Radiation Oncology Pratice Accreditation Program
1891 Preston White Drive
Reston, VA 20191

OWNERSHIP CHANGE/FACILITY ID DESIGNATION FORM

Please fill in ALL applicable accredited facility ID numbers for your location. **FML#**

All information below must be completed

Contact Name: _____ **Title:** _____

Email Address: _____ **Phone Number:** _____

Accredited Facility Name: _____

Facility Location Address: _____

1. **Is the facility under new ownership?** ☐ **Yes** ☐ **No**
   If so, Effective Date of ownership change: _____
2. **Is the facility changing its name?** ☐ **Yes** ☐ **No**
   If so, New Name: _____
3. **Are any of the accredited facilities moving to a new location address?** ☐ **Yes** ☐ **No**
4. **Are the NPI, Medicare ID and/or EIN/Tax ID number changing?** ☐ **Yes** ☐ **No**
5. **Were you required to complete a new CMS-855B form?** ☐ **Yes** ☐ **No**
6. **Are at least 50% of the radiation oncologists new?** ☐ **Yes** ☐ **No**
7. **Are at least 50% of the therapists new?** ☐ **Yes** ☐ **No**
8. **Are there significant changes in the treatment protocols?** ☐ **Yes** ☐ **No**
9. **Is the Medical Director changing?** ☐ **Yes** ☐ **No**

Old owner information: _____
New owner information: _____

Name and Signature of Facility Medical Director or Facility Administrator or Facility Owner (Old or New)

Name: _____ **Title:** _____

Signature: _____

For ACR Use Only

Program Manager(s): _____ New ID # needed? YES NO