The Medicare PECOS & CMS-855 Form Selection Master Guide

A Decision-Tree Protocol for Initial Enrollment, Reassignment, Group Practices, and 5-Year Revalidations

Executive Summary

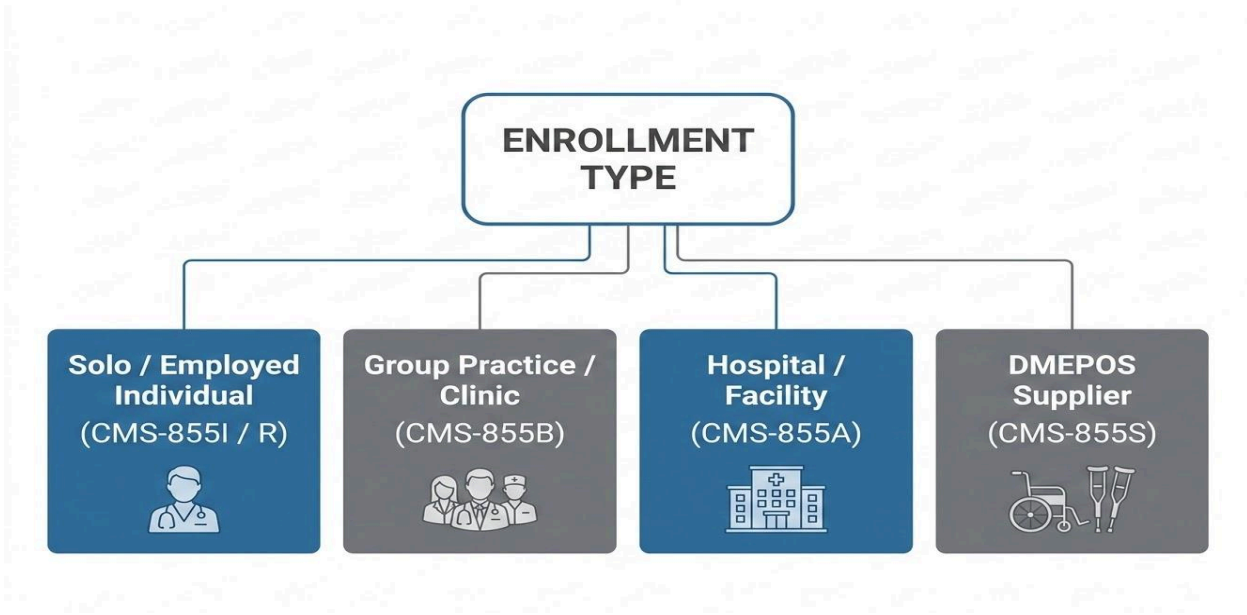
Medicare provider enrollment is governed by the Centers for Medicare & Medicaid Services (CMS) and processed through regional Medicare Administrative Contractors (MACs) via the PECOS (Provider Enrollment, Chain, and Ownership System) online portal.

Submitting the wrong CMS-855 form variant, failing to properly reassign billing rights, or using paper submissions instead of PECOS will result in processing delays of 90 to 180+ days or outright application rejection.

Use this decision matrix and checklist to select the exact enrollment pathway and submit a zero-defect Medicare package.

Part 1: CMS-855 Form Selection Matrix (Which Form Do You Need?)

Use this flowchart and matrix to determine the exact form(s) required for your practice structure:



Comprehensive Form Reference Breakdown

Form Variant	Official Title	Who Must Submit This Form?	Primary Purpose
CMS-855I	Individual Physicians and Non-Physician Practitioners	All individual MDs, DOs, PAs, NPs, CRNAs, LCSWs, Psychologists, PTs, OTs, DCs, DPMs.	Initial enrollment of individual provider (PTAN assignment), adding new state license, or updating practice location.
CMS-855R	Reassignment of Medicare Benefits	Rendering providers who are employed by or contracted with a medical group/clinic.	Reassigns individual provider's right to bill Medicare to the group's Type 2 NPI / Tax ID.

Form Variant	Official Title	Who Must Submit This Form?	Primary Purpose
CMS-855B	Healthcare Organization / Clinics / Group Practices	Multi-specialty clinics, solo corporations (PC, LLC, PLLC), urgent care centers, IDTFs.	Establishes the group practice entity, assigns Group PTAN, and links authorized officials/owners.
CMS-855A	Institutional Providers	Hospitals, Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), FQHCs, Home Health, Hospice.	Facility-level enrollment, initial CMS certification, changes in ownership (CHOW).
CMS-855S	DMEPOS Suppliers	Pharmacies, medical supply companies, physicians supplying orthotics/prosthetics or DME.	Managed by the National Supplier Clearinghouse (NSC) / Palmetto GBA for DME Medicare billing.
CMS-855O	Ordering / Referring / Prescribing Only	Providers who do NOT bill Medicare directly but order diagnostic tests, DME, or refer patients.	Establishes enrollment exclusively on the CMS Ordering & Referring file without obtaining billing PTAN.
CMS-588	Electronic Funds Transfer (EFT) Authorization	Every group practice or independent billing provider.	Directs Medicare reimbursements directly into the clinic's commercial bank account (mandatory).

Part 2: Regional MAC Jurisdiction Map

Medicare Part A and Part B applications must be submitted to the contractor governing your physical practice state:

MAC Contractor	Jurisdictions	States Covered
Noridian Healthcare Solutions	JF & JE	AK, AZ, CA, HI, ID, MT, ND, NV, OR, SD, UT,

MAC Contractor	Jurisdictions	States Covered
		WA, WY
Palmetto GBA	JM & JJ	AL, GA, NC, SC, TN, VA, WV
National Government Services (NGS)	J6 & JK	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
WPS Government Health Administrators	J5 & J8	IA, IN, KS, MI, MO, NE
Novitas Solutions	JH & JL	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX
CGS Administrators	J15	KY, OH
First Coast Service Options (FCSO)	JN	FL, PR, US Virgin Islands

Part 3: Step-by-Step PECOS Submission Checklist

[Step 1: NPPES Audit] ──► [Step 2: PECOS Setup] ──► [Step 3: Upload Docs] ──► [Step 4: Sign & Track]

STEP 1: NPPES Identity & Registry Audit

- ☐ Verify the provider's NPI Type 1 (Individual) is active and the legal name matches the Social Security Administration database exactly.
- ☐ If enrolling a group, verify the NPI Type 2 (Organization) matches the IRS CP-575 document.
- ☐ Ensure primary taxonomy codes in NPPES align with the requested Medicare specialty.

STEP 2: Identity & Access (I&A) Management Setup

- ☐ Create and log into the CMS Identity & Access (I&A) system.
- ☐ If working as a practice administrator, request the "Authorized Official (AO)", "Delegated Official (DO)", or "Surrogate" role from the provider to manage filings.

STEP 3: Electronic PECOS Data Entry

- ☐ Demographics: Enter provider/group details, contact person (credentialing coordinator), and physical practice locations (specialty suites, hospital departments).
- ☐ Adverse Legal History: Report any final adverse legal actions (felonies, license suspensions, exclusions) within the past 10 years.
- ☐ Billing Agency Details: If using a third-party medical billing service, input their company name, address, and billing contact.
- ☐ Managing Employees & Ownership (for CMS-855B/A): List all 5%+ owners, managing employees, and upload organizational chart.

STEP 4: Mandatory Document Uploads

Attach clear, high-resolution PDF files to the PECOS upload queue:

- ☐ IRS Form CP-575 or IRS 147C Letter (proof of FEIN).
- ☐ Voided Check or Bank Confirmation Letter (must match legal entity name on CMS-588).
- ☐ State Professional Licenses & DEA Certificate.
- ☐ Signed CMS-588 EFT Agreement.
- ☐ Supervisory / Collaborative Agreements (mandatory for mid-levels where required).

STEP 5: Electronic Signatures & MAC Tracking

- ☐ Route the application for electronic signature via email to the Authorized Official and the Rendering Provider.
- ☐ Log the unique PECOS Tracking ID / Web Reference Number.
- ☐ Set a 14-day calendar alert to monitor the assigned MAC Intake Status.

Part 4: The 5-Year Medicare Revalidation Protocol

CMS requires all enrolled providers to revalidate their Medicare enrollment every 5 years (every 3 years for DMEPOS).

Medicare Revalidation Warning Flags	
DO NOT Submitting Unsolicited Revalidations	Only submit revalidation after CMS issues the formal 60-day notice.
Watch the CMS Revalidation List Portal Monthly	Check the CMS Medicare Revalidation Lookup Tool (data.cms.gov) monthly.
Failure to Respond Within 60 Days	Leads to immediate PTAN deactivation and total stop of Medicare payment.

1. Monitor the CMS Revalidation Lookup Tool: Check data.cms.gov/revalidation every 30 days for your practice NPIs.
2. Submit via PECOS Within 60 Days: Complete the streamlined revalidation workflow in PECOS rather than paper to reduce processing from 120 days to under 45 days.
3. Verify Continued Reassignment: Ensure all employed associates remain correctly mapped under CMS-855R.

Part 5: Top 4 Mistakes That Cause Medicare Enrollment Rejections

Mistake	Consequence	How to Avoid
Name Mismatch on Bank Letter	Application returned immediately.	Account name on voided check must match IRS CP-575 letter character-for-character.
Missing Gap in Employment	Development letter issued (30-day delay).	Account for every 30-day gap across the entire 5-year work history section.
Unsigned CMS-855R by Group	Reassignment rejected.	Both the rendering provider and the group's Authorized Official must sign.
Paper Form Usage	90–120 day processing timeline.	Always submit online via PECOS for 30–45 day turnaround.

Need Expert Medicare Enrollment & Revalidation Support?

EXP Credentialing Services manages initial Medicare enrollments, PECOS setups, group reassignments, and revalidations across all 50 states and MAC jurisdictions.

- Website: expcredentialingservices.com
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