



Enrolling in Medicare as a Federally Qualified Health Center

One of the most critical steps to opening your new health center site is enrolling in Medicare. This process officially designates the health center as a Federally Qualified Health Center (FQHC), which allows you to bill Medicare using the FQHC PPS rate. Additionally, some states require a site to have completed the Medicare enrollment process before it can seek to enroll in Medicaid. Below you will find a snapshot of what is required to enroll in Medicare and some helpful resources to walk you through the process. We recommend you review each of these resources before you begin the process.

In order to ensure a seamless enrollment process, it is important for you to complete the Medicare application properly and in its entirety. We understand the average processing time is 45 days, so please plan accordingly. Do not hesitate to contact [NACHC](#) if you have any questions or concerns about the process.

To enroll in Medicare a health center must:

- The site must be open and operational before it can submit its application package.
- Submit a complete application package to your [Medicare Administrative Contractor](#) (MAC). Per the Manual cited above, a complete application package includes the following documents:
 - A completed [CMS 855A Enrollment Application](#) (we encourage you to use the online [PECOS](#) system)
 - The health center's HRSA Notice of Grant Award or "Look-Alike" Designation
 - Two signed and dated copies of the [Attestation Statement \(Exhibit 177\)](#). Note that this must not be signed prior to the day that the new site become operational. (This statement serves as the Medicare FQHC agreement when it is also signed and dated by the Regional Office.)
 - Form [CMS-588 Electronic Funds Transfer \(EFT\) Authorization Agreement](#)
 - CLIA Certificate (if applicable)
 - Copy of State License (if applicable)

Your application, along with the [application fee](#), is sent to the [Medicare Administrative Contractor](#) who conducts an initial review. Once this is complete, the MAC sends the application to the [CMS Regional Office](#) for final review.

Once the Regional Office completes its review, the health center will receive a certification letter from CMS with an effective date. That effective date is the date that the MAC approved the application and sent it to the Regional Office for review. Please note you **cannot** bill the Medicare FQHC PPS rate for any services you provided prior to the effective date; however, you can bill Medicare for these services under Part B (the provider fee schedule) if you have an agreement with them.

Resources

- [CMS State Operations Manual](#) – Chapter 2 (see Section 2825 for FQHC specific information)
- [CMS Information on Medicare Participation for Federally Qualified Health Centers](#)
- [HRSA PAL 2011-04](#): Process for Becoming Eligible for Medicare Reimbursement under the FQHC Benefit
- [Contact information for Medicare Administrative Contractors](#)
- [Map](#) and [Contact Information](#) for CMS Regional Office
- [CMS FQHC website](#)
- [CMS FQHC Fact Sheet](#)