

**HEALTH INSURANCE BENEFIT AGREEMENT**

(Agreement with Provider Pursuant to Section 1866 of the Social Security Act (as amended)  
and Title 42 Code of Federal Regulations (CFR) Title IV, Part 489)

**AGREEMENT**

**Between**

**THE SECRETARY OF HEALTH AND HUMAN SERVICES**

**and**

(Insert name of provider)

doing business as (D/B/A)

(Insert business name of  
provider, if applicable)

In order to receive payment under title XVIII of the Social Security Act,

(Insert name of provider)

D/B/A

(Insert business name of  
provider, if applicable)

as the provider of services, agrees to conform to the provisions of section of 1866 of the Social Security Act  
and applicable provisions in 42 CFR.

This agreement, upon submission by the provider of services of acceptable assurance of compliance with title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 as amended, and upon acceptance by the Secretary of Health and Human Services, shall be binding on the provider of services and the Secretary.

In the event of a transfer of ownership, this agreement is automatically assigned to the new owner subject to the conditions specified in this agreement and 42 CFR 489, to include existing plans of correction and the duration of this agreement, if the agreement is time limited.

**ATTENTION:** Read the following provision of Federal law carefully before signing.

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than \$10,000 or imprisoned not more than 5 years or both (18 U.S.C. section 1001).

**ACCEPTED FOR PROVIDER OF SERVICES BY:**

Signature	Title
Printed Name	Date

**HEALTH INSURANCE BENEFIT AGREEMENT**  
**CMS-1561**

ACCEPTED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES BY:

Signature	Title
Printed Name	Date

ACCEPTED FOR THE SUCCESSOR PROVIDER OF SERVICES BY:

Signature	Title
Printed Name	Date

**PRA Disclosure Statement**

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**\*\*\*\*CMS Disclosure\*\*\*\***

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