

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 247	Date: MARCH 21, 2008
	Change Request 5832

SUBJECT: Model Letters for Provider Enrollment

I. SUMMARY OF CHANGES: Contractors shall use the model letters attached when corresponding with providers and suppliers on Medicare enrollment issues.

NEW/REVISED MATERIAL

EFFECTIVE DATE: APRIL 1, 2008

IMPLEMENTATION DATE: APRIL 7, 2008

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
N/A	

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:

One-Time Notification

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

Attachment - One-Time Notification

Pub. 100-08	Transmittal: 247	Date: March 21, 2008	Change Request: 5832
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SUBJECT: Provider Enrollment Model Letter

Effective Date: April 1, 2008

Implementation Date: April 7, 2008

I. GENERAL INFORMATION

A. Background: To ensure consistency, CMS is establishing model letters for use by Medicare contractors when issuing a determination letter or request for information for Medicare enrollment issues.

B. Policy: Contractors shall use the model letters attached when corresponding with providers and suppliers on Medicare enrollment issues. The model letters language can be altered if needed.

The Program Integrity Manual, Pub. 100-08, chapter 10, shall be updated with the model letters in a future manual revision.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
5832.1	Contractors shall implement the model letter attachments when corresponding with providers and suppliers during the Medicare enrollment process.	X		X	X	X					
5832.2	Contractors may alter the language as necessary or as appropriate.	X		X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	None.										

IV. SUPPORTING INFORMATION

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:

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

V. CONTACTS

Pre-Implementation Contact(s): Sandra Olson Sandra.olson@cms.hhs.gov (410) 786-1325

Post-Implementation Contact(s): Sandra Olson Sandra.olson@cms.hhs.gov (410) 786-1325

VI. FUNDING

A. For *Fiscal Intermediaries and Carriers*, use only one of the following statements:

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

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

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). 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.

Attachment

Model Acknowledgement Letter

CMS alpha representation
Contractor

[Month Day & Year]

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

Dear [Insert Provider/Supplier name]:

Your Medicare enrollment application [insert application type] was received on [date] and is/are currently being reviewed. You will receive a letter within 30 calendar days if we need any additional information.

[Insert this language if a reference number is provided: Your application reference number is: **(insert reference number)**]

Please retain this letter [insert this language if a reference number is provided: **(insert reference number)**] in the event that you must submit additional information in support of your application. If you have any questions, please contact our office at [insert phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]
[Title]

Model Development Letter

CMS alpha representation
Contractor

[Month Day & Year]

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

[Insert application reference number]

Dear [Insert Provider/Supplier name]:

We have received your Medicare enrollment application [insert application type]. In order to complete processing your application we are requesting the following revisions and or supporting documentation. Consistent with regulations found at 42 CFR §424.525, we may reject this application if you do not furnish complete information within 60 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 revision needed. Try to limit descriptions to two sentences or less. (See examples below.)]
- Section 1A
 - National Provider Identifier (NPI)
- Section 6 and 16
 - Complete these sections for each Delegated Official
- Section 15
 - Print, sign, and date this section to approve the changes requested

Medicare enrollment application(s) [insert application type] 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]

Finally, please attach a copy of this letter with your revised application. 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]

Model Rejection Letter

CMS alpha representation
Contractor

[Month Day & Year]

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

Dear [Insert Provider/Supplier name]:

We received your Medicare enrollment application(s) [insert application type] 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 and all supporting documentation within 60 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) [insert application type(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.

Medicare enrollment application(s) [insert application type] 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 [phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]
[Title]

Model Returned Application Letter

CMS alpha representation
Contractor

[Month Day & Year]

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

[Insert application reference number]

Dear [Insert Provider/Supplier name]:

We received your Medicare enrollment application(s) [insert application type] 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 you must complete a [insert application type] application with an original signature and date before we can begin processing your application. Please make sure to address the issues stated above on your resubmitted application.

Medicare enrollment application(s) [insert application type] 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]

Model Revalidation Letter

CMS alpha representation
Contractor

[Month Day & Year]

[Provider/Supplier Name]

[Address]

[City, State & Zip Code]

Dear [Insert Provider/Supplier name]:

Consistent with Medicare regulations found at 42 CFR §424.515, [insert contractor name], a Medicare contractor, requires that you submit a Medicare enrollment application [insert application type] and all applicable supporting documentation, including the National Provider Identifier (NPI) and the Authorization Agreement Electronic Funds Transfer (CMS-588) within 60 calendar days of the postmark date of this letter.

Enclosed is the appropriate [insert application type] enrollment application for your provider or supplier type. Additional copies of the Medicare enrollment application(s) [insert application type] must be downloaded from the Centers for Medicare & Medicaid Services (CMS) Web site at www.cms.hhs.gov/MedicareProviderSupEnroll.

While the submission of this application will start your 5-year revalidation cycle, you are required by regulations found at 42 CFR §424.520 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) doing business as (DBA) name, (3) practice location, (4) ownership, (5) authorized/delegated officials and (6) changes in payment information such as changes in electronic funds transfer information. In addition, you are required to report any adverse legal actions, including felony convictions, license suspensions and debarments and exclusions.

Failure to submit a complete [insert application type] 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]

Model Approval Recommended Letter for Part A Providers & Certified Suppliers

CMS alpha representation
Contractor

[Month Day & Year]

[Provider/Supplier Name]

[Address]

[City, State & Zip Code]

Dear [Insert Provider/Supplier name]:

[Name of contractor] has processed your Medicare enrollment application [insert application type] to enroll in the Medicare Program and forwarded a recommendation to the regional office. The next step of the enrollment process involves a site visit or survey conducted by the State Survey agency or an accrediting organization to ensure compliance with the conditions of participation for your provider or supplier type.

If you have any questions concerning this letter, please contact the State or regional office at [insert phone number(s)].

Sincerely,

[Your Name]

[Title]

Enclosure

cc:

Model Approval Letter for Initial Enrollment

CMS alpha representation
Contractor

[Month Day & Year]

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

Dear [Insert Provider/Supplier name]:

We are pleased to inform you that your Medicare enrollment application [insert application type] 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).

Your NPI is now approved to bill the Medicare program. You must use your NPI on all Medicare claim submissions. Your PTAN is also activated for use and is required to access the interactive voice response (IVR) system for inquires concerning claims status, beneficiary eligibility, check status or other supplier related transactions.

Medicare Enrollment Information

Provider\Supplier name:	[Insert name]
Practice location:	[Insert practice location]
National Provider Identifier (NPI):	[Insert NPI]
Provider Transaction Access Number (PTAN):	[Insert PTAN]
Specialty:	[Insert specialty]
You are a:	[Insert participation status]
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)

Finally, you are required by regulations found at 42 CFR §424.520 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) doing business as (DBA) name, (3) practice location, (4) ownership, (5) authorized/delegated officials and (6) changes in payment information such as changes in electronic funds transfer information. In addition, you are required to report any adverse legal actions, including felony convictions, license suspensions and debarments and exclusions.

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. Please verify the accuracy of your enrollment information, if changes are necessary or if you have any questions, please call [insert phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]

[Title]

Model Approval Letter for Change of Information

CMS alpha representation
Contractor

[Month Day & Year]

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

Dear [Insert Provider/Supplier 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 issued NPI]
[Insert active or terminated here]	[Insert active or inactive PTAN]
Provider Transaction Access Number (PTAN):	
Specialty:	[Insert provider/supplier specialty]
You are a:	[Insert participating or nonparticipating]
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)

ADDITIONAL INFORMATION

The provider/supplier’s PTAN will be the required authentication element for all inquiries to Interactive Voice Response (IVR) systems, customer service representatives (CSRs), and written inquiry units, therefore keep your PTAN secure.

If you are an existing Medicare provider and currently 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 maintain an active enrollment status in the Medicare program, regulations found at 42 CFR §424.33 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) doing business as (DBA) name, (3) practice location, (4) ownership, (5) authorized/delegated officials and (6) changes in payment information such as changes in electronic funds transfer information. In addition, you are required to report any adverse legal actions, including felony convictions, license suspensions and debarments and exclusions.

As a Medicare health provider or supplier, you must also obtain or update your National Provider Identifier (NPI) maintained with the National Plan and Provider Enumeration System (NPPES). To make changes to an NPI, please contact the NPI Enumerator at <https://NPPES.cms.hhs.gov> or call the Enumerator at 1-800-465-3203 or TTY 1-800-692-2326. For more information about NPI enumeration, visit www.cms.hhs.gov/NationalProvIdentStand.

Please verify the accuracy of your enrollment information, if additional changes are necessary or if you have any questions, please call [insert phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]

[Title]

Model Revalidation Approval Letter

CMS alpha representation
Contractor

[Month Day & Year]

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

Dear [Insert Provider/Supplier name]:

We have processed your Medicare enrollment application [insert application type] 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]

(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].

Sincerely,

[Your Name]
[Title]

Model Decision Letter for Part B, Non-IDTF

CMS alpha representation
Contractor

[Month Day & Year]

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

RE: [insert decision]

Dear [Insert Provider/Supplier name]:

We have received your request to enroll in the Medicare program. However, your application request to receive Medicare payment is [insert decision: **approved** or **denied**]. After reviewing the submitted Medicare enrollment application [insert application type], 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, etc.]

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

(Repeat for multiple, if necessary)

You may take steps to correct the deficiencies and reapply to establish your eligibility by submitting 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 request 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 would 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. The reconsideration should be sent to:

[Insert contact address]

You may submit additional information with the reconsideration request that you believe may have a bearing on the decision. Failure to request a reconsideration within the specified period 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.

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

Sincerely,

[Your Name]

[Title]

Model Denial Letter for IDTFs

CMS alpha representation
Contractor

[Month Day & Year]

[Provider/Supplier Name]

[Address]

[City, State & Zip Code]

Re: [Subject]

Dear [Insert Provider/Supplier Name]:

We have received your request to enroll in the Medicare program. After reviewing the submitted Medicare enrollment application [insert application type], 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 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 reason(s) for denial]. [Provider Name] failed to meet the following standards:

STANDARDS: [List ALL performance standards not met].

FACTS: [List ALL applicable regulatory authority that corresponds to the performance standards not met. For example, 42 CFR §410.33(c), 42 CFR §410.33(g)(4)(i) and 42 CFR §410.33(g)(5)(ii)].

You may take steps to correct the deficiencies by submitting 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 Medicare contractor reconsideration. The reconsideration is an independent review, and will be conducted by a person who was not involved in the initial determination. Reconsiderations are conducted on-the-record by an independent reviewer. Therefore, you should submit with the reconsideration request, any and all supporting documentation that you believe may have a bearing on the decision. You must request the reconsideration, in writing, to the address above within 60 calendar days from the postmark date of this letter. The request must be signed by an authorized official. The request for a reconsideration must 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]

Model Revocation Letter

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/Supplier name]:

This is to inform you that your Medicare Provider Transaction Access Number (PTAN) [insert PTAN] that is associated to the National Provider Identifier (NPI) [insert NPI] is being revoked effective [insert date 30 days from date of letter].

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

You may take steps to correct the deficiencies by submitting 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 this determination is not correct, you may request a reconsideration. The reconsideration must be filed in writing within 60 calendar days of the postmark date of revocation. All reconsideration requests should be sent to:

[Insert contact address]

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]

Model Reconsideration Letter

CMS alpha representation
Contractor

[Month Day & Year]

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

[Reference number]

Dear [Insert Provider/Supplier name]:

This decision letter is in response to your request received by [insert contractor name]. This request is based on the above referenced providers [revocation or denial] of your [insert Medicare number or application type]. 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 Medicare laws, regulations and guidelines. 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)

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 not provided evidence to show you have fully complied with the standards for which they were [revoked or denied]. Therefore, we cannot grant them access to the Medicare Trust Fund [by way or issuance] of a Medicare number.

This decision is 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 of the Medicare regulations. The regulation explains the appeal rights following the determinations 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]