



## SPOT enrollment form for new provider organizations

Please complete this form for enrollment to SPOT (Secure Provider Online Tool), First Coast Service Options' internet portal. All fields marked with \* are required and must be completed or the request will be rejected.

This form is for organizations to designate who the approver and backup approver will be. Individuals designated by their organization as approvers and backup approvers must register in IDM (Identity Management System) once they receive approval from First Coast. Go here for more on how to register in IDM -- <https://medicare.fcso.com/faqs/answers/241528.asp>.

**Note:** Those requesting end user access to SPOT are not required to complete this form.

### LINE OF BUSINESS/LOCATION

\*Line of business: Part A (Institutional)      Part B (Professional)

\*State: FL      PR      USVI

### BILLING PROVIDER INFORMATION

\*Provider legal business name:

\*Contact name:

\*Contact phone number:

\*Contact fax number:

\*Street address:

\*City:

\*State:

\*ZIP Code:

\*PTAN:

\*NPI:

\*Tax ID #/EIN/SSN (all nine digits):

### APPROVER(S) DESIGNATION

\*Approver First Name:

\*Approver Last Name:

\*Approver email:

Backup Approver First Name:

Backup Approver Last Name

Backup Approver email:

## ADDITIONAL NPI/PTAN ASSOCIATIONS

Please provide in the fields below any additional NPI/PTAN combinations that you want associated with your organization and the Tax Identification Number listed above on your registration form. An example would be to include the NPI/PTAN combination of a rendering physician within your organization, which SPOT could use to return a comparative billing report (CBR) specific to that physician and their specialty. These combinations, which are optional, will be validated as well during the time your request is evaluated.

Department/Nickname	PTAN	NPI
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## ATTESTATION

Federal law shall govern both the interpretation of this document and the appropriate jurisdiction and venue for appealing any final decision made by CMS under this document.

This document shall become effective when signed by the provider. Either party may terminate this arrangement by giving the other party thirty (30) days written notice of its intent to terminate. In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as established by the postmark or other appropriate evidence of transmittal.

## \* AUTHORIZED OFFICIAL SIGNATURE REQUIREMENTS

By signing below I certify that I have been appointed an authorized official to whom the provider has granted the legal authority to enroll it in the Medicare Program, to make changes and/or updates to the provider's status in the Medicare Program (e.g., new practice locations, change of address, etc.), and to commit the provider to abide by the laws, regulations, and the program instructions of Medicare. I authorize the above listed entities to communicate electronically with First Coast on my behalf.

By signing below the provider confirms they have read and agree with the provider EDI agreement, the CMS' obligations, and the attestation sections of this document and above signature requirements.

**\*Authorized Official Signature**

**\*Date**

**\*Name of Authorized Official (Print)**

**\*Title of Authorized Official**

Once you complete the form and sign it, click the **Submit** button below to email the form to First Coast Service Options' EDI Department, or you can fax or mail a printed version of the completed form using the information below.

**Email:** MedicareEDI@fcso.com | **Fax:** (904) 361-0470 | **Mail:** First Coast Medicare EDI, P.O. Box 3703 Mechanicsburg, PA 17055-1861