORGANIZATION
Associated Valley Radiologists Ltd
NPI: 1932683257
Due Date: TBD
State: WV
Specialty: Clinic/Group Practice
Reassigned Providers: 1
Enrollment Type: Non-DME Part B

Information about the tool

UPDATES

This data was last refreshed on November 3, 2025. The next data refresh is on December 1, 2025.

Due Dates for April 2026 have been added on 11/03/2025.

No new due dates were issued for November 2024 - May 2025.

Any established due dates prior to July 2023 have been removed and replaced with TBD. CMS is reestablishing new due dates due to the impacts of the COVID-19 PHE.

Providers/suppliers should not submit their revalidation until they see the newly established Due Date on the tool.

CMS has extended the deadline for enrolled skilled nursing facilities (SNFs) to submit their revalidation to August 1, 2025. The revalidation look up tool and the revalidation list in PECOS will not be updated with the revised date. SNFs should refer to the Guidance for SNF Attachment on Form CMS-855A for this information.

This tool is a searchable database that allows you to look up the revalidation due date for Medicare providers who must revalidate their enrollment record information every three or five years. CMS sets every provider's revalidation due date at the end of a month and posts the revalidation due date six to seven months in advance.

A due date of "TBD" means that CMS has not set the due date yet.

- Affiliations now include reassignments as well as Physician Assistant (PA) employment relationships.
- All providers are identified on the downloadable file in a new column called "Enrollment Type" and are identified as follows:
  - 1-Part A
  - 2-DME
  - 3-Part B (Non-DME)

Resources (2)

Featured Resource
Additional Information on Revalidation
View Methodology

Featured Resource
Revalidation Due Date List Data Dictionary
View Data Dictionary

Information about associated datasets

The Revalidation Due Date List dataset contains revalidation due dates for Medicare providers who are due to revalidate in the following six months. If a provider's due date does not fall within the ensuing six months, the due date is marked 'TBD'. In addition, the dataset also includes subfiles with reassignment information for a given provider as well as due date listings for clinics and group practices and their providers.

The Revalidation Reassignment List dataset provides information on reassignments of providers who are due for revalidation.

The Revalidation Clinic Group Practice Reassignment dataset provides information between the physician and the group practice they reassign their billing to. It also includes individual employer association counts and the revalidation dates for the individual physician as well as the clinic group practice.

Related Datasets

Dataset
Revalidation Due Date List
Page last modified
November 3, 2025

Dataset
Revalidation Reassignment List
Page last modified
November 3, 2025

Dataset
Revalidation Clinic Group Practice Reassignment
Page last modified
November 3, 2025

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Associated Valley Reddlington Lawn Cemetery

Established	Burials	Status
1867	1,842	Active

Add Photo | Add Memorial | Edit Cemetery | Request Maintenance

Add Memorial

Individuals in the organization

Found 1,842 results

Previous page · Next ›

Abbott, Albert Wilson Born [illegible]	Section 1 Plot 0001	Section 1 Monumental Mason Ltd Plot 0001
Abbott, Ernest Charles Born [illegible]	Section 1 Plot 0002	Section 1 Monumental Mason Ltd Plot 0002
Abbott, Mildred Ethel Born [illegible]	Section 1 Plot 0003	Section 1 Monumental Mason Ltd Plot 0003
Abbott, Reginald Ernest Born [illegible]	Section 1 Plot 0004	Section 1 Monumental Mason Ltd Plot 0004
Abbott, Abigail Dagmar Born [illegible]	Section 1 Plot 0005	Section 1 Monumental Mason Ltd Plot 0005
Abbott, Albert Collingwood Born [illegible]	Section 1 Plot 0006	Section 1 Monumental Mason Ltd Plot 0006
Abbott, Ernest Reginald Born [illegible]	Section 1 Plot 0007	Section 1 Monumental Mason Ltd Plot 0007
Abbott, Ethel Gladys Born [illegible]	Section 1 Plot 0008	Section 1 Monumental Mason Ltd Plot 0008
Abbott, Albert Frederick Born [illegible]	Section 1 Plot 0009	Section 1 Monumental Mason Ltd Plot 0009
Abbott, Dorothy Beatrice Born [illegible]	Section 1 Plot 0010	Section 1 Monumental Mason Ltd Plot 0010
Abbott, Percival Aubrey Born [illegible]	Section 1 Plot 0011	Section 1 Monumental Mason Ltd Plot 0011
Abbott, Reginald Stephen Born [illegible]	Section 1 Plot 0012	Section 1 Monumental Mason Ltd Plot 0012
Abbott, Bernadette Dagmar Born [illegible]	Section 1 Plot 0013	Section 1 Monumental Mason Ltd Plot 0013
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Abbott, Bernadette Dagmar Born [illegible]	Section 1 Plot 0021	Section 1 Monumental Mason Ltd Plot 0021
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Abbott, Albert Frederick Born [illegible]	Section 1 Plot 0100	Section 1 Monumental Mason Ltd Plot 0100

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INDEX TO DEFENDANTS REQUEST FOR JUDICIAL NOTICE PART THREE	
Exhibit 21	Southwest Diagnostic Assoc Providers

EXHIBIT 21

An official website of the United States government Here's how you know ▾

All Interactive Tools

Medicare Revalidation List

This tool is a searchable database that allows you to look up the revalidation due date for Medicare providers who must revalidate their enrollment record information every three or five years.

Latest data available: November 2025

Find a Provider:

Search by NPI: Enter NPI

Search for an organization: southwest diagnostic

Search for an individual: Enter provider first name | Enter provider last name

Location: State

Filter records (All, Due Dates Only, Specific Range): All records

Clear All | Find Provider

Displaying **1 - 23** of **23** records

Records per page: 100

Organization	Due Date:	
Southwest Diagnostic Imaging Llc **NPI:** 1902896236	TBD	**State:** AL **Specialty:** Clinic/Group Practice **Reassigned Providers:** 1 **Enrollment Type:** Non-DME Part B
Southwest Diagnostic Imaging Llc **NPI:** 1902896236	TBD	**State:** AZ **Specialty:** Clinic/Group Practice **Reassigned Providers:** 163 **Enrollment Type:** Non-DME Part B
Southwest Diagnostic Imaging Llc **NPI:** 1902896236	TBD	**State:** CA **Specialty:** Clinic/Group Practice **Reassigned Providers:** 12 **Enrollment Type:** Non-DME Part B
Southwest Diagnostic Imaging Llc **NPI:** 1902896236	TBD	**State:** CO **Specialty:** Clinic/Group Practice **Reassigned Providers:** 4 **Enrollment Type:** Non-DME Part B
Southwest Diagnostic Imaging Llc **NPI:** 1902896236	TBD	**State:** FL **Specialty:** Clinic/Group Practice **Reassigned Providers:** 8 **Enrollment Type:** Non-DME Part B
Southwest Diagnostic Imaging Llc **NPI:** 1902896236	TBD	**State:** GA **Specialty:** Clinic/Group Practice **Reassigned Providers:** 4 **Enrollment Type:** Non-DME Part B
Southwest Diagnostic Imaging Llc **NPI:** 1902896236	10/31/2025	**State:** HI **Specialty:** Clinic/Group Practice **Reassigned Providers:** 2 **Enrollment Type:** Non-DME Part B
Southwest Diagnostic Imaging Llc **NPI:** 1902896236	TBD	**State:** IA **Specialty:** Clinic/Group Practice **Reassigned Providers:** 1 **Enrollment Type:** Non-DME Part B
Southwest Diagnostic Imaging Llc **NPI:** 1902896236	09/30/2024	**State:** IL **Specialty:** Clinic/Group Practice **Reassigned Providers:** 1 **Enrollment Type:** Non-DME Part B
Southwest Diagnostic Imaging Llc **NPI:** 1902896236	TBD	**State:** LA **Specialty:** Clinic/Group Practice **Reassigned Providers:** 1 **Enrollment Type:** Non-DME Part B
Southwest Diagnostic Imaging Llc **NPI:** 1902896236	TBD	**State:** MA **Specialty:** Clinic/Group Practice **Reassigned Providers:** 2 **Enrollment Type:** Non-DME Part B
Southwest Diagnostic Imaging Llc **NPI:** 1902896236	TBD	**State:** MD **Specialty:** Clinic/Group Practice **Reassigned Providers:** 1 **Enrollment Type:** Non-DME Part B
Southwest Diagnostic Imaging Llc **NPI:** 1902896236	TBD	**State:** NE **Specialty:** Clinic/Group Practice **Reassigned Providers:** 1 **Enrollment Type:** Non-DME Part B
Southwest Diagnostic Imaging Llc **NPI:** 1902896236	TBD	**State:** NV **Specialty:** Clinic/Group Practice **Reassigned Providers:** 5 **Enrollment Type:** Non-DME Part B
Southwest Diagnostic Imaging Llc **NPI:** 1902896236	11/30/2025	**State:** NY **Specialty:** Clinic/Group Practice **Reassigned Providers:** 2 **Enrollment Type:** Non-DME Part B
Southwest Diagnostic Imaging Llc **NPI:** 1902896236	01/31/2026	**State:** OK **Specialty:** Clinic/Group Practice **Reassigned Providers:** 3 **Enrollment Type:** Non-DME Part B
Southwest Diagnostic Imaging Llc **NPI:** 1902896236	08/31/2024	**State:** OR **Specialty:** Clinic/Group Practice **Reassigned Providers:** 1 **Enrollment Type:** Non-DME Part B
Southwest Diagnostic Imaging Llc **NPI:** 1902896236	04/30/2024	**State:** PA **Specialty:** Clinic/Group Practice **Reassigned Providers:** 1 **Enrollment Type:** Non-DME Part B
Southwest Diagnostic Imaging Llc **NPI:** 1902896236	TBD	**State:** TX **Specialty:** Clinic/Group Practice **Reassigned Providers:** 9 **Enrollment Type:** Non-DME Part B
Southwest Diagnostic Imaging Llc **NPI:** 1902896236	TBD	**State:** UT **Specialty:** Clinic/Group Practice **Reassigned Providers:** 6 **Enrollment Type:** Non-DME Part B
Southwest Diagnostic Imaging Llc **NPI:** 1902896236	TBD	**State:** VA **Specialty:** Clinic/Group Practice **Reassigned Providers:** 1 **Enrollment Type:** Non-DME Part B
Southwest Diagnostic Imaging Llc **NPI:** 1902896236	12/31/2025	**State:** WI **Specialty:** Clinic/Group Practice **Reassigned Providers:** 1 **Enrollment Type:** Non-DME Part B

Resources
Datasets

Information about the tool

UPDATES

This data was last refreshed on November 3, 2025. The next data refresh is on December 1, 2025.

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Providers/suppliers should not submit their revalidation until they see the newly established Due Date on the tool.

CMS has extended the deadline for enrolled skilled nursing facilities (SNFs) to submit their revalidation to August 1, 2025. The revalidation look up tool and the revalidation list in PECOS will not be updated with the revised date. SNFs should refer to the Guidance for SNF Attachment on Form CMS-855A for this information.

This tool is a searchable database that allows you to look up the revalidation due date for Medicare providers who must revalidate their enrollment record information every three or five years. CMS sets every provider's revalidation due date at the end of a month and posts the revalidation due date six to seven months in advance.

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- Affiliations now include reassignments as well as Physician Assistant (PA) employment relationships.
- All providers are identified on the downloadable file in a new column called "Enrollment Type" and are identified as follows:
  - 1-PartA
  - 2-DME
  - 3-PartB (Non-DME)

Resources (2)

Featured Resource
Additional Information on Revalidation
View Methodology

Featured Resource
Revalidation Due Date List Data Dictionary
View Data Dictionary

Information about associated datasets

The Revalidation Due Date List dataset contains revalidation due dates for Medicare providers who are due to revalidate in the following six months. If a provider's due date does not fall within the ensuing six months, the due date is marked 'TBD'. In addition, the dataset also includes subfiles with reassignment information for a given provider as well as due date listings for clinics and group practices and their providers.

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The Revalidation Clinic Group Practice Reassignment dataset provides information between the physician and the group practice they reassign their billing to. It also includes individual employer association counts and revalidation dates for the individual physician as well as the clinic group practice.

Related Datasets

Dataset
Revalidation Due Date List
Page last modified
November 3, 2025

Dataset
Revalidation Reassignment List
Page last modified
November 3, 2025

Dataset
Revalidation Clinic Group Practice Reassignment
Page last modified
November 3, 2025

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Individuals in the organization

Sort by: Relevance

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Alfonso Abernathy
Software Engineer

Name Hidden
Title Hidden

Name Hidden
Title Hidden

Name Hidden
Title Hidden

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Exhibit 22	Evac Screenshot_3-11-2025_194345_data.cms.gov
Exhibit 23	Howard Harvin - CMS Data
Exhibit 24	Gavin Slethaug - CMS Data
Exhibit 25	Michelle Dubes - CMS Data
Exhibit 26	Bernadette Diegnan - CMS Data
Exhibit 27	Jason Barclay-White - CMS Data

EXHIBIT 22

An official website of the United States government Here's how you know

Back to search results

Evac Llc

Due Date: TBD
State: AZ
NPI: 1073772588
Enrollment Type: Non-DME Part B
Specialty: Clinic/Group Practice
Last Updated: 11/07/2025

Medicare Revalidation List
Looking for different results?
Start Over

Individuals in this organization:

Displaying **1 - 22** of **22** records

Records per page: 100

INDIVIDUAL
Annette Stevenson
NPI: 1558875435
Due Date: TBD
State: AZ
Specialty: Nurse Practitioner
Total Providers Receiving Reassigned Benefits: 5
Enrollment Type: Non-DME Part B

INDIVIDUAL
Arvind Durvasan
NPI: 1417038548
Due Date: TBD
State: AZ
Specialty: Nephrology
Total Providers Receiving Reassigned Benefits: 7
Enrollment Type: Non-DME Part B

INDIVIDUAL
Bradley Davis
NPI: 1801026893
Due Date: TBD
State: AZ
Specialty: Diagnostic Radiology
Total Providers Receiving Reassigned Benefits: 4
Enrollment Type: Non-DME Part B

INDIVIDUAL
Christopher Davis
NPI: 1659457281
Due Date: TBD
State: AZ
Specialty: Physician Assistant
Total Providers Receiving Reassigned Benefits: 7
Enrollment Type: Non-DME Part B

INDIVIDUAL
Douglas Lewis
NPI: 1205197829
Due Date: TBD
State: AZ
Specialty: Diagnostic Radiology
Total Providers Receiving Reassigned Benefits: 8
Enrollment Type: Non-DME Part B

INDIVIDUAL
James Lyons
NPI: 1124017918
Due Date: TBD
State: AZ
Specialty: Diagnostic Radiology
Total Providers Receiving Reassigned Benefits: 21
Enrollment Type: Non-DME Part B

INDIVIDUAL
Jared Criddle
NPI: 1235364803
Due Date: TBD
State: AZ
Specialty: Interventional Radiology
Total Providers Receiving Reassigned Benefits: 2
Enrollment Type: Non-DME Part B

INDIVIDUAL
Jedidiah Johnson
NPI: 1689155673
Due Date: TBD
State: AZ
Specialty: Physician Assistant
Total Providers Receiving Reassigned Benefits: 3
Enrollment Type: Non-DME Part B

INDIVIDUAL
Jeffrey Packer
NPI: 1578566139
Due Date: TBD
State: AZ
Specialty: Nephrology
Total Providers Receiving Reassigned Benefits: 2
Enrollment Type: Non-DME Part B

INDIVIDUAL
John Santor
NPI: 1750370839
Due Date: TBD
State: AZ
Specialty: Physician Assistant
Total Providers Receiving Reassigned Benefits: 3
Enrollment Type: Non-DME Part B

INDIVIDUAL
Junaid Qureshi
NPI: 1235186628
Due Date: TBD
State: AZ
Specialty: Nephrology
Total Providers Receiving Reassigned Benefits: 7
Enrollment Type: Non-DME Part B

INDIVIDUAL
Keenan Wanamaker
NPI: 1972508968
Due Date: TBD
State: AZ
Specialty: Vascular Surgery
Total Providers Receiving Reassigned Benefits: 3
Enrollment Type: Non-DME Part B

INDIVIDUAL
Kevin Duwe
NPI: 1932198652
Due Date: TBD
State: AZ
Specialty: Diagnostic Radiology
Total Providers Receiving Reassigned Benefits: 10
Enrollment Type: Non-DME Part B

INDIVIDUAL
Maaz Iqbal
NPI: 1265795967
Due Date: TBD
State: AZ
Specialty: Diagnostic Radiology
Total Providers Receiving Reassigned Benefits: 2
Enrollment Type: Non-DME Part B

INDIVIDUAL
Mark Slepian
NPI: 1558350314
Due Date: TBD
State: AZ
Specialty: Diagnostic Radiology
Total Providers Receiving Reassigned Benefits: 12
Enrollment Type: Non-DME Part B

INDIVIDUAL
Ramya Vejella
NPI: 1467779413
Due Date: TBD
State: AZ
Specialty: Nephrology
Total Providers Receiving Reassigned Benefits: 2
Enrollment Type: Non-DME Part B

INDIVIDUAL
Rick Mishler
NPI: 1629071303
Due Date: TBD
State: AZ
Specialty: Nephrology
Total Providers Receiving Reassigned Benefits: 2
Enrollment Type: Non-DME Part B

INDIVIDUAL
Robert Hanna
NPI: 1356503478
Due Date: TBD
State: AZ
Specialty: Interventional Radiology
Total Providers Receiving Reassigned Benefits: 6
Enrollment Type: Non-DME Part B

INDIVIDUAL
Stephanie Wang
NPI: 1629067244
Due Date: TBD
State: AZ
Specialty: Diagnostic Radiology
Total Providers Receiving Reassigned Benefits: 21
Enrollment Type: Non-DME Part B

INDIVIDUAL
Stephen Hu
NPI: 1710087516
Due Date: TBD
State: AZ
Specialty: Diagnostic Radiology
Total Providers Receiving Reassigned Benefits: 11
Enrollment Type: Non-DME Part B

INDIVIDUAL
Steven Maxfield
NPI: 1801885694
Due Date: TBD
State: AZ
Specialty: Diagnostic Radiology
Total Providers Receiving Reassigned Benefits: 3
Enrollment Type: Non-DME Part B

INDIVIDUAL
William Jacoby
NPI: 1700875515
Due Date: TBD
State: AZ
Specialty: Diagnostic Radiology
Total Providers Receiving Reassigned Benefits: 4
Enrollment Type: Non-DME Part B

Medicare Revalidation List
Didn't find the results you were looking for?
Start Over

Interactive tools
Find the answers you need.
View all tools

Medicare Part D Prescriber Look-up Tool
This tool is a searchable database that allows you to look up a Medicare Part D prescriber and view their associated drugs.
Launch Tool

Provider Opt-Out Affidavits Look-up Tool
This tool is a searchable database that allows you to look up a provider who has opted out of Medicare.
Launch Tool

EXHIBIT 23

Data.CMS.gov
Centers for Medicare & Medicaid Services

Medicare Revalidation List

data.cms.gov/tools/medicare-revalidation-list/provider/I20040902000797

Howard Harvin **Due Date:** TBD **State:** AZ **NPI:** **Enrollment Type:** Non-DME Part B **Specialty:** Diagnostic Radiology **Last Updated:** 11/03/2025

Organizations this individual belongs to:

Displaying **1 - 2** of **2** records

ORGANIZATION
Sonoran Radiology Ltd
NPI: 1033745708
Due Date: TBD
State: AZ
Specialty: Clinic/Group Practice
Reassigned Providers: 426
Enrollment Type: Non-DME Part B

ORGANIZATION
Southwest Diagnostic Imaging Llc
NPI: 1902896236
Due Date: TBD
State: AZ
Specialty: Clinic/Group Practice
Reassigned Providers: 163
Enrollment Type: Non-DME Part B

EXHIBIT 24

Data.CMS.gov
Centers for Medicare & Medicaid Services

Medicare Revalidation List

data.cms.gov/tools/medicare-revalidation-list/provider/I20040510000051

Gavin Slethaug **Due Date:** TBD **State:** AZ **NPI:** **Enrollment Type:** Non-DME Part B **Specialty:** Diagnostic Radiology **Last Updated:** 11/03/2025

Organizations this individual belongs to:

Displaying **1 - 18** of **18** records

ORGANIZATION
Associated Valley Radiologists Ltd
NPI: 1932683257
Due Date: 01/31/2026
State: AZ
Specialty: Clinic/Group Practice
Reassigned Providers: 209
Enrollment Type: Non-DME Part B

ORGANIZATION
Banner Imaging Services Llc
NPI: 1770139958, + 1 more
Due Date: 04/30/2026
State: AZ
Specialty: Clinic/Group Practice
Reassigned Providers: 198
Enrollment Type: Non-DME Part B

ORGANIZATION
Coastal Radiology Associates Pllc
NPI: 1144270307
Due Date: 04/30/2026
State: AZ
Specialty: Clinic/Group Practice
Reassigned Providers: 16
Enrollment Type: Non-DME Part B

ORGANIZATION
Ellis Bandt Birkin Kollins & Wong Pllc
NPI: 1578584678
Due Date: 07/31/2023
State: AZ
Specialty: Clinic/Group Practice
Reassigned Providers: 20
Enrollment Type: Non-DME Part B

ORGANIZATION
Empire State Radiology P C
NPI: 1255962783
Due Date: TBD
State: AZ
Specialty: Clinic/Group Practice
Reassigned Providers: 20
Enrollment Type: Non-DME Part B

ORGANIZATION
Golden State Imaging Associates Inc
NPI: 1144872052
Due Date: TBD
State: AZ
Specialty: Clinic/Group Practice
Reassigned Providers: 26
Enrollment Type: Non-DME Part B

ORGANIZATION
Greensboro Radiology Pa
NPI: 1821035999
Due Date: TBD
State: AZ
Specialty: Clinic/Group Practice
Reassigned Providers: 9
Enrollment Type: Non-DME Part B

ORGANIZATION
Imaging Associates Of Indiana, Pc
NPI: 1699072611
Due Date: 02/28/2026
State: AZ
Specialty: Clinic/Group Practice
Reassigned Providers: 17
Enrollment Type: Non-DME Part B

ORGANIZATION
Imaging Associates Of Michigan Pllc
NPI: 1164943007
Due Date: 11/30/2025
State: AZ
Specialty: Clinic/Group Practice
Reassigned Providers: 11
Enrollment Type: Non-DME Part B

ORGANIZATION
Louisville Radiology Imaging Consultants Pllc
NPI: 1639115447
Due Date: 04/30/2026
State: AZ
Specialty: Clinic/Group Practice
Reassigned Providers: 12
Enrollment Type: Non-DME Part B

ORGANIZATION
Mori Bean And Brooks Inc
NPI: 1093782070
Due Date: 07/31/2024
State: AZ
Specialty: Clinic/Group Practice
Reassigned Providers: 26
Enrollment Type: Non-DME Part B

ORGANIZATION
Northside Radiology Associates Llc
NPI: 1013960657
Due Date: TBD
State: AZ
Specialty: Clinic/Group Practice
Reassigned Providers: 22
Enrollment Type: Non-DME Part B

ORGANIZATION
Pikeville Medical Center Inc
NPI: 1194502054
Due Date: TBD
State: AZ
Specialty: Clinic/Group Practice
Reassigned Providers: 5
Enrollment Type: Non-DME Part B

ORGANIZATION
Radiology Affiliates Of Central New Jersey Pc
NPI: 1811994791
Due Date: TBD
State: AZ
Specialty: Clinic/Group Practice
Reassigned Providers: 9
Enrollment Type: Non-DME Part B

ORGANIZATION
Radiology Alliance Pc
NPI: 1861478489
Due Date: 10/31/2024
State: AZ
Specialty: Clinic/Group Practice
Reassigned Providers: 24
Enrollment Type: Non-DME Part B

ORGANIZATION
Singleton Associates Pa
NPI: 1538107875
Due Date: 10/31/2024
State: AZ
Specialty: Clinic/Group Practice
Reassigned Providers: 39
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 1033745708
Due Date: TBD
State: AZ
Specialty: Clinic/Group Practice
Reassigned Providers: 426
Enrollment Type: Non-DME Part B

ORGANIZATION
Virtual Radiologic Professionals Llc
NPI: 1932342029
Due Date: TBD
State: AZ
Specialty: Clinic/Group Practice
Reassigned Providers: 29
Enrollment Type: Non-DME Part B

EXHIBIT 25

Data.CMS.gov
Centers for Medicare & Medicaid Services

Medicare Revalidation List

data.cms.gov/tools/medicare-revalidation-list/provider/I20110526000695

Michelle Dubes **Due Date:** TBD **State:** AZ **NPI:** **Enrollment Type:** Non-DME Part B **Specialty:** Diagnostic Radiology **Last Updated:** 11/03/2025

Organizations this individual belongs to:

Displaying **1 - 2** of **2** records

ORGANIZATION
Sonoran Radiology Ltd
NPI: 1033745708
Due Date: TBD
State: AZ
Specialty: Clinic/Group Practice
Reassigned Providers: 426
Enrollment Type: Non-DME Part B

ORGANIZATION
Southwest Diagnostic Imaging Llc
NPI: 1902896236
Due Date: TBD
State: AZ
Specialty: Clinic/Group Practice
Reassigned Providers: 163
Enrollment Type: Non-DME Part B

EXHIBIT 26

Data.CMS.gov
Centers for Medicare & Medicaid Services

Medicare Revalidation List

data.cms.gov/tools/medicare-revalidation-list/provider/I20181008003122

Bernadette Diegnan **Due Date:** TBD **State:** AZ **NPI:** **Enrollment Type:** Non-DME Part B **Specialty:** Diagnostic Radiology **Last Updated:** 11/03/2025

Organizations this individual belongs to:

Displaying **1 - 4** of **4** records

ORGANIZATION
Associated Valley Radiologists Ltd
NPI: 1932683257
Due Date: 01/31/2026
State: AZ
Specialty: Clinic/Group Practice
Reassigned Providers: 209
Enrollment Type: Non-DME Part B

ORGANIZATION
Page Hospital
NPI: 1578515789
Due Date: TBD
State: AZ
Specialty: Clinic/Group Practice
Reassigned Providers: 59
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 1033745708
Due Date: TBD
State: AZ
Specialty: Clinic/Group Practice
Reassigned Providers: 426
Enrollment Type: Non-DME Part B

ORGANIZATION
Southwest Diagnostic Imaging Llc
NPI: 1902896236
Due Date: TBD
State: AZ
Specialty: Clinic/Group Practice
Reassigned Providers: 163
Enrollment Type: Non-DME Part B

EXHIBIT 27

Data.CMS.gov
Centers for Medicare & Medicaid Services

Medicare Revalidation List

data.cms.gov/tools/medicare-revalidation-list/provider/I20040519000078

Jason Barclay-White **Due Date:** TBD **State:** AZ **NPI:** **Enrollment Type:** Non-DME Part B **Specialty:** Diagnostic Radiology **Last Updated:** 11/03/2025

Organizations this individual belongs to:

Displaying **1 - 3** of **3** records

ORGANIZATION
Associated Valley Radiologists Ltd
NPI: 1932683257
Due Date: 01/31/2026
State: AZ
Specialty: Clinic/Group Practice
Reassigned Providers: 209
Enrollment Type: Non-DME Part B

ORGANIZATION
Banner Imaging Services Llc
NPI: 1770139958, + 1 more
Due Date: 04/30/2026
State: AZ
Specialty: Clinic/Group Practice
Reassigned Providers: 198
Enrollment Type: Non-DME Part B

ORGANIZATION
Sonoran Radiology Ltd
NPI: 1033745708
Due Date: TBD
State: AZ
Specialty: Clinic/Group Practice
Reassigned Providers: 426
Enrollment Type: Non-DME Part B