Surgical Center – Closure

Complete all the following information.

Health Facility Identification Number (HFID): _____

CMS Certification Number (CCN) (if applicable): _____

Surgical Center Doing Business Name (DBA) name: _____

Surgical center address: _____

Effective date of Medicare certification termination: _____

Will the surgical center remain licensed? ☐ No ☐ Yes, effective date of license closure: _____

Next Steps for Surgical Center

- Email form to health.hrd-fedlcr@state.mn.us.
- Submit CMS 855A to the Medicare Administrator Contractor (MAC) (if applicable).
- If deemed status, notify the accrediting organization (if applicable).

Affirmation

☐ I certify that the information provided on this form is accurate and complete.

Signature of Administrator/Authorized Agent: _____

Name (print or type): _____

Title: _____

Date: _____

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
651-201-4200
Health.HRD-FedLCR@state.mn.us

10/30/2026

If you have questions, please email Health.HRD-FedLCR@state.mn.us or call 651-201-4200.