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Agenda Item #: 3S-1

PALM BEACH COUNTY
BOARD OF COUNTY COMMISSIONERS

AGENDA ITEM SUMMARY

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Meeting Date: 1/24/12 **[X] Consent [ ] Regular [ ] Workshop [ ] Public Hearing**

Department:

Submitted For: FIRE RESCUE

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I. EXECUTIVE BRIEF

Motion and Title: **Staff recommends motion to:**

A) **ratify** the appointment of the Fire Rescue Administrator as an Authorized Official to enroll the County (Fire Rescue) in the Medicare program as an ambulance service provider, to make changes or updates to the County's status in the Medicare program, and to commit the County to fully abide by the statutes, regulations, and program instructions of the Medicare program, including the authority to sign and submit any Medicare applications, contracts, certifications, attestations, and other related documents on the County's behalf; and

B) **authorize** the reimbursement of the Medicare Enrollment Application Fee in the amount of five-hundred five dollars ($505.00) to ADPI/Intermedix.

Summary: In accordance with recent federal law, Medicare providers are being required to complete a Medicare Enrollment Application to revalidate their enrollment information under new screening criteria. This allows the County to continue to submit fire rescue emergency transport claims directly to Medicare and binds the County to the Medicare program laws and regulations. The enrollment package requires the County to directly appoint an Authorized Official to enroll the County (Fire Rescue) in the Medicare program, to make changes or updates to the County's status in the Medicare program, and to commit the County to fully abide by the statutes, regulations, and program instructions of the Medicare program. Due to a stringent deadline and late notice to the County, the Fire Rescue Administrator signed the necessary documentation, and the County's third party billing agent, ADPI/Intermedix, processed submittal of the application and the required application fee on the County's behalf. Countywide (SGB)

Background and Justification: Provider enrollment in the Medicare program allows Palm Beach County Fire-Rescue to submit claims directly to Medicare for those patients with Medicare insurance. In November 2011, the Fire Rescue Department was advised by its third party billing agent that the Centers for Medicare and Medicaid Services (CMS) set a stringent deadline of November 28th to submit the required revalidation application and related support documentation. Failure to submit these executed forms before the deadline would have resulted in termination of our Medicare provider number.

Attachments:

1. Department of Health & Human Services – Medicare Enrollment Application Package

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Recommended By: _____ 12/13/11
Deputy Chief **Date**

Approved By: _____ 12/12/11
Fire-Rescue Administrator **Date**

II. FISCAL IMPACT ANALYSIS

A. Five Year Summary of Fiscal Impact:

Fiscal Years	2012	2013	2014	2015	2016
Capital Expenditures					
Operating Costs					
External Revenues	505				
Program Income (County)					
In-Kind Match (County)					
NET FISCAL IMPACT	505				
# ADDITIONAL FTE POSITIONS (Cumulative)					

Is Item Included in Current Budget? Yes X No

Budget Account No.: Fund 1300 **Dept** 440 **Unit** 4215 **Object** 4901

B. Recommended Sources of Funds/Summary of Fiscal Impact:

There is no direct fiscal impact from the approval of this item. However, approval does provide the County with the authority to directly submit claims to Medicare for patients with Medicare insurance. For reference, the Department received $7.2M in Medicare payments in FY 2010.

C. Departmental Fiscal Review: [signature]

III. REVIEW COMMENTS

A. OFMB Fiscal and/or Contract Dev. and Control Comments:

There is no direct fiscal impact from the approval except for the reimbursement of the application fee $ 505.

[signature] 12/27/11
OFMB

[signature] 12/28/11
Contract Dev. and Control
12-08-11 13:10 hrs

B. Legal Sufficiency:

VM 12/30/11 2/20/11

[signature] 1/3/12
Assistant County Attorney

C. Other Department Review:

Department Director

THIS SUMMARY IS NOT TO BE USED AS A BASIS FOR PAYMENT.

MEDICARE ENROLLMENT APPLICATION

Clinics/Group Practices and Certain Other Suppliers

CMS-855B

SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION.

SEE PAGE 2 FOR INFORMATION ON WHERE TO MAIL THIS APPLICATION.

SEE PAGE 35 TO FIND A LIST OF THE SUPPORTING DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

WHO SHOULD SUBMIT THIS APPLICATION

Clinics and group practices 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 enrollment application process (e.g., CMS 855B).

For additional information regarding the Medicare enrollment process, including Internet-based PECOS, go to *http://www.cms.gov/MedicareProviderSupEnroll*.

Clinics and group practices who are enrolled in the Medicare program, but have not submitted the CMS 855B since 2003, are required to submit a Medicare enrollment application (i.e., Internet-based PECOS or the CMS 855B) as an initial application when reporting a change for the first time.

The following suppliers must complete this application to initiate the enrollment process:

- Ambulance Service Supplier
- Ambulatory Surgical Center
- Clinic/Group Practice
- Independent Clinical Laboratory
- Independent Diagnostic Testing Facility (IDTF)
- Intensive Cardiac Rehabilitation Supplier
- Mammography Center
- Mass Immunization (Roster Biller Only)
- Part B Drug Vendor
- Portable X-ray Supplier
- Radiation Therapy Center

If your supplier type is not listed above, contact your designated fee-for-service contractor before you submit this application.

Complete and submit this application if you are an organization/group that plans to bill Medicare and you are:

- A **medical practice or clinic that will bill for Medicare Part B services** (e.g., group practices, clinics, independent laboratories, portable x-ray suppliers).
- A **hospital 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 bill Medicare Part B.
- **Currently enrolled with a Medicare fee-for-service contractor but need to enroll in another fee-for-service contractor's jurisdiction** (e.g., you have opened a practice location in a geographic territory serviced by another Medicare fee-for-service contractor).
- **Currently enrolled in Medicare and need to make changes to your enrollment data** (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. § 424.516(d). (IDTF changes of information must be reported in accordance with 42 C.F.R. § 410.33.)

BILLING NUMBER INFORMATION

The National Provider Identifier (NPI) is the standard unique health identifier for health care providers and is assigned by the National Plan and Provider Enumeration System (NPPES). **As a Medicare health supplier, you must obtain an NPI prior to enrolling in Medicare or before submitting a change for your existing Medicare enrollment information.** Applying for an 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.

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*. For more information about subparts, visit *www.cms.gov/NationalProvIdentStand* to view the "Medicare Expectations Subparts Paper."

The Medicare Identification Number, often referred to as a Provider Transaction Access Number (PTAN) or Medicare "legacy" number, is a generic term for any number other than the NPI that is used to identify a Medicare supplier.

INSTRUCTIONS FOR COMPLETING AND SUBMITTING THIS APPLICATION

- Type or print all information so that it is legible. Do not use pencil.
- Report additional information within a section by copying and completing that section for each additional entry.
- Attach all required supporting documentation.
- Keep a copy of your completed Medicare enrollment package for your records.
- Send the completed application with original signatures and all required documentation to your designated Medicare fee-for-service contractor.

AVOID DELAYS IN YOUR ENROLLMENT

To avoid delays in the enrollment process, you should:

- Complete all required sections.
- 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 in the applicable sections.
- Enter all applicable dates.
- Ensure that the correct person signs the application.
- Send your application and all supporting documentation to the designated fee-for-service contractor.

ADDITIONAL INFORMATION

For additional information regarding the Medicare enrollment process, visit *www.cms.gov/MedicareProviderSupEnroll.*

The fee-for-service contractor may request, at any time during the enrollment process, documentation to support and validate information reported on the application. You are responsible for providing this documentation in a timely manner.

Certain information you provide on this application is considered to be 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 for the Privacy Act Statement.

MAIL YOUR APPLICATION

The Medicare fee-for-service contractor (also referred to as a carrier or a Medicare administrative contractor) that services your State is responsible for processing your enrollment application. To locate the mailing address for your fee-for-service contractor, go to *www.cms.gov/MedicareProviderSupEnroll.*

SECTION 1: BASIC INFORMATION

NEW ENROLLEES AND THOSE WITH A NEW TAX ID NUMBER

If you are:

- Enrolling in the Medicare program for the first time with this Medicare fee-for-service contractor under this tax identification number.
- Already enrolled with a Medicare fee-for-service contractor but are establishing a practice location in another fee-for-service contractor's jurisdiction.
- Enrolled with a Medicare fee-for-service contractor but have a new tax identification number. If you are reporting a change to your tax identification number, you must complete a new application.
- A hospital or an individual hospital department that is enrolling with a fee-for-service contractor to bill for Part B services.

The following actions apply to Medicare suppliers already enrolled in the program:

ENROLLED MEDICARE SUPPLIERS

Reactivation

To reactivate your Medicare billing privileges, submit this enrollment application. In addition, prior to being reactivated, you must be able to submit a valid claim and meet all current requirements for your supplier type before reactivation may occur.

Voluntary Termination

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.

Change of Ownership

If a hospital, ambulatory surgical center, or portable X-ray supplier is undergoing a change of ownership (CHOW) in accordance with the principles outlined in 42 C.F.R. 489.18, the entity must submit a new application for the new ownership.

Change of Information

A change of information should be submitted if you are changing, adding or deleting information under your current tax identification number.

Changes in your existing enrollment data must be reported to the fee-for-service contractor in accordance with 42 C.F.R. § 424.516 (Physician and Non Physician Practitioner Organizations). (IDTF changes of information must comply with the provisions found at 42 C.F.R. § 410.33.)

If you are already enrolled in Medicare and are not receiving Medicare payments via EFT, any change to your enrollment information will require you to submit a CMS-588 form. All future payments will then be made via EFT.

Revalidation

CMS may require you to submit or update your enrollment information. The fee-for-service contractor 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 the fee-for-service contractor.

SECTION 1: BASIC INFORMATION
ALL APPLICANTS MUST COMPLETE THIS SECTION *(See instructions for details.)*

A. Check one box and complete the required sections.

REASON FOR APPLICATION	BILLING NUMBER INFORMATION	REQUIRED SECTIONS
☐ You are a **new enrollee** in Medicare	Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4.	**Complete all applicable sections** **Ambulance suppliers** must complete **Attachment 1** **IDTF suppliers** must complete **Attachment 2**
☐ You are **enrolling in another fee-for-service contractor's jurisdiction**	Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4.	**Complete all applicable sections** **Ambulance suppliers** must complete **Attachment 1** **IDTF suppliers** must complete **Attachment 2**
☐ You are **reactivating** your Medicare enrollment	Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4. Medicare Identification Number(s) *(if issued):* National Provider Identifier *(if issued):*	**Complete all applicable sections** **Ambulance suppliers** must complete **Attachment 1** **IDTF suppliers** must complete **Attachment 2**
☐ You are **voluntarily terminating** your Medicare enrollment. (This is not the same as "opting out" of the program)	Effective Date of Termination: Medicare Identification Number(s) to Terminate *(if issued):* National Provider Identifier *(if issued):*	Sections **1, 2B1, 13,** and either **15 or 16** If you are terminating an employment arrangement with a physician assistant, complete Sections **1A, 2G, 13,** and either **15 or 16**

SECTION 1: BASIC INFORMATION *(Continued)*
ALL APPLICANTS MUST COMPLETE THIS SECTION *(See instructions for details.)*

A. Check one box and complete the required sections.

REASON FOR APPLICATION	BILLING NUMBER INFORMATION	REQUIRED SECTIONS
☒ You are **changing** your Medicare information	Medicare Identification Number(s) to Terminate *(if issued):* A0663 National Provider Identifier *(if issued):* 1962412072	Go to Section 1B
☒ You are **revalidating** your Medicare enrollment	Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4.	**Complete all applicable sections** **Ambulance suppliers** must complete **Attachment 1** **IDTF suppliers** must complete **Attachment 2**

SECTION 1: BASIC INFORMATION *(Continued)*

B. Check all that apply and complete the required sections:

	REQUIRED SECTIONS
☒ Identifying Information	**1, 2** (complete only those sections that are changing), **3, 13,** and either **15** (if you are an authorized official) **or 16** (if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier
☒ Final Adverse Actions/Convictions	**1, 2B1, 3, 13,** and either **15** (if you are an authorized official) **or 16** (if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier
☒ Practice Location Information, Payment Address & Medical Record Storage Information	**1, 2B1, 3, 4** (complete only those sections that are changing), **13,** and either **15** (if you are an authorized official) **or 16** (if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier
☐ Change of Ownership (Hospitals, Portable X-Ray Suppliers & Ambulatory Surgical Centers Only)	**Complete all sections and provide a copy of the sales agreement**
☒ Ownership Interest and/or Managing Control Information (Organizations)	**1, 2B1, 3, 5, 13,** and either **15** (if you are an authorized official) **or 16** (if you are a delegated official), 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, 2B1, 3, 6, 13,** and either **15** (if you are an authorized official) **or 16** (if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier
☒ Billing Agency Information	**1, 2B1, 3, 8** (complete only those sections that are changing), **13,** and either **15** (if you are an authorized official) **or 16** (if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier
☒ Authorized Official(s)	**1, 2B1, 3, 13, 15 or 16** (if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier
☐ Delegated Official(s) (Optional)	**1, 2B1, 3, 13, 15, 16,** and **6** for the signer if that delegated official has not been established for this supplier.

SECTION 1: BASIC INFORMATION *(Continued)*

ATTACHMENT 1: AMBULANCE SERVICE SUPPLIERS (ONLY)	REQUIRED SECTIONS
☒ Geographic Area	**1, 2B1, 3, 13, and 15** if you are the authorized official **or 16** if you are the delegated official **Attachment 1(A)**
☒ State License Information	**1, 2B1, 3, 13, and 15** if you are the authorized official **or 16** if you are the delegated official **Attachment 1(B)**
☒ Paramedic Intercept Services Information	**1, 2B1, 3, 13, and 15** if you are the authorized official **or 16** if you are the delegated official **Attachment 1(C)**
☒ Vehicle Information	**1, 2B1, 3, 13, and 15** if you are the authorized official **or 16** if you are the delegated official **Attachment 1(D)**
ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (ONLY)	**REQUIRED SECTIONS**
☐ CPT-4 and HCPCS Codes	**1, 2B1, 3, 13, and 15** if you are the authorized official **or 16** if you are the delegated official **Attachment 2(B)**
☐ Interpreting Physician Information	**1, 2B1, 3, 13, and 15** if you are the authorized official **or 16** if you are the delegated official **Attachment 2(C)**
☐ Personnel (Technicians) Who Perform Tests	**1, 2B1, 3, 13, and 15** if you are the authorized official **or 16** if you are the delegated official **Attachment 2(D)**
☐ Supervising Physician(s)	**1, 2B1, 3, 13, and 15** if you are the authorized official **or 16** if you are the delegated official **Attachment 2(E)**
☐ Liability Insurance Information	**1, 2B1, 3, 13, and 15** if you are the authorized official **or 16** if you are the delegated official **Attachment 2(F)**

SECTION 2: IDENTIFYING INFORMATION

A. 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)
- ☐ Pharmacy
- ☐ Physical/Occupational Therapy Group in Private Practice
- ☐ Portable X-ray Supplier
- ☐ Radiation Therapy Center
- ☐ Other *(Specify)*: _____

B. Supplier Identification Information

1. BUSINESS INFORMATION

Legal Business Name (not the "Doing Business As" name) as reported to the Internal Revenue Service

Board of County Commissioners Palm Beach County

Tax Identification Number

596000785

Other Name	Type of Other Name
Palm Beach County Fire Rescue	☐ Former Legal Business Name ☒ Doing Business As Name ☐ Other *(Specify)*: _____

Identify how your business is registered with the IRS. **(NOTE:** If your business is a Federal and/or State government provider or supplier, indicate "Non-Profit" below.)

☐ Proprietary ☒ Non-Profit

NOTE: If a checkbox indicating Proprietary or non-profit status is not completed, the provider/supplier will be defaulted to "Proprietary."

Identify the type of organizational structure of this provider/supplier *(Check one)*

☐ Corporation ☐ Limited Liability Company ☐ Partnership
☐ Sole Proprietor ☒ Other *(Specify)*: Government

Incorporation Date *(mm/dd/yyyy) (if applicable)*	State Where Incorporated *(if applicable)*

Is this supplier an Indian Health Facility enrolling with the designated Indian Health Service (IHS) Medicare Administrative Contractor (MAC)?

☐ Yes ☒ No

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

2. STATE LICENSE INFORMATION/CERTIFICATION INFORMATION

Provide the following information if the supplier has a State license/certification to operate as the supplier type for which you are enrolling.

☐ State License Not Applicable

License Number	State Where Issued
3285	Florida
Effective Date *(mm/dd/yyyy)*	**Expiration/Renewal Date** *(mm/dd/yyyy)*
07/12/2010	09/09/2012

Certification Information

☒ Certification Not Applicable

Certification Number	State Where Issued
Effective Date *(mm/dd/yyyy)*	**Expiration/Renewal Date** *(mm/dd/yyyy)*

3. CORRESPONDENCE ADDRESS

Provide contact information for the entity or person listed in Question 1 of this section. Once enrolled, the information provided below will be used by the fee-for-service contractor if it needs to contact you directly. This address cannot be a billing agency's address.

Mailing Address Line 1 *(Street Name and Number)*

PO Box 862036

Mailing Address Line 2 *(Suite, Room, etc.)*

City/Town		State	ZIP Code + 4
Orlando		FL	32886-2036
Telephone Number	**Fax Number** *(if applicable)*	**E-mail Address** *(if applicable)*	
(561) 616-7000			

C. Hospitals Only

This section should only be completed by hospitals that are currently enrolled or enrolling with a fee-for-service contractor (the Part A Medicare contractor), and will be billing a fee-for-service contractor for Medicare Part B services, as follows:

- Hospitals that need departmental billing numbers to bill for Part B practitioner services.
- 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, 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 fee-for-service contractor to determine if this form should be submitted.

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

C. Hospitals Only *(Continued)*

NOTE: If your hospital is enrolling a clinic that is not provider-based, do not complete this section.

Check ☐ "Clinic/Group Practice" in Section 2A and complete this entire application for the clinic.

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

D. Comments/Special Circumstances

Explain any unique circumstances concerning your practice location, the method by which you render health care services, etc.

E. Physical Therapy (PT) and Occupational Therapy (OT) Groups Only

1. Are all of the group's PT/OT services rendered in patients' homes or in the group's private office space?	☐ 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 any of the questions 2–5 above, submit a copy of the lease agreement that gives the group exclusive use of the facilities for PT/OT services.

F. 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 providers).

Name of Accrediting Organization

Effective Date of Current Accreditation *(mm/dd/yyyy)*	Expiration of Current Accreditation *(mm/dd/yyyy)*

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

G. Termination of Physician Assistants *(Only)*

Complete this section to delete employed physician assistants from your group or clinic.

EFFECTIVE DATE OF DEPARTURE	PHYSICIAN ASSISTANT'S NAME	PHYSICIAN ASSISTANT'S MEDICARE IDENTIFICATION NUMBER	PHYSICIAN ASSISTANT'S NPI

H. Advanced Diagnostic Imaging (ADI) Suppliers Only

This section must be completed by all Independent Diagnostic Testing Facilities (IDTF) that also furnish and will bill Medicare for ADI services. All IDTF suppliers furnishing ADI services MUST be accredited in each ADI Modality checked below to qualify to bill Medicare for those services.

Check each ADI modality this IDTF supplier will furnish and the name of the Accrediting Organization that accredited that ADI Modality for this supplier.

☐ **Magnetic Resonance Imaging (MRI)**

Name of Accrediting Organization for MRI

Effective Date of Current Accreditation *(mm/dd/yyyy)*	Expiration Date of Current Accreditation *(mm/dd/yyyy)*

☐ **Computed Tomography (CT)**

Name of Accrediting Organization for CT

Effective Date of Current Accreditation *(mm/dd/yyyy)*	Expiration Date of Current Accreditation *(mm/dd/yyyy)*

☐ **Nuclear Medicine (NM)**

Name of Accrediting Organization for NM

Effective Date of Current Accreditation *(mm/dd/yyyy)*	Expiration Date of Current Accreditation *(mm/dd/yyyy)*

☐ **Positron Emission Tomography (PET)**

Name of Accrediting Organization for PET

Effective Date of Current Accreditation *(mm/dd/yyyy)*	Expiration Date of Current Accreditation *(mm/dd/yyyy)*

SECTION 3: FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Convictions

1. The provider, supplier, or any owner of the provider or supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include:

   Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicare program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Act.

2. 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.
3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
5. Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation or suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any current Medicare payment suspension under any Medicare billing number.
5. Any Medicare revocation of any Medicare billing number.

SECTION 3: FINAL ADVERSE ACTIONS/CONVICTIONS *(Continued)*

FINAL ADVERSE HISTORY

1. Has your organization, under any current or former name or business identity, ever had any of the final adverse actions listed on page 13 of this application imposed against it?

   ☒ YES–Continue Below ☐ NO–Skip to Section 4

2. If yes, report each final adverse action, when it occurred, the Federal or State agency or the court/ administrative body that imposed the action, and the resolution, if any.

   Attach a copy of the final adverse action documentation and resolution.

FINAL ADVERSE ACTION	DATE	TAKEN BY	RESOLUTION
Administrative Complaint	6/06/2011	Department of Health	Settlement Agreement
Administrative Complaint	05/15/2008	Health Care Administration	Settlement Agreement

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.

Only report those practice locations within the jurisdiction of the Medicare fee-for-service contractor to which you will submit this application. If you have practice locations in another Medicare fee-for-service contractor's jurisdiction, complete a separate enrollment application (CMS-855B) for those practice locations and submit it to the Medicare fee-for-service contractor that has jurisdiction over those locations.

Provide the specific street address as recorded by the United States Postal Service. Do not provide a P.O. Box. If you provide services in a hospital and/or other health care facility for which you bill Medicare directly for the services rendered at that facility, provide the name and address of the hospital or facility.

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.

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

A. Practice Location Information

If you see patients in more than one practice location, copy and complete Section 4A for each location.

To ensure that CMS establishes the correct association between your Medicare legacy number and your NPI, providers and suppliers must list a Medicare legacy number—NPI combination for each practice location. If you have multiple NPIs associated with both a single legacy number and a single practice location, please list below all NPIs and associated legacy numbers for that practice location.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☒ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*		11/21/2011	

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.

Practice Location Name *("Doing Business As" name if different from Legal Business Name)*

Palm Beach County Fire Rescue

Practice Location Street Address Line 1 *(Street Name and Number – NOT a P.O. Box)*

405 Pike Road

Practice Location Street Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4
West Palm Beach	FL	33411-3815

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*
(561) 838-5420		

Date you saw your first Medicare patient at this practice location *(mm/dd/yyyy)*

01/01/2008

Medicare Identification Number *(if issued)*	National Provider Identifier
A0663	1962412072
Medicare Identification Number *(if issued)*	National Provider Identifier
Medicare Identification Number *(if issued)*	National Provider Identifier
Medicare Identification Number *(if issued)*	National Provider Identifier
Medicare Identification Number *(if issued)*	National Provider Identifier

Is this practice location a:

☐ Group practice office/clinic
☐ Hospital
☐ Retirement/assisted living community
☐ Skilled Nursing Facility and/or Nursing Facility
☒ Other health care facility
(Specify): Fire Department

CLIA Number for this location *(if applicable)*

Attach a copy of the most current CLIA certifications for each of the practice locations 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 of the practice locations reported on this application.

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

B. Where do you want remittance notices or special payments sent?
If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☒ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*		11/21/2011	

Medicare will issue payments via electronic funds transfer (EFT). Since payments will be made by EFT, the "Special Payments" address should indicate where all other payment information (e.g., remittance notices, special payments) should be sent.

☐ "Special Payments" address is the same as the practice location (only one address is listed in Section 4A). Skip to Section 4C.

☒ "Special Payments" address is different than that listed in Section 4A, or multiple locations are listed. Provide address below.

"Special Payments" Address Line 1 *(PO Box or Street Name and Number)*

PO Box 862036

"Special Payments" Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4
Orlando	FL	32886-2036

C. Where do you keep patients' medical records?
If you store patients' medical records (current and/or former patients) at a location other than the location in Section 4A or 4E, complete this section with the address of the storage location.

Post Office boxes and drop boxes are not acceptable as physical addresses where patients' records are maintained. For IDTFs and mobile facilities/portable units, the patients' medical records must be under the supplier's control. The records must be the supplier's records, not the records of another supplier. If this section is not completed, you are indicating that all records are stored at the practice locations reported in Section 4A or 4E.

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

First Medical Record Storage Facility (for current and former patients)

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Storage Facility Address Line 1 *(Street Name and Number)*

Storage Facility Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Second Medical Record Storage Facility (for current and former patients)

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Storage Facility Address Line 1 *(Street Name and Number)*

Storage Facility Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

D. Rendering Services in Patients' Homes

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Furnish the city/town, State and ZIP code for all locations where health care services are rendered in patients' homes. If you provide health care services in more than one State and those States are serviced by different Medicare fee-for-service contractors, complete a separate CMS-855B enrollment application for each Medicare fee-for-service contractor's jurisdiction.

If you are adding or deleting an entire State, it is not necessary to report each city/town. Simply check the box below and specify the State.

☐ Entire State of _____

If you are providing services in selected cities/towns, furnish the locations below. Only list ZIP codes if you are not servicing the entire city/town.

CITY/TOWN	STATE	ZIP CODE

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.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
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.

Street Address Line 1 *(Street Name and Number)*

Street Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number	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. 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 two vehicles are used, copy and complete this section as needed.

If you are changing, adding, or deleting 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
☐ CHANGE ☐ ADD ☐ DELETE		
Effective Date:		
☐ CHANGE ☐ ADD ☐ DELETE		
Effective Date:		

For each vehicle, submit a copy of all health care related permits/licenses/registrations.

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, State, 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 and those States are serviced by different Medicare fee-for-service contractors, complete a separate enrollment application (CMS-855B) for each Medicare fee-for-service contractor's jurisdiction.

INITIAL REPORTING AND/OR ADDITIONS

If you are reporting or adding an entire State, it is not necessary to report each city/town. Simply check the box below and specify the State.

☐ Entire State of _____

If services are provided in selected cities/towns, provide the locations below. Only list ZIP codes if you are not servicing the entire city/town.

CITY/TOWN	STATE	ZIP CODE

DELETIONS

If you are deleting an entire State, it is not necessary to report each city/town. Simply check the box below and specify the State.

☐ Entire State of _____

If services you are deleting are furnished in selected cities/towns, provide the locations below. Only list ZIP codes if you are not servicing the entire city/town.

CITY/TOWN	STATE	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.

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. For instance, it could be a management services organization under contract with the supplier to furnish management services for the business.

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)*

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.

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, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☒ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*		11/21/2011	

Check all that apply:

☐ 5 Percent or More Ownership Interest ☐ Partner ☒ Managing Control

Legal Business Name as Reported to the Internal Revenue Service

Board of County Commissioners Palm Beach County

"Doing Business As" Name *(if applicable)*

Palm Beach County Fire Rescue

Address Line 1 *(Street Name and Number)*

405 Pike Road

Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4
West Palm Beach	FL	33411-3815

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*
(305) 616-7000		

NPI *(if issued)*	Tax Identification Number *(Required)*	Medicare Identification Number(s) *(if issued)*
1968412072	596000785	A0663

What is the effective date this owner acquired ownership of the provider identified in Section 2B1 of this application? *(mm/dd/yyyy)* _____

What is the effective date this organization acquired managing control of the provider identified in Section 2B1 of this application? *(mm/dd/yyyy)* 01/01/2008

NOTE: Furnish both dates if applicable.

SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS) *(Continued)*

B. Final Adverse Legal Action History

If reporting a change to existing information, check "Change," provide the effective date of the change, and complete the appropriate fields in this section.

☒ Change
Effective Date: 11/21/2011

1. Has this individual in Section 5A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 13 of this application imposed against him/her?

   ☒ YES–Continue Below ☐ NO–Skip to Section 6

2. If YES, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

   Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION
Administrative Complaint	06/06/2011	Department of Health	Settlement Agreement
Administrative Complaint	5/15/2008	Health Care Administration	Settlement Agreement

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS)

NOTE: Only Individuals should be reported in Section 6. Organizations must be reported in Section 5. For more information on "direct" and "indirect" owners, go to *www.cms.hhs.gov/MedicareProviderSupEnroll.*

The supplier MUST have at least ONE owner and/or managing employee.

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;
- 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.

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 submit with your application a 501(c)(3) document verifying non-profit status.

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 this section must be furnished. If there is more than one individual, copy and complete this section for each individual. Owners, Authorized Officials and/or Delegated Officials must complete this section.

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, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☒ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*		11/21/2011	

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.

First Name	Middle Initial	Last Name	Jr., Sr., etc.	Title
Steven	B	Jerauld		Fire Rescue Administra

Date of Birth *(mm/dd/yyyy)*	Place of Birth *(State)*	Country of Birth
06/04/1957	Washington	United States

Social Security Number *(Required)*	Medicare Identification Number *(if issued)*	NPI *(if issued)*
[redacted] confidential and/or exempt information redacted pursuant to Section 119.071, Fla. Stat.		

What is the above individual's relationship with the supplier in Section 2B1? *(Check all that apply.)*

☐ 5 Percent or Greater Direct/Indirect Owner
☒ Authorized Official
☐ Delegated Official
☐ Partner
☒ Director/Officer
☐ Contracted Managing Employee
☐ Managing Employee (W-2)

What is the effective date this owner acquired ownership of the provider identified in Section 2B1 of this application? *(mm/dd/yyyy)* _____

What is the effective date this individual acquired managing control of the provider identified in Section 2B1 of this application? *(mm/dd/yyyy)* 08/15/2009

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 reporting a change to existing information, check "change," provide the effective date of the change and complete the appropriate fields in this section.

☒ Change
Effective Date: 11/21/2011

1. Has this individual in Section 6A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 13 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, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

   Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

SECTION 7: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 8: BILLING AGENCY INFORMATION

A billing agency is a company or individual that you contract with to prepare and submit your claims. If you use a billing agency, you are responsible for the claims submitted on your behalf.

☐ **Check here if this section does not apply and skip to Section 13.**

BILLING AGENCY NAME AND ADDRESS

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☒ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*		11/21/2011	

Legal Business/Individual Name as Reported to the Social Security Administration or the Internal Revenue Service	If Individual, Billing Agent Date of Birth *(mm/dd/yyyy)*
Advanced Data Processing, INC	

"Doing Business As" Name *(if applicable)*	Tax Identification/Social Security Number *(required)*
Intermedix	225873190

Billing Agency Street Address Line 1 *(Street Name and Number)*

500 NW 165th Street

Billing Agency Street Address Line 2 *(Suite, Room, etc.)*

Suite #102

City/Town	State	ZIP Code + 4
Miami	FL	33169-60307

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*
305-945-2280	305-521-0781	

SECTION 9: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 10: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 11: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 12: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 13: CONTACT PERSON

If questions arise during the processing of this application, the fee-for-service contractor will contact the individual shown below. If the contact person is either an authorized or delegated official, check the appropriate box below.

☐ Contact an Authorized Official listed in Section 15.

☐ Contact a Delegated Official listed in Section 16.

First Name	Middle Initial	Last Name	Jr., Sr., etc.
Nick	E	Adler	

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*
305-945-2280 ext 2296	305-521-0781	nick.adler@intermedix.com

Address Line 1 *(Street Name and Number)*

500 NW 165th Street

Address Line 2 *(Suite, Room, etc.)*

Suite 102

City/Town	State	ZIP Code + 4
Miami	FL	33169-6306

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION

This section explains the penalties for deliberately falsifying information in this application to gain or maintain enrollment in the Medicare program.

1. 18 U.S.C. § 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. § 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:

   a) knowingly presents, or causes to be presented, to an officer or any employee of the United States Government a false or fraudulent claim for payment or approval;

   b) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or

   c) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

   The Act imposes a civil penalty of $5,000 to $10,000 per violation, plus three times the amount of damages sustained by the Government.

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION *(Continued)*

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 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** means 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** means 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 Medicare fee-for-service contractor. **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.**

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. All signatures must be original and in ink. Faxed, photocopied, or stamped signatures will not be accepted.

Only an authorized official has the authority to sign (1) the initial enrollment application on behalf of the supplier or (2) the enrollment application that must be submitted as part of the periodic revalidation process. A delegated official does not have this authority.

By signing this application, an authorized official agrees to immediately notify the Medicare fee-for-service contractor if any information furnished on the application is not true, correct, or complete. In addition, an authorized official, by his/her signature, agrees to notify the Medicare fee-for-service contractor 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. 424.520(b). (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

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 16 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. § 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 this supplier. 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 the supplier's compliance with all applicable conditions of participation in Medicare.
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. 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 Medicare fee-for-service contractor 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 Medicare fee-for-service contractor of this fact in accordance with the time frames established in 42 CFR § 424.516.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☒ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*		11/21/2011	

Authorized Official's Information and Signature

First Name	Middle Initial	Last Name	Suffix *(e.g., Jr., Sr.)*
Steven	B	Jerauld	

Telephone Number	Title/Position
(561) 616-7000	Fire Rescue Administrator

Authorized Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*
Steven B Jerauld	11/21/2011

(blue ink preferred)

C. 2ND 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 Medicare fee-for-service contractor 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 Medicare fee-for-service contractor of this fact in accordance with the time frames established in 42 CFR § 424.516.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Authorized Official's Information and Signature

First Name	Middle Initial	Last Name	Suffix *(e.g., Jr., Sr.)*

Telephone Number	Title/Position

Authorized Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

All signatures must be original and signed in ink (blue ink preferred). Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

SECTION 16: DELEGATED OFFICIAL (OPTIONAL)

- 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.
- 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.
- Delegated officials being deleted do not have to sign or date this application.
- Independent contractors are not considered "employed" by the supplier, and therefore cannot be delegated officials.
- The signature(s) of an authorized official in Section 16 constitutes a legal delegation of authority to all delegated official(s) assigned in Section 16.
- If there are more than two individuals, copy and complete this section for each individual.

A. 1ST Delegated Official Signature

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Delegated Official First Name	Middle Initial	Last Name	Suffix *(e.g., Jr., Sr.)*

Delegated Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., 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., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

(blue ink preferred)

SECTION 16: DELEGATED OFFICIAL (OPTIONAL)

B. 2ND Delegated Official Signature

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Delegated Official First Name	Middle Initial	Last Name	Suffix *(e.g., Jr., Sr.)*

Delegated Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., 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., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

(blue ink preferred)

All signatures must be original and signed in ink (blue ink preferred). Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

SECTION 17: SUPPORTING DOCUMENTS

This section lists the documents that, if applicable, must be submitted with this enrollment application. If you are newly enrolling, or are reactivating or revalidating your enrollment, you must provide all applicable documents. For changes, only submit documents that are applicable to that change.

The fee-for-service contractor may request, at any time during the enrollment process, documentation to support or validate information reported on the application. The Medicare fee-for-service contractor may also request documents from you, other than those identified in this Section 17, as are necessary to bill Medicare.

MANDATORY FOR ALL PROVIDER/SUPPLIER TYPES

☒ Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name (e.g., IRS form CP 575) provided in Section 2.
(**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.)"

☒ Completed Form CMS-588, for Electronic Funds Transfer Authorization Agreement.
(**NOTE:** If a supplier already receives payments electronically and is not making a change to its banking information, the CMS-588 is not required.)

MANDATORY FOR SELECTED PROVIDER/SUPPLIER TYPES

☐ Copy(s) of all documentation verifying IDTF Supervisory Physician(s) proficiency and/or State licenses or certification 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.

MANDATORY, IF APPLICABLE

☐ Copy of IRS Determination Letter, if supplier is registered with the IRS as non-profit.

☐ Written confirmation from the IRS confirming your Limited Liability Company (LLC) is automatically classified as a Disregarded Entity. (e.g., Form 8832).
(**NOTE:** A disregarded entity is an eligible entity that is treated as an entity not separate from its single owner for income tax purposes.

☐ Statement in writing from the bank. If Medicare payment due a supplier of services is being sent to a bank (or similar financial institution) with whom the supplier has a lending relationship (that is, any type of loan), then the supplier 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.

☒ Copy(s) of all final adverse action documentation (e.g., notifications, resolutions, and reinstatement letters).

☐ Completed Form(s) CMS 855R, Reassignment of Medicare Benefits.

☒ Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement.

☒ Copy of an attestation for government entities and tribal organizations.

☐ Copy of FAA 135 certificate (air ambulance suppliers).

☐ Copy(s) of comprehensive liability insurance policy (IDTFs only).

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. 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 deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

Provide the city/town, State, and ZIP code for all locations where this ambulance company renders services.

CHECK ONE	☐ CHANGE	☒ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*		11/21/2011	

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 fee-for-service contractor.

1. INITIAL REPORTING AND/OR ADDITIONS

If services are provided in selected cities/towns, provide the locations below. List ZIP codes only if they are not within the entire city/town.

CITY/TOWN	STATE	ZIP CODE
Palm Beach County	FL	

2. DELETIONS

If services are no longer provided in selected cities/towns, provide the locations below. List ZIP codes only if they are not within the entire city/town.

CITY/TOWN	STATE	ZIP CODE

ATTACHMENT 1: AMBULANCE SERVICE SUPPLIERS *(Continued)*

B. State License 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.

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 Medicare fee-for-service contractor.

CHECK ONE	☐ CHANGE	☒ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*		11/21/2011	

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)*
3285	Florida	Palm Beach

Effective Date *(mm/dd/yyyy)*	Expiration Date *(mm/dd/yyyy)*
07/12/2010	09/09/2012

C. Paramedic Intercept Services Information

Paramedic Intercept Services involve 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. If such an arrangement exists between the enrolling ambulance company and another ambulance company, the enrolling ambulance company must attach a copy of the signed contract. For more information, see 42 C.F.R. 410.40.

If reporting a change to information about a previously reported agreement/contract, check "Change" and provide the effective date of the change.

☒ Change
Effective Date: 11/21/2011

Does this ambulance company currently participate in a paramedic intercept services arrangement?

☐ YES ☒ NO

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, the following is required:

- A written statement, signed by the President, Chief Executive Officer or Chief Operating Officer of the airport from where the aircraft is hangared that gives the name and address of the facility, and
- 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 deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☒ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*		11/21/2011	

Type *(automobile, aircraft, boat, etc.)*	Vehicle Identification Number
Ambulance	1HTMRAALOAH172511

Make *(e.g., Ford)*	Model *(e.g., 350T)*	Year *(yyyy)*
Horton	Rescue	2010

Does this vehicle provide:

Advanced life support (Level 1)	☒ YES	☐ NO	Specialty care transport	☒ YES	☐ NO
Advanced life support (Level 2)	☒ YES	☐ NO	Land ambulance	☒ YES	☐ NO
Basic life support	☒ YES	☐ NO	Air ambulance–fixed wing	☐ YES	☒ NO
Emergency runs	☒ YES	☐ NO	Air ambulance–rotary wing	☐ YES	☒ NO
Non-emergency runs	☒ YES	☐ NO	Marine ambulance	☐ YES	☒ NO

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES

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 fee-for-service contractor 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.
   (i) 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.
   (ii) 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 designated fee-for-service contractor upon request, and notify the contractor 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:
   (i) Ensure that the insurance policy must remain in force at all times and provide coverage of at least $300,000 per incident; and
   (ii) 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. Nonphysician practitioners may order tests as set forth in §410.32(a)(3).

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES *(Continued)*

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:
   (i) The name, address, telephone number, and health insurance claim number of the beneficiary.
   (ii) The date the complaint was received; the name of the person receiving the complaint; and a summary of actions taken to resolve the complaint.
   (iii) If an investigation was not conducted, the name of the person making the decision and the reason for the decision.
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 its fee-for-service contractor within 2 business days.
14. Permit CMS, including its agents, or its designated fee-for-service contractors, 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:
   (i) Sharing a practice location with another Medicare-enrolled individual or organization.
   (ii) Leasing or subleasing its operations or its practice location to another Medicare enrolled individual or organization.
   (iii) 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.

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES *(Continued)*

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 on page 40 of this application. Not all suppliers that perform diagnostic tests are required to enroll as an IDTF.

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.

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 40 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.

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES *(Continued)*

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 deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

All codes 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	EQUIPMENT	MODEL NUMBER *(Required)*
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES *(Continued)*

C. Interpreting Physician Information

Check here ☐ if this section does not apply because the interpreting physician will bill separate from the IDTF.

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 three physicians, copy and complete this section as needed. All interpreting physicians must be currently enrolled in the Medicare program.

If you are billing for interpretations as an individual reassigning benefits, the interpreting physician must complete the Reassignment of Benefits Form (CMS 855R). Note: Both the IDTF and individual physician must be enrolled with the fee-for-service contractor where the IDTF is located.

If you are billing for purchased interpretations, all requirements for purchased interpretations must be met.

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.

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.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
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	

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.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
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	

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES *(Continued)*

3RD 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.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
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

D. Personnel (Technicians) Who Perform Tests

Complete this section with information about all non-physician personnel who perform tests for this IDTF. Notarized or certified true copies of the State license or certificate should be attached.

1ST PERSONNEL (TECHNICIAN) 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.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
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)*

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)*

Is this technician employed by a hospital? ☐ YES ☐ NO

If **YES**, provide the name of the hospital here: _____

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES *(Continued)*

2ND Personnel (Technician) 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.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
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)*

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)*

Is this technician employed by a hospital? ☐ YES ☐ NO

If YES, provide the name of the hospital here: _____

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 Medicare fee-for-service contractor. 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.

The type of supervision being performed by each physician who signs the attestation on page 47 of this application should be listed in this section.

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.

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES *(Continued)*

E. Supervising Physicians *(Continued)*

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

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)*

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

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 *(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 reported in this Attachment. (See number 2 below if all reported CPT-4 and HCPCS codes 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 code in this Attachment (except for those CPT-4 or HCPCS codes 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	CPT–4 OR HCPCS CODE	CPT–4 OR HCPCS CODE

3. Signature of Supervising Physician *(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)*	Date *(mm/dd/yyyy)*

All signatures must be original and signed and dated in ink (blue ink preferred). Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

MEDICARE SUPPLIER ENROLLMENT APPLICATION PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) is authorized to collect the information requested on this form by sections 1124(a)(1), 1124A(a)(3), 1128, 1814, 1815, 1833(e), and 1842(r) of the Social Security Act [42 U.S.C. §§ 1320a-3(a)(1), 1320a-7, 1395f, 1395g, 1395(l)(e), and 1395u(r)] and section 31001(1) of the Debt Collection Improvement Act [31 U.S.C. § 7701(c)].

The purpose of collecting this information is to determine or verify the eligibility of individuals and organizations to enroll in the Medicare program as suppliers of goods and services to Medicare beneficiaries and to assist in the administration of the Medicare program. This information will also be used to ensure that no payments will be made to providers who are excluded from participation in the Medicare program. All information on this form is required, with the exception of those sections marked as "optional" on the form. Without this information, the ability to make payments will be delayed or denied.

The information collected will be entered into the Provider Enrollment, Chain and Ownership System (PECOS). The information in this application will be disclosed according to the routine uses described below.

Information from these systems may be disclosed under specific circumstances to:

1. CMS contractors to carry out Medicare functions, collating or analyzing data, or to detect fraud or abuse;
2. A congressional office from the record of an individual health care provider in response to an inquiry from the congressional office at the written request of that individual health care practitioner;
3. The Railroad Retirement Board to administer provisions of the Railroad Retirement or Social Security Acts;
4. Peer Review Organizations in connection with the review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XVIII of the Social Security Act;
5. To the Department of Justice or an adjudicative body when the agency, an agency employee, or the United States Government is a party to litigation and the use of the information is compatible with the purpose for which the agency collected the information;
6. To the Department of Justice for investigating and prosecuting violations of the Social Security Act, to which criminal penalties are attached;
7. To the American Medical Association (AMA), for the purpose of attempting to identify medical doctors when the National Plan and Provider Enumeration System is unable to establish identity after matching contractor submitted data to the data extract provided by the AMA;
8. An individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, or to the restoration or maintenance of health;
9. Other Federal agencies that administer a Federal health care benefit program to enumerate/enroll providers of medical services or to detect fraud or abuse;
10. State Licensing Boards for review of unethical practices or non-professional conduct;
11. States for the purpose of administration of health care programs; and/or
12. Insurance companies, self insurers, health maintenance organizations, multiple employer trusts, and other health care groups providing health care claims processing, when a link to Medicare or Medicaid claims is established, and data are used solely to process supplier's health care claims.

The supplier 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. § 552a, to permit the government to verify information through computer matching.

Protection of Proprietary Information

Privileged or confidential commercial or financial information collected in this form is protected from public disclosure by Federal law 5 U.S.C. § 552(b)(4) and Executive Order 12600.

Protection of Confidential Commercial and/or Sensitive Personal Information

If any information within this application (or attachments thereto) constitutes a trade secret or privileged or confidential information (as such terms are interpreted under the Freedom of Information Act and applicable case law), or is of a highly sensitive personal nature such that disclosure would constitute a clearly unwarranted invasion of the personal privacy of one or more persons, then such information will be protected from release by CMS under 5 U.S.C. §§ 552(b)(4) and/or (b)(6), respectively.

OMB No. 0938-0373

MEDICARE
PARTICIPATING PHYSICIAN OR SUPPLIER AGREEMENT

Name(s) and Address of Participant*

Physician or Supplier Identification Code(s)*

The above named person or organization, called "the participant," hereby enters into an agreement with the Medicare program to accept assignment of the Medicare Part B payment for all services for which the participant is eligible to accept assignment under the Medicare law and regulations and which are furnished while this agreement is in effect.

1. Meaning of Assignment - For purposes of this agreement, accepting assignment of the Medicare Part B payment means requesting direct Part B payment from the Medicare program. Under an assignment, the approved charge, determined by the Medicare carrier, shall be the full charge for the service covered under Part B. The participant shall not collect from the beneficiary or other person or organization for covered services more than the applicable deductible and coinsurance.

2. Effective Date - If the participant files the agreement with any Medicare carrier during the enrollment period, the agreement becomes effective 11/21/2011.

3. Term and Termination of Agreement - This agreement shall continue in effect through December 31 following the date the agreement becomes effective and shall be renewed automatically for each 12-month period January 1 through December 31 thereafter unless one of the following occurs:

a. During the enrollment period provided near the end of any calendar year, the participant notifies in writing every Medicare carrier with whom the participant has filed the agreement or a copy of the agreement that the participant wishes to terminate the agreement at the end of the current term. In the event such notification is mailed or delivered during the enrollment period provided near the end of any calendar year, the agreement shall end on December 31 of that year.

b. The Centers for Medicare & Medicaid Services may find, after notice to and opportunity for a hearing for the participant, that the participant has substantially failed to comply with the agreement. In the event such a finding is made, the Centers for Medicare & Medicaid Services will notify the participant in writing that the agreement will be terminated at a time designated in the notice. Civil and criminal penalties may also be imposed for violation of the agreement.

Signature of participant (or authorized representative of participating organization)	Fire Rescue Administrator Title (if signer is authorized representative of organization)	11/21/11 Date

(561) 616-7000
(including area code) Office phone number

*List all names and identification codes under which the participant files claims with the carrier with whom this agreement is being filed.

Received by
(name of carrier)

Effective date

Initials of carrier official

INSTRUCTIONS

For the Medicare Participating Physician and Supplier Agreement (CMS-460)

To sign a participation agreement is to agree to accept assignment for all covered services that you provide to Medicare patients.

WHY PARTICIPATE?

If you bill for physicians' professional services, services and supplies provided incident to physicians' professional services, outpatient physical and occupational therapy services, diagnostic tests, or radiology services, your Medicare fee schedule amounts are 5 percent higher if you participate. Also, providers receive direct and timely reimbursement from Medicare.

Regardless of the Medicare Part B services for which you are billing, participants have "one stop" billing for beneficiaries who have Medigap coverage not connected with their employment and who assign both their Medicare and Medigap payments to participants. After we have made payment, Medicare will send the claim on to the Medigap insurer for payment of all coinsurance and deductible amounts due under the Medigap policy. The Medigap insurer must pay the participant directly.

Currently, the large majority of physicians, practitioners and suppliers are billing under Medicare participation agreements.

WHEN THE DECISION TO PARTICIPATE CAN BE MADE:

- Toward the end of each calendar year, all Medicare carriers have an open enrollment period. The open enrollment period generally is from mid-November through December 31. During this period, providers who are currently enrolled in the Medicare Program can change their current participation status beginning the next calendar year on January 1. This is the only time these providers are given the opportunity to change their participation status. These providers should contact their local Medicare carrier to learn where to send the agreement, and get the exact dates for the open enrollment period when the agreement will be accepted.
- New physicians, practitioners, and suppliers can sign the participation agreement and become a Medicare participant at the time of their enrollment into the Medicare Program. The participation agreement will become effective on the date of filing; i.e., the date the participant mails (post-mark date) the agreement to the carrier or delivers it to the carrier.

  Contact your Medicare carrier to get the exact dates the participation agreement will be accepted, and to learn where to send the agreement.

WHAT TO DO DURING OPEN ENROLLMENT:

If you choose to be a participant:

- Do nothing if you are currently participating, or
- If you are not currently a Medicare participant, complete the blank agreement (CMS-460) and mail it (or a copy) to each carrier to which you submit Part B claims. (On the form show the name(s) and identification number(s) under which you bill.)

If you decide not to participate:

- Do nothing if you are currently not participating, or
- If you are currently a participant, write to each carrier to which you submit claims, advising of your termination effective the first day of the next calendar year. This written notice must be postmarked prior to the end of the current calendar year.

WHAT TO DO IF YOU'RE A NEW PHYSICIAN, PRACTITIONER OR SUPPLIER:

If you choose to be a participant:

- Complete the blank agreement (CMS-460) and submit it with your Medicare enrollment application to your carrier.
- If you have already enrolled in the Medicare program, you have 90 days from when you are enrolled to decide if you want to participate. If you decide to participate within this 90-day timeframe, complete the CMS-460 and send to your carrier.

If you decide not to participate:

- Do nothing. All new physicians, practitioners, and suppliers that are newly enrolled are automatically non-participating. You are not considered to be participating unless you submit the CMS-460 form to your carrier.

We hope you will decide to be a Medicare participant.

Please call the Medicare carrier in your jurisdiction if you have any questions or need further information on participation.

DO NOT SEND YOUR CMS-460 FORM TO CMS, SEND TO YOUR CARRIER. IF YOU SEND YOUR FORMS TO CMS, IT WILL DELAY PROCESSING OF YOUR CMS-460 FORMS.

To view updates and the latest information about Medicare, or to obtain telephone numbers of the various carrier contacts including the carrier medical directors, please visit the CMS web site at *http://www.cms.hhs.gov/.*

Department of the Treasury
Internal Revenue Service
Ogden, UT 84201

In reply refer to: 0440527499
Oct 30, 2006 LTR 147C
59-6000785

BOARD OF COUNTY COMMISSIONERS
PALM BEACH COUNTY
PO BOX 4036
WEST PALM BCH FL 33402-4036 366

Taxpayer Identification Number: 59-6000785

Form(s): Established in January of 1962 (Exempt Organization)

Dear Taxpayer:

This letter is in response to your telephone inquiry of October 30th, 2006.

The Employer Identification Number (EIN) shown above has been assigned to you for business Federal tax purposes. Please include it when making Federal tax deposits, filing tax returns, and when corresponding with, or speaking to, the Internal Revenue Service.

If you have any questions regarding this letter, please call our Customer Service Department at 1-800-829-0115 between the hours of 7:00 AM and 10:00 PM. If you prefer, you may write to us at the address shown at the top of the first page of this letter. When you write, please include a telephone number where you may be reached and the best time to call.

Sincerely,

S. Burraston

S. BURRASTON
2974635
Customer Service Representative

3285

STATE OF FLORIDA

DEPARTMENT OF HEALTH
BUREAU OF EMERGENCY MEDICAL SERVICES
ADVANCED LIFE SUPPORT LICENSE

This is to certify that PALM BEACH COUNTY FIRE-RESCUE
Name of Provider

405 PIKE ROAD, WEST PALM BEACH, FL 33411
Address

has complied with Chapter 401, Florida Statutes, and Chapter 64J-1, Florida Administrative Code, and is authorized to operate as an Advanced Life Support Service subject to any and all limitations specified in applicable Certificate(s) of Public Convenience and Necessity for the County(ies) listed below:

☒ TRANSPORT ☐ NON-TRANSPORT

PALM BEACH
County(ies)

Chief, Bureau of Emergency Medical Services
Florida Department of Health

Date 07/12/2010 Expires 09/09/2012

DH Form 1161, March 09

This certificate shall be posted in the above mentioned establishment.

Adler, Nick

From: customerservice@npienumerator.com
Sent: Wednesday, August 09, 2006 12:43 PM
To: Darryl Hartung
Subject: National Provider Identifier

A request for a National Provider Identifier for the following provider was recently submitted to https://nppes.cms.hhs.gov:

Palm Beach County Fire Rescue
596000785

Practice Location: 50 S Military Trl
West Palm Beach, FL 33415-3132

Other Identification Numbers: MEDICAID 400028500 FL
MEDICARE A0663 FL

Provider Taxonomies: 341600000X Ambulance 002509 FL

Since you were listed as the contact person, this is to inform you that the request was successfully processed, and the following NPI has been assigned to the organization above: 1962412072. The User ID you selected for this NPI is palmbeachcou. Please use this User ID when logging on to the National Provider System at https://nppes.cms.hhs.gov.

If you have any questions about this identifier you may:

1.) Refer to the NPI website (https://nppes.cms.hhs.gov), or
2.) Contact the NPI Enumerator at:

NPI Enumerator
PO Box 6059
Fargo, ND 58108-6059
1-800-465-3203 (NPI Toll-Free)
1-800-692-2326 (NPI TTY)
customerservice@npienumerator.com

Please note: The information provided in the NPI application may be shared with and used by others only in accordance with the privacy notice to which you agreed at the time of application. In addition, you agreed to keep the NPPES updated with any changes to data listed on the provider's application form within 30 days of the effective date of the change. If you are not the provider, you are required to inform the provider of the information in this email and furnish a copy of this notification to the provider.

Certificate of Public Convenience and Necessity
Palm Beach County Emergency Medical Services

WHEREAS, there is a need for Palm Beach County Fire Rescue to operate and provide essential emergency medical services to the citizens and visitors of Palm Beach County, Florida; and WHEREAS, said agency has applied to provide these services; and WHEREAS, said agency has indicated that it will comply with the requirements of Palm Beach County's Emergency Medical Services Ordinance (#2006-040), the Board of County Commissioners of Palm Beach County hereby issues a Certificate of Public Convenience and Necessity to said emergency medical service provider, valid from January 1, 2011 to December 31, 2016.

In issuing this Certificate, it is understood that the agency named hereon will meet the requirements of all pertinent county and state legislation and will provide emergency medical services on a twenty-four hour basis in the area(s) or zone(s) designated, providing the level of service endorsed as follows:

Area(s): All unincorporated areas of Palm Beach County and those Municipalities that have contracted for service or in a Fire/Rescue MSTU. The unincorporated areas and incorporated areas of the City of Belle Glade, Towns of Glen Ridge, Juno Beach, Lake Clarke Shores, Cloud Lake, Haverhill, Lake Park, Lantana, Jupiter, City of Lake Worth, Mangonar, Pahokee, Village of Palm Springs, South Bay, South Palm Beach, and the Villages of Wellington and Royal Palm Beach; Air Ambulance

(Countywide) R2010 2130 DEC 21 2010

Service Endorsed: Primary ALS Provider – ALS Transport, Routinely Transport BLS

Director, Division of Emergency Management

Chair, Board of County Commissioners Karen T. Marcus

Fire Rescue
Chief Steven B. Jerauld

405 Pike Road
West Palm Beach, FL 33411
(561) 616-7000
www.pbcgov.com

November 21, 2011

Medicare
Provider Enrollment
P.O. Box 44021
Jacksonville, FL 32231-4021

RE: Palm Beach County Attestation Letter

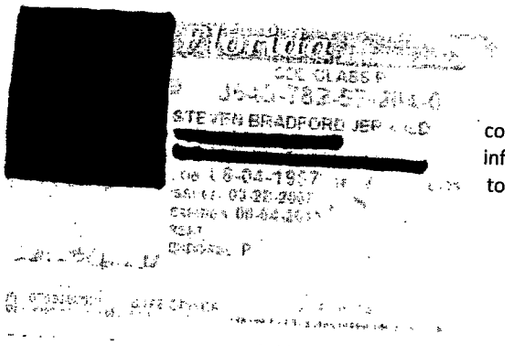
To Whom It May Concern:

As per Section 5 of the CMS Medicare 855B application, Palm Beach County attests that it will be legally and financially responsible in the event that there is any outstanding debt owed to CMS as a result of the filing and receiving of payments (including any potential overpayments) associated with ambulance related claims for Palm Beach County Fire Rescue.

If there are any questions or concerns, please feel free to contact me at (561) 616-7000.

Sincerely,

Steven B. Jerauld
Fire Rescue Administrator
Palm Beach County Fire Rescue



confidential and/or exempt information redacted pursuant to Section 119.071, Fla. Stat.

AC# 4107538

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	CERTIFICATION NO.	CONTROL NO.
11/05/2010	PMD 1125	60620

The **PARAMEDIC**
named below has met all requirements of
the laws and rules of the state of Florida.
Expiration Date: **DECEMBER 1, 2012**

STEVEN B JERAULD
50 S MILITARY TRAIL SUITE 101
WEST PALM BEACH, FL 33415

Charlie Crist
GOVERNOR

Ana M. Viamonte Ros, M.D., M.P.H.
STATE SURGEON GENERAL

DISPLAY IF REQUIRED BY LAW

AC# 4107538

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	CERTIFICATION NO.	CONTROL NO.
11/05/2010	PMD 1125	60620

The PARAMEDIC
named below has met all requirements of
the laws and rules of the state of Florida.
Expiration Date: DECEMBER 1, 2012

STEVEN B JERAULD

EXPIRATION DATE: **DECEMBER 1, 2012**

Your certificate number is **PMD 1125**, please use it in all correspondence with your board/council. Each certificate holder is solely responsible for notifying the department in writing of the certificate holder's current mailing address and practice location address. If you have not received your renewal notice 90 days prior to the expiration date shown on this certificate, please call (850) 488-0595.

Use this section to report name change. Name changes require legal documentation showing the name change. Please make sure that a photocopy of one of the following accompanies this form: a marriage license, a divorce decree or a court order. **A driver's license or social security card is not considered legal documentation.**

Medical Quality Assurance offers you the convenience of several online services. These services give you the ability to renew your certificate, update your mailing and practic location addresses and update your profile information.

1. Go to **www.flhealthsource.com**
2. Click on Licensee/Provider
3. Click on Practitioner Login
4. Select your profession
5. Enter the account ID and password that was provided to you on your initial certificate and click on **"Login"**.
6. If you do not know your account ID and password, click on **"Get Login Help"** or call our Customer Contact Center at (850) 488-0595 for assistance.

MAIL TO: DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSING AND AUDITING SERVICES UNIT
P.O. BOX 6320
TALLAHASSEE, FLORIDA 32314-6320

☐ NAME CHANGE (ATTACH LEGAL DOCUMENTATION)

FROM: _____
LAST FIRST MIDDLE

TO: _____
LAST FIRST MIDDLE

DH 2103, 5/98

IMPORTANT_INFORMATION

SECTION 320.0605, Florida Statutes, requires this registration certificate or an official copy or a true copy of a rental or lease agreement issued for the motor vehicle described be in possession of the operator or carried in the vehicle while the vehicle is being used or operated on the highways or streets of this state.

SECTION 316.613, Florida Statutes, requires every operator of a motor vehicle while transporting a child in a passenger car, van or pickup truck registered in this state and operated on the highways of this state, shall, if the child is 5 years of age or younger, provide for protection of the child by properly using a crash-tested, federally approved child restraint device. For children aged through 3 years, such restraint device must be a separate carrier or a vehicle manufacturer's integrated child seat, for children aged 4 through 5 years, a separate carrier or seat belt may be used.

FILE

SECTION 627.733, Florida Statutes, requires mandatory Florida No-Fault Insurance to be maintained continuously throughout the entire registration period; failure to maintain the required coverage could result in suspension of your driver license and registration.

Mail To:
BOARD OF COUNTY COMMISSIONERS OF PBC
301 N OLIVE AVE
WEST PALM BEACH, FL 33401

Important note: If you cancel the insurance for this vehicle, immediately return the license plate from this registration to a Florida driver license or tax collector office or mail it to: Dept. of Highway Safety, Return Tags, 2900 Apalachee Parkway, Tallahassee, FL 32399. Surrendering the plate will prevent your driving privilege from being suspended.

FLORIDA VEHICLE REGISTRATION

CO/AGY 6 / 1 T# 598203197 B# 837262

PLATE **COUN167268** DECAL Expires **NO EXPIRATION**

YR/MK	**2010/HRTN**	BODY	**AM**	COLOR	**RED**	Reg. Tax	4.85	Class Code	97
VIN	**1HTMRAAL0AH172511**			TITLE	**103163408**	Init. Reg.		Tax Months	0
Plate Type	**NVR**	NET WT	**17880**	GVW	**25500**	County Fee	3.00	Back Tax Mos	
						Mail Fee		Credit Class	97
DL/FEID	-					Sales Tax		Credit Months	0
Date Issued	**9/30/2009**	Plate Issued	**6/14/2001**	TRANSFER:	**X**	Voluntary Fees			
						Grand Total	7.85		

BOARD OF COUNTY COMMISSIONERS OF PBC
301 N OLIVE AVE
WEST PALM BEACH, FL 33401

THIS IS YOUR REGISTRATION
PLEASE DO NOT DESTROY

IMPORTANT INFORMATION

1. The Florida license plate must remain with the registrant upon sale of vehicle.
2. The registration must be delivered to a Tax Collector or Tag Agent for transfer to a replacement vehicle.
3. Your registration must be updated to your new address within 20 days of moving.
4. Registration renewals are the responsibility of the registrant and shall occur during the 30-day period prior to the expiration date shown on this registration. Renewal notices are provided as a courtesy and are not required for renewal purposes.

NVR - COUNTY VEHICLES

10188444

Rescue Truck

6	1	TLF	2712
AUDIT #			

STATE OF FLORIDA
APPLICATION FOR VEHICLE/VESSEL CERTIFICATE OF TITLE

TRANSACTION ID'S

L# 1738327
T# 598203145
B# 837262

TITLE NUMBER	VEHICLE/VESSEL IDENTIFICATION #	YR.	MAKE	MAKE or MANUFACTURER	BODY TYPE	VEHICLE COLOR		WT/LENGTH	GVW/LOC
103163408	1HTMRAAL0AH172511	2010	HRTN		AM	RED		17880	

DATE OF ISSUE MO. DAY YEAR	TRANS CODE	VEHICLE USE	HULL MATERIAL	PROPULSION	FUEL	VESSEL TYPE	WATER	FL NUMBER
09 30 09	ORT	PRIVATE						

Applicant/Owner's Name & Address
BOARD OF COUNTY COMMISSIONERS OF PBC
301 N OLIVE AVE
WEST PALM BEACH, FL 33401

BIRTHDATE SEX	MO.	DAY	YEAR	RESIDENT Y	N	ALIEN	CNTY RES.#
				X			6

1st OWNER FL/DL# OR F.E.I.D.#: -

2nd OWNER FL/DL# OR UNIT #:

VOLUNTARY CONTRIBUTIONS

AGENCY FEE	TITLE FEE	SALES TAX	GRAND TOTAL
4.75	73.50	0.00	78.25

Action Requested: ORIG NEW TITLE

Brands:

PREV. STATE	DATE ACQUIRED	NEW	USED	ODOMETER / VESSEL MANUFACTURER	ODOMETER DECLARATION CERTIFICATION
	09/02/2009	XX		1,073 MILES 09/02/2009 ACTUAL	☐

LIEN INFORMATION

DATE OF LIEN | RECEIVED DATE | FEID # OR FL / DL AND SEX AND DATE OF BIRTH | DMV ACCOUNT #

NAME OF FIRST LIENHOLDER:

ADDRESS

SALVAGE TYPE

SELLER INFORMATION

NAME OF SELLER, FLORIDA DEALER, OR OTHER PREVIOUS OWNER

ADDRESS

DEALER LICENSE NO.

CONSUMER OR SALES TAX EXEMPTION # 858012622286C8

SALES TAX AND USE REPORT

TRANSFER OF TITLE IS EXEMPT FROM FLORIDA SALES OR USE TAX FOR THE REASON(S) CHECKED

☒ PURCHASER HOLDS VALID EXEMPTION CERTIFICATE

☐ VEHICLE / VESSEL WILL BE USED EXCLUSIVELY FOR RENTAL

☒ OTHER EXEMPT

INDICATE TOTAL PURCHASE PRICE, INCLUDING ANY UNPAID BALANCE DUE SELLER, BANK OR OTHERS $

INDICATE SALES OR USE TAX DUE AS PROVIDED BY CHAPTER 212, FLORIDA STATUTES $ 0.00

☐ SELLING PRICE VERIFIED

APPLICANT CERTIFICATION

___ I/WE HEREBY CERTIFY THAT THE VEHICLE/VESSEL TO BE TITLED WILL NOT BE OPERATED UPON THE PUBLIC HIGHWAYS/WATERWAYS OF THIS STATE.

___ I CERTIFY THAT THE CERTIFICATE OF TITLE IS LOST OR DESTROYED.

___ I CERTIFY THAT THIS MOTOR VEHICLE/VESSEL WAS REPOSSESSED UPON DEFAULT OF THE LIEN INSTRUMENT AND IS NOW IN MY POSSESSION.

I/WE HEREBY CERTIFY THAT I/WE LAWFULLY OWN THE ABOVE DESCRIBED VEHICLE/VESSEL, AND MAKE APPLICATION FOR TITLE. IF LIEN IS BEING RECORDED NOTICE IS HEREBY GIVEN THAT THERE IS AN EXISTING WRITTEN LIEN INSTRUMENT INVOLVING THE VEHICLE/VESSEL DESCRIBED ABOVE AND HELD BY LIENHOLDER SHOWN ABOVE. I/WE FURTHER AGREE TO DEFEND THE TITLE AGAINST ALL CLAIMS.

UNDER PENALTIES OF PERJURY, I DECLARE THAT I HAVE READ THE FOREGOING DOCUMENT AND THAT THE FACTS STATED IN IT ARE TRUE.

Signature of Applicant/Owner

Signature of Applicant/Co-Owner

HSMV 82041 REVISED 02/06

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

PALM BEACH COUNTY FIRE RESCUE,

Petitioner,

vs.

FRAES No.: 2008004394
RENDITION NO.: AHCA-08-0487-S-CON

STATE OF FLORIDA, AGENCY FOR HEALTH CARE AMINISTRATION,

Respondent.
_____/

FINAL ORDER

Having reviewed the notice of intent to deem application incomplete and withdrawn from further review, dated April 8, 2008, attached hereto and incorporated herein (Ex. 1), and all other matters of record, the Agency for Health Care Administration ("Agency") has entered into a Settlement Agreement (Ex. 2) with the other party to these proceedings, and being otherwise well-advised in the premises, finds and concludes as follows:

ORDERED:

1. The attached Settlement Agreement is approved and adopted as part of this Final Order, and the parties are directed to comply with the terms of the Settlement Agreement.

2. Each party shall bear its own costs and attorney's fees.

3. The above-styled case is hereby closed.

4. The Petitioner shall remit to the Agency, within thirty (30) days of the entry of a Final Order adopting this Agreement, an Administrative fee in the sum of fifty Dollars ($50.00).

DONE and **ORDERED** this 15 day of May, 2008 in Tallahassee, Leon County, Florida.

Holly Benson, Secretary
Agency for Health Care Administration

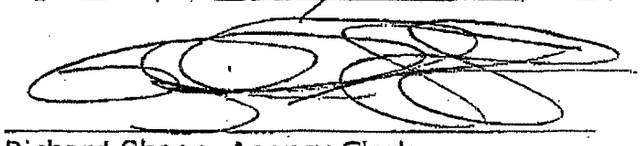
A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW WHICH SHALL BE INSTITUTED BY FILING ONE COPY OF A NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A SECOND COPY, ALONG WITH FILING FEE AS PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW OF PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF RENDITION OF THE ORDER TO BE REVIEWED.

Copies furnished to:

Thomas H. Matese, Jr. Administrator Palm Beach County Fire Rescue 50 S. Military Trl., Suite 101 West Palm Beach, Florida 33415 (U. S. Mail)	Michael O. Mathis Assistant General Counsel Agency for Health Care Administration 2727 Mahan Drive, Bldg #3, MS #3 Tallahassee, Florida 32308 (Interoffice Mail)
Jan Mills Agency for Health Care Administration 2727 Mahan Drive, Bldg #3, MS #3 Tallahassee, Florida 32308 (Interoffice Mail)	Elizabeth Dudek Deputy Secretary Agency for Health Care Administration 2727 Mahan Drive, Bldg #1, MS #9 Tallahassee, Florida 32308 (Interoffice Mail)
	Karen Rivera Laboratory Unit Manager Agency for Health Care Administration 2727 Mahan Drive, MS #28 Tallahassee, Florida 32308 (Interoffice Mail)

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of this Final Order was served on the above-named person(s) and entities by U.S. Mail, or the method designated, on this the 19th day of May, 2008.



Richard Shoop, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Building #3
Tallahassee, Florida 32308-5403
(850) 922-5873

2008043944

Certified Article Number
7160 3901 9845 4789 1820
SENDERS RECORD

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

CHARLIE CRIST
GOVERNOR

HOLLY BENSON
SECRETARY

RECEIVED
GENERAL COUNSEL
APR 08 2008
Agency for Health Care Administration

April 8, 2008

Certified Mail

Palm Beach County Fire Rescue
50 S. Military Trl., Suite 101
West Palm Beach, FL 33415

License/File Number: 800016713
Case #: 2008004394

NOTICE OF INTENT T0 DEEM APPLICATION INCOMPLETE AND WITHDRAWN FROM FURTHER REVIEW

Your application for renewal is deemed incomplete and withdrawn from further consideration pursuant to Section 408.806(3)(b), Florida Statutes.

> Section 408.806(3)(b), F.S. contains the following language: Requested information omitted from an application for licensure, license renewal, or change of ownership, other than an inspection, must be filed with the agency within 21 days after the agency's request for omitted information or the application shall be deemed incomplete and shall be withdrawn from further consideration and the fees shall be forfeited.

You were notified by correspondence dated October 24, 2007 to provide further information addressing identified apparent errors or omissions within twenty-one days from the receipt of the Agency's correspondence. Our records indicate you received this correspondence by certified mail on October 29, 2007.

As the following information was not received within required time frames, your application is deemed incomplete and withdrawn from further consideration:

Refer to enclosed copy of omission letter dated October 24, 2007.

EXPLANATION OF RIGHTS

Pursuant to Section 120.569, F.S., you have the right to request an administrative hearing. In order to obtain a formal proceeding before the Division of Administrative Hearings under Section 120.57(1), F.S., your request for an administrative hearing must conform to the requirements in Section 28-106.201, Florida Administrative Code (F.A.C), and must state the material facts you dispute.

EXHIBIT #1

SEE ATTACHED ELECTION AND EXPLANATION OF RIGHTS FORMS.

Agency for Health Care Administration

By: Karen Rivera, Manager
Laboratory Unit

cc: Agency Clerk, Mail Stop 3
Legal Intake Unit, Mail Stop 3

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

RE: Palm Beach County Fire Rescue
CASE NO: 2008004394

ELECTION OF RIGHTS

This Election of Rights form is attached to a proposed Notice of Intent to Deem Incomplete and Withdraw from Further Review of the Agency for Health Care Administration (AHCA). The title may be **Notice of Intent to Deem Incomplete and Withdraw from Further Review or some other notice of intended action by AHCA.**

An Election of Rights must be returned by mail or by fax within 21 days of the day you receive the attached Notice of Intent to Deem Incomplete and Withdraw from Further Review or any other proposed action by AHCA.

If an Election of Rights with your selected option is not received by AHCA within twenty-one (21) days from the date you received this notice of proposed action, you will have given up your right to contest the Agency's proposed action and **a final order will be issued.**

(Please reply using this Election of Rights form unless you, your attorney or your representative prefer to reply according to Chapter 120, Florida Statutes (2006) and Rule 28, Florida Administrative Code.)

Please return your ELECTION OF RIGHTS to:

Agency for Health Care Administration
Attention: Agency Clerk
2727 Mahan Drive, Mail Stop #3
Tallahassee, Florida 32308
Phone: (850) 922-5873 Fax: (850) 921-0158

PLEASE SELECT ONLY 1 OF THESE 3 OPTIONS:

OPTION ONE (1) ____ **I admit to the allegations of facts and law contained in the Notice of Intent to Deem Incomplete and Withdraw from Further Review, or other notice of intended action by AHCA and I waive my right to object and have a hearing.** I understand that by giving up my right to a hearing, a final order will be issued that adopts the proposed agency action and imposes the proposed penalty, fine or action.

OPTION TWO (2) ____ **I admit to the allegations of facts contained in the Notice of Intent to Deem Incomplete and Withdraw from Further Review, or other proposed action by AHCA, but I wish to be heard at an informal proceeding** (pursuant to Section 120.57(2), Florida Statutes) where I may submit testimony and written evidence to the Agency to show that the proposed administrative action is too severe or that the fine should be reduced.

OPTION THREE (3) ____ **I dispute the allegations of fact contained in the Notice of Intent to Deem Incomplete and Withdraw from Further Review or other proposed action by AHCA, and I request a formal hearing** (pursuant to Section 120.57(1), Florida Statutes) before an Administrative Law Judge appointed by the Division of Administrative Hearings.

PLEASE NOTE: Choosing OPTION THREE (3), by itself, is NOT sufficient to obtain a formal hearing. You also must file a written petition in order to obtain a formal hearing before the Division of Administrative Hearings under Subsection 120.57(1), Florida Statutes. It must be **received** by the Agency Clerk at the address above **within 21 days** of receipt of this proposed administrative action. The request for formal hearing must conform to the requirements of Rule 28-106.201, Florida Administrative Code, which requires that it contain:

1. The name and address of each agency affected and each agency's file or identification number, if known;
2. Your name, address, and telephone number, and the name, address, and telephone number of your representative or lawyer, if any;
3. An explanation of how your substantial interests will be affected by the Agency's proposed action;
4. A statement of when and how you received notice of the Agency's proposed action;
5. A statement of all disputed issues of material fact. If there are none, you must state that there are none;
6. A concise statement of the ultimate facts alleged, including the specific facts you contend warrant reversal or modification of the Agency's proposed action;
7. A statement of the specific rules or statutes you claim require reversal or modification of the Agency's proposed action; and
8. A statement of the relief you are seeking, stating exactly what action you wish the Agency to take with respect to its proposed action.

(Mediation under Section 120.573, Florida Statutes, may be available in this matter if the Agency agrees.)

License type: **Clinical Laboratory** License number: **800016713**
Licensee Name: **Palm Beach County Fire Rescue**

Contact person: _____
Name Title

Address: _____
Street and number City Zip Code

Telephone No. _____ Fax No. _____ Email (optional) _____

I hereby certify that I am duly authorized to submit this Notice of Election of Rights to the Agency for Health Care Administration on behalf of the licensee referred to above.

Signed: _____ Date: _____

Print Name: _____ Title: _____

UNITED STATES POSTAL SERVICE®

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Track & Confirm

Search Results

Label/Receipt Number: 7160 3901 9845 4789 1820
Status: Delivered

Your item was delivered at 11:28 AM on April 10, 2008 in WEST PALM BEACH, FL 33415.

Track & Confirm
Enter Label/Receipt Number.
Go >

Notification Options

Track & Confirm by email

Get current event information or updates for your item sent to you or others by email. Go >

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

PALM BEACH COUNTY FIRE RESCUE,

Petitioner,

vs. FRAES No.: 2008004394

STATE OF FLORIDA, AGENCY FOR HEALTH CARE AMINISTRATION,

Respondent.

SETTLEMENT AGREEMENT

Respondent, State of Florida, Agency for Health Care Administration (hereinafter the "Agency"), through its undersigned representatives, and Petitioner, Palm Beach County Fire Rescue (hereinafter "Petitioner"), pursuant to Section 120.57(4), Florida Statutes, each individually, a "party," collectively as "parties," hereby enter into this Settlement Agreement ("Agreement") and agree as follows:

WHEREAS, the Petitioner is a clinical laboratory licensed pursuant to Chapter 483, Part I, Florida Statutes and the Chapter 59A-7, Florida Administrative Code; and

WHEREAS, the Agency has jurisdiction by virtue of being the regulatory and licensing authority over licensure of Petitioner; and

EXHIBIT #2

WHEREAS, the Agency served the Petitioner with a Notice of Intent to Deem Application Incomplete, notifying the Petitioner of its intent to withdraw its application from further review; and

WHEREAS, the parties have agreed that a fair, efficient, and cost effective resolution of this dispute would avoid the expenditure of substantial sums to litigate the dispute; and

WHEREAS, the parties stipulate to the adequacy of considerations exchanged; and

WHEREAS, the parties have negotiated in good faith and agreed that the best interest of all the parties will be served by a settlement of this proceeding; and

NOW THEREFORE, in consideration of the mutual promises and recitals herein, the parties intending to be legally bound, agree as follows:

1. All recitals are true and correct and are expressly incorporated herein.

2. Both parties agree that the "whereas" clauses incorporated herein are binding findings of the parties.

3. Upon full execution of this Agreement, Petitioner agrees to waive any and all proceedings and appeals to which it may be entitled including, but not limited to, an informal proceeding under Subsection 120.57(2), a formal proceeding under Subsection 120.57(1), appeals under Section 120.68, Florida Statutes; and declaratory and all writs of relief in any court

or quasi-court (DOAH) of competent jurisdiction; and further agrees to waive compliance with the form of the Final Order (findings of fact and conclusions of law) to which it may be entitled. Provided, however, that no agreement herein, shall be deemed a waiver by either party of its right to judicial enforcement of this Agreement.

4. Upon full execution of this Agreement, the parties agree to the following:

a. The Petitioner shall remit to the Agency, within thirty (30) days of the entry of a Final Order adopting this Agreement, an Administrative fee in the sum of fifty Dollars ($50.00).

b. The Notice of Intent to Deem Application Incomplete and Withdrawn From Further Review is deemed superseded by this agreement.

c. Upon the full execution of this Agreement, the Agency shall begin processing Petitioner's application.

d. Nothing in this Agreement shall prohibit the Agency from denying Petitioner's application for licensure based upon any statutory and/or regulatory provision, including, but not limited to, the failure of Petitioner to satisfactorily complete a survey reflecting compliance with all statutory and rule provisions as required by law.

5. Venue for any action brought to interpret, challenge or enforce the terms of this Agreement or the Final Order entered pursuant hereto shall lie solely in the Circuit Court in Leon County, Florida.

6. By executing this Agreement, the Petitioner neither admits nor denies the allegations raised in the Notice of Intent to Deny referenced herein.

7. Upon full execution of this Agreement, the Agency shall enter a Final Order adopting and incorporating the terms of this Agreement and closing the above-styled case(s).

8. Each party shall bear its own costs and attorney's fees.

9. This Agreement shall become effective on the date upon which it is fully executed by all the parties.

10. The Petitioner for itself and for its related or resulting organizations, its successors or transferees, attorneys, heirs, and executors or administrators, does hereby discharge the Agency and its agents, representatives, and attorneys of all claims, demands, actions, causes of action, suits, damages, losses, and expenses, of any and every nature whatsoever, arising out of or in any way related to this matter and the Agency's actions, including, but not limited to, any claims that were or may be asserted in any federal or state court or administrative forum, including any claims arising out of this Agreement, by or on behalf of the Petitioner or related or resulting organizations.

11. This Agreement is binding upon all parties herein and those identified in the aforementioned paragraph of this Agreement.

12. In the event that Petitioner is or was a Medicaid provider, this settlement does not prevent the Agency from seeking Medicaid overpayments or from imposing any sanctions pursuant to Rule 59G-9.070, Florida Administrative Code.

13. The undersigned have read and understand this Agreement and have authority to bind their respective principals to it. Petitioner's representative has the capacity to execute this Agreement and has done so without the advice of counsel. The Petitioner understands that it has the right to consult with counsel and has knowingly and freely entered into this Agreement without exercising its right to consult with counsel. The Petitioner fully understands that counsel for the Agency represents solely the Agency and Agency counsel has not provided legal advice to or influenced the Petitioner in its decision to enter into this Agreement.

14. This Agreement contains the entire understandings and agreements of the parties.

15. This Agreement supersedes any prior oral or written agreements between the parties. This Agreement may not be amended except in writing. Any attempted assignment of this Agreement shall be void.

16. All parties agree that a facsimile signature suffices for an original signature.

17. The following representatives hereby acknowledge that they are duly authorized to enter into this Agreement.

Elizabeth Dudek
HQA, Deputy Secretary
Agency for Health Care Administration
2727 Mahan Drive, Bldg #1
Tallahassee, Florida 32308

DATED: 5/15/2008

Michael O. Mathis
Assistant General Counsel
Agency for Health Care Admin.
2727 Mahan Drive, MS #3
Tallahassee, Florida 32308

DATED: 4/29/08

HERMAN W. BRICE

~~Thomas H. Matese, Jr.~~ Administrator
Palm Beach County Fire Rescue
50 S. Military Tri., Suite 101
West Palm Beach, Florida 33415

DATED: 5/1/08

Craig H. Smith, General Counsel
Florida Bar No. 96598
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #3
Tallahassee, Florida 32308

DATED: 5/14/08

AUTHORIZED BY:
Robert Weisman
County Administrator
Palm Beach County

CONCURRENCE BY:
Denise M. Nieman
County Attorney
Palm Beach County

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

Petitioner,

vs.

Case No.: 2008-20865

PALM BEACH COUNTY FIRE RESCUE,

DOH-11-1346-S-HSEM

Respondent.

_____/

FINAL ORDER

Having received a Stipulation, this matter is before the Department of Health for entry of a Final Order.

The Stipulation was fully executed on or about June 06, 2011. The Stipulation is accepted and incorporated by reference. Respondent's payment of a $3,000.00 administrative fine is due within sixty (60) days of the date the Final Order issues and is to be mailed to the Bureau of Emergency Medical Services, Investigation Unit at 4052 Bald Cypress Way, Bin C-18, Tallahassee, Florida 32399. The parties are directed to comply with the terms of the Stipulation. This proceeding is closed.

DONE and **ORDERED** this 10TH day of June, 2011 at Tallahassee, Leon County, Florida.

By: _____
Shairi Turner, M.D., M.P.H.
Deputy Secretary for Health

NOTICE OF RIGHT TO JUDICIAL REVIEW

A PARTY ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW PURSUANT TO SECTION 120.68, FLORIDA STATUTES. A REVIEW PROCEEDING IS GOVERNED BY THE FLORIDA RULES OF APPELLATE PROCEDURE. A PROCEEDING IS COMMENCED BY FILING A NOTICE OF APPEAL WITH THE CLERK OF THE DEPARTMENT OF HEALTH AND A COPY ACCOMPANIED BY THE FILING FEE WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE PARTY RESIDES OR THE FIRST DISTRICT COURT OF APPEAL. A NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF THE FILING DATE OF THIS FINAL ORDER.

Copies furnished to:

Amy Taylor Petrick, Esq.
Assistant County Attorney
Palm Beach County
300 North Dixie Highway
Suite 359
West Palm Beach, Florida 33401

Richard McNelis, Esq.
Department of Health
Office of the General Counsel
4052 Bald Cypress Way, Bin A-02
Tallahassee, Florida 32399-1703

Palm Beach County Fire Rescue
c/o William Peters, Chief
405 Pike Road
West Palm Beach, Florida 33411

CERTIFICATE OF SERVICE

I CERTIFY that a copy of the foregoing FINAL ORDER has been sent by U.S. Mail, inter-office mail, or by hand delivery to each of the above-named persons this 16th day of June, 2011.

Agency Clerk
Department of Health
Central Records
4052 Bald Cypress Way, Bin C01
Tallahassee, Florida 32399-3251
Phone (850) 245-4121

STATE OF FLORIDA
DEPARTMENT OF HEALTH
BUREAU OF EMERGENCY MEDICAL SERVICES

DEPARTMENT OF HEALTH,

Petitioner,

vs. Case No.: 2008-20865

PALM BEACH COUNTY FIRE RESCUE,

Respondent.
_____/

SETTLEMENT

By signature of the parties below, the Petitioner Department of Health ("Department") and Palm Beach County Fire Rescue ("Respondent") stipulate and agree to the following Settlement and to the entry of a Final Order by the Department incorporating the Stipulated Facts and Stipulated Disposition in this matter.

STIPULATED FACTS

1. Department is the state agency charged with regulating the practice of emergency medical services pursuant to Section 20.43, Florida Statutes, and Chapter 401, Florida Statutes.

2. At all times material, Respondent was licensed as an EMS provider, ALS, license #5013, subject to the disciplinary authority of the Department under Chapter 401, Florida Statutes.

3. Respondent was charged by Administrative Complaint, served upon Respondent, with allegations setting out violations of Chapter 401 and the rules enacted pursuant thereto. This Settlement Stipulation follows negotiation of the parties subsequent to service of the Administrative Complaint on Respondent and receipt thereof.

4. Respondent admits that the allegations of fact contained in the Administrative Complaint are true and accurate.

STIPULATED CONCLUSIONS OF LAW

5. Respondent admits that the facts set forth in the Administrative Complaint, if proven at final hearing and if not excused or avoided through additional facts and affirmative defenses, would constitute violation(s) of Chapter 401, Florida Statutes, as alleged in the Administrative Complaint.

6. Respondent agrees that it could be disciplined by fines for the above, totaling a significant amount.

7. Respondent admits that the stipulated disposition of this case is fair, appropriate and acceptable to Respondent.

STIPULATED DISPOSITION

8. **FUTURE CONDUCT.** Respondent shall not in the future violate Chapter 401, Florida Statutes, or the rules promulgated pursuant thereto. Prior to signing this stipulation, Respondent shall read Chapter 401, Florida Statutes, and the rules of the Department, with particular attention to renewal of licensure.

9. **ADMINISTRATIVE FINE.** In light of Respondent's public service role in providing EMS services to the citizens, Respondent shall pay a greatly reduced administrative fine in the amount of $3,000.00, within 30 days of the date the Final Order is filed with the DOH Agency Clerk. The fine shall be paid to the Department, and sent to the Compliance Officer at 4052 Bald Cypress Way, Bin C-01, Tallahassee, Florida 32399.

10. Respondent has filed a Corrective Action Plan attached hereto as Exhibit A with the Bureau of EMS. The Corrective Action Plan is acceptable to the Chief of Bureau of EMS, as

evidenced by the Chief's signature at the foot of this Settlement. Respondent shall comply with the terms of the Corrective Action Plan, which is incorporated by reference into this Settlement.

11. It is expressly understood that a violation of the terms of this Settlement, including the terms of the Corrective Action Plan, shall be considered a violation of a Final Order of the Department for which disciplinary action may be initiated pursuant to Chapter 401, Florida Statutes.

12. It is expressly understood that this Settlement is subject to acceptance by the Department and has no force or effect until the Final Order is entered.

13. This Settlement is executed by Respondent for the purpose of avoiding further administrative action by the Department regarding the acts or omissions specifically set forth in the Administrative Complaint, attached hereto as Exhibit B. Respondent agrees to support this Settlement and shall offer no evidence, testimony or argument that disputes or contravenes any stipulated fact. Respondent authorizes the Department to interview witnesses and investigate any matter relating to this case or any other case pending Department acceptance of this Settlement.

14. If this Settlement is not accepted by the Department, it is agreed that the presentation and consideration of this Stipulation and other documents and matters by the Department shall not unfairly or illegally prejudice the Department from participation in further consideration or resolution of this case.

15. The Department of Health and Respondent fully understand that this Settlement and any subsequent Final Order incorporating same relate solely to the case(s) identified in the style of this stipulation. This Settlement in no way precludes action by the Department of Health (including but not limited to the Department's Medicaid Program Integrity Office) or the

Department against the Respondent for acts or omissions that are not the subject of the Administrative Complaint attached as Exhibit B.

16. Upon adoption of the Settlement as the Final Order of the Department, Respondent expressly waives all further procedural steps, and expressly waives all rights to seek judicial review or otherwise challenge or contest the validity of the Settlement and Final Order.

17. Respondent waives the right to seek attorneys' fees and/or costs from the Department of Health or the Department in connection with this disciplinary proceeding.

18. The persons executing this Settlement possesses full authority to do so on behalf of both parties.

WHEREFORE, the parties hereto request that the Department enter a Final Order accepting and implementing the terms contained herein.

DATED this 18 day of MAY, 2011

By Palm Beach County:

Robert Weisman
County Administrator

APPROVED AS TO FORM AND
LEGAL SUFFICIENCY

By: _____
County Attorney

On behalf of Department of Health, I accept the foregoing SETTLEMENT.

By: John Bixler, Bureau Chief
Bureau of Emergency Medical Services

Date: February 01, 2011

Corrective Action Plan

Developed by Palm Beach County Fire Rescue for

Timely Compliance of License Renewal

License: **State of Florida, Department of Health, Advanced Life Support License.**

Scope: To assure the timely biennial renewal and updating of the State of Florida, Department of Health, Advanced Life Support License by the use of an Implementation Action Plan (IAP) throughout the licensing time line. To develop roles and responsibilities for timely compliance for Palm Beach County Fire Rescue in Department Policy.

Objectives:

1. Establish position of Compliance Officer for the tracking of all license renewals.
2. Transition application responsibility to the Management Services Division, Operational Division Liaison, and Operational Compliance Officer within Palm Beach County Fire Rescue and assure role clarity.

   A. Operational Liaison

   - Coordinates and provides input necessary for renewal.

   B. Management Services Division

   - Tracking of License Status
   - License preparation, review with legal counsel, and submittal to State of Florida, Department of Health for biennial renewal.

   C. Operational Compliance Officer

   - Redundant compliance tracking.

EXHIBIT tabbies A

3. Use of an Implementation Action Plan (IAP) with GANTT Charting to monitor:

A. Expiration dates of the following:

- State of Florida, Department of Health, Advanced Life Support License
- Medical Director Contract
- Medical Director License
- Medical Director Drug Enforcement Agency License
- Trauma Transport Protocols
- Aero-Medical Aircraft Worthiness Certification
- Aero-Medical Aircraft Insurance Compliance
- FAA Part 135 Compliance
- Aero-Medical Aircraft Pilot License and Medical Certificate Compliance.

B. Policy:

- Develop policy on performance of vehicle permit audits for compliance and complete Vehicle Permit application process for new units or replacement units placed in-service within 15 days.

C. Timeline:

- Establish timeline as part of the Implementation Action Plan to assure the State of Florida, Department of Health receives a completed biennial renewal application no later than thirty (30) days before expiration.

D. Contingency Planning:

- Identify constraints in IAP in the event of disaster (i.e. Hurricanes, man-made disasters, etc.) and strategies to resolve any complications.

E. Record Keeping:

- Maintain complete copies of all applications filed.

Compliance Communication:

- Operational Liaison Officer will establish a checks and balances for communication and documentation between Palm Beach County Fire Rescue and the Department of Health, Regulatory Specialist to keep the biennial renewal and updating process on track.

License Renewal Completion:

- Assure successful biennial renewal of license within established IAP.

Post Renewal Updates:

- Update the State of Florida, Department of Health, Advanced Life Support License and expiration dates of all license requirements after each biennial renewal for Management Services and the Operational Compliance Officer.

STATE OF FLORIDA
DEPARTMENT OF HEALTH
BUREAU OF EMERGENCY MEDICAL SERVICES

DEPARTMENT OF HEALTH,

Petitioner,

vs. Case No. 2008-20865

PALM BEACH COUNTY FIRE RESCUE,

Respondent,

_____/

ADMINISTRATIVE COMPLAINT

COMES NOW Petitioner, Department of Health ("Petitioner"), by and through its undersigned attorneys and files its Administrative Complaint against Respondent, PALM BEACH COUNTY FIRE RESCUE ("Respondent") and alleges:

1. Petitioner is the state agency charged with regulating emergency medical services pursuant to Section 20.43, Florida Statutes, and Chapters 120 and 401, Florida Statutes.

2. At all times material hereto, Respondent has been operating as an Advanced Life Support Service Provider, Provider Number 5013.

3. All classifications of EMS licensure held by Respondent are subject to any Final Order which issues in this case, as provided by Section 401.411(2), Florida Statutes.

4. Respondent's address of record is 405 Pike Road, West Palm Beach, Florida 33411.

EXHIBIT
B

5. On September 04, 2008, Respondent's Advanced Life Support (ALS) license expired. Composite Exhibit A.

6. On September 10, 2008, Respondent's ALS license was renewed for the time period beginning September 10, 2008 and expiring on September 09, 2010.

7. September 05, 2008 to September 09, 2008 is five (5) days.

9. Respondent violated Section 401.25(1), Florida Statutes by failing to be licensed before providing services to the public.

10. Section 401.411(1)(a), Florida Statutes, provides that a licensee may be disciplined for violation of Section 401.25(1), Florida Statutes.

CLAIM FOR RELIEF

WHEREFORE, Petitioner respectfully requests the Bureau of Emergency Medical Services to enter an order imposing one or more of the following disciplinary measures upon Respondent pursuant to Section 401.411(1), Florida Statutes:

a. A reprimand; and

b. An administrative fine of $5,000.00;

c. Strict compliance with any Final Order imposing professional discipline for misconduct in this matter. Any material deviation from or failure to comply with any provision of the Final Order in this case shall constitute unprofessional conduct within the meaning of sec. 401.411(1), F.S., and may result in renewed prosecution and imposition of additional discipline for such unprofessional conduct.

Dated this 9 day of December, 2010

Respectfully submitted,

RICHARD MCNELIS
Assistant General Counsel

Richard P. McNelis
Assistant General Counsel
Bin #C18
4052 Bald Cypress Way
Tallahassee, Florida 32399-1703
Telephone: 850-245-4028
Florida Bar #0990485

PCP: Pippin, Hines & Cash
Date: September 30, 2010

NOTICE OF RIGHTS

A party whose substantial interest is affected by this order may petition for an administrative hearing pursuant to sections 120.569 and 120.57, Florida Statutes. Such petitions and proceedings thereon are governed by Rule 28-106, Florida Administrative Code. A petition for administrative hearing must be in writing and must be received by the Bureau of EMS within twenty-one (21) days from the day you received this Administrative Complaint and must be sent to Department of Health, Bureau of Emergency Medical Services, 4052 Bald Cypress Way, Bin #C18, Tallahassee FL 32399-1703.

Mediation is not available as an alternative remedy.

Your failure to submit a petition for hearing within 21 days from receipt of this Administrative Complaint will constitute a waiver of your right to an administrative hearing, and this Administrative Complaint will thereby become a "final order".

If this Administrative Complaint becomes a final order, a party who is adversely affected by it is entitled to judicial review pursuant to Section 120.68, Florida Statutes. Review proceedings are governed by the Florida Rules of Appellate Procedure. Such proceedings may be commenced by filing a Notice of Appeal, accompanied by the filing fees required by law, with the Court of Appeal in the appropriate District Court, and a copy must be sent to the Agency Clerk of the Department of Health at 4052 Bald Cypress Way, Bin #A02, Tallahassee FL 32399-1703. The notice of appeal must be filed within 30 days of the date that a final order issues in this case.

Emergency Medical Services
License Application Profile Report

AGENCY DATA

Name: PALM BEACH COUNTY FIRE-RESCUE
Manager Name: Chief William Peters
Mailing Address: 50 S Military Tr Ste 101
WEST PALM BEACH, FL 33415
Physical Address: 50 S Military Trail, Suite 101
WEST PALM BEACH, FL 33415

ID NUMBER: 5013
COUNTY: PALM BEACH

Service Type
Fire Department
County
Non-Profit
Public Safety

Phone: (561) 616-7016
Fax: (561) 616-7085
Email: wpeters@pbcgov.com

LICENSE DATA

Certification Number: 2771
Status: Clear
Service Type: ALS

Date Issued: 08/25/2006
Service Sub-Type: Transport
Amount Required: $3,175.00

Expires: 09/04/2008
Amount paid: $3,175.00

PRIMARY MEDICAL DIRECTOR DATA

Name: MATESE, THOMAS HENRY JR
Phone: (561) 616-7016
Address: 50 S Military Tr Ste 101
WEST PALM BEACH FL 33415

License Number: OS 6259
DEA Reg. #: BM 2233853
Contract End Date: 09/30/2008

License Expires: 03/31/2010
DEA Reg. Expires: 01/31/2011

SECONDARY MEDICAL DIRECTOR DATA

Name:
Phone:
Address:

License Number:
DEA Reg. #:
Contract End Date:

License Expires:
DEA Reg. Expires:

Report Date & Time: 1/8/2008 2:35:18PM

INSURANCE DATA

Insurance Company	Type of Insurance	Insurance Expiration Date
Global Aerospace, Inc.	Aircraft Liability	10/01/2008
Self-Insured	Professional Liability	01/01/1901
Self-Insured	Vehicle Liability	01/01/1901

SERVICE AREA DATA

County of Service	Date Certificate of Public Convenience and Necessity Expires
Palm Beach	12/31/2010

Report Date & Time: 1/8/2008 2:35:18PM

Emergency Medical Services
License Application Profile Report

PROVIDER DATA

Name: PALM BEACH COUNTY FIRE-RESCUE
Manager Name: Chief William Peters
Mailing Address: 50 S Military Tr Ste 101
WEST PALM BEACH, FL 33415
Physical Address: 50 S Military Trail, Suite 101
WEST PALM BEACH, FL 33415

ID NUMBER: 5013
COUNTY: PALM BEACH

Service Type
Fire Department
County
Non-Profit
Public Safety

Phone: (561) 616-7016
Fax: (561) 616-7085
Email: wpeters@pbc.gov

LICENSE DATA

Certification Number: 3039
Status: Clear
Service Type: ALS

Date Issued: 09/10/2006
Service Sub-Type: Transport
Amount Required: $3,300.00

Expires: 09/09/2010
Amount paid: $3,300.00

PRIMARY MEDICAL DIRECTOR DATA

Name: MATESE, THOMAS HENRY JR
Phone: (561) 616-7016
Address: 50 S Military Tr Ste 101
WEST PALM BEACH FL 33415

License Number: OS 6269
DEA Reg. #: BM 2233853
Contract End Date: 09/30/2008

License Expires: 03/31/2010
DEA Reg. Expires: 01/31/2011

SECONDARY MEDICAL DIRECTOR DATA

Name:
Phone:
Address:

License Number:
DEA Reg. #:
Contract End Date:

License Expires:
DEA Reg. Expires:

Report Date & Time: 9/11/2008 12:15:36PM

INSURANCE DATA

Insurance Company	Type of Insurance	Insurance Expiration Date
Global Aerospace, Inc.	Aircraft Liability	10/01/2008
Self-Insured	Professional Liability	01/01/1901
Self-Insured	Vehicle Liability	01/01/1901

SERVICE AREA DATA

County of Service	Date Certificate of Public Convenience and Necessity Expires
Palm Beach	12/31/2010

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