Resolving DME Supplier Surety Bond & Enrollment (or re-enroll) MEDICARE Post-Op Cataract Eyewean **Issues**



PRESENTED BY: Pamela B Fritz pfmdresources@sbcglobal.net (860) 669-9057

Pamela Fritz, an optical industry veteran of over 30 years, is President of Ophthalmology Resources, Ilc. a firm which specializes in financial and operational management of the optical dispensary.

Their clients include 100's of dispensing MD and OD practices across the US. They specialize in start-up dispensaries for MD's. Fritz is an expert in Medicare Post-op Cataract Eyewear giving workshops nationwide and at the AAO Annual Meeting.

She serves on the Provider Outreach and Education Panels for Medicare's DME Contractors in Region A (NHIC) Region B (NGS) and Region D (Noridian).

This webinar is sponsored by Hilco/Wilson Ophthalmic



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The New Regulations

- March 25, 2011 (Federal Register, Feb 2, Vol. 76, No.22)
- Requires a \$505 fee
- Enrollment, re-enrollment per location
- Re-activation does not require fee

Surety Bonds

- Physicians are exempt for their optical UNLESS they fill outside Rx's for post-op cataract eyewear
- Optometrists are exempt for their optical UNLESS they fill outside Rx's for post-op cataract eyewear
- The optical can qualify for physician/OD exemption only if the shop and the practice are under/within the same TIN # and business structure (part of the same corp.)

More Surety Bond

- Opticians need a surety bond as they usually fill outside Rx's for post-op eyewear
- Failure to obtain a surety bond can result in revocation of your Medicare billing privileges
- For a list of authorized bonding agencies: www.fms.treas.gov/c570/c570 a-z.html.
- The OAA suggests: LSJ Insurance Agency, Inc. Web site: Isjins.com

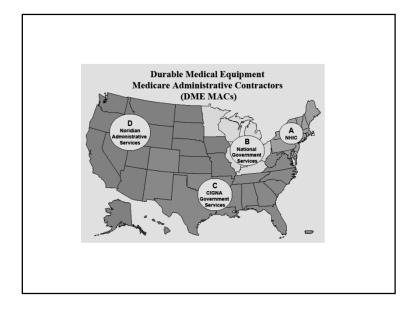
A	
MEDICARE ENROLLMENT APPLICATION Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers	
CMS-8555	
SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION. SEE PAGE 2 FOR INFORMATION ON WHERE TO MAIL THIS APPLICATION.	
SEE PAGE 2S FOR A LIST OF SUPPORTING DOCUMENTS THAT MUST BE SUBMITTED WITH THIS APPLICATION.	
SEE PAGE 36 FOR A LIST OF THE DMEFOS SUPPLIER STANDARDS. EVERY APPLICANT MUST MEET AND MAINTAIN THESE ENROLLMENT STANDARDS. CMS	
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Partnership	WHENT OF	-	
Corporation Limited Liability Company Limited Liability Partnership	MLS.		Suite 100; Winter Park, FL 32789 21) 972,4863; f (407) 628,1671 s.com; www.Lsjins.com
Application For \$50,000 DMEPOS E			
L Bond Amount of bond tiffe	ective Date: Previous Bon	iding Co: Reason fo	or changing:
Information 5			
2. BUSINESS Business Name: (M INFORMATION	lust be exactly as filed with h	rtedicare/CMS)	Pk:
Bus. Address to be covered:		City:	State: Zip code:
Date Susiness Formed: No. of years in th	his business: No. of years I	Licensed: Fed tax ID #	No. of Owners, Partners
			or Members:
Are you an accredited DMEPOS provider?		ganication name:	
NPI No.: NSC/PT		Last Visit Date:	Accreditation Date:
Medicare last audit date: Any	T fut. Next Year revenued.	IS NO How many years po	Annual fevenue 5
tst. Annual Medicare Recepts 5 Who are your primary customers?	Est. Next Year revenue's	Last Year	Annual Revenue 5
Percent of Business transacted through:	Storefront % Ho	me visits % Mail ords	r % internet %
Type of DMEPOS goods you supply:			niced or off shelf?
Warehouse Location: Name of Bank: No.	ame of Banker:	Own Leave Area of sen	Years with bank
Explain Medicare billing process and experi	ence:	•	
Formal line of credit? Amount		outstanding 5	How secured?
	A new enrollee as a DMEPOS currently enrolled as a DMEPOS	i supplier? OR POS Supplier? How many years	,
Mas the business or any of the owners or of			
a) Ever had a license suspended, revoked, o	r denied? []YES []NO	d) Ever been convicted of a cri	me? [hts]wo
b) been the subject of adverse action by Ch			tion items or liens? []YES []NO
(if yes please explain)			ety company? ntsno
c) Have any pending litigation, lawsuits or just the applicant a pharmacy Licensed by a st			clared bankruptcy? [] rts [] to
Pharmacy License No.:	rate occars or marriarly to or	towing State:	Oute:
4. Owners information: List all Owners of t	the company (if additional Ov		
A. Name:		Date of Birth:	55#:
Plant Equity in Home 5	Home Ph:	City:	State: Zig: Oriver Lic:
Bus. Ownership % Involved Full Tir		Spouse Name:	primer exc.
8. Name:		Date of Birth:	558:
Home Address: Dun Dane Equity in Home 5	Home Ph:		State: Zip: Oriver Lic
Bus, Ownership: % Involved Full Tir		Spouse Name:	OFINET CIC
5. General Notes: The undersigned applicant and submit this application on their behalf for approximy time, and obtain additional information from Company's specific Indownshy agreement which is Agreed and signed this	al and agree to the following: a) any source including credit repe secomes an integral part of this s	Authorize the surety bonding con on. b) Agree that if the application application and pay the premium of	gary to verify this information at it approved to properly sign the
Aprenting appearantany at	Applican	rist rane	Sign Nove
(Mail			
	Indennika	Print name	Sign here
LSI OMEPOS App - 3/ 58			

CENTER FOR MEDICARE & MEDICAD SERVICES		Form Approved CNM No. 0508-9035
ELECTRONIC FUNDS TRANS	FER (EFT) AUTHORIZATIO	N AGREEMENT
PART I: REASON FOR SUBMISSION		
Reason for Submission:	☐ Check here if EFT pay	most is being made to
☐ New EFT Authorization ☐ Revision to Current Authorization	the Home Office of C	hain
(n.g. account or bank changes)	(Attach letter Authorizi Chain Home Office)	ng EFT payment to
Since your last EFT authorization agreement su	bmission, have you had a:	
☐ Change of Ownership, and/or		
Change of Practice Location? If you checked either a change of ownership or	channe of practice location above, was me	to around a timelus taux
information (using the Medicare enrollment app area)() prior to or accompanying this EFT author	dication) to the Medicare contractor that	services your geographical
PART II: PROVIDER OR SUPPLIER INFORI	MATION	
ProviderSupplier Legal Business Name		
Chain Organization Name or Home Office Legal Business N	same (if different from Chain Organization Na	iniq
Account Honder's Street Address		
Account Header's City	Account Holder's State	Account Holder's Zip Code
Tax Identification Number: (designate CSSN or CSIN)		
Make an all residence for the second		
National Provider Identifier (IAP)		
PART III: FINANCIAL INSTITUTION INFOR	IMATION	
Triancal nutrution Name		
Timanolar Indiffution City/Town	Financial Indiffution Value	
Financial Indiffution Telephone Number	Financial Institution Contact Peru	on
Trancal Inditution Souting Transit Number (nine digit)		
Depositor Account Number	Type of Account (theck one)	
000000000000000000000000000000000000000		
Please include a confirmation of account infor the documentation, it should contain the nam number and type, if submitting bank letterhea information will be used to verify your account	e on the account, electronic routing id, the bank officer's name and sign	transit number, account
PART IV: CONTACT PERSON		
Contact Person's Name	Contact Person's Title	
Contact Person's Telephone Number	Contact Person's E-mail Address	
CORNE CASE SISK SISK-COR		

MEDICARE PARTICIPATING PHYSICIAN OR SUPPLER AGREEMENT

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DME MAC (Medicare Administrative Contractor) web-sites

- Region A www.medicarenhic.com
- Region B www.ngsmedicare.com
- Region C www.cignagovernmentservices.com
- Region D www.noridianmedicare.com

www.cms.gov

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Thank You!

For attending today's Webinar

Pam Fritz is available for further individual consultation to solve all your DME issues.

Consultation Fees Available Upon Request

To set up an appointment Call 860-669-9057 Or Email

pfmdresources@sbcglobal.net