FILED UNDER SEAL PURSUANT TO 31 U.S.C. § 3730(b)(2)

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA
ex rel. **VANESSA MATHURIN,**

Plaintiffs,

v.

VECTOR REMOTE CARE, LLC, TRIVEK HEALTH SOLUTIONS, INC., and **KEVIN HOFFMAN,**

Defendants.

DOCKET NO. _____

FILED UNDER SEAL PURSUANT TO 31 U.S.C. § 3730(b)(2)

JURY TRIAL DEMANDED

QUI TAM COMPLAINT AND DEMAND FOR JURY TRIAL

Plaintiff and *qui tam* Relator Vanessa Mathurin, by and through her undersigned counsel, Brown, LLC, alleges of personal knowledge as to her own observations and actions, and on information and belief as to all else, as follows:

I. PRELIMINARY STATEMENT

1. This is a *qui tam* action on behalf of the United States of America (the "Government") under the False Claims Act, 31 U.S.C. §§ 3729 *et seq.* (the "FCA"), to recover treble the actual damages sustained by, and civil penalties owed to, the Government arising from Defendants' submission of false claims to Medicare.

2. Defendants Vector Remote Care, LLC ("Vector") and Trivek Health Solutions, Inc. ("Trivek") provide remote cardiac monitoring ("RCM") to patients nationwide.

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3. In October 2019, Vector conjured a sham location in Long Island City, New York even though its true base of operations is in Oregon. Defendants enrolled the sham New York location in Medicare as an Independent Diagnostic Testing Facility ("IDTF").

4. Defendants feigned a New York presence to take advantage of the high Medicare reimbursement rates. Defendants referred most, if not all, of their existing patients to the sham location, and billed Medicare for RCM as though the monitoring had been performed in New York. In reality, virtually none of Defendants' patients and RCM technicians were located in New York.

5. By claiming that the RCM was performed in New York, Defendants submitted false claims to Medicare.

6. Further, the New York location failed to meet minimum certification requirements governing IDTFs and so was ineligible to submit claims to Medicare.

7. In fact, even though the regulations dictate that an IDTF must have a discrete location, this was just a WeWork shared workspace location without proper equipment or staff.

8. The false nature of the New York location became even clearer in June 2020, when Defendants directed their on-site employees to work from home and migrated to a "Hot Desk," which is a commonly-shared-as-needed desk at the WeWork workspace.

9. Because the New York location failed to meet minimum certification requirements for IDTFs, each claim Vector submitted to Medicare from that location was false within the meaning of the False Claims Act.

10. This complaint is being filed *in camera* and under seal pursuant to 31 U.S.C. § 3730(b)(2). A copy of this complaint, along with written disclosure of substantially all material evidence and information that Relator possesses, was served on the Attorney General of the United

States and the United States Attorney for the Eastern District of New York, pursuant to 31 U.S.C. § 3730(b)(2) and Fed. R. Civ. P. 4(d).

II.
JURISDICTION AND VENUE

11. This Court has subject matter jurisdiction pursuant to 28 U.S.C. § 1331, because this action is brought for violations of the FCA, 31 U.S.C. §§ 3729 *et seq.* (as amended).

12. The Court has personal jurisdiction over Defendants because Defendants are licensed to transact and do transact business in this District. Defendant Vector is also headquartered in this District and has carried out its fraudulent scheme in this District.

13. Venue is proper in this District pursuant to 31 U.S.C. § 3732(a) and 28 U.S.C. § 1391(b)(2), because Defendants can be found in, are licensed to do business in, and transact or have transacted business in this District, and events or omissions that give rise to these claims have occurred in this District.

14. This complaint is filed within the time period specified by 31 U.S.C. § 3731(b).

III.
NO PUBLIC DISCLOSURE; INDEPENDENT AND MATERIAL KNOWLEDGE OF VIOLATIONS OF THE FALSE CLAIMS ACT

15. Relator makes the allegations in this complaint based on her own knowledge, experience and observations.

16. Relator is the original source of the information she has given to the Government regarding Defendants' conduct and scheme to violate federal law.

17. There has been no public disclosure, relevant under 31 U.S.C. § 3730(e), of the "allegations or transactions" in this complaint; or, to the extent that any such public disclosure has

been made, Relator has knowledge that is independent of and materially adds to that public disclosure.

IV.
THE PARTIES

A. Plaintiff the United States

18. Relator brings this action on behalf of Plaintiff the United States of America. At all times relevant to this complaint, the United States, acting through the Centers for Medicare & Medicaid Services ("CMS"), which is a part of the federal Department of Health and Human Services ("HHS"), reimbursed Defendants for claims they submitted for RCM.

B. Plaintiff and Relator Mathurin

19. Relator Vanessa Mathurin is a citizen of the United States and, at all relevant times, has been a resident of Elmwood Park, New Jersey.

20. Relator was employed by Vector at the sham New York location from approximately November 19, 2019, to approximately October 20, 2020, and had access to Defendants' electronic and paper records. Relator also participated in monthly conference calls with Vector's staff, including their RCM technicians.

21. Thus, Relator has first-hand knowledge of the fraudulent scheme alleged herein.

C. Defendants

22. Defendant Vector Remote Care, LLC, is a New York limited liability company with a registered principal business address of 27-01 Queens Plaza N, Long Island City, NY 11101, which is in fact the address of a WeWork coworking space. Vector's mailing address is 543 NW York Drive, Suite 160, Bend, Oregon 97703.

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23. Defendant Trivek Health Solutions, Inc., is an Oregon corporation with a principal business address of 543 NW York Drive, Suite 160, Bend, Oregon 97703. At all times relevant to this complaint, Trivek has done business as Vector Remote Care, LLC.

24. Defendant Kevin Hoffman is a resident of Bend, Oregon, and the owner and CEO of both Vector Remote Care, LLC, and Trivek Health Solutions, Inc.

25. Due to the Defendants' interlocking corporate structures and common ownership and control, the conduct alleged in this complaint is attributable to each Defendant.

V.
STATUTORY & REGULATORY FRAMEWORK

A. The False Claims Act

26. The FCA, 31 U.S.C. §§ 3729 *et seq.*, establishes liability for any "person" (natural or corporate) who, *inter alia*:

a. "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval," 31 U.S.C. § 3729(a)(l)(A); or

b. "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim," *id.* § 3729(a)(l)(B).

27. "Knowing" is defined by the FCA to include "deliberate ignorance of the truth" or "reckless disregard of the truth." *Id.* § 3729(b)(1).

28. The FCA defines "claim" to include any request for money that:

> is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government—
>
> (I) provides or has provided any portion of the money or property requested or demanded; or
>
> (II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded....

Id. § 3729(b)(2)(A)(ii).

29. For each false claim or other FCA violation, the statute provides for the assessment of treble damages, plus a civil penalty. *Id.* § 3729(a)(1)(G).[1]

30. The FCA provides for payment of a percentage of the United States' recovery to a private individual who brings suit on behalf of the United States (the "Relator") under the FCA. *See id.* § 3730(d).

B. The Medicare Program

31. The Medicare program pays for certain healthcare services provided to certain segments of the population. Entitlement to Medicare is based on age, disability, or affliction with end-stage renal disease. *See* 42 U.S.C. §§ 1395 *et seq.*

32. HHS, through CMS, administers the Medicare program.

33. The Medicare program has four parts. As relevant here, Medicare Part A covers all inpatient hospital services, 42 U.S.C. §§ 1395c to 1395i-5, and Medicare Part B covers other medical services referred to by an eligible medical professional, 42 U.S.C. §§ 1395j to 1395w-5.

34. To receive payment under Medicare Part A or B, a provider must submit claims to the appropriate Medicare Administrative Contractor or "MAC"[2] using a CMS-1500 form. *See* Form CMS-1500.[3] The CMS-1500 form requires the provider to identify the services for which

[1] 31 U.S.C. § 3729(a)(1)(G) provides a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990, Pub. L. No. 104-410, 104 Stat. 890 (1990), *amended by* the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015, Pub. L. No. 114-74, 129 Stat. 599 (2015); *see* 28 U.S.C. § 2461 note. On June 19, 2020, the Department of Justice promulgated a Final Rule increasing the penalty for FCA violations occurring after November 2, 2015. For such penalties assessed after June 19, 2020, the minimum penalty is $11,665 and the maximum is $23,331. *See* 28 C.F.R. § 85.5; 85 F.R. 37005 (June 19, 2020).

[2] A MAC is a private insurer awarded a geographic jurisdiction to process medical claims for Medicare beneficiaries. The current A/B MAC for New York is National Government Services, Inc. ("NGS").

[3] *Available at* https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1500.pdf (last accessed Nov. 13, 2020).

reimbursement is sought through a five-digit Current Procedural Terminology ("CPT") or Healthcare Common Procedural Coding System ("HCPCS") code. The amount of Medicare reimbursement is based on the lesser of the actual charge and the fee for the appropriate CPT or HCPCS code on a standardized fee schedule established by the Secretary of HHS.

35. The CMS-1500 form also requires the provider to provide the ZIP code for the practice location of the services for which reimbursement is sought. The ZIP code identifies the Medicare payment locality in which the services were performed. *See* Form CMS-1500.

36. CMS has assigned Geographic Practice Cost Index values to each Medicare payment locality, which are used to adjust the allowable reimbursement amount to reflect the variation in practice costs from area to area.[4]

37. The ZIP code is also used to determine which MAC has geographic jurisdiction over the services rendered. *See* Medicare Claims Processing Manual, CMS Publication No. 100-04 (the "Claims Manual"), Ch. 1 § 10.1.1.

38. The CMS-1500 form also requires the provider to make the following certification:

> In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete … [and] 4) **this claim … complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment** …

Form CMS-1500 at 2 (emphasis added).

39. A provider may also submit the electronic equivalent of this claim form, which contains a substantially similar certification.

[4] *See* https://www.cms.gov/apps/physician-fee-schedule/overview.aspx (last accessed Nov. 13, 2020).

40. CMS guidance as to electronic claims submission is found in Chapter 24 of the Claims Manual. Among other things, the guidance specifies the minimum content of the enrollment form that a local MAC may use to sign up providers to submit claims electronically. Per the Claims Manual, such an enrollment form must contain, and the enrolling provider must acknowledge, at least the following statements:

> The provider agrees to the following provisions for submitting Medicare claims electronically to CMS or to CMS' A/B MACs ....
>
> * * *
>
> 7. That it will submit claims that are accurate, complete, and truthful;
>
> * * *
>
> 12. That it will acknowledge that all claims will be paid from Federal funds, that the submission of such claims is a claim for payment under the Medicare program, and that anyone who misrepresents or falsified or causes to be misrepresented or falsified any record or other information relating to that claim that is required pursuant to this agreement may, upon conviction, be subject to a fine and/or imprisonment under applicable Federal law; [and]
>
> * * *
>
> 14. That it will research and correct claim discrepancies[.]

Claims Manual, Ch. 24 § 30.2.

41. The submission of such a certification, if false, is a violation of the FCA. 31 U.S.C. § 3729(a).

42. Each such false certification is a separate violation of the FCA.

C. Independent Diagnostic Testing Facility (IDTF) Requirements

43. To be eligible for Medicare reimbursement, an IDTF must meet the requirements set forth in 42 C.F.R. § 410.33, including the following:

a. An IDTF must "maintain a physical facility" with, inter alia, adequate space to perform the services designated on the enrollment application, necessary diagnostic testing equipment, and "technical staff on duty with the appropriate credentials to perform tests." *Id.* § 410.33(g).

b. An IDTF must have a supervising physician that provides at least general supervision as to the diagnostic procedures performed by the IDTF. *Id.* § 410.33(b).

c. A "fixed-location" IDTF (an IDTF with one practice location) may not share the location with another Medicare-enrolled individual or organization. *Id.* § 410.33(g)(15).

44. CMS will revoke the billing privileges of any IDTF that fails to meet these standards. 42 C.F.R. § 410.33(h).

45. For Medicare billing purposes, diagnostic tests often have two component parts: the technical and professional components (the "TC" and "PC," respectively). For RCM, the TC consists of the preparation and processing of raw RCM data by a certified technician. The PC consists of the interpretation of the RCM data by a physician after the data has been processed.

46. When an IDTF performs the TC, but not the PC, of a diagnostic test, the Claims Manual requires the IDTF to "report the name, address and NPI of the *location where each component was performed*" when submitting claims for reimbursement to CMS. Claims Manual, Ch. 35 § 10.2.2 (emphasis added).

VI.
DEFENDANTS' FRAUD

47. Vector conjured a New York sham location in October 2019. Relator was hired soon thereafter as a patient support coordinator, and worked on-site until April 2020, when Relator began working from home.

48. Vector submitted a single Medicare enrollment application for the New York location to NGS, the A/B MAC for New York.

49. The application falsely designated the New York location as an IDTF that would perform the technical component (TC) of RCM. *See* **Exhibit A** (Medicare Enrollment Application) at 8, 42.

50. About a week before Thanksgiving 2019, a patient support coordinator from the Bend, Oregon office visited the New York location to train Relator. He mentioned that Vector is using the address in New York solely to increase Medicare reimbursements.

51. Relator came to realize that the New York location did not have the staffing or equipment needed for a legitimate IDTF.

52. Vector's New York location billed for over 20,000 patients, most of whom were Medicare beneficiaries. Virtually all of these patients and their treating physicians were located outside New York; most were on the west coast. *See* **Exhibit B** (Redacted Sample Patient List).

53. Defendants' technicians worked remotely outside of New York and performed all RCM-related work off-site. Relator rarely, if ever, saw technicians working at the New York location.

54. Vector employed two certified full-time RCM technicians, Shana Coker and Emma Chamberlain. However, Coker resided in Oregon and Chamberlain resided in Rhode Island; both worked remotely.

55. Vector also employed several per diem technicians who performed the bulk of the RCM data processing work. But, like Coker, these per diem technicians were based outside New York, in California, Georgia, Michigan, Oregon, Rhode Island, and Virginia.

56. Thus, the New York location was not a legitimate testing facility serving the local area. Rather, its sole purpose was to funnel Vector's existing patients through that location to take advantage of the higher Medicare reimbursement rates available in New York City.

57. As an example, the average reimbursement rate for the TC of RCM performed in Bend, Oregon was $24.76.[5] The same procedure, if performed in Queens, New York, would be $31.97. This represents an almost 30% increase in Medicare reimbursement. A similar payment disparity exists between New York City and many parts of California, Georgia, Michigan, Rhode Island, and Virginia.[6]

58. Despite the fact that all of Vector's technicians worked outside New York, the Medicare enrollment application submitted for the New York location identified a single practice location—i.e., the Long Island City address—and listed the staff and equipment available at that location. *See generally* **Exhibit A**. Furthermore, the application explicitly claimed that Medicare patients were seen at the New York location. *Id.* at 15.

59. Further, the cover letter submitted with the Medicare enrollment application described the New York location's operations as follows:

> Vector Remote Care (Vector) is an IDTF that monitors implanted cardiac devices which have been implanted in patients. The business has an administrative office location in Long Island City *out of which our technicians monitor these devices and communicate all findings with the interpreting physicians and staff.*

Exhibit C (Cover Letter) (emphasis added).

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[5] The CPT codes for the technical component of RCM are 93296 and G2066. The MPFS rate for CPT code G2066 is determined by the local MAC. For New York, NGS has set a reimbursement rate for G2066 equal to that of CPT 93296. *See* https://bit.ly/2HHRshb (last accessed Nov. 13, 2020).

[6] The MPFS payment amounts for these and other payment localities are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup (last accessed Nov. 13, 2020).

60. These patently false representations were designed to disguise the true nature of the New York location.

61. Upon information and belief, Vector submitted Medicare claims by falsely representing that RCM was performed at the New York location, and thereby received Medicare payments that it was not entitled to.

62. Indeed, because the New York location was enrolled only with NGS, which does not have geographic jurisdiction covering Oregon, California, or Georgia, Vector could not have received Medicare reimbursement for any services that were properly identified as performed by technicians in those states.[7]

63. If a MAC receives a claim for services performed outside its jurisdiction, it will return the claim as "unprocessable."[8]

64. Moreover, due to the lack of on-site technicians and a host of other regulatory violations, the New York location was not eligible to bill Medicare in the first place.

65. The location lacked the necessary equipment for processing RCM data. The location had a few implantable cardiac monitoring devices in stock, but they were not used because they needed to be connected to patients, and patients never came to the location for testing.

66. The supervising physician hired by Vector and listed on the Medicare enrollment application did not show up at the New York location and did not conduct any review of the equipment or staff at that location.

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[7] NGS has geographic jurisdiction over Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, Vermont, Illinois, Minnesota, and Wisconsin. *See* https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Downloads/AB-Jurisdiction-Map-Jun-2019.pdf (last accessed Nov. 13, 2020).

[8] Claims Manual, Ch. 1 § 10.1.9.1.

67. The location was not a dedicated facility, but a small room inside a WeWork rental workspace shared by dozens of other businesses including healthcare providers, many of whom were likely enrolled in Medicare.

68. In or around April 2020, Vector directed its on-site employees, including Relator, to work from home, meaning that *no one* was working at the New York location.

69. As of June 30, 2020, Vector canceled its WeWork room rental and switched to a "Hot Desk" membership at the same WeWork location, which equates to the rental of a single seat in the common area.[9] The New York location was thus reduced to a desk shared with many other businesses, posing as a full-fledged testing facility.

70. Vector continued to submit claims to Medicare from the New York location even after downgrading the WeWork rental.

71. The above conditions violated numerous eligibility requirements in 42 C.F.R. § 410.33 and thus rendered the New York location ineligible to bill Medicare for services it provided as an IDTF.

72. Through the above scheme, each claim Defendants submitted to Medicare for RCM performed at the New York location was a false claim "presented" within the meaning of the False Claims Act.

73. In submitting these false claims, Defendants made or used false records and statements material to those false and fraudulent claims, as further described below.

[9] *See* https://www.wework.com/workspace/hot-desk (last accessed Nov. 13, 2020).

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COUNT I:
FEDERAL FALSE CLAIMS ACT: PRESENTATION OF FALSE CLAIMS
31 U.S.C. § 3729(a)(l)(A)

74. Relator repeats and re-alleges the preceding paragraphs as if fully set forth herein.

75. As described above, Defendants knowingly presented, or caused to be presented, to an officer, employee, or contractor of the United States, false and fraudulent claims for services and treatments provided to Medicare beneficiaries. The claims were false and fraudulent because in making those claims, Defendants represented that the services were provided at the New York location when in fact the services were performed by technicians located outside New York.

76. The claims were also false and fraudulent because the New York location was not properly certified as an IDTF and thus ineligible to bill Medicare.

77. By virtue of the false and fraudulent claims that Defendants presented or caused to be presented, the United States suffered damages in an amount to be determined at trial, and is entitled to treble the amount of those damages under the FCA, plus civil penalties of not less than $11,665 and up to $23,331 for each violation.

COUNT II:
FEDERAL FALSE CLAIMS ACT: MAKING OR USING
FALSE RECORD OR STATEMENT TO CAUSE FALSE CLAIM TO BE PAID
31 U.S.C. § 3729(a)(l)(B)

78. Relator repeats and re-alleges the preceding paragraphs as if fully set forth herein.

79. As described supra, Defendants knowingly made, used, or caused to be made or used, false records or statements material to false or fraudulent claims for payment from the United States.

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80. By virtue of these false or fraudulent records and statements, the United States suffered damages in an amount to be determined at trial, and is entitled to treble the amount of those damages under the FCA, plus civil penalties of not less than $11,665 and up to $23,331 for each violation.

PRAYER FOR RELIEF

WHEREFORE, Relator respectfully requests that this Court enter judgment in her favor and the United States, granting the following:

(A) an order requiring Defendants to immediately cease and desist from the conduct described herein and all similar conduct;

(B) an award to the United States for treble its damages, a civil penalty for each violation of the FCA, and its costs pursuant to 31 U.S.C. § 3729(a)(3);

(C) an award to Relator in the maximum amount permitted under 31 U.S.C. § 3730(d), and for the reasonable attorney's fees and costs she incurred in prosecuting this action;

(D) awards to the United States and Relator for pre- and post-judgment interest at the rates permitted by law; and

(E) an award of such other and further relief as this Court may deem to be just and proper.

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DEMAND FOR TRIAL BY JURY

Pursuant to Rule 38(b) of the Federal Rules of Civil Procedure, Relator demands trial by jury on all questions of fact raised by the complaint.

Dated: November 18, 2020

Respectfully submitted,

BROWN, LLC

/s/ Chunsoo Park
Chunsoo "Terence" Park
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Patrick S. Almonrode
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Attorneys for Relator Vanessa Mathurin

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CERTIFICATE OF SERVICE

I hereby certify that, on November 18, 2020, I caused a true copy of the Complaint in the matter captioned *United States of America ex rel. Mathurin v. Vector Remote Care, LLC.* to be served upon the following, along with written disclosure of substantially all material evidence and information possessed by Relator:

by hand delivery and USPS Certified Mail, to

Civil Process Clerk
United States Attorney's Office
Eastern District of New York
271 Cadman Plaza East
Brooklyn, NY 11201

by USPS Certified Mail, Return Receipt Requested, to

Office of the Attorney General of the United States
United States Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20530-0001

Patrick S. Almonrode

JS 44 (Rev. 10/20)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS

UNITED STATES OF AMERICA ex rel. VANESSA MATHURIN

(b) County of Residence of First Listed Plaintiff _____
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*
Brown, LLC, 111 Town Square Place, Suite 400
Jersey City, NJ 07310 877-561-0000

DEFENDANTS

VECTOR REMOTE CARE, LLC, TRIVEK HEALTH SOLUTIONS, INC., and KEVIN HOFFMAN

County of Residence of First Listed Defendant Queens County, NY
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

FILED
IN CLERK'S OFFICE
U.S. DISTRICT COURT E.D.N.Y.
★ NOV 18 2020 ★
BROOKLYN OFFICE

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- [x] 1 U.S. Government Plaintiff
- [ ] 3 Federal Question *(U.S. Government Not a Party)*
- [ ] 2 U.S. Government Defendant
- [ ] 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*
(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	[ ] 1	[ ] 1	Incorporated *or* Principal Place of Business In This State	[ ] 4	[ ] 4
Citizen of Another State	[ ] 2	[ ] 2	Incorporated *and* Principal Place of Business In Another State	[ ] 5	[ ] 5
Citizen or Subject of a Foreign Country	[ ] 3	[ ] 3	Foreign Nation	[ ] 6	[ ] 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

Click here for: Nature of Suit Code Descriptions.

CONTRACT
- [ ] 110 Insurance
- [ ] 120 Marine
- [ ] 130 Miller Act
- [ ] 140 Negotiable Instrument
- [ ] 150 Recovery of Overpayment & Enforcement of Judgment
- [ ] 151 Medicare Act
- [ ] 152 Recovery of Defaulted Student Loans (Excludes Veterans)
- [ ] 153 Recovery of Overpayment of Veteran's Benefits
- [ ] 160 Stockholders' Suits
- [ ] 190 Other Contract
- [ ] 195 Contract Product Liability
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PERSONAL INJURY
- [ ] 310 Airplane
- [ ] 315 Airplane Product Liability
- [ ] 320 Assault, Libel & Slander
- [ ] 330 Federal Employers' Liability
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- [ ] 360 Other Personal Injury
- [ ] 362 Personal Injury - Medical Malpractice

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- [ ] 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- [ ] 368 Asbestos Personal Injury Product Liability

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- [ ] 385 Property Damage Product Liability

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- [ ] 690 Other

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- [ ] 720 Labor/Management Relations
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- [ ] 751 Family and Medical Leave Act
- [ ] 790 Other Labor Litigation
- [ ] 791 Employee Retirement Income Security Act

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- [ ] 423 Withdrawal 28 USC 157

PROPERTY RIGHTS
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- [ ] 835 Patent - Abbreviated New Drug Application
- [ ] 840 Trademark
- [ ] 880 Defend Trade Secrets Act of 2016

SOCIAL SECURITY
- [ ] 861 HIA (1395ff)
- [ ] 862 Black Lung (923)
- [ ] 863 DIWC/DIWW (405(g))
- [ ] 864 SSID Title XVI
- [ ] 865 RSI (405(g))

FEDERAL TAX SUITS
- [ ] 870 Taxes (U.S. Plaintiff or Defendant)
- [ ] 871 IRS—Third Party 26 USC 7609

OTHER STATUTES
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- [x] 376 Qui Tam (31 USC 3729(a))
- [ ] 400 State Reapportionment
- [ ] 410 Antitrust
- [ ] 430 Banks and Banking
- [ ] 450 Commerce
- [ ] 460 Deportation
- [ ] 470 Racketeer Influenced and Corrupt Organizations
- [ ] 480 Consumer Credit (15 USC 1681 or 1692)
- [ ] 485 Telephone Consumer Protection Act
- [ ] 490 Cable/Sat TV
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- [ ] 890 Other Statutory Actions
- [ ] 891 Agricultural Acts
- [ ] 893 Environmental Matters
- [ ] 895 Freedom of Information Act
- [ ] 896 Arbitration
- [ ] 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- [ ] 950 Constitutionality of State Statutes

REAL PROPERTY
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- [ ] 230 Rent Lease & Ejectment
- [ ] 240 Torts to Land
- [ ] 245 Tort Product Liability
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CIVIL RIGHTS
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PRISONER PETITIONS

Habeas Corpus:
- [ ] 463 Alien Detainee
- [ ] 510 Motions to Vacate Sentence
- [ ] 530 General
- [ ] 535 Death Penalty

Other:
- [ ] 540 Mandamus & Other
- [ ] 550 Civil Rights
- [ ] 555 Prison Condition
- [ ] 560 Civil Detainee - Conditions of Confinement

V. ORIGIN *(Place an "X" in One Box Only)*

- [x] 1 Original Proceeding
- [ ] 2 Removed from State Court
- [ ] 3 Remanded from Appellate Court
- [ ] 4 Reinstated or Reopened
- [ ] 5 Transferred from Another District *(specify)*
- [ ] 6 Multidistrict Litigation - Transfer
- [ ] 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing *(Do not cite jurisdictional statutes unless diversity)*:
31 U.S.C. § 3729, False Claims Act

Brief description of cause:
fraud upon the Medicare program

VII. REQUESTED IN COMPLAINT:

[ ] CHECK IF THIS IS A CLASS ACTION UNDER RULE 23, F.R.Cv.P.

DEMAND $

CHECK YES only if demanded in complaint:
JURY DEMAND: [x] Yes [ ] No

VIII. RELATED CASE(S) IF ANY *(See instructions)*:

JUDGE _____ DOCKET NUMBER _____

DATE
11/18/20

SIGNATURE OF ATTORNEY OF RECORD

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

465315 3463

CV-20-5714 MKB/Kno

CERTIFICATION OF ARBITRATION ELIGIBILITY

Local Arbitration Rule 83.7 provides that with certain exceptions, actions seeking money damages only in an amount not in excess of $150,000, exclusive of interest and costs, are eligible for compulsory arbitration. The amount of damages is presumed to be below the threshold amount unless a certification to the contrary is filed.

Case is Eligible for Arbitration ☐

I, Patrick S. Almonrode, counsel for Relator Vanessa Mathurin, do hereby certify that the above captioned civil action is ineligible for compulsory arbitration for the following reason(s):

☑ monetary damages sought are in excess of $150,000, exclusive of interest and costs,

☐ the complaint seeks injunctive relief,

☐ the matter is otherwise ineligible for the following reason

DISCLOSURE STATEMENT - FEDERAL RULES CIVIL PROCEDURE 7.1

Identify any parent corporation and any publicly held corporation that owns 10% or more or its stocks:

none

RELATED CASE STATEMENT (Section VIII on the Front of this Form)

Please list all cases that are arguably related pursuant to Division of Business Rule 50.3.1 in Section VIII on the front of this form. Rule 50.3.1 (a) provides that "A civil case is "related" to another civil case for purposes of this guideline when, because of the similarity of facts and legal issues or because the cases arise from the same transactions or events, a substantial saving of judicial resources is likely to result from assigning both cases to the same judge and magistrate judge." Rule 50.3.1 (b) provides that " A civil case shall not be deemed "related" to another civil case merely because the civil case: (A) involves identical legal issues, or (B) involves the same parties." Rule 50.3.1 (c) further provides that "Presumptively, and subject to the power of a judge to determine otherwise pursuant to paragraph (d), civil cases shall not be deemed to be "related" unless both cases are still pending before the court."

NY-E DIVISION OF BUSINESS RULE 50.1(d)(2)

1.) Is the civil action being filed in the Eastern District removed from a New York State Court located in Nassau or Suffolk County? ☐ Yes ☑ No

2.) If you answered "no" above:
a) Did the events or omissions giving rise to the claim or claims, or a substantial part thereof, occur in Nassau or Suffolk County? ☐ Yes ☑ No

b) Did the events or omissions giving rise to the claim or claims, or a substantial part thereof, occur in the Eastern District? ☑ Yes ☐ No

c) If this is a Fair Debt Collection Practice Act case, specify the County in which the offending communication was received:

If your answer to question 2 (b) is "No," does the defendant (or a majority of the defendants, if there is more than one) reside in Nassau or Suffolk County, or, in an interpleader action, does the claimant (or a majority of the claimants, if there is more than one) reside in Nassau or Suffolk County? ☐ Yes ☐ No

(Note: A corporation shall be considered a resident of the County in which it has the most significant contacts).

BAR ADMISSION

I am currently admitted in the Eastern District of New York and currently a member in good standing of the bar of this court.

☑ Yes ☐ No

Are you currently the subject of any disciplinary action (s) in this or any other state or federal court?

☐ Yes (If yes, please explain ☑ No

I certify the accuracy of all information provided above.

Signature: _____

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

WHO SHOULD SUBMIT THIS APPLICATION

Clinics and group practices can apply for enrollment in the Medicare program or make a change to their enrollment information using either:

- The Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or
- The paper enrollment application process (e.g., CMS-855w).

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 2009, 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 diagnostic tests to other entities that bill Medicare Part B.
- **Currently enrolled with a Medicare fee-for-service contractor** and 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). CAUTION: Changes of ownership or control require prior approval (see 42 C.F.R. § 424.550).

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 enrolled supplier, you must obtain an NPI prior to enrolling in Medicare or before updating any changes to your existing Medicare enrollment information. Apply for an NPI by completing the NPPES application. As a member of the organization/group that is enrolling in Medicare, you must report your NPI and the NPIs of all of your practice locations, including all locations where services are furnished to your patients. If you have questions, you may contact the NPPES help desk. Once you have received your NPI, report it on your Medicare enrollment application. You need to report your NPI even if you do not bill Medicare directly.

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 or view the "Medicare Expeditious Subpart 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 3 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 any written information reported on the application. It is your responsibility to provide this documentation in a timely manner.

Certain information you provide on the application is considered to be personal privacy. See Section 552(b)(6) and 552(b)(7), respectively, for more information, see the last page of the application. Section 552(b)(6)

MAIL YOUR APPLICATION

The Medicare fee-for-service contractor does not process [illegible] that services your State is responsible for processing. For the correct address for your fee-for-service contractor, go to www.cms.gov/[illegible]

Section 552

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 the appropriate 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 if 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 an application for the new ownership.

Change of Information
A change of information should be reported if you are changing address or practice location, or if your current tax identification number.

Changes to your existing enrollment data must be reported to the [illegible] within 90 days of the change, with the exception of changes in practice location, which must be reported within 30 days. Physicians and Non-Physician Practitioners must report changes to their information [illegible] 42 C.F.R. § 424.516.
If you are already enrolled in Medicare and are not a [illegible] you must report any change to your enrollment information [illegible] 42 C.F.R. § 424.516. Failure to report changes in a timely manner may result in [illegible] payments will then be made [illegible].

Revalidation
CMS may require you to submit complete enrollment information [illegible] to revalidate your enrollment. CMS will notify you when it is time for you to revalidate your enrollment. [illegible] application and you have been contacted by [illegible]

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 supplier or 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. DMEPOS 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. DMEPOS 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 (if issued) National Provider Identifier (if issued)	Complete all applicable sections. Ambulance suppliers must complete Attachment 1. DMEPOS 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) for Services (if issued) National Provider Identifier (if issued)	Sections 1, 2[illegible]

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: Optional Provider Practice (if known):	Go to Section 1B
☐ You are establishing your Medicare enrollment	Enter your Medicare Identification Number (if known) and the NPI you would like to link to this number in Section 4.	Complete all applicable sections Ambulance suppliers must complete Attachment 1 DMEPOS 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 4 for the signer if that authorized or delegated official has not been established for this supplier
☐ Final Adverse Action/Conviction	1, 2(B), 3, 13, and either 15 (if you are an authorized official) or 16 (if you are a delegated official), and 4 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, 2(B), 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 4 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, 2(B), 3, 4, 13, and either 15 (if you are an authorized official) or 16 (if you are a delegated official), and 4 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, 2(B), 3, 4, 13, and either 15 (if you are an authorized official) or 16 (if you are a delegated official), and 4 for the signer if that authorized or delegated official has not been established for this supplier
☐ Billing Agency Information	1, 2(B), 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 4 for the signer if that authorized or delegated official has not been established for this supplier
☐ Authorized Official	1, 2(B), 3, 13, 15, and 4 for the signer if that authorized or delegated official has not been established for this supplier
☐ Delegated Official(s) (Optional)	1, 2(B), 3, 13, 15, and 4 for the signer if that authorized or delegated official has not been established for this supplier

Continued next

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 Service 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(A)
☐ 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(B)
☐ Persons (Technician) 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(C)
☐ 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(D)
☐ 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(E)

Instructions

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 (Flower Billing 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

Vector Pharma Care LLC

Tax Identification Number

[redacted]

Other Name

Type of Other Name
- ☐ 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 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)

Incorporation State (enter state/country of registration)

DELAWARE

State in which you were authorized to do business

NY

Is this supplier an Indian health facility that is operated by the Indian Health Service (IHS), a Tribe or Tribal organization, or an Urban Indian Organization (I/T/U)?

☐ Yes ☒ No

Comments

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
Effective Date (mm/dd/yyyy)	Expiration/Renewal Date (mm/dd/yyyy)

Certification Information

☒ Certification Not Applicable

Certification Number	Place 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 Medicare contractor to process claims and other correspondence. This address cannot be a billing agency's address.

Mailing Address Line 1 (Street Name and Number)

27-01 Queens Plaza N

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

15th Floor

City/Town	State	ZIP Code + 4
Long Island City	NY	11101
Telephone Number / Fax Number (if applicable)	Email Address (if applicable)	
(347) 328-6258 / (347) 393-1618	[redacted]	

C. Hospitals Only

This section should only be completed by hospitals that are currently enrolled or enrolling in a Medicare service contractor (the Part A Medicare contractor, that will be the Fiscal Intermediary (FI) for Medicare Part B services, as follows:

- Hospitals that need department billing numbers to bill the Part B contractor for services.
- Hospitals requiring a Part B billing number to bill for professional services.
- Hospitals requiring a Medicare Part B billing number to order or refer Medicare Part B items or services.
- If the hospital requires both the Supplemental Security Income (SSI) ratios and a provider specific number.

If your organization is not a hospital, but believes that it should be considered for a provider specific number, designated facility-to-facility transfers, or exemption from the Inpatient Prospective Payment System (IPPS), please contact your Medicare contractor.

Section 1814

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 locations, the method by which you render health care services, etc.

Vector Flow® Cam is an IDE* that receives cardiac devices which have been implanted in patients. The system has an administrative office location set at which its technologist monitor these devices and communicate with the physicians and staff who have implanted them. Vector Flow® Cam does not provide professional services - the company provides only technical services as appropriate to accurately monitor the implanted devices.

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 in 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 location for PT/OT services.

F. Accreditation for Ambulatory Surgical Centers (ASCs) Only

NOTE: Copy and complete this section if more than one accrediting body applies to the ASC.

Check one of the following and furnish any additional information requested:

☐ The existing ASC supplier is accredited.

☐ The existing ASC supplier is not accredited but has received from its accrediting organization

Name of Accrediting Organization

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

Period(s) Surveyed

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 suppliers that bill Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) for ADI services. All suppliers furnishing ADI services MUST be accredited in each ADI modality selected below to qualify to bill Medicare for these services.

Check each ADI modality that applies and furnish to 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):

Name of CT:

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, Medicare or State health care programs, or any debarment from participation as an approved Federal contractor, grantee, 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 every 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

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., home 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 are enrolling 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)			

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)

Master Rehabs Care LLC

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

[redacted]

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

[redacted]

City/Town	State	ZIP Code + 4
Long Island City	NY	[redacted]

Telephone Number	Fax Number (If applicable)	Email Address (If applicable)
(347) 338-8205	(347) 857-1173	support@masterrehabcare.com

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

10/05/2020

Medicare Identification Number (If known)	National Provider Identifier
Pending	[redacted]
Medicare Identification Number (If known)	National Provider Identifier
Medicare Identification Number (If known)	National Provider Identifier
Medicare Identification Number (If known)	National Provider Identifier
Medicare Identification Number (If known)	National Provider Identifier

Is this practice location a:

☐ Group practice office/clinic
☐ Hospital
☐ Retirement/assisted living community
☐ Federally Qualified Health Center (FQHC)
☒ Other (e.g., Home Health Care Facility)
Specify: Rehabilitation Facility

CLIA Number for this location (If applicable)

Attach a copy of the most current CLIA certification for each of these locations if you are a supplier of clinical laboratory services.

ASC/Radiology Billing Facility Certification Number for this location (If known)

Attach a copy of the most current ASC certification for each of these locations if you are a supplier of radiology services.

Facility name

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)			

Medicare will issue payments via electronic funds transfer (EFT). Since payment 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)

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

City/Town	State	ZIP Code + 4

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 address in Section 4A or 4B, 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 EDTFs and mobile facilities/portable units, the patients' medical records must be made by 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 location reported in Section 4A or 4B.

Chain Affiliation

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 5 (cont.)

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

CMS-855B (07/11)

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)	Email Address (If available)

F. Vehicle Information

If the mobile health care services are rendered inside a vehicle, such as a mobile clinic or laboratory, 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 to a nursing facility and used in a bedside 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 [illegible]

Continued on [illegible]

SECTION 4: PRACTICE LOCATION INFORMATION (Continued)

C. 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 these 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, 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 in, any partnership interest in, and/or managing control of, the supplier identified in Section 3, 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 (excluding any collateral organizations, i.e. banks 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 states 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 appointee 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 must submit a copy of its 501(c)(3) document certifying 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 (excluding 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)			

Check all that apply:
☐ 5 Percent or More Ownership Interest ☐ Partner ☐ Managing Control

Legal Business Name as Reported to the Internal Revenue Service

"Doing Business As" Name (if applicable)

Address Line 1 (Street Name and Number)

Address Line 2 (Suite, Room, etc.)

City/Town | State | ZIP Code + 4

Telephone Number | Tax Number (if applicable) | Year Business Was Established

Type of Owner | Tax Identification Number (if applicable) | Ownership Percentage (Must be 25% or more for applicable "Individual" owner type)

When is the effective date that Owner/Officer Interest changed? (Must be on or after the date of Section 3111 of the applicable Ordinance)

NOTE: Persons with Ownership Interest

Continued next

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: _____

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

Continued on page 15

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 generally 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., department director, director of operations). Moreover, where a supplier has a governing body that does not use the terms "board of directors," the members of that governing body will not 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 not the "directors" for Medicare enrollment purposes.

Managing Employee owns 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 responsible for Medicare payments received (per the instructions for Correspondence), that organization's [illegible] is only required to report its managing employees in Section 6. Owners, officers, directors, and others do not need to be reported, except those who are listed as authorized or delegated officials on this application.

Any information on [illegible] must be [illegible]. If there is more than one [illegible] each individual. Owners, Authorized Officials, and/or Managing Employees listed in 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)			

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
Kevin	C	Hollinger		President

Date of Birth (mm/dd/yyyy)	Place of Birth: State	Country of Birth
[redacted]		

Social Security Number (Required)	Employer Identification Number (if issued) (EIN or ITIN)
[redacted]	

What is the above individual's relationship with the supplier in Section 2A? Check all that apply.

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

What is the effective date this owner acquired ownership of the provider identified in Section 1B1 of this application? (mm/dd/yyyy) 08/24/2018

What is the effective date this individual acquired managing control of the provider identified in Section 1B1 of this application? (mm/dd/yyyy) 08/24/2018

NOTE: Furnish both dates if applicable.

Continued ▷

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: _____

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 7

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 11.

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)			

Legal Business Name as Reported to the Social Security Administration or the Internal Revenue Service	If Preferred, Billing Agent Doing Business As (DBA) Name (if applicable)
Bellevue Medical, LLC	

"Doing Business As" Name (if applicable)	Tax Identification Number (Social Security Number preferred)
	[redacted]

Billing Agency Street Address Line 1 (Street Name and Number)
530 Industry Drive
Billing Agency Street Address Line 2 (Suite, Room, etc.)
Suite #200

City/Town	State	ZIP Code + 4
Seattle	WA	98188

Telephone Number	Fax Number (If applicable)	E-mail Address (If applicable)
425-615-6488		

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.
Tommy		Miller	

Telephone Number	Fax Number (if applicable)	E-mail Address (if applicable)
(856) 787-9427		tommy.miller@processingcorp.com

Address Line 1 (Street Name and Number)

2701 Queens Plaza North

Address Line 2 (Suite, Room, etc.)

15th Floor

City/Town	State	ZIP Code + 4
Long Island City	NY	11101

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION

This section explains the penalties for deliberately falsifying information in the 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 or twice the gross loss to the person specifically authorized by the criminal statute.

2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against any person 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 on any person who:

   a) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States 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;

   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 [illegible] plus three times the amount of damages sustained by the Government.

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 15.

First Name	Middle Initial	Last Name	Jr., Sr., etc.
Tiffany		Lange	

Telephone Number	Fax Number (if applicable)	E-mail Address (if applicable)
(516) 612-3017	(516) 353-1771	angelconsulting@verizon.net

Address Line 1 (Street Name and Number)

37-22 Queens Plaza North

Address Line 2 (Ste., Room, etc.)

13th Floor

City/Town	State	ZIP Code + 4
Long Island City	NY	11101

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION

This section explains the penalties for deliberately falsifying information in this application to get 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 on any person who:

   a) knowingly presents, or causes to be presented, to an officer or 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 $5,500 to $11,000 per violation, plus three times the amount of damages sustained by the Government.

Please go to

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 execute a scheme or artifice to defraud any health care benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by or under the control of any, health care benefit program in connection with the delivery of or payment for health care benefits, items, or services. Individuals must 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 convicted shall be fined or imprisoned for any term of years or for life, or both.

7. The government may seek civil remedies for cases such as "unjust enrichment," "money paid by mistake," and "equal entitlement."

   Remedies include compensatory and punitive damages, restitution, and recovery of the amount the payor 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 employee 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 on 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 on the form, after the supplier is enrolled in Medicare, in accordance with the timeframes established in 42 C.F.R. 424.516, (a)(3). Changes of information must be reported in accordance with 42 C.F.R. 424.516.

The supplier can have as many authorized officials as it wants. If there is more than one authorized official, 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 punishable by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare billing privileges, and/or the imposition of fines, civil damages, and/or imprisonment.
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 excluded, suspended, debarred, or otherwise ineligible to participate in the Medicare program, the 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 met by this supplier in order to assist the Medicare program in processing my enrollment application, and grant access to survey reports, including any accreditation survey, together with all evidence related to the survey that may be requested, 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)			

Authorized Official's Information and Signature

First Name	Middle Initial	Last Name	Suffix (e.g., Jr., III)
Kevin	C	Hoffman	

Telephone Number	Title/Position
(847) 338-6383	President

Authorized Official Signature (First, Middle, Last Name, Jr., Sr., MD, DDS, etc.)	Date Signed (mm/dd/yyyy)
	10/8/2019

(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., III)

Telephone Number	Title/Position

Authorized Official Signature (First, Middle, Last Name, Jr., Sr., MD, DDS, etc.)	Date Signed (mm/dd/yyyy)

All signatures must be original and signed in blue ink. Photocopied, typed, or stamped signatures will not be processed. Computer, fax, or mail generated applications will not be accepted.

(Blue ink preferred)

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 denied 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 15 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. 1° 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 Non-Employee | Telephone Number

Authorized Official's Signature Assigning the Delegated (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.) | Date Signed (mm/dd/yyyy)

Reserved for Future Use

CMS-855 (Rev. 1)

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 the 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 Supervising Physician's proficiency and/or State license or certificate 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 appropriately 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 for a supplier of services is being sent to a bank (or similar financial institution) with whom the supplier has a lockbox or other similar type of lease), then the supplier must provide a statement in writing from the bank which states that the lease agreement(s) that the bank has signed includes no right of offset for Medicare overpayments.
- ☐ Copy(s) of all final adverse action documentation (e.g., notice letter, revocation letter, reinstatement letter).
- ☐ Completed Form CMS-855B, Reassignment of Medicare Benefits.
- ☒ Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement.
- ☐ Copy of an attestation for government-owned and/or operated entity.
- ☐ Copy of FAA 135 certificate (for ambulance suppliers).
- ☒ Copy(s) of completed Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) accreditation organization documentation.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1056. The time required to complete this information collection is estimated to average 45 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Do not mail applications to this address. (Applications sent to this address will not be processed.)

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)			

NOTE: If the ambulance company has vehicles garaged within a different Medicare contractor's jurisdiction, a separate CMS-855S 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 cities/towns.

CITY/TOWN	STATE	ZIP CODE

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 cities/towns.

CITY/TOWN	STATE	ZIP CODE

Optional Text:

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)			

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 the ambulance service supplier will be rendering services and billing Medicare. Attach a copy of the current State license.

License Number	Issuing State (If applicable)	Issuing City/Town (If applicable)

Effective Date (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)

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 service. (There is a written agreement exists between the enrolling ambulance company and the intercept ambulance company, the enrolling ambulance company must attach a copy of the agreement to your enrollment application. See 42 CFR 410.41).

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

☐ Change
Effective Date: _____

Does the ambulance company currently participate as a paramedic intercept provider?

☐ YES ☐ NO

Remarks:

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 dispatched 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)			

Type (wheelchair, aircraft, boat, etc.)	Call for Service Phone Number

Make (e.g., Ford)	Model (e.g., E350)	Year (yyyy)

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	Water ambulance	☐ YES	☐ NO

(Continued)

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 test reading, adequate patient privacy accommodations, and the storage of test histories records and current medical records within the office setting of the IDTF, or IDTF home office, not within the vehicle/mobile unit.

   (ii) IDTF suppliers that provide services remotely and do not see beneficiaries at their practice location are exempt from providing test reading and adequate patient privacy accommodations.

4. Have all applicable diagnostic testing equipment available at the physical site enclosing 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 Medicare contractor upon request, and notify the contractor of any changes in equipment within 30 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, i.e., within the home office of the mobile IDTF units. The telephone number or toll free numbers must be listed in a local phone directory and through directory assistance.

6. Have a comprehensive liability insurance policy of at least $[illegible] per occurrence that covers the place of business and all employees of the IDTF. The insurance policy must be carried by a non-relative owned company. Failure to maintain required insurance shall result in revocation of the IDTF's billing privileges effective on the date the insurance lapsed. IDTF suppliers are responsible for providing the contractor with documentation that demonstrates the existence of the insurance policy upon request.

   (i) Ensure that the insurance policy must contain [illegible] per occurrence and at least $300,000 per incident, and

   (ii) Notify the CMS designated contractor in writing of any [illegible] cancellation.

7. Agree not to directly solicit patients, which include, but is not limited to, [illegible] employees, or in person contact. The IDTF must accept only those patients referred for testing by an attending physician who is treating a beneficiary's specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Supplier may order tests [illegible]

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 certificates 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 contractor, to conduct announced, 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 supplier or organization.

   (ii) Leasing or subleasing its operations or its practice location to another Medicare-enrolled individual or organization.

   (iii) Sharing diagnostic testing equipment owned or the lease of which is paid for by another Medicare-enrolled individual or organization.

16. Enrolls in Medicare for any diagnostic testing service that it furnishes as a [illegible] regardless of whether the service is furnished in a mobile or fixed-base location.

17. Bills for all mobile diagnostic services that are furnished as a Medicare-enrolled supplier. A mobile diagnostic service is part of a service provided [illegible] section 1861(s)(3) of the Act.

[illegible]

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 considered 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 the IDTF will bill Medicare, including the following:

- Provide the CPT-4 or HCPCS codes for which the 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 exam/exams (including the order 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 usually carried out in nature, which must be performed in a hospital or ambulatory surgical center, should not be reported.

Consistent with IDTF supplier standard from page 40 of this application, all IDTFs enrolling in Medicare must have a comprehensive liability insurance policy of at least $300,000 per occurrence, that covers both the place of business and all employees of the IDTF. The policy must be carried by a non-related owned company. Failure to maintain the required insurance at all times will result in revocation of the Medicare supplier billing number, retroactive to the last day 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 the application.

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (Continued)

A. Standards Qualifications

Provide the date the 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 (If applicable)
1.	93224	Interpretive System	5400C
2.	93229	Interpretive System	5400C
3.	93701	Interpretive System	5400C
4.	0021T-C	Interpretive System	5400
5.	0021T-C	Interpretive System	5400
6.		Interpretive System	5400
7.		Interpretive System	5400
8.		Interpretive System	EK1-50
9.		Interpretive System	EK1-55
10.		Interpretive System	Cardio Workstation 1-5
11.		Interpretive System	Cardio Workstation 2Plus
12.		Interpretive System	Cardio Workstation 1-5 or 2Plus
13.			
14.			
15.			

CMS-855I (11)

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 separately for 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 assigning benefits, the interpreting physician must complete the Reassignment of Benefits Form (CMS 855B). 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 interpreting 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, provide 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., III)

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, provide 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., III)

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)

National Practitioner 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.)
Shana	T	Cole	

Social Security Number (Required)	Date of Birth (mm/dd/yyyy) (Required)
[redacted]	[redacted]

Is this technician State licensed or State certified? (See instructions for certification.) ☐ YES ☐ NO

License/Certification Number (If applicable)	Current certification expiration date (mm/dd/yyyy) (If applicable)

Is this technician certified by a national credentialing organization? ☐ YES ☐ NO

Name of credentialing organization (If applicable)	Level (If applicable)
Cardiovascular Credentialing International (CCI)	CRT

Is this technician employed by a hospital? ☐ YES ☐ NO
If YES, provide the name of the hospital here:

Other Info

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.

CHECK ONE	☐ CHANGE	☒ ADD	☐ DELETE
DATE (mm/dd/yyyy)		12/23/2019	

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

Social Security Number (Required)	Date of Birth (mm/dd/yyyy) (Required)
[redacted]	

Physician Identification Number (If issued)	PTAN
	1700253877

Telephone Number	Fax Number (If applicable)	Email Address (If applicable)
(757)434-0654		mileebeer1@gmail.com

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. 410.33(b)(5)(ii) (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. Each supervising physician must complete and sign the supervisory physician section of this application. Each physician must 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 ensuring 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 IDTFs? ☐ YES ☒ NO

If yes, list all other IDTFs for which this physician provides supervision. Use a continuation sheet if necessary.

	NAME OF FACILITY	ADDRESS	TELEPHONE NUMBER (Including Area Code)	EFFECTIVE DATE OF SUPERVISION
a.				
b.				
c.				
d.				
e.				

Continued ...

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (Continued)

B. 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 terminate 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 (Non-physician (i.e., CNS, NP, PA) and Date (mm/dd/yyyy)

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

Page 5 of 10

Department of Health and Human Services
Centers for Medicare & Medicaid Services

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)(2), 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, 1395g(e), and 1395u(r)] and section 31001(i) 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 assigning or verifying medical doctor (MD) and the National Plan and Provider Enumeration System (NPPES) unable to disclose directly the matching physician 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, or to enforce Federal provisions of medical services or to detect fraud or abuse;
10. State Licensing Boards for review of unethical practices and non-professional conduct;
11. States for the purpose of administration of health care programs; and
12. Insurance companies, self-insurers, health maintenance organizations, health care corporations, and other health care groups providing health care claims processing, when it is determined that such disclosure is necessary and the information is relevant to process requests for 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

It is CMS' policy to safeguard confidential commercial or financial information that is privileged or trade secrets. 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 on the application (or attachments) is considered confidential commercial and/or sensitive personal information (for example, social security numbers unrelated to business, personal financial information, or medical records), please indicate which information is considered confidential and why it is considered confidential. Such information will be protected to the extent consistent with applicable law. In addition, CMS will notify you of any requests for this information, in accordance with the requirements of the Freedom of Information Act (FOIA) and Privacy Act, 5 U.S.C. §§ 552 and 552a, respectively.

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER

Contact Name:

Phone: (866) 904-8633 Fax:

E-Mail Address: customer.service@ironshore.com

INSURED

Victor Recruit Care, LLC

2701 Queens Plz N FL 8

Long Island City, NY 11101

United States

INSURER(S) AFFORDING COVERAGE | NAIC #

INSURER A : Ironshore Specialty Insurance Company

INSURER B :

INSURER C :

INSURER D :

INSURER E :

COVERAGES | CERTIFICATE NUMBER: | REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	X COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE $ 1,000,000
	CLAIMS-MADE X OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence) $ 100,000
							MED EXP (Any one person) $ 5,000
							PERSONAL & ADV INJURY $ 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE $ 2,000,000
	X POLICY PRO- JECT LOC						PRODUCTS - COMP/OP AGG $ 2,000,000
	OTHER:						$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident) $
	ANY AUTO						BODILY INJURY (Per person) $
	ALL OWNED AUTOS						BODILY INJURY (Per accident) $
	SCHEDULED AUTOS						PROPERTY DAMAGE (Per accident) $
	HIRED AUTOS						$
	NON-OWNED AUTOS						$
	UMBRELLA LIAB						EACH OCCURRENCE $
	EXCESS LIAB						AGGREGATE $
	DED RETENTION $						$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY						PER STATUTE OTH-ER
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	N/A					E.L. EACH ACCIDENT $
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE $
							E.L. DISEASE - POLICY LIMIT $

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

Proof of Coverage

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

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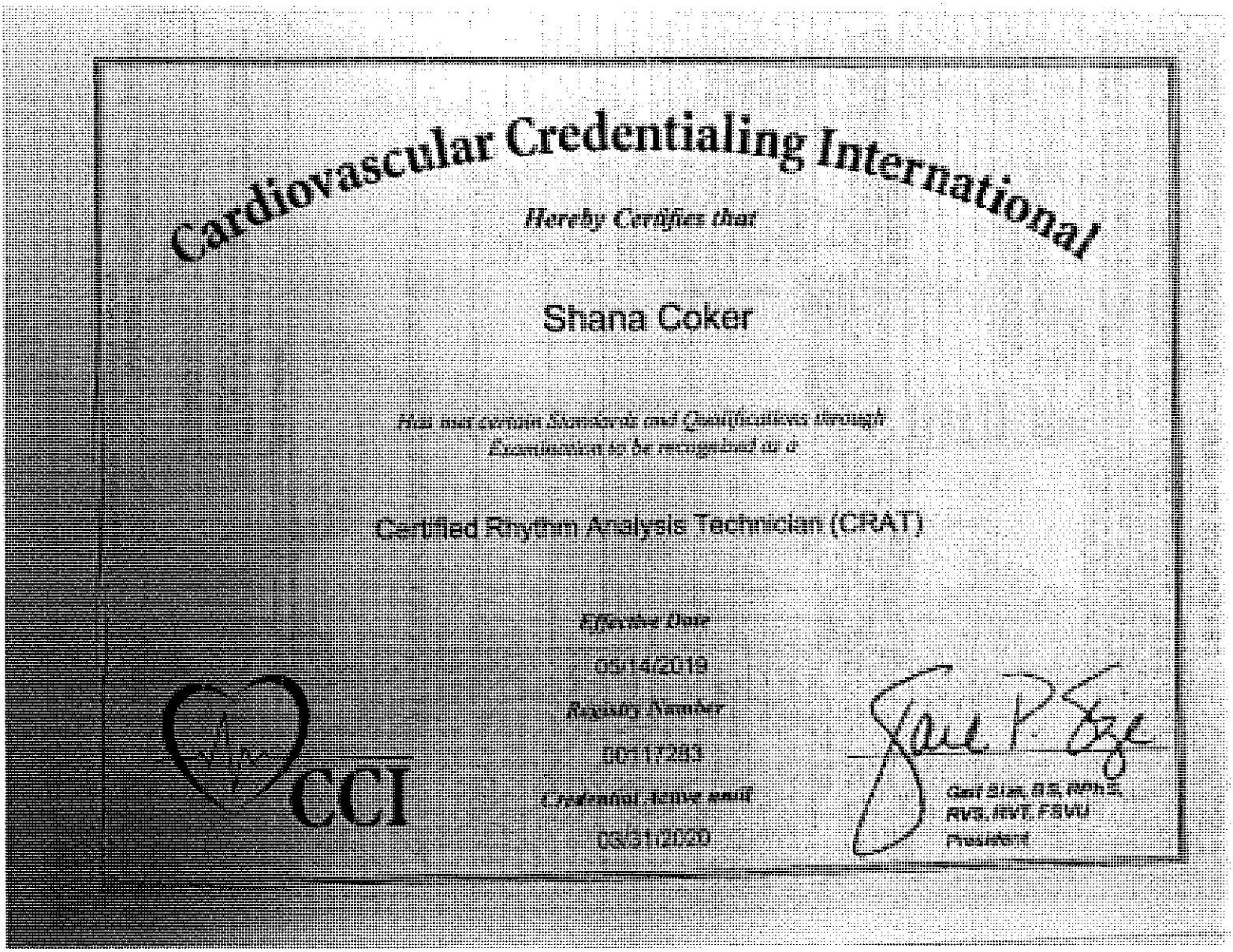


Cardiovascular Credentialing International

Hereby Certifies that

Shana Coker

Has met certain Standards and Qualifications through Examination to be recognized as a

Certified Rhythm Analysis Technician (CRAT)

Effective Date

05/14/2019

Registry Number

CCI 17283

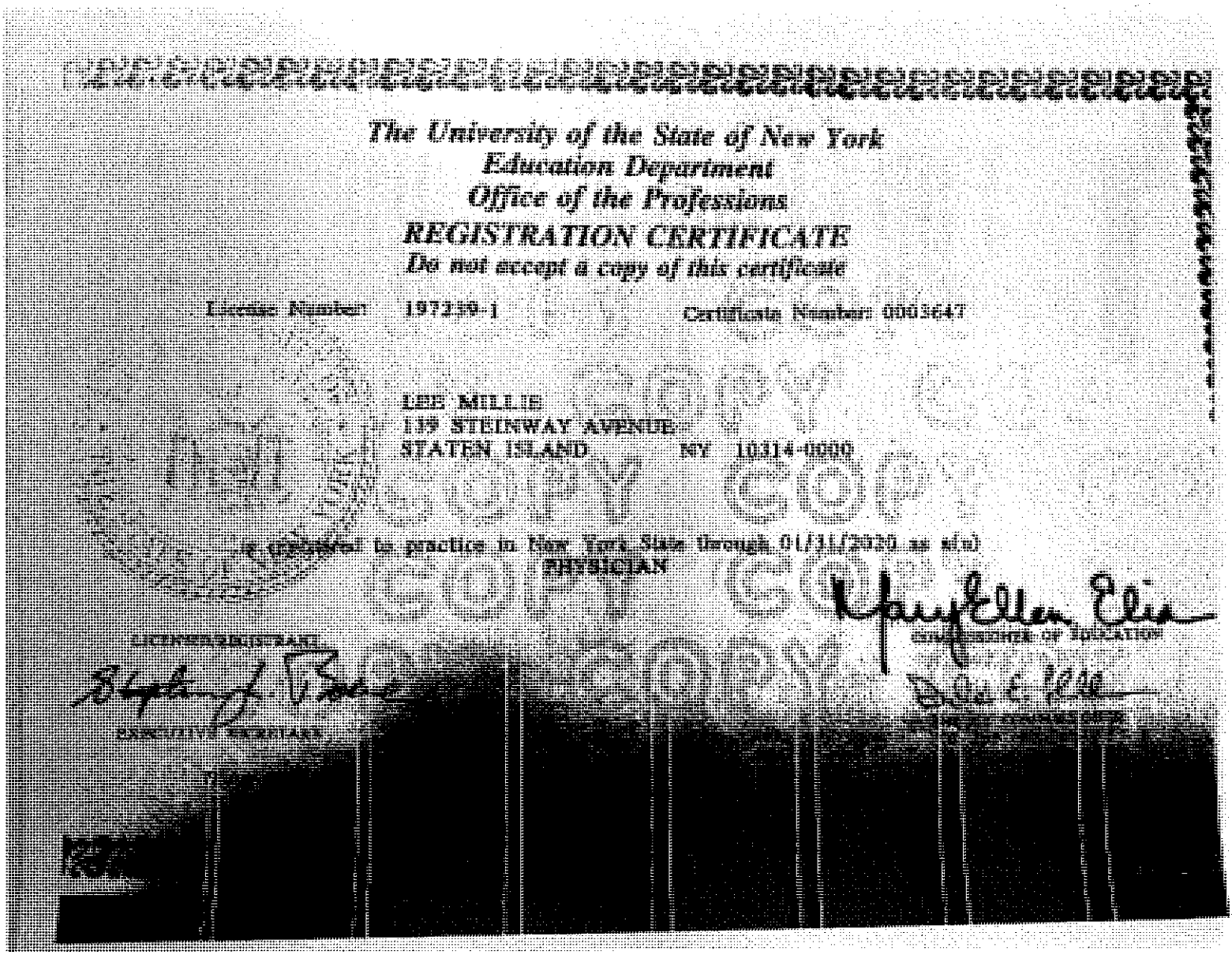
Credential Expires

05/31/2020

CCI

Gail Sias, B.S., MPH, RVS, RVT, FSVU

President



The University of the State of New York
Education Department
Office of the Professions

REGISTRATION CERTIFICATE

Do not accept a copy of this certificate

License Number: 197259-1 Certificate Number: 0003647

LEE MILLIE
139 STEINWAY AVENUE
STATEN ISLAND NY 10314-0000

is registered to practice in New York State through 01/31/2020 as a(n)
PHYSICIAN

LICENSE/REGISTRANT

EXECUTIVE SECRETARY

COMMISSIONER OF EDUCATION

DATE ISSUED

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved OMB
No. 0938-1003
Expires: 10/31/2021

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

PART I: REASON FOR SUBMISSION

Reason for Submission:

☒ New EFT Enrollment
- ○ Individual
- ○ Group

☐ Change to Current EFT Enrollment
(e.g. account or bank changes)

☐ Cancel EFT Enrollment

☐ Check here if EFT payment is being made to the Home Office of the Chain Organization (attach letter authorizing EFT payment to Chain Home Office)

Since your last EFT authorization agreement submission, have you had a:

☐ Change of Ownership, and/or

☐ Change of Practice Location?

If you checked either a change of ownership or change of practice location above, you must submit a change of information using the Medicare enrollment application for the Medicare contractor that services your geographical area(s) prior to or accompanying this EFT authorization agreement submission.

PART II: ACCOUNT HOLDER INFORMATION

Name of Supplier/Individual Payment Receives EFT, If Not Legal Business Name

Vyaire Remote Care LLC

Chain Organization Name or Home Office Legal Business Name, if different from Chain Organization Name

[redacted]

Address Number, Street, and/or Suite

[redacted]

City

Long Island City

State

NY

ZIP Code (Nine Digits, No Dashes)

[redacted]

Telephone Number (Include Area Code)

[redacted]

Medicare Identification Number (If Issued)

[redacted]

National Provider Identifier (NPI)

1 1 9 4 6 7 8 2 8 3

National Provider Identifier (NPI)

[redacted]

Personal Provider Identifier (PPI)

[redacted]

PART III: FINANCIAL INSTITUTION INFORMATION

[redacted]

Please include a voided check or savings account deposit slip with this agreement. If you do not have a check or savings account deposit slip, please contact your financial institution for assistance in completing this section. Do not submit a starter check or deposit slip. Some financial institutions will not accept the routing number for certain types of accounts, such as money market accounts. Please verify with your financial institution that the routing number you provided can be used for electronic funds transfer (EFT) transactions.

PLEASE NOTE: If accompanied with an invalid check or deposit slip, this agreement will be rejected. Any electronic funds transfer authorization may be terminated if terms are not met. Allow 60 days for the Medicare program to process this agreement.

Name Discrepancy

PART IV: CONTACT PERSON

This is the person we will contact for any questions regarding this EFT.

Contact Person's Name	Contact Person's Title
Kevin Hellman	President
Contact Person's Telephone Number	Contact Person's E-mail Address
(347) 881-5110	kevin@medamerica.com

PART V: AUTHORIZATION

I hereby authorize the Centers for Medicare & Medicaid Services (CMS) to initiate credit entries, and in accordance with 31 CFR part 210.05 to initiate adjustments for any duplicate or erroneous entries made in error to the account indicated above. I hereby authorize the financial institution/bank named above to credit and/or debit the same to such account. CMS may assign its rights and obligations under this agreement to CMS' designated fee-for-service contractor. CMS may change its designated contractor at CMS' discretion.

If payment is being made to an account controlled by a Chain Home Office, the Provider of Services hereby acknowledges that payment to the Chain Office under these instructions is not considered payment to the Provider, and the Provider authorizes the forwarding of Medicare payments to the Chain Home Office.

If the account is known in the Physician's or Individual Practitioner's Name, or the Legal Business Name of the Provider/Supplier or IPP entity, the said Provider/Supplier or IPP entity certifies that he/she has sole control of the account referenced above, and certifies that all arrangements between the Financial Institution and the said Provider/Supplier or IPP entity are in accordance with all applicable Medicare regulations and instructions.

This authorization agreement is effective as of the signature date below and is to remain in full force and effect until CMS has received written notification from me of its termination in such time and such manner as to afford CMS and the Financial Institution a reasonable opportunity to act on it. CMS will continue to send the direct deposit to the Financial Institution designated above until notified by me that I wish to change the Financial Institution receiving the direct deposit. If my Financial Institution information changes, I agree to submit to CMS an updated EFT Authorization Agreement.

SIGNATURE LINE

Authorized Official Name (Type)	Authorized Official Telephone Number
Kevin Hellman	(347) 881-5110
Authorized Official Title	Authorized Official E-mail Address
President	kevin@medamerica.com
Authorized Official Signature (Note: Must be original signature, black or blue ink)	Date
	10/9/2020

PRIVACY ACT ADVISORY STATEMENT

Sections 1842, 1862(a) and 1874 of the Act of the Social Security Act authorize the collection of this information. The purpose of collecting this information is to authorize electronic funds transfer.

Per 42 CFR 424.516(e)(1), providers and suppliers are required to receive electronic funds transfer (EFT) at the time of enrollment, revalidation, change of Medicare contractor, or addition of a new practice/practice location, and (2) submit the CMS-588 form to receive Medicare payment via electronic funds transfer.

The information collected will be entered into system No. 09-70-0501, titled "Enterprise Medicare Claims Records" and No. 09-70-0502, titled "Intermediary Medicare Claims Records" published in the Federal Register Volume 71, Number 203, Tuesday, [illegible] Comp. Vol. 1, pages 415 and 424, or as updated and republished. The routine uses for this system can be found in this notice.

You should be aware that P.L. 104-191, the Computer Matching and Privacy Protection Act of 1988, permits the government, under certain circumstances, to verify the information you provide by computer or other means.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is [illegible]. The time required to complete this information collection is estimated to average [illegible] minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, [illegible] Baltimore, Maryland [illegible].

DO NOT SEND YOUR COMPLETED FORM TO THIS ADDRESS.

SEND THE COMPLETED FORM TO THE APPROPRIATE CONTRACTOR AS INSTRUCTED.

INSTRUCTIONS FOR COMPLETING THE EFT AUTHORIZATION AGREEMENT

All EFT requests are subject to a 45-day pre-participation period in which all accounts are verified by the qualifying financial institution before any Medicare direct deposits are made.

PART I: REASON FOR SUBMISSION

Indicate your reason for completing this form by checking the appropriate box. New EFT enrollment, change to your EFT enrollment account information, or cancellation of your EFT enrollment. If you are submitting EFT payments to the home office of a chain organization of which you are a member, you must provide a letter authorizing the organization to receive payments for the provider of services in the account maintained by the home office of the chain organization. The letter must be signed by an authorized official of the provider of services and an authorized official of the chain home office.

PART II: ACCOUNT HOLDER INFORMATION

Line 1: Enter the provider's/supplier's/medical payment processor's EFT payee legal business name as the name of the physician or individual practitioner, as reported to the Internal Revenue Service (IRS). The account to which EFT payments are sent must bear the name of the physician or individual practitioner, or the legal business name of the person or entity enrolled with Medicare.
NOTE: Providers enrolled in IPP billers must report the legal business name provided on the IRS CP-575 form.

Line 2: Enter the chain organization's name or the lower-tier legal business name if different from the chain organization name.
NOTE: Providers participating in IPP billers must report the legal business name provided on the IRS CP-575 form.

Line 3: Enter the account holder's street address.

Line 4: Enter the account holder's city, state, and zip code.

Line 5: Enter the tax identification number as reported to the IRS. If the business is a group, organization or corporation, provide the Federal employer identification number. If enrolling as an individual provide your Social Security Number. If issued, enter the Medicare identification number assigned by a Medicare fee-for-service contractor. If you are not enrolled in Medicare, leave this field blank.

Line 6: IPP billers, enter the NPI or OSCI assigned by CMS.

Line 7: Enter the 14 digit EFT number(s). The EFT is required to process this form.
NOTE: Institutional providers enter only ONE EFT.

PART III: FINANCIAL INSTITUTION INFORMATION

Line 8: Enter your Financial Institution's name (i.e., is the name of the bank or qualifying depository that will receive the direct deposit payments). The account name to which EFT payments will be paid is the name indicated on Part II of this form.

Line 9: Enter the financial institution's street address.

Line 10: Enter the financial institution's city, state or province, and postal code.

Line 11: Enter the bank or financial institutional telephone number and contact person's name.

Line 12: Enter the bank or financial institutional nine-digit routing number, including applicable leading zeros.

Line 13: Enter the provider's/supplier's EFT entity's account number with the financial institution, including applicable leading zeros. Select the account type.

NOTE: Supporting bank documents must be in the provider's/supplier's EFT identified by's legal business name as it appears on the submitted bank documents. If you do not submit this information, your EFT authorization agreement will be returned without further processing.

PART IV: CONTACT PERSON

Line 14: Enter the name and title of a contact person who can provide additional information regarding the information provided on this CMS-588 form.

Line 15: Enter the contact person's telephone number, enter the contact person's e-mail address.

PART V: AUTHORIZATION

Line 16: By your signature on this form you are certifying that the account(s) you are providing for use of the Provider, or Individual Practitioner, or the Legal Business Name of the person or entity listed in Part II of this form into which EFT payments are made in accordance with all applicable Medicare requirements. In the event of a dispute between the Financial Institution and Medicare payment is wrongly sent to your account, you authorize the Medicare contractor to recover the payment by reversing a debit to your account. You agree to maintain proper notification of changes to the account to the Medicare contractor in accordance with the procedures established by Medicare. You also agree to indemnify the United States for any payment made to your account that Medicare is not authorized by law to pay.

The EFT authorization form must be signed and dated by the same individual whose name appears in Part II of this form or the CMS-855 Medicare enrollment application (i.e., the provider, supplier, physician, or other practitioner) or by the authorized representative or delegated official of such entity.

Mail this form with the original signature to (check or fill in the box for your type of contractor—see appendix for contractor that services your geographic area; if it is not listed, contact your contractor's provider enrollment area to inquire where your claims are processed. To locate the appropriate contractor, see the CMS website at www.cms.gov/MedicareProviderSupEnroll):

Form CMS-588 (08-05)

MEDICARE PARTICIPATING PHYSICIAN OR SUPPLIER AGREEMENT

Vector Forensic Care LLC

2901 Queens Plaza S., 5th Floor

Long Island City, NY 11101

1124975253

*List all names and the PTAN under which the participant files claims with the Medicare Administrative Contractor (MAC) program with whom this agreement is being filed.

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

1. **Meaning of Assignment:** For purposes of this agreement, accepting assignment of the Medicare Part B payment means accepting direct Part B payment from the Medicare program. Under an assignment, the approved charge, determined by the MAC's payment rules, will 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 while not participating in the Medicare program, the agreement becomes effective 10/26/2018.

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 calendar year (January 1 through December 31) thereafter, unless one of the following occurs:

   a. During the month before a calendar year ends, the participant notifies the MAC in writing of termination of the agreement, in the form of the participant's choice, to be effective at the end of the calendar year. The participant may also notify the MAC of termination of the agreement in the event of the participant's retirement, permanent departure from the area served by the MAC, or illness or other incapacity that will prevent the participant from furnishing services for a period of at least 30 days. The participant's notification must be received by the MAC at least 30 days before the end of the calendar year or the date of departure, retirement, or incapacity, or the agreement will be renewed automatically for the next calendar year.

   b. The Centers for Medicare & Medicaid Services (CMS) or its agent terminates the agreement because it is no longer in the best interests of the Medicare program or the participant's billing practices are inconsistent with the assignment provisions of the agreement. The termination will be effective 15 days after the date of the notice of termination, unless a hearing is requested. If a hearing is requested, the termination will not be effective until a hearing decision is rendered supporting the termination. If no hearing is requested, but the participant submits additional information during the 15-day period before the termination is effective, CMS or its agent may delay the termination for an additional 15 days.

Signature of participant (or authorized representative of participant's organization)

Date

Title (if signed on behalf of participant)

Printed name

Signature of witness (if mark)

Date

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0373. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-855 (06/12)

[illegible]

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.

DO YOU WANT TO OPT OUT OF MEDICARE?

Certain physicians and practitioners who do not want to engage with the Medicare program when treating Medicare beneficiaries may choose to "opt out" of Medicare. With Medicare does not pay for covered items or services provided by an "opt-out" physician or practitioner, beneficiaries and opt-out physicians or practitioners have the flexibility to set mutually acceptable payment terms through a private contract. Medicare will still pay opt-out physicians or practitioners for emergency or urgent care services rendered to beneficiaries with whom they have not privately contracted. The opt-out decision applies to all items and services provided by the physician or practitioner to any Medicare beneficiary for the entire opt-out period. A physician or practitioner who chooses to opt-out must do so for a two-year period, which automatically renews for successive two-year periods unless the physician or practitioner affirmatively requests that his or her opt-out status not be renewed. Opt-out physicians and practitioners also need not consider certain Medicare requirements, such as [illegible] on a case-by-case basis whether to provide an advance beneficiary notice of [illegible] coverage to beneficiaries consistent with Medicare rules and guidance. More information can be found by visiting opt-out.cms.hhs.gov. WARNING: YOU CANNOT OPT OUT IF YOU ARE "ON OUT" NOW.

WHEN THE DECISION TO PARTICIPATE CAN BE MADE:

- Toward the end of each calendar year, all Medicare providers have an open enrollment period. The open enrollment period generally is from mid-November through December 31. During this time, providers who are currently enrolled in the Medigap program can change their participation status beginning the next calendar year. Because [illegible] the opportunity to change their participation status. [illegible] to learn where to send the agreement, and [illegible] agreement will be accepted.

- New physicians, practitioners, and suppliers can get 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 practitioner mails (postmark date) the agreement to the carrier or delivers it to the carrier.

Contact your MAC/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 MAC/carrier.
- If you have already enrolled in the Medicare program, you have 30 days from when you are enrolled to decide if you want to participate. If you decide to participate within the 30-day timeframe, complete the CMS-460 and send to your MAC/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 an CMS-460 form to your MAC/carrier.

We hope you will decide to be a Medicare participant.

Please call the MAC/carrier in your jurisdiction if you have any questions or need further assistance on participation.

DO NOT SEND YOUR CMS-460 FORM TO CMS, SEND TO YOUR MAC 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 access your Medicare claims, visit the Medicare Administrative Contractor (MAC) that processes your claims. To find your MAC, visit the CMS website at http://www.cms.hhs.gov.

Form CMS-460 instructions (back)

Department of the Treasury
Internal Revenue Service
Cincinnati, OH 45999-0023

Date of this notice: 03-03-2017

[redacted]

Dear [redacted]

Thank you for applying for an Employer Identification Number (EIN). We assigned you EIN [redacted]. This EIN will identify you, your business accounts, tax returns, and documents, even if you have no employees. Please keep this notice in your permanent records.

When filing tax documents, payments, and related correspondence, it is very important that you use your EIN and complete name and address exactly as shown above. Any variation may cause a delay in processing, result in improper notices and penalty charges, or may cause you to be assigned more than one EIN. If the information you entered is shown above, please make the correction using the attached tear off stub and return it to us.

A limited liability company (LLC) may file Form 8832, Entity Classification Election, and elect to be classified as an association taxable as a corporation. If the LLC is eligible to be treated as a corporation that meets certain tests and it will be timely filing Form 8832, it can request relief to be effective as a corporation. To request relief, you must file Form 8832 and write at the top of the form "Filed pursuant to Rev. Proc. 2009-41." Also, the LLC will be treated as a corporation as of the effective date of the corporation election and should not need to file Form 8832.

To obtain tax forms and publications, including those referenced in this notice, visit our Web site at www.irs.gov. If you do not have access to the Internet, call 1-800-829-3676 (TTY/TDD 1-800-829-4059) or visit your local IRS office.

Important Reminders:

- Keep a copy of this notice in your permanent records. This notice is all you will ever receive showing the EIN, and the IRS will not be able to reissue a duplicate copy for you. You may give a copy of this document to anyone asking for proof of your EIN.
- Use the full EIN and your name exactly as they appear on the CP 575 A on all your federal tax forms.
- Refer to this EIN on your tax-related correspondence and documents.

If you have questions about your EIN, you can [redacted]

Thank you for your cooperation.

[redacted]

Name of business:
[redacted]

Type: SS-4

Number to call us: CP 575 G

For assistance you may call us at:
1-800-829-4933

IF YOU WRITE, ATTACH THE STUB AT THE END OF THIS LETTER.

We assigned you an employer identification number

Please keep this notice in your permanent records.

Your EIN is:
[redacted]

Form **W-9**

(Rev. October 2018)

Department of the Treasury

Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ Go to www.irs.gov/FormW9 for instructions and the latest information.

Give Form to the requester. Do not send to the IRS.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

Sterling Pharmacy Care, LLC

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes.

☑ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from FATCA reporting code (if any)

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

91-01 Queens Plaza N Floor 11

6 City, state, and ZIP code

Long Island City, NY 11101

7 List account number(s) here (optional)

Requester's name and address (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Social security number

[redacted]

or

Employer identification number

[redacted]

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA coding entered on this form (if any) indicating that I am exempt from the FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here | Signature of U.S. person ▶ Date ▶ 11/16/2020

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

If the entity/person on line 1 is a(n)...	Check only one box for ...
• Corporation	Corporation
• Individual • Sole proprietorship, or • Single-member limited liability company (LLC) owned by an individual and disregarded for U.S. federal tax purposes.	Individual/sole proprietor or single-member LLC
• LLC classified as a partnership for U.S. federal tax purposes, • LLC that has filed Form 8832 or 2553 to be classified as a corporation, or • LLC that is disregarded as an entity separate from its owner but the owner is another LLC that is not disregarded for U.S. federal tax purposes.	Limited liability company and enter the appropriate tax classification. (P=Partnership; C=C corporation; or S=S corporation)
• Partnership • Trust/estate	Partnership Trust/estate

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space on line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the U.S., the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

Cat. No. 10231X

Form W-9 (Rev. 12-2014)

General penalty for failing to provide information. Willful failure to furnish or certify taxpayer identification or certification may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; do not leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account (other than an account maintained by a foreign financial institution (FFI)), list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9. If you are providing Form W-9 to an FFI to document a joint account, each holder of the account that is a U.S. person must provide a Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note. ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, or corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income will be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box on line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box on line 3.

For this type of account:	Give name and EIN of:
1. Individual	The individual
2. Two or more individuals (joint account) other than an account maintained by an FFI	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Two or more U.S. persons (joint account maintained by an FFI)	Each owner of the account
4. Custodial account of a minor (Uniform Gift to Minors Act)	The minor[2]
5. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee[1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner[1]
6. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
7. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor[4]

For this type of account:	Give name and EIN of:
8. Disregarded entity not owned by an individual	The owner
9. A valid trust, estate, or pension trust	Legal entity[5]
10. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
11. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
12. Partnership or multi-member LLC	The partnership
13. A broker or registered nominee	The broker or nominee

For this type of account:	Give name and EIN of:
14. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
15. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships*, earlier.

[5] Custodial account of a minor (Uniform Gift to Minors Act).

Note: The grantor also must provide a Form W-9 to trustee of trust.

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

What Name and Number To Give the Requester

Secure Your Tax Records From Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft. The IRS does not initiate contact with taxpayers by email to request personal or financial information. This includes any type of electronic communication, such as text messages and social media channels.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to phishing@irs.gov. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at spam@uce.gov or report them at www.ftc.gov/complaint. You can contact the IRS at www.irs.gov/identitytheft or 1-877-IDTHEFT (1-877-438-4338). If you have been the victim of identity theft, see www.identitytheft.gov and Pub. 5027.

Visit www.irs.gov/identitytheft to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

EXHIBIT B

Patients: Heartscape

	Status	Status Change	SELECT HERE (REMOVAL)	SELECT HERE (FACESHEET)	Brand	Patient Last, First	DOB
1	Connected	08/05/19			BIO	[redacted]	
2	Connected	08/05/19			ABT		
3	Connected	05/11/20			MDT		
4	Connected	12/18/19			BIO		
5	Connected	08/05/19			BIO		
6	Connected	02/03/20			MDT		
7	Connected	08/05/19			BIO		
8	Connected	11/27/19			BIO		
9	Connected	08/05/19			BIO		
10	Connected	01/15/20			BIO		
11	Connected	08/07/19			BIO		
12	Connected	06/03/20			BIO		
13	Connected	04/16/20			MDT		
14	Connected	08/05/19			BIO		
15	Connected	04/01/20			BIO		
16	Connected	09/25/20		VECTOR Updated	BIO		
17	Connected	01/15/20			BIO		
18	Connected	08/05/19			BIO		
19	Connected	08/05/19			BIO		
20	Connected	06/03/20			BIO		
21	Connected	08/05/19			BIO		
22	Connected	10/05/20			ABT		
23	Removed	07/29/20			BIO		
24	Connected	02/04/20			BIO		
25	Removal Ready	04/28/20			MDT		

Phone Number	Street Address	City	State	Zip	Prescribing MD
[redacted]	[redacted]	Seal Beach	Ca	90740	Rex Winters, MD
		Huntington Beach	Ca	92649	Rex Winters, MD
		Cypress	CA	90630	Rex Winters, MD
		Long Beach	Ca	90810-4071	Rex Winters, MD
		Cerritos	Ca	90703	Rex Winters, MD
		Marina Del Rey	CA	90292	Rex Winters, MD
		Seal Beach	Ca	90740	Rex Winters, MD
		Long Beach	Ca	90815	Rex Winters, MD
		Long Beach	Ca	90815	Rex Winters, MD
		Long Beach	Ca	90814	Rex Winters, MD
		Long Beach	Ca	90814	Rex Winters, MD
		Long Beach California	CA	90808	Rex Winters, MD
		Long Beach	CA	90803	Rex Winters, MD
		Wilmington	Ca	90744	Rex Winters, MD
		Huntington Beach	Ca	92649	Rex Winters, MD
		Stanton	CA	90680	Rex Winters, MD
		Garden Grove,	CA	92845-2628	Rex Winters, MD
		Anaheim	Ca	92804	Rex Winters, MD
		Long Beach	Ca	90815-1317	Rex Winters, MD
		Long Beach	Ca	90807	Rex Winters, MD
		Seal Beach	Ca	90740	Rex Winters, MD
		Carson	CA	90746	Rex Winters, MD
		Avalon	Ca	90704	Rex Winters, MD
		Long Beach	Ca	90804	Rex Winters, MD
		Seal Beach	CA	90740	Rex Winters, MD

Primary Policy Holder Name	Primary Policy Carrier	Primary Policy Number	Secondary Policy Carrier	Secondary Policy Number
	Medicare		AARP	
	Monarch Healthcare			
	Medicare			
	monarch			
	Blue Cross PPO			
	Medicare			
	Medicare		AARP	
	Memorial healthcare			
	Blue Cross		Great West PPO	
	Medicare		Blue Cross	
	Medicare		Blue Cross	
	Monarch Healthcare Medical		Scan Classic HMO	
	BC			
	Medicare		Medi-Cal	
	Medicare		Blue Cross	
	Medicare			
	AETNA			
	Medicare		Blue Cross	
	Medicare		United Healthcare AARP	
	Monarch Healthcare			
	Medicare		Tricare for Life	
	Medicare		United Healthcare AARP	
	City Of Long Beach		medicare secondary	
	Medicare		Blue Cross	

Billing Exceptions	No HF Reporting	Created	Modified	Patient ID	Account
	☐	07/30/18 6:45 PM	04/01/20 12:12 PM	[redacted]	
	☐	09/07/18 2:46 PM	04/01/20 12:12 PM		
	☐	08/22/19 10:23 AM	05/11/20 1:16 PM		
	☐	01/31/19 6:12 PM	03/26/20 1:23 AM		
	☐	07/30/18 6:46 PM	03/26/20 1:23 AM		
	☐	08/01/19 11:11 AM	03/26/20 1:23 AM		
	☐	06/06/19 12:30 PM	03/26/20 1:23 AM		
	☐	07/30/18 6:50 PM	03/26/20 1:23 AM		
	☐	07/30/18 6:51 PM	03/26/20 1:23 AM		
	☐	08/02/19 5:49 PM	03/26/20 1:23 AM		
	☐	07/30/18 6:54 PM	03/26/20 1:23 AM		
	☐	03/25/20 2:55 PM	06/03/20 12:22 PM		
	☐	06/27/19 5:43 PM	04/16/20 12:22 PM		
	☐	07/30/18 6:56 PM	03/26/20 1:23 AM		
	☐	04/01/20 12:22 PM	04/01/20 12:22 PM		
	☐	08/18/20 3:18 AM	10/02/20 10:18 AM		
	☐	08/15/19 11:08 AM	03/26/20 1:23 AM		
	☐	10/17/18 4:21 PM	03/26/20 1:23 AM		
	☐	05/07/19 7:33 PM	03/26/20 1:23 AM		
	☐	07/30/18 6:58 PM	06/03/20 12:22 PM		
	☐	07/30/18 7:01 PM	03/26/20 1:23 AM		
	☐	01/09/19 7:47 PM	10/05/20 12:36 PM		
	☐	07/30/18 7:02 PM	07/29/20 7:41 PM		
	☐	07/30/18 7:15 PM	03/26/20 1:23 AM		
	☐	10/26/18 3:44 PM	08/31/20 10:08 AM		

Primary	Secondary

	Status	Status Change	SELECT HERE (REMOVAL)	SELECT HERE (FACESHEET)	Brand	Patient Last, First	DOB
26	Connected	09/19/19			BIO	[redacted]	
27	Removed	03/31/20			BIO		
28	Connected	08/05/19			BIO		
29	Connected	08/05/19			BIO		
30	Connected	08/05/19			BIO		
31	Connected	08/05/19			BIO		
32	Connected	08/05/19			BIO		
33	Connected	08/05/19			BIO		
34	Connected	10/02/20		VECTOR Updated	BSX		
35	Removed	09/11/19			BIO		
36	Connected	09/11/19			BIO		
37	Connected	05/09/20			BIO		
38	Connected	12/16/19			BIO		
39	Connected	08/05/19			BIO		
40	Connected	04/21/20		VECTOR Updated	BIO		
41	Connected	08/13/20			BIO		
42	Connected	08/05/19			BIO		
43	Connected	08/05/19			BIO		
44	Removal Ready	12/10/19			MDT		
45	Connected	06/03/20			BIO		
46	Removed	09/25/20		VECTOR Updated	BIO		
47	Connected	01/15/20			BSX		
48	Removal Ready	12/10/19			ABT		
49	Connected	08/05/19			BIO		
50	Connected	05/21/20			BIO		
51	Connected	09/25/20		VECTOR Updated	BIO		
52	Removal Ready	02/27/20			MDT		

Phone Number	Street Address	City	State	Zip	Prescribing MD
[redacted]	[redacted]	Cypress	Ca	90630	Rex Winters, MD
		Los Alamitos	Ca	90720	Rex Winters, MD
		Lakewood	Ca	90715	Rex Winters, MD
		Buena Park	Ca	90621	Rex Winters, MD
		Long Beach	Ca	90815	Rex Winters, MD
		Anaheim	Ca	92804	Rex Winters, MD
		Huntington Beach	Ca	92647	Rex Winters, MD
		Buena Park	Ca	90620	Rex Winters, MD
		Garden Grove	CA	92845	Rex Winters, MD
		Long Beach	Ca	90805	Rex Winters, MD
		Cerritos	Ca	90703	Rex Winters, MD
		DOWNEY	CA	90241 -3208	Rex Winters, MD
		Long Beach	Ca	90815	Rex Winters, MD
		Long Beach	Ca	90808	Rex Winters, MD
		SEAL BEACH	CA	90740	Rex Winters, MD
		Lakewood	CA	90713	Rex Winters, MD
		Buena Park	CA	90620	Rex Winters, MD
		Hesperia	Ca	92344	Rex Winters, MD
		Costa Mesa	Ca	92626	Rex Winters, MD
		Long Beach	CA	90808	Rex Winters, MD
		Artesia	CA	90701	Rex Winters, MD
		Lakewood	CA	90712	Rex Winters, MD
		Long Beach	Ca	90805	Rex Winters, MD
		Long Beach	Ca	90807	Rex Winters, MD
		Garden Grove	Ca	92845-2317	Rex Winters, MD
		Long Beach	CA	90815	Rex Winters, MD
		Corona	Ca	92882	Rex Winters, MD

Primary Policy Holder Name	Primary Policy Carrier	Primary Policy Number	Secondary Policy Carrier	Secondary Policy Number
	Monarch Healthcare			
	Medicare		Blue Cross	
	Monarch Healthcare			
	Zurich North America		Blue Shield of Ca	
	Medicare		Blue Cross	
	Monarch Healthcare			
	Blue Cross		medicare secondary	
	Medicare		Blue Cross	
	Medicare			
	Medicare		Blue Shield	
	Monarch Healthcare Medical			
	Monarch Healthcare			
	Monarch Healthcare			
SELF	Medicare	[redacted]		
	Medicare		Blue Cross	
	Blue Shield			
	Medicare			
	Medicare			
	Medicare			
	Needs Insurance			
	Medicare		Health Net	
	Monarch Healthcare			
	Monarch Healthcare			
	Medicare		AARP	
	Monarch Healthcare			

Billing Exceptions	No HF Reporting	Created	Modified	Patient ID	Account
	☐	07/30/18 7:16 PM	03/26/20 1:23 AM	[redacted]	
	☐	04/01/19 6:04 PM	03/31/20 2:20 PM		
	☐	09/17/18 8:04 PM	03/26/20 1:23 AM		
	☐	07/30/18 7:20 PM	03/26/20 1:23 AM		
	☐	07/30/18 7:21 PM	03/26/20 1:23 AM		
	☐	07/30/18 7:22 PM	05/18/20 8:08 PM		
	☐	07/30/18 7:23 PM	03/26/20 1:23 AM		
	☐	07/30/18 7:30 PM	03/26/20 1:23 AM		
	☐	08/06/20 3:18 AM	10/02/20 12:36 PM		
	☐	07/30/18 7:32 PM	03/26/20 1:23 AM		
	☐	09/21/18 5:30 PM	03/26/20 1:23 AM		
	☐	02/04/20 9:50 AM	05/09/20 1:20 PM		EDORA 8 DRT SERIAL # 6943
	☐	08/02/18 12:37 PM	03/26/20 1:23 AM		
	☐	07/30/18 7:35 PM	03/26/20 1:23 AM		
	☐	04/10/20 12:05 PM	04/22/20 12:10 PM		
	☐	07/30/18 7:36 PM	08/13/20 5:52 PM		
	☐	07/30/18 7:37 PM	08/31/20 10:08 AM		
	☐	07/30/18 7:38 PM	03/26/20 1:23 AM		
	☐	06/12/19 4:12 PM	03/26/20 1:23 AM		
	☐	02/04/20 9:50 AM	06/03/20 12:22 PM		Biotronik Edora implant d
	☐	03/18/20 8:20 PM	10/02/20 10:20 AM		
	☐	08/13/19 2:51 PM	03/26/20 1:23 AM		
	☐	01/09/19 7:52 PM	03/26/20 1:23 AM		
	☐	07/30/18 7:40 PM	03/26/20 1:23 AM		
	☐	01/31/19 6:17 PM	05/21/20 12:12 PM		
	☐	03/31/20 6:13 PM	10/02/20 10:18 AM		
	☐	07/30/18 7:41 PM	03/26/20 1:23 AM		

Primary	Secondary

EXHIBIT C

MEMORANDUM

TO: National Government Services

Cc:

FROM: Kevin Hoffman

DATE: October 9, 2019

RE: IDTF Application

I would like to thank you in advance for your time and consideration in processing the attached application. Please allow me to provide some background information which may clarify any questions you may have as you review the attached materials, which include:

- CMS 855b – Vector Remote Care LLC
- CMS 460 – Vector Remove Care LLC
- CMS 588 – Vector Remote Care LLC
- Supporting Documentation:
  - IRS Letter
  - Technologist Certification
  - Supervising Physician Licensure
  - Certificate of Insurance
  - Bank Letter (for EFT/CMS 588)
- CMS 855i – Dr. Millie Lee

I have recently started a new company, Vector Remote Care LLC, based out of Long Island City, NY. As of October 9, 2019, we are ready to begin monitoring patients. Vector Remote Care (Vector) is an IDTF that monitors implanted cardiac devices which have been implanted in patients. The business has an administrative office location in Long Island City out of which our technicians monitor these devices and communicate all findings with the interpreting physicians and staff. Vector does not provide professional services; we provide only those technical services required to comprehensively monitor the implantable devices. We do not employ interpreting physicians. We have a Supervising Physician, Dr. Millie Lee, a well-established cardiologist who provides all required oversight. Dr. Lee is a Medicare participating physician out of Virginia (PTAN 006996C00, VV7216A); however she has recently relocated her practice to New York, NY. While the IDTF Fact Sheet published by CMS states that our supervising physician "need not necessarily be Medicare enrolled in the State where the IDTF is enrolled," we plan to enroll her in this jurisdiction as a sole proprietor and have enclosed an 855i in an effort to do so. Please note that Dr. Lee does <u>not</u> plan to bill Medicare (she is only providing oversight) so we have not included the Form CMS 588.

We will be billing for only five CPT codes which are listed in Attachment 2 of the 855b application. Each code can be billed for work performed by each of the model numbers listed in the Attachment. It is our understanding that code 93299 may soon go away and be replaced by a temporary code, GTTT1, or by two new codes, 93297TC and 93298TC. We have included each of these codes on our application.

Finally, I understand that at some point in the near future, you will need to conduct a site visit. I wanted to make you aware that our offices are open Tuesday – Thursday each week from 9 a.m. to 4 p.m. If you need to schedule a visit outside that time frame, please let me know in advance so we can be sure that a company representative is available and the office is open for you.

Again, I hope that this brief overview will provide some context around our business and how our IDTF provides services and conducts business. We have two contact persons listed in the application, our attorney, Tommy Miller, and our consultant, Tiffany Lange. Please feel free to contact either of them or myself with any questions. I thank you in advance for your time and consideration.

Many thanks!

Kevin Hoffman
347-308-6203