



Radiation Oncology Practice Accreditation Program
1892 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