

Louisiana Provider Enrollment Disaster Recovery Emergency Update Form

Instructions:

This form is to be completed in its entirety by Individual/Supplier providers who wish to update information on file due to the Disaster.

1. Provider/Supplier Identification	
This section is to be completed with identifying information about the provider/supplier who is requesting an emergency update to their provider number	
Legal Business Name of Provider/Supplier as Reported to IRS	
Tax Identification Number	Medicare Identification Number

2. Individual Practitioner Identification			
This section is to be completed with identifying information about the individual practitioner who is requesting an emergency update to their provider number			
Name First	Middle	Last	Jr., Sr., etc.
Social Security Number		Medicare Identification Number	

3A. Previous Practice Location			
This section is to be completed with the practice locations of the individual/supplier identified in Section 1 or 2 indicating where the individual/supplier previously rendered services.			
Practice Location Information			
1. Practice Location Name		Date practitioner began/will start rendering services at this location (MM/DD/YYYY)	
2. Practice Location Street Address Line 1			
Practice Location Street Address Line 2			
City	County/Parish	State	ZIP Code + 4
Telephone Number ()	(Ext.) ()	Fax Number (if applicable) ()	E-mail Address (if applicable)

3B. Previous Pay-to Address			
This section is to be completed with the address where payments were previously received for the individual/supplier in Section 1 or 2.			
Pay-to Address Information			
Pay-to Location Street Address Line 1			
Pay-to Location Street Address Line 2			
City	County/Parish	State	ZIP Code + 4

4A. New Practice Location

This section is to be completed with the practice locations of the individual/supplier identified in Section 1 or 2 indicating where the individual/supplier identified in Section 1 or 2 will be rendering services on a temporary basis.

Practice Location Information

3. Practice Location Name		Date practitioner began/will start rendering services at this location (MM/DD/YYYY)	
4. Practice Location Street Address Line 1			
Practice Location Street Address Line 2			
City	County/Parish	State	ZIP Code + 4
Telephone Number ()	(Ext.) ()	Fax Number (if applicable) ()	E-mail Address (if applicable)

4B. New Pay-to Address

This section is to be completed with the address where payments are to be received for the individual/supplier in Section 1 or 2.

Pay-to Address Information

Pay-to Location Street Address Line 1			
Pay-to Location Street Address Line 2			
City	County/Parish	State	ZIP Code + 4

5. Ownership Interest and/or Managing Control Information (Individuals)

This section is to be completed with information about the individual who will be signing as Authorized/Delegated Official of the Supplier listed in section 1. Furnish the individual's name, social security number, date of birth, Medicare number (if applicable), and effective date of ownership and/or control.

A. Individual with Ownership Interest and/or Managing Control—Identification Information

<input type="checkbox"/> Add		<input type="checkbox"/> Delete		<input type="checkbox"/> Change		Effective Date: _____	
1. Name	First	Middle	Last			Jr., Sr., etc.	
Social Security Number			Date of Birth (MM/DD/YYYY)		Credentials (M.D., O.D., etc.)		
Medicare Identification Number (if applicable)		Effective Date of <u>Ownership</u> (MM/DD/YYYY)		Effective Date of <u>Control</u> (MM/DD/YYYY)			

6. Contact Person

This section must be completed with the name and telephone number of the person representing the Supplier listed in section 1. It **may** also be completed for any person other than the individual in section 2 who can answer questions about the information furnished in this application.

Contact Name and Telephone Number

Name	First	Last	E-mail Address (if applicable)	Telephone Number	(Ext.)
				()	()

Comments

Any additional information the provider feels we need to know concerning their Medicare enrollment issue.

Certification Statement

You **MUST** sign and date the certification statement below in order to update your Medicare information. In doing so, you are attesting to meeting and maintaining the Medicare requirements stated below.

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 the Medicare program contractor of this fact immediately.
- 2.) 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 form within 90 days of the effective date of the change.
- 3.) I understand that at a later date, Medicare may require the submission of an official CMS 855 application.
- 4.) 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 revocation of Medicare billing privileges, and/or the imposition of fines, civil damages, and/or imprisonment.
- 5.) I agree to abide by the Medicare laws, regulations and program instructions that apply to me. The Medicare laws, regulations, and program instructions are available through the Medicare 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 and the Stark law), and on my compliance with any applicable conditions of participation in Medicare.
- 6.) Neither I, nor any W-2 managing employee, is currently sanctioned, suspended, debarred, or excluded by the Medicare or Medicaid program, or any other Federal program, or is otherwise prohibited from providing services to Medicare or other Federal program beneficiaries.
- 7.) I agree that any existing or future overpayment made to me by the Medicare program may be recouped by Medicare through the withholding of future payments.
- 8.) I understand that the Medicare billing number issued to me can only be used by me or by a provider or supplier to whom I have reassigned my benefits under current Medicare regulations, when billing for services rendered by me.
- 9.) 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.

Name First Print	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Signature			Date (MM/DD/YYYY) Signed	
(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)				

Once complete, this form should be faxed to our office at 225-231-2128, or mailed to:

**Medicare LA Disaster Recovery
P.O. Box 83860
Baton Rouge, LA 70884-3860**