

Supplemental Facility-Based/Fiscal Year End Request Statement

Facility-Based Request

This is not a Provider-Based enrollment as defined at the Medicare Regulations 42 CFR §413.65. For Provider-Based participation and requirements, please go to our web site at [www.NoridianMedicare.com](http://www.NoridianMedicare.com).

However for purposes of cost report submission the provider is completing the accompanying 855 with the following intentions:

1. \_\_\_\_\_ This provider will be a free-standing provider and will file its own Medicare cost report.
2. \_\_\_\_\_ This provider will be a facility-based provider and will file a Medicare cost report in affiliation with the following main provider:

Main Provider's Medicare Provider Number \_\_\_\_\_

Main Provider's Name: \_\_\_\_\_

Main Provider's Address: \_\_\_\_\_  
\_\_\_\_\_

Facility/Organization Name: \_\_\_\_\_

Facility/Organization **exact** Address: \_\_\_\_\_  
\_\_\_\_\_

Facility/Organization's Medicare Provider Number, if there is one: \_\_\_\_\_

Fiscal Year End Request

The provider completing the accompanying 855 is requesting the following fiscal year end: \_\_\_\_\_

Signed: \_\_\_\_\_  
(Signature of Officer or Administrator or authorized person)

\_\_\_\_\_  
(PRINT Name of Signature)

Title: \_\_\_\_\_  
(Title of authorized person acting on behalf of the provider)

\_\_\_\_\_  
(Direct telephone number)

Date: \_\_\_\_\_