CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 284	Date: FEBRUARY 20, 2009
	Change Request 6244

SUBJECT: Model Letter Updates

I. SUMMARY OF CHANGES: Model letter updates and addition of several new model letters.

NEW / REVISED MATERIAL
EFFECTIVE DATE: March 20, 2009
IMPLEMENTATION DATE: March 20, 2009

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/Table of Contents
R	10/14.2/Model Development Letter
R	10/14.3/Model Rejection Letter
R	10/14.4/Model Returned Application Letter
R	10/14.5/Model Revalidation Letter
R	10/14.7/Model Approval Letter for Initial Enrollment
R	10/14.8/Model Approval Letter for Change of Information
R	10/14.9/Model Revalidation Approval Letter
R	10/14.10/Model Denial Letter for Certified Providers & Suppliers: Denial Based on a Condition of Participation
R	10/14.11/Model Denial Letter for Certified Providers & Suppliers: Denial Based on an Enrollment Reason(s)
R	10/14.12/Model Denial Letter for Suppliers, Non-IDTF, Furnishing Part B Services
R	10/14.13/Model Denial Letter for IDTFs
R	10/14.14/Model Revocation Letter for Certified Providers & Suppliers: Revocation Based on a Condition of Participation

N	10/14.15/Model Revocation Letter for Certified Providers & Suppliers: Revocation Based on an Enrollment Reason(s)
N	10/14.16/Model Revocation Letter for Suppliers Furnishing Part B Services
N	10/14.17/Model Revocation Letter for OIG Sanctioned Providers/Suppliers
N	10/14.18/Model Revocation Letter for National Clearinghouse Supplier (NSC)
N	10/14.19/Model Reconsideration Letter
N	10/14.20/Model Identity Theft Prevention Letter

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-08	Transmittal: 284	Date: February 20, 2009	Change Request: 6244

SUBJECT: Model Letter Updates

Effective Date: March 20, 2009
Implementation Date: March 20, 2009

I. GENERAL INFORMATION

A. Background: This change request revises existing model provider enrollment language and adds several new model letters to chapter 10, section 14, of the PIM.

B. Policy: Contractors shall establish and use model provider enrollment correspondence that clearly informs an applicant about the status or disposition of an enrollment action.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6244.1	Contractors shall establish and use model provider enrollment correspondence that clearly informs an applicant about the status or disposition of an enrollment action. As necessary, contractors may revise the model language contained in section 14 for grammatical changes.	X		X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	None

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Ann Marie Reimer (Vale) Annmarie.reimer@cms.hhs.gov (410) 786-4898
Post-Implementation Contact(s): Ann Marie Reimer (Vale) Annmarie.reimer@cms.hhs.gov (410) 786-4898

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers and Regional Home Health Carriers (RHHIs),* use the following statement:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs),* use the following statement:

The Medicare administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Program Integrity Manual
Chapter 10 - Medicare Provider/Supplier Enrollment

Table of Contents
(Rev. 284, 02-20-09)

14.2 – Model Development Letter

(Rev. 284; Issued: 02-20-09; Effective/Implementation Date: 03-20-09)

See section 3.1 of this manual for information on the requirements for the development letter.

CMS alpha representation
Contractor

[Month Day & Year]

[Provider/Supplier Name]
[Address]
[City, State & Zip Code]

[Insert application reference number]

Dear [Insert Provider/Suppler name]:

We have received your Medicare enrollment application*(s)*. In order to complete processing your application*(s)*, we request the following revisions and/or supporting documentation. Consistent with regulations found at 42 CFR 424.525, we may reject *your* application*(s)* if you do not furnish complete information within *30* calendar days of the postmark date of this letter.

Requested Revisions:

(The following are examples)

- [Insert section number and subsection letter (if applicable)]
    - [Insert a brief description of *the* revision*(s)* needed. Try to limit *the description(s)* to two sentences or less. (See examples below.)]

- Section 1A
    - National Provider Identifier

- Section 6 and 16
    - Complete these sections for each Delegated Official

- Section 15
    - Print, sign and date this section to approve the changes requested

- Section 17
    - Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement

- *If a Change of Ownership (CHOW), provide your Medicare Year-End Cost Report date (Month & Day)*

To facilitate the processing of *your* application*(s)*, you should submit the requested revisions and/or supporting documentation within 30 days to the address listed below:

[Insert contact address]

Finally, please attach a copy of this letter with your revised application*(s)*. If you have any questions, please contact our office at [insert phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]
[Title]

[Enclosure]

14.3 – Model Rejection Letter

(Rev. 284; Issued: 02-20-09; Effective/Implementation Date: 03-20-09)

See section 3.1 of this manual *and/or 42 CFR 424.525* for specific reasons when a contractor shall reject the provider or supplier's enrollment application(s). This policy applies to all applications identified in sections 2.1 and 2.2 of this manual.

CMS alpha representation
Contractor

[Month Day & Year]

[Provider/Supplier Name]
[Address]
[City, State & Zip Code]

Dear [Insert Provider/Suppler name]:

We received your Medicare enrollment application(s) on [insert date]. We are rejecting your Medicare enrollment application(s) and returning your application(s) for the following reason(s):

FACTS: [Insert ALL rejection reason(s) and cite the applicable regulatory authority]

(Repeat for multiple, if necessary)

In compliance with Federal regulations found at 42 CFR 424.525, providers and suppliers are required to submit complete *application(s)* and all supporting documentation within *30* calendar days from the postmark date of the contractor request for missing/incomplete information. If you would like to resubmit an application, you must complete a new Medicare enrollment application(s). Please make sure to address the issues stated above as well as sign and date the new certification statement page on your resubmitted application*(s)*.

You should return the complete application(s) to the address listed below:

[Insert contact address]

If you have any questions regarding this letter, please call [phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]
[Title]

14.4 – Model Returned Application Letter

(Rev. 284; Issued: 02-20-09; Effective/Implementation Date: 03-20-09)

See section 3.2 of this manual for information on when a contractor shall return the enrollment application(s) to the provider or supplier. This policy applies to all applications identified in sections 2.1 and 2.2 of this manual.

CMS alpha representation
Contractor

[Month Day & Year]

[Provider/Supplier Name]
[Address]
[City, State & Zip Code]

[Insert application reference number]

Dear [Insert Provider/Suppler name]:

We received your Medicare enrollment application(s) on [insert date]. We are closing this request and returning your application(s) for the following reason(s):

FACTS: [Insert ALL return reason(s) and cite the applicable regulatory authority, if applicable]

In order to resubmit your application*(s)* you must complete *the* [insert application type] application*(s)* with an original signature and date before we can begin processing your application*(s)*. Please make sure to address the issues stated above on your resubmitted application*(s)*.

Physicians and non-physician practitioners can enroll in the Medicare program using either the:

1. Paper application process. To apply by paper, download and complete the Medicare enrollment application(s) from the Centers for Medicare & Medicaid Services (CMS) Web site at www.cms.hhs.gov/MedicareProviderSupEnroll.

2. Internet-based based Provider Enrollment, Chain and Organization System (PECOS). To apply via the Internet-based PECOS, go to http://www.cms.hhs.gov/MedicareProviderSupEnroll.

Organizations that would like to apply should download and complete the paper application(s) [insert application type]. The Medicare enrollment application(s) must be downloaded from the Centers for Medicare & Medicaid Services (CMS) Web site at www.cms.hhs.gov/MedicareProviderSupEnroll.

You should return the complete application(s) to the address listed below:

[Insert contact address]

If you have any questions regarding this letter, please call [insert phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]
[Title]

14.5 – Model Revalidation Letter

(Rev. 284; Issued: 02-20-09; Effective/Implementation Date: 03-20-09)

See section 9 of this manual for information regarding revalidation.

CMS alpha representation
Contractor

[Month Day & Year]

[Provider/Supplier Name]
[Address]
[City, State & Zip Code]

Dear [Insert Provider/Suppler name]:

Consistent with Medicare regulations found at 42 CFR 424.515, [insert contractor name], a Medicare contractor, requires that you complete and submit a Medicare enrollment application(s) and submit all applicable supporting documentation within 60 calendar days of the postmark date of this letter.

Physicians and non-physician practitioners can enroll in the Medicare program using either the:

1. Paper application process. To apply by paper, download and complete the Medicare enrollment application(s) from the Centers for Medicare & Medicaid Services (CMS) Web site at www.cms.hhs.gov/MedicareProviderSupEnroll.

2. Internet-based based Provider Enrollment, Chain and Organization System (PECOS). To apply via the Internet-based PECOS, go to http://www.cms.hhs.gov/MedicareProviderSupEnroll.

Organizations that would like to apply should download and complete the paper application(s). The Medicare enrollment application(s) must be downloaded from the Centers for Medicare & Medicaid Services (CMS) Web site at www.cms.hhs.gov/MedicareProviderSupEnroll.

While the submission of *your Medicare enrollment* application*(s)* will start your 5-year revalidation cycle, you are required by regulations found at 42 CFR 424.*516* to submit updates and changes to your enrollment information in accordance with specified timeframes. Reportable changes include, but are not limited to changes in: (1) legal business name (LBN)/tax identification number (TIN), *(2) practice location, (3) ownership, (4) authorized/delegated officials, (5) changes in payment information such as changes in electronic funds transfer information, and (6) final adverse legal actions, including felony convictions, license suspensions or revocations of a health care license, an exclusion or debarment from participation in Federal or State health care program, or a Medicare revocation by a different Medicare contractor.*

Failure to submit complete *enrollment application(s)* and all supporting documentation within 60 calendar days of the postmark date of this letter may result in your Medicare billing privileges being revoked.

Please return the completed application(s) to:

[Insert application return address]

If you have any questions regarding this letter, please call [insert phone number] between the hours of [insert office hours] or visit our Web site at [insert Web site] for additional information regarding the enrollment process or the [insert application type].

Sincerely,

[Your Name]
[Title]

[Enclosure]

14.7 – Model Approval Letter for Initial Enrollment

(Rev. 284; Issued: 02-20-09; Effective/Implementation Date: 03-20-09)

CMS alpha representation
Contractor

[Month Day & Year]

[Provider/Supplier Name]
[Address]
[City, State & Zip Code]

Dear [Insert Provider/Suppler name]:

We are pleased to inform you that your Medicare enrollment application is approved. Listed below is the information reflected in your Medicare enrollment record, including your National Provider Identifier (NPI) and Provider Transaction Access Number (PTAN).

If you are an existing Medicare provider and currently do not submit claims electronically, or are new to the Medicare program and plan on filing claims electronically, please contact our EDI department at [insert phone number]. To start billing the Medicare program*, y*ou must use your NPI on all Medicare claim submissions. Your PTAN is also activated for use and *will be the required authentication element for all inquiries to customer service representatives (CSRs), written inquiry units and the Interactive Voice Response (IVR) system for inquiries concerning claims status, beneficiary eligibility and to check status or other supplier related transactions, therefore keep your PTAN secure.* Because the PTAN is not considered a Medicare legacy identifier, do <u>not</u> report this identifier to the National Plan and Provider Enumeration System (NPPES) as an “other” provider identification number.

Medicare Enrollment Information

Provider\supplier name:	[Insert name]
Practice location:	[Insert *address*]
National Provider Identifier (NPI):	[Insert NPI]
Provider Transaction Access Number (PTAN):	[Insert PTAN]
Specialty:	[Insert *provider/supplier* specialty]
You are a:	[Insert *participating or non-participating*]
Effective date [Insert "of termination" if the applicant is voluntarily terminating Medicare participation]	[Insert effective date or effective date of termination]

(Repeat for multiple, if necessary, for each additional location and NPI/PTAN combination)

Please verify the accuracy of your enrollment information. If you disagree with any portion of this initial determination or have any questions, please call your Medicare Fee-For-Service contractor at [insert phone number] between the hours of [insert office hours].

You are required by regulations found at 42 CFR 424.*516* to submit updates and changes to your enrollment information in accordance with specified timeframes. Reportable changes include, but are not limited to changes in: (1) legal business name (LBN)/tax identification number (TIN), *(2) practice location, (3) ownership, (4) authorized/delegated officials, (5) changes in payment information such as changes in electronic funds transfer information, and (6) final adverse legal actions, including felony convictions, license suspensions or revocations of a health care license, an exclusion or debarment from participation in Federal or State health care program, or a Medicare revocation by a different Medicare contractor.*

Additional information about the Medicare program, including billing, fee schedules, and Medicare polices and regulations can be found at our Web site at [insert Web site address] or the Centers for Medicare & Medicaid Services' (CMS) Web site at www.cms.hhs.gov/home/medicare.asp.

Sincerely,

[Your Name]
[Title]

14.8 – Model Approval Letter for Change of Information

(Rev. 284; Issued: 02-20-09; Effective/Implementation Date: 03-20-09)

CMS alpha representation
Contractor

[Month Day & Year]

[Provider/Supplier Name]
[Address]
[City, State & Zip Code]

Dear [Insert Provider/Suppler name]:

We have approved your information change request. Listed below is the [insert "new" or "updated"] information reflected in your Medicare enrollment record.

Medicare Enrollment Information

Provider\supplier name:	[Insert name]
[Insert revised item on the application]:	[Insert updated or changed item on the application]
National Provider Identifier (NPI):	[Insert NPI]
Provider Transaction Access Number (PTAN):	[Insert active or inactive PTAN]
Specialty:	[Insert provider/supplier specialty]
You are a:	[Insert participating or non-participating]
Effective date [Insert "of termination" if the applicant is voluntarily terminating Medicare participation]	[Insert effective date or effective date of termination*]*
If a Change of Ownership (CHOW, insert Medicare Year-End Cost Report date:	*[Insert Month and Day]*

(Repeat for multiple, if necessary, for each additional location and NPI/PTAN combination)

Please verify the accuracy of your enrollment information. If you disagree with any portion of this initial determination or have any questions, please call your Medicare Fee-For-Service contractor at [insert phone number] between the hours of [insert office hours].

ADDITIONAL INFORMATION

If you are an existing Medicare provider and currently *do not* submit claims electronically, or are new to the Medicare program and plan on filing claims electronically, please contact our EDI department at [insert phone number]. *To start billing the Medicare program, you must use your NPI on all Medicare claims submissions. Your* PTAN will be the required authentication element for all inquiries *to customer service representatives (CSRs), written inquiry units and the Interactive Voice Response (IVR) system for inquiries concerning claims status, beneficiary eligibility and to check status or other supplier related transactions, therefore keep your PTAN secure*.

To maintain an active enrollment status in the Medicare Program, regulations found at 42 CFR 424.*516* require that you submit updates and changes to your enrollment information in accordance with specified timeframes. Reportable changes include, but are not limited to changes in: (1) legal business name (LBN)/tax identification number (TIN), *(2) practice location, (3) ownership, (4) authorized/delegated officials, (5) changes in payment information such as changes in electronic funds transfer information, and (6) final adverse legal actions, including felony convictions, license suspensions or revocations of a health care license, an exclusion or debarment from participation in Federal or State health care program, or a Medicare revocation by a different Medicare contractor.*

Sincerely,

[Your Name]
[Title]

14.9 – Model Revalidation Approval Letter

(Rev. 284; Issued: 02-20-09; Effective/Implementation Date: 03-20-09)

CMS alpha representation
Contractor

[Month Day & Year]

[Provider/Supplier Name]
[Address]
[City, State & Zip Code]

Dear [Insert Provider/Suppler name]:

We have processed your Medicare enrollment application*(s)* to revalidate your Medicare enrollment information.

Listed below is the information reflected in your Medicare enrollment record.

Medicare Enrollment Information:

Provider Name:	[Insert name]
Practice Location:	[Insert address]
National Provider Identifier (NPI):	[Insert NPI]
Provider Transaction Access Number (PTAN):	[Insert PTAN]
You are a:	[Insert participating or non-participating]
Effective Date:	[Insert month day, year]
If a Change of Ownership (CHOW), insert Medicare Year-End Cost Report date:	*[Insert Month and Day]*

(Repeat for multiple, if necessary, for each additional location and NPI/PTAN combination)

Please verify the accuracy of your enrollment information, if additional changes are necessary or if you have any questions, feel free to contact our office at [insert phone number] between the hours of [insert office hours].

To maintain an active enrollment status in the Medicare Program, regulations found at 42 CFR 424.516 require that you submit updates and changes to your enrollment information in accordance with specified timeframes. Reportable changes include, but are not limited to changes in: (1) legal business name (LBN)/tax identification number (TIN), (2) practice location, (3) ownership, (4) authorized/delegated officials, (5) changes in payment information such as changes in electronic funds transfer information, and (6) final adverse legal actions, including felony convictions, license suspensions or revocations of a health care license, an exclusion or debarment from participation in Federal or State health care program, or a Medicare revocation by a different Medicare contractor.

Sincerely,

[Your Name]
[Title]

14.10 – Model Denial Letter for *Certified Providers & Suppliers: Denial Based on a Condition of Participation*

(Rev. 284; Issued: 02-20-09; Effective/Implementation Date: 03-20-09)

See section 6.2, of this manual and/or 42 CFR 424.530 *to view circumstances that warrant a fee-for-service contractor to deny a provider or supplier's enrollment in the Medicare program. If the provider or supplier is denied based on a condition of participation, then the applicant or enrolled entity must submit a reconsideration or a corrective action plan to the applicable regional office.*

CMS alpha representation
Contractor

[Month Day & Year]

[Provider/Supplier Name]
[Address]
[City, State & Zip Code]

RE: Notice of Denial

Dear [Insert Provider/Suppler name]:

We have received your request to enroll in the Medicare program. However, your application request to receive Medicare payment is denied. After reviewing the submitted Medicare enrollment application*(s)*, it was determined that you do not meet the conditions of enrollment or meet the requirement to qualify as a [insert provider or supplier type e.g., *hospital, skilled nursing facility, hospice*, etc.]

FACTS: [Insert ALL the reason(s) for denial and cite the applicable regulatory authority]

(Repeat for multiple, if necessary)

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. CAP requests should be sent to:

[Insert *applicable regional office* address]

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person who was not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The request for reconsideration must state the issues, or the findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration request that you believe may have a bearing on the decision. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review. [The following statement should only be

used if the denial involves exclusions or sanction: You may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action]. The request for reconsideration should be sent to:

[Insert *applicable regional office* address]

If you have any questions regarding this letter, please call [phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]
[Title]

14.11 – Model Denial Letter for *Certified Providers & Suppliers: Denial Based on an Enrollment Reason(s)*

(Rev. 284; Issued: 02-20-09; Effective/Implementation Date: 03-20-09)

See section *6.2* of this manual and/or 42 CFR *424.530 to view circumstances that warrant a fee-for-service contractor to deny a provider or supplier's enrollment in the Medicare program. If the provider or supplier is denied based on an enrollment reason(s), then the applicant or enrolled entity must file a reconsideration with CMS.*

CMS alpha representation
Contractor

[Month Day & Year]

[Provider/Supplier Name]
[Address]
[City, State & Zip Code]

RE: Notice of Denial

Dear [Insert Provider/Suppler Name]:

We have received your request to enroll in the Medicare program. *However, your application request to receive Medicare payment is denied. After reviewing the submitted Medicare enrollment application(s), it was determined that you do not meet the conditions of enrollment or meet the requirement to qualify as a [insert provider or supplier type e.g., hospital, skilled nursing facility, hospice].*

FACTS: [Insert ALL *the reason(s) for denial and cite the applicable regulatory authority]*

(Repeat for multiple, if necessary)

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. CAP requests should be sent to:

Centers for Medicare & Medicaid Services
Division of Provider & Supplier Enrollment
7500 Security Blvd.
Mailstop: C3-02-16
Baltimore, MD 21244-1850

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person who was not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The request for reconsideration must state the issues, or the findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration request that you believe may have a bearing on the decision. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review. [The following statement should only be used if the denial involves exclusions or sanction: You may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action]. The request for reconsideration should be sent to:

Centers for Medicare & Medicaid Services
Division of Provider & Supplier Enrollment
7500 Security Blvd.
Mailstop: C3-02-16
Baltimore, MD 21244-1850

If you have any questions regarding this letter, please call [phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]
[Title]

14.12 – Model *Denial Letter for Suppliers, Non-IDTF, Furnishing Part B Services*

(Rev. 284; Issued: 02-20-09; Effective/Implementation Date: 03-20-09)

See section *6.2* of this manual *and/or 42 CFR 424.530* to view circumstances that warrant a fee-for-service contractor to *deny* a provider or supplier's enrollment in the Medicare program.

CMS alpha representation
Contractor

[Month Day & Year]

[Provider/Supplier Name]
[Address]
[City, State & Zip Code]

RE: [insert decision]

Dear [Insert Provider/Suppler name]:

We have received your request to enroll in the Medicare program. However, your application request to receive Medicare payment is denied. After reviewing the submitted Medicare enrollment application(s), it was determined that you do not meet the conditions of enrollment or meet the requirement to qualify as a [insert provider or supplier type e.g., doctor of medicine, physicians assistant, nurse practitioner].

FACTS: [Insert ALL the reason(s) for *denial* and cite the applicable regulatory authority]

(Repeat for multiple, if necessary)

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. CAP requests should be sent to:

[Insert contact address]

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person who was not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The request for reconsideration must state the issues, or the findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration request that you believe may have

a bearing on the decision. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review. [The following statement should only be used if the denial involves exclusions or sanction: You may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action]. The request for reconsideration should be sent to:

[Insert contact address]

If you have any questions regarding this letter, please call [phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]
[Title]

14.13 – Model *Denial Letter for IDTFs*

(Rev. 284; Issued: 02-20-09; Effective/Implementation Date: 03-20-09)

See section 4.19 of this manual and/or 42 CFR 410.33 for the IDTF performance standards and requirements.

CMS alpha representation
Contractor

[Month Day & Year]

[Provider/Supplier Name]
[Address]
[City, State & Zip Code]

Re: [Subject]

Dear [Insert Provider/Suppler Name]:

We have received your request to enroll in the Medicare program. After reviewing the submitted Medicare enrollment application*(s),* it was determined that you do not meet the conditions of enrollment or meet the requirements to qualify as an Independent Diagnostic Testing Facility (IDTF). Accordingly, your application(s) to enroll in the Medicare program is denied.

In order to obtain Medicare billing privileges, an IDTF must meet all of the performance standards found at 42 CFR 410.33. *[Insert Provider Name]* failed to meet the following standards:

STANDARDS: [Insert ALL performance standards not met].

FACTS: [*Insert* ALL *the reason(s) for denial and cite the* applicable regulatory authority that corresponds to the performance standards not met e.g., 42 CFR 410.33(c), 42 CFR 410.33(g)(4)(i) and 42 CFR 410.33(g)(5)(ii)].

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. CAP requests should be sent to:

[Contractor Address]

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person who was not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The request for reconsideration must state the issues, or the findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration request that you believe may have a bearing on the decision. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review. [The following statement should only be used if the denial involves exclusions or sanction: You may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.] The request for reconsideration should be sent to:

[Contractor Address]

If you have any questions regarding this letter, please call [phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]
[Title]

14.14 – Model *Revocation Letter for Certified Providers & Suppliers: Revocation Based on a Condition of Participation*

(Rev. 284; Issued: 02-20-09; Effective/Implementation Date: 03-20-09)

See section 13 of this manual and/or 42 CFR 424.535 to view the circumstances that warrant a fee-for-service contractor to revoke a provider or supplier's Medicare billing privileges. If the provider or supplier is revoked based on a condition of participation, then the applicant or enrolled entity must submit a reconsideration or corrective action plan to the applicable regional office.

CMS alpha representation
Contractor

[Month Day & Year]

[Provider/Supplier Name]
[Address]
[City, State & Zip Code]

RE: Notice of Revocation of Medicare Billing Privileges

Dear [Insert Provider/Suppler name]:

This is to inform you that your Medicare privileges are being revoked effective [insert effective date of revocation]. Pursuant to 42 CFR 424.545(a), this action will also terminate your corresponding provider agreement.

FACTS: [Insert ALL reason(s) for revocation and cite the applicable regulatory authority]

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. CAP requests should be sent to:

[Insert applicable regional office address]

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person who was not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The request for reconsideration must state the issues, or the findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration request that you believe may have a bearing on the decision. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review. [The following statement should only be used if the denial involves exclusions or sanction: You may not appeal through

this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.] The request for reconsideration should be sent to:

[Insert applicable regional office address]

Pursuant to 42 CFR 424.535(c), [insert contractor name] is establishing a re-enrollment bar for a period of [insert amount of time]. This enrollment bar only applies to your participation in the Medicare program. In order to re-enroll, you must meet all requirements for your provider or supplier type.

If you have any questions regarding this determination, please contact [insert contact name] at [insert phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]
[Title]

Enclosure [Attach a copy of the development letter if applicable]

14.15 – Model Revocation Letter for Certified Providers & Suppliers: Revocation Based on an Enrollment Reason(s)

(Rev. 284; Issued: 02-20-09; Effective/Implementation Date: 03-20-09)

See section 13 of this manual and/or 42 CFR 424.535 to view the circumstances that warrant a fee-for-service contractor to revoke a provider or supplier's Medicare billing privileges. If the provider or supplier is revoked based on an enrollment reason(s), then the applicant or enrolled entity must file a reconsideration with CMS.

CMS alpha representation
Contractor

[Month Day & Year]

[Provider/Supplier Name]
[Address]
[City, State & Zip Code]

RE: Notice of Revocation of Medicare Billing Privileges

Dear [Insert Provider/Suppler name]:

This is to inform you that your Medicare billing privileges are being revoked effective [insert effective date of revocation]. Pursuant to 42 CFR 424.545(a), this action will also terminate your corresponding provider agreement.

FACTS: [Insert ALL the reason(s) for revocation and cite the applicable regulatory authority]

(Repeat for multiple, if necessary)

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. CAP requests should be sent to:

Centers for Medicare & Medicaid Services
Division of Provider & Supplier Enrollment
7500 Security Blvd.
Mailstop: C3-02-16
Baltimore, MD 21244-1850

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person who was not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The request for reconsideration must state the issues, or the findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration request that you believe may have a bearing on the decision. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review. [The following statement should only be used if the denial involves exclusions or sanction: You may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action]. The request for reconsideration should be sent to:

Centers for Medicare & Medicaid Services
Division of Provider & Supplier Enrollment
7500 Security Blvd.
Mailstop: C3-02-16
Baltimore, MD 21244-1850

Pursuant to 42 CFR 424.535(c), [insert contractor name] is establishing a re-enrollment bar for a period of [insert amount of time]. This enrollment bar only applies to your participation in the Medicare program. In order to re-enroll, you must meet all requirements for your provider or supplier type.

If you have any questions regarding this letter, please call [phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]
[Title]

14.16 – Model Revocation Letter for Suppliers Furnishing Part B Services
(Rev. 284; Issued: 02-20-09; Effective/Implementation Date: 03-20-09)

See section 13 of this manual and/or 42 CFR 424.535 to view the circumstances that warrant a fee-for-service contractor to revoke a provider or supplier's Medicare billing privileges.

CMS alpha representation
Contractor

[Month Day & Year]

[Provider/Supplier Name]
[Address]
[City, State & Zip Code]

RE: Notice of Revocation of Medicare Billing Privileges

Dear [Insert Provider/Suppler name]:

This is to inform you that your Medicare billing privileges are being revoked effective [insert effective date of revocation]. Note: The revocation date in this letter must comport to the provisions found in 42 CFR 424.535(g).

FACTS: [Insert ALL reason(s) for revocation and cite the applicable regulatory authority]

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. CAP requests should be sent to:

[Insert contract address]

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person who was not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The request for reconsideration must state the issues, or the findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration request that you believe may have a bearing on the decision. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review. [The following statement should only be used if the denial involves exclusions or sanction: You may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.] The request for reconsideration should be sent to:

[Insert contact address]

Pursuant to 42 CFR 424.535(c), [insert contractor name] is establishing a re-enrollment bar for a period of [insert amount of time]. This enrollment bar only applies to your participation in the Medicare program. In order to re-enroll, you must meet all requirements for your provider or supplier type.

[The following statement should only be used if a contractor determines that a Final Adverse Action occurred: Finally, in accordance with 42 CFR 424.565, [insert name of contractor] is assessing an overpayment in the amount of [insert dollar amount] because the physician or non-physician practitioner continued to furnish services to Medicare beneficiaries after a final adverse action precluded enrollment in the Medicare program.] [Note: As stated in 42 CFR 424.565, Medicare contractors should assess an overpayment back to January 1, 2009, not the date of the final adverse action if the adverse action occurred prior to January 1, 2009.]

If you have any questions regarding this determination, please contact [insert contact name] at [insert phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]
[Title]

14.17 – Model Revocation Letter for OIG Sanctioned Providers/Suppliers
(Rev. 284; Issued: 02-20-09; Effective/Implementation Date: 03-20-09)

[Month Day & Year]

[Provider/Supplier Name]
[Address]
[City, State & Zip Code]

RE: Notice of Revocation of Medicare Billing Privileges

Dear [Insert Provider/Supplier name]:

This is to inform you that your Medicare billing privileges are being revoked effective [insert date of OIG debarment or exclusion].

FACTS: The Department of Health and Human Services, Office of Inspector General notified us that you are excluded from the Medicare, Medicaid, or any other Federal health care program as defined in 42 CFR 1001.2; in accordance with section 1128, 1128A, 1156, 1842, 1862, 1867 or 1892 of the Social Security Act. You are excluded as of [insert effective date of exclusion] for [Cite the regulatory basis for exclusion. For example: 1128(b)(14)-Default on health education loan and scholarship obligations].

If you believe that this determination is not correct, you may request an appeal with the Department of Health and Human Services, Office of Inspector General the Federal agency that took the action.

Finally, in accordance with 42 CFR 424.565, [insert name of contractor] is assessing an overpayment in the amount of [insert dollar amount] because the physician or non-physician practitioner continued to furnish services to Medicare beneficiaries after a final adverse action precluded enrollment in the Medicare program.] [Note: As stated in 42 CFR 424.565, Medicare contractors should assess an overpayment back to January 1, 2009, not the date of the final adverse action if the adverse action occurred prior to January 1, 2009.]

If you have any questions regarding this letter, please call [insert phone number] between the hours of [insert office hours]

Sincerely,

[Your name]
[Title]

14.18 – Model Revocation Letter for National Supplier Clearinghouse (NSC)

(Rev. 284; Issued: 02-20-09; Effective/Implementation Date: 03-20-09)

CMS alpha representation
Contractor

[Month Day & Year]

[Supplier Name]
[Address]
[City, State & Zip Code]

RE: Notice of Revocation of Medicare Billing Privileges

Dear [Insert Supplier Name]:

This is to inform you that your Medicare billing privileges are being revoked effective [insert date 30 days from the date of the letter], 30 days from the postmark date of this letter.

The durable medical equipment medicare administrative contractors (DME MACs) use these numbers to identify suppliers. This revocation has the concurrence of the Centers for Medicare & Medicaid Services (CMS). In addition, pursuant to 42 CFR 424.535(c), [insert contractor name] is establishing a re-enrollment bar for a period of [insert amount of time] year(s) from the effective date of the revocation. This enrollment bar only applies to your participation in the Medicare program. In order to re-enroll, you must meet all requirements for your supplier type.

[This next paragraph will be included if a response to the development request was received in the field below, remember the date needs to be written out.]
The Supplier Audit and Compliance Unit (SACU) reviewed and evaluated the documents you submitted in response to the developmental letter dated [insert date]. This developmental letter afforded you the opportunity to demonstrate your full compliance with the durable medical equipment, prosthetics & orthotics standards (DMEPOS) supplier standards and/or to correct the deficient compliance requirement(s). However, after review of the information, it has been determined that you have not demonstrated compliance with the supplier standards noted below:

STANDARDS: [Insert ALL performance standard(s) not met and cite the applicable regulatory authority that corresponds to the performance standard(s) not met e.g., 42 CFR 410.33(c), 42 CFR 410.33(g)(4)(i) and 42 CFR 410.33(g)(5)(ii)].

[The next paragraph will be included if a response to the development request was not received.]

The Supplier Audit and Compliance Unit (SACU) has not received a response to the developmental letter sent to you on [insert date]. This request afforded you the opportunity to demonstrate your full compliance with the durable medical equipment, prosthetics & orthotics standards (DMEPOS) supplier standards and/or to correct the deficient compliance requirement(s). Therefore, we have determined that you are not in compliance with the supplier standards noted below:

STANDARDS: [Insert ALL performance standard(s) not met and cite the applicable regulatory authority that corresponds to the performance standard(s) not met e.g., 42 CFR 410.33(c), 42 CFR 410.33(g)(4)(i) and 42 CFR 410.33(g)(5)(ii)].

For Example: Supplier standard number one states that a supplier "Operates its business and furnishes Medicare-covered items in compliance with all applicable Federal and State licensure and regulatory requirements." Explanation of specific deficiency goes here [regulatory cite to applicable standard(s) for revocation]

Section 1834 (j) of the Social Security Act states that, with the exception of medical equipment and supplies furnished incident to a physician's service, no payment may be made by Medicare for items furnished by a supplier unless the supplier has a valid Medicare billing number. Therefore, any expenses for items you supply to a Medicare beneficiary on or after the effective date of the revocation of your billing numbers are your responsibility and not the beneficiary's, unless you have proof that you have notified the beneficiary in accordance with section 1834 (a) (18) (ii) of the Social Security Act, and the beneficiary has agreed to take financial responsibility if the items you supply are not covered by Medicare. You will be required to refund on a timely basis to the beneficiary (and will be liable to the beneficiary for) any amounts collected from the beneficiary for such items. If you fail to refund the beneficiary as required under 1834 (j) (4) and 1879 (h) of the Social Security Act, you may be liable for Civil Monetary penalties.

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. The National Supplier Clearinghouse (NSC), with Centers for Medicare & Medicaid Services (CMS) approval, may reinstate your supplier number after it reviews your CAP and any additional evidence you submit and determines you are now in compliance with all supplier standards [see 42 C.F.R. 424.57(c)]. CAP requests should be sent to:

[Insert contract address]

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person who was not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The request for reconsideration must state the issues, or the findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration request that you believe may have a bearing on the decision. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review. The request must be made in writing and signed by an authorized official, owner or partner of the business. [The following statement should only be used if the denial involves exclusions or sanction: You may not appeal through this process the merits of any exclusion by another Federal agency. Any

further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.] The request for reconsideration should be sent to:

[Insert contact address]

If you choose not to request a reconsideration of this decision, or you do not receive a favorable decision through the administrative review process, you must wait [insert number of year(s)] before resubmitting your CMS-855S application, per the re-enrollment bar cited above. Applications received in the NSC prior to this timeframe will be returned.

If you have any questions regarding this determination, please contact [insert contact name] at [insert phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]
[Title]

14.19 – Model Reconsideration Letter

(Rev. 284; Issued: 02-20-09; Effective/Implementation Date: 03-20-09)

See section 19 of this manual for information on the appeals process.

CMS alpha representation
Contractor

[Month Day & Year]

[Provider/Supplier Name]
[Address]
[City, State & Zip Code]

[Reference number]

Dear [Insert Provider/Suppler name]:

This decision letter is in response to your reconsideration request received by [insert contractor name]. The reconsideration request is based on the above referenced provider or suppliers [revocation or denial]. The initial determination letter was dated [insert date of initial determination letter] and thus, this appeal is timely submitted. This letter contains the decision.

The decision is based on Social Security Act, Medicare regulations and/or CMS manual instructions. This decision is based on the evidence in the file, and any information that you may have sent with or since the time of your hearing request.

FACTS: [Insert Regulation]

RATIONALE: [Insert denial/revocation rationale based on the regulation]

(Repeat for multiple, if necessary)

SUMMARY OF SUBMITTED DOCUMENTATION: [Insert all documentation/supporting information submitted]

EVALUATION OF SUBMITTED DOCUMENTATION: [Insert evaluation of documentation/supporting information submitted]

DECISION: All of the documentation in the file for this case has been reviewed and the decision has been made in accordance with Medicare guidelines as outlined in [insert regulation]. Specifically, [name of provider/supplier] [has or has not] provided evidence to show you have fully complied with the standards for which you were [revoked or denied]. Therefore, we [grant or cannot grant] you access to the Medicare Trust Fund (by way or issuance) of a Medicare number.

This decision is [a FAVORABLE DECISION (or) an UNFAVORABLE DECISION]. Please see below for additional appeal rights.

FURTHER APPEAL RIGHTS: ADMINISTRATIVE LAW JUDGE (ALJ)

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request a final ALJ review, you must act quickly and you must meet the requirements for requesting a final ALJ review. You must file your appeal within 60 calendar days after the date of receipt of this decision by writing to the following address:

Department of Health and Human Services
Departmental Appeals Board
Civil Remedies Division, Mail Stop 6132
330 Independence Avenue, S.W.
Cohen Building, Room G-644
Washington, D.C. 20201
Attn: CMS Enrollment Appeal

Appeal rights can be found at 42 CFR 498. The regulation explains the appeal rights following the determination by the Centers for Medicare & Medicaid Services as to whether such entities [meet and/or continue to meet] the requirements for enrollment in the Medicare program.

If you have any questions regarding this decision, please call [insert phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]
[Title]

14.20 – Model Identity Theft Prevention Letter
(Rev. 284; Issued: 02-20-09; Effective/Implementation Date: 03-20-09)

CMS alpha representation
Contractor

[Month Day & Year]

[Provider/Supplier or Contact Name]
[Address]
[City, State & Zip Code]

Dear [Insert Provider/Suppler or Contact name]:

As a security precaution, we are writing to confirm that you submitted a Medicare enrollment application(s) to enroll or change an existing enrollment at the following address:

[Insert Provider/Supplier Address]

If this application was submitted without your authorization, please call the Medicare contractor that processes your claims. The Medicare Fee-For-Service contact information can be found at www.cms.hhs.gov/MedicareProviderSupEnroll.

If this is a legitimate application(s) then no action is needed at this time. We will process your application(s) according to The Centers for Medicare & Medicaid (CMS) timeliness standards and will contact you if there is a need for additional information. We will notify you once processing is complete.

Please contact our office with any questions at [insert phone number] between the hours of [insert office hours] and refer to your application(s) reference number [insert reference number].

Sincerely,

[Your Name]
[Title]