



Dear Applicant:

This letter outlines the requirements and procedures through which your institution may be approved to participate in Medicare as a provider of services. The Agency for Health Care Administration (AHCA) certifies and periodically recertifies whether providers of services meet the Medicare Conditions of Participation, and assists the Centers for Medicare and Medicaid Services (CMS) in determining whether institutions and agencies can participate in Medicare. Such approval, when required, is prerequisite to qualifying to participate in the State Medicaid program as well.

To initiate the application process it will be necessary for you to submit CMS Form 855A "Medicare Federal Health Care Provider Application" to the Medicare Administrative Contractor (MAC), First Coast Service Options Inc., for processing. This form may be obtained by calling the carrier at (877) 602-8816, or by downloading it from the following CMS website: <http://www.cms.hhs.gov/cmsforms/cmsforms/>

In addition, please complete and forward the following forms in order to avoid delaying approval. You should retain copies of these forms for your records and send copies to the Agency for Health Care Administration, 2727 Mahan Dr, MS # 31, Tallahassee, FL 32308.

- Request for Certification in the Medicare and/or Medicaid Program to Provide Outpatient Physical Therapy and/or Speech Pathology Services – CMS Form 1856 (12/2006)
- Health Insurance Benefit Agreement – CMS Form 1561 (submit 2 originals please)
- Medicare Administrative Contractor Choice Form
- Assurance of Compliance – HHS Form 690
- Medicare Certification of Civil Rights Information Form – OMB 0990-0243 and related documents (policies & procedures, etc.).
- If accredited, a copy of the AAAASF accreditation award letter.

Forms and information can be found on our web site:

[http://ahca.myflorida.com/MCHQ/Health\\_Facility\\_Regulation/Hospital\\_Outpatient/rehabilitation.shtml](http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Hospital_Outpatient/rehabilitation.shtml)

On the second line of the Health Insurance Benefits Agreement, after the term, Social Security Act, enter the entrepreneurial name of the enterprise, followed by the trade name (if different from the entrepreneurial name). Ordinarily, this is the same as the business name used on all official IRS correspondence concerning payroll withholding taxes, such as the W3 or 941 forms. For example, the ABC Corporation, owner of Community General Hospital, would enter on the agreement, "ABC Corporation d/b/a Community General Hospital." A partnership of several persons might complete the agreement to read: "Robert Johnson, Louis Miller and Paul Allen, partner, Easy Care Home Health Services." A sole proprietorship would complete the agreement to read: "John Smith d/b/a Mercy Hospital." The person signing the Health Insurance Benefits Agreement must be someone who has the authorization of the owners of the enterprise to enter into this agreement.

Also available on the website are the applicable Medicare Conditions of Participation. The Conditions are only a part of the regulations contained in Title 42, Chapter IV of the Code of Federal Regulations which Medicare providers must meet. You can also purchase 42 CFR Chapter IV from the Superintendent of Documents, U.S. Government Printing Office, Washington D.C. 20402. However, the information you need is supplied in Medicare materials provided to you without charge, and explanations are furnished either by this office or by your MAC.

If non-accredited, AHCA surveyors will inspect the institution, interview you and members of your staff, review documents, and undertake other procedures necessary to evaluate the extent to which your institution meets the Conditions of Participation. If your institution has significant deficiencies in any of the Conditions, you will be informed and given an opportunity to correct them. Following the survey, this agency will recommend to the Centers for Medicare and Medicaid Services whether your institution should participate. Please also read the CMS priority notice found on our web site.

After it is determined by the Centers for Medicare and Medicaid Services that all requirements are met, the Health Insurance Benefits Agreement will be countersigned. One copy will be returned to you along with the notification that your institution has been approved. If operation of the entire institution is later transferred to another owner, ownership group, or to a lessee, the agreement will usually be automatically assigned to the successor. However, you are required to notify the Centers for Medicare and Medicaid Services and this Agency at the time you are planning such a transfer.

Those institutions and agencies that are denied approval to participate in the Medicare program are sent notification giving the reasons for the denial and information about their rights to appeal the decision.

On November 14, 2003, Senate Bill 32A, known as the "Motor Vehicle Insurance Reform Act," became law, requiring the licensure of health care clinics by the Agency for Health Care Administration (Agency). This law, known as the "Health Care Clinic Act," was codified as part XIII, chapter 400, F.S. (2003). The Agency's health care clinic licensure and exemption process became effective March 1, 2004. Health care clinic application forms are available on the Agency website at:

[http://www.fdhc.state.fl.us/MCHQ/Health\\_Facility\\_Regulation/HealthCareClinic/index.shtml](http://www.fdhc.state.fl.us/MCHQ/Health_Facility_Regulation/HealthCareClinic/index.shtml)

Should you have any questions concerning this material, please use the following contacts:

- MAC, First Coast Service Options, Inc. at (877) 602-8816, for CMS Form 855A
- AHCA, Hospital & Outpatient Services Unit, at (850) 412-4549, for certification inquiries
- AHCA, Health Care Clinic Unit, at (850) 412-4404, for health care clinic licensure inquiries
- AAAASF at (847) 853-6060, for accreditation information