



CENTER FOR
INTEGRATIVE NEUROSCIENCE

The Medicare Enrollment Cheat-Sheet

From eligible to enrolled to billing.

NATIONAL • COUNSELORS AND MFTS • 2026

01 THE PATH 02 PECOS 03 PARTICIPATION 04 CHECK PAYMENT PRIMARY SOURCES

Written from the primary sources and the Behavioral Health Workforce
Observatory's records. CMS source data, verified August 2026. Free,
ungated, and yours either way.

What should I understand before I start Medicare enrollment?

Medicare enrollment looks like one application until you are inside it. It is a sequence of decisions, and several of them are made before anyone tells you they are decisions. Once you can see the sequence, the work becomes manageable.

Counselors and marriage and family therapists became eligible to enroll in Medicare in January 2024. Eligibility was the first step, not the last one.

This Cheat-Sheet walks the enrollment sequence in plain language and flags the decisions people make without realizing they are decisions. Every number and requirement here comes from published CMS material. Nothing here rests on correspondence with an agency or a payer.

WHO THIS IS FOR

- A counselor or MFT enrolling for the first time.
- A practice manager or credentialer enrolling someone else.
- A medical practice adding a behavioral health clinician who will need Medicare.
- Anyone who enrolled, is waiting, and cannot tell whether the wait is normal.

YOU WILL LEAVE KNOWING

- The five steps, in order, and what each one asks of you.
- What to gather before you open PECOS, so the application does not bounce.
- That there are three positions, not two, and what each one decides.
- Why the specialty code is a decision and not a formality.
- How to look up what a code pays in your own locality, and how to date it.

HOW TO READ THIS DOCUMENT

Three kinds of line, and the difference is the whole method.

The key first, then what this particular document covers.

SOLID LINE

A cited public source establishes this.

The source is named where the claim is made, and dated. If you want to check it, you can.

DASHED LINE

This describes what happens today.

Current practice, or your own situation. True as a description, and not asserted as a rule.

DOTTED LINE, ENDING IN ?

The record does not tell us this yet.

Nobody has measured it. A question mark is printed rather than a confident-sounding phrase standing in for a number.

AND WHAT IT COVERS

THIS GUIDE CAN ANSWER

What the federal rules say, and what each step asks of you.

Written from published CMS material. Nothing here rests on correspondence with an agency or a payer.

THIS GUIDE CANNOT ANSWER

What your state, payer, contract, staffing structure, or billing arrangement requires.

Those are confirmed with your Medicare Administrative Contractor, your payers, and your compliance advisor. The last page says where that question goes.

Every publication from the Center works this way. Once you know the two lines, you can read any of them quickly, and you can always tell what is established from what is merely stated.

Five steps, and each one assumes the last is finished.

Enrollment is a sequence. Much of the difficulty people describe is not difficulty with a form. It is discovering that a decision made three steps earlier now has to be undone. How common that is has not been measured, which is what the study at the end of this document is for.

FIGURE 01

The enrollment path, start to first claim.

The questions under each step are the ones the step actually asks you.

01	02	03	04	05
ELIGIBLE	ENROLL	CHOOSE	VERIFY	BILL
Do I meet the requirements for my profession? Do I have an NPI?	Which application? Which specialty code? Which practice locations?	Participating, non-participating, or opted out? What does assignment mean?	Is the record active? What is the effective date? What may I bill from?	Which arrangement am I billing under, and what does it require?

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Two places to slow down

One is identity, at step 02. Enrollment is checked against your existing records, so an NPI record carrying an old address, an old taxonomy, or a name that does not match the license exactly is a problem before the application is even read. Correct the NPI record first.

The other is the effective date, at step 04. An approved application has one, and it is not always the date you applied. Claims for services before that date do not become payable because the application was later approved. Verify the date, in writing, before the first claim goes out.

FIGURE 02

Step 05 is three different structures.

People often treat these as one question. They have different requirements, and enrollment answers only part of any of them.

MY OWN SERVICE

Clinician



Medicare

Your own enrollment is what makes this possible. This document is about this lane.

ANOTHER BILLING ARRANGEMENT

Clinician



qualifying arrangement



billing practitioner

Separate requirements govern who may bill, and under what conditions. Verify them for the specific arrangement.

COLLABORATIVE CARE

Care manager, psychiatric consultant, medical provider



monthly service

A team model. The monthly service is billed by the treating medical practitioner, not by the clinician doing the care-management work.

Enrollment answers who is enrolled. It does not by itself answer whether an arrangement is compliant.

CENTER FOR INTEGRATIVE NEUROSCIENCE · COLLABORATIVE CARE STRUCTURE PER CMS BOOKLET
MLN909432 · CHECKED AUGUST 2026 · INTEGRATIVE-NEUROSCIENCE.COM/GUIDES/MEDICARE

The CoCM Startup Brief covers the third lane in full. This Cheat-Sheet stops at your own enrollment.

02 · PECOS

Gather everything first. The form is the easy part.

PECOS is the Provider Enrollment, Chain and Ownership System: the CMS system where enrollment applications are filed and where your enrollment record lives afterwards. Paper equivalents exist, and the electronic route is the one most people use.

What to have in front of you

- Your NPI and the login for the system that holds it, with the record already corrected.
- Your license number, issuing state, and expiration date, exactly as issued.
- Every practice location where you will see Medicare patients, with the address as the postal service writes it.
- The correspondence address, and the special payments address if they differ.
- Bank details for electronic funds transfer, and the legal business name and tax identification the payments belong to.
- Your professional history, including gaps, for the period the application asks about.
- The identity of any organization that will bill for your services, and its identifiers.

Applications are returned for mismatches between these records. How often that happens, compared with substantive problems, is not something the Center has measured. Consistency across the license, the NPI record, the tax record, and the application is what keeps an application moving.

The specialty code, and why it matters later

Somewhere in the application you select the specialty your enrollment is filed under. It takes a moment and it is easy to treat as a formality. It is not. The specialty on your record travels with you: it appears in directories, it is visible to plans and to practices deciding who to contract with, and it is one of the fields a contractor looks at when a claim behaves unexpectedly.

Choose it deliberately, record what you chose and the date, and check it again when you verify the approved record. Changing it later is a change of information, which is another application.

WORKSHEET

Before you open PECOS

Nine boxes, all of them from what this document has already told you. Nothing here requires a login.

- | | |
|---|---|
| ☐ NPI record opened and checked against the license. | ☐ Name, address, and taxonomy match across every record. |
| ☐ License number, issuing state, and expiration date to hand. | ☐ Every practice location listed, in postal form. |
| ☐ Legal business name and tax identification confirmed. | ☐ Bank details ready for electronic funds transfer. |
| ☐ Specialty code considered as a decision, and written down. | ☐ Participation position understood, all three of them. |
| ☐ A single folder created for the application and everything that follows it. Revalidation will ask you to reproduce most of it, and the person doing that may not be you. | |

If those boxes are checked, open PECOS.

03 • PARTICIPATION

Three positions, and the one you pick matters.

This is where most people assume there are two options. There are three. Participating and non-participating are both inside Medicare and differ on assignment. Opting out is outside it: no Medicare payment at all, and a private contract with each patient instead.

Changing position later is possible, on the schedule the rules allow, and it is disruptive. It is worth an hour now rather than a year of billing built on a choice nobody made deliberately.

FIGURE 03

The three positions, side by side.

Two are inside Medicare. One is outside it. The arithmetic is public; the appropriate choice depends on your practice.

PARTICIPATING

Inside Medicare. Assignment accepted in advance.

- You accept assignment on every claim.
- Payment is based on the full fee schedule amount for your locality.
- Medicare pays you directly and you collect the patient share.
- You appear as participating in the public directories.

Practical implication: the highest approved amount of the three, direct payment from Medicare, and the least billing administration.

NON-PARTICIPATING

Inside Medicare. Assignment decided claim by claim.

- You choose, per claim, whether to accept assignment.
- The approved amount on these claims is lower than the participating amount.
- On unassigned claims a limiting charge caps what you may bill, and the patient pays you.
- More administration, and more of the collection risk sits with you.

Practical implication: flexibility on each claim, in exchange for a lower approved amount and more billing and collection work carried by the practice.

OPTED OUT

Outside Medicare. Private contracts instead.

- No Medicare payment for your services, to you or to the patient.
- A private contract is required with each Medicare patient you see.
- The opt-out runs for a set period and renews unless it is cancelled in time.
- Whether your practitioner type may opt out, and on what terms, is verified with CMS first.

Practical implication: no Medicare payment from these patients at all, and a contracting and disclosure obligation with each one, for the length of the opt-out period.

Not enrolling is not a fourth option. A clinician who simply never enrolls has still made a decision, and it is the one with the fewest protections for the patient.

CENTER FOR INTEGRATIVE NEUROSCIENCE · CMS PARTICIPATION AND ASSIGNMENT GUIDANCE, AND CMS OPT-OUT AND PRIVATE CONTRACT GUIDANCE · CHECKED AUGUST 2026 · INTEGRATIVE-NEUROSCIENCE.COM/GUIDES/MEDICARE

The non-participating reduction, the limiting charge, and the opt-out period are all set in public rule as fixed terms. Look up the current figures rather than carrying a number you remember, and verify the opt-out requirements that apply to your profession before choosing that column.

What assignment actually means

Accepting assignment means agreeing that the Medicare-approved amount is the whole payment for that service: Medicare's share plus the patient's share, and nothing beyond it. It is a statement about the ceiling, not about who pays first.

Assignment is what separates the first two columns. It is not what separates them from the third: opting out is not a position on assignment at all, because there is no Medicare claim to assign. The choice between participating and non-participating is made at enrollment, with a window to change it; opting out is a separate process with its own paperwork and its own timing.

NOT ESTABLISHED

Which of the three positions is better for a small behavioral health practice is not a settled question, and this document does not pretend to answer it. It depends on your locality's rates, your patient mix, your collection rates, and your administrative capacity. Run the arithmetic with your own numbers.

04 • CHECK PAYMENT

Look it up, in your locality, and write down the date.

Medicare payment is not one national number. The fee schedule is adjusted by locality, and it is updated. A figure someone quoted you last year is not a current figure, and a figure from a neighboring locality is not your figure.

Four steps, every time

1. **Find your locality.** It follows the practice location on your enrollment, which is why the address on the application matters after the application is over.
2. **Open the current Physician Fee Schedule lookup** on the CMS site, for the year you are billing in.
3. **Look up the codes you actually bill**, one at a time, and note the participating and non-participating amounts separately.

4. **Record the date you checked**, next to the figure, in the same file. Every rate in your own records carries a date, or it will be quoted a year from now as though it were current.

FIGURE 04

A worksheet, not a table of rates.

The Center does not print Medicare rates. They change, and a printed rate outlives its accuracy. Fill this in yourself, from the current schedule.

Locality	?
Code, participating amount	?
Code, non-participating amount	?
Limiting charge on unassigned claims	?
Date checked	?

VALUES TO BE COMPLETED BY THE READER FROM THE CURRENT CMS PHYSICIAN FEE SCHEDULE

THE OPEN QUESTION

*What gets in the way when
clinicians and practices try to put
these arrangements together?*

WHAT IS ESTABLISHED

The federal rules are published. Eligibility, the application, the participation choice, and the fee schedule are all matters of public record, and this document cites them.

WHAT IS NOT MEASURED

How long enrollment actually takes, how often it has to be corrected, who in a practice ends up doing it, and how often a delay postpones or ends an arrangement that was otherwise ready.

Median weeks from submission to effective date ?

Share of applications returned for correction ?

Arrangements delayed or abandoned while waiting ?

You may know one of the numbers nobody has.

If you enrolled yourself, enrolled someone else, corrected an application, waited on an effective date, or watched enrollment delay a care arrangement, your experience belongs in the record above. The enrollment file shows the outcome. It does not show the elapsed time, the corrections, or the staff hours behind it, and no public dataset does.

Put your experience in the record.

Five minutes. What happened to you becomes part of what the field can finally measure.

TELL THE OBSERVATORY WHAT HAPPENED →

integrative-neuroscience.com/research/medicare

Findings return to respondents before broader publication.
Participation is optional. The Cheat-Sheet is yours whether you answer or not.

NEXT MOVE

You have the federal path. What comes next depends on why you are here.

→ **I am enrolling myself**

Work section 02 as a checklist, choose the specialty code deliberately, and verify the approved record and its effective date before the first claim.

→ **I am adding behavioral health to medical care**

Enrollment is one piece of the third lane in Figure 02. The CoCM Startup Brief covers the model, the team, the codes, and what a practice works out before it begins.

→ **I want help getting this done**

JOIN KEDGE EARLY ACCESS →

Understanding the path is not the same as walking it. Kedge is building guided Medicare enrollment for practices and clinicians, with step-by-step help based on your role, state, payer, and practice structure.

Kedge is a separate software platform, and it is not open yet. The Cheat-Sheet is free and complete whether or not you ever use it.

PRIMARY SOURCES

Everything above comes from these, and each carries a date.

Public sources only. No payer or agency correspondence appears in this document. Where a source is a landing page rather than a specific section, that is stated rather than hidden.

SOURCE	USED FOR	CHECKED
CMS provider enrollment guidance	The enrollment sequence, application types, and what a change of information requires	August 2026
PECOS, the CMS enrollment system	What the system is, what it holds, and what an applicant needs before starting	August 2026
CMS participation and assignment guidance	Participating and non-participating positions, assignment, and the limiting charge	August 2026
CMS opt-out and private contract guidance	The third position: private contracts, the opt-out period, and which practitioner types may use it	August 2026
Medicare Physician Fee Schedule lookup	Locality-adjusted amounts, and the instruction to look up rather than to quote	August 2026
CMS booklet MLN909432	The Collaborative Care model requirements referenced under Which arrangement	August 2026

Requirements and rates change. Confirm what applies to your practice with your Medicare Administrative Contractor and your compliance advisor before acting on anything here. Found something stale? Write to the correction address on the last page. We will correct the record and date the correction.

COLOPHON

*Independent educational research
and practice guidance, grounded in
primary sources.*

Educational information, not medical, legal, billing, or licensure advice.

Payer and regulatory requirements change; confirm what applies to your practice with the relevant payer, agency, and compliance advisor. Each publication carries the date its sources were last checked. Do not send protected health information.

AUTHORSHIP

Co-authored by the co-founders of the Center for Integrative Neuroscience, from the primary sources and the Behavioral Health Workforce Observatory's records.

CORRECTIONS

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integrative-neuroscience.com/sources

FOUR NAMES, FOUR JOBS

Center for Integrative Neuroscience · what the public rules say

Kedge · guided enrollment, in build. A separate company

Behavioral Health Workforce Observatory · what the record cannot show. The Center's research arm

Integral Neuroscience Initiative · evidence carried into public-interest work. A separate nonprofit

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