Stacy Pendleton

From: Dawn M Adams <dawnmadamsihc@gmail.com>
Sent: Sunday, August 19, 2018 7:19 PM
To: dawn.adams@dbhds.virginia.gov
Subject: Re: Sorted PDF

Thanks

On Sun, Aug 19, 2018 at 7:18 PM Dawn M Adams <dawnmadamsihc@gmail.com> wrote:

---------- Forwarded message ---------
From: **Maureen Hains** <maureen@delegateadams.com>
Date: Sun, Aug 19, 2018 at 7:18 PM
Subject: Sorted PDF
To: Dawn M Adams <dawnmadamsihc@gmail.com>

I sorted them alphabetically and by location.
--

Dr. Dawn M. Adams, DNP, ANP-BC

Integrated Health Consulting

--

Dr. Dawn M. Adams, DNP, ANP-BC

Integrated Health Consulting

Stacy Pendleton

From: Dawn M Adams <dawnmadamsihc@gmail.com>
Sent: Sunday, August 19, 2018 7:19 PM
To: dawn.adams@dbhds.virginia.gov
Subject: Fwd: Sorted PDF

---------- Forwarded message ---------
From: **Maureen Hains** <maureen@delegateadams.com>
Date: Sun, Aug 19, 2018 at 7:18 PM
Subject: Sorted PDF
To: Dawn M Adams <dawnmadamsihc@gmail.com>

I sorted them alphabetically and by location.
--

Dr. Dawn M. Adams, DNP, ANP-BC

Integrated Health Consulting

LGS LegacyCare

Number of Logs: _____
Number of Patients: _____

Initial: DMA

Billing Log is 2 Pages - This being Page 1 and the Quality Data Page 2

Fax To: 804-368-1480

Provider: Dawn M. Adams, DNP, ANP-BC, CHC

Provider certification: I certify my notes, which are properly documented in the patient's chart, are complete, legible, and support the services indicated below.

Date Seen:	Patient Name	DOB	Location	Diagnoses (Primary Listed First)					CPT	Hospice?	LTC (Non-Skilled)
8/19/2018			OBA	R54	I50.32	I25.10			99308		
8/19/2018			OBA	R54	M10.051	F02.80			99309		
8/19/2018			OBA	R60.0	R09.02	E11.9			99309		
8/19/2018			OBA	F06.4	F02.80	R54			99309		
8/19/2018			OBA	L29.9	R09.02	I10			99309		
8/19/2018			OBA	N32.89	N76.1	I10	R54		99309		
8/19/2018			OBA	G89.18	I10	I50.22	R54		99309		
8/19/2018			OBA	R60.0	R09.02	J44.9			99309		
8/19/2018			OWC	R50.9	C4A.9	E11.9			99309		
8/19/2018			OWC	L29.9	L24	F31.61			99308		
8/19/2018			OWC	F03.91	I10	E03.9			99309		
8/19/2018			OWC	R50.9	R41.82	M25.50			99309		
8/19/2018			OWC	F33.0	R50.9	E11.9			99309		
8/19/2018			OWC	R09.82	R69.7	R54			99309		

Year 2018

Date: 8/19/2018

		Care Plan			Falls: Risk Assessment			Falls: Plan of Care			CHF w/ LVEF <40% - ACE or ARB Prescribed			CHF w LVEF <40% - Beta Blocker Prescribed			IF Diabetes Dx: Hemoglobin A1c Poor Control		
		Discussed & Documented	Discussed & Documented but No Decision	Discussed NOT Documented	Assessed & Documented Risk - 2 or More Falls in Past Year	Not Assessed - Medical Reason Documented - 2 or More Falls in Past Year	Not Documented Fall Status	Documented	No Plan - Medical Reason Documented	Not Documented - Reason Not Specified	ACE or ARB Prescribed or Being Taken	Not Prescribed - Medical Reason	Not Prescribed - Reason Not Specified	Beta-Blocker Therapy Prescribed	Not Prescribed - Medical Reason	Not Prescribed - Reason Not Specified	less than 7%	Between 7% and 9%	Level NOT Performed
Location	Patient Name	1123F	1124F	1123F-8P	3288F and 1100F	3288F-1P and 1100F	3288F-8P and 1100F	0518F	0518F-1P	0518F-8P	3021F and 4010F-1P	3021F and 4010F-1P	3021F and 4010F-8P	G8923 and G8450	G8923 and G8451	G8923 and G8452	3044F	3045F	3046F-8P
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Stacy Pendleton

From: Dawn M Adams <dawnmadamsihc@gmail.com>
Sent: Wednesday, July 25, 2018 1:23 PM
To: dawn.adams@dbhds.virginia.gov
Subject: Fwd: invoice

---------- Forwarded message ---------
From: **K Anderson** <KAnderson@lgslegacycare.com>
Date: Wed, Jul 25, 2018 at 1:22 PM
Subject: invoice
To: Dawn Adams (dawnmadamsihc@gmail.com) <dawnmadamsihc@gmail.com>

Kathleen Anderson, MSN, ACNP-BS

Regional Director Central Virginia

Legacy Care,LLC

Cell 804-357-5004

Fax 804-675-1755

kanderson@lgslegacycare.com

www.lgslegacycare.com

Please consider the environment before printing this email.

--

Dr. Dawn M. Adams, DNP, ANP-BC

INVOICE

Date:

TO:

FOR:
Data entry

DESCRIPTION	LOCATION	DATE	HOURS	RATE	AMOUNT
				TOTAL	

Make all checks payable to

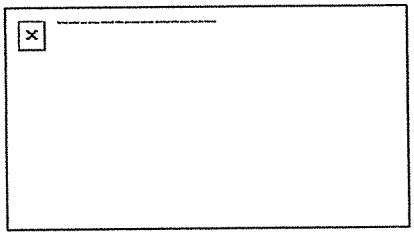
Stacy Pendleton

From: Dawn M Adams <dawnmadamsihc@gmail.com>
Sent: Monday, July 23, 2018 1:57 PM
To: dawn.adams@dbhds.virginia.gov
Subject: Fwd:

---------- Forwarded message ---------
From: **Maureen Hains** <maureen@delegateadams.com>
Date: Mon, Jul 23, 2018 at 1:50 PM
Subject: Re:
To: Dawn M Adams <dawnmadamsihc@gmail.com>

So I'm not sure I'm reading your handwriting correctly on all of this, especially on [redacted] - it looks like the first two codes are formatted differently, no letter in the front? Not sure.

Let me know if you need something changed!



Maureen K. D. Hains, *Legislative Assistant*
District 68 News | Newsletters | District 68 Calendar

Delegate Dr. Dawn M. Adams, *Nurse Practitioner*
Virginia House of Delegates - District 68
Office: (804) 698-1068
Cell: (804) 839-5934
DelegateAdams.com

On Mon, Jul 23, 2018 at 1:24 PM, Dawn M Adams <dawnmadamsihc@gmail.com> wrote:

--

Dr. Dawn M. Adams, DNP, ANP-BC

Integrated Health Consulting

--

Dr. Dawn M. Adams, DNP, ANP-BC

Integrated Health Consulting

Patient Name	DOB	Diagnoses (List Primary First)
		K21.9, J30.89, E11.9, R41.0
		R50.9, K46.9, F4.19
		R53.8, H10.9, E11.8
		E10.649, E11.65, F03.90, I15.9
		B96.20, I97.2, I50.30
		I97.2, M25.50, I10, E11.8
		R09.09, I50.22, E11, F02.80
		R53.83, C80.1, K03.90
		B95.62, M54.56, R29.898
		N39.0, R60, H04.12, F03
		150, 125.0, I110
		G89.180, Z96.651, K59, Z79.895
		163.40, I110, F03.90
		G89.12, F06.4, L89.303, J98.11
		A04.72, I50.32, R29.898, G40.909
		G89.11, G81.0, R29.989, I10
		R60.0, I11.0, R29.898, I50.22, I25.119
		H10.9, E11.8, 125.10
		I10, M18.19, I25.119

Stacy Pendleton

From: Dawn M Adams <dawnmadamsihc@gmail.com>
Sent: Monday, July 23, 2018 1:20 PM
To: dawn.adams@dbhds.virginia.gov
Subject: Fwd: ICH - Daily Log

---------- Forwarded message ---------
From: **Maureen Hains** <maureen@delegateadams.com>
Date: Mon, Jul 23, 2018 at 1:14 PM
Subject: ICH - Daily Log
To: <dawnmadamsihc@gmail.com>

--

Dr. Dawn M. Adams, DNP, ANP-BC

Integrated Health Consulting

Patient Name	DOB	Diagnoses (List Primary First)	CPT
		‹21.9, J30.89, E11.9, R41.0	8
		‹50.9, K46.9, F4.19	9
		‹53.8, H10.9, E11.8	9
		‹10.649, E11.65, F03.90, I15.9	9

Hospice?	LTC (Non-Skilled)

Stacy Pendleton

From: Dawn M Adams <dawnmadamsihc@gmail.com>
Sent: Friday, July 20, 2018 10:29 AM
To: dawn.adams@dbhds.virginia.gov
Subject: Fwd:

---------- Forwarded message ---------
From: **Jeremy Kellems** <JKellems@lgslegacycare.com>
Date: Thu, Jul 19, 2018 at 3:51 PM
Subject:
To: dawnmadamsihc@gmail.com <dawnmadamsihc@gmail.com>

Jeremy Kellems, MSN, NP-C

Training Manager

7400 Beaufont Springs Drive Suite #300

Richmond, VA 23225

(office) 804.955.4814

(fax) 757.216.0122

--

Dr. Dawn M. Adams, DNP, ANP-BC

Integrated Health Consulting

DISCHARGE SUMMARY
LEGACY CARE

CODE STATUS: Full
DISCHARGE DATE:

CHIEF COMPLAINT:

RECAPITULATION OF STAY:

PAST MEDICAL / SURGICAL HISTORY: Reviewed, see H&P for details _____

SOCIAL HISTORY: Reviewed- Denies tobacco and alcohol.

CURRENT MEDS / ALLERGIES: Reviewed

HOSPITAL RECORDS: Reviewed

ROS:
12 systems reviewed, positive for: . All other ROS negative.

ADMITTING DIAGNOSIS;

1.
2.
3.
4.

PHYSICAL EXAM:
VITALS: BP T P R SpO2

GEN: NAD; No Lethargy
EYES: PERRLA, Lids/conjunctiva normal; sclera anicteric
ENT: NCAT; Oropharnynx/Oral mucosa moist
NECK: neck symmetrical with trachea midline; thyroid normal size with no masses
RESP: Nml effort; clear bilateral; no SOB; good lung expansion, no cough, no wheezing
CV: No JVD; no murmurs; Regular rate; Regular rhythm; Nml S1 S2
ABD: Nml bowel sounds; soft; nontender; nondistended; no guarding upon palpation
GU: deferred
MUSCULOKELETAL: Age related General muscle weakness; No active joint swelling
SKIN: Turgor normal; capillary refill <3 sec; no cyanosis; warm; dry

NEURO: Alert; Oriented x ___; no abnormal movements; follows commands
PSYCH: Nml Mood/affect; cooperative; not anxious; not agitated
MENTAL STATUS: Unchanged from baseline

PERTINENT LAB DATA / TEST RESULTS;

ASSESSMENT/PLAN:

SEE MEDICATION LIST
Controlled (CII – CIV): none

1)

2)

3)

CONDITION on DISCHARGE:
Improved_____Unchaged_____Declined_____AMA_____Deceased_____

DISCHARGED TO:
Home with family

___Greater than 35 minutes spent with >50% time in care coordination/counseling

Key: ** indicates positive

Jeremy Kellems, MSN, NP-C
Electronically signed

LegacyCare
A Division of LGS Medical Services Group

Legacy Care Discharge Summary

Code Status:
Admission Date:
Discharge Date:

CC:

Recapitulation of Stay:

Past Medical / Surgical History:
Social Hx: Reviewed- Denies tobacco and alcohol.
Hospital Records: Reviewed

Medications/allergies: Reviewed

ROS:
Constitutional: no fever/chills/night sweats, dizziness, lightheadedness
Skin: no rash, itching
ENT: no runny nose, nasal congestion or sore throat
Resp: no SOB, DOE, cough, sputum production
CV: no chest pain, palpitations, edema
GI: no N/V/D/C, no abd pain
GU: no dysuria, hematuria, polyuria
Musculoskeletal: no weakness, joint pain
Neuro: no HA, weakness, speech deficits
Psych: no agitation
All other ROS Negative

Admitting Diagnosis;

1.
2.
3.
4.

Physical Exam:
Vitals: T: BP: HR: RR: Spo2
Gen: NAD,
Eyes: lids/conjunctive nml, sclera anicteric
ENT: NCAT, OP/oral mucosa moist
Neck: symmetrical and trachea midline
Resp: nml effort, clear bil. No SOB, no crepitus palpated
CV: nondisplaced PMI, no murmur, regular rate, regular rhythm, nml S1 S2, radial pulses palpable
Abd: bowel sounds present, soft, no tenderness, nondistended,
Musculoskeletal: no contractures, nml muscle tone, nml strength
Skin: no rash, turgor nml, cap refill <3sec, no cyanosis, warm, dry, no edema
Neuro: alert, oriented x ___, no focal deficits, follows commands
Psych: cooperative, not anxious, not agitated

PERTINENT LAB DATA/TEST RESULTS:

ASSESSMENT/PLAN:

SEE MEDICATION LIST
Controlled (CII – CIV): none

1. DX: Status, plan
2. Dx: Status, plan
3. Dx: status, plan

CONDITION on DISCHARGE:
Improved_____Unchaged_____Declined_____AMA_____Deceased_____

DISCHARGED TO:
Home with family

First Name Last Name, MSN, NP-C
Electronically signed

___ Greater than 50% of time of the visit was for counseling and/or coordination of care
(____min of total ____ __min)

(Version July 2018)

PROGRESS NOTE

Patient Name:	DOB:	Date:

Room #:
Code Status: ☐ Full Code or ☐ DNR
Nsg Level: Skilled or LTC ALF ILF or Hospice

Feeding Status: ☐ Feeds self ☐ Needs assistance
Functional Status: ☐ Amb independent or with use of: ☐ Nonambulatory

Chief Complaint:

Interval History: (also see PMSH below)

☐PMSH Reviewed ☐FHX Reviewed ☐SocHX Reviewed (ETOH Y / N, TOB Y / N ☐ Meds/Allergies Reviewed

PMSH (reviewed, see _____ progress note/H&P for details)

•	•	•
•	•	•
•	•	•
•	•	•

ROS: (**Circle** if present, **cross out** if asked and negative (2-9=309/336, 10=310/337))
☐**Constitutional**: Wt loss, Wt Gain, Dizziness, Fever, Chills Lethargy, Fatigue, Night Sweats, Lightheadedness
☐**Skin**: Rash, Pruritus, Blister, Ulcer
☐**Eyes**: Poor/Blurred Vision, Diplopia, Blindness, Glaucoma, Discharge
☐**ENT**: Hearing prob, Tinnitus, Runny nose, Nasal congestion, Sore throat,
☐**Resp**: SOB, DOE, PND, Orthopnea, Wheezing, Cough, Tachypnea, Sputum Prod.
☐**CV**: Chest pain, Tightness, Palpitations, Edema
☐**Breasts**: Lumps/Masses, Nipple discharge
☐**GI**: Loss of appetite, Dysphagia, Nausea, Vomiting, Diarrhea, Constipation, Pain Hematemesis, Blood in stool, Heartburn, Stool incontinence
☐**GU**: Dysuria, Hematuria, Polyuria, Hesitancy, Frequency, Urinary incontinence Discharge, Vaginal bleeding, Pruritus
☐**Immuno/Allergies**: Seasonal allergies, Joint pain, Swelling, Arthritis
☐**Endo**: Polydipsia, Polyphagia, Polyuria, Heat/Cold intolerance
☐**MSK**: Weakness, Debility, Joint pain, Swelling, Stiffness, AKA/BKA, Speech problem
☐**Neuro**: HA, Confusion, Seizures, Syncope, Numbness, Tingling, Burning, Weakness, Paresthesia, Dysphasia, Memory loss, Tremors
☐**Psych**: Anxiety, Depression, Insomnia, Suicidal/Homicidal Ideation
☐**Heme/Lymphatic**: DVT, PE, Bleeding disorder, Easy bruising, Enlarged lymph nodes

KEY FINDINGS:

☐Poor Historian due to:
☐Dementia
☐Adv dementia
☐CVA/CVA with Aphasia
☐AMS
☐Behavioral Disturbance

☐ All other ROS negative as noted

☐Hospital records reviewed

PHYSICAL EXAM: (Check if nl, if abnl write results), (6 sys with 2 elements= 309/336
VITALS: T _____ P _____ BP _____ R_____ SpO2_____
GEN: ☐NAD ☐Obese ☐ WD/WN ☐Thin ☐ No lethargy
EYES: ☐ Lids/Conjunctiva Nml ☐ EOM intact ☐ PERRL ☐ Sclera Anicteric
ENT: ☐ NCAT ☐ Nml Nasal Mucosa ☐ Oropharynx/Oral mucosa moist
☐ Nml TMs/EACs ☐ Nml Dentition/Gum
NECK: ☐ Neck symmetrical and trachea midline: ☐No lymphadenopathy
☐ Thyroid normal size with no masses ☐ supple

PROGRESS NOTE

Patient Name:	DOB:	Date:

RESP: ☐ Nml Effort ☐ Clear Bilat: ☐ No SOB
☐ good lung expansion ☐ No accessory muscle use ☐ No wheezing
☐ No rales ☐ No cough
CV: ☐ Regular Rate ☐ Regular Rhythm ☐ Nml S1 S2 ☐ No JVD ☐ No murmur
☐ No Periph Edema ☐ Non-pitting/pitting edema: Tr, 1+, 2+, 3+, 4+_____
☐ DP/PT/radial Pulses ____+ bil. ☐ Pacemaker/Defibrillator
☐ **Access:** ☐PIV ☐Central Line /PICC ☐AV fistula for HD
ABD: ☐ + BS ☐ Soft ☐ Nontender ☐ Nondistended ☐ No Hepatosplenomegaly
☐No guarding w palp. ☐ No flank pain ☐ No Masses ☐ Nml Rectal Tone
☐ No Hemorrhoids ☐PEG intact ☐obese
☐Condom Catheter ☐Colostomy/Ileostomy ☐Indwelling Foley
GU: **MALE**: ☐ Nml Testes ☐ No Penile Lesion ☐ No Discharge
FEMALE: ☐ Nml External Genitalia ☐ No Vaginal Discharge
BREAST: ☐ No Masses ☐ No Skin changes ☐ No Nipple Discharge
LYMPH: ☐ No adenopathy palpated in Neck /Supraclavicular/Axilla/Groin
MSK: ☐ No Spinal tenderness ☐ baseline DJD ☐ baseline gait and station
☐ No Contractures ☐ No Active joint swelling ☐ WNL muscle tone
☐ WNL ROM ☐ WNL strength ☐ general muscle weakness ☐ AKA/BKA
SKIN: ☐ No Rash ☐ No Ulcers ☐ no cyanosis ☐ warm ☐ dry
☐ No nodules or induration ☐ No clubbing
☐ Turgor normal ☐ Capillary refill <3sec
NEURO ☐ Alert ☐ Oriented x ___☐ Follows commands ☐ No Abn movements
☐Neuro checks WNL ☐ WNL Light Touch ☐ WNL DTR's
☐ No focal deficits ☐ Aphasic:_____ ☐ MAE x 4
PSYCH: ☐Nml Mood/Affect ☐ Cooperative ☐ Not anxious ☐ Not agitated
☐Flat affect ☐Withdrawn ☐ Labile mood
MENTAL STATUS: ☐Unchanged from baseline ☐See attached cognitive eval

KEY FINDINGS:

PERTINENT LAB DATA/TEST RESULTS:

ASSESSMENT AND PLAN:

____Greater than 50% of time of the visit was for counseling and/or coordination of care (____min of total ____ min)

Signature: _____ _____
, MD / NP MD / NP

NURSE PRACTITIONER PROGRESS NOTE
LEGACY CARE

CODE STATUS: Full
NURSING LEVEL: LTC

FEEDING STATUS: feeds self
FUNCTIONAL STATUS: w/c

CC:

INTERVAL HISTORY (also see PMSH below):

PAST MEDICAL / SURGICAL HISTORY:
Reviewed - See H&P for details

SOCIAL HISTORY:
Reviewed- Denies tobacco and alcohol.

CURRENT MEDS / ALLERGIES: Reviewed

ROS:
12 systems reviewed, positive for: . All other ROS negative.

PHYSICAL EXAM:
VITALS: reviewed / stable

GEN: NAD; No Lethargy
EYES: PERRLA, Lids/conjunctiva normal; sclera anicteric
ENT: NCAT; Oropharnynx/Oral mucosa moist
NECK: neck symmetrical with trachea midline
RESP: Nml effort; clear bilateral; no SOB; good lung expansion, no cough, no wheezing
CV: No JVD; no murmurs; Regular rate; Regular rhythm; Nml S1 S2
ABD: Nml bowel sounds; soft; nontender; nondistended; no guarding upon palpation
GU: deferred
MUSCULOKELETAL: General muscle weakness; No active joint swelling
SKIN: Turgor normal; capillary refill <3 sec; no cyanosis; warm; dry
NEURO: Alert; Oriented x ___; no abnormal movements; follows commands
PSYCH: Nml Mood/affect; cooperative; not anxious; not agitated
MENTAL STATUS: Unchanged from baseline

PERTINENT LAB DATA / TEST RESULTS;

___ Labs Reviewed in chart & Stable
___Daily Blood glucose reviewed in PCC/Stable

ASSESSMENT/PLAN:

1)

2)

3)

___Greater than 35 minutes spent with >50% time in care coordination/counseling

Key: ** indicates positive

Electronically signed:
Jeremy Kellems, MSN, NP-C

Stacy Pendleton

From: Dawn M Adams <dawnmadamsihc@gmail.com>
Sent: Wednesday, July 18, 2018 1:48 PM
To: dawn.adams@dbhds.virginia.gov
Subject: Fwd: FW: Legacy Care, LLC Credentialing

---------- Forwarded message ---------
From: **Stan Chenault - LC** <stan.chenault@legacycare-services.com>
Date: Thu, Jul 12, 2018 at 11:38 AM
Subject: FW: Legacy Care, LLC Credentialing
To: Dawn M Adams <dawnmadamsihc@gmail.com>

Good morning,

Here is the corrected form with your middle initial added.

Thanks.

Stan

From: Stan Chenault - LC
Sent: Thursday, July 12, 2018 11:26 AM
To: 'dawnmadamsihc@gmail.com' <dawnmadamsihc@gmail.com>
Cc: Jim Kistler - LC <jim.kistler@legacycare-services.com>
Subject: Legacy Care, LLC Credentialing

Good morning Ms. Adams,

My name is Stan Chenault and I assist Legacy Care, LLC with their credentialing needs. I was notified that you are joining the group, so I have begun the process. When I was online doing the Medicare Reassignment to the Legacy Care, LLC group, I noticed that you are currently deactivated with Medicare, I can get that fixed with no problem.

However, I also noticed that you were marked as "not participating" prior to that Deactivation. To correct the Participation Status, I need the attached form signed at the bottom where I have indicated and returned to me.

My address for the return of the form is:

Attn: Stan Chenault

Legacy Care, LLC Credentialing

P O Box 11768

Richmond, VA 23230

Medicare requires original signature, so I cannot accept email or fax of this form back.

Thanks for your time.

Stan

Stan Chenault - LC
Direct Dial: 804-281-3319

--

Dr. Dawn M. Adams, DNP, ANP-BC

Integrated Health Consulting

FORM APPROVED
OMB NO. 0938-0373

MEDICARE PARTICIPATING PHYSICIAN OR SUPPLIER AGREEMENT

Name(s) and Address of Participant*	National Provider Identifier (NPI)*
Dawn M. Adams, NP	

*List all names and the NPI under which the participant files claims with the Medicare Administrative Contractor (MAC)/carrier 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 of the Medicare Part B payment for all services for which the participant is eligible to accept assignment under the Medicare law and regulations and which are furnished while this agreement is in effect.

1. **Meaning of Assignment:** For purposes of this agreement, accepting assignment of the Medicare Part B payment means requesting direct Part B payment from the Medicare program. Under an assignment, the approved charge, determined by the MAC/carrier, shall be the full charge for the service covered under Part B. The participant shall not collect from the beneficiary or other person or organization for covered services more than the applicable deductible and coinsurance.
2. **Effective Date:** If the participant files the agreement with any MAC/carrier during the enrollment period, the agreement becomes effective _____.
3. **Term and Termination of Agreement:** This agreement shall continue in effect through December 31 following the date the agreement becomes effective and shall be renewed automatically for each 12-month period January 1 through December 31 thereafter unless one of the following occurs:
   a. During the enrollment period provided near the end of any calendar year, the participant notifies in writing every MAC/carrier with whom the participant has filed the agreement or a copy of the agreement that the participant wishes to terminate the agreement at the end of the current term. In the event such notification is mailed or delivered during the enrollment period provided near the end of any calendar year, the agreement shall end on December 31 of that year.
   b. The Centers for Medicare & Medicaid Services may find, after notice to and opportunity for a hearing for the participant, that the participant has substantially failed to comply with the agreement. In the event such a finding is made, the Centers for Medicare & Medicaid Services will notify the participant in writing that the agreement will be terminated at a time designated in the notice. Civil and criminal penalties may also be imposed for violation of the agreement.

Signature of participant (or authorized representative of participating organization)		Date
Title (if signer is authorized representative of organization)		Office Phone Number (including area code)
Received by (name of carrier)	Initials of Carrier Official	Effective Date

INSTRUCTIONS FOR THE MEDICARE PARTICIPATING PHYSICIAN AND SUPPLIER AGREEMENT (CMS-460)

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

WHY PARTICIPATE?

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

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

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

WHEN THE DECISION TO PARTICIPATE CAN BE MADE:

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

Contact your 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 90 days from when you are enrolled to decide if you want to participate. If you decide to participate within this 90-day timeframe, complete the CMS-460 and send to your 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 the 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 information 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 obtain telephone numbers of the various Medicare Administrative Contractor (MAC)/carrier contacts including the MAC/carrier medical directors, please visit the CMS web site at *http://www.cms.gov/*.