CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13355	**Date: August 13, 2025**
	Change Request 13981

Transmittal 13154, issued April 04, 2025, is being rescinded and replaced by Transmittal 13355, dated August 13, 2025, to-- (1) Place the correct language from Change Request (CR) 13981 into Sections 10.2.3.9, 10.2.3.10, 10.2.3.12 through 10.2.3.15, 10.2.3.17, and 10.6.22 in Chapter 10 of Publication (Pub.) 100-08; and (2) Reinsert inadvertently deleted Sections 10.2.2.5 and 10.7.10 into Chapter 10. All other information remains the same.

SUBJECT: Removal of Gender References from CMS Publication (Pub.) 100-08, Chapter 10

I. SUMMARY OF CHANGES: The purpose of this CR is to remove references to gender from Chapter 10 of CMS Pub. 100-08.

EFFECTIVE DATE: May 5, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 5, 2025

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-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/10.2/10.2.1.8/Hospitals and Hospital Units
R	10/10.2/10.2.1.9/Indian Health Services (IHS) Facilities
R	10/10.2/10.2.2.4/Independent Diagnostic Testing Facilities (IDTFs)
R	10/10.2/10.2.2.5/Intensive Cardiac Rehabilitation (ICR)
R	10/10.2/10.2.3.2/Audiologists
R	10/10.2/10.2.3.5/Clinical Nurse Specialists
R	10/10.2/10.2.3.6/Clinical Psychologists
R	10/10.2/10.2.3.9/Occupational Therapists in Private Practice
R	10/10.2/10.2.3.10/Physical Therapists in Private Practice
R	10/10.2/10.2.3.11/Physicians
R	10/10.2/10.2.3.12/Physician Assistants
R	10/10.2/10.2.3.13/Psychologists Practicing Independently
R	10/10.2/10.2.3.14/Registered Dietitians/Nutrition Professionals
R	10/10.2/10.2.3.15/Speech Language Pathologists in Private Practice
R	10/10.2/10.2.3.17/Marriage and Family Therapists (MFTs)
R	10/10.2/10.2.3.18/Mental Health Counselors (MHCs)
R	10/10.2/10.2.4/Other Medicare Part B Services
R	10/10.2/10.2.5.3.1/Basics of the Surety Bond Requirement
R	10/10.2/10.2.7/Opioid Treatment Programs
R	10/10.3/Medicare Enrollment Forms – Information, Processing, and PECOS 2.0
R	10/10.3/10.3.1.1.11/Section 15 (Authorized Officials) - Form CMS-855A
R	10/10.3/10.3.1.1.12/Section 16 (Delegated Officials) - Form CMS-855A
R	10/10.3/10.3.1.2.4/Section 4 (Practice Location Information) – Form CMS-855B
R	10/10.3/10.3.1.2.8/Section 15 (Authorized Officials) - Form CMS-855B
R	10/10.3/10.3.1.2.9/Section 16 (Delegated Officials) - Form CMS-855B
R	10/10.3/10.3.1.3.1/Section 1 (Basic Information) – Form CMS-855I

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/10.3/10.3.1.3.2/Section 2 (Personal Identifying Information) – Form CMS-855I
R	10/10.3/10.3.1.3.4/Section 4 (Business Information) - Form CMS-855I
R	10/10.3/10.3.1.3.6/Section 15 (Certification Statement) - Form CMS-855I
R	10/10.3/10.3.1.3.7/Additional Processing Information and Alternatives – Form CMS-855I
R	10/10.3/10.3.1.4/Reassignment of Medicare Benefits Via the Form CMS-855I
R	10/10.3/10.3.1.5/Form CMS-855O – Medicare Enrollment Application for Eligible Ordering and Certifying Physicians, and other Eligible Professionals
R	10/10.3/10.3.1.5.1/Sections 1 through 7 of the Form CMS-855O
R	10/10.3/10.3.1.5.2/Section 8 (Certification Statement) - Form CMS-855O
R	10/10.3/10.3.1.5.3/Form CMS-855O Initial Applications and Change Requests
R	10/10.3/10.3.1.5.4/Form CMS-855O Processing Alternatives and Miscellaneous Policies
R	10/10.3/10.3.1.5.5/Form CMS-855O Revocations
R	10/10.3/10.3.1.6.2/Authorized and Delegated Officials – Form CMS-855S
R	10/10.3/10.3.2.4/CMS-20134 (Section 4 - MDPP Location Information)
R	10/10.3/10.3.2.7/CMS-20134 (Section 7 – Coach Roster)
R	10/10.3/10.3.2.11/CMS-20134 (Section 15 – Certification Statement and Authorized Officials)
R	10/10.3/10.3.2.12/CMS-20134 (Section 16 – Delegated Officials)
R	10/10.3/10.3.3.1/Form CMS-588 – Electronic Funds Transfer (EFT) Authorization Agreement
R	10/10.3/10.3.3.2/Form CMS-460 – Medicare Participating Physician or Supplier Agreement
R	10/10.4/10.4.1.3.2/Data Verification

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/10.4/10.4.1.3.3/Requesting Missing/Clarifying Data/Documentation (Development)
R	10/10.4/10.4.1.4.2/Returns
R	10/10.4/10.4.2.2/Denial Reasons
R	10/10.4/10.4.5.2/Non-Responses to Revalidation and Extension Requests
R	10/10.4/10.4.7.1/Revocations – Background and General Requirements
R	10/10.4/10.4.7.3/Revocation Reasons
R	10/10.4/10.4.7.4/Reenrollment Bar
R	10/10.4/10.4.8.1/Deactivation Rebuttals
R	10/10.4/10.4.9/Stay of Enrollment
R	10/10.4/10.4.9.1/Stay of Enrollment Rebuttals
R	10/10.6/10.6.1.1.2/Examples of CHOW and Non-CHOW Situations
R	10/10.6/10.6.1.1.3.1/Step 1 - Initial Review of the CHOW Application
R	10/10.6/10.6.1.1.3.1.1/Special Processing Instructions and Considerations for the Initial Review Process
R	10/10.6/10.6.1.1.4/Additional CHOW Processing Policies
R	10/10.6/10.6.1.1.5/HHA and Hospice Ownership Changes
R	10/10.6/10.6.1.2/Changes of Information – Transitioned Certified Providers and Suppliers
R	10/10.6/10.6.1.3/Voluntary Terminations
R	10/10.6/10.6.2/Establishing Effective Dates
R	10/10.6/10.6.4/Provider and Supplier Business Structures
R	10/10.6/10.6.6/Final Adverse Actions
R	10/10.6/10.6.7.2/Individual Owning and Managing Information
R	10/10.6/10.6.11/Participation (Par) Agreements and the Acceptance of Assignment – General Information
R	10/10.6/10.6.12/Opting-Out of Medicare
R	10/10.6/10.6.15/Risk-Based Screening

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/10.6/10.6.17/Deceased Practitioners
R	10/10.6/10.6.18/Appeals Process
R	10/10.6/10.6.19/Other Medicare Contractor Duties
R	10/10.6/10.6.22/Non-Transitioned Certified Provider/Supplier Changes of Ownership
R	10/10.7/10.7.4/DME Approval Letter Templates
R	10/10.7/10.7.5/Part A/B Certified Provider and Supplier Approval Letter Templates
R	10/10.7/10.7.5.1/Part A/B Certified Provider and Supplier Letter Templates – Post-Transition
R	10/10.7/10.7.6/Part B Non-Certified Provider and Supplier Approval Letter Templates
R	10/10.7/10.7.8/Denial Model Letters
R	10/10.7/10.7.9/Revocation Letters
R	10/10.7/10.7.10/Corrective Action Plan (CAP) Model Letters
R	10/10.7/10.7.11/Reconsideration Request Model Letters
R	10/10.7/10.7.12/Deactivation Model Letters
R	10/10.7/10.7.13/Deactivation Rebuttal Model Letters
R	10/10.7/10.7.14/Model Opt-out Letters
R	10/10.7/10.7.15/Revalidation Notification Letters
R	10/10.7/10.7.19/ESRD Approval Letters
R	10/10.7/10.7.20/Stay of Enrollment Letters

III. FUNDING:

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 13355	Date: August 12, 2025	Change Request: 13981

Transmittal 13154, issued April 04, 2025, is being rescinded and replaced by Transmittal 13355, dated August 13, 2025, to-- (1) Place the correct language from Change Request (CR) 13981 into Sections 10.2.3.9, 10.2.3.10, 10.2.3.12 through 10.2.3.15, 10.2.3.17, and 10.6.22 in Chapter 10 of Publication (Pub.) 100-08; and (2) Reinsert inadvertently deleted Sections 10.2.2.5 and 10.7.10 into Chapter 10. All other information remains the same.

SUBJECT: Removal of Gender References from CMS Publication (Pub.) 100-08, Chapter 10

EFFECTIVE DATE: May 5, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 5, 2025

I. SUMMARY OF CHANGES: The purpose of this CR is to remove references to gender from Chapter 10 of CMS Pub. 100-08.

II. GENERAL INFORMATION

A. Background: On January 20, 2025, President Trump issued Executive Order 14168, entitled "Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government (Defending Women)." This CR will delete references to gender from CMS Pub. 100-08, Chapter 10.

B. Policy: This CR does not involve any legislative or regulatory policies.

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13981.1	The contractor shall observe the removal of references to gender from Chapter 10 of CMS Pub. 100-	X	X	X						NPEAST, NPWEST

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	08.									

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Pre-Implementation Contact(s): Frank Whelan, 410-786-1302 or frank.whelan@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: 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.

ATTACHMENTS: 0

Medicare Program Integrity Manual
Chapter 10 – Medicare Enrollment

Table of Contents
(Rev. 13355; Issued: 08-13-25)

Transmittals for Chapter 10

10.2.1.8 - Hospitals and Hospital Units

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

(This section 10.2.1.8 applies to "standard" hospitals (as the term "hospital" is defined in § 1861(e)(1)), psychiatric hospitals, hospital units, and transplant programs. It does not apply to critical access hospitals, which are a separate provider type and are not "transitioning.")

A. General Background Information

Hospitals and hospital units are a provider type that enrolls via the Form CMS-855A. An exception to this is when the hospital is requesting enrollment to bill for practitioner services for hospital departments, outpatient departments, outpatient locations, and/or hospital clinics; in this circumstance, a new Form CMS-855B enrollment application is required.

B. Processing Instructions for Hospital Initial Form CMS-855A Applications

1. Receipt of Application

Upon receipt of a hospital initial Form CMS-855A application, the contractor shall undertake the following (in whichever order the contractor prefers unless directed otherwise in this chapter):

(A) Perform all data validations otherwise required per this chapter.

(B) Ensure that the application(s) is complete consistent with the instructions in this chapter.

(C) Ensure that the hospital has submitted all documentation otherwise required per this chapter. For hospital initial enrollment, this also includes the following:

- Form CMS-1561 (Health Insurance Benefit Agreement, also known as a "provider agreement")

- Evidence of successful electronic submission of the Form HHS-690 through the Office of Civil Rights (OCR) portal, as applicable. (Evidence should be either written or electronic documentation.) (See https://www.hhs.gov/sites/default/files/forms/hhs-690.pdf for more information.)

(An authorized official (as defined in § 424.502) must complete, sign, date, and include the Form CMS-1561, though the hospital need not complete those sections of the form reserved for CMS.)

Notwithstanding the foregoing, if the Form CMS-1561 or the Form HHS-690 evidence is missing, unsigned, undated, or otherwise incomplete, the contractor need not develop for the form(s) or the information thereon; the contractor shall instead notify the state in its recommendation letter which document(s) was/were missing or otherwise incomplete. For all other missing or incomplete required documentation, the contractor shall follow the normal development instructions in this chapter.

2. Conclusion of Initial Contractor Review

(Nothing in this section 10.2.1.8(B) prohibits the contractor from returning or rejecting the hospital application if otherwise permitted to do so per this chapter. When returning or rejecting the application, the contractor shall follow this chapter's procedures for doing so.)

(A) Approval Recommendation

If, consistent with the instructions in section 10.2.1.8(B)(2) and this chapter, the contractor believes an approval recommendation is warranted, the contractor shall send the recommendation to the state pursuant to existing practice and this chapter's instructions. The contractor need not copy the SOG Location or PEOG on the recommendation. Unless CMS directs otherwise, the contractor shall also send to the provider the notification letter in section 10.7.5.1(E) of this chapter.

The state will: (1) review the recommendation package for completeness; (2) review the contractor's recommendation for approval; (3) perform any state-specific functions; and (4) contact the contractor with any questions. The contractor shall respond to any state inquiry in Item (4) within 5 business days. If the inquiry involves the need for the contractor to obtain additional data, documentation, or clarification from the hospital, however, the timeframe is 15 business days; if the provider fails to respond to the contractor within this timeframe, it shall notify the state thereof. The contractor may always contact its PEOG BFL should it need the latter's assistance with a particular state inquiry.

(B) Denial

If the contractor determines that a denial is warranted, it shall follow the denial procedures outlined in this chapter. This includes: (1) using the appropriate denial letter format in section 10.7.5.1 of this chapter; and (2) if required under section 10.6.6 (or another CMS directive) of this chapter, referring the matter to PEOG for review prior to denying the application.

3. Completion of State Review

The state will notify the contractor once it has completed its review. There are two potential outcomes:

(A) Approval Not Recommended

If the state does not recommend approval, it will notify the contractor thereof. (The contractor may accept any notification that is in writing (e-mail is fine).) The site visit described in subsection (D)(1) below need not be performed. No later than 5 business days after receiving this notification, the contractor shall commence the actions described in section 10.2.1.8(B)(2)(B) above.

(B) Approval Recommended

If the state recommends approval, it will typically (though not always) do so via a Form CMS-1539; the contractor may accept any documentation from the state signifying that the latter recommends approval. (Note that the contractor will not receive a formal tie-in notice.)

No later than 5 business days after receipt of the recommendation from the state, the contractor shall send an e-mail to MedicareProviderEnrollment@cms.hhs.gov with the following information and documents:

- The Form CMS-855 application (or PECOS Application Data Report) and all application attachments
- A copy of the Form CMS-1539 from the state or similar documentation received from the accrediting organization
- A copy of the provider-signed Form CMS-1561
- A copy of the draft approval letter, with the effective date shown on the Form CMS-1539 (or similar documentation) included in the draft letter. (See section 10.7.5.1 for the model approval letter.)

PEOG will countersign the provider agreement. Based on the information received from the contractor, PEOG will also (1) assign an effective date, (2) assign a CCN, and (3) enter the applicable data into the applicable national database, and (4) approve (with possible edits) the approval letter. Within 5 business days of receiving from PEOG the signed provider agreement, effective date, and CCN, the contractor shall: (1) send the approval letter and a copy of the CMS-countersigned provider agreement to the hospital; (2) send a copy of both the approval letter and the provider agreement to the state and/or accrediting organization (as applicable); and (3) switch the PECOS record from "approval recommended" to "approved" consistent with existing instructions.

C. Additional Enrollment Information

1. Swing-Bed Designation

A "swing-bed" hospital is one that is approved by CMS to furnish post-hospital skilled nursing facility (SNF) services. That is, hospital (or critical access hospital (CAH)) patients' beds can "swing" from furnishing hospital services to providing SNF care without the patient necessarily being moved to another part of the building. It receives a separate survey and certification from that of the hospital. Thus, if swing-bed designation is terminated, the hospital still maintains its certification. In addition, the hospital is given an additional CCN to bill for swing-bed services. (The third digit of the CCN will be the letter U, W, Y or Z.)

In general, and as stated in 42 CFR § 482.58, in order to obtain swing-bed status the hospital must, among other things: (1) have a Medicare provider agreement; (2) be located in a rural area; and (3) have fewer than 100 non-newborn or intensive care beds. Swing-bed hospitals, therefore, are generally small hospitals in rural areas where there may not be enough SNFs, and the hospital is thus used to furnish SNF services.

A separate provider agreement and enrollment for the swing-bed unit is not required. (The hospital's provider agreement incorporates the swing-bed services.) The hospital can add the swing-bed unit as a practice location via the Form CMS-855A.

Additional data on "swing-bed" units can be found in Pub. 100-07, chapter 2, sections 2036 – 2040.

2. Psychiatric and Rehabilitation Units

Though these units receive a state survey, a separate provider agreement and enrollment is not required. (The hospital's provider agreement incorporates these units.) The hospital can add the unit as a practice location to the Form CMS-855A.

3. Multi-Campus Hospitals

A multi-campus hospital (MCH) has two or more hospital campuses operating under one CCN. The MCH would report its various units/campuses as practice locations on the Form CMS-855A. For additional information on multi-campus hospitals, see Pub. 100-07, chapter 2, section 2024.

4. Physician-Owned Hospitals

As defined in 42 CFR § 489.3, a physician-owned hospital (POH) means any participating hospital (as defined in 42 CFR §489.24) in which a physician or an immediate family member of a physician has an ownership or investment interest in the hospital. The ownership or investment interest may be through equity, debt, or other means, and includes an interest in an entity that holds an ownership or investment interest in the hospital. (This definition does not include a hospital with physician ownership or investment interests that satisfy the requirements at 42 CFR § 411.356(a) or (b).)

Section 2(A)(4) of the Form CMS-855A asks the applicant to identify whether it is a physician-owned hospital. If the applicant indicates in Section 2(A)(2) that it is a hospital, it must complete Section 2(A)(4). Applicants that are not hospitals need not complete Section 2(A)(4).

At this time, POHs are not required to submit a completed Form CMS-855POH or a completed Attachment 1 of the Form CMS-855A. As stated in the March 12, 2015 announcement in MLN Connects Provider eNews, CMS has extended the deadline for the POH Initial Annual Ownership/Investment Report due to concerns about the accuracy of the data collected in the report. Future instruction regarding the reporting of POH ownership and investment will be provided on the CMS physician self-referral website.

5. Critical Access Hospitals

Critical access hospitals (CAHs) are not considered to be a hospital sub-type for enrollment purposes. CAHs instead must be enrolled as a separate, distinct provider type. Thus, if an existing hospital wishes to convert to a CAH, it must submit a Form CMS-855A as an initial enrollment.

6. Hospital Addition of Practice Location

In situations where a hospital is adding a practice location, the contractor shall notify the provider in writing that its recommendation for approval does not constitute approval of the facility or group as provider-based under 42 CFR § 413.65.

If the contractor makes a recommendation for approval of the provider's request to add a hospital unit, the contractor shall forward the package to the state agency as described in this chapter.

7. Transplant Programs

A transplant program is a component within a transplant hospital that provides transplantation of a particular type of organ to include: heart, lung, liver, kidney, pancreas, or intestine. All organ transplant programs must be located in a hospital that has a Medicare provider agreement. The transplant program will receive a CCN that is separate and distinct from the hospital.

For purposes of Medicare enrollment, a hospital transplant program is treated similarly to a hospital sub-unit. If the hospital wishes to add a transplant program, it must check the "other" box in Section 2A2 of the Form CMS-855A, write "transplant program" (and the type(s) thereof, such as liver transplant program, kidney transplant program, etc.) on the space provided, and follow the standard instructions for adding a hospital sub-unit. (If multiple types of transplant programs are listed, the contractor shall (a) treat each as a separate sub-unit for enrollment purposes and (b) process the application in the same fashion it would a hospital application that is reporting/adding multiple sub-units.) No separate enrollment in PECOS need or will be created for the transplant center.

D. Section 4 of the Form CMS-855A

Regarding Section 4 of the Form CMS-855A, the hospital must list all addresses where it - and not a separately enrolled provider or supplier it owns or operates, such as a nursing home - furnishes services. The hospital's primary practice location should be the first location identified in Section 4A and the contractor shall treat it as such – unless there is evidence indicating otherwise. NOTE: Hospital departments located at the same address as the main facility need not be listed as practice locations on the Form CMS-855A.

If an enrolled hospital seeks to add or delete a rehabilitation, psychiatric, or swing-bed unit, it should submit a Form CMS-855 change of information request and not, respectively, an initial enrollment application or a voluntary termination application.

E. Non-Participating Emergency Hospitals, Veterans Administration (VA) Hospitals, and Department of Defense (DOD) Hospitals

Non-participating emergency hospitals, VA hospitals and DOD hospitals no longer need to complete a Form CMS-855A enrollment application in order to bill Medicare.

F. Form CMS-855B Applications Submitted by Hospitals

1. Group Practices

If an entity is enrolling via the Form CMS-855B as a hospital-owned clinic/physician practice, the contractor shall contact the applicant to determine whether the latter will be billing any of the listed locations as provider-based. If the applicant will not be billing as provider-based, the contractor shall process the application normally. If, however, the applicant will bill as provider-based, the contractor shall notify the applicant that the hospital must report any changed practice locations to its contractor via the Form CMS-855A.

If the supplier is enrolling as a hospital department (under the "Clinic/Group Practice" category on the Form CMS-855B) or an existing hospital department is undergoing a change of ownership (CHOW), the contractor shall only issue the necessary billing numbers upon notification that a provider agreement has been issued – or, in the case of a CHOW, the provider agreement has been transferred to the new owner. If, however, the supplier is enrolling as a group practice that is merely owned by a hospital (as opposed to being a hospital department), the contractor need not wait until the provider agreement is issued before conveying billing privileges to the group.

2. Individual Billings

Assume an individual physician works for a hospital and will bill for services as an individual (i.e., not as part of the hospital service/payment). However, *the physician* wants to reassign these benefits to the hospital. The hospital will need to enroll with the contractor via the Form CMS-855B (e.g., as a hospital department, outpatient location).

10.2.1.9 - Indian Health Services (IHS) Facilities

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. General Background Information

For purposes of provider enrollment only, there are several types of IHS facilities: (1) those that are wholly owned and operated by the IHS; (2) facilities owned by the IHS but tribally operated; and (3) facilities wholly owned and operated by a tribe, though under the general IHS umbrella. When an IHS facility wishes to enroll with the Part A contractor, it may check in Section 2A of the Form CMS-855A either (a) "Indian Health Services Facility" or (b) the specific provider type it is. For instance, if an IHS hospital is involved, the provider may check "Indian Health Services Facility" or "Hospital" on the application - or perhaps both. Even if it only checked "Hospital," the LBN or DBA Name will typically contain some type of reference to Indian Health Services. The contractor will therefore know that an IHS facility is involved.

The overwhelming majority of IHS facilities on the Part A side are either hospitals, SNFs, CAHs, or ESRD facilities. The contractor processes IHS applications in the same manner (and via the same procedures) as it would with a hospital, SNF, etc. (This also applies to procedures for PECOS entry.)

As for CCNs, the IHS facility uses the same series that its concomitant provider type does. That is, an IHS hospital uses the same CCN series as a "regular" hospital, an IHS CAH utilizes the same series as a regular CAH, and so forth.

B. Enrollment Information

IHS facilities and tribal providers may use Internet-based PECOS or the paper Form CMS-855 enrollment application for their enrollment transactions. The designated Medicare contractor for IHS facilities and tribal providers is Novitas Solutions (Novitas).

If the IHS facility or tribal provider mails its Form CMS-855 to a Medicare contractor other than Novitas, that contractor shall forward the application directly to Novitas at the following address:

Novitas Solutions, Inc.
P.O. Box 3115
Mechanicsburg, PA 17055-1858

C. Licensure Requirements for Physicians and Practitioners Enrolling to Work in or Reassign Benefits to an Indian Tribe or Tribal Organization

The Affordable Care Act (Pub. L 111-148) amended Section 221 of the Indian Health Care Improvement Act such that licensed health professionals employed by a tribal health program are, if licensed in any state, exempt from the licensing requirements of the state in which the tribal program performs the services described in the contract or compact of the tribal health program under the Indian Self-Determination and Education Assistance Act (ISDEAA) (25 U.S.C. 450, et seq.). Pursuant to this statutory provision, therefore, a physician or practitioner need only be licensed in one state – regardless of whether that state is the one in which the *individual* practices – if *the individual* is employed by a tribal health program performing services as permitted under the ISDEAA (see Pub. 100-04, chapter 19, section 10 for definitions).

The contractor shall apply this policy when processing applications from these individuals. In terms of the effective date of Medicare billing privileges, the contractor shall continue to apply the provisions of 42 CFR §§ 424.520(d) and 424.521(a) and section 10.6.2 of this chapter.

D. Additional Information

For additional general information on IHS facilities, see Pub. 100-04, chapter 19.

10.2.2.4 – Independent Diagnostic Testing Facilities (IDTFs)

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

IDTFs are a supplier type that enrolls via the Form CMS-855B.

A. Introduction

1. General Background

An IDTF is a facility that is independent both of an attending or consulting physician's office and of a hospital. However, IDTF general coverage and payment policy rules apply when an IDTF furnishes diagnostic procedures in a physician's office (see 42 CFR § 410.33(a)(1)).

Effective for diagnostic procedures performed on or after March 15, 1999, MACs pay for diagnostic procedures under the physician fee schedule when performed by an IDTF. An IDTF may be a fixed location or a mobile entity. It is independent of a physician's office or hospital.

2. Place of IDTF Service

i. "Indirect IDTFs" – Background

IDTFs generally perform diagnostic tests on beneficiaries in, for instance, a health care facility, physician's office, or mobile setting. The IDTF standards at § 410.33(g) (as well as other provisions in § 410.33) were, in fact, designed for traditional IDTF suppliers that engage in direct or in-person beneficiary interaction, treatment, and/or testing. Yet some health care entities have developed or utilize diagnostic tests that do not require such interaction (hereafter occasionally referenced as "indirect IDTFs"). That is, certain IDTFs perform diagnostic services via computer modeling and analytics, or other forms of testing not involving direct beneficiary interaction. The service is often conducted by a technician who undertakes a computer analysis offsite or at another location at which the patient is not present. The physician then reviews the image to determine the appropriate course of action. In short, these entities generally, though not exclusively, have two overriding characteristics. First, the tests they perform do not involve direct patient interaction, meaning that the test is conducted away from the patient's physical presence and is non-invasive. Second, the test involves off-site computer modeling and analytics.

Despite the comparatively new and innovative forms of testing these entities undertake, they can still qualify as IDTFs (notwithstanding the offsite and indirect nature of the test) so long as they meet the applicable requirements of § 410.33. In the past, however, these entities have often been unable to meet certain IDTF requirements (and thus cannot enroll in Medicare) strictly because of the test's indirect nature. In other words, the types of tests at issue do not fall within the category of those to which several of the standards in § 410.33 were intended to apply (specifically, to in-person procedures).

ii. "Indirect IDTFs" – General Description, Exemptions, and Verification

To account for such technological advances in diagnostic testing, we revised § 410.33 in the CY 2022 Physician Fee Schedule final rule such that **IDTFs that have no beneficiary interaction, treatment, or testing whatsoever at their practice location are wholly exempt from the following requirements in § 410.33(g).**

- § 410.33(g)(6)) - The IDTF must have a comprehensive liability insurance policy of at least $300,000 per location that covers both the place of business and all customers and employees of the IDTF.

- § 410.33(g)(8)) - The IDTF must answer, document, and maintain documentation of a beneficiary's written clinical complaint at the physical site of the IDTF.

- § 410.33(g)(9)) - The IDTF must openly post the standards outlined in § 410.33(g) for review by patients and the public.

In addition. 42 CFR § 410.33(c) previously stated in full: "Any nonphysician personnel used by the IDTF to perform tests must demonstrate the basic qualifications to perform the tests in question and have training and proficiency as evidenced by licensure or certification by the appropriate State health or education department. In the absence of a State licensing board, the technician must be certified by an appropriate national credentialing body. The IDTF must maintain documentation available for review that these requirements are met." This requirement (now codified in § 410.33(c)(1)) remains intact for IDTFs that perform direct, in-person testing. For indirect IDTFs, however, new § 410.33(c)(2) states that---for services that do not require direct or in-person beneficiary interaction, treatment, or testing---any nonphysician personnel performing the test must meet all applicable state licensure requirements for doing so; if such state licensure requirements exist, the IDTF must maintain documentation available for review that these requirements have been met. If no state licensure requirements for such personnel exist, the contractor need not undertake additional verification activities under § 410.33(c)(2) concerning the technician in question; the contractor shall not establish its own additional certification, credentialing, or similar technician requirements (e.g., federal accreditation) above and beyond the requirements in § 410.33(c)(2).

The only complete or partial exemptions in § 410.33 that apply to indirect IDTFs are those described in this subsection (A)(2) (i.e., § 410.33(c)(2), (g)(6), (g)(8), and (g)(9)).

iii. Synopsis

In sum:

(A) IDTFs that perform direct, in-person testing on beneficiaries must still meet all requirements and standards in 42 CFR § 410.33. Also, the personnel performing these tests must comply with the requirements in § 410.33(c)(1).

(B) Indirect IDTFs need not meet the standards in § 410.33(g)(6), (g)(8), and (g)(9). The personnel performing these tests must comply with the requirements in § 410.33(c)(2) rather than § 410.33(c)(1).

(C) If an IDTF performs both direct and indirect tests:

- It must meet the standards in § 410.33(g)(6), (g)(8), and (g)(9). **An IDTF must exclusively and only perform tests involving no beneficiary interaction, treatment, or testing to be exempt from § 410.33(g)(6), (g)(8), and (g)(9). Thus, even if the overwhelming majority of the IDTF's tests are those described in the previous sentence, the above-mentioned exemptions are inapplicable if the IDTF conducts any tests requiring direct, in-person patient interaction.**

- Personnel performing direct patient interaction tests must meet the requirements of § 410.33(c)(1). Personnel conducting indirect, non-person tests must meet the requirements of § 410.33(c)(2). If a particular technician at an IDTF performs both categories of tests, *the technician* must meet § 410.33(c)(1)'s requirements for the direct, in-person tests and § 410.33(c)(2)'s requirements for the indirect, non-in-person tests.

(D) The contractor will typically be able to determine during application processing whether the IDTF is an "indirect IDTF." This can be done via, for instance, reviewing: (1) the site visit results; or (2) the tests reported in Attachment 2 of the Form CMS-855B. In this matter, the contractor shall abide by the following:

- Unless there is evidence that the IDTF only performs indirect tests, the contractor may assume that the supplier is not an "indirect IDTF."
- If the contractor determines that the IDTF performs both indirect and direct tests, it shall follow the instructions described in this subsection (A)(2).

Note that the contractor is not required to submit all potential indirect IDTF applications to PEOG for review or prior approval. The contractor need only contact its PEOG BFL if it: (1) is truly unsure if an indirect IDTF situation is involved; or (2) does not believe the supplier is an indirect IDTF but the supplier states that it is.

B. IDTF Standards

Consistent with 42 CFR § 410.33(g)—and excluding § 410.33(g)(6), (g)(8), and (g)(9) for indirect IDTFs---each IDTF must certify on its Form CMS-855B enrollment application that it meets the following standards and all other requirements:

1. Operates its business in compliance with all applicable federal and state licensure and regulatory requirements for the health and safety of patients (§ 410.33(g)(1)).

- The purpose of this standard is to ensure that suppliers are licensed in the business and specialties being provided to Medicare beneficiaries. Licenses are required by state and/or federal agencies to make certain that guidelines and regulations are being followed and to ensure that businesses are furnishing quality services to Medicare beneficiaries.

- The responsibility for determining what licenses are required to operate a supplier's business is the sole responsibility of the supplier. The contractor is not responsible for notifying any supplier of what licenses are required or that any changes have occurred in the licensure requirements. No exemptions to applicable state licensing requirements are permitted, except when granted by the state.

- The contractor shall not grant billing privileges to any business not appropriately licensed as required by the appropriate state or federal agency. If a supplier is found providing services for which it is not properly licensed, billing privileges may be revoked and appropriate recoupment actions taken.

2. Provides complete and accurate information on its enrollment application. Changes in ownership, changes of location, changes in general supervision, and final adverse actions must be reported to the contractor within 30 calendar days of the change. All other changes to the enrollment application must be reported within 90 days (§ 410.33(g)(2)).

(NOTE: This 30-day requirement takes precedence over the certification in Section 15 of the Form CMS-855B whereby the supplier agrees to notify Medicare of any changes to its enrollment data within 90 days of the effective date of the change. By signing the certification statement, the IDTF agrees to abide by all Medicare rules for its supplier type, including the 30-day rule in 42 CFR §410.33(g)(2)).

3. Maintain a physical facility on an appropriate site. (For purposes of this standard, a post office box, commercial mailbox, hotel, or motel is not an appropriate site. The physical facility, including mobile units, must contain space for equipment appropriate to the services designated on the enrollment application, facilities for hand washing, adequate patient privacy accommodations, and the storage of both business records and current medical records within the office setting of the IDTF, or IDTF home office, not within the actual mobile unit.) (§410.33(g)(3)).

- IDTF suppliers that provide services remotely and do not see beneficiaries at their practice location are exempt from providing hand washing and adequate patient privacy accommodations.

- The requirements in 42 CFR § 410.33(g)(3) take precedence over the guidelines in section 10.3.1(B)(1)(d) of this chapter pertaining to the supplier's practice location requirements.

- The physical location must have an address, including the suite identifier, which is recognized by the United States Postal Service (USPS).

4. Has all applicable diagnostic testing equipment available at the physical site excluding portable diagnostic testing equipment. The IDTF must—

(i) Maintain a catalog of portable diagnostic equipment, including diagnostic testing equipment serial numbers at the physical site;

(ii) Make portable diagnostic testing equipment available for inspection within 2 business days of a CMS inspection request; and

(iii) Maintain a current inventory of the diagnostic testing equipment, including serial and registration numbers, and provide this information to the designated fee-for-service contractor upon request, and notify the contractor of any changes in equipment within 90 days. (§ 410.33(g)(4)).

5. Maintain a primary business phone under the name of the designated business. The IDTF must have its –

(i) Primary business phone located at the designated site of the business or within the home office of the mobile IDTF units.

(ii) Telephone or toll free telephone numbers available in a local directory and through directory assistance. (§ 410.33(g)(5)).

The requirements in 42 CFR § 410.33(g)(5) take precedence over the guidelines in section 10.3.1(B)(1)(d) of this chapter regarding the supplier's telephone requirements.

IDTFs may not use "call forwarding" or an answering service as their primary method of receiving calls from beneficiaries during posted operating hours.

6. Have a comprehensive liability insurance policy of at least $300,000 per location that covers both the place of business and all customers and employees of the IDTF. The policy must be carried by a non-relative-owned company. Failure to maintain required insurance at all times will result in revocation of the IDTF's billing privileges retroactive to the date the insurance lapsed. IDTF suppliers are responsible for providing the contact information for the issuing insurance agent and the underwriter. In addition, the IDTF must--

(i) Ensure that the insurance policy remains in force at all times and provide coverage of at least $300,000 per incident; and

(ii) Notify the CMS designated contractor in writing of any policy changes or cancellations. (§ 410.33(g)(6))

7. Agree not to directly solicit patients; this includes - but is not limited to - a prohibition on telephone, computer, or in-person contacts. The IDTF must accept only those patients referred for diagnostic testing by an attending physician who: (a) is furnishing a consultation or treating a beneficiary for a specific medical problem; and (2) uses the results in the management of the beneficiary's specific medical problem. Non-physician practitioners may order tests as set forth in § 410.32(a)(3). (§ 410.33(g)(7))

- By the signature of the authorized official in Section 15 of the Form CMS-855B, the IDTF agrees to comply with 42 CFR § 410.33(g)(7).

- The supplier is prohibited from directly contacting any individual beneficiary for the purpose of soliciting business for the IDTF. This includes contacting the individual beneficiary by telephone or via door-to-door sales.

- There is no prohibition on television, radio, or Internet advertisements, mass mailings, or similar efforts to attract potential clients to an IDTF.

8. Answer, document, and maintain documentation of a beneficiary's written clinical complaint at the physical site of the IDTF. (For mobile IDTFs, this documentation would be stored at their home office.) This includes, but is not limited to, the following:

(i) The name, address, telephone number, and health insurance claim number of the beneficiary.

(ii) The date the complaint was received, the name of the person receiving the complaint, and a summary of actions taken to resolve the complaint.

(iii) If an investigation was not conducted, the name of the person making the decision and the reason for the decision. (§ 410.33(g)(8))

9. Openly post these standards for review by patients and the public. (§ 410.33(g)(9))

10. Disclose to the government any person having ownership, financial, or control interest or any other legal interest in the supplier at the time of enrollment or within 30 days of a change. (§ 410.33(g)(10))

11. Have its testing equipment calibrated and maintained per equipment instructions and in compliance with applicable manufacturers' suggested maintenance and calibration standards. (§ 410.33(g)(11))

12. Have technical staff on duty with the appropriate credentials to perform tests. The IDTF must be able to produce the applicable federal or state licenses or certifications of the individuals performing these services. (§ 410.33(g)(12))

13. Have proper medical record storage and be able to retrieve medical records upon request from CMS or its fee-for-service contractor within 2 business days. (§ 410.33(g)(13))

14. Permit CMS, including its agents, or its designated fee-for-service contractors, to conduct unannounced, on-site inspections to confirm the IDTF's compliance with these standards. The IDTF must---

(i) Be accessible during regular business hours to CMS and beneficiaries; and

(ii) Maintain a visible sign posting its normal business hours. (§ 410.33(g)(14))

15. With the exception of hospital-based and mobile IDTFs, a fixed-base IDTF is prohibited from the following:

(i) Sharing a practice location with another Medicare-enrolled individual or organization;

(ii) Leasing or subleasing its operations or its practice location to another Medicare-enrolled individual or organization; or

(iii) Sharing diagnostic testing equipment used in the initial diagnostic test with another Medicare-enrolled individual or organization. (§ 410.33(g)(15))

16. Enrolls in Medicare for any diagnostic testing services that it furnishes to a Medicare beneficiary, regardless of whether the service is furnished in a mobile or fixed-base location. (§ 410.33(g)(16))

17. Bills for all mobile diagnostic services that are furnished to a Medicare beneficiary, unless the mobile diagnostic service is part of a service provided under arrangement as described in section 1861(w)(1) of the Act (§ 410.33(g)(17)) (Section 1861(w)(1) states that the term "arrangements" is limited to arrangements under which receipt of payments by the hospital, critical access hospital, skilled nursing facility, home health agency or hospice program (whether in its own right or as an agent), with respect to services for which an individual is entitled to have payment made under this title, discharges the liability of such individual or any other person to pay for the services.)

If the IDTF claims that it is furnishing services under arrangement as described in section 1861(w)(1), the IDTF must provide documentation of such with its initial or revalidation Form CMS-855 application.

The IDTF must meet all of the standards in 42 CFR § 410.33 – as well as all other federal and state statutory and regulatory requirements – in order to be enrolled in, and to maintain its enrollment in, the Medicare program. Failure to meet any standard in 42 CFR § 410.33 or any other applicable requirement will result in the denial of the supplier's Form CMS-855 application or, if the supplier is already enrolled in Medicare, the revocation of its Medicare billing privileges.

C. Leasing and Staffing

For purposes of the provisions in 42 CFR § 410.33, a "mobile IDTF" does not include entities that lease or contract with a Medicare enrolled provider or supplier to provide: (1) diagnostic testing equipment; (2) non-physician personnel described in 42 CFR § 410.33(c); or (3) diagnostic testing equipment and non-physician personnel described in 42 CFR § 410.33(c). This is because the provider/supplier is responsible for providing the appropriate level of physician supervision for the diagnostic testing.

An IDTF is not required to report equipment that the IDTF is leasing for a period less than 90 days unless the IDTF is leasing equipment for services that they have not already reported on a Form CMS-855B IDTF Attachment. For all new services being provided, IDTFs would need to complete a change of information to include the equipment and CPT/HCPCS codes that will be billed. Any accreditation for the services provided would need to be obtained by the IDTF.

D. Sharing of Space and Equipment

As previously noted, the standard in § 410.33(g)(15) states that, with the exception of hospital-based and mobile IDTFs, a fixed-base IDTF cannot: (i) share a practice location with another Medicare-enrolled individual or organization; (ii) lease or sublease its operations or its practice location to another Medicare-enrolled individual or organization; or (iii) share diagnostic testing equipment used in the initial diagnostic test with another Medicare-enrolled individual or organization.

If the contractor determines that an IDTF is violating at least one of the three prohibitions in § 410.33(g)(15), the contractor shall revoke the supplier's Medicare billing privileges.

E. Multi-State IDTFs

As stated in 42 CFR § 410.33(e)(1), an IDTF that operates across state boundaries must:

a. Maintain documentation that its supervising physicians and technicians are licensed and certified in each of the states in which it operates; and

b. Operate in compliance with all applicable federal, state, and local licensure and regulatory requirements with regard to the health and safety of patients.

Under § 410.33(e)(2), the point of the actual delivery of service means the place of service on the claim form. When the IDTF performs or administers an entire diagnostic test at the beneficiary's location, the beneficiary's location is the place of service. When one or more aspects of the diagnostic testing are performed at the IDTF, the IDTF is the place of service.

F. One Enrollment per Practice Location

An IDTF must separately enroll each of its practice locations (with the exception of locations that are used solely as warehouses or repair facilities). This means that an enrolling IDTF can only have one practice location on its Form CMS-855B enrollment application; thus, if an IDTF is adding a practice location to its existing enrollment, it must submit a new, complete Form CMS-855B application for that location and have that location undergo a separate site visit. Also, each of the IDTF's mobile units must enroll separately; if a fixed IDTF site also contains a mobile unit, the mobile unit must therefore enroll separately from the fixed location.

Each separately enrolled practice location of the IDTF must meet all applicable IDTF requirements. The location's failure to comply with any of these requirements will result in the revocation of its Medicare billing privileges.

If an IDTF adds equipment for diagnostic testing that is mobile in nature but is fixed permanently to the IDTF's physical location (i.e., a CT scanner that is mounted in a bus or trailer but is parked at the IDTF's site for use by the IDTF), a second enrollment is not necessary. This equipment can be listed in the Form CMS-855B along with the services performed on the equipment. In these cases, the contractor shall indicate the use of a fixed mobile unit is in use at the IDTF's site in the site visit request so the site inspector will know to view the fixed mobile equipment as part of the IDTF.

G. Interpreting Physicians

1. Reporting Interpreting Physicians on the Form CMS-855B

The applicant shall list all physicians for whose diagnostic test interpretations it will bill. This includes physicians who will provide interpretations subject to the anti-markup payment limitation as detailed in CMS Pub. 100-04, chapter 1, § 30.2.9 - whether the service is provided to the IDTF on a contract basis or is reassigned.

The contractor shall ensure and document that:

- All listed physicians are enrolled in Medicare*;*

- All interpreting physicians who are reassigning their benefits to the IDTF have the right to do so*; and*

- The interpreting physicians listed are qualified to interpret the types of tests (codes) listed. (The contractor may need to contact another contractor to obtain this information.) If the applicant does not list any interpreting physicians, the contractor need not request additional information because the applicant may not be billing for the interpretations; that is, the physicians may be billing for the interpretation themselves.

If an interpreting physician has been recently added or changed, the new interpreting physician must have met all of the interpreting physician requirements at the time any tests were performed.

A Form CMS-855R need not accompany a Form CMS-855B application submitted by an IDTF that employs or contracts with an interpreting physician.

2. Changes of Interpreting Physicians

If an interpreting physician is being added or changed, the updated information must be reported via a Form CMS-855B change request. To perform services as an interpreting physician, the new interpreting physician must have met all requirements at the time any tests were performed.

If the contractor receives notification from an interpreting physician that *the latter* is no longer interpreting tests at the IDTF, the contractor shall request from the supplier a Form CMS-855B change of information to end date the interpreting physician from the enrollment.

H. Effective Date of IDTF Billing Privileges

As stated in 42 CFR § 410.33(i), the filing date of an IDTF Medicare enrollment application is the date the contractor receives a signed application that it is able to process to approval. The effective date of billing privileges for a newly enrolled IDTF is the later of the following:

(1) The filing date of the Medicare enrollment application that was subsequently approved by the contractor; or

(2) The date the IDTF first started furnishing services at its new practice location.

A newly-enrolled IDTF, therefore, may not receive reimbursement for services furnished before the effective date of billing privileges.

The contractor shall note that if it rejects an IDTF application under 42 CFR § 424.525 and a new application is later submitted, the date of filing is the date the contractor receives the new enrollment application.

If an IDTF undergoes an ownership change that results in a new enrollment (e.g., a new federal tax information number (TIN) results from this change), the contractor should use the transfer of ownership/business date as indicated by the IDTF, instead of establishing a new effective date.

I. IDTF Technicians Must Be Listed on the Form CMS-855B

Each non-physician who performs IDTF diagnostic tests must be listed. These persons are often referred to as technicians.

J. IDTF Technician Licensure and Certification Requirements

All technicians must meet state licensure or state certification standards at the time of the IDTF's enrollment. The contractor may not grant temporary exemptions from such requirements.

In lieu of requiring a copy of the technician's certification card, the contractor may validate a technician's credentials online via organizations such as the American Registry for Diagnostic Medical Sonography (ARDMS), the American Registry of Radiology Technologists (ARRT), and the Nuclear Medicine Technology Certification Board (NMTCB). If online verification is not available or cannot be made, the contractor shall request a copy of the technician's certification card.

K. IDTF - Changes of Technicians

If a technician is being added or changed, the updated information must be reported via a Form CMS-855B change request. The new technician must have met all of the necessary credentialing requirements at the time any tests were performed.

If the contractor receives notification from a technician that *the latter* is no longer performing tests at the IDTF, the contractor shall request from the supplier a Form CMS-855B change of information. If the supplier did not have another technician qualified to perform the tests listed on the current application, the supplier must submit significant documentation in the form of payroll records, etc. to substantiate the performance of the test by a properly qualified technician after the date the original technician was no longer performing procedures at the IDTF.

L. IDTF Supervising Physicians – General Principles

An IDTF must have one or more supervising physicians who are responsible for:

- The direct and ongoing oversight of the quality of the testing performed;
- The proper operation and calibration of equipment used to perform tests; and
- The qualifications of non-physician IDTF personnel who use the equipment.

Not every supervising physician has to be responsible for all of these functions. For instance, one supervising physician can be responsible for the operation and calibration of equipment, while another supervising physician can be responsible for test supervision and the qualifications

of non-physician personnel. The basic requirement, however, is that all supervising physician functions must be properly met at each location, regardless of the number of physicians involved. This is particularly applicable to mobile IDTF units that are allowed to use different supervising physicians at different locations. They may have a different physician supervise the test at each location. The physicians used need only meet the proficiency standards for the tests they are supervising.

Under 42 CFR § 410.33(b)(1), each supervising physician must be limited to providing general supervision at no more than three IDTF sites. This applies to both fixed sites and mobile units where three concurrent operations are capable of performing tests.

M. IDTF - Information about Supervising Physicians

The contractor shall ensure and document in PECOS that each supervising physician is: (1) licensed to practice in the state(s) where the diagnostic tests the *physician* supervises will be performed; (2) Medicare-enrolled; and (3) not currently excluded or debarred. The physician(s) need not necessarily be Medicare-enrolled in the state where the IDTF is enrolled; moreover, the physician need not be furnishing medical services outside of the *physician's* role as a supervising physician (i.e., the physician need not have *a* medical practice separate from the IDTF). If the physician is enrolled in another state or with another contractor, however, the contractor shall ensure that *the physician* is appropriately licensed in that state.

In addition:

- Each physician of the group who actually performs an IDTF supervisory function must be listed.

- If a supervising physician has been recently added or changed, the updated information must be reported via a Form CMS-855B change request. The new physician must have met all of the supervising physician requirements at the time any tests were performed.

- If the contractor knows that a reported supervising physician has been listed with several other IDTFs, the contractor shall check with the physician to determine whether *the latter* is still acting as supervising physician for these other IDTFs.

- If the supervising physician is enrolling in Medicare and does not intend to perform medical services outside of *the physician's* role as a supervising physician: (1) the contractor shall still send the physician an approval letter (assuming successful enrollment) and issue a PTAN; (2) the physician shall list the IDTF's address as a practice location; and (3) the space-sharing prohibition in 42 CFR § 410.33(g) does not apply in this particular scenario.

N. IDTF - General, Direct, and Personal Supervision

Section 410.33(b)(2) states that if a procedure requires the direct or personal supervision of a physician as set forth in, respectively, 42 CFR § 410.32(b)(3)(ii) or (iii), the contractor shall ensure that the IDTF's supervising physician furnishes this level of supervision.

The contractor shall: (a) be familiar with the definitions of personal, direct and general supervision set forth at 42 CFR § 410.32(b)(3); and (b) ensure that the applicant has checked the highest required level of supervision for the tests being performed.

Each box that begins with "Assumes responsibility" must be checked. However, as indicated previously, the boxes can be checked through the use of more than one physician.

O. IDTF - Attestation Statement for Supervising Physicians

A separate attestation statement must be completed and signed by each supervising physician listed. If Question E2 is not completed, the contractor may assume – unless it has reason to suspect otherwise - that the supervising physician in question supervises for all codes listed in Section 2 of the IDTF attachment. If Question E2 is completed, the contractor shall ensure that all codes listed in Section 2 are covered through the use of multiple supervising physicians.

The contractor no longer needs to contact each supervisory physician by telephone or otherwise to verify that the physician: (1) actually exists (e.g., is not using a false or inactive physician number); (2) indeed signed the attestation; and (3) is aware of *the physician's* responsibilities.

If the physician is enrolled with a different contractor, the contractor shall contact the latter contractor and obtain the listed telephone number of the physician.

P. IDTF - Changes of Supervising Physicians

If a supervising physician is being added or changed, the updated information must be reported via a Form CMS-855B change request. To perform services as a supervising physician, the new supervising physician must have met all requirements at the time any tests were performed.

If the contractor receives notification from a supervising physician that *the latter* is no longer supervising tests at the IDTF, the contractor shall request from the supplier a Form CMS-855B change of information. If the IDTF did not have another supervising physician listed on the current application, the IDTF must submit a change of information adding a new supervising physician. If the IDTF does not provide this information, the contractor shall proceed with non-compliance revocation procedures as noted in section 10.4.7 et seq. of this chapter.

Q. Desk and Site Reviews

All initial and revalidating IDTF applicants shall receive: (1) a thorough desk review; and (2) a mandatory site visit prior to the contractor's approval of the application. The general purposes of these reviews are to determine whether:

- The information listed on Attachment 2 of the Form CMS-855B is correct, verifiable, and in accordance with all IDTF regulatory and enrollment requirements.

- To the extent applicable, the IDTF meets the criteria outlined in sections 10.6.20(A) and 10.6.20(B) of this chapter.

- The IDTF meets the supplier standards in 42 CFR § 410.33.

The contractor shall order the site visit through PECOS. The NSVC will perform the site visit. The contractor shall not make a final decision regarding the application prior to the completion of the NSVC's site visit and the contractor's review of the results.

R. Mobile Units

Mobile units must list their geographic service areas in Section 4 of the Form CMS-855B. Based on the information furnished therein, the NSVC will generally perform the site visit via one of the following methods: (1) the mobile unit visits the office of the NSVC (or some other agreed-to location) for inspection; (2) the NSVC visits the mobile unit's base of operations to inspect the unit; or (3) the NSVC obtains an advance schedule of the locations at which the IDTF will be performing services and conducts the site visit at one of those locations.

Units performing CPT-4 or HCPCS code procedures that require direct or personal supervision mandate special attention. To this end, the contractor shall maintain a listing of all mobile IDTFs that perform procedure codes that require such levels of supervision. The contractor shall also discuss with the applicant and all supervising physicians listed:

- How they will perform these types of supervision on a mobile basis;

- What their responsibilities are; and

- That a patient's physician who is performing direct or personal supervision for the IDTF on *the* patient should be aware of the prohibition concerning physician self-referral for testing (in particular, this concerns potentially illegal compensation to the supervisory physician from the IDTF).

S. Addition of Codes

An enrolled IDTF that wants to perform additional CPT-4 or HCPCS codes must submit a Form CMS-855B change request. If the additional procedures are of a type and supervision level similar to those previously reported (e.g., an IDTF that performs MRIs for shoulders wants to perform MRIs for hips), a new site visit is typically not required, though the contractor reserves the right to request that the NSVC perform one.

If, however, the enrolled IDTF wants to perform additional procedures that are not similar to those previously reported (e.g., an IDTF that conducts sleep studies wants to perform ultrasound tests or skeletal x-rays), the contractor shall order an NSVC site visit through PECOS. All IDTF claims for the additional procedures shall be suspended until the IDTF: (1) passes all enrollment requirements for the additional procedures (e.g., supervisory physician, non-physician personnel, equipment); and (2) presents evidence that all requirements for the new procedures were met when the tests were actually performed.

If the enrolled IDTF (1) originally listed only general supervision codes, (2) was only reviewed for general supervision tests, and (3) now wants to perform tests that require direct or personal

supervision, the contractor shall promptly suspend all payments for all codes other than those requiring general supervision. The contractor shall order an NSVC site visit through PECOS. All IDTF claims for the additional procedures shall be suspended until the IDTF: (1) passes all enrollment requirements for the additional procedures (e.g., supervisory physician, non-physician personnel, equipment); and (2) presents evidence that all requirements for the new procedures were met when the tests were actually performed.

In the situations described in the two previous paragraphs, the contractor shall not approve the application prior to the completion of the NSVC's site visit and the contractor's review of the results.

T. IDTF That Performs Diagnostic Mammography

If an IDTF performs diagnostic mammography services, it must have a Food and Drug Administration certification to perform the mammography. However, an entity that only performs diagnostic mammography services should not be enrolled as an IDTF. Rather, it should be separately enrolled as a mammography screening center.

U. IDTF Ownership of CLIA Laboratory

An IDTF may not perform or bill for CLIA tests. However, an entity with one tax identification number may own both an IDTF and an independent CLIA laboratory. In such a situation, they should be separately enrolled and advised to bill separately. The contractor shall also advise its claims unit to ensure that the CLIA codes are not being billed under the IDTF provider number.

V. Denials and Revocations for Non-Compliance with IDTF Supplier Standards

Pursuant to 42 CFR §§ 424.530(a)(1)/(18) and 424.535(a)(1)/(23), an IDTF's enrollment may be denied or revoked if it violates any applicable standard in § 410.33(g). The contractor shall abide by the following in such situations:

1. <u>(a)(1) – Prior approval unnecessary</u>

For violations of any of the following supplier standards in § 410.33(g), the contractor shall deny or revoke enrollment under, respectively, §§ 424.530(a)(1) or 424.535(a)(1). Prior PEOG approval is unnecessary. Corrective action plan (CAP) rights under §§ 424.530(a)(1) or 424.535(a)(1) apply.

- § 410.33(g)(1) through (g)(6) as well as (g)(8) through (17).

2. <u>(a)(1) and (a)(23) – Prior approval unnecessary</u>

For violations of the following supplier standard in § 410.33(g), the contractor shall deny or revoke enrollment under, respectively, §§ 424.530(a)(1) or 424.535(a)(23). Prior PEOG approval is unnecessary. CAP rights under §§ 424.530(a)(1) apply but no CAP rights apply for § 424.535(a)(23) revocations.

- § 410.33(g)(7)

10.2.2.5 – Intensive Cardiac Rehabilitation (ICR)

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

ICR suppliers are a supplier type that enrolls via the Form CMS-855B.

A. Background

Under 42 CFR § 410.49(a), an intensive cardiac rehabilitation (ICR) program is defined as a physician or non-physician practitioner-supervised program that furnishes cardiac rehabilitation and has shown, in peer-reviewed published research, that it improves patients' cardiovascular disease through specific outcome measurements described in § 410.49(c). (Nonphysician practitioners are eligible to supervise an ICR effective January 1, 2024.)

ICR programs must be approved by CMS through the national coverage determination (NCD) process and must meet certain criteria for approval. Individual sites seeking to provide ICR services via an approved ICR program must enroll with their local Medicare contractor as an ICR program supplier.

B. ICR Enrollment

To enroll as an ICR site, a supplier must complete a Form CMS-855B with the supplier type of "Intensive Cardiac Rehabilitation" selected. The contractor shall verify that CMS has approved the ICR program through the NCD process. A list of approved ICR programs will be identified through the NCD listings, the CMS Web site, and the Federal Register. The contractor shall use one of these options to verify that the ICR program has met CMS approval.

An ICR supplier must separately and individually enroll each of its practice locations. The supplier can therefore only have one practice location (which shall receive its own Provider Transaction Access Number (PTAN)) on its Form CMS-855B enrollment application. The contractor shall use specialty code 31 for these enrollments.

The contractor may accept and process reassignments to ICRs from physicians and nonphysicians who are otherwise authorized to reassign benefits under existing law and policy.

It is important that the contractor review and adhere to the following regulations and instructions regarding the required qualifications of ICR suppliers:

- 42 CFR § 410.49
- Pub. 100-04, chapter 32, sections 140.2.2 - 140.2.2.6
- Pub. 100-02, chapter 15, section 232

10.2.3.2 – Audiologists

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

Section 1861(ll)(3)(B) of the Social Security Act and Pub. 100-02, chapter 15, section 80.3.1 state that a qualified audiologist means an individual with a master's or doctoral degree in audiology who:

1. Is licensed as an audiologist by the state in which the individual furnishes such services; or

2. In the case of an individual who furnishes services in a state that does not license audiologists, has:

    - Successfully completed 350 clock hours of supervised clinical practicum (or is in the process of accumulating such supervised clinical experience), and

    - Performed not less than 9 months of supervised full-time audiology services after obtaining a master's or doctoral degree in audiology or a related field, and

    - Successfully completed a national examination in audiology approved by the Secretary.

Given these requirements (and as stated in the aforementioned section 80.3.1), a Doctor of Audiology (AuD) 4th year student with a provisional license from a state does not qualify unless the *individual* also holds a master's or doctoral degree in audiology.

See Pub. 100-04, chapter 12, section 30.3 for further information regarding audiologist billing.

10.2.3.5 – Clinical Nurse Specialists

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

Federal regulations at 42 CFR § 410.76 state that a clinical nurse specialist must meet all of the following requirements:

1. Be a registered nurse who is currently licensed to practice in the state where *the individual* practices and be authorized to furnish the services of a clinical nurse specialist in accordance with state law.

2. Have a master's degree in a defined clinical area of nursing from an accredited educational institution or a Doctor of Nursing Practice (DNP) doctoral degree; and

3. Be certified as a clinical nurse specialist by a recognized national certifying body that has established standards for clinical nurse specialists and that is approved by the Secretary.

Pub. 100-02, chapter 15, section 210 states that CMS recognizes the following organizations as national certifying bodies for clinical nurse specialists at the advanced practice level:

a. American Academy of Nurse Practitioners

b. American Nurses Credentialing Center

c. National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties

d. Pediatric Nursing Certification Board (previously named the National Certification Board of Pediatric Nurse Practitioners and Nurses)

e. Oncology Nurses Certification Corporation

f. AACN Certification Corporation

g. National Board on Certification of Hospice and Palliative Nurses

h. Nurses Portfolio Credentialing Commission (NPCC)

10.2.3.6 – Clinical Psychologists

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

Federal regulations at 42 CFR § 410.71(d) state that to qualify as a clinical psychologist, a practitioner must meet the following requirements:

1. Hold a doctoral degree in psychology (that is, a Ph.D., Ed.D., Psy.D.), and

2. Is licensed or certified, on the basis of the doctoral degree in psychology, by the state in which *the individual* practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

A clinical psychologist must agree to meet the consultation requirements of 42 CFR § 410.71(e)(1) through (e)(3). Under 42 CFR § 410.71(e), the individual's signing of the Form CMS-855I indicates *the individual's* agreement to adhere to the requirements of § 410.71(e)(1) through (e)(3).

For more information on clinical psychologists, refer to Pub. 100-02, chapter 15, section 160.

10.2.3.9 – Occupational Therapists in Private Practice

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Regulatory Requirements - Occupational Therapist in Private Practice

Section 42 CFR § 410.59(c)(1)(i) through (iv) state that an occupational therapist in private practice must meet all the following:

(i) Be legally authorized (if applicable, licensed, certified, or registered) to engage in the private practice of occupational therapy by the state in which *the individual* practices, and practice only within the scope of *the individual's* license, certification, or registration.

(ii) Engage in the private practice of occupational therapy on a regular basis as an individual, in one of the following practice types: (A) solo practice; (B) a partnership; (C) group practice; or (D) as an employee of one of these.

(iii) Bill Medicare only for services furnished in *the individual's* private practice office space, or in the patient's home. (A therapist's private practice office space refers to the location(s) where the practice is operated in the state(s) where the therapist (and practice, if applicable) is legally authorized to furnish services, during the hours that the therapist engages in practice at that location. When services are furnished in private practice office space, such space must be owned, leased, or rented by the practice and used for the exclusive purpose of operating the practice. A patient's home does not include any institution that is a hospital, a critical access hospital, or a SNF.))

(iv) Treat individuals who are patients of the practice and for whom the practice collects fees for the services furnished.

B. Qualified Occupational Therapist Requirements

Pub. 100-02, chapter 15, section 230.2(B) states that a qualified occupational therapist is an individual who meets the requirements in one of the four categories below:

Category #1 – The occupational therapist: (i) is licensed (if licensure applies) or otherwise regulated (if applicable) as an occupational therapist by the state in which practicing; (ii) graduated from an accredited education program for occupational therapists; and (iii) is eligible to take or has passed the examination for occupational therapists administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT). The phrase "by the state in which practicing" includes any authorization to practice provided by the same state in which the service is furnished (including temporary licensure), regardless of the location of the entity billing the services. The education program for U.S. trained occupational therapists is accredited by the Accreditation Council for Occupational Therapy Education (ACOTE).

The requirements above apply to all occupational therapists effective January 1, 2010 if the occupational therapist has not met any of the following requirements prior to January 1, 2010.

Category #2 - On or before December 31, 2009, the individual --

(a) Is licensed or otherwise regulated as an occupational therapist in the state in which practicing (regardless of the qualifications they met to obtain that licensure or regulation); or

(b) When licensure or other regulation does not apply--

(i) Graduated from an occupational therapist education program accredited by ACOTE; and

(ii) Is eligible to take, or has successfully completed, the NCBOT examination for occupational therapists.

Category #3 - On or before January 1, 2008 (and if the individual met the Medicare requirements for occupational therapists that were in 42 CFR § 484.4 prior to January 1, 2008), the individual--

(a) Graduated from an occupational therapy program approved jointly by the American Medical Association and the American Occupational Therapy Association (AOTA); or

(b) Is eligible for the National Registration Examination of AOTA or NBCOT.

Category #4 - On or before December 31, 1977, the individual--

(a) Had 2 years of appropriate experience as an occupational therapist; and

(b) Had achieved a satisfactory grade on an occupational therapist proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

C. Occupational Therapist Educated Outside the United States

Pub. 100-02, chapter 15, section 230.2(B) states that individuals educated outside the U.S. may meet the same qualifications as domestic trained occupational therapists; for example, the individual qualifies if licensed or otherwise regulated by the state in which practicing on or before December 31, 2009. The *individual* also qualifies if *the person:*

- Graduated from an occupational therapy education program accredited as substantially equivalent to a U.S. occupational therapy education program by ACOTE, the World Federation of Occupational Therapists, or a credentialing body approved by AOTA;

- Passed the NBCOT examination for occupational therapists; and

- Effective January 1, 2010, *is* licensed or otherwise regulated, if applicable, as an occupational therapy by the state in which practicing.

D. Occupational Therapists - Additional References

In Pub. 100-02, chapter 15, see section 230.2(B) for more information regarding the required qualifications of occupational therapists and section 230.4 for information regarding the term “private practice.”

E. Other Enrollment Information - Form CMS-855 Completion

All occupational therapists in private practice must respond to the questions in Section 2J of the Form CMS-855I. However, Section 2J does not apply if the occupational therapist: (1) plans to provide services as a member of an established occupational therapist group, an employee of a physician-directed group, or an employee of a non-professional corporation; and (2) wishes to reassign benefits to that group.

If the occupational therapist checks *that all services are furnished* in patients' homes, the contractor shall verify that *the individual* has an established private practice where *the individual* can be contacted directly and where *the individual* maintains patient records. (This can be the person's home address, though all Medicare rules and instructions regarding the maintenance of patient records apply.) In addition, Section 4B of the Form CMS-855I should indicate where services are rendered (e.g., county, state, city of the patients' homes). Post office boxes are not acceptable.

If the *individual* answers "Yes" to question 2, 3, 4, or 5, the contractor shall request a copy of the lease agreement giving *the individual* exclusive use of the facilities for occupational therapy services only if it has reason to question the accuracy of *the individual's* response. If the contractor makes this request and the supplier cannot furnish a copy of the lease, the contractor shall deny the application.

10.2.3.10 – Physical Therapists in Private Practice

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Regulatory Requirements - Physical Therapist in Private Practice

Section 42 CFR § 410.60(c) states that to qualify under Medicare as a supplier of outpatient physical therapy services, each individual physical therapist in private practice must meet the following requirements:

1. Be legally authorized (if applicable, licensed, certified, or registered) to engage in the private practice of physical therapy by the state in which the *individual* practices, and practice only within the scope of *the individual's* license, certification, or registration.

2. Engage in the private practice of physical therapy on a regular basis as an individual in one of the following practice types: (i) a solo practice; (ii) a partnership; (iii) a group practice; or (iv) as an employee of any of (i), (ii), or (iii).

3. Bill Medicare only for services furnished in *the individual's* private practice office space, or in the patient's home. A therapist's private practice office space refers to the location(s) where the practice is operated, in the state(s) where the therapist (and practice, if applicable) is legally authorized to furnish services during the hours that the therapist engages in practice at that location. When services are furnished in private practice office space, such space must be owned, leased, or rented by the practice and used for the exclusive purpose of operating the practice. A patient's home does not include any institution that is a hospital, a CAH, or a SNF.

4. Treat individuals who are patients of the practice and for whom the practice collects fees for the services furnished.

B. Qualified Physical Therapist Definition

Pub. 100-02, chapter 15, section 230.1 states that a qualified physical therapist is a person who: (1) is licensed, if applicable, by the state in which *the individual* is practicing (unless licensure does not apply); (2) has graduated from an accredited physical therapist education program; and (3) passed an examination approved by the state in which physical therapy services are provided. The phrase "by the state in which practicing" includes any authorization to practice provided by the same state in which the service is provided, including temporary licensure, regardless of the location of the entity billing the services. The curriculum accreditation is provided by the Commission on Accreditation in Physical Therapy Education (CAPTE) or, for those who graduated before CAPTE, curriculum approval was provided by the American Physical Therapy Association (APTA). For internationally educated physical therapists, curricula are approved by a credentials evaluation organization either approved by the APTA or identified in 8 CFR 212.15(e) as it relates to physical therapists. For example, in 2007, 8 CFR 212.15(e) approved the credentials evaluation provided by the Federation of State Boards of Physical Therapy (FSBPT) and the Foreign Credentialing Commission on Physical Therapy (FCCPT).

The requirements above do not apply to a physical therapist effective January 1, 2010, if *the individual* has otherwise met the requirements outlined in Category #2, Category #3, Category #4, or Category #5 below. (Category #1 is outlined in the previous paragraph.)

Category #2 – A physical therapist whose current license was obtained on or prior to December 31, 2009, qualifies to provide physical therapy services to Medicare beneficiaries if the *individual:*

(a) Graduated from a CAPTE approved program in physical therapy on or before December 31, 2009 (examination is not required); or

(b) Meets both of the following:

(i) Graduated on or before December 31, 2009, from a physical therapy program outside the U.S. that is determined to be substantially equivalent to a U.S. program by a credentialed evaluation organization approved by the APTA or identified in 8 CFR § 212.15(e).

(ii) Passed an examination for physical therapists approved by the state in which *the individual* is practicing.

Category #3 – A physical therapist whose current license was obtained before January 1, 2008, may meet the requirements in place on that date (i.e., graduation from a curriculum approved by either the APTA, the American Medical Association, or both).

Category #4 – A physical therapist meets the requirements if *the individual* (a) is currently licensed as a physical therapist, (b) was licensed or qualified as a physical therapist on or before

December 31, 1977, (c) had 2 years of appropriate experience as a physical therapist, and (d) passed a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

Category #5 – A physical therapist meets the requirements if *the individual* is currently licensed and before January 1, 1966, was:

- Admitted to membership by the APTA; or
- Admitted to registration by the American Registry of Physical Therapists; or
- Graduated from a 4-year physical therapist curriculum approved by a state Department of Education; or
- Licensed or registered and prior to January 1, 1970, had 15 years of full-time experience in physical therapy under the order and direction of attending and referring doctors of medicine or osteopathy.

C. Physical Therapist Trained Outside the United States

Pub. 100-02, chapter 15, section 230.1(B) states that a physical therapist meets the requirements if *the individual*: (a) is currently licensed; (b) was trained outside the U.S. before January 1, 2008; (c) after 1928 graduated from a physical therapy curriculum approved in the country in which the curriculum was located and that country had an organization that was a member of the World Confederation for Physical Therapy; and (d) qualified as a member of that organization.

D. Physical Therapists - Additional References

In Pub. 100-02, chapter 15, see section 230.2(B) for more information regarding the required qualifications of physical therapists and section 230.4 for detailed information regarding the term "private practice."

E. Site Visits of Physical Therapists in Private Practice

(This site visit requirement is pursuant to 42 CFR § 424.518(b).)

Unless otherwise stated in this chapter or another CMS directive, site visits will be performed in accordance with the following:

i. Initial application – If a physical therapist or physical therapist group submits an initial application for private practice, the contractor shall order a site visit through PECOS. This is to ensure that the supplier is in compliance with CMS's enrollment requirements. The scope of the site visit will be consistent with sections 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not convey Medicare billing privileges to the supplier prior to the completion of the NSVC's site visit and the contractor's review of the results.

ii. Revalidation – If a private practice physical therapist or physical therapist group submits a revalidation application, the contractor shall order a site visit through PECOS. This is to ensure that the supplier is still in compliance with CMS's enrollment requirements. The scope of the site visit will be consistent with sections 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not make a final decision regarding the revalidation application prior to the completion of the NSVC's site visit and the contractor's review of the results.

iii. New/changed location – Unless CMS has directed otherwise, if a private practice physical therapist or physical therapist group is (1) adding a new location or (2) changing the physical location of an existing location, the contractor shall order a site visit of the new/changed location through PECOS. This is to ensure that the new/changed location complies with CMS's enrollment requirements. The scope of the site visit will be consistent with sections 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not make a final decision regarding the application prior to the completion of the NSVC's site visit and the contractor's review of the results.

Note that if the PT (being a moderate-risk provider under § 424.518) has multiple practice locations, the SVC will conduct a site visit of each location rather than simply one selected location.

F. Physical Therapists: Additional Site Visit Information

The contractor is also advised of the following:

- In Section 2B of the Form CMS-855B application, physical and occupational therapy groups are denoted as "Physical/Occupational Therapy Group in Private Practice." If a supplier that checks this box in Section 2B is exclusively an occupational therapy group in private practice – that is, there are no physical therapists in the group – the contractor shall process the application using the procedures in the "limited" screening category. No site visit is necessary. If there is at least one physical therapist in the group, however, the application shall be processed using the procedures in the "moderate" screening category. A site visit by the NSVC is required unless CMS has directed otherwise.

- If an entity is enrolled as a physician practice and employs a physical therapist within the practice, the practice itself falls within the "limited" screening category. This is because the entity is enrolled as a physician practice and not a physical therapy group in private practice. However, this does not exempt the physical therapist from the screening required at the "moderate" risk level.

- Unless CMS has directed otherwise, a site visit by the NSVC is required when a physical therapist submits an application for private practice initial enrollment and reassignment of benefits (Form CMS-855I). However, a site visit is not required for an enrolled private practice physical therapist who is reassigning benefits only.

- If the private practice physical therapist's practice location is the home address and *the individual* exclusively performs services in patients' homes, nursing homes, etc., no site visit is necessary.

G. Other Enrollment Information

All physical therapists in private practice must respond to the questions in Section 2J of the Form CMS-855I. However, Section 2J does not apply if the physical therapist: (1) plans to provide services as a member of an established PT group, an employee of a physician-directed group, or an employee of a non-professional corporation; and (2) the person wishes to reassign benefits to that group. Such information will be captured on the group's Form CMS-855B application.

If the physical therapist checks that *the individual* renders all services in patients' homes, the contractor shall verify that *the individual* has an established private practice where *at which direct contact can be made* and where *the individual* maintains patient records. (This can be the person's home address, though all Medicare rules and instructions regarding the maintenance of patient records apply.) In addition, Section 4E of the Form CMS-855I should indicate where services are rendered (e.g., county, state, city of the patients' homes). Post office boxes are not acceptable.

If the *individual* answers "Yes" to question 2, 3, 4, or 5, the contractor shall request a copy of the lease agreement giving *the individual* exclusive use of the facilities for physical therapist services only if it has reason to question the accuracy of *the individual's* response. If the contractor makes this request and the supplier cannot furnish a copy of the lease, the contractor shall deny the application.

10.2.3.11 – Physicians

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

As described in § 1861(r)(1) of the Social Security Act and in 42 CFR § 410.20(b), a physician must be legally authorized to practice medicine by the state in which *the individual* performs such services in order to enroll in the Medicare program and to retain Medicare billing privileges. Such individuals include: (1) doctors of medicine or osteopathy, dental surgery or dental medicine, podiatric medicine, or optometry; and (2) a chiropractor who meets the qualifications specified in 42 CFR § 410.22.

See Pub. 100-04, chapter 19, section 40.1.2 for special licensure rules regarding practitioners who work in or reassign benefits to hospitals or freestanding ambulatory care clinics operated by the Indian Health Service or by an Indian tribe or tribal organization.

10.2.3.12 – Physician Assistants

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

(The physician assistant (PA) enrollment instructions in this section 10.2.3.12 supersede all other PA-specific instructions in this chapter.)

A. PA Requirements Under § 410.74

Current federal regulations at 42 CFR §§ 410.74 discuss the requirements that a PA must meet.

Among the requirements for coverage of PA services outlined in 42 CFR §§ 410.74(a) are that the PA (as listed in §§ 410.74(a)(2)):

(i) Meets the qualifications set forth in § 410.74(c);

(ii) Is legally authorized to perform the services in the state in which they are performed;

(iii) Performs services that are not otherwise precluded from coverage because of a statutory exclusion;

(iv) Performs the services in accordance with state law and state scope of practice rules for PAs in the state in which the PA's professional services are furnished. Any state laws and scope of practice rules that describe the required practice relationship between physicians and PAs (including explicit supervisory or collaborative practice requirements) describe a form of supervision for purposes of section 1861(s)(2)(K)(i) of the Social Security Act. For states with no explicit state law and scope of practice rules regarding physician supervision of a PA's services, physician supervision is a process in which a PA has a working relationship with one or more physicians to supervise the delivery of their health care services. Such physician supervision is evidenced by documenting at the practice level the PA's scope of practice and the working relationships the PA has with the supervising physician(s) when furnishing professional services; and

(v) Performs the services: (A) in all settings in either rural and urban areas; or (B) as an assistant at surgery.

Section 410.74(c), meanwhile, states that for Medicare Part B coverage of the *individual's* services, a PA must meet all the following conditions:

- (1) Have graduated from a PA educational program that is accredited by the Commission on Accreditation of Allied Health Education Programs; OR (2) have passed the national certification examination that is administered by the National Commission on Certification of Physician Assistants (NCCPA);

  AND

- (2) Be licensed by the state to practice as a PA. (The PA need not be currently NCCPA-certified.)

(In other words, either (1) or (2) in the first bullet must be met, and the licensure requirement in the second bullet must always be met.)

B. PA Employer

Prior to January 1, 2022, payment for the PA's services could only be made to the PA's employer, not to the P*A*. That is, the PA could not individually enroll in Medicare to receive direct payment for services. This also meant that the PA could not reassign benefits to the employer, for the employer must receive direct payment anyway. Pursuant to the CY 2022 Physician Fee Schedule Final Rule, however, a PA may:

- Individually enroll in Medicare (e.g., as a sole proprietorship, professional corporation)
- Receive direct payment for services
- Establish PA groups (e.g., LLCs)
- Reassign benefits to employer.

The previous requirement that the PA's employer must bill for *the PA's* services has hence been eliminated.

C. PA Enrollment Information

With the above-mentioned change concerning PA employers (and except as stated in this subsection (C)), the contractor is advised of and/or shall adhere to the below policies, which are effective January 1, 2022. Note that reassignments of benefits are now captured via the Form CMS-855I, for the Form CMS-855R has been discontinued.

1. Newly enrolling, revalidating, and reactivating PAs shall complete the applicable Form CMS-855I sections to the same extent as would any other individual practitioner who is able to individually enroll in and bill Medicare.

2. Transactions

a. Initial Enrollment - If a PA is initially enrolling in Medicare and does not intend to reassign benefits, *the PA* need not complete Sections 4(F)(1) and (2) of the Form CMS-855I. (The PA may, but is not required to, furnish the primary and secondary practice location information in Section 4(F)(3).)

b. Initial Enrollment - If a PA is initially enrolling in Medicare and intends to reassign benefits, the PA shall complete Sections 4(F)(1) and (2) of the Form CMS-855I. (Section 4(F)(3) is optional.)

See section 10.3.1.4 of this chapter for more information on reassignments.

10.2.3.13 – Psychologists Practicing Independently

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

Pub. 100-02, chapter 15, section 80.2 states that a psychologist practices independently when:

- The *individual* renders services on the *individual's* own responsibility, free of the administrative and professional control of an employer, such as a physician, institution, or agency;

- The persons the *individual* treats are *the latter's* own patients;

- The *individual* has the right to bill directly, collect and retain the fee for services *performed*; and

- The *individual* is state-licensed or certified in the state where furnishing services.

A psychologist practicing in an office located in an institution may be considered an independently practicing psychologist when both of the following conditions are met: (1) the office is confined to a separately-identified part of the facility that is used solely as the psychologist's office and cannot be construed as extending throughout the entire institution; and (2) the psychologist conducts a private practice (i.e., services are rendered to patients from outside the institution as well as to institutional patients).

Independently practicing psychologists have a more limited benefit under the Medicare program than clinical psychologists. With a degree starting at the master's level of psychology, independently practicing psychologists are authorized to bill the program directly solely for diagnostic psychological and neuropsychological tests that have been ordered by a physician, clinical psychologist, or non-physician practitioner who is authorized to order diagnostic tests. Independently practicing psychologists are not authorized to supervise diagnostic psychological and neuropsychological tests. Any tests performed by an independently practicing psychologist must fall under the psychologist's state scope of practice.

The contractor shall ensure that all persons who check "Psychologist Billing Independently" in Section 2H of the Form CMS-855I answer all questions in Section 2J2. If the supplier answers "no" to question 1, 2, 3, 4a, or 4b, the contractor shall deny the application.

See Pub. 100-04, chapter 12, sections 160 and 160.1 for more information on psychologists billing independently.

10.2.3.14 – Registered Dietitians/Nutrition Professionals

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

Federal regulations at 42 CFR § 410.134(a) through (c) state that a registered dietitian (or nutrition professional) is an individual who, on or after December 22, 2000:

(a) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose;

(b) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional; and

(c) Is licensed or certified as a dietitian or nutrition professional by the state in which the services are performed. In a state that does not provide for licensure or certification, the individual will be deemed to have met this requirement if *the individual* is recognized as a "registered dietitian"' by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a) and (b) above.

There are two exceptions to these requirements (as stated in 42 CFR § 410.134(d)(i) and (ii)):

(i) A dietitian or nutritionist licensed or certified in a state as of December 21, 2000, is not required to meet the requirements of (a) and (b) above.

(ii) A registered dietitian in good standing, as recognized by the Commission of Dietetic Registration or its successor organization, is deemed to have met the requirements of (a) and (b) above.

10.2.3.15 – Speech Language Pathologists in Private Practice

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

Consistent with 42 CFR § 410.62(c), in order to qualify as an outpatient speech-language pathologist in private practice, an individual must meet the following requirements:

(i) Be legally authorized (if applicable, licensed, certified, or registered) to engage in the private practice of speech-language pathology by the state in which the *individual* practices, and practice only within the scope of *the individual's* license and/or certification.

(ii) Engage in the private practice of speech-language pathology on a regular basis as an individual in one of the following practice types: a solo practice, partnership, group practice, or as an employee of one of these.

(iii) Bill Medicare only for services furnished in one of the following:

(A) A speech-language pathologist's private practice office space that meets all of the following: (1) the location(s) where the practice is operated, in the state(s) where the therapist (and practice, if applicable) is legally authorized to furnish services and during the hours that the therapist engages in practice at that location; and (2) the space must be owned, leased, or rented by the practice, and used for the exclusive purpose of operating the practice; or

(B) A patient's home not including any institution that is a hospital, a CAH, or a SNF.

(iv) Treat individuals who are patients of the practice and for whom the practice collects fees for the services furnished.

For more information on speech language pathologists in private practice, refer to Pub. 100-02, chapter 15, section 230.

10.2.3.17 – Marriage and Family Therapists (MFTs)

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Definition and Requirements

Effective January 1, 2024, Medicare covers services furnished by MFTs. An MFT is defined in CFR § 410.53(a)(1)-(3) as an individual who:

(1) Possesses a master's or doctor's degree which qualifies for licensure or certification as a MFT pursuant to state law of the state in which such individual furnishes the services defined as MFT services;

(2) After obtaining such degree, has performed at least 2 years or 3,000 hours of post-master's degree clinical supervised experience in marriage and family therapy in an appropriate setting such as a hospital, SNF, private practice, or clinic; and

(3) Is licensed or certified as an MFT by the state in which the services are performed.

Under 42 CFR § 410.53(b)(1), MFT services means services furnished by an MFT (as defined in § 410.53(a)) for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital), which the MFT is legally authorized to perform under state law (or the state regulatory mechanism provided by state law) of the state in which such services are furnished. The services must be of a type that would be covered if they were furnished by a physician or as incident to a physician's professional service and must meet the requirements of § 410.53(b)(1).

Per 42 CFR § 410.53(b)(2), MFT services furnished by an MFT to an inpatient of a Medicare-participating hospital are not MFT services for purposes of billing Medicare Part B under the MFT benefit category.

B. Verification

As it does with Medicare supplier types, the contractor shall familiarize itself with the applicable state licensure and associated education requirements for MFTs. This will assist the contractor in ascertaining whether the MFT meets all state requirements.

In verifying the supplier's compliance with:

1. § 410.53(a)(1) – Except as stated in the discussion of § 410.53(a)(3) below, the contractor shall require the supplier to submit a copy of *the individual's* master's or doctor's degree. Whether a master's or, instead, a doctor's degree is required will depend on the applicable state's requirements.

2. § 410.53(a)(2) – Except as stated in the discussion of § 410.53(a)(3) below, the contractor shall require the supplier to submit documentation verifying that they have performed, at a minimum, either 2 years or 3,000 hours of post-master's clinical supervised experience in marriage and family therapy in an appropriate setting, such as a hospital, SNF, private practice, or clinic. (The supplier need only meet the 2-year or the 3,000-hour standard, not both.) Such documentation shall be one of the following:

   (i) A statement from the provider/supplier at which the MFT performed the services in question (e.g., hospital, clinic) verifying that the MFT performed services at that setting for the required number of years or hours. The statement shall:

   (a) Be on the provider's/supplier's letterhead (e-mail is not acceptable); and

   (b) Be signed by: (1) the provider/supplier supervisor under whom the MFT performed the services; (2) an applicable department head (e.g., chief of psychology) of the provider/supplier; or (3) a current authorized or delegated official of the provider/supplier (i.e., the AO/DO has already been approved as such in the provider/supplier's enrollment record) if the provider/supplier is Medicare-enrolled.

   The statement need not contain standard, boilerplate language. It need only confirm to the contractor's satisfaction that the year or hour requirement was met. Also, the contractor may accept statements from multiple providers/suppliers if the year or hour requirement was met by performing services at more than one setting. For instance, suppose Dr. Smith earned her MFT experience by performing 1,000 hours at Hospital X and 2,000 hours at Hospital Y. The contractor can accept one statement from Hospital X concerning the 1,000 hours and another from Hospital Y regarding the remaining 2,000 hours so long as each statement meets the requirements of subsections (B)(2)(i)(a) and (B)(2)(i)(b) above. Put otherwise, the MFT can combine years and hours from multiple providers/suppliers to meet § 410.53(a)(2).

   In addition:

   - A statement from the MFT's current employer that the MFT met the year or time requirement at other settings besides the employer is not acceptable. All statements must be from the provider/supplier in which setting(s) the MFT performed the services. Using our example above, suppose Dr. Smith's supervisor at Hospital X was Dr. Jones. Dr. Jones is no longer with Hospital X, however. Dr. Smith submits a statement from Dr. Jones stating that Dr. Smith performed 1,000 hours of MFT services at Hospital X. This statement cannot be accepted because it is not from Hospital X.

   - The setting can be any provider/supplier at which MFT services are furnished. It need not be one of the four provider/supplier types listed in § 410.53(a)(2). Moreover, the provider/supplier need not have been (or currently be) enrolled in Medicare at the time the MFT performed the services there.

   OR

(ii) A statement verifying that the MFT meets the year or hour requirements from a: (1) licensing or credentialing body for the state in which the MFT is enrolling; or (2) national MFT credentialing organization. The statement can be signed by any official of the state licensing/credentialing or national credentialing body. It must, however, be on the body's letterhead.

If the MFT fails to furnish the above documentation, the contractor shall develop for it consistent with the instructions in this chapter.

3. § 410.53(a)(3) – The contractor shall verify state licensure or certification consistent with existing policies for doing so in this chapter.

If the contractor confirms to its satisfaction that the state already requires, as a condition of licensure or credentialing, the MFT to have:

- Performed, at a minimum, either 2 years or 3,000 hours of post-master's clinical supervised experience in marriage and family therapy in an appropriate setting such as a hospital, SNF, private practice, or clinic, the contractor can forgo verifying separate compliance with the § 410.53(a)(2) requirement described above; the MFT need not submit the documentation specified in subsection (B)(2). (This is because the licensure/credentialing already includes the year/hour requirement.)

- A master's or doctor's degree (as applicable), the MFT need not submit a copy of *the individual's* degree nor need the contractor verify that the MFT received said degree.

C. Additional Information

1. Pre/Post Degree - As indicated above, all 2 years/3,000 hours of clinical supervised experience must have been performed post-degree. Pre-degree experience does not count towards the required time total under § 410.53(a)(2), even if the state permits pre-degree experience to be counted towards meeting state requirements. For example, suppose State X requires 1,000 hours of supervised experience for licensure. The hours can be performed pre-degree or post-degree. Jones, who is licensed by X, performed her 1,000 hours before receiving her degree. Jones cannot apply these hours towards the § 410.53(a)(2) time requirement – even though *Jones* is licensed – and must furnish evidence of 2 years/3,000 hours post-degree experience. If, however, Jones had performed 500 hours pre-degree and 500 hours post-degree, the latter (but not the former) *could be applied* to the § 410.53(a)(2) time requirement.

2. Additional Policies

Like certain other individual practitioners, MFTs may opt-out of Medicare, form groups, reassign their benefits under § 424.80, receive reassigned benefits, and order/certify services to the extent otherwise permitted by law. They will complete the Form CMS-855I to bill for services and be subject to limited-risk screening (except as described in § 424.518(c)(3)).

Until the Form CMS-855I is revised to include MFTs, the MFT shall check the "Undefined Non-Physician Practitioner Specialty" box and state "marriage and family therapist" in the line next thereto.

10.2.3.18 – Mental Health Counselors (MHCs)

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Definitions and Requirements

Effective January 1, 2024, Medicare covers services furnished by MHCs. An MHC is defined in 42 CFR § 410.54(a) as an individual who:

(1) Possesses a master's or doctor's degree which qualifies for licensure or certification as an MHC, clinical professional counselor, or professional counselor under the state law of the state in which such individual furnishes the services defined as mental health counselor services;

(2) After obtaining such a degree, has performed at least 2 years or 3,000 hours of post-master's degree clinical supervised experience in mental health counseling in an appropriate setting such as a hospital, SNF, private practice, or clinic; and

(3) Is licensed or certified as an MHC, clinical professional counselor, professional counselor, addiction counselor, or alcohol and drug counselor (ADC) by the state in which the services are performed.

Under 42 CFR § 410.54(b)(1), MHC services means services furnished by an MHC (as defined in § 410.54(a)) for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital), which the MHC is legally authorized to perform under state law (or the state regulatory 1417 mechanism provided by state law) of the state in which such services are furnished. The services must be of a type that would be covered if they were furnished by a physician or as incident to a physician's professional service and must meet the requirements of § 410.54.

Per 42 CFR § 410.54(c)(2), MHC services furnished by an MHC to an inpatient of a Medicare-participating hospital are not MHC services for purposes of billing Medicare Part B:

B. Verification

As it does with Medicare supplier types, the contractor shall familiarize itself with the state licensure and associated education requirements for MHCs. This will assist the contractor in ascertaining whether the MHC meets all state requirements.

In verifying the supplier's compliance with:

1. § 410.54(a)(1) – Except as stated in the discussion of § 410.54(a)(3) below, the contractor shall require the supplier to submit a copy of *the individual's* master's or doctor's degree. Whether a master's or, instead, a doctor's degree is required will depend on the applicable state's requirements.

2. § 410.54(a)(2) – Except as stated in the discussion of § 410.54(a)(3) below, the contractor shall require the supplier to submit documentation verifying that they have performed, at a minimum, either 2 years or 3,000 hours of post-master's clinical supervised experience in mental health counseling in an appropriate setting such as a hospital, SNF, private practice, or clinic. (The supplier need only meet the 2-year or the 3,000-hour standard, not both.) Such documentation shall be one of the following:

   (i) A statement from the provider/supplier at which the MHC performed the services in question (e.g., hospital, clinic) verifying that the MHC performed services at that setting for the required number of years or hours. The statement shall:

   (a) Be on the provider's/supplier's letterhead (e-mail is not acceptable); and

   (b) Be signed by: (1) the supervisor under whom the MHC performed the services; (2) an applicable department head (e.g., chief of psychology) of the provider/supplier; or (3) a current authorized or delegated official of the provider/supplier (i.e., the AO/DO has already been approved as such in the provider/supplier's enrollment record) if the provider/supplier is Medicare-enrolled.

   The statement need not contain standard, boilerplate language. It need only confirm to the contractor's satisfaction that the year or hour requirement was met. Also, the contractor may accept statements from multiple providers/suppliers if the year or hour requirement was met by performing services at more than one setting. For instance, suppose Dr. Smith earned MHC experience by performing 1,000 hours at Hospital X and 2,000 hours at Hospital Y. The contractor can accept one statement from Hospital X concerning the 1,000 hours and another from Hospital Y regarding the remaining 2,000 hours so long as each statement meets the requirements of subsections (B)(2)(i)(a) and (B)(2)(i)(b) above. Put otherwise, the MHC can combine years and hours from multiple providers/suppliers to meet the requirements in § 410.54(a)(2).

   In addition:

   - A statement from the MHC's current employer that the MHC met the year or time requirement at other settings besides the employer is not acceptable. All statements must be from the provider/supplier in which setting(s) the MHC performed the services. Using our example above, suppose Dr. Smith's supervisor at Hospital X was Dr. Jones. Dr. Jones is no longer with Hospital X, however. Dr. Smith submits a statement from Dr. Jones stating that Dr. Smith performed 1,000 hours of MHC service at Hospital X. This statement cannot be accepted because it is not from Hospital X.
   - The setting can be any provider/supplier at which MHC services are furnished. It need not be one of the four provider/supplier types listed in § 410.54(a)(2). Moreover, the provider/supplier need not have been (or currently be) enrolled in Medicare at the time the MHC performed the services there; or

(ii) A statement verifying that the MHC meets the year or hour requirements from a: (1) licensing or credentialing body for the state in which the MHC is enrolling; or (2) national MHC credentialing organization. The statement can be signed by any official of the state licensing/credentialing or national credentialing body. It must, however, be on the body's letterhead.

If the MHC fails to furnish the above documentation, the contractor shall develop for it consistent with the instructions in this chapter.

3. § 410.54(a)(3) – The contractor shall verify state licensure or certification consistent with existing policies for doing so in this chapter.

   If the contractor confirms to its satisfaction that the state already requires, as a condition of licensure or credentialing, the MHC to have:

   - Performed, at a minimum, either 2 years or 3,000 hours of clinical supervised experience in mental health counseling in an appropriate setting such as a hospital, SNF, private practice, or clinic, the contractor can forgo verifying separate compliance with the § 410.54(a)(2) requirement described above; the MHC need not submit the documentation specified in subsection (B)(2). (This is because the licensure/credentialing already includes the year/hour requirement.)

   - A master's or doctor's degree (as applicable), the MHC need not submit a copy of *the individual's* degree nor need the contractor verify that the MHC received said degree.

C. Further Information

1. Other Titles - Individuals who meet all applicable statutory and regulatory qualifications to be an MHC --- even though they may be licensed or certified by their state under a different title to furnish mental health counseling --- may enroll as an MHC. This includes mental health professionals who otherwise meet the requirements of § 410.54(a). (While a clinical psychologist, for instance, must possess a doctoral degree in psychology to enroll as such in Medicare, only a master's degree is required for MHC enrollment.) In short, the individual's specific title under state law for purposes of mental health counseling is less important than whether the requirements of § 410.54(a) are met.

   As an example, addiction counselors, ADCs, and licensed professional counselors (LPCs) may enroll as MHCs if they meet the MHC requirements. They cannot, however, enroll as addiction counselors, ADCs, or LPCs, for Medicare does not recognize such supplier types.

2. Pre/Post Degree – As indicated above, all 2 years/3,000 hours of clinical supervised experience must have been performed post-degree. Pre-degree experience does not count towards the required time total under § 410.53(a)(2), even if the state permits pre-degree experience to be counted towards meeting state requirements. For example, suppose State X requires 1,000 hours of supervised experience for licensure. The hours can be performed pre-degree or post-degree. Jones, who is licensed by X, performed 1,000 hours before

receiving *the* degree. Jones cannot apply these hours towards the § 410.53(a)(2) time requirement – even though *Jones* is licensed – and must furnish evidence of 2 years/3,000 hours post-degree experience. If, however, Jones had performed 500 hours pre-degree and 500 hours post-degree, *the latter* (but not the former) *could be applied* to the § 410.53(a)(2) time requirement.

3. Additional Policies - Like certain other individual practitioners, MHCs may opt-out of Medicare, form groups, reassign their benefits under § 424.80, receive reassigned benefits, and order/certify services to the extent otherwise permitted by law. They will complete the Form CMS-855I to bill for services and be subject to limited-risk screening (except as described in § 424.518(c)(3)).

   Until the Form CMS-855I is revised to include MHCs, the MHC shall check the "Undefined Non-Physician Practitioner Specialty" box and state "mental health counselor" in the line next thereto.

10.2.4 - Other Medicare Part B Services

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Residents and Interns

1. General Background Information

If the applicant is a "resident" in an "approved medical residency program" (as these two terms are defined at 42 CFR § 413.75(b)), the contractor shall refer to Pub. 100-02, chapter 15, section 30.3 for further instructions. (The contractor can also refer to 42 CFR § 415.200, which states that services furnished by residents in approved programs are not "physician services.")

The physician should indicate the exact date on which its residency program, internship, or fellowship was completed, so that the appropriate effective date can be issued.

2. Interns are Ineligible to Enroll in the Medicare Program

An intern cannot enroll in the Medicare program. (For purposes of this requirement, the term "intern" means an individual who is not licensed by the state because *the person* is still in post-graduate year (PGY) 1.)

B. Diabetes Self-Management Training

Diabetes self-management training (DSMT) is not a separately recognized provider type, such as a physician or nurse practitioner. A person or entity cannot enroll in Medicare for the sole purpose of performing DSMT. Rather, DSMT is an extra service that an enrolled provider or supplier can bill for, assuming it meets all of the necessary DSMT requirements. If the person or entity enrolls as a provider type (i.e., pharmacy, mass immunizer) that requires the submission of an application fee, the fee shall be submitted with the application.

All DSMT programs must be accredited as meeting quality standards by a CMS-approved national accreditation organization. CMS recognizes the American Diabetes Association (ADA) and the Association of Diabetes Care & Education Specialists (ADCES) (formerly known as the American Association of Diabetes Educators or AADE) as approved national accreditation organizations. A Medicare-enrolled provider or non-DMEPOS supplier that wishes to bill for DSMT may simply submit the appropriate accreditation certificate to its contractor. No Form CMS-855 is required unless the provider or supplier is not in the Provider Enrollment, Chain and Ownership System (PECOS), in which case a complete Form CMS-855 application must be submitted.

If the supplier is exclusively a DMEPOS supplier, it must complete and submit a Form CMS-855B application to its local Part A/B MAC. This is because A/B MACs, rather than Durable Medical Equipment Medicare Administrative Contractors, pay DSMT claims. Thus, the DMEPOS supplier must separately enroll with its A/B MAC even if it has already completed a Form CMS-855S. If an A/B MAC receives an application from a DMEPOS supplier that would like to bill for DMST, it shall verify with the applicable NPE contractor that the applicant is currently enrolled and eligible to bill the Medicare program.

For more information on DSMT, refer to:

- 42 CFR Part 410 (subpart H)

- Publication 100-02, Medicare Benefit Policy Manual, chapter 15, sections 300 – 300.5.1

C. Mass Immunizers Who Roster Bill

An entity or individual who wishes to furnish mass immunization services - but may not otherwise qualify as a Medicare provider - may be eligible to enroll as a "Mass Immunizer" via the Form CMS-855I (individuals) or the Form CMS-855B (entities). Such suppliers must meet the following requirements:

1. They may not bill Medicare for any services other than pneumococcal pneumonia vaccines (PPVs), influenza virus vaccines, and their administration.

2. They must submit claims through the roster billing process.

3. The supplier, as well as all personnel who administer the shots, must meet all applicable state and local licensure or certification requirements.

The roster billing process was developed to enable Medicare beneficiaries to participate in mass PPV and influenza virus vaccination programs offered by public health clinics and other organizations.

In addition:

- See 42 CFR §§ 424.520(d) and 424.521(a) for information regarding mass immunizer effective dates.

- In Section 4 of the Form CMS-855, the supplier need not list each off-site location (e.g., county fair, shopping mall) at which it furnishes services. It need only list its base of operations (e.g., county health department headquarters, drug store location).

For more information on mass immunization roster billing, refer to:

- Publication 100-02, Benefit Policy Manual, chapter 15, section 50.4.4.2

- Publication 100-04, Claims Processing Manual, chapter 18, sections 10 through 10.3.2.3

D. Advanced Diagnostic Imaging

Section 135(a) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended section 1834(e) of the Social Security Act. It required the Secretary to designate organizations to accredit suppliers – including, but not limited to, physicians, non-physician practitioners, and independent diagnostic testing facilities - that furnish the technical component (TC) of advanced diagnostic imaging services. MIPPA specifically defined advanced diagnostic imaging procedures as including diagnostic magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine imaging, such as positron emission tomography (PET). The law also authorizes the Secretary to specify other diagnostic imaging services in consultation with physician specialty organizations and other stakeholders.

The CMS has approved four national accreditation organizations (AOs) – the American College of Radiology, the Inter-societal Accreditation Commission, the Joint Commission, and Rad Site - to provide accreditation services for suppliers of the TC of advanced diagnostic imaging procedures. The accreditation applies only to: (1) the suppliers of the images, not to the physician's interpretation of the image; and (2) those who are paid under the Physician Fee Schedule. All AOs have quality standards that address the safety of the equipment as well as the safety of the patients and staff. Each of these designated AOs submits monthly reports to CMS that list the suppliers who have been or are accredited, as well as the beginning and end-dates of the accreditation and the respective modalities for which they receive accreditation.

Newly enrolling physicians and non-physician practitioners described above do not need to complete the appropriate boxes for Advanced Diagnostic Imaging (ADI) on Internet-based PECOS or the appropriate Form CMS-855. Information for all ADI accredited suppliers is provided to CMS by the approved ADI AOs. The contractor need not verify ADI information submitted on the application.

10.2.5.3.1 – Basics of the Surety Bond Requirement

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Parties Subject and Not Subject to Surety Bond Requirement

All DMEPOS suppliers are subject to the surety bond requirement except:

(1) Government-operated DMEPOS suppliers are exempted if the supplier has provided CMS with a comparable surety bond under state law.

(2) State-licensed orthotic and prosthetic personnel (which, for purposes of the surety bond requirement, does not include pedorthists) in private practice making custom- made orthotics and prosthetics are exempted if—

- The business is solely-owned and operated by the orthotic and prosthetic personnel, and
- The business is only billing for orthotic, prosthetics, and supplies.

(3) Physicians and non-physician practitioners, as defined in section 1842(b)(18) of the Social Security Act, are exempted if the items are furnished only to the physician or non-physician practitioner's own patients as part of *the individual's* service. The non-physicians covered under this exception are: physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals.

(4) Physical and occupational therapists in private practice are exempted if—

- The business is solely-owned and operated by the physical or occupational therapist;
- The items are furnished only to the physical or occupational therapist's own patients as part of *the individual's* professional service; and
- The business is only billing for orthotics, prosthetics, and supplies.

If a previously-exempted supplier no longer qualifies for an exception, it must submit a surety bond to the contractor - in accordance with the requirements in 42 CFR § 424.57 - within 60 days after it knows or has reason to know that it no longer meets the criteria for an exception.

B. Bond Submission

Effective May 4, 2009, DMEPOS suppliers submitting: (1) an initial enrollment application to enroll in the Medicare program for the first time, (2) an initial application to establish a new practice location, or (3) an enrollment application to change the ownership of an existing supplier, are required to obtain and submit a copy of its required surety bond to the contractor with their Form CMS-855S enrollment application. (**NOTE:** Ownership changes that do not involve a change in the status of the legal entity as evidenced by no change in the tax identification number (or changes that result in the same ownership at the level of individuals (corporate reorganizations and individuals incorporating)) are not considered to be "changes of ownership" for purposes of the May 4, 2009, effective date – meaning that such suppliers are considered "existing" suppliers).

For any Form CMS-855S application submitted on or after May 4, 2009 by a non-exempt supplier described in this subsection (B), the contractor shall reject the application if the supplier

does not furnish a valid surety bond at the time it submits its application. The rejection shall be done in accordance with existing procedures (e.g., reject application after 30 days).

C. Amount and Basis

The surety bond must be in an amount of not less than $50,000 and is predicated on the NPI, not the tax identification number. Thus, if a supplier has two separately-enrolled DMEPOS locations, each with its own NPI, a $50,000 bond must be obtained for each site.

A supplier may obtain a single bond that encompasses multiple NPIs/locations. For instance, if a supplier has 10 separately-enrolled DMEPOS locations, it may obtain a $500,000 bond that covers all 10 locations.

As stated in 42 CFR § 424.57(d)(3), a supplier will be required to maintain an elevated surety bond amount of $50,000 for each final adverse action imposed against it within the 10 years preceding enrollment or reenrollment. This amount is in addition to, and not in lieu of, the base $50,000 amount that must be maintained. Thus, if a supplier has had two adverse actions imposed against it, the bond amount will be $150,000.

A final adverse action is one of the following:

- A Medicare-imposed revocation of Medicare billing privileges;
- Suspension or revocation of a license to provide health care by any State licensing authority;
- Revocation or suspension by an accreditation organization;
- A conviction of a federal or state felony offense (as defined in § 424.535(a)(3)(i)) within the last 10 years preceding enrollment or re-enrollment; or
- An exclusion or debarment from participation in a federal or state health care program.

D. Bond Terms

The supplier is required to submit a copy of the bond that - on its face - reflects the requirements of 42 CFR §424.57(d). Specific terms that the bond must contain include:

- A guarantee that the surety will - within 30 days of receiving written notice from CMS containing sufficient evidence to establish the surety's liability under the bond of unpaid claims, civil money penalties (CMPs), or assessments - pay CMS a total of up to the full penal amount of the bond in the following amounts:

  a. The amount of any unpaid claim, plus accrued interest, for which the DMEPOS supplier is responsible, and

  b. The amount of any unpaid claims, CMPs, or assessments imposed by CMS or the OIG on the DMEPOS supplier, plus accrued interest.

- A statement that the surety is liable for unpaid claims, CMPs, or assessments that occur during the term of the bond.

- A statement that actions under the bond may be brought by CMS or by CMS contractors.

- The surety's name, street address or post office box number, city, state, and zip code.

- Identification of the DMEPOS supplier as the Principal, CMS as the Obligee, and the surety (and its heirs, executors, administrators, successors and assignees, jointly and severally) as the surety.

The term of the initial surety bond must be effective on the date that the application is submitted to the contractor. Moreover, the bond must be continuous.

E. List of Sureties

The list of sureties from which a bond can be secured is found at Department of the Treasury's "Listing of Certified (Surety Bond) Companies;" the Web site is https://www.fiscal.treasury.gov/fsreports/ref/suretyBnd/c570_a-z.htm. For purposes of the surety bond requirement, these sureties are considered "authorized" sureties, and are therefore the only sureties from which the supplier may obtain a bond.

F. Bond Cancellations and Gaps in Coverage

A DMEPOS supplier may cancel its surety bond, but it must provide written notice of such to the contractor and the surety at least 30 days before the effective date of the cancellation. Cancellation of a surety bond is grounds for revocation of the supplier's Medicare billing privileges unless the supplier provides a new bond before the effective date of the cancellation. The liability of the surety continues through the termination effective date.

The contractor shall:

- Process post-dated surety bond cancellations within 45 calendar days from the date the contractor received the cancellation.
- Process future-dated surety bond cancellations within 45 calendar days from the effective date of cancellation.

(The contractor may apply a clock stoppage if a surety bond gap is involved and the case must be sent to PEOG for review. The clock stoppage remains in effect until the contractor receives PEOG's final determination.)

If a supplier changes its surety during the term of the bond, the new surety is responsible for any overpayments, CMPs, or assessments incurred by the DMEPOS supplier beginning with the effective date of the new surety bond. The previous surety is responsible for any overpayments, CMPs, or assessments that occurred up to the date of the change of surety.

Pursuant to 42 CFR § 424.57(d)(6)(iv), the surety must notify the contractor if there is a lapse in the surety's coverage of the DMEPOS supplier. This can be done via letter, fax, or e-mail to the contractor.

G. Reenrollment and Reactivation

The supplier must furnish the paperwork described above with any Form CMS-855S reenrollment or reactivation application it submits to the contractor unless it already has the information on file with the contractor. For example, if a supplier has submitted a continuous surety bond to the contractor prior to submission of its reenrollment application, a new copy of surety bond is not required unless the contractor specifically requests it.

H. Surety Bond Changes

A DMEPOS supplier must submit an addendum to the existing bond (or, if the supplier prefers, a new bond) to the contractor in the following instances: (1) change in bond terms; (2) change in bond amount; or (3) a location on a bond covering multiple non-chain locations is being added or deleted.

10.2.7 - Opioid Treatment Programs

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

Legislative and Regulatory Background

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (hereafter referenced as the "SUPPORT Act") was designed to alleviate the nationwide opioid crisis by: (1) reducing the abuse and supply of opioids; (2) helping individuals recover from opioid addiction and supporting the families of these persons; and (3) establishing innovative and long-term solutions to the crisis. Section 2005 of the SUPPORT Act attempted to fulfill these objectives, in part, by establishing a new Medicare benefit category for opioid treatment programs (OTPs).

An OTP is currently defined in 42 CFR § 8.2 as a program or practitioner engaged in opioid treatment of individuals with an opioid agonist treatment medication registered under 21 U.S.C. § 823(g)(1). There are three overarching (but not exclusive) requirements that an OTP must meet to bill for OTP services:

1. Accreditation

The OTP must have a current, valid accreditation by an accrediting body or other entity approved by the Substance Abuse and Mental Health Services Administration (SAMHSA), the federal agency that oversees OTPs. The accreditation process includes, but is not limited to, an accreditation survey, which involves an onsite review and evaluation of the OTP to determine compliance with applicable federal standards. There are currently six SAMHSA-approved accreditation bodies.

2. Certification

The OTP must have a current, full, valid certification by SAMHSA for such a program. The prerequisites for certification (as well as the certification process itself) are addressed in 42 CFR §8.11 and include, but are not restricted to, the following:

- Current and valid accreditation (described in subsection (A)(1) above)
- Adherence to the federal opioid treatment standards described in 42 CFR § 8.12
- Compliance with all pertinent state laws and regulations, as stated in § 8.11(f)(1)

Under 42 CFR §8.11(a)(3), certification is generally for a maximum 3-year period, though this may be extended by 1 year if an application for accreditation is pending. SAMHSA may revoke or suspend an OTP's certification if any of the applicable grounds identified in 42 CFR § 8.14(a) or (b), respectively, exist.

3. Enrollment

The SUPPORT Act also required that an OTP be enrolled in the Medicare program under section 1866(j) of the Act to bill and receive payment from Medicare for opioid use disorder treatment services.

In the Calendar Year (CY) 2020 Physician Fee Schedule final rule (published in the **Federal Register** on November 15, 2019 (84 FR 62567)), CMS established a new 42 CFR § 424.67 containing requirements that OTPs must meet and continually adhere to in order to enroll (and remain enrolled) in Medicare effective January 1, 2020. Since this latter date, OTPs have enrolled in Medicare consistent with 42 CFR § 424.67 and the general provider enrollment requirements of 42 CFR Part 424, subpart P (42 CFR § 424.500 et seq.). This section 10.2.7 outlines the specific enrollment policies associated with OTP enrollment.

A. OTP Enrollment Process

The instructions in this section 10.2.7(B) are in addition to, and not in lieu of, those in CMS Pub. 100-08, Program Integrity Manual (PIM), chapter 10. To the extent there are conflicting instructions, the policies in this section 10.2.7 shall take precedence.

1. Applicable Form CMS-855

a. General Requirements

As of November 16, 2020, OTPs may enroll (and remain enrolled) via the Form CMS-855B or the Form CMS-855A, but not both. Some OTPs currently enrolled via the Form CMS-855B may accordingly seek to change their enrollment to a Form CMS-855A. To ensure that the OTP is at no time enrolled under both Form CMS-855 application types, the contractor shall do the following:

- Upon receipt of an initial Form CMS-855A or Form CMS 855B from an OTP, the contractor shall confirm that the OTP is not currently enrolled as such via another Form CMS-855 application type. (For example, if the contractor receives an initial Form

CMS-855A from an OTP, the contractor shall verify that the OTP is not already enrolled via the Form CMS-855B.)

- If the contractor determines that the OTP is not already enrolled as such, the contractor shall process the application normally.

- If, however, the contractor determines that the OTP is already enrolled as such via a different Form CMS-855 application type, the contractor shall verify with an authorized or delegated official of the OTP (by telephone or e-mail) that the OTP is changing its enrollment from a Form CMS-855B to a Form CMS-855A (or vice versa). The OTP in this situation is not required to submit a Form CMS-855 application to voluntarily terminate its prior enrollment.

The Form CMS-855B has been updated to add "Opioid Treatment Program" as a listed provider type. (For the Form CMS-855A (at least until that form is updated), the OTP shall check the "Other" box in Section 2 and state "Opioid Treatment Program.")

An entity that is enrolling or is already enrolled in Medicare as another provider or supplier type may also seek enrollment as an OTP. It must, however, submit a separate Form CMS-855 application to do so; it cannot enroll or be enrolled as an OTP and another provider/supplier type via the same enrollment.

Note that the policies in this section 10.2.7 regarding an OTP's transition from a Form CMS-855B enrollment to a Form CMS-855A enrollment (or vice versa) only apply if the OTP is doing so in the same state in which it is currently enrolled as an OTP. If an OTP is enrolling under a different Form CMS-855 in a state different from that in which it is currently enrolled (e.g., a Form CMS-855B enrolled OTP in State X is enrolling via the Form CMS-855A in State Y), it is considered a brand new enrollment (and not merely a "switch" in OTP enrollment type); this would thus require, for instance, moderate or high-level screening as opposed to limited screening (as discussed further in section 10.2.7(B)(3) below).

2. Applicable Fee

An OTP is an "institutional provider" under 42 CFR § 424.502 and thus is required to pay an application fee pursuant to 42 CFR § 424.514. The contractor shall follow the application fee procedures outlined in chapter 10 of the PIM. A fee is required even when the OTP is changing its enrollment from a Form CMS-855B to a Form CMS-855A, or vice versa.

3. Categorical Screening

Consistent with 42 CFR § 424.518, the contractor shall categorically screen OTP applications as follows:

a. Newly enrolling OTPs that **are not** changing their enrollment from a Form CMS-855B to a Form CMS-855A, or vice versa -

- If the OTP has not been fully and continuously certified by SAMHSA since October 24, 2018, the contractor shall conduct high-risk level categorical screening.

- If the OTP has been fully and continuously certified by SAMHSA since October 24, 2018, the contractor shall conduct moderate-risk level categorical screening.

b. Newly enrolling OTPs that **are** changing their enrollment from a Form CMS-855B to a Form CMS-855A, or vice versa - The contractor shall conduct limited-risk level categorical screening if the OTP had previously completed, as applicable, the moderate or high-risk level screening as part of its initial enrollment. Otherwise, moderate or high-risk level screening (as applicable under § 424.518) shall be conducted.

c. Revalidating OTPs – The contractor shall conduct moderate-risk level categorical screening.

d. Practice Location Addition – The contractor shall conduct moderate-risk level categorical screening (i.e., site visit of the new location consistent with the procedures outlined in this chapter 10).

4. Confirmation of Certification

When processing OTP initial applications (including those involving a change in Form CMS-855 application type) and revalidation applications, the contractor shall confirm and record in PECOS the OTP's SAMHSA certification status as follows:

a. Review the OTP directory at https://dpt2.samhsa.gov/treatment/directory.aspx. The OTP's certification must be full, current, and valid. ("Provisional" certification status is not acceptable.) The OTPs SAMHSA certificate (and the OTP's identification in the SAMHSA directory) need not have the exact same legal business name as that on the OTP's IRS document, though the contractor shall develop for clarification if it has questions as to whether the OTP on the application and in the directory are truly the same.

b. Verify that each location listed on the Form CMS-855 is separately and uniquely certified.

c. Enter into PECOS the OTP's relevant certification data obtained from the aforementioned OTP directory. This includes: (1) the OTP number; and (2) the certification effective date (which can be obtained from the OTP's renewal letter). The certification effective date is the date on which SAMHSA acknowledged notification from the accrediting organization and can be verified by reviewing the OTP's renewal letter information in the database. (The contractor need not obtain a copy of the letter from the OTP.)

The expiration date must be obtained via the SAMHSA operating certificate for the location in question; the OTP should submit said certificate with its application.

Irrespective of whether the OTP reported the data described in (4)(c) on the Form CMS-855, the contractor shall use the information in the OTP directory for purposes of data entry.

5. OTP Managing Employees

As with all enrolling providers and suppliers, the OTP must disclose all of its managing employees in Section 6 of the Form CMS-855. Such managing employees must include the OTP's medical director and program sponsor, which the OTP must have pursuant to 42 CFR §§ 8.12(b) and §§ 424.67(b)(5). The contractor shall verify that the medical director is a validly licensed physician or psychiatrist; *the individual* must be licensed by the state in which the OTP's primary practice location is situated. The contractor may develop with the OTP for any information it needs (and via any manner it chooses) to verify the person's licensure. If the contractor determines that the individual is not appropriately licensed, it shall contact its PEOG BFL for guidance.

The OTP must submit a copy of the organizational diagram required under Section 5 of the Form CMS-855 even if it merely changing its enrollment type from a Form CMS-855B to a Form CMS-855A (or vice versa).

6. OTP Personnel

i. Regulatory Background

Section 424.67 contains several important provisions concerning OTP personnel. These include:

- Completion of Attachment/Supplement (§ 424.67(b)(1)(i)) - Requires the OTP to maintain and submit to CMS (via the applicable Form CMS-855 supplement or attachment) a list of all physicians, other eligible professionals, and pharmacists (regardless of whether the individual is a W-2 employee of the OTP) who are legally authorized to prescribe, order, or dispense controlled substances on the OTP's behalf. The list must include the individual's (1) first and last name and middle initial, (2) social security number, (3) NPI, and (4) license number (if applicable).

- Felony Convictions (§ 424.67(b)(6)(i)(A)) - The OTP must not employ or contract with a prescribing or ordering physician or eligible professional or with any individual legally authorized to dispense narcotics who, within the preceding 10 years, has been convicted of a federal or state felony that CMS deems detrimental to the best interests of the Medicare program and its beneficiaries. The applicable felonies are based on the same categories of detrimental felonies (as well as case-by-case detrimental determinations) found at § 424.535(a)(3). (It is immaterial whether the individual is (1) currently dispensing narcotics at or on behalf of the OTP or (2) a W-2 employee of the OTP.)

- Revoked/Preclusion List (§ 424.67(b)(6)(ii)) - The OTP must not employ or contract with any personnel (regardless of whether the individual is a W-2 employee of the OTP) who is (1) revoked from Medicare under § 424.535 or any other applicable section in Title 42 or (2) on the preclusion list.

- State Board Action (§ 424.67(b)(6)(iii)) - The OTP must not employ or contract with any personnel (W-2 or otherwise) who has a prior adverse action by a state oversight board (including, but not limited to, a reprimand, fine, or restriction) for a case involving patient

harm that CMS deems detrimental to the best interests of the Medicare program and its beneficiaries.

ii. Attachment and Verification

Attachment 3 of the Form CMS-855B and Section 10 of the Form CMS-855A (hereafter collectively referenced as "attachment") collect information on the individuals described in § 424.67(b)(1)(i) above. OTPs submitting the Form CMS-855B or the Form CMS-855A must complete this attachment as described in (and subject to) (ii)(A) below and --- once enrolled --- report any changes to the information thereon (e.g., new or deleted prescribers) consistent with 42 CFR § 424.516(e).

(A) When to Submit Attachment

(1) General Principles

The OTP need only submit the attachment for the first time as part of (i) an initial Form CMS-855B or Form CMS-855A enrollment, (ii) a Form CMS-855B or Form CMS-855A revalidation (periodic or off-cycle), or (iii) a change from a Form CMS-855A enrollment to a Form CMS-855B enrollment (or vice versa). The OTP is not required to complete it for the first time as part of a change of information request. Consider the following examples:

Example 1 - Smith OTP enrolled in Medicare via the Form CMS-855A in February 2023, prior to the Form CMS-855A being revised to include the attachment. Smith submits a change request in July 2024 to add a new billing agency. Smith need not complete the attachment at this time because Smith's application does not fall within any of the three categories in (A)(i) through (iii) above.

Example 2 - Using Example 1, suppose Smith submitted a Form CMS-855A revalidation application (rather than a change of information) in July 2024. Smith would have to complete the attachment at that time per (A)(1)(ii) above.

Example 3 - Again using Example 1, suppose Smith is currently enrolled via the Form CMS-855B, which it completed in July 2023. (The OTP attachment was completed, too.) Smith submits a Form CMS-855A in May 2024 to change its OTP enrollment to that form. Smith would have to complete the attachment on the CMS-855A form because (A)(1)(i) and (iii) above are met.

Example 4 - Again using Example 1, assume Smith enrolled via the Form CMS-855A in February 2023. Smith hires two pharmacists in March 2024. Smith need not report these persons on the attachment nor complete the attachment in full, for no category in (A)(i) through (iii) above applies. If, however, Smith enrolled via the Form CMS-855A in March 2024 (completing the attachment in the process) and hired the two pharmacists in June 2024, the latter would have to be reported on the attachment via a change of information.

(2) Submission When Not Required

Instances could occur where the OTP submits the Form CMS-855 attachment for the first time when it was not required to do so (i.e., no category in (6)(A)(i) through (iii) applies). The two most likely scenarios would involve: (a) a Form CMS-855A OTP application submission (e.g., initial, change request); or (b) a Form CMS-855B-enrolled OTP submitting a change request.

In the case of (a), the contractor shall not process the attachment and may either keep it in the provider file or return it to the OTP via the general procedures in this chapter for returning applications. Regardless of which of the latter two approaches the contractor takes, the contractor shall: (i) notify the OTP that the attachment was not processed; (ii) explain why; and (iii) state that the attachment will need to be submitted at a later time as determined by CMS. If the contractor elects to retain the attachment, the notification in (i)/(ii)/(iii) above may be given in any matter the contractor chooses.

For (b), the contractor shall process the attachment consistent with the instructions in this section (6)(ii).

(B) Owning/Managing Individuals - Notwithstanding (6)(ii)(A) above, any person otherwise required to be reported on the attachment must also be disclosed in Section 6 of the Form CMS-855B if *the individual* qualifies as a 5 percent or greater owner, managing employee, partner, etc. To illustrate, assume Dr. Jones prescribes controlled substances on the OTP's behalf. *Jones* is also a managing employee of the OTP. The OTP is initially enrolling in Medicare via the Form CMS-855B. Jones would have to be listed in Section 6 and on the attachment. If Jones left the OTP altogether, the OTP would have to report this in both Section 6 and the attachment; if Jones no longer prescribes drugs for the OTP but remains a managing employee, this would have to be reported via the attachment but not in Section 6.

(C) Timeframe for Changes - Additions/deletions/changes to the information in the attachment must be reported within 90 days of the change per 42 CFR § 424.516(e)(2).

(D) Missing Data - In general, the contractor shall develop (using the procedures outlined in this chapter) for any data that is missing or unverifiable on the attachment. (This includes individuals who the contractor learns (via any means) should be listed on the attachment but were not.) However, and excluding names and social security numbers, the contractor may forgo such development if the missing/unverifiable information can be located and validated via other means. This could include, for example: (i) the NPI of the individual (who is also a managing employee) is listed in Section 6 of the Form CMS-855B; or (ii) the person's license number can be obtained through PECOS.

Note that the specific processing exception addressed in (D) applies only to OTPs. Other processing exceptions applicable to other provider and supplier types (as well as to OTPs) can be found elsewhere in this chapter.

(E) Validation of Individuals on Attachment - The contractor shall review all individuals listed on the attachment against the MED and the SAM. (The contractor may combine this step with its check of the same individual if the latter is also listed in Section 6 of the form; it need not perform two separate reviews.) The contractor shall contact its PEOG BFL for further guidance if the contractor determines or learns during its screening that the individual:

- Is OIG excluded;
- Is debarred (per the SAM);
- Is on the preclusion list;
- Has one of the actions described in §§ 424.67(b)(6)(i)(A), 424.67(b)(6)(ii); or §§ 424.67(b)(6)(iii) above; or
- Does not meet applicable requirements to prescribe, order, or dispense controlled substances on the OTP's behalf.

In reviewing all individuals listed on the attachment (and absent a CMS directive to the contrary), the contractor is not required to perform any validation activities beyond those which it would ordinarily perform for persons listed in Section 6. (For example, the contractor need not research each person to determine (i) whether *the individual* is licensed, (2) what *the individual's* license number is, or (3) whether *the individual* has ever had a fine imposed related to patient harm.)

(F) Multiple Locations and Off-Site – All persons who meet the requirements of § 424.67(b)(1)(i) must be listed on the OTP's attachment regardless of where the individual is located (e.g., the primary practice location, one of the OTP's multiple locations, *the individual's* home, etc.) The central issue is whether the individual is authorized to act on the OTP's behalf, not *the individual's* location.

(G) Appropriate Attachment Sections

As there is no section on the Form CMS-855B attachment specific to prescribers, such persons should be listed in the "Ordering Personnel Identification" section rather than the "Dispensing Personnel Information" section. However, if the contractor determines that the prescriber was inadvertently listed in the "Dispensing" section, it need not require the OTP to move *the individual* to the "Ordering" section. In addition:

- If the person qualifies as both an ordering and dispensing individual but is only listed in one of the two sections of the attachment, the contractor need not require the OTP to list *the individual* in both.
- If the person qualifies as either an ordering or dispensing individual but is listed in the incorrect section (e.g., a dispenser is listed in the ordering section), the contractor need not require the OTP to move *the individual* to the other section.

iii. Person With Adverse Action but Need Not Be Listed on Attachment or in Section 6

There may be instances where the contractor learns (via any means) that an individual described in §§ 424.67(b)(6)(i)(A), 424.67(b)(6)(ii), or §§ 424.67(b)(6)(iii) has one of the actions described within those regulatory sections but was not required to be listed on the OTP's application (either on the attachment or elsewhere on the application). Examples could include the following:

- A W-2 nurse has restrictions on *the nurse's* license due to a patient harm case
- A non-prescribing/non-ordering physician under contract is currently on the preclusion list
- A physician assistant employee is currently revoked from Medicare.

These individuals may not have met the criteria under § 424.67(b)(1)(i) to be reported on the attachment or the OTP may not have yet been required to submit the attachment (e.g., the OTP is enrolled via the Form CMS-855A.) Regardless, if the contractor becomes aware of such an individual, it shall contact its PEOG BFL for guidance.

7. Provider Agreement

i. Basic Requirement

To enroll (and remain enrolled) in Medicare as an OTP, the OTP (including provider-based OTPs, as discussed in subsection (B)(9) below) must sign and adhere to the terms of the Form CMS-1561 Provider Agreement. (This is the same agreement signed by certified providers such as hospitals, hospices, and home health agencies. See 42 CFR Part 489, Subparts A through E (as well as CMS Pub. 100-07, State Operational Manual) for general information on provider agreements.) Given this, the contractor shall verify that the OTP submitted a signed and dated Form CMS-1561 with its initial enrollment package. The provider agreement must be signed by an authorized or delegated official (as those terms are defined in § 424.502) of the OTP; the signature can be handwritten or digital. This form may be accepted via mail, fax, email, or document upload. The legal business name on the Form CMS-1561 must match that on the Form CMS-855.

If the OTP failed to submit the Form CMS-1561 as described in the previous paragraph, the contractor shall develop for the document (or any missing or inconsistent data thereon) consistent with the procedures outlined in chapter 10 of the PIM.

ii. Criteria for Inapplicability

The requirement to submit, sign, and date a new Form CMS-1561 does not apply if the OTP meets all of the following requirements: (1) the OTP is already enrolled as such in Medicare; (2) the OTP already has a valid Form CMS-1561 agreement in effect; and (3) the OTP is newly enrolling solely to change its existing Form CMS-855B enrollment to a Form CMS-855A, or vice versa.

8. Locations

An OTP may have multiple practice locations under a single enrollment so long as they all have the same legal business name and employer identification number. However, it may not split its locations between a Form CMS-855A enrollment and a Form CMS-855B enrollment. All locations must be under one enrollment. To illustrate, suppose an OTP is currently enrolled via the Form CMS-855B. It has four locations - W, X, Y, and Z. The OTP cannot keep W and X under its Form CMS-855B enrollment and switch Y and Z to a Form CMS-855A enrollment. It must retain all locations under the Form CMS-855B enrollment or move them all to a Form CMS-855A enrollment.

Instances might arise where an OTP lists multiple locations on its enrollment application, and one or more locations do not meet full status while one or more do. (For purposes of this situation, “full status” means that the location is separately and uniquely certified. See sections

10.2.7(a)(2) and (B)(4)(b) for more information.) Here, the contractor, in lieu of denying the entire application, may develop with the OTP to either: (1) update the location's status (if full status for it has since been obtained); or (2) remove the location from the enrollment application. Any such development---while encouraged, is not required---shall be performed consistent with the procedures and timeframes outlined in this chapter. The OTP's failure to fully and timely comply with the development request shall result in application's rejection. If the OTP does comply, the contractor can proceed as normal.

9. Provider-Based

As indicated in section 10.3.1.1.13(F)(1) of this chapter, an unenrolled OTP that wishes to become provider-based to a hospital cannot do so via the hospital's submission of a change of information application that adds the OTP as a practice location. The OTP must first enroll as an OTP via an initial enrollment, sign a provider agreement, undergo screening, etc. Once the OTP is enrolled, the hospital may add the OTP as a practice location on its enrollment. The situation is akin to that described in section 10.3.1.1.3(F)(1) regarding provider-based HHAs; section 10.3.1.1.3(F)(1) emphasizes that the HHA must separately enroll as such.

If a hospital submits an application to add--

(i) An unenrolled OTP as a practice location, the contractor shall return the change request on the basis of § 424.526(a)(7); the OTP must submit an initial enrollment application.

(ii) An enrolled OTP as a practice location, the contractor shall process the application consistent with the instructions in this chapter. A separate PECOS record for the OTP site (in its capacity as a hospital practice location) need not be created. Moreover:

- The enrolled OTP need not sign a new/additional provider agreement.
- The hospital need not complete the attachment regarding ordering, prescribing, and dispensing personnel, for the attachment is only completed by OTPs. However, if the OTP's addition as a provider-based location results in a change to any of the individually enrolled OTP's existing attachment information (e.g., new prescribers), the OTP must submit a change of information consistent with 42 CFR § 424.516(e)(2). Likewise, any other change to the OTP's individual enrollment stemming from its provider-based status (e.g., new ownership, change in managing employees) must be reported consistent with this chapter's instructions as well as 42 CFR Part 424, subpart P, § 424.67, and any other applicable regulations.
- The contractor need not confirm that the OTP location is still SAMHSA-certified.
- The hospital must pay an application fee since it is adding a new location.
- The application shall be screened at the limited screening level per 42 CFR § 424.518.
- Notwithstanding any other instruction to the contrary in this chapter, the contractor shall follow the basic process in subsection (C)(2)(a) below with respect to referring the practice location addition to PEOG so that a CCN can be assigned to the OTP practice location (e.g., include in the e-mail the hospital's and OTP's respective names, the hospital's CCN and NPI, and the individually enrolled OTP's CCN and NPI)

C. Approval

1. No State Agency or CMS Survey & Operations Group (SOG) Location Involvement

Unlike with many entities that complete the Form CMS-855A, there is no state agency or SOG Location involvement with OTP Form CMS-855A enrollments. Accordingly, no recommendations for approval or other type of referral need be made to the state or SOG Location nor will the SOG Location send any tie-in notice to the contractor. Except as otherwise stated in this section 10.2.7, the application will be reviewed and handled entirely at the contractor level.

2. Process of Approval

If the contractor determines that the OTP's application should be approved, it shall undertake the following:

a. For Form CMS-855A applications only, request via PEMACReports@cms.hhs.gov that CMS assign a Form CMS-855A CCN to the enrollment. (This task is required even if the OTP is merely changing its existing enrollment from a Form CMS-855B to a Form CMS-855A.)

b. As applicable (and except as stated in section (B)(7)(ii) above), send the Form CMS-1561 to PEMACReports@cms.hhs.gov for CMS to execute the signature on behalf of the Secretary. CMS will return the executed provider agreement within 3 business days. (The tasks in 2(a) and 2(b) can be completed via the same e-mail.)

c. As applicable, send a copy of the executed provider agreement to the OTP along with the enrollment approval letter. (The contractor shall retain the original provider agreement.)

3. Effective Date of Billing

For newly enrolling OTPs that are not changing their enrollment from a Form CMS-855B to a Form CMS-855A (or vice versa), the contractor shall apply the effective date policies outlined in 42 CFR §§ 424.520(d) and 424.521(a) and explained in chapter 10 of the PIM.

For newly enrolling OTPs that are changing their enrollment from a Form CMS-855B to a Form CMS-855A (or vice versa), the contractor shall apply to the new/changed enrollment the same effective date of billing that was applied to the OTP's initial/former enrollment. (See 42 CFR § 424.67(c)(2).) To illustrate, suppose an OTP initially enrolled via the Form CMS-855B in 2020. The effective date of billing was April 1, 2020. Wishing to submit an 837I claim form for the services it has provided since April 1, 2020, the OTP elects to end its Form CMS-855B enrollment and enroll via the Form CMS-855A pursuant. It successfully does the latter in March 2021. Under § 424.67(c)(2), the billing effective date of the Form CMS-855A enrollment would be retroactive to April 1, 2020 (though the time limits for filing claims found in § 424.44 would continue to apply).

4. In cases where the OTP is changing its Form CMS-855 enrollment type, the contractor shall do the following:

a. End-date/deactivate the prior enrollment effective: (1) the date following that on which the OTP submitted its last claim under its prior enrollment; or (2) the prior enrollment's effective date of billing if no claims were submitted under the prior enrollment. The PECOS L & T basis shall be "Voluntary Termination." The deactivation reason shall be "Voluntary withdrawal: Applicant voluntarily withdrew from Medicare program.

b. Notify the OTP in the approval letter that the OTP's prior enrollment has been end-dated/deactivated and specify said end-date.

10.3 – Medicare Enrollment Forms – Information, Processing, and PECOS 2.0

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

Sections 10.3, 10.3.1, 10.3.2 and 10.3.3 of this chapter provide guidance and information regarding the processing of provider enrollment forms. They also include new verification and operational instructions pertaining to the implementation of PECOS 2.0. Upon the implementation of PECOS 2.0 (and except as stated otherwise), said instructions in sections 10.3 through 10.3.3 take precedence over all other contrary guidance in this chapter. The contractor shall not follow the PECOS 2.0 instructions in this chapter prior to the system's implementation (or, as applicable, before PECOS 2.0 has been updated to include a certain feature to which the instruction applies). For more detailed information concerning the contractor's logistical navigation of the PECOS 2.0 system, the contractor can consult the PECOS 2.0 "Knowledge Base" (available within PECOS) and other technical direction.

Section 10.3 discusses the basic processes, capabilities, and policies associated with PECOS 2.0. The contractor shall adhere to the instructions in 10.3 when processing the applications described in sections 10.3.1 through 10.3.3.

A. Basic Function

Except as otherwise specified by CMS, PECOS 2.0 automatically processes all web-based applications upon submission as well as all paper applications after the contractor performs intake actions (e.g., entering the paper-submitted data into PECOS). (This includes all CMS-855, CMS-20134, CMS-588, and CMS-460 forms, and irrespective of the type of enrollment transaction involved (e.g., initial applications, change requests.) In general, PECOS 2.0 will only halt the automated process: (a) for more complex application situations (e.g., changes of ownership); or (b) if the contractor must manually perform certain verification activities (e.g., review of adverse action documentation). Upon this stoppage:

(i) The application exits the automatic process and requires the contractor to manually intervene.

(ii) PECOS 2.0 creates a list that outlines the verifications/checks performed and when they occurred.

For web-based applications, providers and suppliers must upload all required documentation, submit all signatures, and pay an application fee or submit a hardship request before submitting the application. PECOS requires the application (including the Form CMS-588 and Form CMS-

460) to be 100% complete before the provider/supplier submits it. This reduces the amount of development the contractor must undertake. In addition, PECOS notifies the contractor of any change in the status of an application, which helps expedite processing.

(Note that PECOS 2.0 will also conduct certain validations/checks for paper applications after the contractor completes its data entry of the provider's or supplier's application information.)

B. Important Aspects of PECOS 2.0

This subsection (B) discusses various aspects of PECOS 2.0's capabilities and other concepts and instructions related thereto. (For purposes of the remainder of section 10.3 and of section 10.3.1, the term "PECOS" means "PECOS 2.0" (although PECOS 2.0 will still occasionally be used) and the term "PECOS applications" means "web-based applications.")

1. Verification

Some of the Form CMS-855/20134 application data elements and other enrollment functions that will be part of PECOS's verification/operational capabilities are:

(i) Validation of Social Security Numbers (SSN) (though PECOS will not verify employer identification numbers (EIN) with the IRS)

(ii) Validation of National Provider Identifiers (NPI)

(iii) Performing Delivery Point Verification

(iv) Review of the Death Master File (DMF)

(v) Reviewing for Office of Inspector General (OIG) exclusions per the Medicare Exclusions Database (MED) (Note that if the System for Award Management (SAM) is not part of PECOS's or APS's verifications, the contractor must perform SAM reviews manually.)

(vi) Checking whether an active reenrollment bar exists. (PECOS maintains the reenrollment bar list. For each individual or entity added to an application, PECOS will perform a processing check.))

(vii) Inclusion of high-risk screening list and all other CMS generated lists (e.g., overpayments, affiliations, Medicaid terminations)

(viii) Facilitation and verification of application fee payment

(ix) Ordering site visit and fingerprinting

(x) Reviewing licensure status via APS. (Note that the contractor may rely on APS licensure verification in limited scenarios, including revalidation and some changes of information. See subsection (B)(8) below for more information on licensure.) However, the contractor must still manually check for certifications, such as for non-physician practitioners.

(xi) Criminal background (e.g., the contractor need not click into APS)

(xii) Complete automated processing of revalidation applications that do not include any changed information and the application is e-signed

(xiii) Excluding CMS Certification Numbers (CCNs) for certified providers/suppliers, generation and management of provider transaction access numbers (PTANs) as needed. (PECOS can allocate locality information as well as determine how many PTANs are required for the enrollment situation in question and the associated effective date(s). The contractor can make edits as warranted and consistent with CMS policy. The contractor shall ensure that: (1) any PECOS-established effective date for a PECOS-issued PTAN is consistent with CMS regulations and policy; and (2) all PECOS-generated PTANs were issued consistent with CMS policy.

Except as otherwise specified in current or future CMS guidance, the contractor must manually handle all other validation and processing activities not referenced in (i) through (xiii) above. As previously indicated, and after performing validations, PECOS will identify for the contractor those data elements requiring manual intervention because the data element (e.g., EIN, certain adverse actions, legal business name, certifications) is not one that PECOS checks. Moreover, automatic processing only occurs with applications for which PECOS has not identified errors (e.g., additional screening needed, unverified addresses, etc.). If errors exist and/or the application cannot otherwise be automatically processed further, PECOS reverts to manual processing and notifies the contractor thereof.

If the contractor manually corrects a data element that PECOS could not validate, PECOS attempts to reverify said data; the contractor need not manually perform this task.

All required data verification checks must be documented in PECOS (though some of these will be automatically recorded in PECOS if the system itself verifies the particular data element).

2. Documentation

a. Basic Principle

As a general rule (and for both web and paper applications), the provider/supplier need not submit documentation unless either of the following instances applies:

i. All other means the contractor is authorized to use (per this chapter) for validating the information have been exhausted (e.g., licensure web sites, state board web sites, APS, etc.) AND the supplier has not previously submitted said documentation in PECOS 1.0 or 2.0 (e.g., as part of a prior revalidation); OR

ii. The provider/supplier is furnishing or changing data for which this chapter specifically and unequivocally requires the submission of documentation to validate (e.g., adverse legal action

documentation per section 10.6.6) AND the supplier has not previously submitted said documentation in PECOS 1.0 or 2.0.

The above principle applies to all application types and transactions and notwithstanding any other instruction to the contrary in this chapter.

Note that documents that have been uploaded into PECOS 1.0 will be migrated to PECOS 2.0.

b. Operational Procedures When Documentation Is Required

i. PECOS Applications – As mentioned earlier, providers/suppliers must upload required documentation before submitting the application. However, because PECOS cannot "read" documents or verify their exact contents, the contractor shall manually review and confirm the type and contents of the submitted document. Once this confirmation occurs, the contractor need not reverify the document when subsequent applications are submitted unless information relative to that document has changed.

Except as stated in subsection (2)(a) above, a provider/supplier submitting a web application need not upload required documentation if it has previously submitted that document. The provider/supplier will be able to see the document in question in its PECOS record and select and apply that document to its current application.

ii. Paper Applications - The provider/supplier shall mail, fax, or e-mail such documentation (e.g., organizational charts per Section 5 of the Form CMS-855A) with its application. The contractor shall upload received documentation into PECOS when processing the application; each document, however, must be separately uploaded (e.g., the Form CMS-855 CHOW application must be uploaded separately from the sales agreement). For paper applications (including initial enrollments), if the provider failed to submit required documentation, the contractor shall review the provider/supplier's enrollment record to see if the provider/supplier previously submitted the document with a prior application. If it was previously submitted, the contractor shall apply the document to the current application without developing for it with the provider/supplier. If it was not previously submitted, the contractor shall develop for it.

iii. Documentation Classification

When documentation is uploaded into PECOS by the provider/supplier (PECOS applications) or the contractor (paper applications), the contractor shall ensure that, as applicable:

- Each document is uploaded in the application section with which it is most closely associated (e.g., criminal conviction documentation in the final adverse action section; IDTF technician certifications in the IDTF section).

- If the provider/supplier submits one file containing different document types (e.g., a CP-575, an ownership chart), each document type within said file is separated and uploaded in its appropriate application section (per the prior bullet).

If the provider/supplier does not submit its documents consistent with the practices in the two above bullets, the contractor shall remedy the issue itself without requesting the provider/supplier to do so.

Note that each page within a multi-page document need not be separately and individually uploaded in its own file. The document and all of the pages therein can be uploaded as a single, combined file.

3. Correspondence and Coordination – PECOS Applications Only

a. General Concept

Except as otherwise permitted or specified in sections 10.3.1 through 10.3.3, the contractor shall send written enrollment-related correspondence to the provider/supplier via PECOS (hereafter sometimes referenced as the PECOS Communication Vehicle (PCV)). This includes most types of provider-contractor correspondence, such as emails, revalidation requests, development requests, approval letters, etc. PECOS will store all such correspondence. Certain written communications, however, cannot be made through the PCV at this point; in such situations, the contractor shall: (1) follow current procedures for sending/receiving such communications; and (2) manually upload a copy of the written correspondence to the related application in PECOS.

Note that the "PCV" is not a separate system or module but is simply a term to describe PECOS's automated processes for sending correspondence, automatically e-mailing letters and/or generating letters for mailing, etc. It is not an interface the contractor will go to review incoming correspondence.

b. Telephonic Communications

It is emphasized that nothing in sections 10.3 through 10.3.3 precludes the use of telephonic communication/development (including for web applications) with the provider/supplier if it is otherwise permitted under these sections. However, the contractor shall document such telephonic communications in PECOS' Application Timeline with the same data elements as those required under section 10.6.19(L) of this chapter.

4. Party Relationships

a. Consolidated Applications and National Entity Profiles

In PECOS 2.0, individuals and organizations will have National Entity Profiles (hereafter "Profile(s)" or "National Profile(s)") that are unique by legal name, tax identification number, and ownership. (This is similar to the associate profile in legacy PECOS, the difference being that an entity's ownership information and other data unique to that organization is shared at the National Profile level in PECOS 2.0.) A party's National Profile will show Medicare enrollment record(s) for each of their provider/supplier types (e.g., ABC, Inc. will have one National Profile that includes 3 separate Medicare enrollment records: one for its clinic/group, one for its durable medical equipment (DME) enrollment, and one for its IDTF enrollment). All such records will

be grouped by provider/supplier type due to differences in data collection and/or processing requirements.

Under PECOS 2.0, a provider/supplier can submit one "consolidated application" per provider/supplier type; said application will be split such that it results in the submission of one application to each contractor jurisdiction per provider/supplier type group. Consider the following examples:

EXAMPLE A: A group practice exists in Nebraska, Iowa, and Missouri, all of which are in the same contractor jurisdiction. Here: (1) only one application is submitted to the contractor as opposed to three (one for each state); and (2) for inventory purposes, this will constitute only one application (not three). (Note that the contractor need only send one determination letter (approval, denial, etc.) to the group practice even though three states are involved. This is because only one application was submitted.)

EXAMPLE B: A group practice exists in Ohio, Pennsylvania, and West Virginia, each of which are in separate contractor jurisdictions. Here, the group may submit a consolidated application for all three enrollments, which PECOS would then split into three separate applications because there are three separate contractor jurisdictions. (In this example, the fact that there are three separate states involved is largely irrelevant for application submission purposes. The central consideration is the number of contractor jurisdictions.)

EXAMPLE C: An organization has a group practice and an IDTF in one contractor jurisdiction. The entity must submit two applications because the clinic and IDTF are two distinct provider/supplier types and the enrollments are therefore grouped separately.

(Regarding Example C, note that a physician/practitioner can change a specialty within its broad supplier type category via PECOS 2.0 (e.g., changing from a nurse practitioner to a physician assistant). However (and as with the aforementioned group-IDTF scenario), a physician cannot change *an* enrollment to that of an NPP, or vice versa, by this means absent a new enrollment.)

National Profile (or "global") data is only screened when changed. This means that global information is not rescreened each time the provider/supplier submits an application pertaining to an enrollment record under/within that National Profile. In a similar vein, though, changes to National Profile information (e.g., legal business names (LBN), ownership) made on a single application are applied to all of the provider/supplier's enrollments. That is, an authorized or delegated official can make changes to National Profile information for numerous and associated providers/suppliers at one time, whereas data changes that are specific to a unique enrollment only apply to that enrollment. An illustration follows:

EXAMPLE D: Suppose 20 separately enrolled IDTFs have four common owners: W, X, Y, and Z. W sells its 25 percent interest to V. Under PECOS, this change can be reported via a single/consolidated application submission. Twenty separate submissions are unnecessary. Now assume that two of these group practices are changing their respective addresses. Here, the entity must submit an application that indicates the two separate change requests because the practice location data is unique to each enrollment.

Once the consolidated application has been processed and finalized, PECOS creates/updates all applicable individual enrollment records as though a single application had been submitted for each.

Though providers/suppliers may submit consolidated applications that update multiple enrollments of the same provider/supplier type or grouping, they still remain free to submit separate/individual applications for each enrollment.

When the provider/supplier is making a National Profile level change and that profile has multiple enrollments, the provider/supplier must check the box in PECOS confirming that it understands that this change: (1) is related to the National Profile for (XYY) with (TIN 123); and (2) will accordingly update all of the provider's/supplier's other active Medicare enrollments within PECOS, regardless of what is shown on this particular application. (This is sometimes labeled an "indirect enrollment record update" (IERU). With a National Profile level change that revises an enrollment record, PECOS may notify the provider/supplier (typically the contact person or the correspondence address) of the IERU.

b. Consolidated Application Exceptions

(i) Providers/suppliers may only submit one type of provider enrollment transaction in a consolidated application (e.g., the provider cannot submit a consolidated application to reactivate the billing privileges of three of its enrolled suppliers and to report a CHOW involving two of its enrolled providers).

(ii) Initial enrollments for certain provider/supplier types (e.g., certified providers) cannot be submitted via a consolidated application.

(iii) DMEPOS suppliers may be limited in the number of individual enrollments than can be included in a consolidated application.

(iv) Consolidated applications are only for PECOS applications, not paper applications; that is, consolidated applications cannot be submitted via paper

c. Associations

Certain types of relationships (excluding ownership and management relationships) between enrolled persons and organizations in PECOS are labeled "associations." (This is not to be confused with the definition of "affiliation" in § 424.502 for purposes of § 424.519.) These associations/relationships frequently involve: (1) reassignors and reassignees; (2) IDTFs and supervising physicians; and (3) CAH II relationships. In all cases, both parties in the relationship must be enrolled for the affiliation to exist. The purpose of the "association" designation is to give a formal label to certain types of relationships for PECOS purposes.

d. Signatures

i. General Policy - If an application is submitted that will create multiple enrollments or enrollment records and the signer is authorized to sign all enrollments, the application's signature will be automatically applied to the other enrollments.

ii. Authorized Officials

In a consolidated application with multiple enrollments, an authorized official can only sign for those enrollments for which *the individual* is on record as an authorized official. To illustrate, suppose a consolidated application contains enrollments in Pennsylvania and Ohio. Smith is listed as an authorized official for the Pennsylvania enrollment but not the Ohio enrollment. Smith therefore cannot serve as an authorized official for the latter.

e. Multiple Contractor Involvement

As already referenced, situations will arise where a submitted consolidated application that changes National Profile information impacts multiple contractors. (To illustrate, a provider that is enrolled in three contractor jurisdictions (X, Y, Z) might submit a consolidated application to change its DBA name.) The contractor shall observe that:

(i) Each contractor is responsible for processing the application it receives. It cannot rely on one of the other affected contractors to process all of the applications. Using our above illustration, X must process the application it received that is unique to its jurisdiction, Y must process the application specific to its jurisdiction, and so forth.
(ii) The term "processing" in (i) above includes, but it not limited to, verifying data, developing for clarifying information, approving/denying the application, etc. Thus, for example, Contractor X cannot rely exclusively on Contractor Y's verifications without attempting to validate the same data concerning the Contractor X application. Nor can Contractor Y use Contractor X's development letter to solicit the same data. Each application in this situation stands alone on its own merits and must be handled separately (e.g., each contractor must: (a) make its own determination (approval, denial, etc.) regarding the application it is processing; (b) send its own approval/denial/rejection letter; (c) develop for clarifying data pertaining to its application; and (d) process its application consistent with applicable timeliness requirements).

5. Letter Generation

i. Automation

Except as stated in subsection (5)(ii) below and as otherwise stated in this section 10.3, PECOS generates and sends to the provider/supplier all required letters (e.g., approval letters under section 10.7 et seq. of this chapter), though the contractor must manually select which letter must be sent. Note that each letter will have an issue date that signifies both (1) the date of the letter and (2) the date it is sent. The contractor shall treat this issue date as the "date of letter" and

"date sent" for purposes of establishing applicable effective dates, the conclusion of development periods, and other timeframes that are based on the letter date or sent date.

ii. Exceptions to Automated Letter Process

There may be isolated instances when the contractor has to produce and/or send letters outside of PECOS. This could include, for example:

- PECOS can produce most letters requiring certified mail, but the contractor must manually print and send them
- The letter type is not available in PECOS

(Note that the contractor can always override a particular automated letter creation and upload/use a different letter.)

For letters the contractor must prepare and/or send outside of PECOS, the contractor shall ensure that: (1) the letter has an "issue date" consistent with subsection (5)(i) above; and (2) it uploads a copy of the letter to PECOS. Except for certified letters (which must be mailed via hard-copy), the contractor may send the letter via mail, e-mail, fax, or the PCV, although the PCV is very highly preferred if the printed letter can be uploaded into PECOS and sent via this means.

The "date of the letter" is the date on which the letter was created. The "issue date" is the date on which the letter was sent. For letters that PECOS sends (see subsection (5)(i) above), the letter and issue dates will be the same. For the letters discussed in subsection (5)(ii), however, they may be different (i.e., the contractor may send the letter the day after it is created).

iii. Additional Information

- Editing - If the contractor must edit a letter after it has been sent, the contractor shall (a) edit it outside of PECOS and (b) upload it consistent with the document upload instructions described in this chapter and other CMS guidance.
- Verbiage Insertion – Any language the contractor must insert into a letter shall be entered using the language insertion feature in the letter module.
- Outside Letter - If CMS instructs the contractor to submit a letter that is typically not generated by PECOS (e.g., an educational letter to supplement an approval letter), the contractor shall create the letter outside of PECOS and upload it to the appropriate location.
- All opt-out letters (e.g., approval, denial) shall be created outside of PECOS.

6. Site Visits and Application Fees

a. Site Visits (SVs) -

i. General Principle

All SVs are ordered through PECOS, and all SV results (with photos) are entered/uploaded into said system. The National SV Contractor(s): (i) completes SV requests directly in PECOS; or

(ii) receives the request from PECOS and sends the full SV record back to PECOS from its system when complete. They either are ordered for and attached to the relevant application or they occur ad-hoc. However, the contractor must still review the site visit results and indicate pass/fail, consistent with existing instructions.

PECOS can identify a completed/passed site visit within the previous 12 months so that a new site visit is unnecessary.

ii. Ordering

- PECOS Applications – PECOS will automatically order a site visit (if one is required) only in the following situations:

  (A) An initial application
  (B) Excluding certified providers/suppliers, a change of information or revalidation application if the provider/supplier is currently in the high or moderate screening level and the practice location in question has not passed a site visit within the previous 12 months.

Notwithstanding the foregoing, the contractor can manually intervene to postpone or cancel this site visit if warranted under the circumstances (and consistent with the instructions in this chapter).

For all other situations not referenced in subsection (ii)(A) and (B) above, the contractor must manually order the site visit.

- Paper Applications – The contractor must manually order the site visit if one is required.

b. Application Fees

Application fees can be combined if multiple enrollment records are implicated by the submission (e.g., consolidated application), but each application still requires a separate fee. To illustrate, suppose an entity is enrolling 5 different IDTFs, and the fee amount is $631 per IDTF. The provider can submit separate $631 fees or can combine them into a single $3,155 payment. In the case of hardship waivers, however, 5 separate hardship waivers – one for each enrollment – must be submitted; they cannot be combined into one waiver request.

In addition:

- If the provider/supplier is submitting an application requiring a fee, PECOS will automatically indicate the appropriate fee amount.
- For consolidated applications in which multiple fees are required, the provider/supplier can remove an enrollment record from its submission (e.g., the provider wishes to rescind its prospective enrollment because the fee amount is excessive), PECOS will correspondingly reduce the required total fee amount. If the provider/supplier does this after it has paid the fee, it can request a refund via the instructions in this chapter.

- If the provider/supplier makes an "out of bound" fee payment (that is, a payment outside of the application submission), the provider/supplier can apply the fee(s) to its application by entering Pay.gov tracking IDs.
- Providers/suppliers can request hardship waivers directly via PECOS.
- Fee refunds shall continue to be processed consistent with existing instructions.

7. Application Re-Routing and Returns

For web applications incorrectly sent to the contractor, the latter can re-route the application to the correct contractor via PECOS. For paper applications incorrectly sent to the contractor (and unless otherwise stated in this chapter or in another CMS directive), the contractor may return the application per 42 CFR § 424.526 without completing application intake.

PECOS cannot independently determine whether an application should be returned (e.g., initial Form CMS-855A application submitted more than 180 days prior to the effective date). The contractor must make this assessment.

8. Licensure

As already mentioned, APS will present to the contractor its review of the provider/supplier's licensure status. In some cases, however, the contractor will have to also manually verify the provider/supplier's licensure using an original source, such as a state licensing board website. In this regard, the contractor shall adhere to the following:

- Applications Other Than Initial Enrollments and Reactivations – The contractor need not review licensure original sources if all three of the following requirements are met: (1) all of the licensure information on the application (regardless of the data's materiality) matches that shown in APS (e.g., same name, active status); (2) the license contains no restrictions or qualifiers insofar as the contractor can determine from the application and the APS review; and (3) it is otherwise clear to the contractor that the provider/supplier is appropriately licensed.
- Applications Other Than Initial Enrollments and Reactivations -- If any of the three criteria in the previous bullet are not met OR the contractor is in any way uncertain as to whether the provider/supplier is appropriately licensed, the contractor shall review an original source. (Note that the data match between APS and that on the application must be 100%, regardless of the materiality of the data or the extent of the discrepancy. Even if there is a slight difference in the individual's name, an original source must be reviewed.)
- Initial Enrollment Applications and Reactivations – The contractor shall use an original source to verify licensure notwithstanding the APS results.

In all cases, the contractor shall ensure that all licensure reviews required under this chapter are performed. If licensure is not required for the provider/supplier, the contractor shall treat this in PECOS as a situation where the provider/supplier passed the licensure review.

APS will display all licensure information relevant to the enrollment that the contractor is processing. It is possible, though, that licensure data may appear involving enrollments and

parties other than those under review. The contractor need only take action based on licenses related to the specific enrollment being processed.

10. Development

Should a PECOS or paper application require development --- and unless this chapter permits telephonic development for the specific matter/info in question – the contractor shall issue the development request via PECOS's RFI functionality.

C. Impact on Application Transaction Types and Formats

This subsection (C) addresses certain PECOS functions, capabilities, and policies regarding specific enrollment-related transactions, application types, and application formats (e.g., web, paper), including associated signature requirements.

1. Revalidations

Except as otherwise described in this chapter, PECOS automatically handles revalidation requests, tracking, and correspondence. It also prevents the submission of web applications outside of the revalidation window. PECOS establishes timeframes and then queues mailings based on revalidation history and enrollment dates, although CMS can modify timeframes and request off-cycle revalidations at any time. Failure to respond to a revalidation request would result in, as applicable to the situation, an automatic pend, deactivation, etc.

2. Form CMS-588/Electronic Funds Transfer (EFT)/Multi-Carrier System (MCS)/Special Payment Addresses

Under PECOS:

a. All EFT information (including bank account data) must be entered, processed, and stored in PECOS. The contractor shall no longer use the shared system to enter bank information.

b. All MCS transactions related to provider enrollment shall be entered into and updated through PECOS. This includes provider codes, options, do not forward (DNF), effective periods, linkages to PTANs, banking, etc.

c. The contractor shall continue to follow the instructions in section 10.6.23 of this chapter 10.

d. Notwithstanding any other instruction in this subsection (C)(2), the contractor need not undertake pre-notification review of an EFT account if the latter already exists under the provider/supplier's TIN and the provider/supplier is merely adding it to a new enrollment under that same TIN.

e. EFT Processing Checks – The contractor shall document in PECOS: (1) its verification that the banking information is complete and correct; and (2) any required verification with the authorized official, delegated official, contact person, or the individual physician/practitioner.

3. Reassignments

a. General Principle

As stated earlier, PECOS automatically processes reassignments received online; this includes preventing a supplier from reassigning benefits to an ineligible party.

b. Location Group Assignment – When establishing a reassignment for PECOS applications, the provider/supplier must determine and select which "Locations Groups" of the clinic/group at which the provider/supplier will be performing services (i.e., billing from); this will help support proper PTAN assignment. For paper applications, however, the contractor must make the aforementioned determination based strictly on the information submitted (i.e., without development on this specific issue); such data could include, for instance, the reported primary and secondary practice locations and information that the group submitted.

4. Form CMS-855O and Form CMS-855I Conversions and Terminations

If a supplier who is enrolled via the Form CMS-855I or Form CMS-855O submits, respectively, a web Form CMS-855O or a web Form CMS-855I to change *the individual's* enrollment, the supplier need not terminate *the* prior enrollment. PECOS 2.0 performs this function. (This only applies to web applications.)

5. Certified Provider/Supplier Application – State Involvement

The contractor cannot send/email documents, approval recommendation packages, etc., to the states, accrediting organizations (AO), and SOG Locations via PECOS. Said materials shall continue to be sent via the Box system consistent with existing policy. (States, AOs, and the SOG Locations do not have access to PECOS.) However, certain other components of the survey/certification process are handled/managed through PECOS. This includes, but is not limited to: (1) tracking applications sent to the state; and (2) storing and/or generating approval letters to and from the state.

6. Appeals and Rebuttals

Appeals and rebuttals are stored in PECOS. The contractor can process the appeal/rebuttal via PECOS and, as applicable, revise the enrollment record based on the appeal/rebuttal decision.

If the contractor receives an appeal that should have instead been sent to CMS, the contractor shall enter the appeals data into PECOS and forward the appeal to CMS consistent with existing instructions.

The provider cannot submit appeals and rebuttals via PECOS.

7. Web vs. Paper Applications

a. Paper Applications

The contractor shall: (i) enter into PECOS the basic information about a received application (a process called "intake") such that PECOS can send a confirmation correspondence and, if

applicable, associate the application with an existing enrollment; and (ii) upload into PECOS any images of the paper application and/or all supporting documentation. Note that these tasks do not constitute the creation of a web-based application. Providers/suppliers submitting paper applications:

- Must use fillable versions thereof, meaning the information cannot be handwritten. (This includes situations where the provider/supplier is submitting an application page pursuant to a development request; the page must be from a fillable application. If the provider/supplier submits a handwritten application or page, the contractor shall develop for a fillable one rather than return the application, though intake shall still be completed.) Note that this requirement applies:
    - To all CMS applications for which a fillable version thereof is available (e.g., CMS-588), including situations where the provider must submit corrected/revised pages of the application pursuant to a development request
    - Only to CMS form applications and not to (i) supporting documentation or (ii) responses to development requests not involving the submission of corrected/revised application pages (e.g., supporting documentation need not be in a fillable format).
- Must submit the application via mail
- Will receive correspondence via the PCV. (However, the provider/supplier must still submit any additional materials related to its application (e.g., application pages, supporting documents) via paper.)

One hundred percent (100%) of paper applications and appeals/rebuttals/CAPs (regardless of type (A/B/I) or transaction (initial/change of information)) must be entered into PECOS within two business days of receipt. This includes uploading all hard copies of received applications/appeals/rebuttals and attachments into PECOS.

The minimum data elements that must be part of the contractor's "intake" are:

- Type of document (application or supporting document)
- Date of Receipt
- Method of receipt (mail, email, fax, upload)
- Application type
- Submission reason (initial, change, revalidation)
- State
- Name
- TIN
- DCN

(Regarding the intake of attachments and supporting documentation, the contractor need not separate the documents (or pages of documents) within the 2-business day period if they are submitted in bulk. Only the bulk document need be uploaded.)

At a minimum, the contractor shall upload the image of the entire application submission package (i.e., the application and all supporting documentation) as a single document at application intake, though the contractor may upload each document separately (i.e., application,

EFT, PAR, license, etc.). The effective date of the document upload/received date is the same as the date of contractor entry/intake.

If the application fails to include all the information needed to perform intake, the application shall not be considered a submission. No action is required in PECOS, and the contractor shall handle the document consistent with the document retention polices in the contractor's internal document control system.

b. Signatures

For paper applications, handwritten (wet) signatures in ink and digital/electronic signatures (digital or electronic signatures such as those created by digital signature options, such as Adobe) are acceptable. For web applications, electronic signatures (which can be uploaded) are required.

Given the advent of PECOS 2.0, certain previous certification statement instructions pertaining to Internet-based PECOS applications are no longer applicable (e.g., the ability to submit paper certification statements after submission). In addition, because certification statements must be signed before the application is submitted, there will be much less need for the contractor to develop for them. Nevertheless, the contractor must still verify signatures consistent with the instructions in this chapter; this includes documenting the validity of an uploaded signature via the PECOS signature upload processing check.

c. Web and Paper Usage

A provider/supplier that submits a web application is not prohibited from submitting future enrollment applications via paper. Likewise, a provider/supplier that submitted its initial application via paper may always submit future applications via web. In each scenario, the contractor shall follow the instructions in this section 10.3 et seq. that are applicable to the type of application (PECOS vs. paper) that was submitted. For instance, suppose a provider previously submitted its initial application via web and now submits a paper change of information request. The contractor shall upload the submission into PECOS, develop for any missing or unsigned/undated certification statement, avail itself of any processing alternatives that are applicable to paper applications, etc.

Notwithstanding the above, when the provider/supplier submits a web application, any updates to the application---such as, for example, pursuant to a development request or the submission of additional documentation---before the application is processed to conclusion (e.g., approved, denied, rejected) must be via PECOS. The provider/supplier cannot submit its update via paper.

d. Documents Received Outside of Application Submissions

(1) General Guidance - The contractor may receive documents unrelated to a particular application submission, appeal, or rebuttal. This could include, for example, a W-9, a new CLIA certificate, an updated license, a surety bond cancellation notice, an FDA certification, a CMS-460, insurance documents, etc. These documents must be uploaded into PECOS consistent with the instructions in this section 10.3 et al. and the timeframe described in section 10.3(C)(7)(a).

(2) Special Situations

- For submitted stand-alone paper Form CMS-588s and CMS-460s, the contractor shall intake the document as the application type that corresponds to the enrollment record that will be impacted by the submission (e.g., Form CMS-855I, CMS-855A).
- When paper Form CMS-855I and Form CMS-855B applications are submitted concurrently pursuant to a reassignment, the contractor shall intake the two applications separately and individually.

8. Business and Practice Location Names/Assignments

The "DBA name" and "Other name" data fields are not required in PECOS. If the provider/supplier nevertheless submits this data, the other name/DBA name should be at the organization level while the name at the practice location level should be, in effect, the name on the location's "front door."

In reassignment situations, providers/suppliers can assign in PECOS multiple primary practice locations (PPLs), one PPL, or none at all. If the provider/supplier wishes to add, change, or remove a PPL designation, no signature is necessary.

9. Contact Persons/Parties for PECOS Applications

(The instructions in this subsection (C)(9) supersede those in section 10.6.9 of this chapter with respect to PECOS applications.)

For PECOS applications only, there are three types of contacts:

a. "Enrollment Representatives" (ER): These are persons whom the provider/supplier may designate in its PECOS application submission as having the authority to contact the contractor about the provider/supplier's enrollment once the provider/supplier is enrolled. ERs will not be contacted by CMS (except in response to an ER's inquiry) either by mail, e-mail, telephone, the PCV, etc., and their contact information will not be part of the official application or be shown on the PECOS screens. Moreover, the provider/supplier need not have any ERs if it so chooses.

b. "Application Contacts" (AC): These individuals are somewhat akin to the longstanding category of "contact persons." They are: (1) optional for the provider/supplier; (2) valid contacts only for the application in question; and (3) neither added to the formal enrollment record nor contacted by CMS on any matter other than the application. If the provider/supplier chooses to list ACs, it must also designate a "Primary AC" from this list; this person will receive any physical letters the contractor sends while the other ACs will receive e-mails.

(In addition:

- If the provider/supplier submits a paper application -- which does not differentiate between an ER and an AC -- the contractor can leave the ER field in PECOS blank.

- If a provider/supplier submitting a PECOS application chooses not to have an ER, the contractor shall follow current guidance regarding with whom it can discuss post-enrollment matters if no contact person is listed (e.g., with authorized and delegated officials).
- If an ER requests information regarding a pending application, the contractor shall follow current guidance regarding with whom it can discuss matters concerning pending applications.)

c. Correspondence Address – This is the same address that has long been used for provider enrollment applications. Its meaning and use will not change with the advent of PECOS 2.0.

Except as otherwise stated in subsections 9(a) through (c) above, the contractor shall:

- Continue to use the correspondence address as normal
- Use ACs (as opposed to ERs) for communications regarding the application in question
- Respond to any ER questions if they are related to a matter outside of the contractor's current processing of an application. (If the question is not related to the present application, the contractor shall notify the ER that it cannot respond to the query.)

10. Contacting CMS

For matters that require CMS/PEOG BFL input or decision --- and unless otherwise instructed in this chapter --- the contractor shall request CMS 'review' using the 'assignment' functionality in PECOS. The contractor shall include the pertinent data/question/note in the section provided during the assignment/review process and attach any pertinent documentation (e.g., review of adverse legal action documentation).

D. Additional Guidance

1. Revocations – Except as otherwise instructed by CMS, all CMS-directed revocations will be processed in their entirety by CMS within PECOS.

2. Screening Levels – PECOS will automatically set the provider/supplier's correct screening level. Should the screening level nonetheless need to be adjusted, the contractor shall seek CMS approval via PECOS.

E. Chapter 10 Applicability

1. Except as otherwise noted, the PECOS instructions in section 10.3 et seq. take precedence over all others in this chapter pertaining to the same issue or operational procedure.

2. Certain existing instructions in chapter 10 (including those in section 10.3 et seq.) require (or, in a few cases, do not require) particular data elements on the application to be completed. The contractor shall observe that PECOS may or may not mandate that the provider complete particular data fields before proceeding to succeeding fields. This might render moot some of

the processing alternatives and exemptions discussed in this chapter. The contractor may therefore disregard those alternatives/exemptions that are immaterial to the situation.

3. Certain existing data elements on the applications and which are listed in this chapter 10 may not be reflected in PECOS. In such cases, the contractor may disregard the instructions in this chapter pertaining thereto.

4. Except as otherwise stated, the term "PECOS" in this chapter refers to PECOS 2.0 and incorporates the phrase "Internet-based PECOS."

5. All instances in section 10.3 et seq. in which the contractor must now document a data element verification or a telephonic communication in PECOS rather than in the provider file shall include the applicable information required under section 10.6.19(L). Note that the contractor may document such communications in PECOS even for paper applications.

6. In cases where use of the PCV is not required but permissible, the contractor is very strongly encouraged to utilize that mechanism.

7. All clock stoppages otherwise permitted under this chapter can be applied with respect to the policies in this section 10.3.

10.3.1.1.11 – Section 15 (Authorized Officials) - Form CMS-855A

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. General Requirements

An authorized official must be a 5 percent direct owner, chairman of the board, etc., of the enrolling provider with the authority to bind the provider, both legally and financially, to the requirements set forth in 42 CFR § 424.510. This person must also have an ownership or control interest in the provider--- such as the general partner, chairman of the board, chief financial officer, chief executive officer, president, or someone holding a position of similar status and authority within the provider organization. One cannot use *a* status as the chief executive officer, chief financial officer, etc., of the provider's parent company, management company, or chain home office as a basis for *the individual's* role as the provider's authorized official.

Section 424.502 specifically defines an authorized official as an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program. Note that an authorized official is not restricted to the examples of the titles outlined above but can be a person of equivalent status who is an appointed official to whom the organization has granted the legal authority to act on the organization's behalf. These additional titles could include, but are not limited to, executive director, administrator, president, and vice-president. The contractor shall consider the individual's title as well as the authority granted by the organization when determining whether an individual qualifies as an authorized official. If the contractor is unsure of an authorized official's qualifications or authority, it shall

contact its PEOG BFL for guidance. In addition, the contractor shall obtain PEOG BFL approval if the only role of the listed authorized official is "Contracted Managing Employee" notwithstanding *the individual's* title or other qualifications; the PEOG BFL will confirm authority.

If the person is not listed as a "Contracted Managing Employee" in the Individual Ownership Interest and/or Managing Control Information section and the contractor has no reason to suspect that the person does not qualify as an authorized official, no further investigation is required. Should the contractor have doubts that the individual qualifies as an authorized official, it shall contact the official or the applicant's contact person to obtain more information about the official's job title and/or authority to bind. If the contractor remains unconvinced that the individual qualifies as an authorized official, it shall notify the provider that the person cannot be an authorized official. If that person is the only authorized official listed and the provider refuses to use a different authorized official, the contractor shall deny the application.

B. Number of Authorized Officials

The provider can have an unlimited number of authorized officials, so long as each meets the definition of an authorized official. However, the provider must complete the Individual Ownership and/or Managing Control section of the Form CMS-855A for each authorized official.

C. Deletion of Authorized Official

For authorized official deletions, the contractor need not obtain (1) that official's signature, or (2) documentation verifying that the person is no longer an authorized official.

D. Change in Authorized Officials

A change in authorized officials does not impact the authority of existing delegated officials to report changes and/or updates to the provider's enrollment data or to sign revalidation applications.

E. Authorized Official Not on File

If the provider submits a change request (e.g., change of address) and the authorized official signing it is not on file, the contractor shall ensure that: (1) the person meets the definition of an authorized official; and (2) the Individual Ownership Interest and/or Managing Control Information section of the Form CMS-855 is completed for *the individual*. The signature of an existing authorized official is not needed to add a new authorized official. Note that the original change request and the addition of the new official shall be treated as a single change request (i.e., one change request encompassing two different actions) for purposes of enrollment processing and reporting.

F. Effective Date

The effective date in PECOS for an authorized official should be the date of signature.

G. Social Security Number

To be an authorized official, the person must have and submit *an* SSN. *The individual* may not use an Individual Taxpayer Identification Number (ITIN) in lieu of an SSN in this regard.

H. Identifying the Provider

As stated earlier, an authorized official must be an authorized official of the provider, not of an owning organization, parent company, chain home office, or management company. Identifying the provider is not - for purposes of determining an authorized official's qualifications - determined solely by the provider's tax identification number (TIN). Rather, the organizational structure is the central factor. For instance, suppose that a chain drug store, Company X, wants to enroll 100 of its pharmacies with the contractor. Each pharmacy has a separate TIN and must therefore enroll separately. Yet all of the pharmacies are part of a single corporate entity – Company X. In other words, there are not 100 separate corporations in our scenario, but merely one corporation whose individual locations have different TINs. Here, an authorized official for Pharmacy #76, can be someone at X's headquarters (assuming that the definition of authorized official is otherwise met), even though this main office might be operating under a TIN that is different from that of #76. This is because headquarters and Pharmacy #76 are part of the same organization/corporation. Conversely, if #76 was a corporation that was separate and distinct from Company X, only individuals that were part of #76 could be authorized officials.

I. Signatory Requirements

1. Valid Signatures – See section 10.3.1.1.10(A) of this chapter for information on the types of acceptable signatures. If the contractor receives a digital signature that differs from those described in section 10.3.1.1.10(A), the contractor shall contact its PEOG BFL for guidance.

2. Form CMS-855A Initial Applications – For these transactions, an authorized official must sign and date the certification statement.

3. Change Requests and Revalidations - For these transactions, an authorized or delegated official may sign the certification statement. This applies to: (1) signatures on the paper Form CMS-855; (2) signatures on the certification statement for Internet-based provider enrollment; and (3) electronic signatures.

4. The authorized official's telephone number can be left blank. No further development is needed.

10.3.1.1.12 – Section 16 (Delegated Officials) - Form CMS-855A

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. General Requirements

A delegated official is an individual to whom an authorized official listed in the Certification Statement section of the Form CMS-855A delegates the authority to report changes and updates to the provider's enrollment record or to sign revalidation applications. The delegated official's

signature binds the organization both legally and financially, as if the signature were that of the authorized official. Before the delegation of authority is established, the only acceptable signature on the enrollment application to report updates or changes to the enrollment information is that of an authorized official currently on file with Medicare. The delegated official must be an individual with an "ownership or control interest" in (as that term is defined in § 1124(a)(3) of the Social Security Act) or be a W-2 managing employee of the provider.

Section 1124(a)(3) defines an individual with an ownership or control interest as:

- A five percent direct or indirect owner of the provider,
- An officer or director of the provider (if the provider is a corporation), or
- Someone with a partnership interest in the provider if the provider is a partnership

The delegated official must be a delegated official of the provider, not of an owning organization, parent company, chain home office, or management company. One cannot use *a* status as a W-2 managing employee of the provider's parent company, management company, or chain home office as a basis for *the individual's* role as the provider's delegated official.

The provider must complete the Ownership Interest and Managing Control Information for Individuals section of the Form CMS-855A for all delegated officials.

A delegated official has no authority to sign an initial application. However, the delegated official may (i) sign a revalidation application and (ii) sign off on changes/updates submitted in response to a contractor's request to clarify or submit information needed to continue processing the provider's initial application.

Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the provider's Medicare data or to sign revalidation applications.

For purposes of the Delegated Officials information captured in the Delegated Official section only, the term "managing employee" means any individual (including a general manager, business manager, or administrator) who exercises operational or managerial control over the provider, or who conducts the day-to-day operations of the provider. However, this does not include persons who, either under contract or through some other arrangement, manage the day-to-day operations of the provider but who are not actual W-2 employees. For instance, suppose the provider hires Smith as an independent contractor to run its day-to-day-operations. Under the definition of "managing employee" in the Ownership Interest and Managing Control Information for Individuals section of the Form CMS-855A, Smith would have to be listed in that section. Yet under the Delegated Officials section definition (as described above), Smith cannot be a delegated official because *Smith* is not an actual W-2 employee of the provider. Independent contractors are not considered "managing employees" under the Delegated Officials section of the Form CMS-855A.

B. W-2 Form

Unless the contractor requests it to do so, the provider need not submit a copy of the owning/managing individual's W-2 to verify an employment relationship.

C. Number of Delegated Officials

The provider can have as many delegated officials as it chooses. It also need not have any delegated officials at all. If the provider lists no delegated officials, however, the authorized official(s) remains the only individual(s) who can report changes and/or updates to the provider's enrollment data.

D. Effective Date

The effective date in PECOS for a delegated official should be the date of signature.

E. SSN

To be a delegated official, the person must have and submit *an* SSN. *An individual* may not use an ITIN in lieu of an SSN in this regard.

F. Deletion of a Delegated Official

For delegated official deletions, documentation verifying that the person no longer is or qualifies as a delegated official is not required. In addition, the delegated official's signature is unnecessary.

G. Delegated Official Not on File

If the provider submits a change of information (e.g., change of address) and the delegated official signing the form is not on file, the contractor shall ensure that:

(i) The person meets the definition of a delegated official,
(ii) The provider completes the Individual Ownership and/or Managing Control section of the Form CMS-855A for that person, and
(iii) An authorized official signs off on the addition of the delegated official.

(NOTE: The original change request and the addition of the new official constitute a single change request (i.e., one change request encompassing two different actions) for purpose of enrollment processing and reporting)).

H. Signature on Paper Application

If the provider submits a paper Form CMS-855A change request, the contractor may accept a delegated official's signature in the Certification Statement or Delegated Official section of the Form CMS-855A.

I. Telephone Number

The delegated official's telephone number can be left blank. No further development is needed.

10.3.1.2.4 – Section 4 (Practice Location Information) – Form CMS-855B

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Reporting and Verification Policies

1. ZIP Code – The supplier must submit the 9-digit ZIP Code for each practice location listed.

2. Practice Location Name - For suppliers paid via the Multi-Carrier System (MCS), the practice location name entered into PECOS shall be the legal business name. (Beginning with PECOS 2.0, however, the DBA name can be entered as the practice location name.)

3. Practice Location Verification – Except as stated otherwise in this chapter or in another CMS directive, the contractor shall verify that the practice locations listed on the application actually exist and are valid addresses with the United States Postal Service (USPS). PECOS includes a USPS Address Matching System Application Program Interface (API), which validates address information entered and flags the address if it is determined to be invalid, unknown, undeliverable, vacant, unlikely to deliver mail (No-Stat), a CMRA (i.e., UPS Store, mailboxes, etc.), or a known invalid address false positive. These address types are not permitted in PECOS and are flagged upon entry.

4. Phone Number Verification - The contractor need not verify the supplier's telephone number listed on the application, though the supplier must report one. If it does not, the contractor shall develop for a phone number using the procedures outlined in this chapter.

5. Special Certified Supplier Instructions (ASCs and Portable X-Ray Suppliers (PXRS)) - If the supplier's address and/or telephone number cannot be verified, the contractor shall request clarifying information from the supplier. If the supplier states that the facility and its phone number are not yet operational, the contractor may continue processing the application. However, it shall indicate in its recommendation letter that the address and telephone number of the facility could not be verified. For purposes of PECOS, the contractor can temporarily use the date the certification statement was signed as the effective date.

6. Specific Section 4 Subsection Policies

a. Practice Location Type - In Section 4A, if the "type of practice location" checkbox is blank, the contractor can confirm the information via the PCV, e-mail, or fax.

b. Section 4B - If neither box is checked and no address is provided, the contractor can contact the supplier by telephone, the PCV, e-mail, or fax to confirm the supplier's intentions. If the "special payments" address is indeed the same as the practice location, no further development is needed. If, however, the supplier wants payments to be sent to a different address, the address in Section 4B must be completed via the Form CMS-855B.

c. Updated Questionnaire - If the supplier (1) is adding a practice location and (2) is normally required to complete a questionnaire in the Form CMS-855B specific to its supplier type (i.e.:

physical or occupational therapist groups), the entity must submit an updated questionnaire to incorporate services rendered at the new location.

d. Section 4E – If the "Check here" box in Section 4E is not checked and no address is provided, the contractor can contact the supplier by telephone, the PCV, e-mail, or fax to confirm the supplier's intentions. If the base of operations address is the same as the practice location, no further development is needed. If the supplier indicates that the base of operations is at a different location, the address in Section 4E must be furnished via the Form CMS-855B.

e. Section 4F - If the vehicle certificates are furnished but the applicable Form CMS-855B sections are blank, the contractor can verify via telephone, the PCV, e-mail, or fax that said vehicles are the only ones the supplier has.

B. Do Not Forward (DNF)

Unless instructed otherwise in another CMS directive, the contractor shall follow the DNF initiative instructions in Pub. 100-04, chapter 1, section 80.5. Returned paper checks, remittance notices, or EFT payments shall be flagged if returned from the post office or banking institution, respectively, as this may indicate that the supplier's "special payment" address (the Practice Location Information section of the Form CMS-855B) or EFT information has changed. The supplier should submit a Form CMS-855B to change this address; if the supplier does not have an established enrollment record in PECOS, it must complete an entire Form CMS-855B. (For DMEPOS suppliers, the DME MAC is responsible for obtaining, updating, and processing Form CMS-588 changes.)

If a supplier is closing *the* business and has a termination date (e.g., is retiring), the contractor will likely need to make payments for prior services rendered. Since the practice location has been terminated, the contractor may encounter a DNF message. If so, the contractor should request the supplier to complete the "special payment" address section of the Form CMS-855B and to sign the certification statement. The contractor, however, shall not collect any other information unless there is a need to do so.

C. Remittance Notices/Special Payments

For new enrollees, all payments must be made via EFT. The contractor shall thus ensure that the supplier has completed and signed the Form CMS-588 and shall verify that the bank account complies with Pub. 100-04, chapter 1, section 30.2.

If an enrolled supplier that currently receives paper checks submits a Form CMS-855 change request – no matter what the change involves – the supplier must also submit:

- A Form CMS-588 that switches its payment mechanism to EFT. (The change request cannot be processed until the Form CMS-588 is submitted.) All future payments (excluding special payments) must be made via EFT.

- The contractor shall also verify that the bank account complies with Pub. 100-04, chapter 1, section 30.2.

(Once a supplier changes its method of payment from paper checks to EFT, it must continue using EFT. A supplier cannot switch from EFT to paper checks.)

The "special payment" address may only be one of the following:

- One of the supplier's practice locations
- A P.O. Box
- The supplier's billing agent. The contractor shall request additional information if it has any reason to suspect that the arrangement – at least with respect to any special payments that might be made – may violate the Payment to Agent rules in Pub. 100-04, chapter 1, section 30.2.
- Correspondence address
- A lockbox. The contractor shall request additional information if it has any reason to suspect that the arrangement - at least with respect to any special payments that might be made - may violate the Payment to Agent rules in Pub. 100-04, chapter 1, section 30.2.

D. Out-of-State Practice Locations

(The policies in this section 10.3.1.2.4(D) apply unless CMS instructs otherwise in this chapter or in another directive.)

If a supplier is adding a practice location in another state that is within the contractor's jurisdiction, a separate, initial Form CMS-855B enrollment application is not required if the following 5 conditions are met:

(i) The location is not part of a separate organization (e.g., a separate corporation, partnership);

(ii) The location does not have a separate TIN and LBN;

(iii) The state in which the new location is being added does not require the location to be surveyed;

(iv) Neither the new location nor its owner is required to sign a separate certified supplier agreement; and

(v) The location is not an IDTF, ASC, or other supplier type that must individually and separately enroll each of its locations.

Consider the following scenarios:

EXAMPLE 1 - The contractor's jurisdiction consists of States X, Y and Z. Jones Group Practice (JGP), Inc., is enrolled in State X with 3 locations. It wants to add a fourth location in State Y.

The new location will be under JGP, Inc. JGP will not be establishing a separate corporation, LBN, or TIN for the fourth location. Since there is no state agency or SOG Location involvement with group practices, all five conditions are met. JGP can add the fourth location via a change of information request, rather than an initial application. The change request must include all information relevant to the new location (e.g., licensure, new managing employees). (For paper applications only---and to the extent required---the contractor shall create a separate PECOS enrollment record for the State Y location.)

EXAMPLE 2 - The contractor's jurisdiction consists of States X, Y and Z. Jones Group Practice (JGP), Inc., is enrolled in State X with 3 locations. It wants to add a fourth location in State Y but under a newly-created, separate entity - Jones Group Practice, LP. The fourth location must be enrolled via a separate, initial Form CMS-855B.

EXAMPLE 3 - The contractor's jurisdiction consists of States X, Y and Z. Jones Group Practice (JGP), Inc., is enrolled in State X with 3 locations. It wants to add a fourth location in State Q. Since State Q is not within the contractor's jurisdiction, a separate initial enrollment for the fourth location is necessary.

E. Unavoidable Phone Number or Address Changes

Unless CMS specifies otherwise, any change in the supplier's phone number or address that the supplier did not cause (e.g., area code change, municipality renames the supplier's street) must still be updated via the Form CMS-855B.

10.3.1.2.8 – Section 15 (Authorized Officials) - Form CMS-855B

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. General Requirements

An authorized official must be a 5 percent direct owner, chairman of the board, etc., of the enrolling supplier with the authority to bind the supplier, both legally and financially, to the requirements set forth in 42 CFR §424.510. This person must also have an ownership or control interest in the supplier--- such as the general partner, chairman of the board, chief financial officer, chief executive officer, president, or someone holding a position of similar status and authority within the provider organization. One cannot use *a* status as the chief executive officer, chief financial officer, etc., of the supplier's parent company, management company, or chain home office as a basis for *the individual's* role as the provider's authorized official.

Section 424.502 specifically defines an authorized official as an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program. Note that an authorized official is not restricted to the examples of the titles outlined above but can be a person of equivalent status who is an appointed official to whom the organization has granted the legal authority to act on the organization's behalf. These additional titles could include, but are not limited to, executive director, administrator, president,

and vice-president. The contractor shall consider the individual's title as well as the authority granted by the organization when determining whether an individual qualifies as an authorized official. If the contractor is unsure of an authorized official's qualifications or authority, it shall contact its PEOG BFL for guidance. In addition, the contractor shall obtain PEOG BFL approval if the only role of the listed authorized official is "Contracted Managing Employee" notwithstanding *the individual's* title or other qualifications; the PEOG BFL will confirm authority.

If the person is not listed as a "Contracted Managing Employee" in the Individual Ownership Interest and/or Managing Control Information section and the contractor has no reason to suspect that the person does not qualify as an authorized official, no further investigation is required. Should the contractor have doubts that the individual qualifies as an authorized official, it shall contact the official or the applicant's contact person to obtain more information about the official's job title and/or authority to bind. If the contractor remains unconvinced that the individual qualifies as an authorized official, it shall notify the supplier that the person cannot be an authorized official. If that person is the only authorized official listed and the supplier refuses to use a different authorized official, the contractor shall deny the application.

B. Number of Authorized Officials

The supplier can have an unlimited number of authorized officials, so long as each meets the definition of an authorized official. However, the supplier must complete the Individual Ownership and/or Managing Control section of the Form CMS-855B for each authorized official.

C. Deletion of Authorized Official

For authorized official deletions, the contractor need not obtain (1) that official's signature, or (2) documentation verifying that the person is no longer an authorized official.

D. Change in Authorized Officials

A change in authorized officials does not impact the authority of existing delegated officials to report changes and/or updates to the supplier's enrollment data or to sign revalidation applications.

E. Authorized Official Not on File

If the supplier submits a change request (e.g., change of address) and the authorized official signing it is not on file, the contractor shall ensure that: (1) the person meets the definition of an authorized official; and (2) the Individual Ownership Interest and/or Managing Control Information section of the Form CMS-855B is completed for *the individual*. The signature of an existing authorized official is not needed to add a new authorized official. Note that the original change request and the addition of the new official shall be treated as a single change request (i.e., one change request encompassing two different actions) for purposes of enrollment processing and reporting.

F. Effective Date

The effective date in PECOS for an authorized official should be the date of signature.

G. Social Security Number

To be an authorized official, the person must have and submit *an* SSN. The *individual* may not use an Individual Taxpayer Identification Number (ITIN) in lieu of an SSN in this regard.

H. Identifying the Supplier

As stated earlier, an authorized official must be an authorized official of the supplier, not of an owning organization, parent company, chain home office, or management company. Identifying the supplier is not - for purposes of determining an authorized official's qualifications - determined solely by the supplier's tax identification number (TIN). Rather, the organizational structure is the central factor. For instance, suppose that a chain drug store, Company X, wants to enroll 100 of its pharmacies with the contractor. Each pharmacy has a separate TIN and must therefore enroll separately. Yet all of the pharmacies are part of a single corporate entity – Company X. In other words, there are not 100 separate corporations in our scenario, but merely one corporation whose individual locations have different TINs. Here, an authorized official for Pharmacy #76, can be someone at X's headquarters (assuming that the definition of authorized official is otherwise met), even though this main office might be operating under a TIN that is different from that of #76. This is because headquarters and Pharmacy #76 are part of the same organization/corporation. Conversely, if #76 was a corporation that was separate and distinct from Company X, only individuals that were part of #76 could be authorized officials.

I. Signatory Requirements

1. Valid Signatures – See section 10.3.1.2.7(A) of this chapter for information on the types of acceptable signatures. If the contractor receives a digital signature that differs from those described in section 10.3.1.2.7(A), the contractor shall contact its PEOG BFL for guidance.

2. Form CMS-855B Initial Applications – For these transactions, an authorized official must sign and date the certification statement.

3. Change Requests and Revalidations - For these transactions, an authorized or delegated official may sign the certification statement. This applies to: (1) signatures on the paper Form CMS-855B; (2) signatures on the certification statement for Internet-based provider enrollment; and (3) electronic signatures.

4. The authorized official's telephone number can be left blank. No further development is needed.

10.3.1.2.9 – Section 16 (Delegated Officials) - Form CMS-855B

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. General Requirements

A delegated official is an individual to whom an authorized official listed in the Certification Statement section of the Form CMS-855B delegates the authority to report changes and updates to the supplier's enrollment record or to sign revalidation applications. The delegated official's signature binds the organization both legally and financially, as if the signature were that of the authorized official. Before the delegation of authority is established, the only acceptable signature on the enrollment application to report updates or changes to the enrollment information is that of an authorized official currently on file with Medicare. The delegated official must be an individual with an "ownership or control interest" in (as that term is defined in § 1124(a)(3) of the Social Security Act) or be a W-2 managing employee of the supplier.

Section 1124(a)(3) defines an individual with an ownership or control interest as:

- A five percent direct or indirect owner of the supplier,
- An officer or director of the supplier (if the supplier is a corporation), or
- Someone with a partnership interest in the supplier if the supplier is a partnership

The delegated official must be a delegated official of the supplier, not of an owning organization, parent company, chain home office, or management company. One cannot use *a* status as a W-2 managing employee of the supplier's parent company, management company, or chain home office as a basis for *the individual's* role as the supplier's delegated official.

The supplier must complete the Ownership Interest and Managing Control Information for Individuals section of the Form CMS-855B for all delegated officials.

A delegated official has no authority to sign an initial application. However, the delegated official may (i) sign a revalidation application and (ii) sign off on changes/updates submitted in response to a contractor's request to clarify or submit information needed to continue processing the supplier's initial application.

Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the supplier's Medicare data or to sign revalidation applications.

For purposes of the Delegated Officials information captured in the Delegated Official section only, the term "managing employee" means any individual (including a general manager, business manager, or administrator) who exercises operational or managerial control over the provider, or who conducts the day-to-day operations of the supplier. However, this does not include persons who, either under contract or through some other arrangement, manage the day-to-day operations of the supplier but who are not actual W-2 employees. For instance, suppose the provider hires Smith as an independent contractor to run its day-to-day-operations. Under the definition of "managing employee" in the Ownership Interest and Managing Control Information for Individuals section of the Form CMS-855B, Smith would have to be listed in that section. Yet under the Delegated Officials section definition (as described above), Smith cannot be a delegated official because *Smith* is not an actual W-2 employee of the provider.

Independent contractors are not considered "managing employees" under the Delegated Officials section of the Form CMS-855B.

B. W-2 Form

Unless the contractor requests it to do so, the supplier need not submit a copy of the owning/managing individual's W-2 to verify an employment relationship.

C. Number of Delegated Officials

The supplier can have as many delegated officials as it chooses. It also need not have any delegated officials at all. If the supplier lists no delegated officials, however, the authorized official(s) remains the only individual(s) who can report changes and/or updates to the supplier's enrollment data.

D. Effective Date

The effective date in PECOS for a delegated official should be the date of signature.

E. SSN

To be a delegated official, the person must have and submit *an* SSN. *An individual* may not use an ITIN in lieu of an SSN in this regard.

F. Deletion of a Delegated Official

For delegated official deletions, documentation verifying that the person no longer is or qualifies as a delegated official is not required. In addition, the delegated official's signature is unnecessary.

G. Delegated Official Not on File

If the supplier submits a change of information (e.g., change of address) and the delegated official signing the form is not on file, the contractor shall ensure that:

(i) The person meets the definition of a delegated official,
(ii) The supplier completes the Individual Ownership and/or Managing Control section of the Form CMS-855B for that person, and
(iii) An authorized official signs off on the addition of the delegated official.

(NOTE: The original change request and the addition of the new official constitute a single change request (i.e., one change request encompassing two different actions) for purpose of enrollment processing and reporting)).

H. Signature on Paper Application

If the provider submits a paper Form CMS-855B change request, the contractor may accept a delegated official's signature in the Certification Statement or Delegated Official section of the Form CMS-855B.

I. Telephone Number

The delegated official's telephone number can be left blank. No further development is needed

10.3.1.3.1 - Section 1 (Basic Information) – Form CMS-855I

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Purpose and Verification

In this section, the supplier indicates the reason for submittal of the application. (This includes establishing, terminating, or changing reassignments.) Unless otherwise stated in this chapter, in another CMS directive, or as permitted by PECOS, the supplier may only check one reason for submittal. For example, suppose a supplier is voluntarily terminating an enrollment as one supplier type and enrolling as a different supplier type; both transactions cannot be reported on the same application.

Excluding (1) the voluntary termination checkbox and (2) the effective date of termination---and except as stated in section 10.6.1.3 of this chapter---any blank data/checkboxes in the Basic Information section can be verified through any means (e.g., the PCV, e-mail, telephone, fax).

B. Voluntary Termination Reminder

When a practitioner submits a Form CMS-855I application to either (1) add a practice location in a new state or (2) relocate to a new state entirely, the contractor that received the application shall determine whether the practitioner still has an active PECOS enrollment record in the "other" state(s). If PECOS indeed indicates that the individual has an active practice location in the other state(s), the contractor should remind the practitioner that if *the latter* no longer intends to practice in that state, *the individual* must submit a Form CMS-855I voluntary termination application to the contractor for that jurisdiction. The reminder should be furnished in the approval letter that the receiving contractor sends to the practitioner or, if more appropriate, via the PCV, e-mail, or other form of written correspondence.

C. Break in Medical Practice

If the contractor receives a Form CMS-855I from a practitioner who was once enrolled in Medicare but has not been enrolled with any Medicare contractor for the previous 2 years, the contractor shall verify with the state (a) where the practitioner last worked and (b) whether the practitioner was convicted of a felony or had *licensure* suspended or revoked. If such an adverse action was imposed, the contractor shall take action consistent with the instructions in this chapter.

10.3.1.3.2 - Section 2 (Personal Identifying Information) – Form CMS-855I

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Licensure Information

1. General Instructions

(The extent to which the applicant must complete the licensure information depends upon the supplier type involved. Requirements will vary by supplier type and by location; for instance, some states may require a particular supplier type to be "certified" but not "licensed," or vice versa. (The license and certification "Not Applicable" checkboxes are for instances where a state does not require licensure).)

The only licenses that must be submitted with the application are those required by Medicare or the state to function as the supplier type in question. Licenses and permits that are not of a medical nature are not required. In addition, and as mentioned above, instances can occur where the supplier need not be licensed at all in a particular state; the contractor shall still ensure, however, that the supplier meets all applicable state and Medicare requirements.

The contractor shall verify that the supplier is licensed and/or certified to furnish services in:

- The state in which the supplier is enrolling.

- Any other state within the contractor's jurisdiction in which the supplier (per the "Practice Location Information" section of the Form CMS-855I) will maintain a practice location.

The contractor shall also ensure that the individual answers "Yes" or "No" to the Section 2(B)(1) question regarding compact licenses if individual indicates that *the individual* is licensed. (See subsection (A)(6) below for more information on compact licenses.)

2. Notarization

If the applicant submits a license that is not notarized or "certified true," the contractor shall verify the license with the appropriate state agency. (A notarized copy of an original document has a stamp that states "official seal," along with the name of the notary public, the state, the county, and the expiration date of the notary's commission. A certified "true copy" of an original document has a raised seal that identifies the state and county in which it originated or is stored.)

3. Temporary Licenses

If the supplier submits a temporary license, the contractor shall note the expiration date in PECOS. Should the supplier fail to submit the permanent license after the temporary license expiration date, the contractor shall initiate revocation procedures. (A temporary permit – one in which the applicant is not yet fully licensed and must complete a specified number of hours of practice to obtain the license – is not acceptable.)

4. Revoked/Suspended Licenses

If the applicant had a previously revoked or suspended license reinstated, the applicant must submit a copy of the reinstatement notice with the application.

5. License Expiration/Revocation Dates for Non-Certified Suppliers

For expired licenses, the contractor shall enter in PECOS the day after the expiration as the expiration date. For revoked and suspended licenses, the contractor shall enter in PECOS the revocation date (not the day after) as the expiration date. (See section 10.6.19(T) of this chapter for special instructions related to periodic license reviews.)

6. Interstate License Compacts

A new trend in medicine has arisen involving interstate license compacts. While physician compacts streamline the licensure process for physicians who want to practice in multiple states, a separate license from each state in which the physician intends to practice is still issued (if all requirements are met). CMS will continue to rely on the license issued by the state medical board to help confirm compliance with federal requirements.

In a similar vein, certain non-physician practitioner (NPP) compacts allow the NPP to work in a compact member state (other than *the individual's* home state) without going through the normal process for licensure in the remote state. NPPs working under the authorization of such a compact must meet both the licensure requirements outlined in the primary state of residence and those established by the compact laws adopted by the legislatures of the interstate compact states.

At present, there are interstate compacts involving physicians, physical therapists, occupational therapists, speech language pathologists, and psychologists (though none for nurse practitioners). More are possible.

Licenses obtained through an interstate license compact for the above supplier types shall be treated as valid, full licenses for the purposes of meeting federal requirements. The contractor shall thus accept Form CMS-855I applications from applicants reporting a license obtained via an interstate license compact. In addition, the contractor shall attempt to verify the interstate license obtained through the compact using the state licensing board website(s) or compact website (if one exists); if neither technique can confirm the interstate license, the contractor shall request documentation from the supplier that validates said data.

B. Correspondence Address, Medical Record Correspondence Address, and Telephone Number

1. Correspondence Address

The correspondence address must be one where the contractor can directly contact the applicant to resolve any issues once the supplier is enrolled in Medicare. It cannot be the address of a billing agency, management services organization, or the supplier's representative (e.g., attorney, financial advisor). It can, however, be a P.O. Box or, in the case of an individual practitioner, the person's home address.

The contractor need not verify the correspondence address.

2. Medical Records Correspondence Address

The medical records correspondence address must be one where the contractor can directly contact the applicant regarding medical records once the supplier is enrolled in Medicare. It cannot be the address of a billing agency, management services organization, or the supplier's representative (e.g., attorney, financial advisor). It can, however, be a P.O. Box or, in the case of an individual practitioner, the person's home address.

Note that: (1) the contractor need not verify the medical records correspondence address; and (2) the medical records correspondence address does not apply to individuals reassigning all benefits.

3. Telephone Number

The supplier may list any telephone number as the correspondence or medical record correspondence phone number. The number need not link to the listed correspondence address. If the supplier fails to list a correspondence or medical record telephone number and it is required for the application submission, the contractor shall develop for this information – preferably via the PCV, e-mail, or fax. The contractor shall accept a particular phone number if it has no reason to suspect that it does not belong to or is not somehow associated with the supplier. The contractor need not verify the telephone number.

C. E-mail Addresses

An e-mail address listed on the application can be a generic e-mail address. It need not be that of a specific individual. The contractor may accept a particular e-mail address if it has no reason to suspect that it does not belong to or is not somehow associated with the supplier.

D. Specialties

A physician must indicate *the* supplier specialty via a checkmark, an "X," or other symbol; if the physician has more than one specialty, *these* specialties must *be* indicated, showing "P" for primary and "S" for secondary. (Non-physician practitioners must indicate their supplier type.)

The contractor shall verify that any supplier identifying a secondary specialty on the Form CMS-855I application has the appropriate medical license. The contractor shall validate the license using the state's medical license website. If an active license is not found, the contractor shall develop via telephone, fax, email, or mail to confirm the supplier's intent and to obtain a copy of the license, if applicable.

The contractor shall deny the application if the individual fails to meet the requirements of *the* physician specialty (primary and/or secondary) or supplier type.

Notwithstanding the foregoing instructions in this subsection (D), if a Form CMS-855I enrollment application is submitted to report a primary or secondary specialty change, the

contractor shall not contact the physician, practitioner, or contact person directly to confirm either the change itself or the individual's intent to change specialty.

E. Education

1. Non-Physician Practitioners - The contractor shall verify all required educational information for non-physician practitioners. While the non-physician practitioner must meet all federal and state requirements, *the individual* need not provide documentation of courses or degrees taken to satisfy these requirements unless the contractor requests it. To the maximum extent possible, the contractor shall use means other than the practitioner's submission of documentation---such as a state or school web site---to validate the person's educational qualifications.

2. Physicians - A physician need not submit a copy of *the* degree unless the contractor requests it. To the maximum extent possible, the contractor shall use means other than the physician's submission of documentation---such as a state or school web site--to validate the person's educational status.

F. Relocation to a New State: License Reviews

When a practitioner submits a Form CMS-855I application to either (1) add a practice location in a new state or (2) relocate to a new state entirely, the contractor that received the application shall review state licensing board information for the "prior" state to determine:

- Whether the practitioner had *a* medical license revoked, suspended, or inactive (due to retirement, death, or voluntary surrender of license), or otherwise lost *a* license, and

- If the practitioner has indeed lost *a* medical license, whether *this* was reported via the Form CMS-855I within the timeframe specified in 42 CFR § 424.520.

If the practitioner is currently enrolled and did not report the adverse action to Medicare in a timely manner, the contractor shall---unless another directive in this chapter instructs otherwise, such as section 10.6.6----revoke the practitioner's Medicare enrollment and establish the appropriate reenrollment bar length. If the practitioner is submitting an initial enrollment application (e.g., is moving to a new state and contractor jurisdiction) and did not report the adverse action in Section 3 of the CMS-855I, the contractor shall--- unless another directive in this chapter instructs otherwise---- deny the enrollment application.

10.3.1.3.4 – Section 4 (Business Information) - Form CMS-855I

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Practice Location Verification

The contractor shall verify that the practice locations listed on the application exist and are valid addresses with the United States Postal Service (USPS). PECOS includes a USPS Address Matching System Application Program Interface (API), which validates address information entered and flags the address if it is determined to be invalid, unknown, undeliverable, vacant, unlikely to deliver mail (No-Stat), a CMRA (i.e., UPS Store, mailboxes, etc.), or a known invalid

address false positive. These address types are not permitted in PECOS and are flagged upon entry. To reiterate: the practice location address in the Practice Location Information section must be a valid address with USPS; addresses entered in PECOS are verified via computer software to determine if they are valid and deliverable.

Each practice location is to be verified. However, the contractor shall not call the practice locations (or the contact person listed on the application) to validate them. The verification means described in the previous paragraph (and, if applicable to the provider/supplier type, a site visit) shall instead be used. Only if development is needed to confirm the location (e.g., USPS cannot validate the location) may the contractor telephone the location or contact person.

Any supplier submitting a Form CMS-855I application must submit the 9-digit ZIP Code for each practice location listed.

If the "Business Structure Information" checkboxes in Section 4A are blank, the contractor can confirm the information via the PCV, e-mail, or fax.

A practitioner who only renders services in patients' homes (i.e., house calls) must supply *the practitioner's* home address in the Practice Location Information section. In addition, if a practitioner renders services in a retirement or assisted living community, the Practice Location Information section must include the name and address of that community. In either case, the contractor shall verify that the address is a physical address. Post office boxes and drop boxes are not acceptable.

If the physician or non-physician practitioner uses *a* home address as *the* practice location and exclusively performs services in patients' homes, nursing homes, etc., no site visit is necessary.

If an individual practitioner (1) is adding a practice location and (2) is normally required to complete a questionnaire in the Personal Identifying Information section of the Form CMS-855I specific to its supplier type (i.e., physical therapists), the person must submit an updated questionnaire to incorporate services rendered at the new location.

For suppliers paid via the Multi-Carrier System (MCS)--and except as otherwise stated in section 10.3--the practice location name entered in PECOS shall be the legal business name.

B. Telephone Number Verification

The contractor need not verify the supplier's telephone number listed on the application, though the supplier must report one. If the supplier does not, the contractor shall develop for a phone number using the procedures outlined in this chapter.

C. Unintended Changes

Unless CMS specifies otherwise, any change in the supplier's phone number or address that the supplier did not cause (i.e., area code change, municipality renames the supplier's street) must still be updated via the Form CMS-855I.

D. Remittance Notices/Special Payments Mailing Address section

The "special payment" address may only be one of the following:

- One of the supplier's practice locations
- A P.O. Box
- A Lockbox. (The contractor shall request additional information if it has any reason to suspect that the arrangement---at least with respect to any special payments that might be made---may violate the Payment to Agent rules in Pub. 100-04, chapter 1, section 30.2.)
- The supplier's billing agent. The contractor shall request additional information if it has any reason to suspect that the arrangement – at least with respect to any special payments that might be made – may violate the Payment to Agent rules in Pub. 100-04, chapter 1, section 30.2.
- Correspondence address

If neither box in this section is checked and no address is provided, the contractor can contact the supplier by telephone, the PCV, e-mail, or fax to confirm the supplier's intentions. If the "special payments" address is the same as the practice location, no further development is needed. If, however, the supplier wants payments to be sent to a different address, the address in the Remittance Notices/Special Payments Mailing Address section must be completed via the Form CMS-855I.

E. Do Not Forward (DNF)

Unless instructed otherwise in another CMS directive, the contractor shall follow the DNF initiative instructions in Pub. 100-04, chapter 1, section 80.5. Returned paper checks, remittance notices, or EFT payments shall be flagged if returned from the post office or banking institution, respectively, as this may indicate that the supplier's "special payment" address (Business Information of the Form CMS-855I) or EFT information has changed. The supplier should submit a Form CMS-855I to change this address; if the supplier does not have an established enrollment record in PECOS, it must complete an entire Form CMS-855I and Form CMS-588. The Durable Medical Equipment MAC is responsible for obtaining, updating, and processing Form CMS-588 changes.

In situations where a supplier is closing *the* business and has a termination date (e.g., *is* retiring), the contractor will likely need to make payments for prior services rendered. Since the practice location has been terminated, the contractor may encounter a DNF message. If so, the contractor should request the supplier to complete the "special payment" address section of the Form CMS-855I and to sign the certification statement. The contractor, however, shall not collect any other information unless there is a need to do so.

F. EFT

For new enrollees, all payments must be made via EFT. The contractor shall thus ensure that the supplier has completed and signed the Form CMS-588 and shall verify that the bank account complies with Pub. 100-04, chapter 1, section 30.2.

If an enrolled supplier that currently receives paper checks submits a Form CMS-855I change request – no matter what the change involves – the supplier must also submit:

- A Form CMS-588 that switches its payment mechanism to EFT. (The change request cannot be processed until the Form CMS-588 is submitted.) All future payments (excluding special payments) must be made via EFT.

- The contractor shall also verify that the bank account complies with Pub. 100-04, chapter 1, section 30.2.

(Once a supplier changes its method of payment from paper checks to EFT, it must continue using EFT. A supplier cannot switch from EFT to paper checks.)

G. Solely-Owned Organizations

1. Paper Applications

All pertinent data for solely-owned organizations can be furnished via the Form CMS-855I alone. The contractor, however, shall require the supplier to submit a Form CMS-855B and CMS-855I if, during the verification process, it discovers that the supplier is not a solely-owned organization. (**NOTE**: A solely-owned supplier type that normally completes the Form CMS-855B to enroll in Medicare must still do so. For example, a solely-owned LLC that is an ambulance company must complete the Form CMS-855B even though the Practice Location Information/Sole Proprietor/Sole Proprietorship section makes mention of solely-owned LLCs. Use of the Practice Location Information section of the Form CMS-855I is limited to suppliers that perform physician or practitioner services.)

(Sole proprietorships need not complete the Business Information portions of Section 4 of the Form CMS-855I. Per definition, a sole proprietorship is not a corporation, professional association, etc. Do not confuse a sole proprietor with a physician whose business is that of a corporation, LLC, etc., of which *the physician* is the sole owner.)

In the Business Information section, the supplier may list a type of business organization other than a professional corporation, a professional association, or a limited liability company (e.g., closely-held corporation). This is acceptable so long as that business type is recognized by the state in which the supplier is located.

The contractor shall verify all data furnished in the Business Information section (e.g., legal business name, TIN, adverse legal actions). If the Business Information section is left blank, the contractor may assume it does not pertain to the applicant.

A solely-owned physician or practitioner organization that utilizes the Business Information section to enroll in Medicare can generally submit change of information requests to Medicare

via the Form CMS-855I. However, if the change involves data not captured on the Form CMS-855I, the change must be made on the applicable CMS form (e.g., Form CMS-855B).

H. Individual Reassignment/Affiliation Information

If the applicant indicates *an intention* to render all or part of *the individual's* services in a private practice, clinic/group, or any organization *to which benefits would be reassigned*, the contractor shall ensure that the applicant (or the group or organization, as applicable) has completed Section 4(F)(1)/(2) of the Form CMS-855I for each party to which the applicant is reassigning benefits. The contractor shall also verify that each individual, clinic/group practice, or organization to which benefits are being reassigned is enrolled in Medicare. If it is not, the contractor shall enroll the individual, clinic/group practice, or organization prior to approving the reassignment.

See section 10.3.1.4 of this chapter for detailed instructions regarding the processing of reassignments.

I. Sole Proprietor Use of EIN

The practitioner may obtain a separate EIN if *the individual* wants to receive reassigned benefits as a sole proprietor.

J. NPI Information for Groups

If a reassignee is already established in PECOS (i.e., status of "approved" unless the Form CMS-855I is submitted for the purpose of revalidation), the reassignor need not submit the reassignee's NPI in Section 4(F) of the Form CMS-855I.

K. Out-of-State Practice Locations

Except as stated otherwise in section 10.3 or in another CMS directive, if a supplier is adding a practice location in another state, a separate, initial Form CMS-855I enrollment application is required for that location even if:

- The location is part of the same organization (e.g., a solely-owned corporation),
- The location has the same tax identification number (TIN) and legal business name (LBN), and
- The location is in the same contractor jurisdiction.

To illustrate, suppose the contractor's jurisdiction consists of States X, Y, and Z. Dr. Jones, a sole proprietor, is enrolled in State X with 2 locations. *Jones* wants to add a third location in State Y under *Jones'* social security number and *the* sole proprietorship's employer identification number. A separate, initial Form CMS-855I application is required for the State Y location.

10.3.1.3.6 - Section 15 (Certification Statement) - Form CMS-855I

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Applicability and Format

Unless otherwise specified, the instructions in this section 10.3.1.3.6 apply to (1) signatures on the paper Form CMS-855I and (2) electronic signatures.

For paper applications, valid signatures include handwritten (wet) signatures in ink and digital/electronic signatures (digital or electronic signatures such as those created by digital signature options established via software, such as Adobe). For web applications, electronic signatures are required; the contractor can contact its PEOG BFL for questions regarding electronic signatures.

B. Signatories

The enrolling or enrolled physician or non-physician practitioner is the only person who can sign the Form CMS-855I. (This applies to initial enrollments, changes of information, reactivations, revalidations, etc.). This includes solely-owned entities listed in the Business Information section of Section 4 of the Form CMS-855I. A physician or non-physician practitioner may not delegate the authority to sign the Form CMS-855I on *the physician's/practitioner's* behalf to any other person. (In the case of death, however, an executor of the estate may sign on behalf of the deceased supplier, though this only applies to change of information applications.)

C. Paper Submissions

A signed certification statement must accompany the paper Form CMS-855I application. If the supplier submits an invalid certification statement or fails to submit a certification statement at all, the contractor shall still proceed with processing the application. An appropriate certification statement shall be solicited as part of the development process – preferably via the PCV, e-mail, or fax. This includes certification statements that are: (a) unsigned; (b) undated; (c) signed (as reflected by the date of signature) more than 120 days prior to the date on which the contractor received the application; (d) signed by someone other than the physician or non-physician practitioner (except as noted in section 10.3.1.3.6(B)); (e) missing; or (f) stamped. The contractor shall send one development request to include a list of all of the missing required data/documentation, including the certification statement. The contractor may reject the supplier's application if the supplier fails to furnish the missing information on the enrollment application - including all necessary documentation - within 30 calendar days from the date the contractor requested it.

Unless stated otherwise in this chapter or in another CMS directive:

(i) The contractor shall begin processing the application upon receipt and shall develop for missing certification statements and all other missing information.

(ii) The certification statement may be returned via scanned email or fax.

(iii) Signature dates cannot be more than 120 days prior to the receipt date of the application.

(iv) The contractor need not compare the supplier's signature with one already on file for that person to ensure it is the same individual.

(v) The contractor shall not request the submission of a driver's license or passport to verify a person's signature or identity.

D. PECOS Submissions

If the supplier submits an invalid certification statement, the contractor shall treat this as missing information and develop for a correct certification statement – preferably via the PCV, e-mail or fax. (This includes certification statements that are: signed by someone other than the physician or non-physician practitioner (except as noted in section 10.3.1.3.6(B)). The contractor shall send one development request to include a list of all of the data/documentation to be furnished or clarified, including, as applicable, the certification statement. The contractor may reject the supplier's application if the supplier fails to furnish said data/documentation within 30 calendar days from the date the contractor requested the missing information or documentation.

Unless stated otherwise in this chapter or in another CMS directive:

(i) The contractor shall (a) begin processing the application upon receipt via PECOS, (b) perform all required manual validations, and (c) develop for any needed clarifying or missing information or documentation consistent with section 10.3 above and all other applicable instructions in this chapter.

(ii) The contractor need not compare the supplier's signature with one already on file for that person to ensure it is the same individual.

(iii) The contractor shall not request the submission of a driver's license or passport to verify a person's signature or identity.

E. Certification Statement Development

The supplier must submit a newly signed certification statement as part of a development request as follows:

(i) Paper applications: Via scanned e-mail, fax, or mail. (Only the actual signature page is required; the additional page containing the certification terms need not be submitted. This also applies to the supplier's initial submission of a certification statement; such instances require the submission of only the signature page and not the certification terms.)

(ii) Web applications – Via electronic signature.

F. Privacy Statement

All information collected on the Form CMS-855I shall be entered into PECOS. The Privacy Act permits CMS to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. Any such disclosure of data is known as a "routine use." CMS will only release

PECOS information that can be associated with an individual as provided for under Section III "Proposed Routine Use Disclosures of Data in the System." Both identifiable and non-identifiable data may be disclosed under a routine use. CMS will only collect the minimum personal data necessary to achieve the purpose of PECOS. To view the routine uses in their entirety, go to: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/Downloads/0532-PECOS.pdf.

10.3.1.3.7 - Additional Processing Information and Alternatives – Form CMS-855I

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Processing a Form CMS-855I Ownership Change of Information Application

When a sole owner practitioner has sold *the practitioner's* group to another individual practitioner and the EIN remains unchanged, the contractor shall process the transaction as a change of information via the Form CMS-855I to change the group's owner. In doing so, the contractor shall:

(i) Verify that the EIN is solely owned by the new owner.

(ii) Make no change to the PTAN or effective date.

(iii) If applicable, require the prior sole owner individual to submit a voluntary termination application to terminate *the person's* individual enrollment/reassignment.

B. Unsolicited Additional Information

If the supplier submits missing/clarifying data or documentation on its own volition (i.e., without being contacted by the contractor), the contractor shall include this additional data/documentation in its overall application review. Any new or changed information that a supplier submits prior to the date the contractor finishes processing a previously submitted change request shall be processed as a separate change request rather than an update to the original change request. The contractor may process both changes simultaneously, but the change that was submitted first shall be processed to completion prior to the second one being processed to completion.

C. Processing Alternatives

As stated in section 10.3, some of the application data elements and verification procedures that have previously been subject to a processing exception/alternative may no longer be so or are moot under PECOS 2.0. (See section 10.3 for a discussion of such data and procedures.) In such situations, the contractor shall disregard the exception/alternative and follow the instructions in section 10.3 and sections 10.3.1.3 through 10.3.1.3.6.

1. Information Disclosed Elsewhere

If a data element on the supplier's Form CMS-855I application is missing but the information is disclosed (1) elsewhere on the application or (2) in the supporting documentation submitted with the application, the contractor need not obtain the missing data via an updated Form CMS-855I page and a newly-signed certification statement; no further development – not even by telephone – is required. The following information, however, must be furnished in the appropriate section(s) of the Form CMS-855I, even if the data is identified elsewhere on the form or in the supporting documentation:

a. Except as otherwise stated in section 10.6.6 of this chapter, any final adverse action data requested in sections 3, 4A, and 6B of the Form CMS-855I

b Legal business names (LBN) or legal names (Note: If an application is submitted with a valid NPI-PTAN combination but (1) the LBN field is blank, (2) an incomplete or inaccurate LBN is submitted, or (3) the applicant includes a DBA name in the Business Information section of the Form CMS-855I --- and the contractor can confirm the correct LBN based on the NPI-PTAN combination provided, the contractor need not develop. (This also applies to the Employer's Name for PAs in the Personal Identifying Information (PA Information) section of the Form CMS-855I).)

c. Tax identification numbers (TIN)

d. NPI-legacy number combinations in the Business Information section of the Form CMS-855I. (The contractor may use the shared systems, PECOS, or its provider files as a resource to determine the PTAN or NPI before developing with the supplier.)

e. Practitioner type in the Personal Identifying Information section of the Form CMS-855I

If the supporting documentation currently exists in the supplier's file, the supplier need not submit that documentation again during the enrollment process. The contractor shall utilize the existing documentation for verification. Unless stated otherwise in this chapter or another CMS directive, documentation submitted with a previously submitted enrollment application (or documentation currently uploaded in PECOS) qualifies as a processing alternative. Also, the contractor shall document in PECOS that the missing information was found elsewhere in the enrollment package. (This excludes information that must be verified at the current point in time (i.e., a license without a primary source verification method).) In addition, the contractor shall not utilize information submitted along with opt-out applications for enrollment application processing or vice-versa.

2. Licenses

If the supplier is required to submit a copy of a particular professional or business license, certification, registration, or degree but fails to do so, the contractor need not obtain such documentation from the supplier if the contractor can verify the information independently. This can be done by: (1) reviewing and printing confirming pages from the applicable state, professional, or school web site; (2) requesting and receiving from the appropriate state, professional, or educational body written confirmation of the supplier's status therewith; or (3) utilizing another third-party verification source. Similarly, if the supplier submits a copy of the applicable license, certification, registration, or degree but fails to complete the applicable

section of the form, the section need not be completed if the data in question can be verified on the license/certification itself or via any of the three mechanisms described above.

(The above-referenced written confirmation of the supplier's status can be in the form of a letter, fax, or e-mail, but it must be in writing. Documentation of a verbal conversation between the contractor and the body in question does not qualify as appropriate confirmation.)

This exception only applies to documents that traditionally fall within the category of licenses, registrations, certifications, or degrees. It is inapplicable to items such as adverse action documentation, etc. Furthermore, the exception is moot in cases where the state does not require a particular license/certification.

3. Drug Enforcement Agency Certificates (DEA)

DEA certificates are not required. If the applicable DEA certificate is not furnished or the applicable Form CMS-855I section is blank, no further development is needed.

4. City, State, and ZIP Code

If an address (e.g., correspondence address, practice location) lacks a city, state, or zip + four, the contractor can verify the missing data in any manner it chooses. In addition, the contractor can obtain the zip + four from either the U.S. Postal Service or the Delivery Point Validation in PECOS.

5. Inapplicable Questions

The supplier need not check "no" for questions that obviously do not apply to its supplier type. For instance, a nurse practitioner need not complete the Personal Identifying Information (Resident Information) section of the Form CMS-855I.

6. Additional Alternatives

(i) If blank, the "Type of Other Name" can be captured orally.

(ii) If the contractor is aware that a particular state does not require licensure/certification and the "Not Applicable" boxes are not checked in the Personal Identifying Information section, no further development is needed.

(iii) Personal Identifying Information (Physician Specialty) section - If the supplier uses a checkmark, an "X," or other symbol to identify *the* primary and secondary specialties (as opposed to a "P" or "S"), no additional development is needed.

(iv) When processing a non-physician practitioner's (NPP) application, the contractor need not automatically request a copy of the NPP's degree or diploma (if it is not submitted) if education can be verified through other authorized means. Requesting a copy of the degree or diploma should only be done if educational information cannot otherwise be verified.

(v) Medical or Professional School and Year of Graduation – If the Form CMS-855I lacks the medical or professional school and/or the year of graduation but the information is disclosed in the supporting documentation submitted with the application or it already exists in PECOS, no further development is needed.

10.3.1.4 - Reassignment of Medicare Benefits Via the Form CMS-855I

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Background

Consistent with 42 CFR § 424.80(b)(1) and (b)(2) and Pub. 100-04, Chapter 1, sections 30.2.1(D) and (E) and 30.2.6 and 30.2.7, Medicare may pay: (1) a physician or other provider's or supplier's employer if the provider or supplier is required, as a condition of employment, to turn over to the employer the fees for *the individual's* services; or (2) an entity (i.e., a person, group, or facility) that is enrolled in the Medicare program for services furnished by a physician or other provider or supplier under a contractual arrangement with that entity. This means that Part A and Part B entities other than physician/practitioner group practices can receive reassigned benefits, assuming the requirements for a reassignment exception are otherwise met.

Reassignments of benefits are now facilitated via the Form CMS-855I. The Form CMS-855R has been discontinued.

B. General Reassignor Policies

An individual who renders Medicare Part B services and seeks to reassign benefits to an eligible entity should complete Sections 4(F)(1) and (2) of the Form CMS-855I for each party eligible to receive reassigned benefits; the individual must be enrolled in Medicare as a physician/practitioner prior to reassigning benefits. The applicable sections of the Form CMS-855I (e.g., Section 1(A) (Reason for Submittal); Section 1(B) (Reassignment of Benefits checkbox); Sections 4(F)(1) and (2); Section 15; etc.) must also be completed for any individual who is adding, terminating, changing an existing reassignment. (Note that Section 4(F)(3) is optional.)

The individual can report multiple new, changed, or terminated reassignments to parties with the same or different employer identification numbers (EINs) on a single Form CMS-855I by submitting separate Section 4(F)s and Section 15(C)s with the appropriate reassignee signatures. (For instance, if a physician is reassigning to Groups A, B, and C, an authorized/delegated official of A, B, and C, respectively, must sign a separate Section 15(C).) The contractor shall issue one approval letter using the applicable model letter in sections 10.7.6(D) and 10.7.6(M) of chapter 10.

For reassignment terminations, the effective date of termination as indicated on the Form CMS-855I is the day after the effective date of termination. Payment will no longer be made to the reassignee the day after the termination effective date. To illustrate, suppose a physician submits a Form CMS-855I to terminate a reassignment to a group. June 30, 2025, *is listed* as the termination date. The termination effective date listed in PECOS and any correspondence to the supplier should be July 1, 2025.

There could be rare situations where an unenrolled individual seeks to reassign benefits and submits only Section 4(F) of the Form CMS-855I. The contractor in this situation shall develop for an initial enrollment application from the individual.

The contractor need not verify whether the reassigning individual is a W-2 employee or a 1099 contractor.

Regarding reassignment and revoked or deceased physicians, see section 10.6.17(G)(1) of this chapter.

C. Policies Concerning Reassignees

1. Site of Service

Per Pub. 100-04, chapter 1, section 30.2.7, a reassignment of benefits to any eligible party is permitted regardless of where the service was rendered or whether the party owns or leases that location. As such, the contractor need not verify the reassignee's ownership or leasing arrangement with respect to the reassignment.

2. Organization/Group Receiving the Reassigned Benefits

The most common reassignment situation is a physician/practitioner who reassigns benefits to a physician/practitioner group. Here, the reassignee's authorized or delegated official must sign Section 15(C) of the reassignor's Form CMS-855I.

3. Individual Receiving Reassigned Benefits

An individual can receive reassigned benefits. This can occur, for instance, when a physician/practitioner reassigns benefits to a physician/practitioner who is either (1) a sole proprietor or (2) the sole owner of an entity listed in the Business Information section of the Form CMS-855I. Here, the only required forms are separate Form CMS-855Is from the reassignor and the reassignee. (No Form CMS-855B or Form CMS-855A is involved.) The reassignee must sign Section 15(C) of the reassignor's Form CMS-855I. (Note that Section 15(C) applies to all reassignees, regardless of whether they are organizations or individuals. In the former case, the organization's authorized/delegated official must sign Section 15(C); with the latter, the individual reassignee must sign.)

The contractor shall follow the instructions in Pub. 100-04, Chapter 1, sections 30.2 – 30.2.16 to ensure that the reassignee is indeed eligible to receive reassigned benefits.

4. Additional Information

If the reassignee is not enrolled in Medicare, said party must complete, as applicable, an initial Form CMS-855B, Form CMS-855A, or Form CMS-855I.

Benefits are reassigned to a provider or supplier, not to the provider/supplier's practice location(s). As such, the reassignor need not update *the individual's* reassignment data on the Form CMS-855I each time the reassignee adds a practice location.

When a group practice adds a new practice location, each physician/practitioner who reassigns to the group and wants to bill from this new location must have a new PTA*N i*f the group is issued a new PTAN. (The group will only be issued a new PTAN if the new location is in a separate fee locality.)

D. Additional Signature Policies

1. Who Must Sign

For initial/new reassignments, both the reassignor and reassignee (or an authorized/delegated official of the latter) must sign, respectively, Section 15(B) and (C) of the reassignor's Form CMS-855I. If either required signature is missing, the contractor shall develop for it.

For changes in reassignment data or for reassignment terminations (and as similar situations were handled with the Form CMS-855R), only the reassignor or reassignee must submit the termination or applicable changed information in Section 4(F) and sign Section 15(B) or (C) (as applicable).

2. Official On/Not on File

An authorized/delegated official who signs Section 15(C) of the Form CMS-855I must be currently on file with the contractor as such. If this is a new enrollment --- with a joint submission of the Form(s) CMS-855A or CMS 855B and Form CMS-855I --- the person must be listed on the Form CMS-855A or Form CMS-855B as an authorized/delegated official.

There may be situations where a Form CMS-855I is submitted and the reassignee is already enrolled in Medicare via the Form CMS-855B. However, the authorized/delegated official is not on file. In this case, the contractor shall develop for a Form(s) CMS-855A or CMS-855B change request that adds the new authorized/delegated official.

3. Development Needed

If the contractor must develop for information in Section 4(F)(1) or (2), the following apply:

(i) Initial reassignments (as part of an initial Form CMS-855I or a Form CMS-855I change of information that adds a new reassignment): Both the reassignor and reassignee (or, for entities, an authorized/delegated official thereof) must sign any certification statement that must accompany the reassignor's response.

(ii) All other transactions – Only the reassignor or reassignee need sign any required certification statement.

4. Other Signature Policies

The contractor shall follow all other applicable signature policies (e.g., form of signature) outlined in section 10.3.1.3.6 of this chapter.

5. Processing Alternatives

As applicable, the contractor may apply the processing alternatives identified in section 10.3.1.3.7 to the Section 4(F) data.

E. Inter-Jurisdictional Reassignments

If a reassignor is reassigning *b*enefits to a reassignee located in another contractor jurisdiction (a permissible practice), the principles in this section 10.3.1.4(E) apply unless another CMS directive states otherwise.

1. The reassignor must be properly licensed or otherwise authorized to perform services in the state in which *the individual* has *the* practice location. The practice location can be an office or even the individual's home (for example, a physician interprets test results in *the physician's* home for an independent diagnostic testing facility).

2. The reassignor need not – pursuant to the reassignment - enroll in the reassignee's contractor jurisdiction nor be licensed/authorized to practice in the reassignee's state. If the reassignor will be performing services within the reassignee's state, the reassignor must enroll with the contractor for (and be licensed/authorized to practice in) that state.

3. The reassignee must enroll in the contractor jurisdictions in which (1) it has its own practice location(s), and (2) the reassignor has *the* practice location(s). In Case (2), the reassignee:

(i) Shall identify the reassignor's practice location as a practice location on its Form CMS-855B or Form CMS-855I.

(ii) Shall select the practice location type as "Other health care facility" and specify "Telemedicine location" in the Practice Location Information of its Form CMS-855.

(iii) Need not be licensed/authorized to perform services in the reassignor's state.

To illustrate, suppose Dr. Smith is in Contractor Jurisdiction X and is reassigning benefits to Jones Medical Group in Contractor Jurisdiction Y. Jones must enroll with X and with Y. Jones need not be licensed/authorized to perform services in Dr. Smith's state. However, in the Practice Location Information section of the Form CMS- 855B it submits to X, Jones must list Dr. Smith's location as its practice location.

F. Reassignment to CAHs

Reassignment to a Part A provider or supplier might occur when: (1) a physician or practitioner reassigns benefits to a hospital, skilled nursing facility, or critical access hospital billing under Method II (CAH II); or (2) a nurse practitioner reassigns to a CAH II.

If the entity receiving the reassigned benefits is not a CAH II, it must enroll with the contractor via a Form CMS-855B, and the physician/practitioner reassigning benefits must complete and submit a Form CMS-855I.

If the entity receiving the reassigned benefits is a CAH II, the entity need not complete a separate Form CMS-855B to receive reassigned benefits. The physician/practitioner can reassign benefits directly to the CAH II's Part A enrollment. The distinction between CAHs billing Method I vs. Method II only applies to outpatient services. It does not apply to inpatient services.

Under Method I:

- The CAH bills for facility services
- The physicians/practitioners bill separately for their professional services

Under Method II:

- The CAH bills for facility services
- If a physician/practitioner has reassigned benefits to the CAH, the CAH bills for that particular physician's/practitioner's professional service
- If a CAH has elected Method II, the physician/practitioner need not reassign benefits to the CAH. For those physicians/practitioners who do not reassign their benefits to the CAH, the CAH only bills for facility services and the physicians/practitioners separately bill for their professional services (akin to Method I).

Although physicians and non-physician practitioners are not required to reassign their benefits to a CAH that bills Method II, doing so allows them to participate in the Electronic Health Records (EHR) Incentive Program for Eligible Professionals (EPs).

In this scenario, the Form CMS-855I shall be submitted to the Part B MAC and the Form CMS-855A submitted to the Part A MAC. The Part B MAC is responsible for reassigning the individual to the Part A entity.

The reassignment to the Part A entity shall only occur if the Form CMS-855A for the CAH II has been finalized. This can be determined by viewing PECOS to identify if an approved enrollment exists for the CAH II. If one does not, the Part B MAC shall return the Form CMS-855I to the provider on the ground that it is inapplicable to the transaction in question (i.e., the Form CMS-855A has not been finalized). If an enrollment record exists but is pending state/SOG review, the Part B MAC shall contact the Part A MAC to determine if state/SOG Location (as applicable) approval has been received but not yet updated in PECOS prior to returning the applications.

G. Reassignments Related to Revoked or Deactivated Reassignee

The contractor shall end-date in PECOS all reassignment associations and the associated

Provider Transaction Access Numbers (PTANs) when revoking or deactivating an individual or organization (reassignee) that is receiving reassigned benefits from an individual practitioner. The end-date shall be the same as the effective date of the revocation or deactivation; this will ensure the appropriate end-date in the Multi-Carrier System (MCS) and prevent improper use of those PTANs. However, the contractor shall not deactivate the individual practitioner's (reassignor's) enrollment record even if (1) the reassigned PTAN is the only PTAN on the individual's enrollment record and/or (2) no other active locations exist (private practice locations or reassignments); the contractor shall allow the practitioner's/reassignor's enrollment record to remain in an approved status.

When sending a deactivation, revocation, or voluntary withdrawal letter to the deactivated or revoked non-certified Part B supplier, said letter shall include the following language: "Please notify all physician assistants and/or group members who reassign benefits to your organization that, in accordance with 42 CFR §424.540(a)(2), their Medicare enrollment status may be deactivated if they fail to update their enrollment record within 90 calendar days."

H. Group and Reassignment Reactivation

If a group practice submits a reactivation application after being deactivated for non-response to a revalidation request, the contractor shall reactivate the group's reassignments when the group's reactivation application has been approved; Form CMS-855I applications for the reassignments are not required. The effective dates assigned to the reassigned providers shall align with the group's effective date per existing reactivation instructions. (This section 10.3.1.4(H) only applies to deactivations based on a non-response to a revalidation request.)

I. Additional Information

The contractor:

- Shall follow this chapter's existing instructions (and all other applicable CMS guidance) for validating information furnished by a physician/practitioner on the Form CMS-855I, including any reassignment data in Sections 4(F)(1) and (2).

- Shall follow the instructions in section 10.6.2 of this chapter regarding the application of effective dates.

10.3.1.5 – Form CMS-855O – Medicare Enrollment Application for Eligible Ordering and Certifying Physicians, and other Eligible Professionals

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

This form is used by physicians and other eligible professionals who wish to enroll in Medicare solely for the purpose of ordering and certifying the services/items described in 42 CFR § 424.507(a) and (b). These physicians and other eligible professionals do not and will not send claims to a contractor for the services they furnish. In addition, suppliers who have opted out of Medicare are not permitted to enroll via the Form CMS-855O for purposes of ordering or certifying.

The physician/other eligible professional need not submit a Form CMS-460, a Form CMS-588, or an application fee with *the* Form CMS-855O.

10.3.1.5.1 – Sections 1 through 7 of the Form CMS-855O

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Basic Information (Section 1)

In this section, the ordering or certifying individual indicates the reason for the application submittal. Unless otherwise stated in this chapter, in another CMS directive, or as permitted by PECOS, the ordering or certifying individual may only check one reason for submittal.

With the exception of the voluntary termination checkbox---and except as stated in section 10.6.1.3 of this chapter---any blank data/checkboxes in the Basic Information section can be verified via any means (e.g., e-mail, telephone, fax).

B. Identifying Information (Section 2)

1. License/Certification/Registration Information

The extent to which the ordering or certifying individual must complete the licensure, certification, or accreditation information depends upon the individual's supplier type. Requirements will vary by supplier type and by location; for instance, some states may require a particular supplier type to be "certified" but not "licensed," or vice versa. In general, individuals will have licensure information to submit. However, a "License Not Applicable" check box is furnished for cases where a state does not require licensure or, for unlicensed residents, if the application submission includes either:

(a) A residency contract signed and dated by both an official of the institution and the resident physician; or

(b) A letter on institution letterhead signed and dated by an official of the institution that (i) confirms the applicant's status as a resident physician and (ii) contains, at a minimum, the applicant's name.

The only licenses that must be submitted with the application are those required by Medicare or the state to function as the ordering or certifying supplier type in question. Licenses and permits not of a medical nature are not required. In addition, cases might arise where the individual need not be licensed in a particular state at all; however, the contractor shall still ensure that the supplier meets all applicable state and Medicare requirements.

If the supplier is required to submit a copy of a particular professional or business license, certification, registration, or degree but fails to do so, the contractor need not obtain such documentation from the supplier if the contractor can verify the information independently. This can be done by: (1) reviewing and printing confirming pages from the applicable state, professional, or school web site; (2) requesting and receiving from the appropriate state, professional, or educational body written confirmation of the supplier's status therewith; or (3)

utilizing another third-party verification source. Likewise, if the supplier submits a copy of the applicable license, certification, registration, or degree but fails to complete the applicable section of the form, the section need not be completed if the data in question can be verified on the license/certification itself or via any of the three mechanisms above.

2. Correspondence Address and Telephone Number

The correspondence address must be one at which the contractor can directly contact the applicant to resolve any issues once the supplier is enrolled in Medicare. It cannot be the address of a billing agency, management services organization, chain home office, or the supplier's representative (e.g., attorney, financial advisor). It can, however, be a P.O. Box or, in the case of an individual practitioner, the person's home address. The contractor need not verify the correspondence address.

The applicant may list any telephone number as the correspondence phone number. The number need not link to the listed correspondence address. If the supplier fails to list a correspondence telephone number and the latter is required for the application submission, the contractor shall develop for this information – preferably via the PCV, e-mail, or fax. The contractor shall accept a particular phone number if it has no reason to suspect it does not belong to or is not somehow associated with the supplier. The contractor need not verify the telephone number.

3. E-mail Addresses

An e-mail address listed on the application can be a generic one. It need not be that of a specific individual. The contractor may accept a particular e-mail address if it has no reason to suspect it does not belong to or is not somehow associated with the supplier.

4. Drug Enforcement Agency (DEA)

DEA certificates need not be submitted if the applicable DEA information was furnished on the Form CMS-855. Likewise, if the aforementioned certificates are furnished but the applicable Form CMS-855 sections are blank, no further development is needed.

C. Final Adverse Legal Actions/Convictions (Section 3)

See section 10.6.6 of this chapter for information regarding final adverse actions. Except as otherwise stated, the PECOS policies in section 10.3 supersede those in section 10.6.6 (e.g., communicating with the provider via the PCV).

D. Medical Specialty Information (Section 4)

The contractor shall validate that any supplier identifying a primary specialty on the Form CMS-855O has the appropriate medical license. The contractor shall validate the license using the state's medical license website. If an active license is not found, the contractor shall develop via telephone, fax, the PCV, e-mail, or mail to confirm the supplier's intent and to obtain a copy of the license, if applicable.

E. Important Address Information (Section 5)

The address information furnished in the Important Address Information section of the Form CMS-855O helps the contractor contact the supplier directly, if necessary.

F. Contact Person Information (Section 6)

(See section 10.6.9 of this chapter for more information on contact persons. Except as otherwise stated, the PECOS policies in section 10.3 above supersede those in section 10.6.9.)

If Section 6 is completely blank, the contractor need not develop for this information and can simply contact the physician or practitioner.

There is no existing option on the Form CMS-855O form to delete a contact person. The contractor shall therefore accept end-dates of a contact person via phone, the PCV, e-mail, fax, or mail from the individual or a current contact person on file. The contractor shall document in PECOS who requested the termination, how it was requested (email, phone or fax), and when it was requested. The addition of contact persons must still be reported via the Form CMS-855O.

G. Penalties for Falsifying Information (Section 7)

See the Penalties for Falsifying Information section of the Form CMS-855O for the penalties that apply to suppliers for deliberately furnishing false information on this application to gain or maintain Medicare enrollment.

10.3.1.5.2 – Section 8 (Certification Statement) - Form CMS-855O

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. General Policies

The enrolling or enrolled physician or other eligible professional is the only person who can sign the Form CMS-855O. This person cannot delegate the authority to sign the Form CMS-855O to any other individual. This applies to initial enrollments, changes of information, reactivations, voluntary withdrawals, etc. (Note: In the case of death, an executor of the estate may sign on behalf of the deceased supplier. This situation would only apply to change of information applications.)

For paper applications, handwritten (wet) signatures in ink and digital/electronic signatures (digital or electronic signatures such as those created by digital signature options created in software, such as Adobe) are acceptable. For web applications, electronic signatures are required; the contractor may contact its PEOG BFL for questions regarding electronic signatures.

B. Paper Applications

A signed certification statement shall accompany the paper Form CMS-855O application. If the supplier submits an invalid certification statement or fails to submit any certification statement at all, the contractor shall still proceed with processing the application. An appropriate certification statement shall be solicited as part of the development process – preferably via the PCV, e-mail,

or fax. This includes certification statements that are: (a) unsigned; (b) undated; (c) signed (as reflected by the date of signature) more than 120 days prior to the date on which the contractor received the application); (d) signed by someone other than the physician or practitioner (except as otherwise noted in this section 10.3.1.5.2); (e) missing; or (f) stamped. The contractor shall send one development request to include a list of all of the missing required data/documentation, including the certification statement. The contractor may reject the supplier's application if the supplier fails to furnish the missing information on the enrollment application - including all necessary documentation - within 30 calendar days from the date the contractor requested the missing information or documentation.

Unless stated otherwise in this chapter or in another CMS directive:

(i) The contractor shall begin processing the application upon receipt and shall develop for missing certification statements and all other missing information.

(ii) The certification statement may be returned via scanned email or fax.

(iii) Signature dates cannot be more than 120 days prior to the receipt date of the application.

(iv) For paper applications that require development, the supplier's dated signature must be on the certification statement that is to be submitted within 30 days.

(v) For paper changes of information applications---and except as stated in section 10.3.1.5.2(A)--the contractor shall only accept a certification statement signed by the individual physician or practitioner.

(vi) The contractor need not compare the Form CMS-855O signature with the same person's signature on file to ensure it is the same individual.

(vii) The contractor shall not request the submission of a driver's license or passport to verify a person's signature or identity.

C. PECOS Submissions

Unless stated otherwise in this chapter or in another CMS directive:

(i) The contractor shall (a) begin processing the application upon receipt via PECOS; (b) perform all required manual validations; and (c) develop for any needed clarifying or missing information or documentation consistent with section 10.3 and all other applicable instructions in this chapter.

(ii) If the supplier submits an invalid certification statement, the contractor shall treat this as missing information and develop for a correct certification statement – preferably via the PCV, e-mail, or fax. (This includes certification statements that are signed by someone other than the physician or practitioner who signed the form (except as otherwise noted in this section 10.3.1.5.2(A)). The contractor shall send one development request to include a list of all of data/documentation to be furnished or clarified, including, as applicable, the certification

statement. The contractor may reject the supplier's application if the supplier fails to furnish said data/documentation within 30 calendar days from the date of the contractor's request.

(iii) For PECOS applications that require development, the supplier's dated signature must be on the certification statement to be sent in within 30 days.

(iv) For PECOS change of information applications, the contractor shall only accept a certification statement signed by the individual physician or practitioner.

(v) The contractor need not compare the Form CMS-855O signature with the same person's signature on file to ensure it is the same individual.

(vi) The contractor shall not request the submission of a driver's license or passport to verify a person's signature or identity.

D. Certification Statement Development

Newly signed certification statements furnished per a development request must be submitted as follows:

(i) Paper applications -- Via scanned email, fax, or mail. Only the actual signature page is required; the provider need not submit the additional page containing the certification terms. (This also applies to the provider's initial submission of a certification statement. Such instances require the submission of only the signature page and not the certification terms.)

(ii) Web applications – Via electronic signature.

E. Privacy Statement

The Privacy Act permits CMS to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. Any such disclosure of data is known as a "routine use." The CMS will only release PECOS information that can be associated with an individual as provided for under Section III "Proposed Routine Use Disclosures of Data in the System." Both identifiable and non-identifiable data may be disclosed under a routine use. CMS will only collect the minimum personal data necessary to achieve the purpose of PECOS. To view the routine uses in their entirety go to: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/Downloads/0532-PECOS.pdf.

10.3.1.5.3 – Form CMS-855O Initial Applications and Change Requests

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

The contractor shall follow all applicable instructions in section 10.3 when processing Form CMS-855O initial applications and change requests.

A. Processing Initial Form CMS-855O Submissions

1. Returns

Section 10.4.1.4.2 of this chapter (which reflects 42 CFR § 424.526) outlines the reasons for which the contractor may immediately return a Form CMS-855O. If the contractor determines that one or more of these reasons applies, it may return the form in accordance with the instructions outlined in that section.

2. Verification

Unless stated otherwise in this chapter or in another CMS directive, the contractor shall ensure that all information on the Form CMS-855O is verified. This includes, but is not limited to:

a. Verification of the individual's name, date of birth, social security number, and NPI.

b. Verification that the individual meets the *supplier type's* requirements.

c. Verification that the individual is of a supplier type that can legally order or certify.

d. Reviewing the Medicare Exclusion Database (MED) and System for Award Management (SAM) to ensure that the individual is not excluded or debarred. (See section 10.6.6 of this chapter for additional adverse action verifications that may be required.)

If, at any time during the verification process, the contractor needs additional or clarifying information from the physician/eligible professional, it shall follow existing CMS instructions for obtaining said data (e.g., sending a development letter). The information must be furnished to the contractor within 30 calendar days of the contractor's request.

3. Disposition

Upon completion of its review of the form, the contractor shall approve, deny, or reject it.

a. Denial

Grounds for denial are as follows:

i. The supplier is not of a type that is eligible to use the Form CMS-855O.

ii. The supplier is not of a type that is eligible to order or certify items or services for Medicare beneficiaries.

iii. The supplier does not meet the *supplier type's* licensure, certification, or educational requirements.

iv. The supplier is excluded per the MED and/or debarred per the SAM.

If the contractor believes that another ground for denial exists for a particular submission, it should contact its PEOG BFL for guidance.

b. Rejection

The Form CMS-855O may be rejected if the supplier fails to furnish all required information on the form within 30 calendar days of the contractor's request to do so. (This includes situations in which information was submitted but could not be verified.) The basis for rejection shall be 42 CFR § 424.525(a). (See section 4.1.4.3(A)(1) for more information on rejection bases.)

c. Denial or Rejection – PECOS and Letters

When denying or rejecting an initial Form CMS-855O, the contractor shall: (1) switch the PECOS record to a "denied" or "rejected" status (as applicable); and (2) send a letter to the supplier *notifying the latter of* the denial or rejection and the reason(s) for it. The letter shall follow the applicable letter formats described in section 10.7, et seq. Denial letters shall be sent via certified mail. Rejection letters shall be sent by mail, the PCV, or e-mail. (NOTE: A denial triggers appeal rights. A rejection does not.)

d. Approval

If the Form CMS-855O is approved, the contractor shall: (1) switch the PECOS record to an "approved" status, and (2) send a letter (via mail, the PCV, or e-mail) to the supplier notifying *the latter of* the approval. The letter shall follow the applicable format outlined in section 10.7.3 of this chapter.

4. Miscellaneous Policies

The contractor shall observe the following:

a. The supplier shall be treated as a non-participating supplier (or "non-par").

b. If the supplier is employed by the DVA, the DOD, or the IHS, *the individual* – for purposes of the Form CMS-855O - need only be licensed or certified in one state. Said state need not be the one in which the DVA or DOD office is located.

c. Nothing in this section 10.3.1.5.3(A) affects any existing CMS instructions regarding the processing of opt-out affidavits.

d. Suppliers cannot submit an abbreviated version of the Form CMS-855I in lieu of the Form CMS-855O.

e. Per 42 CFR § 424.522(b), the effective date of a Form CMS-855O enrollment shall be the date on which the contractor received the application if all other requirements are met.

f. If the supplier's Form CMS-855O has been approved and *the individual* later wants to obtain Medicare billing privileges, *the individual* must voluntarily withdraw *the* Form CMS-855O enrollment prior to receiving Medicare billing privileges. (The supplier must complete the Form CMS-855I in order to receive Medicare billing privileges.)

B. Processing Form CMS-855O Change of Information Requests

1. Receipt

Section 10.4.1.4.2 of this chapter outlines the reasons for which the contractor may immediately return a Form CMS-855O. If the contractor determines that one or more of these reasons applies, it may return the change request via the instructions outlined in that section.

Suppliers who are enrolled in Medicare via the Form CMS-855I may not report changes to their enrollment information via the Form CMS-855O. They must use the Form CMS-855I. Likewise, suppliers whose Form CMS-855O submissions have been approved must use the Form CMS-855O to report information changes; they cannot use the Form CMS-855I for this purpose.

2. Verification

Unless stated otherwise in this chapter or in another CMS directive, the contractor shall verify the new information that the supplier furnished on the Form CMS-855O. (This includes checking the supplier against the MED and the SAM.) If, at any time during the verification process, the contractor needs additional or clarifying information, it shall follow existing CMS instructions for obtaining said data (e.g., sending a developmental letter). The information must be furnished to the contractor within 30 calendar days of the contractor's request.

C. Disposition

Upon completion of its review of the change request, the contractor shall approve, deny, or reject the submission. The principal ground for denial will be that the new information was furnished but could not be verified. If the contractor believes this is the case or if another ground for denial exists with respect to a particular submission, it should contact its PEOG BFL for guidance.

The change request may be rejected if the supplier failed to furnish all required information on the form within 30 calendar days of the contractor's request to do so. The basis for rejection shall be 42 CFR § 424.525(a). (See section 4.1.4.3(A)(1) for more information on rejection bases.)

When denying or rejecting the change request, the contractor shall: (1) switch the PECOS record to a "denied" or "rejected" status (as applicable); and (2) send a letter (via mail, the PCV, or e-mail) to the supplier notifying *the latter* of the denial or rejection and the reason(s) for it.

If the change request is approved, the contractor shall (1) switch the PECOS record to an "approved" status and (2) send a letter (via mail, the PCV, or e-mail) to the supplier notifying *the latter* of the approval.

D. Relocation

Since the Form CMS-855O is a national enrollment, suppliers who relocate to another state need not disenroll in the current state and reenroll in the new state. The contractor that maintains the Form CMS-855O enrollment in PECOS is responsible for processing the change request, even if the supplier is relocating to a state outside of *the individual's* jurisdiction. If any new licenses

and/or certifications are obtained as a result of the supplier's relocation, the contractor shall ensure that the updated information is captured in the supplier's enrollment record.

This policy applies to any physician, non-physician practitioner, or resident who is enrolled via the Form CMS-855O.

10.3.1.5.4 – Form CMS-855O Processing Alternatives and Miscellaneous Policies

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Processing Alternatives

The alternatives in this section 10.3.1.5.4(A) are applicable to all sections of the Form CMS-855O, unless otherwise specified. As stated in section 10.3, however, some of the application data elements and verification procedures that have previously been subject to a processing exception/alternative may no longer be so or are moot under PECOS 2.0. (See section 10.3 for a discussion of such data and procedures.) In such situations, the contractor shall disregard the exception/alternative and follow the instructions in sections 10.3 through 10.3.1.5.3.

1. General Alternatives

(i) If blank, "Type of Other Name*"* *c*an be captured orally.

(ii) If the contractor knows that a particular state does not require licensure/certification and the "Not Applicable" boxes are not checked in the Personal Identifying Information (License/ Certification/Registration Information) section, no further development is needed.

(iii) When processing a non-physician practitioner's (NPP) application, the contractor need not request a copy of the NPP's degree or diploma (if it is not submitted) if education can be verified through other authorized means. Requesting a copy of the degree or diploma should only be done if educational information cannot otherwise be verified.

2. Information Disclosed Elsewhere

If a data element on the Form CMS-855O application is missing but the information is disclosed (1) elsewhere on the application or (2) in the supporting documentation submitted with the application, the contractor need not obtain the missing data via an updated Form CMS-855O page and a newly-signed certification statement; no further development – not even by telephone – is required. The following information, however, must be furnished in the appropriate section(s) of the Form CMS-855O, even if the data is identified elsewhere on the form or in the supporting documentation:

(i) Except as otherwise stated in section 10.6.6 of this chapter, any final adverse action data requested in the Final Adverse Legal Actions section

(ii) Legal names

(iii) Tax identification number (TIN)

(iv) NPI-legacy number combinations in the Identifying Information section (if applicable) (Note: The contractor may use the shared systems, PECOS, or its provider files as a resource to determine the PTAN or NPI before developing with the supplier.)

(v) Data in the Basic Information section

If the supporting documentation currently exists in the supplier's file, the supplier need not submit that documentation again during the enrollment process. The contractor shall utilize the existing documentation for verification. Documentation submitted with a previously submitted enrollment application (or documentation currently uploaded in PECOS) qualifies as a processing alternative unless stated otherwise in this chapter or in another CMS directive. Also, the contractor shall document in PECOS that the missing information was found elsewhere in the enrollment package. (However, this excludes information that must be verified at the current point in time (i.e., a license without a primary source verification method)). In addition, the contractor shall not utilize information submitted along with opt-out applications for enrollment application processing or vice-versa.

3. City, State, and ZIP Code

If a particular address lacks a city or state, the contractor can verify the missing data in any manner it chooses. In addition, the contractor can obtain the zip + four from either the U.S. Postal Service or Delivery Point Validation in PECOS.

4. Sectional Processing Alternatives

The processing alternatives in this section 10.3.1.5.4 are in addition to, and not in lieu of, all other processing alternatives in section 10.3.1.5, et seq.

B. Unsolicited Additional Information

If the supplier submits additional/missing/clarifying data or documentation on its own volition (i.e., without being contacted by the contractor), the contractor shall include this additional data/documentation in its overall application review. Any new or changed information that a supplier submits prior to the date the contractor finishes processing a previously submitted change request constitutes a separate change request rather than an update to the original change request. The contractor may process both changes simultaneously; however, the change that was submitted first shall be processed to completion prior to the second one being processed to completion.

C. Conversion from Form CMS-855O to Form CMS-855I – PECOS Requirements

Internet-based PECOS permits an individual supplier to convert *a* current Form CMS-855O application to a Form CMS-855I enrollment and vice versa. Such suppliers shall follow the current process for creating a new application. When PECOS detects existing approved enrollments, the supplier will be prompted to select from a list of those enrollments that will be

used to pre-populate the information for the new application. The supplier must confirm *the desire* to withdraw the existing enrollments before the new application may be submitted.

The enrollments to be withdrawn are displayed in a new section of the ADR in PECOS Administrative Interface (AI). The contractor shall review this information and take the appropriate action to voluntarily withdraw the enrollments listed. The contractor shall begin processing the Form CMS-855I enrollment but leave it in "In Review" status while withdrawing the other enrollments. (For paper applications, a logging and tracking (L&T) submittal reason of Voluntary Termination shall be used to withdraw the Form CMS-855O enrollment.) The effective date of the withdrawn enrollments shall be one day prior to the effective date of the Form CMS-855I enrollment. If the Form CMS-855O enrollment requiring withdrawal is outside of the contractor's jurisdiction, the contractor shall notify the other contractor via the PCV or email using the "Associate Profile Contact List," stating that the enrollment needs to be voluntarily withdrawn. The second contractor shall take action based on the email and retain the email as documentation.

If the supplier submits a paper Form CMS-855I and a current Form CMS-855O enrollment exists within the contractor jurisdiction, the contractor shall voluntarily withdraw the Form CMS-855O enrollment. If the current Form CMS-855O enrollment is outside of the contractor's jurisdiction, the contractor shall notify the other contractor via the PCV or e-mail (using the "Associate Profile Contact List") that the enrollment needs to be voluntary withdrawn. The second contractor shall take action based on the email and retain the email as documentation.

If the supplier submits a paper Form CMS-855O to voluntarily withdraw enrollment as well as a paper Form CMS-855I to begin billing Medicare, the contractor shall not contact the supplier to confirm the submissions unless the contractor has reason to believe that what was submitted was not the supplier's intention. If it is determined that the supplier submitted applications to convert *the* existing Form CMS-855O enrollment into a Form CMS-855I enrollment in error (either via paper or PECOS), the contractor shall return the application (thus returning the enrollment record back to its previous state) because it is not needed and/or is inapplicable to the situation.

D. Form CMS-855O Processing Guide

Go to https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019033.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending to view the CMS-855O Processing Guide, which constitutes a general Form CMS-855O processing guide for suppliers and contractors. The procedures described in the Guide, which include processing alternatives and processing instructions for the Form CMS-855O, take precedence over all other instructions in this chapter concerning the processing of Form CMS-855O applications.

10.3.1.5.5 – Form CMS-855O Revocations

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

If the contractor determines that grounds exist for revoking the supplier's Form CMS-855O enrollment, it shall:

(i) Switch the supplier's PECOS record to a "revoked" status

(ii) End-date the PECOS record

(iii) Send a letter via certified mail to the supplier stating that *the* Form CMS-855O enrollment has been revoked. The letter shall follow the format outlined in section 10.7.8 of this chapter.

Grounds for revoking the supplier's Form CMS-855O enrollment are as follows:

(i) The supplier is no longer of a type that is eligible to order or certify

(ii) The supplier no longer meets the licensure, certification, or educational requirements for *the* supplier type

(iii) The supplier is excluded per the MED and/or debarred per the SAM

For purposes of the Form CMS-855O only, the term "revocation" effectively means that:

(i) The supplier may no longer order or certify Medicare services based o*n h*aving completed the Form CMS-855O process.

(ii) If the supplier wishes to submit another Form CMS-855O, *this must be done* as an initial applicant.

There are appeal rights associated with the revocation of a supplier's Form CMS-855O enrollment.

10.3.1.6.2 – Authorized and Delegated Officials – Form CMS-855S

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. General Requirement

For Form CMS-855S initial applications, the certification statement must be signed and dated by an authorized official of the supplier. (See section 10.1.1 for a definition of "authorized official" and section 10.3.1.1.11 for detailed information on authorized officials.). For Form CMS-855S applications to change, update, and/or revalidate the supplier's Medicare enrollment data, the certification statement may be signed and dated by an authorized or delegated official of the supplier.

For paper applications, handwritten (wet) signatures in ink and digital/electronic signatures (digital or electronic signatures such as those created by digital signature options created in software, such as Adobe) are acceptable. For web applications, electronic signatures are required; the contractor may contact its PEOG BFL for questions regarding electronic signatures.

B. Qualifications

1. Authorized Officials

See section 10.3.1.1.11 for information regarding the requirements to be an authorized official.

2. Delegated Officials

A delegated official is an individual to whom an authorized official delegates the authority to report changes and updates to the supplier's enrollment record or to sign revalidation applications. The delegated official's signature binds the organization both legally and financially, as if the signature was that of the authorized official. Before the delegation of authority is established, the only acceptable signature on the enrollment application to report updates or changes to the enrollment information is that of the authorized official currently on file with Medicare.

The delegated official must be an individual with an "ownership or control interest" in (as that term is defined in §1124(a)(3) of the Social Security Act) or be a W-2 managing employee of the supplier. Section 1124(a)(3) defines an individual with an ownership or control interest as:

(i) A five percent direct or indirect owner of the supplier,

(ii) An officer or director of the supplier (if the supplier is a corporation), or

(iii) Someone with a partnership interest in the supplier if the supplier is a partnership

The delegated official must be a delegated official of the supplier, not of an owning organization, parent company, chain home office, or management company. One cannot use *a* status as a W-2 managing employee of the supplier's parent company, management company, or chain home office as a basis for *serving as* the supplier's delegated official.

Section 6 (Ownership Interest and/or Managing Control Information) of the Form CMS-855S must be completed for all delegated officials.

A delegated official has no authority to sign an initial application. However, as explained above, a delegated official may (i) sign a revalidation application or change request and (ii) sign off on changes/updates submitted in response to a contractor's request to clarify or submit information needed to continue processing the supplier's initial application.

Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the supplier's Medicare data or to sign revalidation applications.

For purposes of the Delegated Officials information captured in the Individual Ownership Interest and/or Managing Control Information section only, the term "managing employee" means any individual--including a general manager, business manager, or administrator--who exercises operational or managerial control over the supplier, or who conducts the day-to-day operations of the supplier. However, this does not include persons who, either under contract or through some other arrangement, manage the day-to-day operations of the supplier but who are not actual W-2 employees. For instance, suppose the supplier hires Smith as an independent

contractor to run its day-to-day-operations. Under the definition of "managing employee" in the Individual Ownership and/or Managing Control section of the Form CMS-855S, Smith would have to be listed in that section. Yet Smith cannot be a delegated official because *Smith* is not an actual W-2 employee of the supplier. Independent contractors are not considered "managing employees" for purposes of qualifying as a delegated official.

2. W-2 Form - Unless the contractor requests it to do so, the supplier need not submit a copy of the owning/managing individual's W-2 to verify an employment relationship.

3. Number of Delegated Officials - The supplier can have as many delegated officials as it chooses. Conversely, the supplier need not have any delegated officials. Should no delegated officials be listed, however, the authorized official(s) remains the only individual(s) who can report changes and/or updates to the supplier's enrollment data.

4. Effective Date - The delegated official's effective date in PECOS should be the effective date listed in the Delegated Officials section or the receipt date of the Form CMS-855S application.

5. Social Security Number - To be a delegated official, the person must have and must submit *a* social security number (SSN). An Individual Taxpayer Identification Number (ITIN) cannot be used in lieu of an SSN in this regard.

6. Deletion of a Delegated Official - If a delegated official is being deleted, documentation verifying that the person no longer is or qualifies as a delegated official is not required. Also, the signature of the deleted official is not needed.

7. Delegated Official Not on File - If the supplier submits a change of information (e.g., change of address) and the delegated official signing the form is not on file, the contractor shall ensure that: (1) the person meets the definition of a delegated official; (2) Section 6 of the Form CMS-855S is completed for that person; and (3) an authorized official signs off on the addition of the delegated official. (NOTE: The original change request and the addition of the new official shall be treated as a single change request (i.e., one change request encompassing two different actions) for purposes of enrollment processing and reporting.)

8. Signature on Paper Application

If the supplier submits a paper Form CMS-855S change request, the contractor may accept the signature of a delegated official in the Assignment of Delegated Officials or Authorized Official Certification Statement and Signature sections of the Form CMS-855S.

In addition, the Delegated Official's telephone number can be left blank. No further development is needed.

C. Privacy Statement

The Privacy Act permits CMS to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. Any such disclosure of data is known as a "routine use." The CMS will only release PECOS information that can be associated with an individual as provided for

under Section III "Proposed Routine Use Disclosures of Data in the System." Both identifiable and non-identifiable data may be disclosed under a routine use. CMS will only collect the minimum personal data necessary to achieve the purpose of PECOS. To view the routine uses in their entirety go to: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/Downloads/0532-PECOS.pdf.

10.3.2.4 – CMS-20134 (Section 4 - MDPP Location Information)

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Background

The MDPP location address must be a valid address with the United States Postal Service (USPS). Addresses entered into PECOS are verified via computer software to determine if they are valid and deliverable. The contractor shall verify that each practice location listed on the application actually exists and is a valid address with the USPS. PECOS includes a USPS Address Matching System Application Program Interface (API), which validates address information entered and flags the address if it is determined to be invalid, unknown, undeliverable, vacant, unlikely to deliver mail (No-Stat), a CMRA (i.e., UPS Store, mailboxes, etc.) or a known invalid address false positive. These address types are not permitted in PECOS and are flagged upon entry.

The contractor shall verify that the reported telephone number is operational and connects to the practice location/business listed on the application. However, the contractor need not contact every location for applicants that are enrolling multiple locations; the contractor can verify each location's telephone number with the applicable contact person listed on the application and note the verification accordingly in PECOS. (The telephone number must be one where patients and/or customers can reach the applicant to ask questions or register complaints.) The contractor may also match the applicant's telephone number with known, in-service telephone numbers - via, for instance, the Yellow Pages or the Internet - to correlate telephone numbers with addresses. If the provider uses a cell phone for the business, the contractor shall verify that this is a telephone connected directly to the business. If the contractor cannot verify the telephone number, it shall request clarifying information; the inability to confirm a telephone number may indicate that an onsite visit is necessary. In some instances, a 1-800 number or out-of-state number may be acceptable if the MDPP location is in another state but *the* practice locations are within the contractor's jurisdiction.

In addition:

- Any supplier submitting a Form CMS-20134 application must submit the 9-digit ZIP Code for each practice location listed.

- In the MDPP Location Information section of the Form CMS-20134, the checkboxes identifying the type of MDPP location must be completed to indicate if the location is the MDPP supplier's administrative location or the community setting. If the type of location is apparent to the contractor, the MDPP supplier need

not complete the administrative location type. The contractor can confirm the information via telephone, e-mail, the PCV, or fax.

- Each administrative location shall be verified. However, the contractor need not separately contact each location on the application. Such verification can be done via the contact person listed on the application; the contact person's verification shall be documented in PECOS.

B. Do Not Forward (DNF)

Unless instructed otherwise in another CMS directive, the contractor shall follow the DNF initiative instructions in CMS Publication (Pub.) 100-04, chapter 1, section 80.5. Returned paper checks, remittance notices, or electronic funds transfer (EFT) payments shall be flagged if returned from the post office or banking institution, respectively, as this may indicate that the supplier's "special payment" address (Practice Location section of the Form CMS-20134) or EFT information has changed. The supplier should submit a Form CMS-20134 or Form CMS-588 request to change this address; if the supplier does not have an established enrollment record in PECOS, it must complete an entire Form CMS-20134 and Form CMS-588. The Durable Medical Equipment MAC is responsible for obtaining, updating, and processing Form CMS-588 changes.

In situations where the supplier is closing *the* business and has a termination date (e.g., is retiring), the contractor will likely need to make payments for prior services rendered. Since the practice location has been terminated, the contractor may encounter a DNF message. If so, the contractor should request the supplier to complete the "special payment" address section of the Form CMS-20134 and to sign the certification statement. The contractor, however, shall not collect any other information unless there is a need to do so.

C. Remittance Notices/Special Payments

For new enrollees, all payments must be made via EFT. The contractor shall thus ensure that the supplier has completed and signed the Form CMS-588 and shall verify that the bank account complies with Pub. 100-04, chapter 1, section 30.2.

In the MDPP Location Information/Remittance Notice and Special Payments Address section of the Form CMS-20134, if neither box is checked and no address is provided, the contractor can contact the supplier by telephone, e-mail, the PCV, or fax to confirm the supplier's intentions. If the "special payments" address is indeed the same as the practice location, no further development is needed. If, however, the supplier wants payments to be sent to a different address, the address in Section 4B of the Form CMS-20134 must be completed.

If an enrolled supplier that currently receives paper checks submits a Form CMS-20134 change request – no matter what the change involves – the following apply:

- The supplier must submit a Form CMS-588 that switches its payment mechanism to EFT. (The change request cannot be processed until the Form CMS-588 is

submitted.) All future payments (excluding special payments) must be made via EFT.

- The contractor shall verify that the bank account complies with Pub. 100-04, chapter 1, section 30.2.

- Once a supplier changes its method of payment from paper checks to EFT, it must continue using EFT. A supplier cannot switch from EFT to paper checks.)

The "special payment" address may only be one of the following:

- One of the supplier's practice locations

- A P.O. box

- The supplier's billing agent. The contractor shall request additional information if it has any reason to suspect that the arrangement – at least with respect to any special payments that might be made – may violate the Payment to Agent rules in Pub. 100-04, chapter 1, section 30.2.

- The chain home office address. Per Pub.100-04, chapter 1, section 30.2, a chain organization may have payments to its providers sent to the chain home office. The LBN of the chain home office must be listed on the Form CMS-588. The TIN on the Form CMS-588 should be that of the supplier.

- Correspondence address

- A lock box

D. Additional MDPP Supplier Location Information

The MDPP set of services is unique in that it is delivered in group settings and can be delivered by non-traditional health care providers who meet certain eligibility criteria. Given this aspect of MDPP suppliers, MDPP services are often delivered within community locations to increase access. Thus, the locations associated with MDPP suppliers differ slightly than traditional practice locations of other health care providers and suppliers.

1. Administrative Locations

MDPP suppliers must have at least one administrative location and report all administrative locations on their Form CMS-20134 or PECOS equivalent. As noted in section 10.1.1 of this chapter, an administrative location is the physical location: (1) associated with the supplier's operations; (2) from where coaches are dispatched or based; and (3) where MDPP services may or may not be furnished. If an entity enrolls as an MDPP supplier but does not furnish MDPP services at its administrative location, it should deliver and disclose any and all community settings where it furnishes MDPP services.

An administrative location:

- Cannot be a private residence
- Must have signage posted on the exterior of the building or suite, in a building directory, or on materials located inside of the building. Such signage may include, for example, the MDPP supplier's LBN or doing business as (DBA) name, as well as hours of operation.
- Must be open for business and have employees, staff, or volunteers present during operational hours

All administrative locations related to the MDPP supplier must be disclosed. However, given that MDPP suppliers may be non-traditional health care providers engaged in non-health care related activities, not all organizations run by the entity may constitute an administrative location. For example, if an advocacy organization operates two sites and only one of them offers MDPP services, only the site offering MDPP would be considered an administrative location. Should a coach be based or dispatched from the non-administrative location site to offer MDPP services in community settings, this location would become an administrative location. (See section 10.2.6 of this chapter for information regarding the frequency with which MDPP suppliers must report this change.)

As MDPP suppliers fall within the high-risk level of categorical screening under 42 CFR § 424.518, their administrative locations are subject to site visits. See sections 10.6.20(A) and (B) of this chapter for additional information concerning site visits.

2. Community Settings

When determining whether a location is considered an administrative location or a community setting, MDPP suppliers must consider whether their organizational entity is the primary user of that space and whether coaches are based or dispatched from this location. If so, the location would be considered an administrative location, even if this location dually provides other services benefiting the community. In comparison, community settings are locations not primarily associated with the supplier where many activities occur, including MDPP services; that is, a community setting is a location where the supplier furnishes MDPP services outside of its administrative locations in a meeting location that is open to the public but not primarily associated with the supplier.

An MDPP supplier must update its enrollment application with locations where services are furnished in community settings. While these settings are not subject to site visits, they serve as a form of recordkeeping and accountability for the MDPP supplier.

3. Out-of-State Practice Locations

If a supplier is adding a practice location in another state that is within the contractor's jurisdiction, a separate, initial Form CMS-20134 enrollment application is not required if both of the following conditions are met:

- The location is not part of a separate organization (e.g., a separate corporation, partnership)

- The location does not have a separate TIN and LBN

Consider the following examples:

Example 1 - The contractor's jurisdiction consists of States X, Y and Z. Jones MDPP Center (JMC), Inc., is enrolled in State X with 3 locations. It wants to add a fourth location in State Y. The new location will be under JMC, Inc. JMC will not be establishing a separate corporation, LBN, or TIN for the fourth location. Both of the above conditions are therefore met. JMC can add the fourth location via a change of information request rather than an initial application. The change request must include all information relevant to the new location (e.g., licensure, new managing employees).

Example 2 - The contractor's jurisdiction consists of States X, Y and Z. Jones MDPP Practice (JMP), Inc., is enrolled in State X with three locations. It wants to add a fourth location in State Y but under a newly-created, separate entity - Jones MDPP Practice, LP. The fourth location must be enrolled via a separate, initial Form CMS-20134.

Example 3 - The contractor's jurisdiction consists of States X, Y and Z. Jones MDPP Practice (JMP), Inc., is enrolled in State X with three locations. It wants to add a fourth location in State Q. Since State Q is not within the contractor's jurisdiction, a separate initial enrollment for the fourth location is necessary.

10.3.2.7 – CMS-20134 (Section 7 – Coach Roster)

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Background Information

Only organizations, and not individuals, are eligible to enroll as an MDPP supplier. However, MDPP services are furnished to Medicare beneficiaries by MDPP coaches in group settings. Though these individuals furnish MDPP services on behalf of MDPP suppliers, only the MDPP supplier itself enrolls in Medicare. To enable CMS to better ensure the integrity of the program and the safety of the beneficiaries it serves, MDPP suppliers must report identifying information on coaches in the Coach Roster section of the Form CMS-20134. If a coach is being added or changed, the updated information must be reported via a Form CMS-20134 change request

B. Coach Eligibility and Screening

As indicated in section 10.2.6 of this chapter and as outlined in the MDPP supplier standards, MDPP suppliers cannot include on their roster (or allow MDPP services to be furnished by) an ineligible coach. Accordingly, an MDPP coach must not:

- Currently have Medicare billing privileges revoked and be currently subject to a reenrollment bar

- Currently have its Medicaid billing privileges terminated for-cause or be excluded by a state Medicaid agency

- Currently be excluded from 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 Act.

- Currently be debarred, suspended, or otherwise excluded from participating in any other federal procurement or non-procurement program or activity in accordance with the Federal Acquisition Streamlining Act implementing regulations and the Department of Health and Human Services non-procurement common rule at 45 CFR part 76.

- Have, in the previous 10 years, one of the following state or federal felony convictions:

    - Crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, as defined under 42 CFR 1001.2, had a guilty plea or adjudicated pretrial diversion.

    - Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, as defined under 42 CFR 1001.2, had a guilty plea or adjudicated pretrial diversion.

    - Any felony that placed the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in the individual being convicted, as defined under 42 CFR 1001.2, had a guilty plea or adjudicated pretrial diversion of criminal neglect or misconduct.

    - Any felonies for which the individual was convicted, as defined under 42 CFR 1001.2, had a guilty plea or adjudicated pretrial diversion that would result in mandatory exclusion under section 1128(a) of the Act.

Upon enrollment or any changes to the Coach Roster section of the Form CMS-20134 that results in a new coach being added, the contractor shall verify that the coach is not presently excluded from the Medicare program by the HHS Office of the Inspector General (OIG) or through the System for Award Management (SAM) (formerly, the General Services Administration Excluded Parties List System) and, to the extent possible, whether or not an individual coach meets the above eligibility criteria. Should the contractor determine that an ineligibility criterion has been met pursuant to that screening but is either unsure of the matter or unclear as to what action should next be taken, the contractor may

contact its Provider Enrollment & Oversight Group (PEOG) Business Function Lead (BFL) for guidance.

C. Coach Eligibility Start and End-Dates

MDPP coaches may have a high turnover rate. To document which coaches are active with a supplier at a given time, each coach will have an eligibility start and, if applicable, an eligibility end-date.

For each change to the Coach Roster section of the Form CMS-20134, the MDPP supplier must indicate the date of such change. (If the date of change for an individual coach is completely blank, the contractor must develop for this information.) Per 42 CFR § 424.205(d), an MDPP supplier must report all changes to its coach roster within 30 days of the change.

If the contractor determines the coach to be ineligible, the coach's eligibility start and end-date shall be documented as the same date; this effectively means that the coach was never eligible. Two other means by which a coach may get an eligibility end-date are as follows:

- When the MDPP supplier removes that coach from its roster. Here, the eligibility end-date would be the date the MDPP supplier indicated when it updated the Coach Roster section to remove the coach.
- When the MDPP supplier with which the *coach* is associated is revoked or does not revalidate its enrollment. Here, the coach's eligibility end-date is the same as the date the MDPP supplier's billing privileges were no longer effective.

An MDPP supplier may only be paid for services furnished by eligible coaches within their eligibility start and end-dates.

D. Consequences for Coach Ineligibility

If the contractor or CMS determines that an MDPP supplier has an ineligible coach on its roster, the MDPP coach would be non-compliant with the MDPP supplier standards. The supplier would thus have its enrollment denied or revoked, as appropriate under §§ 424.530(a)(1) or 424.535(a)(1). Consistent with existing procedures, MDPP suppliers may submit a corrective action plan (CAP) removing this coach from its roster within 30 days of receiving notice of its enrollment denial or revocation, and, if compliant and as applicable, could obtain or maintain Medicare enrollment. (See section 10.6.18 of this chapter for more information on CAPs.) In this CAP situation, the supplier need not submit any documentation beyond updating the Coach Roster section of the Form CMS-20134 to remove the ineligible coach.

E. Special Revocation for Knowingly Using an Ineligible Coach

While MDPP supplier standards indicate that an MDPP supplier may not include an ineligible coach on its roster or allow *the latter* to furnish MDPP services on its behalf to Medicare beneficiaries, the MDPP supplier is not prohibited from continuing to employ or

otherwise permit the coach to volunteer for other services unrelated to MDPP. Should CMS identify that an MDPP supplier is knowingly allowing an ineligible coach to continue furnishing MDPP services, the MDPP supplier would be revoked under § 424.205(h)(5) and any other revocation authority. In this context, "knowingly" means that the MDPP supplier meets all of the following five conditions; specifically, the supplier:

- Received an enrollment denial or revocation notice for failing to meet the MDPP standard in § 424.205(d)(3);
- Was provided notice by CMS or the contractor of the coach's ineligibility, and the applicable reason(s);
- Submitted a CAP to remove the coach;
- Became compliant once again and obtained or maintained its enrollment; but
- Continued to allow the ineligible coach who was removed from the Coach Roster section of the Form CMS-20134 to provide MDPP services in violation of the CAP.

10.3.2.11 – CMS-20134 (Section 15 – Certification Statement and Authorized Officials)

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

(Unless indicated otherwise below or in another CMS directive, the instructions in this section apply to (1) signatures on the paper Form CMS-20134, and (2) signatures for PECOS applications.)

For paper applications, handwritten (wet) signatures in ink and digital/electronic signatures (digital or electronic signatures such as those created by digital signature options in software, such as Adobe) are acceptable. For web applications, the supplier can sign it electronically or upload the signature and then submit the application. The contractor shall contact its PEOG BFL for questions regarding electronic signatures.

A. Paper Submissions

A signed certification statement shall accompany the paper Form CMS-20134. If the supplier submits an invalid certification statement or no certification statement at all, the contractor shall still continue processing the application. An appropriate certification statement shall be solicited as part of the development process – preferably via the PCV, email, or fax. This includes certification statements that are: (a) unsigned; (b) undated; (c) was signed (as reflected by the date of signature) more than 120 days prior to the date on which the contractor received the application; (d) missing altogether; or (e) stamped. The contractor shall send one development request that lists all of the missing/deficient required data/documentation, including the certification statement. The contractor may reject the supplier's application if the supplier fails to furnish the missing information and/or correct the deficient data on the enrollment application - including all necessary documentation - within 30 calendar days from the date the contractor requested the information or documentation.

Unless stated otherwise in this chapter or in another CMS directive:

- The contractor shall begin processing the application upon receipt and shall develop for missing/deficient certification statements and all other missing/deficient information, including the application fee, upon review.

- As applicable, the certification statement may be returned via scanned email or fax.

- As mentioned previously, signature dates cannot be prior to 120 days of the receipt date of the application.

- For paper applications that require development, it is only necessary that the dated signature of at least one of the supplier's authorized or delegated officials be on the certification statement that must be sent in within 30 days; the signatures of the other authorized and delegated officials need not be obtained.

- For paper change of information applications (as the term "changes of information" is defined in section 10.4 et al. of this chapter), if the certification statement is signed by an individual who is not on file with the contractor as being an authorized or delegated official of the supplier, the contractor may accept the certification statement but shall develop for information on this person.

- The contractor need not compare the signature on the Form CMS-20134 with the same authorized or delegated official's signature on file to ensure that it is the same person.

- The contractor shall not request the submission of a driver's license or passport to verify a person's signature or identity.

B. PECOS Submissions

Unless stated otherwise in this chapter or in another CMS directive:

(i) The contractor shall (a) begin processing the application upon receipt via PECOS; (b) perform all required manual validations; and (c) develop for any needed clarifying or missing information or documentation consistent with section 10.3 and all other applicable instructions in this chapter.

(ii) If the supplier submits an invalid certification statement, the contractor shall treat this as missing information and develop for a correct certification statement – preferably via the PCV, email, or fax. (This includes certification statements that are signed by a person unauthorized to do so under 42 CFR Part 424, subpart P.) The contractor shall send one development request that includes a list of all of the data/documentation to be furnished or clarified, including, as applicable, a correct certification statement. The contractor may reject the supplier's application if the supplier fails to furnish said data/documentation within 30 calendar days from the date of the contractor's request.

(iii) For PECOS applications that require development, at least one of the supplier's authorized or delegated officials has to sign any certification statement that must accompany the supplier's response. Obtaining the signatures of the other authorized and delegated officials is not required.

(iv) For PECOS changes of information (as the term "changes of information" is defined in section 10.4.4 of this chapter), if the certification statement is signed by an individual who is not on file with the contractor as an authorized or delegated official of the supplier, the contractor may accept the certification statement. However, it shall develop for information on the person in question consistent with the procedures in this chapter.

(v) The contractor is not required to compare the signature thereon with the same supplier's, authorized official's, or delegated official's signature on file to ensure that it is the same person.

(vi) The contractor shall not request the submission of a driver's license or passport to verify a person's signature or identity.

C. Certification Statement Development

If, as already mentioned, the supplier submits an invalid certification statement (as described in subsections (A) and (B)), the contractor shall develop for a correct certification statement and send a development letter to the supplier. The provider must submit the requested certification statement as follows:

(i) Paper applications -- Via scanned email, fax, or mail. Only the actual signature page is required; the provider need not submit the additional page containing the certification terms. (This also applies to the provider's initial submission of a certification statement. Such instances require the submission of only the signature page and not the certification terms.)

(ii) PECOS applications – Via electronic or uploaded signature.

D. Authorized Officials

Except as stated otherwise, the instructions in this section 10.3.2.11(D) apply to: (1) signatures on the paper Form CMS-20134; and (2) electronic or uploaded signatures for PECOS applications.)

1. Requirements

As defined in 42 CFR § 424.502, an authorized official is an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program. The person must have the authority to legally and financially bind the supplier to) the requirements set forth in 42 CFR § 424.510 (and other applicable Medicare regulations) and to act on behalf of the organization.

An authorized official is not restricted to the examples of the titles outlined above; however, the person must hold a position of similar status and authority within the provider or supplier organization. Additional titles could include, but are not limited to, executive director, administrator, president, and vice-president. The contractor shall consider the individual's title and the authority granted by the organization when determining whether an individual qualifies as an authorized organization. If the contractor is unsure of the person's qualifications or authority, it shall contact its PEOG BFL for further clarification. The contractor shall obtain PEOG BFL approval if the only role of the listed authorized official is "Contracted Managing Employee."

If an authorized official is listed as a "Contracted Managing Employee" in the Individual Ownership and/or Managing Control section of the Form CMS-20134 and does not qualify as an authorized official under some other category in this section, the *individual* cannot be an authorized official. The contractor shall notify the supplier accordingly. If the person is not listed as a "Contracted Managing Employee" in the Individual Ownership and/or Managing Control section and the contractor has no reason to suspect that the person does not qualify as an authorized official, no further investigation is required. Should the contractor have doubts that the individual qualifies as an authorized official, it shall contact the official or the applicant's contact person to obtain more information about the official's job title and/or authority to bind. If the contractor remains unconvinced that the individual qualifies as an authorized official, it shall notify the supplier that the person cannot be an authorized official. If that person is the only authorized official listed and the supplier refuses to use a different authorized official, the contractor shall deny the application.

For purposes of determining an authorized official's qualifications, identifying the supplier is not determined solely by the supplier's TIN. Rather, the organizational structure is the central factor. For instance, suppose a chain drug store, Company X, wants to enroll 100 of its pharmacies with the contractor. Each pharmacy has a separate TIN and must therefore enroll separately. Yet all of the pharmacies are part of a single corporate entity – Company X. In other words, there are not 100 separate corporations in our scenario but merely one corporation whose individual locations have different TINs. Here, an authorized official for Pharmacy #76 can be someone at X's headquarters (assuming the definition of authorized official is otherwise met), even though this main office might be operating under a TIN that is different from that of #76. This is because headquarters and Pharmacy #76 are part of the same organization/corporation.

2. Required Signature

For Form CMS-20134 initial applications, the certification statement must be signed and dated by an authorized official of the supplier. (See sections 10.1.1 and 10.3.2.11(D) of this chapter for a definition of "authorized official.") The supplier can have an unlimited number of authorized officials so long as each meets the definition of an authorized official. The Individual Ownership and/or Managing Control section of the Form CMS-20134 must be completed for each authorized official.

(For revalidation and changes of information, either the authorized or delegated official must sign the application. (See sections 10.1.1 and 10.3.2.12 of this chapter for a definition of "delegated official.").

3. Changes and Deletions in Authorized Officials

A change in authorized officials does not impact the authority of existing delegated officials to report changes and/or updates to the supplier's enrollment data or to sign revalidation applications.

If an authorized official is being deleted, the contractor need not obtain (1) that official's signature or (2) documentation verifying that the person is no longer an authorized official.

4. Authorized Official Not on File

If the supplier submits a change of information (e.g., change of address) and the authorized official signing the form is not on file, the contractor shall ensure that: (1) the person meets the definition of an authorized official; and (2) the Individual Ownership and/or Managing Control section of the Form CMS-20134 is completed for that person. The signature of an existing authorized official is not needed to add a new authorized official. Note that the original change request and the addition of the new official shall be treated as a single change request (i.e., one change request encompassing two different actions) for purpose of enrollment processing and reporting.

5. Effective Date

The effective date in PECOS for the Certification Statement section of the Form CMS-20134 should be the date of signature.

6. Social Security Number

To be an authorized official, the person must have and must submit *a* social security number (SSN). An Individual Taxpayer Identification Number (ITIN) cannot be used in lieu of an SSN in this regard.

7. Telephone Number

The authorized official's telephone number can be left blank. No further development is needed.

10.3.2.12 – CMS-20134 (Section 16 – Delegated Officials)

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Background

A delegated official is an individual to whom an authorized official listed in the Certification Statement section of the Form CMS-20134 delegates the authority to report

changes and updates to the supplier's enrollment record or to sign revalidation applications. The delegated official's signature binds the organization both legally and financially, as if the signature was that of the authorized official. Before the delegation of authority is established, the only acceptable signature on the enrollment application to report updates or changes to enrollment information is that of the authorized official currently on file with Medicare. A delegated official has no authority to sign an initial application. However, the delegated official may (i) sign a revalidation application and (ii) sign off on changes/updates submitted in response to a contractor's request to clarify or submit information needed to continue processing the supplier's initial application.

The delegated official must be an individual with an "ownership or control interest" in (as that term is defined in § 1124(a)(3) of the Social Security Act), or be a W-2 managing employee of, the supplier.

Section 1124(a)(3) defines an individual with an ownership or control interest as:

- A five percent direct or indirect owner of the provider,
- An officer or director of the provider (if the provider is a corporation), or
- Someone with a partnership interest in the provider (if the provider is a partnership)

For purposes of information captured in the Delegated Official section only, the term "managing employee" means any individual (including a general manager, business manager, or administrator) who exercises operational or managerial control over the supplier, or who conducts the day-to-day operations of the supplier. However, this does not include persons who, either under contract or through some other arrangement, manage the day-to-day operations of the supplier but who are not actual W-2 employees. For instance, suppose the supplier hires Smith as an independent contractor to run its day-to-day operations. Under the definition of "managing employee" in the Individual Ownership and/or Managing Control section of the Form CMS-20134, Smith would have to be listed in that section. Yet under the Delegated Official section definition (as described above), Smith cannot be a delegated official because *Smith* is not an actual W-2 employee of the supplier. Independent contractors are not considered "managing employees" under the Delegated Official section of the Form CMS-20134.

The Ownership Interest and Managing Control Information in the Individual Ownership and/or Managing Control section of Form CMS-20134 must be completed for all delegated officials.

B. Specific Delegated Official Policies

1. Further Delegation – A delegated official may not delegate authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the supplier's Medicare data or to sign revalidation applications.

2. W-2 Form - Unless the contractor requests it to do so, the supplier need not submit a copy of the owning/managing individual's W-2 to verify an employment relationship.

3. Number of Delegated Officials - The supplier can have as many delegated officials as it chooses. Conversely, the supplier need not have any delegated officials. Should no delegated officials be listed, however, the authorized official(s) remains the only individual(s) who can report changes and/or updates to the supplier's enrollment data.

4. Effective Date - The effective date in PECOS for the Delegated Official section of the Form CMS-20134 should be the date of signature.

5. Social Security Number - To be a delegated official, the person must have and must submit *an* SSN. An ITIN cannot be used in lieu of an SSN in this regard.

6. Deletion of Delegated Official - If a delegated official is being deleted, documentation verifying that the person no longer is or qualifies as a delegated official is not required. Also, the signature of the deleted official is not needed.

7. Delegated Official Not on File - If the supplier submits a change of information (e.g., change of address) and the delegated official signing the form is not on file, the contractor shall ensure that (1) the person meets the definition of a delegated official, (2) the Individual Ownership and/or Managing Control section of the Form CMS-20134 is completed for that person, and (3) an authorized official signs off on the addition of the delegated official. (NOTE: The original change request and the addition of the new official shall be treated as a single change request (i.e., one change request encompassing two different actions) for purpose of enrollment processing and reporting.)

8. Signature on Paper Application - If the supplier submits a paper Form CMS-20134 change request, the contractor may accept the signature of a delegated official in the Certification Statement or Delegated Official sections of the Form CMS-20134.

9. Telephone Number - In addition, the delegated official's telephone number can be left blank. No further development is needed.

10.3.3.1 – Form CMS-588 – Electronic Funds Transfer (EFT) Authorization Agreement

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

An EFT agreement (Form CMS-588) authorizes CMS to deposit Medicare payments directly into a provider/supplier's bank account.

A. Processing the Form CMS-588 – Specific Situations

When a Form CMS-588 is received, the contractor shall review the form and develop for any deficiencies or missing information prior to approval. All EFT data shall be entered into PECOS.

1. Unsolicited Information

If the provider/supplier submits missing/clarifying data or documentation on its own volition (i.e., without being contacted by the contractor), the contractor shall include this additional data/documentation in its overall form review.

2. Missing or Incorrect Provider Transaction Access Number (PTAN) or CMS Certification Number (CCN) on the Form CMS-588

If the PTAN and/or CCN is missing or incorrect but the contractor can ascertain the correct number (1) via the supporting documents submitted, (2) elsewhere on the form, or (3) via PECOS, the shared systems, or the provider files, the contractor need not pursue development. (Note that social security numbers and employer identification numbers do not fall within this exception.)

3. Missing or Incorrect Social Security Number (SSN) or Employer Identification Number (EIN) Checkbox on the Form CMS-588

If the Form CMS-588 is received and the checkbox for the SSN or EIN is either not checked or is incorrectly checked, the contractor may proceed without further development if the contractor can ascertain the correct option via the supporting documents submitted or elsewhere on the form.

4. Name on Account

As stated on the Form CMS-588, the account to which EFT payments are made must exclusively bear the name of the physician or individual practitioner, or the legal business name (LBN) of the person or entity enrolled with Medicare. Accordingly, the contractor shall accept accounts that (1) solely list the LBN or (2) list the LBN and the Doing Business As name (so long as the LBN is listed first).

B. Form CMS-588 Information Specific to Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

For Form CMS-855S enrollments, CMS only requires the Form CMS-588 with initial enrollment applications.

C. Form CMS-588 Signature Requirements

For paper applications, handwritten (wet) signatures in ink and digital/electronic signatures (digital or electronic signatures such as those created by digital signature options created in software, such as Adobe) are acceptable. For web applications, the supplier can sign it electronically or upload the signature and then submit the application. The contractor shall contact its PEOG BFL for questions regarding electronic signatures.

D. Verification

Providers and suppliers may submit a Form CMS-588 via paper or through PECOS. In either case, the contractor shall ensure that:

(i) All EFT arrangements comply with CMS Pub. 100-04, chapter 1, section 30.2.5.

(ii) The information submitted on the Form CMS-588 is complete and accurate. (Except as otherwise stated in this chapter or another CMS directive, the contractor shall develop for any missing information.)

(iii) The provider/supplier submitted (1) a voided check or (2) a letter from the bank verifying the account information.

(iv) The routing number and account number matches what was provided on the Form CMS-588.

(v) The signature is valid.

(vi) The contractor shall forgo development if the "Part I: Reason for Submission (Individual vs. Group)" section is left blank or an incorrect option is selected but the contractor can make the correct determination based on the provider/supplier's existing file or additional information submitted with the application.

E. Miscellaneous EFT Policies

1. Banking Institutions

All payments must be made to a banking institution. EFT payments to non-banking institutions (e.g., brokerage houses, mutual fund families) are not permitted.

If the provider/supplier's bank of choice does not or will not participate in the provider/supplier's proposed EFT arrangement, the provider/supplier must select another financial institution.

2. Sent to the Wrong Unit

If a provider/supplier submits an EFT change request to the contractor but not to the latter's enrollment unit, the recipient unit shall forward it to the enrollment staff, which shall then process the change. The enrollment unit is responsible for processing EFT changes. As such, while it may send the original EFT form back to the recipient unit, the enrollment unit shall keep a copy of the EFT form and append it to the provider/supplier's Form CMS-855 in the file.

3. Bankruptcies and Garnishments

If the contractor receives a copy of a court order to send payments to a party other than the provider/supplier, it shall contact the applicable SOG Location's Office of General Counsel.

4. Closure of Bank Account

If a provider/supplier has closed its bank/EFT account but will remain enrolled in Medicare, the contractor shall place the provider/supplier on payment withhold until a Form CMS-588 (and Form CMS-855, if applicable) is submitted and approved by the contractor. If such an agreement is not submitted within 90 days after the contractor learned that the account was closed, the contractor shall commence deactivation procedures in accordance with the instructions in this chapter. The basis for deactivation would be § 424.540(a)(2) due to the provider/supplier's failure to submit updated EFT information within 90 days of the change.

5. Reassignments

If a physician or non-physician practitioner is reassigning al*l b*enefits to another supplier and the latter is not currently on EFT, neither the practitioner nor the reassignee needs to submit a Form CMS-588. This is because (1) the practitioner is not receiving payment directly, and (2) accepting a reassignment does not qualify as a change of information request. If, however, the group later submits a change of information request and is not on EFT, it must submit a Form CMS-588.

6. Final Payments

If a non-certified supplier (e.g., physician; ambulance supplier) voluntarily withdraws from Medicare and needs to obtain its final payments, the contractor shall send such payments to the supplier's EFT account of record. If the account is defunct, the contractor can send payments to the supplier's "special payments" address or, if none is on file, to any of the supplier's practice locations on record. If neither the EFT account nor the aforementioned addresses are available, the supplier shall submit a Form CMS-855 or Form CMS-588 request identifying where it wants payments to be sent.

7. Chain Organizations

Per CMS Pub. 100-04, chapter 1, section 30.2, a chain organization may have payments to its providers be sent to the chain home office. However, and except as otherwise permitted for PECOS applications under PECOS 2.0, any mass EFT changes (involving large numbers of chain providers) must be submitted and processed in the same fashion as any other change in EFT data. For instance, if a chain has 100 providers and each wants to change its EFT account to that of the chain home office, 100 separate Form CMS-588s must be submitted (again, unless PECOS 2.0 permits a consolidated submission for PECOS applications). If any of the chain providers have never completed a Form CMS-855 before, they must do so at that time.

8. Consolidation of EFT Accounts

The contractor shall follow the instructions in section 10.6.23 of this chapter regarding the consolidation of a provider's or supplier's EFT accounts. These instructions take precedence over any contrary guidance in this chapter.

9. Address on EFT Form

Notwithstanding any guidance to the contrary in this chapter or on the Form CMS-588, the account holder's street address (including city, state, and zip) on the EFT form can be the provider's or supplier's:

- Practice location address (if the provider or supplier has multiple practice locations, any location address may be used);
- Correspondence address;
- Special payment address; or
- Chain home office (CHO) address (though only for providers reporting a CHO on the Form CMS-855A).

10.3.3.2 – Form CMS-460 – Medicare Participating Physician or Supplier Agreement

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

This agreement establishes that the Medicare provider/supplier accepts assignment of the Medicare Part B payment for all services (1) for which the participant is eligible to accept assignment under the Medicare law and regulations and (2) which are furnished while the agreement is in effect. (This only applies to suppliers that complete the Forms CMS-855B, CMS-855S, and CMS-855I.) The contractor shall follow the instructions in CMS Pub. 100-04, chapter 1, sections 30 through 30.3.12.3 when handling issues related to par agreements and assignment. Queries concerning the interpretation of such instructions shall be referred to the responsible CMS component.

Individual physicians and non-physician practitioners who only reassign benefits to a clinic/group practice inherit the par status established by the clinic/group practice; accordingly, these physicians and non-physician practitioners need not submit the Form CMS-460. However, if the individual physician/practitioner maintains a private practice separate from the reassignment, *the individual* may designate *the individual's* own par status. See the instructions in CMS Pub. 100-04, chapter 1, section 30 for applying the correct par status to clinic/group practices, organizations and individuals in private practice.

A. PECOS Information

All suppliers must choose to be either par or non-par when enrolling and must maintain the same par status across all lines of business. The contractor shall search PECOS to determine if an enrollment already exists with the enrolling provider/supplier's legal business information (i.e.: legal business name, federal tax identification number).

No par status change shall be made by the contractor without confirmation from the provider/supplier first. In the event that a provider/supplier submits a par agreement and *is* currently enrolled as non-par, the contractor must confirm with the provider/supplier that the change in the par status is valid for all lines of business. Likewise, if a provider/supplier does not submit a par agreement, and they are enrolled as par or non-par, the contractor shall confirm that the provider/supplier is not changing *the* current par status across all lines of business. Note also that an already-enrolled supplier is not required to submit a new CMS-460 if they are enrolling in another state or contractor jurisdiction.

B. Valid signatures

For paper applications, handwritten (wet) signatures in ink and digital/electronic signatures (digital or electronic signatures such as those created by digital signature options created in software, such as Adobe) are acceptable. For web applications, the supplier can sign it electronically or upload the signature and then submit the application. The contractor shall contact its PEOG BFL for questions regarding electronic signatures.

10.4.1.3.2 – Data Verification

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Means of Verification

Except as stated otherwise in this chapter or in another CMS directive, the contractor shall verify and validate – via the most cost-effective methods available, including via PECOS (as described and directed in section 10.3) - all information furnished by the provider on or with *the* application, assuming a data source is available. The general purpose of the verification process is to ensure that all of the data furnished on the Form CMS-855 or Form CMS-20134 is accurate.

Examples of verification techniques include, but are not limited to: (i) site visits; (ii) third-party data validation sources; (iii) state professional licensure and certification websites (e.g., medical board sites); (iv) federal licensure and certification websites (if applicable); (v) state business web sites (e.g., to validate "doing business as" name); and (vi) Yellow Pages (e.g., to verify certain phone numbers).

The list of verification techniques identified in this section 10.4.1.3.2 is not exhaustive. Except as prescribed otherwise in section 10.3, if the contractor is aware of another means of validation that is as cost-effective and accurate as those listed, it may use it. However, all SSNs and NPIs listed on the application shall be verified through PECOS. The contractor shall not request an SSN card or driver's license to verify an individual's identity or SSN.

B. Overall Verification Principles

Unless stated otherwise in this chapter or in another CMS directive, the following apply:

1. A data element is considered "verified" when, after attempting at least one means of validation, the contractor is confident that the data is accurate. (The contractor shall use its best judgment when making this assessment.)

2. The contractor need only make one verification attempt (i.e., need only use one validation technique) before either: (i) concluding that the furnished data is accurate; or (ii) requesting clarifying information if the data element cannot be verified (though the contractor is encouraged to make a second attempt using a different validation means prior to requesting clarification).

C. Concurrent Reviews

(For PECOS application submissions, note that PECOS's automatic verifications of applications from related entities shall take precedence – e.g., in terms of length of time between application submissions, depth of the relationship between the associated parties – over the instructions in this section 10.4.1.3.2(C).)

If the contractor receives multiple Form CMS-855 or Form CMS-20134s for related entities, it can perform concurrent reviews of similar data. For instance, suppose a chain home office submits initial Form CMS-855As for four of its chain providers. The ownership information (Sections 5 and 6) and chain home office data (Section 7) is the same for all four providers. The contractor need only verify the ownership and home office data once; it need not do so four times – once for each provider. However, the contractor shall document in each provider's PECOS record that a single verification check was made for all four applications.

For purposes of this requirement: (1) there must be an organizational, employment, or other business relationship between the entities; and (2) the applications must have been submitted within a few weeks of each other. As an illustration, assume that Group Practice A submits an initial Form CMS-855B on January 1. Group Practice B submits one on October 1. Section 6 indicates that Smith is a co-owner of both practices, though both entities have many other owners that are not similar. In this case, the contractor must verify Smith's data in both January and October. It cannot use the January verification and apply it to Group B's application because: (1) the applications were submitted nine months apart; and (2) there is no evidence that the entities are related.

D. Contacting another Contractor

During the verification process, the contractor may need to contact another Medicare contractor for information regarding the provider. The latter contractor shall respond to the former contractor's request within three business days absent extenuating circumstances.

E. Proof of Life Documentation

When an enrollment record is updated to reflect an erroneous date or report of death, the contractor shall request documentation that supports "proof of life" (e.g., Retirement, Survivors, and Disability Insurance document issued by SSA). If the provider cannot obtain such documentation, the contractor shall submit a request to its PEOG BFL containing the provider's name, date of birth, and SSN so that CMS can confirm proof of life with SSA.

10.4.1.3.3 – Requesting Missing/Clarifying Data/Documentation (Development)

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

This section 10.4.1.3.3 addresses the contractor's solicitation of missing/clarifying information/documentation and/or a valid certification statement. The policies herein apply except as otherwise stated in this chapter (e.g., section 10.3) or another CMS directive.

A. Only One Request Needed

The contractor need only make one request. Of course, the contractor should respond to any of the provider's telephone calls, e-mails, etc., resulting from the request. Yet the contractor need not – on its own volition – make an additional request unless the contractor uncovers missing data (or data that must be clarified) that it failed to detect prior to sending the original development letter.

To the extent possible, the contractor should avoid contacting the provider for missing/clarifying data/documentation until it has attempted to validate all of the data on the application. This will obviate the need to contact the provider each time the contractor discovers an issue.

B. Commencement of Timeframe

The provider has 30 calendar days to furnish the information or documentation the contractor requested. This 30-day clock commences on the day on which the contractor sends the development request (e.g., via the PCV).

C. Telephonic Requests

Unless otherwise stated in this chapter or in another CMS directive, telephonic requests for missing/clarifying data/documentation are generally not permitted for paper or PECOS applications; it is important that requests for information or clarification be formalized in writing. However, in cases where CMS permits telephonic requests for such data, the contractor shall adhere to the following:

1. A telephonic request is made when the contractor: (1) speaks with an appropriate provider official, or (2) leaves a message either with an appropriate official's staff (e.g., executive assistant) or with an appropriate official's voice mail service. In situation (2), the contractor shall leave the name and telephone number of an appropriate individual at the contractor site who the official can contact; otherwise, the contact does not qualify as a legitimate request for clarification.

2. When leaving a message, the contractor shall also state that the requested data/clarification must be furnished within 30 days.

3. Telephone requests shall be made on weekdays between 9 am and 5 pm of the provider's time zone.

4. The 30-day clock begins on the day (1) of the telephone conversation with the appropriate official, or (2) the message is left.

5. All telephone activity that falls within this subsection (C) shall be documented in PECOS consistent with the instructions in section 10.6.19(H) of this chapter.

D. Inability to Contact Provider

If the contractor cannot, for the reasons listed in (i) through (iii) below, communicate with the provider to request information/documentation, it shall attempt one alternative means of communication:

(i) The mailed letter is returned because the provider is not at that address;

(ii) The contractor cannot e-mail (e.g., via the PCV) the letter to the provider because of issues with the recipient's e-mail system; or

(iii) The provider's fax number is repeatedly busy

If an alternative communication, too, cannot be completed for one of the above reasons, the contractor need not make another attempt to obtain the data and may reject the application once the applicable 30-day period expires. However, it is strongly advised that the contractor make a third attempt to contact the provider prior to taking this step, especially if it appears the provider is acting in good faith. (The contractor shall document in PECOS each attempt to contact the provider.)

(With respect to e-mail (including via the PCV), an alternative communication includes sending an e-mail to another listed contact person, delegated official, or authorized official.)

E. Development Reasons and Elements of Letter

1. Paper Applications

a. Reasons to Develop

Development is necessary if the provider or supplier: (i) submits an application with at least one missing required data element; (ii) fails to submit at least one required document; (iii) submits an invalid certification statement; (iv) writes "N/A" (or a variation thereof) in response to a question that requires a "yes" or "no" answer; or (v) submits the full application via fax or e-mail unless the contractor has provided for an exception based on extenuating circumstances or the submission via this means is otherwise authorized by CMS. (If the contractor instructs the provider to submit the application via fax or e-mail, the contractor shall inform its PEOG BFL.)

Development is also required if the contractor determines that clarification is needed regarding certain information (e.g., particular data cannot be verified or there are data inconsistencies).

b. Elements of a Development Letter

If any of the development reasons in section 10.4.1.3.3(E)(1)(a) above apply, the contractor shall send a development letter to the provider – preferably via the PCV, e-mail or fax - that contains, at a minimum, the applicable elements in (i) through (vi) below. (See section 10.7 et seq. of this chapter for these model letters.)

i. A list of all of the missing required data/documentation, an explanation of the certification statement's deficiencies, and/or the issues/information to be clarified.

ii. A request that the provider submit the missing data/documentation, clarification, and/or revised certification statement within 30 calendar days.

iii. Unless the only data that is missing is documentation, a request that the provider submit an appropriately signed and dated certification statement. (This certification statement will cover both the submission of any missing data as well as any deficiencies associated with the original certification statement.) The provider may submit the certification statement via scanned e-mail, fax or mail.

(A new certification statement is not required if the only missing material is documentation or if the requested clarification does not require any changes to the provider's Form CMS-855 or CMS-20134 application.)

iv. If missing data is involved, the contractor shall direct the provider to the CMS Web site at which the CMS-855 or CMS-20134 forms can be found.

v. A fax number and mailing address to which the missing/clarifying data/documentation/correct certification statement can be sent to the contractor. An e-mail address may be included if applicable.

vi. The name and phone number of a contact person at the contractor site. An e-mail address may be included if applicable.

2. PECOS Applications

a. Reasons to Develop

Development is necessary if the provider or supplier: (i) submits an application with at least one required data element that needs clarification; or (ii) fails to submit at least one required document.

b. Elements of a Development Request

When developing for more information, the contractor shall send a request to the provider via the PCV containing:

(i) A list of all missing documentation or information to be clarified;

(ii) A request that the provider submit the data/materials in question within 30 calendar days; and

(iii) The name and phone number (an e-mail address is optional) of a contact person at the contractor site.

The contractor shall not attempt to contact the provider for the missing/clarified information or documentation prior to sending the PCV request referenced above, though the contractor is free to make a follow-up contact with the provider after sending the PCV request.

10.4.1.4.2 - Returns

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Reasons/Grounds for Return

(See 42 CFR § 424.526 for regulatory provisions regarding application returns.)

Notwithstanding any other directive to the contrary in this chapter or another CMS directive, the contractor (including the NSC) may immediately return the enrollment application to the provider only in the instances described below and which are outlined in § 424.526(a)(1) through (13). Except as otherwise indicated in the specific return reason, this policy applies to all applications identified in this chapter (e.g., initial applications, change requests, Form CMS-855O applications, Form CMS-588 submissions, change of ownership (CHOW) applications, revalidations, reactivations, etc.) (Note that some of these return reasons may no longer apply or will be rendered moot with the advent of PECOS 2.0):

(1) The provider/supplier sent its paper Form CMS-855, Form CMS-588, or Form CMS-20134 to the incorrect contractor for processing (e.g., the application was sent to Contractor X instead of Contractor Y).

(2) The contractor received the application more than 60 days prior to the effective date listed on the application. (This does not apply to (i) initial Form CMS-855A applications and (ii) ambulatory surgical centers and portable x-ray suppliers submitting an initial Form CMS-855B application.)

(3) The seller or buyer in a CHOW submitted its Form CMS-855A or Form CMS-855B application more than 90 days prior to the anticipated date of the sale.

(4) The contractor received an initial application more than 180 days prior to the effective date listed on an application from an ambulatory surgical center, a portable x-ray supplier, or a provider/supplier submitting a Form CMS-855A application.

(5) The contractor confirms that the provider or supplier submitted an initial enrollment application prior to the expiration of the time period in which it is entitled to appeal the denial of its previously submitted application.

(6) The provider/supplier submitted an initial application prior to the expiration of their existing reenrollment bar or reapplication bar.

(7) The application is not needed for (or is inapplicable to) the transaction in question. Examples include, but are not limited to, the following:

- A rebuttal decision has been issued (therefore, the submitted Form CMS-855, Form CMS-588, or Form CMS-20134 is not needed). (See section 10.4.8.1(A) of this chapter for more information.)

- The application is to be returned per section 10.6.1.1.3.1.1 of this chapter.

(8) The provider/supplier submitted a revalidation application more than 7 months prior to their revalidation due date.

(9) The MDPP supplier submitted an application with a coach start date more than 30 days in the future.

(10) A provider/supplier requests that their application be withdrawn prior to or during processing.

(11) A provider/supplier submits an application that is an exact duplicate of an application that has already been processed or is currently being processed or is pending processing.

(12) The provider/supplier submits a paper Form CMS-855 or Form CMS-20134 enrollment application that is outdated or has been superseded by a revised version.

(13) The provider/supplier submits a Form CMS-855A or Form CMS-855B initial application followed by a Form CMS-855A or Form CMS-855B change of ownership application. If the Medicare contractor—

(i) Has not yet made a recommendation for approval concerning the initial application, both applications may be returned.

(ii) Has made a recommendation for approval concerning the initial application, the Medicare contractor may return the change of ownership application. If, per the Medicare contractor's written request, the provider or supplier fails to submit a new initial Form CMS-855A or Form CMS-855B application containing the new owner's information within 30 days of the date of the letter, the Medicare contractor may return the originally submitted initial Form CMS-855A or Form CMS-855B application.

(The difference between a "rejected" application and a "returned" application is that the former is typically based on the provider's failure to respond to the contractor's request for missing or clarifying information. A "returned" application is effectively considered a non-submission.)

Note that the contractor need not request additional information in any of these scenarios. For instance, if the application is not necessary for the particular transaction, the contractor can return the application immediately; if the provider already submitted an application fee, the contractor shall follow existing instructions regarding the return of the fee.

B. Procedures for Returning the Application

If the contractor returns the application, the following apply:

(i) The contractor shall notify the provider via the applicable return letter (sent by mail, the PCV, or e-mail) that the application is being returned, the reason(s) for the return, and how to reapply.

(ii) The contractor shall not enter the application into PECOS. No L & T record shall be created.

(iii) Any application resubmission requires a brand new certification statement page containing a signature and date. The provider cannot simply add its signature to the original certification statement it submitted. (This does not apply to e-signature situations.)

(iv) For paper applications, the contractor shall: (A) keep the original application and supporting documents and return a copy; (B) make a copy or scan of the application and documents and return the originals to the provider; or (C) simply send a letter to the provider (in lieu of sending the originals or a copy thereof) explaining that the application is being returned (though not physically returned) and why. (If the contractor chooses the third approach and the provider requests a copy of its application, the contractor should fax or mail it to the provider.)

See section 10.3 of this chapter for more information regarding the return of applications.

C. Special Situations Concerning Changes of Information and Changes of Ownership

1. Expiration of Timeframe for Reporting Changes - If the contractor returns a change of information or CHOW submission and the applicable 90-day or 30-day period for reporting the change has expired, the contractor shall send an e-mail to its PEOG BFL notifying *the latter* of the return. PEOG will determine whether the provider/supplier's Medicare billing privileges should be deactivated or revoked and will notify the contractor of its decision.

2. Timeframe Not Yet Expired - If the contractor returns a change of information or CHOW submission and the applicable 90-day or 30-day period for reporting the change has not yet expired, the contractor shall send the e-mail referenced in section 10.4.1.4.2(C)(1) after the expiration of said time period unless the provider has resubmitted the change request/CHOW.

3 Second Return, Rejection, or Denial – If, per section 10.4.1.4.2, the provider resubmits the change of information or CHOW application and the contractor either returns it again, rejects it, or denies it, the contractor shall send the e-mail referenced in section 10.4.1.4.2(C)(1) regardless of whether the applicable timeframe has expired. PEOG will determine whether the provider/supplier's Medicare billing privileges should be deactivated or revoked and will notify the contractor of its decision.

D. Reactivations

If the contractor returns a reactivation application, the provider's Medicare billing privileges shall remain deactivated.

E. Revalidations

If the contractor returns a revalidation application, the contractor shall – unless an existing CMS instruction or directive states otherwise - deactivate the provider's Medicare billing privileges under 42 CFR § 424.540(a)(3) if the applicable time period for submitting the revalidation application has expired. If it has not expired, the contractor shall deactivate the provider's billing privileges after the applicable time period expires unless the provider has resubmitted the revalidation application. If the provider indeed resubmits the application and the contractor returns it again, rejects it, or denies it, the contractor shall – absent another CMS instruction to the contrary - deactivate the provider's billing privileges, assuming the applicable time period has expired.

10.4.2.2 - Denial Reasons

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Denial Reason 1– Not in Compliance with Medicare Requirements (42 CFR §424.530(a)(1))

"The provider or supplier is determined not to be in compliance with the enrollment requirements in this Title 42 or on the enrollment application applicable to its provider or supplier type and has not submitted a plan of corrective action as outlined in 42 CFR part 488." Such non-compliance includes, but is not limited to, the following situations:

i. The provider or supplier does not have a physical business address or mobile unit where services can be rendered.

ii. The provider or supplier does not have a place where patient records are stored to determine the amounts due such provider or other person.

iii. The provider or supplier is not appropriately licensed.

iv. The provider or supplier is not authorized by the federal/state/local government to perform the services that it intends to render.

v. The provider or supplier does not meet CMS regulatory requirements for the specialty that it seeks to enroll as. (See section 10.2.8 of this chapter for examples of suppliers that are not eligible to participate.)

vi. The provider or supplier does not have a valid social security number (SSN) or employer identification number (EIN) for itself, an owner, partner, managing organization/employee, officer, director, medical director, and/or authorized or delegated official.

vii. The applicant does not qualify as a provider of services or a supplier of medical and health services. (For instance, the applicant is not recognized by any federal statute as a Medicare provider or supplier (see section 10.2.8 of this chapter.)) An entity seeking Medicare payment must be able to receive reassigned benefits from physicians in accordance with the Medicare reassignment provisions in § 1842(b)(6) of the Act (42 U.S.C. 1395u(b)).

viii. The provider or supplier does not otherwise meet general enrollment requirements.

(With respect to (v) above – and, as applicable, (iii) and (iv) - the contractor's denial letter shall cite the appropriate statutory and/or regulatory citation(s) containing the specific licensure/certification/authorization requirement(s) for that provider or supplier type. For a listing of some of these statutes and regulations, refer to section 10.2 et seq. of this chapter.)

NOTE: The contractor must identify in its denial letter the exact provision within said statute(s)/regulation(s) with which the provider/supplier is non-compliant.

(NOTE: For (a)(1) denials involving an individual practitioner who is not appropriately licensed due to a disciplinary action, PEOG -- rather than the contractor -- will make all denial determinations for this noncompliance requirement).

B. Denial Reason 2– Excluded/Debarred from Federal Program (42 CFR § 424.530(a)(2))

(i) "The provider or supplier, or any owner, managing employee, managing organization, officer, director, authorized or delegated official, medical director, supervising physician, or other health care or administrative or management services personnel (such as a billing specialist, accountant, or human resources specialist) furnishing services payable by a federal health care program, of the provider or supplier is—

(A) Excluded from 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, or

(B) Debarred, suspended, or otherwise excluded from participating in any other Federal procurement or non-procurement program or activity in accordance with section 2455 of the Federal Acquisition Streamlining Act."

(ii) The individuals and organizations identified in paragraph (a)(2)(i) of this section include, but are not limited to, W–2 employees and contracted individuals and organizations of the provider or supplier.

(Unless stated otherwise in section 10.6.6 of this chapter or in another CMS directive, the contractor need not review the OIG exclusion list for any "health care or administrative or management services personnel" who are not otherwise required to be reported on the enrollment application.)

C. Denial Reason 3 – Felony Conviction (42 CFR § 424.530(a)(3))

"The provider, supplier, or any owner, managing employee, managing organization, officer, director, of the provider or supplier was, within the preceding 10 years, convicted (as that term is defined in 42 CFR § 1001.2) of a federal or state felony offense that CMS determines to be detrimental to the best interests of the Medicare program and its beneficiaries.

(i) Offenses include, but are not limited in scope and severity to:

(A) Felony crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

(B) Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

(C) Any felony that placed the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit resulting in a conviction of criminal neglect or misconduct.

(D) Any felonies outlined in section 1128 of the Social Security Act.

(ii) Denials based on felony convictions are for a period to be determined by the Secretary, but not less than 10 years from the date of conviction if the individual has been convicted on one previous occasion for one or more offenses.

(iii) The individuals and organizations identified in paragraph (a)(3) of this section include, but are not limited to, W–2 employees and contracted individuals and organizations of the provider or supplier."

While a reenrollment bar is established for revoked providers/suppliers, this does not preclude the contractor from denying reenrollment to a provider/supplier that was convicted of a felony within the preceding 10-year period or that otherwise does not meet all of the criteria necessary to enroll in Medicare.

Note that if an MDPP coach meets the above felony requirements, this would not itself warrant a denial of the MDPP supplier under § 424.535(a)(3). This is because the coach, not the MDPP supplier, has the felony conviction. The MDPP supplier could, however, be denied enrollment under § 424.530(a)(1) (non-compliance with enrollment requirements) for having an ineligible coach.

As explained in section 10.6.6 of this chapter, the contractor shall submit all felonies found on Form CMS-855 and CMS-20134 applications to PEOG for review via ProviderEnrollmentRevocations@cms.hhs.gov. (See section 10.6.6 for more information.)

D. Denial Reason 4– False or Misleading Information on Application (42 CFR § 424.530(a)(4))

"The provider or supplier submitted false or misleading information on the enrollment application to gain enrollment in the Medicare program."

E. Denial Reason 5– On-Site Review/Other Reliable Evidence that Requirements Not Met (42 CFR §424.530(a)(5))

"Upon on-site review or other reliable evidence, CMS determines that the provider or supplier:

(i) Is not operational to furnish Medicare-covered items or services; or
(ii) Otherwise fails to satisfy any Medicare enrollment requirement."

F. Denial Reason 6– Medicare Debt (42 CFR § 424.530(a)(6))

1. Background

Consistent with 42 CFR § 424.530(a)(6), an enrollment application may be denied if:

(i) The provider, supplier, or owner thereof (as defined in § 424.502) has an existing Medicare debt:

(ii) The enrolling provider, supplier, or owner (as defined in § 424.502) thereof was previously the owner of a provider or supplier that had a Medicare debt that existed when the latter's enrollment was voluntarily terminated, involuntarily terminated, or revoked, and all the following criteria are met:

(A) The owner left the provider or supplier with the Medicare debt within 1 year before or after that provider or supplier's voluntary termination, involuntary termination, or revocation.

(B) The Medicare debt has not been fully repaid.

(C) CMS determines that the uncollected debt poses an undue risk of fraud, waste, or abuse. In making this determination [under § 424.530(a)(6)(ii)], CMS considers the following factors:

(1) The amount of the Medicare debt.

(2) The length and timeframe that the enrolling provider, supplier, or owner thereof was an owner of the prior entity.

(3) The percentage of the enrolling provider, supplier, or owner's ownership of the prior entity.

(4) Whether the Medicare debt is currently being appealed.

(5) Whether the enrolling provider, supplier, or owner thereof was an owner of the prior entity at the time the Medicare debt was incurred."

In addition, a denial of Medicare enrollment under paragraph (a)(6)(ii) can be avoided if the enrolling provider, supplier, or owner thereof does either of the following: (1) satisfies the criteria set forth in § 401.607 and agrees to a CMS-approved extended repayment schedule for the entire outstanding Medicare debt; or (2) repays the debt in full.

1. Contractor's Determination of Overpayment

When processing a Form CMS-855A, CMS-855B, CMS-855I, CMS-855S, or CMS-20134 initial or change of ownership application (if applicable), the contractor shall determine – using a system generated monthly listing – whether the provider, supplier, or any owner listed in Section 5 or 6 of the application has an existing or delinquent Medicare overpayment, as described in section 10.4.2.2(F)(1) above and § 424.530(a)(6). If such an overpayment exists, the contractor shall deny the application, using 42 CFR §424.530(a)(6) as the basis. However, prior PEOG approval is required before proceeding with the denial. The contractor shall under no circumstances deny an application under § 424.530(a)(6) without receiving PEOG approval to do so.

2. Examples

Example #1: Dr. X, a sole proprietor, has a $70,000 overpayment. Three months later, *Dr. X* joins Group Y and becomes a 50 percent owner thereof. Group Y submits an initial enrollment application two months thereafter. Group Y's enrollment could be denied because Dr. X is an owner.

Example #2: Dr. Smith's practice ("Smith Medicine") is set up as a sole proprietorship. *Dr. Smith* incurs a $50,000 overpayment. *Dr. Smith* terminates Medicare enrollment. Six months later, Dr. Smith tries to enroll as a sole proprietorship; *the* practice is named "JS Medicine." A denial is warranted because § 424.530(a)(6) applies to physicians and the $50,000 overpayment was attached *to Dr. Smith* as the sole proprietor.

Example #3 - Same scenario as example #2, but assume that *Dr. Smith's* new practice is an LLC of which *Dr. Smith* is only a 30 percent owner. A denial is still warranted because *Dr. Smith* is an owner of the enrolling supplier and the $50,000 overpayment was attached to *Dr. Smith*.

Example #4 - Smith is a nurse practitioner in a solo practice. *The* practice ("Smith Medicine") is set up as a closely-held corporation, of which *Smith* is the 100 percent owner. Smith Medicine is assessed a $20,000 overpayment. *Smith* terminates *the* Medicare enrollment. Nine months later, *Smith* submits a Form CMS-855I application *to enroll Smith* as a new individual *supplier.* The business will be established as a sole proprietorship. A denial is not warranted because the $20,000 overpayment was attached to Smith Medicine, not to Smith.

In each of these examples, however, denial could be avoided if (1) the party with the overpayment is on a Medicare-approved plan of repayment or (2) the overpayments in question are currently being offset or being appealed.

3. Additional Considerations Involving § 424.530(a)(6)

The contractor shall also observe the following with respect to § 424.530(a)(6):

a. In determining whether an overpayment exists, the contractor need only review its own records; it need not contact other contractors to determine whether the person or entity has an overpayment in those contractor jurisdictions.

b. The instructions in this section 10.4.2.2(F) apply only to (i) initial enrollments and (ii) new owners in a change of ownership.

c. The term "owner" under § 424.502 means any individual or entity that has any partnership interest in, or that has 5 percent or more direct or indirect ownership of, the provider or supplier as defined in sections 1124 and 1124A(A) of the Act.

d. If the person or entity had an overpayment at the time the application was filed but repaid it in full by the time the contractor performed the review described in this section 10.4.2.2(F), the contractor shall not deny the application based on § 424.530(a)(6).

G. Denial Reason 7– Medicare or Medicaid Payment Suspension (42 CFR § 424.530(a)(7))

(i) The provider or supplier, or any owning or managing employee or organization of the provider or supplier, is currently under a Medicare or Medicaid payment suspension as defined in §§ 405.370 through 405.372 or in § 455.23 of this chapter.

(ii) CMS may apply the provision in this paragraph (a)(7) to the provider or supplier under any of the provider's, supplier's, or owning or managing employee's or organization's current or former names, numerical identifiers, or business identities or to any of its existing enrollments.

(iii) In determining whether a denial is appropriate, CMS considers the following factors:

(A) The specific behavior in question.

(B) Whether the provider or supplier is the subject of other similar investigations.

(C) Any other information that CMS deems relevant to its determination.

H. Denial Reason 8– Home Health Agency (HHA) Capitalization (42 CFR § 424.530(a)(8))

An HHA submitting an initial application for enrollment:

a. Cannot, within 30 days of a CMS or Medicare contractor request, furnish supporting documentation verifying that the HHA meets the initial reserve operating funds requirement in 42 CFR § 489.28(a); or

b. Fails to satisfy the initial reserve operating funds requirement in 42 CFR § 489.28(a).

I. Denial Reason 9– Hardship Exception Denial and Fee Not Paid (42 CFR § 424.530(a)(9))

"The institutional provider's (as that term is defined in 42 CFR § 424.502) hardship exception request is not granted, and the institutional provider does not submit the required application fee within 30 days of notification that the hardship exception request was not approved."

(This denial reason should only be used when the institutional provider fails to submit the application fee after its hardship request was denied. The contractor shall use § 424.530(a)(1) as a basis for denial when the institutional provider: (a) does not submit a hardship exception request and fails to submit the application fee within the prescribed timeframes; or (b) submits the fee, but it cannot be deposited into a government-owned account.)

J. Denial Reason 10– Temporary Moratorium (42 CFR § 424.530(a)(10))

"The provider or supplier submits an enrollment application for a practice location in a geographic area where CMS has imposed a temporary moratorium." (This denial reason applies to initial enrollment applications and practice location additions.)

K. Denial Reason 11 – Prescribing Authority (42 CFR § 424.530(a)(11))

"1. A physician or eligible professional's Drug Enforcement Administration (DEA) Certificate of Registration to dispense a controlled substance is currently suspended or revoked or is surrendered in response to an order to show cause; or

2. The applicable licensing or administrative body for any state in which a physician or eligible professional practices has suspended or revoked the physician or eligible professional's ability to prescribe drugs, and such suspension or revocation is in effect on the date the physician or eligible professional submits *the* enrollment application to the Medicare contractor."

(Except as otherwise stated in this chapter or in another CMS directive, the contractor need not verify whether an individual's DEA certificate was surrendered in response to a show cause order.)

NOTE: With respect to (a)(11), PEOG -- rather than the contractor – will make all determinations regarding whether this provision applies.

L. Denial Reason 12 (42 CFR § 424.530(a)(12) - Revoked Under Different Name, Numerical Identifier, or Business Identity)

"The provider or supplier is currently revoked under a different name, numerical identifier, or business identity, and the applicable reenrollment bar period has not expired. In making its determination, CMS considers the following factors:

(i) Owning and managing employees and organizations (regardless of whether they have been disclosed on the Form CMS-855 [or CMS-20134] application);
(ii) Geographic location;
(iii) Provider or supplier type;
(iv) Business structure; or
(v) Any evidence indicating that the two parties [the revoked provider/supplier and the newly-enrolling provider/supplier] are similar or that the provider or supplier was created to circumvent the revocation or reenrollment bar."

NOTE: With respect to (a)(12), PEOG – rather than the contractor – will make all determinations regarding whether a provider or supplier was revoked under a different name, numerical identifier or business identity.

M. Denial Reason 13 (42 CFR § 424.530(a)(13) - Affiliation that Poses an Undue Risk)

"The provider or supplier has or has had an affiliation under 42 CFR § 424.519 (specifically, the factors listed in 42 CFR § 424.519(f)) that poses an undue risk of fraud, waste, and abuse to the Medicare program."

An affiliation is defined as any of the following:

(i) A 5 percent or greater direct or indirect ownership interest that an individual or entity has in another organization.
(ii) A general or limited partnership interest (regardless of the percentage) that an individual or entity has in another organization.
(iii) An interest in which an individual or entity exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operations of another organization (including, for purposes of § 424.519 only, sole proprietorships), either under contract or through

some other arrangement, regardless of whether or not the managing individual or entity is a W–2 employee of the organization.
(iv) An interest in which an individual is acting as an officer or director of a corporation.
(v) Any reassignment relationship under § 424.80.

NOTE: With respect to (a)(13), PEOG -- rather than the contractor – will make all determinations regarding whether a provider or supplier has an affiliation per 42 CFR § 424.519 that poses an undue risk of fraud, waste and abuse.

N. Denial Reason 14 (42 CFR § 424.530(a)(14) – Other Program Termination or Suspension)

"(1) The provider or supplier is currently terminated or suspended (or otherwise barred) from participation in a state Medicaid program or any other federal health care program; or (2) the provider or supplier's license is currently revoked or suspended in a state other than that in which the provider or supplier is enrolling."

In determining whether a denial under § 424.530(a)(14) is appropriate, CMS considers the following factors:

a. The reason(s) for the termination, suspension, or revocation;

b. Whether, as applicable, the provider or supplier is currently terminated or suspended (or otherwise barred) from more than one program (for example, more than one state's Medicaid program), has been subject to any other sanctions during its participation in other programs or by any other state licensing boards, or has had any other final adverse actions (as that term is defined in § 424.502) imposed against it; and

c. Any other information that CMS deems relevant to its determination."

NOTE: With respect to (a)(14), PEOG -- rather than the contractor – will make all determinations regarding whether a provider or supplier has a termination or suspension from another program or has a license that is currently revoked or suspended in a state other than that in which the provider or supplier is enrolling.

O. Denial Reason 15 (42 CFR § 424.530(a)(15) – Patient Harm)

"The physician or other eligible professional has been subject to prior action from a state oversight board, federal or state health care program, Independent Review Organization (IRO) determination(s), or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health care with underlying facts reflecting improper physician or other eligible professional conduct that led to patient harm. In determining whether a denial is appropriate, CMS considers the following factors:

(A) The nature of the patient harm

(B) The nature of the physician's or other eligible professional's conduct

(C) The number and type(s) of sanctions or disciplinary actions that have been imposed against the physician or other eligible professional by a state oversight board, IRO, federal or state health care program, or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health care. Such actions include, but are not limited to, procedures or practices; (ii) required compliance appearances before state oversight board members; (iii) license restriction(s) regarding the ability to treat certain types of patients; (iv) administrative/monetary penalties; and (v) formal reprimand(s).

(D) If applicable, the nature of the IRO determination(s).

(E) The number of patients impacted by the physician's or other eligible professional's conduct and the degree of harm thereto or impact upon."

Section 424.530(a)(15) does not apply to actions or orders pertaining exclusively to either of the following: (i) required participation in rehabilitation or mental/behavioral health programs; or (ii) required abstinence from drugs or alcohol and random drug testing.

NOTE: With respect to (a)(15), PEOG -- rather than the contractor – will make all determinations regarding whether this provision applies.

P. Denial Reason 17 – False Claims Act Judgment (42 CFR § 424.530(a)(17))

"(i) The provider or supplier, or any owner, managing employee or organization, officer, or director of the provider or supplier, has had a civil judgment under the False Claims Act (31 U.S.C. 3729 through 3733) imposed against them within the previous 10 years.

(ii) In determining whether a denial under this paragraph is appropriate, CMS considers the following factors:

(A) The number of provider or supplier actions that the judgment incorporates (for example, the number of false claims submitted)

(B) The types of provider or supplier actions involved

(C) The monetary amount of the judgment

(D) When the judgment occurred

(E) Whether the provider or supplier has any history of final adverse actions (as that term is defined in § 424.502)

(F) Any other information that CMS deems relevant to its determination."

NOTE: With respect to (a)(17), PEOG -- rather than the contractor – will make all determinations regarding whether this provision applies.

Q. Denial Reason 18 – Standard or Condition Violation (42 CFR § 424.530(a)(18))

(i) The independent diagnostic testing facility is non-compliant with any provision in 42 CFR 410.33(g).

(ii) The DMEPOS supplier is non-compliant with any provision in § 424.57(c).

(iii) The opioid treatment program is non-compliant with any provision in § 424.67(b) or (e).

(iv) The home infusion therapy supplier is non-compliant with any provision in § 424.68(c) or (e).

(v) The Medicare diabetes prevention program is non-compliant with any provision in § 424.205(b) or (c).

(Similar to current practice with respect to § 424.530(a)(1), the contractor can make denial determinations under § 424.530(a)(18) without prior PEOG approval. The contractor's denial letter shall cite the exact statutory and/or regulatory citation(s) containing the specific standard/condition with which the provider/supplier is non-compliant. For a listing of some of these statutes and regulations, refer to section 10.2 et seq. of this chapter.)

(See section 10.4.2.3 for more information regarding § 424.530(a)(18).)

10.4.5.2 – Non-Responses to Revalidation and Extension Requests

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Phone Calls

The contractor may (but is not required to) continue to contact providers via telephone or e-mail to communicate non-receipt of revalidation applications.

B. Stay of Enrollment and Non-Responses to Revalidation Requests

(The contractor shall follow existing guidance regarding the application of stays of enrollment in revalidation situations, including that in section 10.4.9(D) of this chapter.)

No later than 5 business days after sending the applicable deactivation letter per existing guidance -- and if the deactivated supplier is a physician – the contractor shall search *the physician's* associate record to determine if *the individual* serves as a supervising physician on any independent diagnostic testing facility (IDTF) enrollment. If *the physician* does, the contractor shall disassociate *the individual* as the supervising physician for that entity. If *the individual* is the only supervising physician on file for the IDTF, the contractor shall develop for an active supervising physician to bring the IDTF into compliance. The contractor shall give the IDTF 30 days to respond. Failure to provide an active supervising physician in the designated timeframe shall result in revocation of the IDTF's billing privileges for non-compliance with the IDTF standards.

10.4.7.1 – Revocations – Background and General Requirements

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Introduction

Medicare revokes currently enrolled providers/suppliers' Medicare billing privileges and corresponding provider/supplier agreements pursuant to federal regulations at 42 CFR § 424.535. (A Medicare revocation is a "termination" as defined at 42 CFR § 455.101.) A revocation of Medicare billing privileges does not affect a provider's ability to submit claims to non-Medicare payers using *the provider's* NPI.

If the contractor determines that a provider's billing privileges should be revoked or receives information from PEOG that a provider's billing privileges should be revoked, it shall undertake activities to process the revocation, apply the revocation in PECOS, notify the provider, and afford appeal rights. This section 10.4.7.1 includes, but is not limited to, information concerning the contractor's responsibilities to:

(i) Prepare a draft revocation letter

(ii) E-mail the letter to the appropriate PEOG mailbox with additional pertinent information regarding the basis for revocation

(iii) Receive PEOG's determination and follow PEOG's instructions regarding the case

(iv) If PEOG authorizes the revocation: (a) revoke the provider's billing privileges effective on the appropriate date; (b) establish the applicable reenrollment bar; (c) update PECOS with the appropriate reenrollment bar length; (d) assess an overpayment, as applicable; and (e) send the revocation letter (including affording appeal rights) to the provider via certified mail.

B. Administrative Requirements

This section 10.4.7.1(B) addresses (in greater specificity than section 10.4.7.1(A)) certain contractor administrative activities pertaining to revocations. As stated in section 10.4.7.1(A), however, the contractor shall take into account the instructions in sections 10.6.6 and 10.7 et seq.

1. Processing Timeframes

If the contractor receives approval from PEOG (or receives an unrelated request from PEOG) to revoke a provider's billing privileges, the contractor shall complete all steps associated with the revocation no later than five (5) business days from the date it received PEOG's approval/request. The contractor shall notify PEOG that it has completed all revocation steps no later than three (3) business days after completion.

2. Revocation Letters - Contents

i. General Information

When the contractor discovers a basis for revoking a provider's enrollment under 42 CFR § 424.535 - and, if applicable under section 10.6.6 of this chapter or another CMS directive,

receives PEOG's approval for the revocation - the contractor shall revoke billing privileges and notify the provider by letter. The revocation letter shall contain:

(a) A legal (i.e., regulatory, such as § 424.535(a)(3) or §424.535(a)(9)) basis for each reason for revocation (the contractor shall not use provisions from this chapter as the basis for revocation);

(b) A clear explanation of why Medicare billing privileges are being revoked, including the facts or evidence that the contractor used in making its determination;

(c) An explanation of why the provider does not meet the applicable enrollment criteria;

(d) The effective date of the revocation;

(e) Procedures for submitting a CAP (if revoked under § 424.535(a)(1));

(f) Complete and accurate information about the provider's appeal rights;

(g) Any other information contained in or required by the applicable model letter in section 10.7 et seq.

ii. One Letter Per Enrollment

The contractor shall issue a unique revocation letter per enrollment. For example, regarding revocation letters for solely owned organizations, when revoking a physician/non-physician practitioner's billing privileges and those of *the* solely owned organization, the contractor shall issue **two** revocation letter: one for the individual and the other for the solely owned organization. The contractor shall not issue one letter to convey revoked Medicare billing privileges for both the individual and the solely owned organization.

3. Revocation Letters – PEOG Approval

Using the guidance in this section 10.4.7.1(B) et seq., section 10.6.6, and section 10.7 et seq., the contractor shall determine whether it must submit its draft revocation letter to PEOG for approval prior to sending it to the provider.

i. Prior PEOG Approval Required

If prior PEOG approval of the letter is required, the contractor shall submit the letter to the appropriate PEOG mailbox for PEOG review. PEOG will examine the letter for technical correctness and determine matters such as: (1) whether the revocation affects the revoked provider's other locations; (2) the length and application of the reenrollment bar; and (3) the revocation effective date. PEOG will notify the contractor of the outcome of its review and instruct the contractor how to proceed.

The contractor shall not begin finalizing the revocation until it receives guidance from PEOG.

The contractor may not alter an approved revocation letter; if it needs to revise said letter, the contractor shall submit the letter to PEOG for a new review via the process described above.

Unless CMS has directed otherwise, the contractor shall document and report the impacted application/enrollment in its Monthly Status Reports.

ii. When PEOG Approval of Revocation Letter is Unnecessary

The contractor need not obtain prior PEOG approval of the revocation and the revocation letter if the revocation involves any of the following situations:

- § 424.535(a)(1) (for (a)(1) noncompliance issues other than Noncompliance – Not Professionally Licensed Individual Practitioners OR except as otherwise required in this chapter or another CMS directive)
- § 424.535(a)(6)
- § 424.535(a)(11)

4. Issuing the Revocation Letter to the Provider

The contractor shall send revocation letters by USPS certified mail. (The contractor may e-mail a follow-up copy of the letter after issuing it via USPS certified mail.) The contractor shall date and mail the letter on the same business day.

10.4.7.3 – Revocation Reasons

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

Sections 10.4.7.3(A) through (V) list the revocation reasons in 42 CFR § 424.535. Section 10.4.7.3(W) discusses extensions of revocations per 42 CFR § 424.535(i).

(NOTE: See section 10.2.2.4(V) of this chapter for instructions regarding the application of 42 CFR § 424.535(a)(1) and (23) to IDTF revocations. In the event of any inconsistency, the section 10.2.2.4(V) guidance takes precedence over that in section 10.4.7 et seq.)

A. Revocation Reason 1 – Noncompliance (42 CFR § 424.535(a)(1))

"The provider or supplier is determined not to be in compliance with the enrollment requirements in this Title 42 or in the enrollment application applicable to its provider or supplier type and has not submitted a plan of corrective action as outlined in 42 CFR Part 488. The provider or supplier may also be determined not to be in compliance if it has failed to pay any user fees as assessed under part 488 of this chapter."

(Title 42 includes the principal provider enrollment regulations in 42 CFR Part 424, subpart P; the IDTF enrollment standards in 42 CFR § 410.33; the OTP enrollment standards in 42 CFR § 424.67; etc.)

Noncompliance includes but is not limited to: (1) the provider/supplier no longer has a physical business address or mobile unit where services can be rendered; (2) the provider/supplier does

not have a place where patient records are stored to determine the amounts due such provider or other person; and/or (3) the provider/supplier no longer meets or maintains general enrollment requirements. Noncompliance also includes situations when the provider/supplier has failed to pay any user fees as assessed under 42 CFR Part 488.

Other situations (some of which were mentioned in the previous paragraph) in which § 424.535(a)(1) may be used as a revocation reason include, but are not limited to, the following:

- The provider or supplier does not have a physical business address or mobile unit where services can be rendered.

- The provider or supplier does not have a place where patient records are stored to determine the amounts due such provider or other person.

- The provider or supplier is not appropriately licensed. (NOTE: For (a)(1) revocations involving an individual practitioner who is not appropriately licensed due to a disciplinary action, PEOG -- rather than the contractor -- will make all determinations to revoke for this noncompliance requirement).

- The provider or supplier is not authorized by the federal/state/local government to perform the services that it intends to render.

- The provider or supplier does not meet CMS regulatory requirements for the specialty that it is enrolled as.

- The provider or supplier does not have a valid social security number (SSN) or employer identification number (EIN) for itself, an owner, partner, managing organization/employee, officer, director, medical director, and/or authorized or delegated official.

- The provider or supplier fails to furnish complete and accurate information and all supporting documentation within 60 calendar days of the provider/supplier's notification from CMS or its contractor to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information. (This revocation reason will not apply if CMS has instructed the contractor to use deactivation reason § 424.540(a)(3) in lieu thereof.)

- The provider or supplier does not otherwise meet general enrollment requirements.

(Concerning the last bullet above – and, as applicable, bullets 3, 4 and 5 – the contractor's revocation letter shall cite the appropriate statutory and/or regulatory citation(s) containing the specific licensure/certification/authorization requirement(s) for that provider/supplier type.)

Special Instructions Regarding Certified Providers/Suppliers – The SOG Location may involuntarily terminate a certified provider/supplier if the latter no longer meets CMS requirements, conditions of participation, or conditions of coverage. When this occurs, CMS terminates the provider'/supplier's provider agreement and notifies the contractor thereof. Upon receipt of the CMS notice (and except as otherwise stated in this chapter), the contractor shall

follow the revocation procedures in this chapter (including, as applicable, those in section 10.6.6)), using § 424.535(a)(1) as the revocation basis; the contractor shall not process the involuntary termination as a deactivation based upon a voluntary withdrawal from Medicare.

Note that the contractor need not (but certainly may) contact the SOG Location to obtain further details of the termination.

B. Revocation Reason 2 – Provider or Supplier Conduct (42 CFR § 424.535(a)(2))

"(i) The provider or supplier, or any owner, managing employee, managing organization, officer, director, authorized or delegated official, medical director, supervising physician, or other health care or administrative or management personnel furnishing services payable by a federal health care program, of the provider or supplier is:

(A) Excluded from the Medicare, Medicaid, and 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 Act.

(B) Is debarred, suspended, or otherwise excluded from participating in any other federal procurement or non-procurement program or activity in accordance with the FASA implementing regulations and the Department of Health and Human Services non-procurement common rule at 45 CFR part 76.

(ii) The individuals and organizations identified in paragraph (a)(2)(i) of this section include, but are not limited to, W–2 employees and contracted individuals and organizations of the provider or supplier."

If the contractor finds an excluded party (and unless section 10.6.6 states otherwise, in which case the latter section takes precedence), the contractor shall notify its PEOG BFL immediately. PEOG will notify the Contracting Officer's Representative (COR) for the appropriate Unified Program Integrity Contractor (UPIC). The COR will, in turn, contact the OIG for further investigation.

C. Revocation Reason 3 – Felony Conviction (42 CFR § 424.535(a)(3))

"The provider, supplier, or any owner, managing employee, managing organization, officer, or director of the provider or supplier was, within the preceding 10 years, convicted (as that term is defined in 42 CFR §1001.2) of a federal or state felony offense that CMS determines to be detrimental to the best interests of the Medicare program and its beneficiaries. [Under § 424.535(a)(3)(ii),] [o]ffenses include, but are not limited in scope and severity to:

- Felony crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.
- Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

- Any felony that placed the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.
- Any felonies that would result in mandatory exclusion under section 1128(a) of the Act.

[Under § 424.535(a)(3)(iii),] revocations based on felony convictions are for a period to be determined by the Secretary, but not less than 10 years from the date of conviction if the individual has been convicted on one previous occasion for one or more offenses."]

[Under § 424.535(a)(3)(iv),] the individuals and organizations identified in paragraph (a)(3) of this section include, but are not limited to, W–2 employees and contracted individuals and organizations of the provider or supplier.]

The expiration of a reenrollment bar issued pursuant to 42 CFR § 424.535(c) does not preclude CMS or its contractors from denying reenrollment to a provider that (i) was convicted of a felony within the preceding 10-year period or (ii) otherwise does not meet all criteria necessary to enroll in Medicare.

D. Revocation Reason 4 – False or Misleading Information on Application (42 CFR § 424.535(a)(4))

"The provider or supplier certified as ''true'' misleading or false information on the enrollment application to be enrolled or maintain enrollment in the Medicare program. (Offenders may be subject to either fines or imprisonment, or both, in accordance with current laws and regulations.)"

E. Revocation Reason 5 - On-Site Review/Other Reliable Evidence that Requirements Not Met (42 CFR § 424.535(a)(5))

"Upon on-site review or other reliable evidence, CMS determines that the provider or supplier:

(i) Is not operational to furnish Medicare-covered items or services; or
(ii) Otherwise fails to satisfy any Medicare enrollment requirement."

F. Revocation Reason 6 - Hardship Exception Denial and Fee Not Paid (42 CFR §424.535(a)(6))

(i) An institutional provider does not submit an application fee or hardship exception request that meets the requirements set forth in § 424.514 with the Medicare revalidation application; or

(ii) The hardship exception is not granted and the institutional provider does not submit the applicable application form or application fee within 30 days of being notified that the hardship exception request was denied.

(iii) Either of the following occurs:

- CMS is not able to deposit the full application amount into a government-owned account; or

- The funds are not able to be credited to the United States Treasury;

(iv) The provider or supplier lacks sufficient funds in the account at the banking institution whose name is imprinted on the check or other banking instrument to pay the application fee; or

(v) There is any other reason why CMS or its Medicare contractor is unable to deposit the application fee into a government-owned account.

G. Revocation Reason 7 – Misuse of Billing Number (42 CFR § 424.535(a)(7))

"The provider or supplier knowingly sells to or allows another individual or entity to use its billing number. This does not include those providers or suppliers that enter into a valid reassignment of benefits as specified in 42 CFR § 424.80 or a change of ownership as outlined in 42 CFR § 489.18."

H. Revocation Reason 8 – Abuse of Billing Privileges (42 CFR § 424.535(a)(8))

"Abuse of billing privileges includes either of the following:

(i) The provider or supplier submits a claim or claims for services that could not have been furnished to a specific individual on the date of service. These instances include but are not limited to the following situations:

(A) Where the beneficiary is deceased.

(B) The directing physician or beneficiary is not in the state or country when services were furnished.

(C) When the equipment necessary for testing is not present where the testing is said to have occurred.

(ii) CMS determines that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements. In making this determination, CMS considers, as appropriate or applicable, the following factors:

(A) The percentage of submitted claims that were denied during the period under consideration.

(B) Whether the provider or supplier has any history of final adverse actions (as that term is defined in § 424.502) and the nature of any such actions.

(C) The type of billing non-compliance and the specific facts surrounding said non-compliance (to the extent this can be determined).

(D) Any other information regarding the provider or supplier's specific circumstances that CMS deems relevant to its determination."

(**NOTE**: Concerning (a)(8), PEOG -- rather than the contractor -- will (1) make all determinations regarding whether a provider has a pattern or practice of submitting non-compliant claims; (2) consider the relevant factors; and (3) accumulate all information needed to make such determinations.)

I. Revocation Reason 9 – Failure to Report (42 CFR § 424.535(a)(9))

"The provider or supplier failed to comply with the reporting requirements specified in 42 CFR § 424.516(d) or (e), § 410.33(g)(2), or § 424.57(c)(2) [which pertain to the reporting of changes in adverse actions and practice locations]."

With respect to § 424.535(a)(9) (and except as otherwise stated in section 10.6.6):

- If the provider reports a change in practice location more than 30 days after the effective date of the change, the contractor shall not pursue a revocation on this basis. However, if the contractor independently determines – through an on-site inspection under 42 CFR § 424.535(a)(5)(ii) or via another verification process - that the provider's address has changed but the provider has not notified the contractor thereof within the aforementioned 30-day timeframe, the contractor may pursue a revocation (e.g., seeking PEOG's approval to revoke).

- If an IDTF reports a change in ownership, change of location, change in general supervision or change in adverse legal action more than 30 days after the effective date of the change, the contractor may pursue a revocation on this basis (e.g., seeking PEOG's approval to revoke).

- If a DMEPOS supplier reports a change of information more than 30 days after the effective date of the change, the contractor may pursue a revocation on this basis (e.g., seeking PEOG's approval to revoke).

J. Revocation Reason 10 – Failure to Document or Provide CMS Access to Documentation (42 CFR § 424.535(a)(10))

"The provider or supplier did not comply with the documentation requirements specified in 42 CFR § 424.516(f). A provider that furnishes any covered ordered, certified, referred, or prescribed Part A or B services, items or drugs is required to maintain documentation for 7 years."

K. Revocation Reason 11 - Home Health Agency (HHA) Capitalization (42 CFR § 424.535(a)(11))

"An HHA fails to furnish - within 30 days of a CMS or contractor request - supporting documentation verifying that the HHA meets the initial reserve operating funds requirement found in 42 CFR § 489.28(a)."

L. Revocation Reason 12 – Other Program Termination (42 CFR § 424.535(a)(12))

"The provider or supplier is terminated, revoked, or otherwise barred from participation in a particular State Medicaid Agency or any other federal health care program."

In making its determination, CMS considers the following factors listed in 42 CFR § 424.535(a)(12):

"(A) The reason(s) for the termination or revocation;

(B) Whether the provider or supplier is currently terminated, revoked, or otherwise barred from more than one program (for example, more than one state's Medicaid program) or has been subject to any other sanctions during its participation in other programs; and;

(C) Any other information that CMS deems relevant to its determination."

Under § 424.535(a)(12)(ii), "Medicare may not revoke [a provider/supplier's Medicare billing privileges] unless and until the provider or supplier has exhausted all applicable appeal rights or the timeframe for filing an appeal has expired without the provider or supplier filing an appeal."

M. Revocation Reason 13 - Prescribing Authority (42 CFR § 424.535(a)(13))

"(i) The physician or eligible professional's Drug Enforcement Administration (DEA) Certificate of Registration is suspended or revoked or is surrendered in response to an order to show cause; or

(ii) The applicable licensing or administrative body for any state in which the physician or eligible professional practices suspends or revokes the physician's or other eligible professional's ability to prescribe drugs."

N. Revocation Reason 14 – Improper Prescribing Practices (42 CFR § 424.535(a)(14))

"CMS determines that the physician or other eligible professional has a pattern or practice of prescribing Part B or D drugs that falls into one of the following categories:

(i) The pattern or practice is abusive or represents a threat to the health and safety of Medicare beneficiaries or both. In making this determination, CMS considers the following factors:

(A) Whether there are diagnoses to support the indications for which the drugs were prescribed;

(B) Whether there are instances when the necessary evaluation of the patient for whom the drug was prescribed could not have occurred (for example, the patient was deceased or out of state at the time of the alleged office visit);

(C) Whether the physician or eligible professional has prescribed controlled substances in excessive dosages that are linked to patient overdoses;

(D) The number and type(s) of disciplinary actions taken against the physician or eligible professional by the licensing body or medical board for the State or States in which the *individual* practices, and the reason(s) for the action(s);

(E) Whether the physician or eligible professional has any history of final adverse actions (as that term is defined in § 424.502);

(F) The number and type(s) of malpractice suits that have been filed against the physician or eligible professional related to prescribing that have resulted in a final judgment against the physician or eligible professional or in which the physician or eligible professional has paid a settlement to the plaintiff(s) (to the extent this can be determined);

(G) Whether any State Medicaid program or any other public or private health insurance program has restricted, suspended, revoked, or terminated the physician or eligible professional's ability to prescribe medications, and the reason(s) for any such restriction, suspension, revocation, or termination; and

(H) Any other relevant information provided to CMS.

(ii) The pattern or practice of prescribing fails to meet Medicare requirements. In making this determination, CMS considers the following factors:

(A) Whether the physician or eligible professional has a pattern or practice of prescribing without valid prescribing authority.

(B) Whether the physician or eligible professional has a pattern or practice of prescribing for controlled substances outside the scope of the prescriber's DEA registration.

(C) Whether the physician or eligible professional has a pattern or practice of prescribing drugs for indications that were not medically accepted - that is, for indications neither approved by the FDA nor medically accepted under section 1860D-2(e)(4) of the Act - and whether there is evidence that the physician or eligible professional acted in reckless disregard for the health and safety of the patient."

(**NOTE**: Concerning (a)(14), PEOG -- rather than the contractor -- will (1) make all determinations regarding whether a provider/supplier has a pattern or practice of prescribing Part B or D drugs; (2) consider the relevant factors; and (3) accumulate all information needed to make such determinations.)

O. Revocation Reason 15 – False Claims Act Judgment (42 CFR § 424.535(a)(15))

"(i) The provider or supplier, or any owner, managing employee or organization, officer, or director of the provider or supplier, has had a civil judgment under the False Claims Act (31 U.S.C. 3729 through 3733) imposed against them within the previous 10 years.

(ii) In determining whether a revocation under this paragraph is appropriate, CMS considers the following factors:

(A) The number of provider or supplier actions that the judgment incorporates (for example, the number of false claims submitted)

(B) The types of provider or supplier actions involved

(C) The monetary amount of the judgment

(D) When the judgment occurred

(E) Whether the provider or supplier has any history of final adverse actions (as that term is defined in § 424.502)

(F) Any other information that CMS deems relevant to its determination."

NOTE: With respect to (a)(15), PEOG -- rather than the contractor – will make all determinations regarding whether this provision applies.

P. Revocation Reason 17 – Debt Referred to the United States Department of Treasury (42 CFR § 424.535(a)(17))

"The provider or supplier has failed to repay a debt that CMS appropriately refers to the United States Department of Treasury." In determining whether a revocation is appropriate, CMS considers the following factors:

"(i)(A) The reason(s) for the failure to fully repay the debt (to the extent this can be determined);

(B) Whether the provider or supplier has attempted to repay the debt (to the extent this can be determined);

(C) Whether the provider or supplier has responded to CMS' requests for payment (to the extent this can be determined);

(D) Whether the provider or supplier has any history of final adverse actions or Medicare or Medicaid payment suspensions;

(E) The amount of the debt; and

(F) Any other evidence that CMS deems relevant to its determination."

(NOTE: With respect to (a)(17):

- Section 424.535(a)(17)(ii) excludes from paragraph (a)(17)(i)'s purview those cases where: (1) the provider's or supplier's Medicare debt has been discharged by a bankruptcy court; or (2) the administrative appeals process concerning the debt has not been exhausted or the timeline for filing such an appeal, at the appropriate appeal level, has not expired.
- PEOG – rather than the contractor – will make all (a)(17) determinations.

Q. Revocation Reason 18 – Revoked Under a Different Name, Numerical Identifier or Business Identity (42 CFR § 424.535(a)(18))

"The provider or supplier is currently revoked [from Medicare] under a different name, numerical identifier, or business identity, and the applicable reenrollment bar period has not expired." In making its determination, CMS considers the following factors:

"(i) Owning and managing employees and organizations (regardless of whether they have been disclosed on the Form CMS-855 [or CMS-20134] application);

(ii) Geographic location;

(iii) Provider or supplier type;

(iv) Business structure; or

(v) Any evidence indicating that the two parties [the revoked provider or supplier and newly enrolling provider or supplier] are similar or that the provider or supplier was created to circumvent the revocation or reenrollment bar."

(NOTE: Concerning (a)(18), PEOG – rather than the contractor – will make all determinations regarding whether a provider/supplier was revoked under a different name, numerical identifier, or business identity.)

R. Revocation Reason 19 – Affiliation that Poses an Undue Risk (42 CFR § 424.535(a)(19))

1. Specific Reason

"The provider or supplier has or has had an affiliation under 42 CFR § 424.519 that poses an undue risk of fraud, waste and abuse to the Medicare program." In making this determination, CMS considers the following factors listed in 42 CFR § 424.519(f)(1) through (6):

"(1) The duration of the affiliation

(2) Whether the affiliation still exists and, if not, how long ago it ended

(3) The degree and extent of the affiliation

(4) If applicable, the reason for the termination of the affiliation

(5) Regarding the affiliated provider/supplier's disclosable event [under § 424.519(b)]:

(i) The type of disclosable event.

(ii) When the disclosable event occurred or was imposed.

(iii) Whether the affiliation existed when the disclosable event occurred or was imposed.

(iv) If the disclosable event is an uncollected debt: (A) the amount of the debt; (B) whether the affiliated provider or supplier is repaying the debt; and (C) to whom the debt is owed.

(v) If a denial, revocation, termination, exclusion, or payment suspension is involved, the reason for the disclosable event.

(6) Any other evidence that CMS deems relevant to its determination."

2. Definition of Affiliation

For purposes of § 424.519 only, 42 CFR § 424.502 defines "affiliation" as:

- A 5 percent or greater direct or indirect ownership interest that an individual or entity has in another organization.

- A general or limited partnership interest (regardless of the percentage) that an individual or entity has in another organization.

- An interest in which an individual or entity exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operations of another organization (including, for purposes of [§ 424.519 only], sole proprietorships), either under contract or through some other arrangement, regardless of whether or not the managing individual or entity is a W–2 employee of the organization.

- An interest in which an individual is acting as an officer or director of a corporation.

- Any reassignment relationship under § 424.80."

(NOTE: Concerning (a)(19), PEOG -- rather than the contractor -- will make all determinations regarding whether a provider/supplier has an affiliation per § 424.519 that poses an undue risk of fraud, waste, and abuse.)

S. Revocation Reason 20 – Billing from a Non-Compliant Location (42 CFR § 424.535(a)(20))

"CMS may revoke a provider's or supplier's Medicare enrollment or enrollments, even if all the practice locations associated with a particular enrollment comply with Medicare enrollment requirements, if the provider or supplier billed for services performed at or items furnished from a location that it knew or should have known did not comply with Medicare enrollment requirements. In determining whether and how many of the provider/supplier's enrollments (involving the non-compliant location or other locations) should be revoked, CMS considers the following factors [enumerated in § 424.535(a)(20)(i) through (vii)]:

- The reason(s) for and the specific facts behind the location's non-compliance;

- The number of additional locations involved;

- The provider or suppliers possibly history of final adverse actions or Medicare or Medicaid payment suspensions;

- The degree of risk the location's continuance poses to the Medicare Trust Funds;

- The length of time that the location was considered non-compliant;

- The amount that was billed for services performed at or items furnished from the non-compliant location; and,

- Any other evidence that CMS deems relevant to its determination."

(NOTE: Concerning (a)(20), PEOG – rather than the contractor – will make all determinations regarding whether a provider/supplier has performed services or furnished items from a location that did not comply with Medicare enrollment requirements.)

T. Revocation Reason 21 – Abusive Ordering, Certifying, Referring, or Prescribing of Part A or B Services, Items or Drugs (42 CFR § 424.535(a)(21))

"The physician or eligible professional has a pattern or practice of ordering, certifying, referring or prescribing Medicare Part A or B services, items or drugs that is abusive, represents a threat to the health and safety of Medicare beneficiaries, or otherwise fails to meet Medicare requirements." In making its determination, CMS considers the following factors [enumerated in § 424.535(i) through (ix)]:

- Whether the physician or eligible professional's diagnosis supports the order, certification, referral or prescription in question;

- Whether there are instances where the necessary evaluation of the patient for whom the order, certification, referral or prescription could have not occurred (for example: the patient was deceased or out of state at the time of the alleged office visit);

- The number and types of disciplinary actions taken against the physician or eligible professional by the licensing body or medical board for the state(s) in which *the individual* practices and the reason(s) for the action(s);

- Whether the physician or eligible professional has any history of final adverse actions (as defined by 42 CFR § 424.502);

- The length of time over which the pattern or practice has continued;

- How long the physician or eligible professional has been enrolled in Medicare;

- The number of type(s) of malpractice suits that have been filed against the physician or eligible professional related to ordering, certifying, referring or prescribing that resulted in a

final judgement against the physician or eligible professional or the physician or eligible professional paid a settlement to the plaintiff(s) (to the extent this can be determined);

- Whether any State Medicaid Agency (SMA) or other public health insurance program has restricted, suspended, revoked or terminated the physician's or eligible professional's ability to practice medicine and reason for any such restriction, suspension, revocation or termination; and

- Any other information that CMS deems relevant to its determination.

(NOTE: Concerning (a)(21), PEOG – rather than the contractor – will make all determinations regarding whether a physician or eligible professional has a pattern or practice of ordering, certifying, referring or prescribing Medicare Part A or B services, items, or drugs that is abusive, threatening to the safety of Medicare beneficiaries, or fails to meet Medicare requirements).

U. Revocation Reason 22 – Patient Harm (42 CFR § 424.535(a)(22))

The physician or other eligible professional has been subject to prior action from a state oversight board, federal or state health care program, Independent Review Organization (IRO) determination(s), or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health care with underlying facts reflecting improper physician or other eligible professional conduct that led to patient harm. In determining whether a revocation is appropriate, CMS considers the following factors [enumerated in § 424.535(a)(22)(i)(A) through (E)):

(A) The nature of the patient harm.
(B) The nature of the physician's or other eligible professional's conduct.
(C) The number and type(s) of sanctions or disciplinary actions that have been imposed against the physician or other eligible professional by the state oversight board, IRO, federal or state health care program, or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health care. Such actions include, but are not limited to in scope or degree:

(i) License restriction(s) pertaining to certain procedures or practices.

(ii) Required compliance appearances before State medical board members.

(iii) License restriction(s) regarding the ability to treat certain types of patients.

(iv) Administrative or monetary penalties.

(v) Formal reprimand(s).

(D) If applicable, the nature of the IRO determination(s).

(E) The number of patients impacted by the physician/other eligible professional's conduct and the degree of harm thereto or impact upon."

(Per 42 CFR § 424.535(a)(22)(ii), paragraph (a)(22) does not apply to actions or orders pertaining exclusively to either of the following:

- Required participation in rehabilitation or mental/behavioral health programs; or
- Required abstinence from drugs or alcohol and random drug testing.)

V. Revocation Reason 23 – Standard or Condition Violation (42 CFR § 424.535(a)(23))

(i) The independent diagnostic testing facility is non-compliant with any provision in 42 CFR 410.33(g). (See section 10.2.2.4(V) for more information. The instructions in that section supersede those in this section 10.4.7.3(V).)

(ii) The DMEPOS supplier is non-compliant with any provision in § 424.57(c).

(iii) The opioid treatment program is non-compliant with any provision in § 424.67(b) or (e).

(iv) The home infusion therapy supplier is non-compliant with any provision in § 424.68(c) or (e).

(v) The Medicare diabetes prevention program is non-compliant with any provision in § 424.205(b) or (c).

(The contractor can make revocation determinations under § 424.535(a)(23) without prior PEOG approval. The contractor's revocation letter shall cite the exact statutory and/or regulatory citation(s) containing the specific standard/condition with which the provider/supplier is non-compliant. For a listing of some of these statutes and regulations, refer to section 10.2 et seq. of this chapter.)

(See section 10.4.7.5(A) for more information regarding § 424.535(a)(23).)

W. Extension of Revocation

If a provider's Medicare enrollment is revoked under § 424.535(a), CMS may revoke any and all of the provider's Medicare enrollments, including those under different names, numerical identifiers or business identities and those under different types. In determining whether to revoke a provider's other enrollments, CMS considers the following factors:

(i) The reason for the revocation and the facts of the case;

(ii) Whether any final adverse actions have been imposed against the provider or supplier regarding its other enrollments;

(iii) The number and type(s) of other enrollments; and

(iv) Any other information that CMS deems relevant to its determination.

10.4.7.4 – Reenrollment Bar

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

If any inconsistency exists between an instruction in this section 10.4.7.4 and a directive in section 10.6.6, the latter instruction takes precedence. In addition, the contractor shall adhere to any instruction in section 10.6.6 that addresses a reenrollment bar matter not discussed in section 10.4.7.4.

A. Background

As stated in 42 CFR § 424.535(c), if a provider/supplier has billing privileges revoked, the *provider/supplier* is barred from participating in the Medicare program from the effective date of the revocation until the end of the reenrollment bar. The reenrollment bar begins 30 days after CMS or its contractor mails notice of the revocation and lasts a minimum of 1 year, but not greater than 10 years, depending on the severity of the basis for revocation. In addition, CMS may impose a reenrollment bar of up to 20 years if the provider/supplier is being revoked from Medicare for the second time.

Per § 424.535(c), the reenrollment bar does not apply if the revocation: (i) is based on § 424.535(a)(1); and (ii) stems from a provider/supplier's failure to respond timely to a revalidation request or other request for information. If both of these conditions are met, no reenrollment bar will be applied.

The contractor shall update PECOS to reflect that the individual cannot participate in Medicare for the applicable length of the reenrollment bar. Except as otherwise stated in this chapter, PEOG (rather than the contractor) determines reenrollment bars that exceed 3 years.

In addition, CMS may add up to 3 more years to the provider/supplier's reenrollment bar if it determines that the provider/supplier is attempting to circumvent its existing reenrollment bar.

B. Establishment of Length

The following serves merely as general, non-binding guidance regarding the establishment of the length of reenrollment bars. It is crucial to note that every situation must and will be judged on its own merits, facts, and circumstances. It should not be assumed that a particular timeframe will always be applied to a specific revocation reason in all cases. CMS retains the discretion to apply a reenrollment bar period that is different from that indicated below (though which in no case will be greater than 10 to 20 years).

- § 424.535(a)(1) (Noncompliance) – 1 year
- §424.535(a)(6) (Grounds Related to Screening) – 1 year
- §424.535(a)(11) (Initial Reserve Operating Funds) – 1 year
- §424.535(a)(23) (Provider/Supplier Standards) – 1 year

The following revocation reasons will receive reenrollment bar lengths per CMS discretion:

- §424.535(a)(1) (Noncompliance- Not Professionally Licensed Individual Practitioners)

- §424.535(a)(2) (Provider or supplier conduct)
- §424.535(a)(3) (Felonies)
- §424.535(a)(4) (False or misleading information)
- §424.535(a)(5) (On-site review)
- §424.535(a)(7) (Misuse of billing number)
- §424.535(a)(8) (Abuse of billing privileges)
- §424.535(a)(9) (Failure to Report)
- §424.535(a)(10) (Failure to document or provide CMS access to documentation)
- §424.535(a)(12) (Other program termination)
- §424.535(a)(13) (Prescribing authority)
- §424.535(a)(14) (Improper Prescribing Practices)
- §424.535(a)(15) (False Claims Act Civil Judgment)
- §424.535(a)(17) (Debt Referred to the United States Department of Treasury)
- §424.535(a)(18) (Revoked Under a Different Name, Numerical Identifier or Business Identity)
- §424.535(a)(19) (Affiliation that Poses an Undue Risk)
- §424.535(a)(20) (Billing from a Non-Compliant Location)
- §424.535(a)(21) (Abusive ordering, certifying, referring, or prescribing of Part A or B services, items, or drugs)
- §424.535(a)(22) (Patient Harm)

C. Applicability of Bar

1. Revocation Reasons Other Than § 424.535(a)(1), (a)(5), (a)(6), (a)(9), (a)(10), (a)(11), and (a)(23).

In general, and unless stated otherwise above, any reenrollment bar at a minimum applies to: (1) all practice locations under the provider's PECOS or legacy enrollment record; and (2) any effort to reestablish any of these locations (i) at a different address and/or (ii) under a different business or legal identity, structure, or TIN. If the contractor receives an application and is unsure whether a revoked provider is attempting to reestablish a revoked location, it shall contact its PEOG BFL for guidance. Instances where the provider might be attempting to do so include - but are not limited to – the following:

SCENARIO 1 - Smith was the sole owner of Group Practice X, a sole proprietorship. Six months after X was revoked under § 424.535(a)(9), the contractor receives an initial application from Group Practice Medicine, LLC, of which Smith is the sole owner/member.

SCENARIO 2 - Jones and Smith were 50 percent owners of World Home Health Agency, a partnership. One year after World Home Health was revoked under § 424.535(a)(7), the contractor receives an initial application from XYZ Home Health, a corporation owned by Jones and *spouse*.

SCENARIO 3 - Smith was the sole owner of XYZ Medical Supplies, Inc. XYZ's lone location was at 1 Jones Street. XYZ's billing privileges were revoked after it was determined that the site was non-operational. Nine months later, the contractor receives an initial application from

Johnson Supplies, LLC. The entity has two locations in the same city in which 1 Jones Street is located. Smith is listed as a 75 percent owner.

2. Revocation Reasons § 424.535(a)(1), (a)(5), (a)(6), (a)(9), (a)(10), (a)(11), and (a)(23)

For these revocation reasons, any reenrollment bar applies only to the specific enrollment that was the subject of the reenrollment bar.

D. Discussing Provider Enrollment Appeals Process in Revocation Letter

(If a conflict exists between the instructions in this section 10.4.7.4(D) and those in either (i) those in section 10.6.18 or (ii) the language in the applicable model letter in section 10.7 et seq., the guidance in section 10.6.18 or the model letter takes precedence.)

In the revocation letter, the contractor shall include information concerning the provider's appeal rights. The following table summarizes where the provider must send a corrective action plan (CAP) and/or reconsideration request.

	CAP requests should be sent to:		**Reconsideration request should be sent to:**	
Revocation Regulation	**Institutional***	**Non-institutional**	**Institutional***	**Non-Institutional**
424.535(a)(1) related to an enrollment requirement (i.e., 425.516)	Alone or in combination: CMS	MAC	CMS	MAC
424.535(a)(1) Licensure	CAP rights (to CMS)	CAP rights (to the MAC)	CMS	MAC
424.535(a)(1) DME or IDTF	CAP rights (to CMS)	CAP rights (to the MAC)	CMS	MAC
424.535(a)(2) Exclusion	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(2) Debarment	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(3)	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(4)	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(5)	No CAP rights	No CAP rights	CMS	MAC
424.535(a)(6)	No CAP rights	No CAP rights	CMS	MAC
424.535(a)(7)	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(8)	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(9)	No CAP rights	No CAP rights	CMS	MAC
424.535(a)(10)	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(11)	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(12)	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(13)	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(14)	No CAP rights	No CAP rights	CMS	CMS

	CAP requests should be sent to:		Reconsideration request should be sent to:	
Revocation Regulation	**Institutional***	**Non-institutional**	**Institutional***	**Non-Institutional**
424.535(a)(15)	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(17)	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(18)	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(19)	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(20)	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(21)	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(22)	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(23)	No CAP rights	No CAP rights	CMS	CMS

* Institutional providers:

- Ambulance Service Supplier
- Ambulatory Surgery Centers
- CLIA Labs
- Community Mental Health Center
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Critical Access Hospitals
- End Stage Renal Disease (ESRDs)
- Federally Qualified Health Centers (FQHCs)
- Histocompatibility Laboratories
- Home Health Agencies
- Home Infusion Therapy Suppliers
- Hospices
- Hospitals and Hospital Units
- Independent Diagnostic Testing Facilities (IDTFs)
- Intensive Cardiac Rehabilitation
- Indian Health Service Facility
- Mammography Screening Centers
- Mass Immunization/Flu Roster Billers
- Medicare Diabetes Prevention Programs (MDPPs)
- Opioid Treatment Centers (OTPs)
- Organ Procurement Organizations (OPOs)
- Outpatient Physical Therapy/Outpatient Speech Pathology Services (OPT/OSP)
- Pharmacies
- Portable X-Ray Suppliers (PXRSs)
- Radiation Therapy Centers
- Rehabilitation Services
- Religious Non-Medical Health Care Institutions (RNCHIs)
- Rural Health Clinics (RHCs)
- Skilled Nursing Facilities (SNFs)

The CMS defines "institutional provider" in 42 CFR § 424.502 to mean any provider/supplier that submits a paper Medicare enrollment application using the Form CMS-855A, Form CMS-855B (except physician and non-physician practitioner organizations), or Form CMS-855S, or the associated Internet-based PECOS enrollment application. (Note that MDPP suppliers no longer fall within this regulatory definition of institutional provider. Per 42 CFR § 424.205(b)(5), the provider enrollment application fee is inapplicable to all MDPP suppliers that submit a Form CMS-20134 enrollment application. Solely for purposes of appeal submissions, however, MDPP suppliers are included in the bulleted list above.)

10.4.8.1 – Deactivation Rebuttals

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Background

Pursuant to 42 CFR § 424.546, a provider/supplier whose Medicare billing privileges have been deactivated under 42 CFR § 424.540(a) may file a rebuttal. A rebuttal is an opportunity for the provider/supplier to demonstrate that it meets all applicable enrollment requirements and that its Medicare billing privileges should not have been deactivated. Only one rebuttal request may be submitted per enrollment deactivation. Additional rebuttal requests submitted for the same deactivated enrollment for which a rebuttal has already been received shall be dismissed.

If an application is received for a deactivated provider/supplier while a rebuttal submission is pending or during the rebuttal submission timeframe, the contractor shall process the application consistent with current processing instructions. If the rebuttal determination is issued and overturns the deactivation prior to an application being approved, the contractor shall return the application received while the rebuttal determination was pending unless: (1) the submitted application is required to reactivate the provider/supplier's enrollment; or (2) if there are new changes being reported. If an application (1) is received while a rebuttal submission is pending, (2) is approved prior to the issuance of a rebuttal determination, and (3) results in the provider's or supplier's enrollment being reactivated without a gap in billing privileges, the contractor shall stop processing the rebuttal submission and issue an applicable moot letter.

B. Notification Letters for Deactivations

If a basis is found to deactivate a provider's or supplier's Medicare billing privileges under one of the regulatory authorities in 42 C.F.R. § 424.540, the contractor shall deactivate the provider/supplier unless another CMS directive applies. If a revocation authority is applicable, the contractor shall follow the instructions in sections 10.4.7 and 10.4.8 et seq. of this chapter in lieu of deactivating the enrollment. If no revocation authority applies, the contractor shall send notification of the deactivation using the applicable model deactivation notice. The contractor shall send a notification letter for every deactivated enrollment. The contractor shall ensure the deactivation notice contains sufficient details so it is clear why the provider's or supplier's Medicare billing privileges are being deactivated. The contractor shall send the deactivation notification letter via hard-copy mail and via e-mail (if a valid email address is available); the contractor should also send the notice via fax if a valid fax number is available. All notifications shall be saved in PDF format, and all notification letters shall be mailed on the same date listed on the letter.

C. Rebuttal Submissions

1. Requirements and Submission of Rebuttals

Pursuant to 42 C.F.R. § 424.546(b), to be accepted and processed, the rebuttal submission must:

(1) Be in writing;

(2) Specify the facts or issues concerning the rebuttal with which the provider or supplier disagrees, and the reasons for disagreement;

(3) Include all documentation the provider or supplier wants CMS to consider in its review of the deactivation;

(4) Be submitted in the form of a letter that is signed and dated by the individual supplier (if enrolled as an individual physician or nonphysician practitioner), the authorized official or delegated official (as those terms are defined in 42 C.F.R. § 424.502), or a legal representative (as defined in 42 C.F.R. § 498.10);

- If the legal representative is an attorney, the attorney must include a statement that *the attorney has* the authority to represent the provider or supplier; this statement is sufficient to constitute notice of such authority.
- If the legal representative is not an attorney, the provider or supplier must file with CMS written notice of the appointment of a representative; this notice of appointment must be signed and dated by, as applicable, the individual supplier, the authorized official or delegated official, or a legal representative.
- Authorized or delegated officials for groups cannot sign and submit a rebuttal on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on the *reassigned provider's/supplier's* behalf.
- Signatures may be original or electronic. Valid signatures include handwriting (wet) signatures in ink and digital/electronic signatures. Digital or electronic signatures such as those created by digital signature options, created in software, such as Adobe) and email signatures shall be accepted. Contractors shall contact ProviderEnrollmentAppeals@cms.hhs.gov for questions regarding electronic and digital signatures.

(5) Be received by the contractor within 15 calendar days from the date of the deactivation notice. The contractor shall accept a rebuttal submission via hard-copy mail, e-mail, and/or fax;

If the rebuttal submission is not appropriately signed or if a statement from the attorney or written notice of representation is not included in the submission, the contractor shall send a development request for a proper signature or the missing statement/written notice (using the applicable model letter) before dismissing the rebuttal submission. The contractor shall allow 15

calendar days from the date of the development request letter for the rebuttal submitter to respond to the development request.

If a rebuttal submission: (1) is not appropriately signed and no response is received to the development request (if applicable); (2) is untimely (as described above); (3) does not specify the facts or issues with which the provider/supplier disagrees and the reasons for disagreement and no response is received to the development request; or (4) is a duplicative submission, the contractor shall dismiss the rebuttal submission using the applicable Rebuttal Dismissal Model Letter. For those rebuttal submissions that are improperly signed and/or do not specify the facts or issue with which the provider or supplier disagrees and the reasons for disagreement, the contractor shall send a development request via hard-copy mail, email, if available, to the provider/supplier requesting a proper signature and/or clarification on the facts or issues with which the provider or supplier disagrees and the reasons for disagreement using the applicable Rebuttal Development Model Letter. Sending the development letter via fax is optional. The contractor shall grant an additional 15-calendar days from the date of the development request letter for the provider or supplier to submit an acceptable rebuttal submission. If no response is received or the rebuttal submission is still deficient after the development request and the 15-calendar day timeframe has expired, the contractor shall dismiss the rebuttal submission using the applicable Rebuttal Dismissal Model Letter.

The contractor may make a good cause determination to accept any rebuttal that has been submitted beyond the 15 calendar-day filing timeframe. Good cause may be found where there are circumstances beyond the provider's or supplier's control that prevented the timely submission of a rebuttal. These uncontrollable circumstances do not include the provider/supplier's failure to timely update its enrollment information, specifically its various addresses. If the contractor believes good cause exists to accept an untimely rebuttal submission, the contractor shall send a request approval email to ProviderEnrollmentAppeals@cms.hhs.gov within five calendar days of making the good cause determination. This email shall detail the contractor's reasoning for finding good cause. Processing timeliness standards shall begin on the date the contractor receives a response from CMS.

2. Time Calculations for Rebuttal Submissions

If the 15th calendar day from the date on the deactivation notice falls on a weekend or federally-recognized holiday, the rebuttal shall be accepted as timely if the contractor received it by the next business day.

It is the provider's or supplier's responsibility to timely update *the provider's/supplier's* enrollment record to reflect any changes to the provider's or supplier's enrollment information including, but not limited to, its correspondence address. Failure to timely update a correspondence address or other addresses included in its Medicare enrollment record does not constitute an "in fact" showing that the deactivation notice was received after the presumed receipt date (as described above).

3. Processing Rebuttal Submissions

The contractor shall send an acknowledgement letter via hard-copy mail to the return address on the rebuttal submission within 10 calendar-days of receipt of the accepted rebuttal request using

the Rebuttal Acknowledgment Model Letter, including a rebuttal tracking number and the provider's or supplier's NPI. The acknowledgement letter shall also be sent via email if a valid email address is available (either in the enrollment record or rebuttal submission). It is optional for the contractor to send the acknowledgement letter via fax if a valid fax number is available. If a rebuttal determination is issued within 10 calendar-days of the date of receipt of the rebuttal submission then the contractor is not required to issue a receipt acknowledgement letter.

The contractor shall process all accepted rebuttal submissions within 30 calendar-days of the date of receipt. If, while reviewing the rebuttal submission, the provider or supplier wishes to withdraw its rebuttal, the request to withdraw must be submitted to the contractor in writing before the rebuttal determination is issued. If a provider or supplier submits a written request to withdraw its rebuttal submission prior to the issuance of a rebuttal determination then the contractor shall issue a letter using the applicable Rebuttal Withdrawn Model Letter and no rebuttal determination shall be issued.

The contractor's review of the rebuttal submission shall only consist of whether the provider or supplier met the enrollment requirements and if billing privileges were deactivated appropriately. All materials received by the provider/supplier shall be considered by the contractor in its review.

4. Reason-Specific Instructions

a. § 424.540(a)(1)

For deactivations under § 424.540(a)(1), the contractor shall review submitted documentation and internal systems to confirm whether billing occurred during the 6-month period preceding the date of deactivation, starting with the first day of the first month 6 months prior to the date of deactivation. If it is confirmed that billing occurred within 6 months, the contractor shall issue a favorable rebuttal determination. If no billing occurred during the 6-month period prior to the date of deactivation, the contractor shall issue an unfavorable rebuttal determination. Consider the following illustration:

EXAMPLE: Dr. Awesome has been enrolled in Medicare since 2010. A review of billing data reveals that Dr. Awesome has not submitted any Medicare claims since January 2019. Dr. Awesome's enrollment is deactivated, under 42 C.F.R. § 424.540(a)(1), effective January 1, 2020. Dr. Awesome timely submits a rebuttal in response to the deactivation. Upon review by the contractor, it is confirmed that Dr. Awesome had not submitted claims since January 2019. Therefore, an unfavorable rebuttal determination would therefore be appropriate in this scenario, for the deactivation was appropriate.

b. § 424.540(a)(2)

For deactivations under § 424.540(a)(2), the contractor shall review the submitted documentation and internal records to determine whether the change of information was properly submitted within the required timeframe. The required timeframe to submit updated information is described at 42 C.F.R. §§ 424.550, 410.33(g)(2), 424.57(c)(2), and 424.516(d). If information was submitted properly and timely, the contractor shall approve the rebuttal submission, issue a favorable rebuttal determination, and reinstate the provider 's or supplier's Medicare billing

privileges to an approved status. If it was not submitted properly and timely, the contractor shall deny the rebuttal request and issue an unfavorable rebuttal determination, as the deactivation was appropriate. In making this determination, the contractor shall consider, at minimum, the following.

- Whether the deactivation was implemented after the required timeframe to report a change of enrollment information elapsed;
- Whether the letter notifying the provider/supplier of the deactivation was sent to the correct address as instructed in section 10.7 et seq. of this chapter; and
- Whether the enrollment changes were received in an enrollment application that was processed to completion within the required timeframe.

Consider the following illustration:

EXAMPLE: Dr. Happy has reassigned benefits to a physician group, Smile, LLC. Smile, LLC is Dr. Happy's only reassignment and only practice location. Smile, LLC's enrollment and corresponding billing privileges are revoked effective January 1, 2018. Dr. Happy's enrollment is deactivated on February 1, 2018 for failing to update the enrollment record with respect to the practice location. Dr. Happy timely submits a rebuttal in response to the deactivation of his individual enrollment. Upon review by the contractor of the submitted documentation and internal records, it is discovered that Dr. Happy submitted a change of information application received by the contractor on February 28, 2018 that sought to update the practice location. However, this application was ultimately rejected due to the failure to timely respond to a development request.

In this scenario, the deactivation was correctly implemented after 30 days of the change of enrollment information – the change in practice location. However, an enrollment application updating Dr. Happy's practice location that was processed to completion was not received within 30 days of the change of enrollment information. Though the contractor received an application within 30 days of the change of enrollment information, that application was not processed to completion. Thus, an unfavorable rebuttal determination would be appropriate in this scenario, as the deactivation was appropriately implemented.

c. § 424.540(a)(3)

For deactivations under § 424.540(a)(3), the contractor shall review all submitted documentation and internal records to determine whether the provider or supplier furnished complete and accurate information and all supporting documentation within 90 calendar days of receipt of notification from CMS to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information. In making this determination, the contractor shall consider, at minimum, the following:

- Whether the deactivation was implemented after 90 days of the revalidation request.
- Whether the letter notifying the provider or supplier of the requirement to revalidate was sent to the correct address as instructed in section 10.7 of this chapter.
- Whether a revalidation application was timely received and was processed to completion.

Consider the following scenario:

EXAMPLE: On January 1, 2022, the contractor appropriately and timely informs Dr. Great that the contractor must receive a revalidation application from Dr. Great by April 15, 2022. The contractor receives a revalidation application from Dr. Great on March 1, 2022. The contractor requests that Dr. Great furnish further information needed to process the revalidation application. Dr. Great does not respond to the development request within 30 days as requested. The contractor rejects the March 1, 2022 revalidation application and subsequently deactivates Dr. Great's enrollment on April 16, 2022 under 42 C.F.R. § 424.540(a)(3). Dr. Great timely files a rebuttal in response to the deactivation. Upon review of the submitted documentation and internal records, the contractor confirms that Dr. Great was appropriately and timely notified of the requirement to revalidate and that it did not receive a revalidation application within 90 days of the revalidation request that could be processed to completion. Accordingly, an unfavorable rebuttal determination would be appropriate in this scenario, as the deactivation was appropriately implemented.

d. § 424.540(a)(4) and (5)

For deactivations under § 424.540(a)(4), the contractor shall review all submitted documentation and internal records to determine whether the provider or supplier was, in fact, compliant with all enrollment requirements at the time of the deactivation

For deactivations under § 424.540(a)(5), the contractor shall review all submitted documentation and internal records to determine whether the provider's or supplier's practice location was operational or otherwise valid at the time of the deactivation.

If the provider or supplier was indeed compliant or operational at the time of the deactivation, the contractor shall approve the rebuttal request and reinstate the provider's or supplier's Medicare billing privileges to an approved status; prior PEOG review of the rebuttal or approval of the rebuttal request is not required.

e. § 424.540(a)(6)-(8)

Although rebuttals under § 424.540(a)(6)-(8) these three deactivation grounds are uncommon, the provider or supplier may submit one. Upon receipt of a rebuttal submission, the contractor shall review all submitted documentation and internal records to determine whether the deactivation pursuant to the regulatory basis in question was appropriate. If it was not, the contractor shall approve the rebuttal request and reinstate the provider/supplier's Medicare billing privileges to an approved status; prior PEOG review of the rebuttal or approval of the rebuttal request is not required. If the rebuttal was not submitted properly and timely, the contractor shall dismiss the rebuttal request.

D. Determination

The contractor shall render a determination regarding a rebuttal submission using the appropriate Model Rebuttal Decision Letter. If the contractor is unable to render a determination, the

contactor shall use the appropriate Model Letter for the specific situation. All determinations (including dismissals and withdrawals) related to rebuttal submissions shall be sent (1) via hard-copy mail to the return address on the rebuttal submission; (2) via hard-copy mail to the correspondence mailing address on the enrollment records (if different from return address on rebuttal submission); and (3) by e-mail if a valid e-mail address is available (submitted as part of the rebuttal submission and/or listed in the enrollment record correspondence mailing address). The contractor may also send via fax if a valid fax number is available. All documentation shall be saved in PDF format. All notification letters shall be mailed on the same date listed on the letter.

If the contractor issues a rebuttal determination favorable to the provider or supplier, it shall make the necessary modification(s) to the provider's or supplier's Medicare billing privileges within 10 business days of the date on the favorable determination letter. This may include the elimination of the deactivation altogether so that there is no gap in billing privileges or a change in the deactivation effective date. If the contactor issues a rebuttal determination unfavorable to the provider or supplier, the provider's or supplier's Medicare billing privileges shall remain deactivated until a reactivation application is received and processed to completion.

If a rebuttal determination overturns the deactivation, the contractor shall return any application(s) received while the rebuttal submission was being reviewed or during the rebuttal submission timeframe that has not been processed to completion, unless the application is needed to reactivate the enrollment or if there are new changes being reported. If the contractor confirms that the application is not needed and that no new changes are being reported, the contractor shall use the following return reason in the Returned Application Model Letter found at 10.7.7.A of this chapter in response to the scenario described above: "A rebuttal decision has been issued; therefore, the submitted Form CMS [855/588/20134] is not needed."

If additional information/documentation is needed prior to reinstating the provider or supplier as part of a favorable rebuttal determination (e.g., deactivation due to non-response to revalidation and a complete application or missing information is needed to finalize the revalidation), the contractor shall document these next steps in its rebuttal determination letter. The contractor shall not reinstate the provider or supplier until the requested information is received and processed. If the additional information/documentation is not received within 30 calendar days of the date of the rebuttal determination, the contractor shall contact the provider/supplier to again request the additional information/documentation within 10 calendar days of not receiving a response.

If no response is received within 30 calendar days of the second request for additional information/documentation, the contractor shall contact ProviderEnrollmentAppeals@cms.hhs.gov within 10 calendar days for further instruction.

E. No Further Review

Pursuant to 42 C.F.R. § 424.546(f), a determination made regarding a rebuttal request is not an initial determination and is not subject to further review. Thus, no additional appeal rights shall be included on any rebuttal determination letter.

F. External Monthly Reporting for Rebuttals

Using the provider enrollment rebuttals reporting template, the contractor shall complete all columns listed for all rebuttal submissions received and processed by the contractor. No column shall be left blank (except Column K, as described below). If the contractor is unable to complete all columns for a given rebuttal submission, the contractor shall contact ProviderEnrollmentAppeals@cms.hhs.gov within five business days of discovery to seek further guidance.

The reports shall use only the formats identified below. All dates shall be formatted as mm/dd/yyyy (e.g. 01/13/2021). The reports shall be sent to CMS via email at ProviderEnrollmentAppeals@cms.hhs.gov no later than the 15th of each month. If this day falls on a weekend or a holiday, the report shall be submitted the following business day. The report shall include the prior month's rebuttal submissions, as well as outcomes for all submissions previously received that were not yet completed and reported to CMS (e.g., the February report shall cover all January rebuttals).

IMPORTANT: All submissions shall remain on the monthly report until a final outcome/decision has been reported to CMS.

- **Column A:** The response in Column A labelled, "Provider/Supplier Name" shall be the legal business name of the provider/supplier, exactly as it is spelled and formatted in the PECOS enrollment record (including capitalization, abbreviations, and punctuation). This column shall not be blank.

- **Column B:** The response in Column B labelled, "NPI" shall be the provider's or supplier's NPI number. If a provider/supplier has multiple NPIs, each shall be separated with a semicolon followed by a space (e.g. "1234567890; 1123456789"). This column shall not be blank.

- **Column C:** The response in Column C labelled, "EID" shall be the provider's or supplier's PECOS enrollment identification number (EID) as it appears in PECOS. On the rare occasion that no EID is available, the contractor shall enter "N/A". This column shall not be blank.

- **Column D:** The response in Column D labelled, "PTAN(s)" shall be the provider's or supplier's Provider Transaction Access Number(s) (PTAN(s)), or other Medicare ID number. If the provider/supplier has not yet been assigned a PTAN or Medicare ID, the contractor shall enter "N/A". This column shall not be blank.

- **Column E:** The response in Column E labelled, "Contractor," shall be in one of the following formats, as appropriate. This column shall not be blank. No other formats are acceptable.

    - **CGS**
    - **FCSO**

- **NGS JK**
- **NGS J6**
- **Palmetto JM**
- **Palmetto JJ**
- **NSC**
- **WPS J8**
- **WPS J5**
- **Noridian JE**
- **Noridian JF**
- **Novitas JL**
- **Novitas JH**
- **NPEast**
- **NPWest**

- **Column F:** The response in Column F labelled, "Regulatory Authority," shall be in the following format. If the response is "Other (see Comments)" the Contractors shall use Column K to provide explanatory notes (e.g. when a rebuttal is submitted in response to an enrollment action that does not afford rebuttal rights, describe the enrollment action in Column K). This column shall not be blank. No other formats are acceptable:

  - 424.540(a)(1)
  - 424.540(a)(2)
  - 424.540(a)(3)
  - 424.540(a)(4)
  - 424.540(a)(5)
  - 424.540(a)(6)
  - 424.540(a)(7)
  - 424.540(a)(8)
  - Other (see Comments)

- **Column G:** The response in Column G labelled, "Date Received" shall be the date on which the Contractor received the rebuttal. The date shall be formatted as mm/dd/yyyy (e.g. 10/25/2021); no other formats are acceptable. This column shall not be blank.

- **Column H:** The response in Column H labelled, "Date Receipt Acknowledgement Sent," shall be one of the following:

  - **[mm]/[dd]/[yyyy]**
    The date the receipt acknowledgement email/letter was sent to the provider/supplier or the representative, in "mm/dd/yyyy" format. No other date formats are acceptable.

  - **Not Yet Sent**
    If a receipt acknowledgement email/letter has not been sent to the provider/supplier/legal representative at the time the monthly report is sent to CMS.

- **N/A**
  If a receipt acknowledgement email/letter is not required for that case (i.e., rebuttal determination is issued within 10-calendar days of the date of receipt of the rebuttal submission).

- **Column I:** The response in Column I labelled, “Date Final Decision Issued” shall be the date on which the Contractor issues the rebuttal determination. The date shall be formatted as mm/dd/yyyy (e.g. 09/19/2019). If a final rebuttal determination has not yet been issued, the contractors shall enter "In Process" as the response. No other formats are acceptable. This column shall not be blank.

- **Column J:** The response in Column J labelled, “Final Decision Result,” shall be one of the following. No other formats are acceptable.

  - **Not Actionable**
    Rebuttal is no longer actionable (moot) because the basis for the deactivation has been resolved (e.g. deactivation was rescinded).

  - **Favorable**
    Contractor has determined that an error was made in the implementation of the deactivation. Therefore, the deactivation was overturned and the enrollment record has been placed in approved status with no gap in billing privileges.

  - **Unfavorable**
    Contractor upholds the deactivation resulting in the enrollment remaining deactivated.

  - **Dismissed**
    The rebuttal submission does not meet the rebuttal requirements (e.g. missing proper signature and did not timely respond to development request).

  - **Withdrawn**
    Provider/supplier/representative has submitted written notice of its intent to withdraw its rebuttal before the contractor issued a determination and the contractor has acknowledged the withdrawal.

  - **In Process**
    A final decision has not been issued. The Contractor is still processing the submission.

- **Column K:** The response in Column K labelled, “Comments,” shall include any information related to the deactivation, rebuttal submission, or rebuttal determination that provides context for CMS in reporting the rebuttal and outcome. This column may be left blank if no additional information is necessary.

10.4.9 – Stay of Enrollment

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

(In the event of any inconsistency between the instructions in this section 10.4.9 and other instructions in chapter 10, the 10.4.9 instructions take precedence if a stay of enrollment situation is involved.)

A. Background

In the Calendar Year 2024 Physician Fee Schedule final rule (CMS-1784-F), CMS established a new provider enrollment status in 42 CFR § 424.541 labeled a "stay of enrollment." The purpose was to create a CMS action that would be less burdensome on providers/suppliers (hereafter collectively "provider," except as otherwise noted) than a deactivation or revocation. It represents a middle ground between (1) a deactivation and (2) non-action on CMS' part. It gives CMS greater flexibility to take appropriate, fair, and reasonable measures commensurate with the degree of the provider's non-compliance.

A stay of enrollment (or simply "stay") is a preliminary, interim status---prior to any subsequent deactivation or revocation---that would represent, in a sense, a "pause" in enrollment, during which the provider would nonetheless remain enrolled in Medicare. In this vein, CMS would neither formally nor informally treat the stay as a sanction or adverse action for purposes of Medicare enrollment.

Unless CMS explicitly instructs the contractor to do so (such as per section 10.4.9(D) below), the contractor shall not: (i) initiate or impose a stay; or (ii) refer a potential stay case to PEOG if the contractor believes a certain situation it has encountered may warrant one.

B. Regulatory Requirements for Imposition -- Two-Step Test under § 424.541(a)(1)

As outlined in § 424.541(a)(1)(i) and (ii), there are two requirements for a stay's implementation. Specifically, the provider:

- Is non-compliant with at least one enrollment requirement in Title 42; **and**

- Can remedy the non-compliance via the submission of, as applicable to the situation, a Form CMS-855, Form CMS-20134, or Form CMS-588 change of information or revalidation application (hereafter occasionally and collectively referenced as "the applicable CMS form" or "ACF".)

Examples of how this bright-line, two-pronged test would be met include:

- A provider failed to timely report a change in its address from 10 Smith Street to 20 Smith Street.
- A supplier did not respond to a revalidation request.
- A DMEPOS supplier did not report the deletion of a managing employee.
- A physician did not timely report a change *in a* practice location's zip code.
- An MDPP supplier failed to timely report a change in the address of an organizational owner.

- An IDTF failed to comply with a supplier standard in § 410.33(g) but compliance can be reached by submitting an ACF.

In these illustrations, the provider failed to adhere to a reporting, revalidation, or supplier standard requirement in Title 42 (the first prong of the § 424.541(a)(1) test) but could resume compliance by submitting the applicable CMS form (the second prong). (It is important to understand that if the type of non-compliance involved cannot be corrected via the submission of an ACF, a stay cannot be imposed.) These are merely examples, however, and there are many scenarios in which a stay could apply.

Examples of when the stay of enrollment test would not be met include:

- A provider's owner has been convicted of a felony.
- A physician has lost *a* state medical license.

Although the first prong of the § 424.541(a)(1) test --- non-compliance --- has been met in these situations, the provider cannot correct the non-compliance simply by submitting an ACF.

C. Important Facets of a Stay as Outlined in § 424.541

Section 424.541 also contains the following provisions:

1. Enrollment Status (§ 424.541(a)(2)(i)) – As previously mentioned, the provider remains enrolled in Medicare during the stay.

2. Claims (§ 424.541(a)(2)(ii)):

Per § 424.541(a)(2)(ii)(A) – and except as stated in § 424.541(a)(2)(ii)(B) -- claims submitted by the provider with dates of service within the stay period will be rejected.

Under § 424.541(a)(2)(ii)(B), claims submitted by the provider with dates of service within the stay period are eligible for payment (assuming all other requirements for claim payment are met) if:

- CMS or its contractor determines that the provider has resumed compliance with all Medicare enrollment requirements in Title 42 (§ 424.541(a)(2)(ii)(B)(1)); and
- The stay ends before its original expiration date. (To illustrate, suppose CMS imposes a stay period of 30 days. The claims described in § 424.541(a)(2)(ii)(B) would be payable if the provider resumes compliance on or before the 30th day of the stay.)

To reiterate, the requirements of both § 424.541(a)(2)(ii)(B)(1) and (2) must be met for payments to be made pursuant to § 424.541(a)(2)(ii)(B).

3. Maximum Duration of the Stay (§ 424.541(a)(3)) - A stay of enrollment lasts no longer than 60 days from the postmark date of the notification letter, which is the effective date of the stay. **For purposes of this requirement, the postmark date is the date on which the letter is mailed. For instance, suppose the letter is mailed on June 1. The stay period commences on June 1, which is also the stay's effective date.**

Again, a stay has a maximum length of 60 days and cannot be extended. Note, however, that CMS can impose a stay of less than 60 days. It is not required that each assigned stay period be 60 days.

4. End-Date of the Stay (§ 424.541(a)(5)) – A stay ends on the earlier of the following dates:

- The date on which CMS or its contractor determines that the provider has resumed compliance with all Medicare enrollment requirements in Title 42, OR
- The day after the imposed stay period expires.

For purposes of § 424.541(a)(5) ONLY:

++ The term "has resumed compliance" means the provider has submitted the ACF that CMS requested the provider to submit in the stay notification letter. (See section 10.4.9(C)(5)(f) below for more information.) To illustrate, assume a provider receives a stay notification letter on March 1 because the provider had failed to timely report an address change via the Form CMS-855B. The letter requests the provider to submit this ACF. The provider does so on March 10. The stay thus ends on March 10. Note that the contractor need not have begun processing the ACF for a stay to be lifted. Even if the application is later returned, rejected, or denied, the stay ceases on the date the application is submitted.

++ For paper ACFs, the ACF is considered "submitted" on the date the contractor receives the ACF (e.g., in its mailroom).

5. Additional Considerations

a. Adverse Action - A stay is not considered an adverse legal action of any kind.

b. Deactivations and Revocations - **CMS always reserves the right to impose:**

(i) **A deactivation or revocation instead of a stay, even in cases of minor non-compliance. It should not be assumed that a stay will always be the first step in such situations**.

(ii) **A deactivation prior to the expiration of the stay, in which case the deactivation ends the stay**

c. Multiple Stays and Extensions – CMS will neither extend a stay period beyond 60 days nor apply a subsequent stay based on the same non-compliance (e.g., the provider failed to reach compliance within the imposed/assigned stay period (e.g., within 15 days), so CMS immediately applies another stay). Yet CMS may impose a stay multiple times against the provider for separate instances of non-compliance (e.g., one stay in June 2024, another stay in December 2025, and so forth).

d. Timeliness – Normal timeliness standards (as outlined in section 10.5 of this chapter) and processing alternatives (outlined in chapter 10) apply when the contractor is processing the ACF.

e. Applicable Forms and Transactions – As stated in § 424.541(a)(1), the types of ACFs for stay purposes are the Form CMS-855A, Form CMS-855B, Form CMS-855I, Form CMS-855S, Form CMS-20134, Form CMS-855O (though the CMS-855O will not involve claim submissions, retroactive payments, etc.), and Form CMS-588. The applicable transactions are limited to changes of information and revalidations. For purposes of the stay, however, the term "changes of information" can include, at CMS' discretion, reassignment situations under the Form CMS-855I.

f. Compliance – Except as stated or instructed otherwise by CMS, and strictly and solely for purposes of lifting/ending a stay, compliance under §§ 424.541(a)(2)(ii)(B)(1) and (a)(5) is reached when the provider submits the ACF. **Once the stay expires, though, compliance under Title 42 is only resumed consistent with existing policies (e.g., the contractor approves the change of information).**

g. Ordering/Certifying – A stay has no effect on a physician/practitioner's ability to order/certify/refer/prescribe services, items, or drugs.

h. Stay Periods – Except as instructed otherwise by CMS, all assigned stay periods for revalidation non-responses (see subsection (D)(1) below) will be 30 days (rather than 60 days). For the PEOG-directed stays described in subsection (D)(2) below, PEOG will notify the contractor of the assigned stay period for that specific case.

6. General Stay Process for Revalidations

In general – and subject to the more specific scenarios described in section 10.4.9(D)(1) -- the stay process will work as follows in situations where the provider fails to submit a revalidation application in response to a CMS/contractor revalidation request:

Implementing the Stay - Within 10 days after the expiration of the period in which the provider had to submit the revalidation application, the contractor shall: (a) send to the provider via regular mail the letter identified in section 10.7.20(A); and (b) switch the PECOS status to "Approved – Stay of Enrollment" effective the date the letter is mailed.

Removing the Stay if the Provider Submits the Revalidation Application During the Stay - Within 10 days after the revalidation application is submitted, the contractor shall change the PECOS status to "Approved – Remove Stay of Enrollment."

Failure to Respond During the Allotted Timeframe – Within 10 days of the allotted timeframe described below, the contractor shall deactivate the provider in accordance with CMS directives.

(This also includes the contractor turning on and turning off claim rejection edits as warranted (e.g., implementing the edits when the stay is imposed).)

Note that the above general process will be largely similar in cases where CMS directs the contractor to impose a stay in a specific case, the principal exception being the timeframe for contractor action in certain situations. These cases are addressed in subsections (D)(2)(a) through (D)(2)(c) below.

D. Case Studies

This section 10.4.9(D) contains more detailed scenarios addressing how the stay process will typically operate and the contractor's required activities therein. (Except as otherwise indicated, all days are calendar days.)

1. Non-Response to Revalidation Request

These scenarios assume the provider (Smith Health Care) failed to submit the requested revalidation application within the required revalidation timeframe (RRT) – the last day of which, for purposes of our examples, is February 27.

Scenario A – Revalidation Application Submitted During Stay Period and Is Approved

Step 1 –No later than 10 days after the expiration of the RRT, the contractor shall: (a) send to Smith via regular mail the letter identified in section 10.7.20(A); and (b) switch the PECOS status to "Approved – Stay of Enrollment" effective the date the letter is mailed. Thus, if the letter is mailed March 5, the PECOS status should be changed effective March 5, which will be the effective date of the stay. This means Smith has until April 4 (or 30 days) to submit the revalidation application. Claims for services furnished beginning March 5 to the end of the stay will be rejected except as stated in § 424.541(a)(2)(ii)(B).

(If the contractor receives the revalidation application from Smith after the RRT expires but before it mails the stay notification letter, the contractor can process the application as normal without imposing a stay.)

Step 2 – Smith submits the revalidation application on March 16.

Step 3 – No later than 10 days after the revalidation application is submitted, the contractor shall change the PECOS status to "Approved – Remove Stay of Enrollment" effective on the submission date (March 16 if the application was submitted via PECOS). Claims for services furnished between March 5 and March 16 (i.e., the duration of the stay) are therefore payable.

Step 4 – The contractor processes the revalidation application to approval and takes all standard actions related thereto (e.g., sends approval letter, switches PECOS record to "Approved"). No further action needed.

Scenario B – Revalidation Application Not Submitted at All

Assume that Step 1 is the same as Step 1 in Scenario A.

Step 2 – Smith fails to submit the revalidation application by April 4, the last day of the stay period. The contractor need take no action regarding the lifting of the stay (e.g., notifying the provider of the stay's cessation).

Step 3 – Within 10 days of the April 4 date (i.e., by April 14), the contractor shall: (a) change the PECOS status to "Deactivated" effective the day after the RRT expired (or February 28); and (b) take all other measures normally associated with a deactivation (e.g., send deactivation letter).

Note that the deactivation effective date is retroactive to the date of the non-compliance (again, February 28), or the date by which Smith was required to submit the revalidation application to CMS. This means that even though the stay was lifted effective April 5 and claims furnished on or after that date are thus payable, this will effectively be negated by the retroactive deactivation in a manner akin to how retroactive deactivations currently operate.

Due to the provider's failure to submit the application during the stay period, claims for services furnished during the stay (March 5 – April 4) are not payable.

Scenario C – Revalidation Application Submitted During the Stay but Is Rejected

Assume Steps 1, 2, and 3 are the same as Steps 1, 2, and 3 in Scenario A.

Step 4 – The contractor determines that the revalidation application should be rejected.

Step 5 – The contractor shall:

- Process the rejection consistent with existing procedures.
- Within 10 days of sending the rejection letter, the contractor shall: (a) change the PECOS status to "Deactivated" effective the day after the RRT expired (or February 28); and (b) take all other measures normally associated with a deactivation (e.g., send deactivation letter).

Scenario D – Revalidation Application Not Submitted During the Stay but Is Submitted After the Stay Period Expires

Assume Step 1 is the same as Step 1 in Scenario A. (Note that the stay expired on April 4.)

Step 2 - Smith submits the revalidation application on April 7.
Step 3

Step 3A - If the contractor receives the revalidation application before it mails the deactivation letter (as described in Step 3 of Scenario B), the contractor can process the application as normal without imposing a deactivation.

Step 3B – If the contractor receives the revalidation application after it mails the deactivation letter, it shall process the application as a reactivation application.

Scenario E - Contractor Imposes Stay for Failure to Submit Requested Revalidation Application and Provider Then Submits COI Rather Than Revalidation. Here, the contractor:

(i) Shall not remove the stay. This is because the COI is not an ACF --- that is, it does not address the cause of the stay, which is the failure to submit a revalidation application.

(ii) Shall follow the instructions in section 10.4.5.1(C) of Chapter 10 with respect to the COI submission.

(iii) Shall develop for a revalidation application via any written means (e.g., e-mail but not telephone). The provider shall have 30 additional days from the date the contractor received the COI to submit the revalidation application. In no circumstance, however, shall this latter revalidation timeframe exceed 60 days from the effective date of the stay. To illustrate, suppose the stay's effective date is June 1. The contractor receives the COI on July 2 before it proceeds to a deactivation. (See Scenario D of section 10.4.9(D)(1).) The provider has until July 31 (rather than August 1) to submit the revalidation application.

2. PEOG-Directed Stays

The situations in this subsection (D)(2) only apply when PEOG directs the contractor via e-mail to impose a stay. Except as otherwise instructed, the contractor need not notify PEOG that it has imposed the stay, whether the provider submitted the ACF, whether and when a deactivation was imposed, etc.

a. Ownership Discrepancies

PEOG may notify the contractor via e-mail to apply a stay against a particular provider due to incorrect enrollment information pertaining to ownership; the provider must correct this data by submitting an ACF. In such cases, the contractor shall follow the general stay procedures, steps, and scenarios outlined in subsection (D)(1) above except as follows:

- Step 1 of Scenarios A, B, C, and D - Within **5** days of receiving this e-mail, the contractor shall: (a) send to the provider via regular mail the letter identified in section 10.7.20(B); and (b) switch the PECOS status to "Approved – Stay of Enrollment" effective the date the letter is mailed.

- Step 3 of Scenarios B and D - Within **5** days after the expiration of the 30-day stay period, the contractor shall: (a) change the PECOS status to "Deactivated" effective the date the stay notification letter was mailed; and (b) take all other measures normally associated with a deactivation (e.g., send deactivation letter).

- Step 5 of Scenario C - Within **5** days of sending the rejection letter, the contractor shall: (a) change the PECOS status to "Deactivated" effective the date the stay notification letter was mailed; and (b) take all other measures normally associated with a deactivation (e.g., send deactivation letter).

- Step 3B of Scenario D - If the contractor receives the ACF after it mails the deactivation letter, it shall request the submission of or develop for a reactivation application.

To illustrate the first three exceptions, suppose the contractor receives an e-mail from PEOG on August 1 directing it to impose a stay on Provider X because X's ownership data is incorrect. If

this were a revalidation situation, the contractor would have 10 days (or until August 11) to complete Step 1. Here, however, the contractor must complete Step 1 by August 6.

Now assume the contractor finishes Step 1 on August 4. The stay begins that day and ends on September 3. Provider X fails to submit the ACF during that period. The contractor must complete Step 3 by September 8 (rather than September 13). If X timely submitted the ACF but the contractor rejects it and sends the rejection letter on September 20, the contractor must complete Step 5 of Scenario C by September 25.

In sum, the only material differences between the general procedures in subsections (D)(1) and (D)(2)(a) are:

- The timeframes for contractor action (10 days vs. 5 days)
- (D)(1) addresses revalidations --- for which no prior notification from PEOG is needed to impose a stay --- whereas (D)(2)(a) applies only to ownership discrepancies and requires said notification from PEOG.
- In (D)(1) cases, any deactivation effective date is retroactive to the day after the RRT's expiration. For (D)(2)(a) situations, the deactivation effective date is retroactive to the date of the stay notification letter.

b. Immediate Imposition

Situations could occur when PEOG directs the contractor via e-mail to immediately impose a stay. Here, and except if PEOG directs otherwise:

- Step 1 of Scenarios A, B, C, and D - Within **1 business day** of receiving this e-mail, the contractor shall: (a) send to the provider via regular mail the letter identified in section 10.7.20(B); and (b) switch the PECOS status to "Approved – Stay of Enrollment" effective the date the letter is mailed.

- Step 3 of Scenarios B and D - Within **1 business day** after the expiration of the 30-day stay period, the contractor shall -- (a) Change the PECOS status to "Deactivated" effective the date the stay notification letter was mailed; and (b) Take all other measures normally associated with a deactivation (e.g., send deactivation letter).

- Step 5 of Scenario C - Within **1 business day** of sending the rejection letter, the contractor shall: (a) change the PECOS status to "Deactivated" effective the date the stay notification letter was mailed; and (b) take all other measures normally associated with a deactivation (e.g., send deactivation letter).

- Step 3B of Scenario D - If the contractor receives the ACF after it mails the deactivation letter, it shall request the submission of or develop for a reactivation application.

Aside from the above timeframes, the contractor shall follow the general procedures, steps, and scenarios outlined in subsection (D)(1) above.

c. All Other PEOG-Directed Stays

For all PEOG-directed stays other than those described in subsections (D)(2)(a) and (b), the following apply:

- As with revalidations, the contractor has 10 days to undertake the actions described in Steps 1, 3 (Scenarios B and D), and 5 (Scenario C).

- Step 3B of Scenario D - If the contractor receives the ACF after it mails the deactivation letter, it shall request the submission of or develop for a reactivation application.

d. Additional Case Studies Where PEOG Directs a Stay

This subsection (D)(2)(d) identifies certain scenarios in which PEOG may direct a stay and how the contractor should handle the situation. These scenarios are in addition to, and not in lieu of, others that are addressed in section 10.4.9(D).

(i) ACF Received Before the Stay's Imposition

Assume CMS instructs the contractor to impose a stay in Instance (D)(2)(a), (b), or (c) above. Before the contractor mails the stay notification letter to the provider, however, the contractor receives the ACF (as the term ACF is defined/explained in this section 10.4.9). Here:

1. The contractor shall not impose the PEOG-directed stay and shall instead process the ACF normally (including development as needed).
2. Notwithstanding the language in the opening paragraph of subsection (D)(2) regarding PEOG notification, the contractor shall inform its PEOG BFL via e-mail that the stay was not implemented and why. This e-mail shall be sent no later than 7 calendar days after the contractor received the ACF.

(ii) ACF Submitted During the Stay

Assume Scenario (D)(2)(d)(i) above but further assume that the provider submits the ACF after the stay is implemented. Here, the contractor shall generally follow Step 3 in Scenario A of subsection (D)(1) – specifically: (1) change the PECOS status to "Approved – Remove Stay of Enrollment" effective on the submission date; and (2) process the ACF normally (including development as needed).

If the ACF is approved, the contractor shall generally follow Step 4 in Scenario A of subsection (D)(1).

If the ACF is rejected, the contractor shall follow Step 5 in Scenario C of subsection (D)(1) (though -- as applicable depending on the type of stay involved (e.g., ownership discrepancy) -- modified as described in subsection (D)(2)(a), (b), or (c)) Note that in Step 5, the stay does not go back into effect when the application is rejected and then remain intact until the originally assigned stay period (e.g., 30 days) expires. Rather, the contractor (as described in Step 5) shall proceed to a deactivation without reimposing the stay.

(iii) Contractor Receives COI Before Mailing the Stay Notification Letter

(a) The submitted COI is an ACF, meaning -- as explained in section 10.4.9(B) -- it can remedy the non-compliance in question via the form submission. Here:

(1) The contractor shall not impose the stay and shall instead process the ACF normally (including development as needed).

(2) Notwithstanding the language in the opening paragraph of subsection (D)(2) regarding PEOG notification, the contractor shall inform its PEOG BFL via e-mail that the stay was not implemented and why. This e-mail shall be sent no later than 7 calendar days after the contractor received the ACF.

(b) The submitted COI is **not** an ACF. Here:

(1) The contractor shall impose the stay as directed, using the procedures outlined in section 10.4.9.

(2) The contractor shall develop the COI for the information that will remedy the non-compliance (i.e., the missing/deficient/incorrect ACF data that triggered the stay directive). This means the ACF information, to the maximum extent possible, should be furnished on/via the COI and not through a separate ACF submission. However, the contractor shall accept and process the ACF if it is submitted separate from the COI; in this situation, the contractor shall merge the COI and ACF into a single submission. Note that the processing time clock does not stop when developing the COI for the ACF data.

(3) In its stay notification letter – which, for purposes of this scenario, will also constitute a development letter -- the contractor shall request that the provider update its COI with the ACF. (The specific verbiage lies within the contractor's discretion.) If the COI itself also requires development (e.g., data is incorrect), the letter shall also explain the information to be added, remedied, etc.

(4) Consistent with current policy (assuming the designated stay period (e.g., 30 days) has not expired), the stay ends on the date the provider submits the ACF – either via an update to the COI or as a separate submission.

(5) Final determination

- If the submitted ACF data cannot be approved (irrespective of whether the COI data can), the contractor shall proceed to a deactivation consistent with the instructions in subsection (D)(2). The COI data will ostensibly be captured via the provider's reactivation application.
- If the submitted ACF data can be approved but the COI information cannot, the contractor shall contact its PEOG BFL for guidance on how the matter should be handled.

E. Returns

In any situation where the contractor determines the submitted ACF – be it a revalidation, COI, etc. -- should be returned, the contractor shall treat the matter as it would a rejected ACF. (See Steps 4 and 5 of Scenario C of subsection (D)(1).)

F. Other Scenarios

The contractor may encounter stay situations not explicitly identified in subsection (D) above. In such situations, the contractor shall -- to the maximum extent possible -- still follow the general processes and basic steps outlined in the (D)(1) and (2) scenario(s) most applicable to the case the contractor is handling. If the contractor nonetheless needs additional guidance, it shall contact its PEOG BFL for guidance.

G. Letters

The contractor shall send all stay notification letters via hard-copy mail and via e-mail (if a valid email address is available); the contractor should also send the notice via fax if a valid fax number is available. All notifications shall be saved in PDF format, **and all notification letters shall be mailed on the same date listed on the letter.**

H. Rebuttals

See section 10.4.9.1 of this chapter for information concerning rebuttals of stays of enrollment.

I. NPE and DME MAC Interaction

The NPEs and the DME MACs shall interact, coordinate, and communicate with each other in stay situations consistent with CMS instructions and in instances generally akin to those involving deactivations. This could include, for example:

- The NPE notifying the applicable DME MAC of the imposition or lifting of a stay and any subsequent deactivation.
- Upon being informed of a stay by the NPE, the DME MAC holding payment for services furnished during the stay period.

J. Stay Expires – Deactivation Effective Date

To reiterate, if a stay expires and a deactivation immediately follows, the deactivation effective date is the date on which the provider first became non-compliant. This is consistent with the guidance in section 10.4.9(D).

K. Removal of A/R Code

As indicated in section 10.4.9, the contractor shall remove the stay of enrollment (e.g., A/R 350 or the Part A PARM) from the provider's file upon:

- Deactivation of the enrollment if the provider did not submit an ACF during the stay period.
- Submission of the ACF after the stay period has ended but prior to deactivation.

(Other situations when the stay should be lifted are addressed in section 10.4.9.)

10.4.9.1 – Stay of Enrollment Rebuttals

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

Note that the MAC will handle all non-DMEPOS supplier stay rebuttals consistent with the instructions in this section 10.4.9.1 and all other CMS guidance. DMEPOS supplier stay rebuttals will be handled by the PEOG Division of Provider Enrollment Appeals. All stay of enrollment rebuttals for DMEPOS suppliers shall be forwarded to providerenrollmentappeals@cms.hhs.gov within 5 days of receipt.

A. Background

Pursuant to 42 CFR § 424.541(b), a provider/supplier (hereafter "provider") under a stay of enrollment may file a rebuttal. A rebuttal is an opportunity for the provider to demonstrate that it met all applicable enrollment requirements and that the stay should not have been imposed. Only one rebuttal request may be submitted per enrollment stay. Additional rebuttal requests submitted for the same stay for which a rebuttal has already been received shall be dismissed. If the applicable CMS form (ACF) (see section 10.4.9) is received for a "stayed" provider while a rebuttal submission is pending or during the rebuttal submission timeframe, the contractor shall process the ACF consistent with current instructions.

The CMS's Division of Provider Enrollment Appeals (DPEA) will handle all stay of enrollment rebuttals for DMEPOS suppliers. Stay of enrollment letters for DMEPOS suppliers shall instruct suppliers to files rebuttals with CMS. The Contractor shall forward all stay of enrollment rebuttals for DMEPOS suppliers to ProviderEnrollmentAppeals@cms.hhs.gov within 10 calendar days of receipt. The Contractor shall not process the rebuttal if it is required to be forwarded to CMS.

B. Rebuttal Submissions

1. Requirements and Submission of Rebuttals

Pursuant to 42 C.F.R. § 424.541(b), to be accepted and processed, the rebuttal submission must—

(1) Be in writing;

(2) Specify the facts or issues concerning the rebuttal with which the provider disagrees, and the reasons for disagreement;

(3) Include all documentation the provider wants CMS to consider in its review of the stay;

(4) Be submitted in the form of a letter that is signed and dated by the individual supplier (if enrolled as an individual physician or nonphysician practitioner), the authorized official or delegated official (as those terms are defined in 42 C.F.R. § 424.502), or a legal representative (as defined in 42 C.F.R. § 498.10).

- If the legal representative is an attorney, the attorney must include a statement that *the attorney has* the authority to represent the provider; this statement is sufficient to constitute notice of such authority.
- If the legal representative is not an attorney, the provider must file with CMS written notice of the appointment of a representative; this notice of appointment must be signed and dated by, as applicable, the individual supplier, the authorized official or delegated official, or a legal representative.
- Authorized or delegated officials for groups cannot sign and submit a rebuttal on behalf of a reassigned provider without the provider submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's* behalf.
- Signatures may be original or electronic. Valid signatures include handwriting (wet) signatures in ink and digital/electronic signatures. Digital or electronic signatures such as those created by digital signature options, created in software, such as Adobe) and email signatures shall be accepted. Contractors shall contact ProviderEnrollmentAppeals@cms.hhs.gov for questions regarding electronic and digital signatures.

(5) Be received by the contractor within 15 calendar days from the date of the stay notification letter to the provider. The contractor shall accept a rebuttal submission via hard-copy mail, e-mail, and/or fax.

If the rebuttal submission is not appropriately signed or if a statement from the attorney or written notice of representation is not included in the submission, the contractor shall send a development request for a proper signature or the missing statement/written notice (using the applicable model letter) before dismissing the rebuttal submission. The contractor shall allow 15 calendar days from the date of the development request letter for the rebuttal submitter to respond to the development request.

If a rebuttal submission--(1) Is not appropriately signed and no response is received to the development request (if applicable); (2) Is untimely (as described above); (3) Does not specify the facts or issues with which the provider disagrees and the reasons for disagreement and no response is received to the development request; or (4) Is a duplicative submission, the contractor shall dismiss the rebuttal submission using the applicable rebuttal dismissal model letter. (The contractor shall use the applicable model letter in section 10.7.20 of this chapter. If the applicable model letter does not exist, the contractor should use the same rebuttal dismissal letters applicable to deactivation letters, modifying them to apply to the stay situation.) For those rebuttal submissions that are improperly signed and/or do not specify the facts or issues with which the provider disagrees and the reasons for disagreement, the contractor shall send a development request via hard-copy mail, email, if available, to the provider requesting a proper signature and/or clarification on the facts or issues with which the provider disagrees and the reasons for disagreement using the applicable rebuttal development model letter. Sending the development letter via fax is optional. The contractor shall grant an additional 15-calendar days from the date of the development request letter for the provider to submit an acceptable rebuttal submission. If no response is received or the rebuttal submission is still deficient after the development request and the 15-calendar day timeframe has expired, the contractor shall dismiss the rebuttal submission using the applicable rebuttal dismissal model letter.

The contractor may make a good cause determination to accept any rebuttal that has been submitted beyond the 15 calendar-day filing timeframe. Good cause may be found where there are circumstances beyond the provider's control that prevented the timely submission of a rebuttal. These uncontrollable circumstances do not include the provider's failure to timely update its enrollment information, specifically its various addresses. If the contractor believes good cause exists to accept an untimely rebuttal submission, the contractor shall send a request approval email to ProviderEnrollmentAppeals@cms.hhs.gov within five calendar days of making the good cause determination. This email shall detail the contractor's reasoning for finding good cause. Processing timeliness standards shall begin on the date the contractor receives a response from CMS.

2. Time Calculations for Rebuttal Submissions

If the 15th calendar day from the date of the stay notification letter falls on a weekend or federally-recognized holiday, the rebuttal shall be accepted as timely if the contractor received it by the next business day.

It is the provider's responsibility to timely update *the provider's* enrollment record to reflect any changes to *the provider's* enrollment information including, but not limited to, th*e* correspondence address. Failure to timely update a correspondence address or other addresses included in *the M*edicare enrollment record does not constitute an "in fact" showing that the stay notice was received after the presumed receipt date (as described above).

3. Processing Rebuttal Submissions

The contractor shall send an acknowledgement letter via hard-copy mail to the return address on the rebuttal submission within 10 calendar-days of receipt of the accepted rebuttal request using the rebuttal acknowledgment model letter, including a rebuttal tracking number and the provider's NPI. The acknowledgement letter shall also be sent via email if a valid email address is available (either in the enrollment record or rebuttal submission). It is optional for the contractor to send the acknowledgement letter via fax if a valid fax number is available. If a rebuttal determination is issued within 10 calendar-days of the date of receipt of the rebuttal submission, the contractor is not required to issue a receipt acknowledgement letter.

The contractor shall process all accepted rebuttal submissions within 30 calendar days of the date of receipt. If, while reviewing the rebuttal submission, the provider wishes to withdraw its rebuttal, the request to withdraw must be submitted to the contractor in writing before the rebuttal determination is issued. If a provider submits a written request to withdraw its rebuttal submission prior to the issuance of a rebuttal determination, the contractor shall issue a letter using the applicable rebuttal withdrawn model letter and no rebuttal determination shall be issued.

All materials received from the provider shall be considered by the contractor in its review.

4. Reason-Specific Instructions

As explained in section 10.4.9, CMS may impose a stay if the following two requirements are met:

- The provider is non-compliant with at least one enrollment requirement in Title 42; **and**

- The provider can remedy the non-compliance via the submission of, as applicable to the situation, a Form CMS-855, Form CMS-20134, or Form CMS-588 change of information or revalidation application (hereafter collectively referenced as "the applicable CMS form" or "ACF".)

In its review, therefore, the contractor shall, as a general principle, ascertain whether the provider (1) was indeed non-compliant and (2) can remedy the non-compliance by submitting an ACF. The contractor can review section 10.4.8.1(C)(4) (which addresses deactivation rebuttals) and apply the same basic principles discussed in those illustrations to their factually corresponding stay rebuttal situations.

Note that for stay rebuttals other than that discussed in Example (ii)(A) below, the contractor may need additional information (beyond that referenced in section 10.4.9(A)) regarding PEOG's decision to impose a stay. In such cases, the contractor shall contact ProviderEnrollmentRevocations@cms.hhs.gov and clearly outline the requested data. The 30-day timeframe for processing the rebuttal stops between the times the contractor sends the request and receives the information from PEOG.

C. Determination

The contractor shall render a determination regarding a rebuttal submission using the appropriate model rebuttal decision letter. If the contractor is unable to render a determination, the contactor shall use the appropriate model letter for the specific situation. All determinations (including dismissals and withdrawals) related to rebuttal submissions shall be sent (1) via hard-copy mail to the return address on the rebuttal submission; (2) via hard-copy mail to the correspondence mailing address on the enrollment records (if different from return address on rebuttal submission); and (3) by e-mail if a valid e-mail address is available (submitted as part of the rebuttal submission and/or listed in the enrollment record correspondence mailing address). The contractor may also send via fax if a valid fax number is available. All documentation shall be saved in PDF format. All notification letters shall be mailed on the same date listed on the letter.

If the contractor issues a rebuttal determination favorable to the provider, it shall make the necessary modification(s) to the provider's enrollment within 5 calendar days of the date of the favorable determination letter. This will involve a rescission of the stay regardless of whether the stay has already been lifted or is still in effect. If the contractor confirms that the ACF is not needed and that no new changes are being reported, the contractor shall use the following return reason in the returned application model letter found in section 10.7.7 of this chapter: "A rebuttal decision has been issued; therefore, the submitted Form CMS [855/588/20134] is not needed." If new changes were being reported as part of the ACF, the contractor shall process those changes.

If the contactor issues a rebuttal determination unfavorable to the provider, the stay (irrespective of whether it has been lifted) remains intact. Hence, if a stay existed from March 1 to March 10 and the stay was upheld on April 1, the record shall still reflect that the provider was under a stay between March 1 – 10.

D. No Further Review

Pursuant to § 424.541(b)(6), a determination made regarding a stay rebuttal request is not an initial determination and is not subject to further review. Thus, no additional appeal rights shall be included on any rebuttal determination letter.

E. External Monthly Reporting for Stay Rebuttals

(This data shall be reported in a template separate from that concerning deactivation rebuttals per section 10.4.8.1. of this chapter.)

Using the provider enrollment rebuttals reporting template, the contractor shall complete all columns listed for all stay rebuttal submissions received and processed by the contractor. No column shall be left blank (except Column K, as described below and as applicable). If the contractor is unable to complete all columns for a given rebuttal submission, the contractor shall contact ProviderEnrollmentAppeals@cms.hhs.gov within five business days of discovery to seek further guidance.

The reports shall use only the formats identified below. All dates shall be formatted as mm/dd/yyyy (e.g., 01/13/2021). The reports shall be sent to CMS via email at ProviderEnrollmentAppeals@cms.hhs.gov no later than the 15th of each month. If this day falls on a weekend or a holiday, the report shall be submitted the following business day. The report shall include the prior month's rebuttal submissions, as well as outcomes for all submissions previously received that were not yet completed and reported to CMS (e.g., the February report shall cover all January rebuttals).

IMPORTANT: All submissions shall remain on the monthly report until a final outcome/decision has been reported to CMS.

- **Column A:** The response in Column A labelled, "Provider/Supplier Name" shall be the legal business name of the provider/supplier, exactly as it is spelled and formatted in the PECOS enrollment record (including capitalization, abbreviations, and punctuation). This column shall not be blank.

- **Column B:** The response in Column B labelled "NPI" shall be the provider's or supplier's NPI. If a provider/supplier has multiple NPIs, each shall be separated with a semicolon followed by a space (e.g. "1234567890; 1123456789"). This column shall not be blank.

- **Column C:** The response in Column C labelled, "EID" shall be the provider's or supplier's EID PECOS enrollment identification number (EID) as it appears in PECOS. On the rare occasion that no EID is available, the contractor shall enter "N/A". This column shall not be blank.

- **Column D:** The response in Column D labelled, "PTAN(s)" shall be the provider's or supplier's Provider Transaction Access Number(s) (PTAN(s)), or other Medicare ID

number. If the provider/supplier has not yet been assigned a PTAN or Medicare ID, the contractor shall enter "N/A". This column shall not be blank.

- **Column E:** The response in Column E labelled, "Contractor," shall be in one of the following formats, as appropriate. This column shall not be blank. No other formats are acceptable.

    - CGS
    - FCSO
    - NGS JK
    - NGS J6
    - Palmetto JM
    - Palmetto JJ
    - NSC
    - WPS J8
    - WPS J5
    - Noridian JE
    - Noridian JF
    - Novitas JL
    - Novitas JH
    - NPEast
    - NPWest

- **Column F:** The response in Column F labelled "Non-Compliance" shall briefly describe the non-compliance that led to the stay (e.g., revalidation non-response). This column shall not be blank.

- **Column G:** The response in Column G labelled, "Date Received" shall be the date on which the Contractor received the rebuttal. The date shall be formatted as mm/dd/yyyy (e.g. 10/25/2021); no other formats are acceptable. This column shall not be blank.

- **Column H:** The response in Column H labelled, "Date Receipt Acknowledgement Sent," shall be one of the following:

    - **[mm]/[dd]/[yyyy]**
      The date the receipt acknowledgement email/letter was sent to the provider/supplier or the representative, in "mm/dd/yyyy" format. No other date formats are acceptable.

    - **Not Yet Sent**
      If a receipt acknowledgement email/letter has not been sent to the provider/supplier/legal representative at the time the monthly report is sent to CMS.

    - **N/A**
      If a receipt acknowledgement email/letter is not required for that case (i.e., rebuttal determination is issued within 10-calendar days of the date of receipt of

the rebuttal submission).

- **Column I:** The response in Column I labelled, “Date Final Decision Issued” shall be the date on which the Contractor issues the rebuttal determination. The date shall be formatted as mm/dd/yyyy (e.g. 09/19/2019). If a final rebuttal determination has not yet been issued, the contractors shall enter "In Process" as the response. No other formats are acceptable. This column shall not be blank.

- **Column J:** The response in Column J labelled, “Final Decision Result,” shall be one of the following. No other formats are acceptable.

    - **Not Actionable**
      Rebuttal is no longer actionable (moot) because the basis for the stay has been resolved (e.g., CMS rescinded the stay).

    - **Favorable**
      Contractor has determined that an error was made in the implementation of the stay. Therefore, the initial determination was overturned and the stay has been removed.

    - **Unfavorable**
      Contractor upholds the initial stay determination.

    - **Dismissed**
      The rebuttal submission does not meet the rebuttal submission requirements (e.g. missing proper signature and did not timely respond to development request).

    - **Withdrawn**
      Provider/supplier/representative has submitted written notice of its intent to withdraw its rebuttal before the contractor issued a determination and the contractor has acknowledged the withdrawal.

    - **In Process**
      A final decision has not been issued. The contractor is still processing the submission.

- **Column K:** The response in Column K labelled, “Comments,” shall include any information related to the stay, rebuttal submission, or rebuttal determination that provides context for CMS in reporting the rebuttal and outcome. This column may be left blank if no additional information is necessary.

10.6.1.1.2 – Examples of CHOW and Non-CHOW Situations

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Introduction

Pub. 100-07, chapter 2, section 3210.1D outlines in detail certain types of transactions (based on business type) that involve (or do not involve) a CHOW. This list is not exhaustive, however, and CMS recognizes that scenarios may arise that do not fall within the normal/typical categories of CHOW transactions. Indeed, it is not possible for CMS to address in these instructions every conceivable case. Hence, if the contractor is uncertain as to how to handle a situation that could involve a CHOW under 42 CFR § 489.18, it may contact its PEOG BFL for assistance or the SOG location representative.

In reviewing this section 10.6.1.1.2, the contractor should keep in mind the following:

1. Other Business Types - Although § 489.18 addresses only sole proprietorships, partnerships, corporations, and lease arrangements, other types of business entities (such as limited liability companies (LLCs)) can have CHOWs. These entities will be identified within the category in section 10.6.1.1.2(B) to which they are most applicable.

2. Assignment – Any statement in section 10.6.1.1.2(B) that a particular business transaction constitutes a CHOW assumes that the new owner accepted assignment of the provider agreement. In cases where a § 489.18-type business transaction occurred but assignment was not accepted (as discussed in detail in section 10.6.1.1.3.2 below): (a) no CHOW has taken place; (b) the provider agreement does not transfer; and (c) the entity must enroll as a brand new provider. Moreover, the existing owner must voluntarily terminate the provider's enrollment and agreement consistent with existing regulations and the policies in this chapter.

3. CHOW Categories on the Form CMS-855A - For purposes of provider enrollment only, there are three main categories of CHOWs captured on the Form CMS-855A application:

a. "Standard" CHOW - This occurs when a provider's CMS Certification Number (CCN) and provider agreement are transferred to another entity as a result of the latter's purchase of the provider. To illustrate, suppose Entity A is enrolled in Medicare, but Entity B is not. B acquires A. Assuming all regulatory requirements are met, A's provider agreement and CCN will transfer to B.

This is the most frequently encountered change of ownership scenario. As explained in section 10.6.1.1 et seq., even though it is technically an acquisition (i.e., B bought/acquired A) under § 489.18, this situation falls under the "CHOW" category – as opposed to the "Acquisition/Merger" category – on the Form CMS-855A.

b. Acquisition/Merger - In general, this occurs when two or more Medicare-enrolled entities combine, leaving only one remaining CCN and provider agreement. For instance, suppose Entity A and Entity B are both enrolled in Medicare, each with its own CCN and provider agreement. The two entities decide to merge. Entity B's CCN and provider agreement will be eliminated (leaving only Entity A's CCN and provider agreement).

If the acquisition results in an existing provider having new owners but keeping its existing provider number, the applicant should check the CHOW box in the Basic Information section of the Form CMS-855A.

Unlike the new owner in a CHOW or consolidation, the new owner in an acquisition/merger need not complete the entire Form CMS-855A. This is because the new owner is already enrolled in Medicare. As such, the provider being acquired should be reported as a practice location in the Practice Location Information section of the new owner's Form CMS-855A.

c. Consolidations - This occurs when the merger of two or more Medicare-enrolled entities results in the creation of a brand new entity. To illustrate, if Entities A and B decide to combine and, in the process, create a new entity (Entity C), the CCNs and provider agreements of both A and B will be eliminated. Entity C will have its own CCN and provider agreement.

Note the difference between acquisitions/mergers and consolidations. In an acquisition/merger, when A and B combine there is one surviving entity. In a consolidation, when A and B combine there are no surviving entities. Rather, a new entity is created – Entity C.

Regardless of which of these three categories the particular transaction falls under on the Form CMS-855A, the central issue for the contractor is whether a CHOW has occurred pursuant to § 489.18. In other words, the question of how the transaction is reported on the application is less important than the determination as to whether the CHOW requirements have been met. Indeed, merely because the provider reports a transaction as a § 489.18 CHOW on the Form CMS-855 does not mean that one has legally occurred. The contractor will therefore (as discussed below) have to carefully analyze the scenario and legal documentation to ascertain whether a CHOW is involved.

4. Continued Responsibility – In ascertaining whether a CHOW has occurred, another important consideration for the contractor is whether the owning entity/individual is (or is no longer) responsible for the provider and its operations. If some form of ownership change has occurred but the same individual/entity (e.g., the same corporation) generally remains as the principal owner of the provider, no CHOW has occurred; except as otherwise stated in this chapter, therefore, the transaction should be treated as a change of information.

5. Change in Process – Notwithstanding the expanded CHOW instructions in this section 10.6.1.1 et seq., the contractor should remember that the only changes to the CHOW process are generally as follows:

- The SOG location no longer makes the formal determination as to whether a CHOW has occurred.
- If the contractor recommends approval of the CHOW, it forwards the application to the state only (not to the SOG Location)
- If the state recommends approval to the contractor, the contractor coordinates with PEOG (as described below)
- After PEOG responds to the contractor, the contractor finalizes the application

Except as otherwise stated in these instructions, therefore, the contractor shall continue to follow the procedures it has in the past.

B. CHOWs by Business Type

(See section 10.6.4 of this chapter for basic information on the forms of business structures frequently encountered in provider enrollment.)

The scenarios below are not an exhaustive list of all the types of CHOWs that may or may not occur. Furthermore, the following situations may have different, unique facts that could raise questions as to whether a CHOW has indeed taken place. The contractor will thus encounter CHOW cases not precisely addressed in these instructions and, if uncertain regarding how they should be handled, may contact its PEOG BFL for guidance.

1. Sole Proprietorship

If the provider is an entity owned by a single individual, a transfer of title to the enterprise to another person or firm (whether or not this includes transfer of title to the real estate) constitutes a CHOW. It is also a CHOW if the former owner becomes one of the members of a partnership or corporation succeeding *the former owner* as the new owner (e.g., Jones is the sole proprietor of Provider X and sells the business to a corporation of which Jones will become a shareholder).

As discussed in section 10.6.4 of this chapter, a sole proprietorship is neither a solely-owned corporation nor a solely-owned LLC (e.g., an LLC with only one owner/member remains an LLC and is not a sole proprietorship simply because there is only a single owner/member).

2. Partnership

General partnership (i.e., a partnership with no limited partners) - In a general partnership, the removal, addition, or substitution of an individual/entity as a partner in the entity dissolves the partnership unless: (1) state law holds otherwise; or (2) the partnership agreement expressly states otherwise. If the partnership is indeed dissolved based on a partner's removal/addition/substitution, a new partnership is created and a CHOW has occurred.

Limited partnership – The departure/replacement of a general partner in a limited partnership will often result in the dissolution of the limited partnership, the creation of a new one, and the occurrence of a CHOW; these results typically do not stem from the departure or replacement of a limited partner. In either case, the contractor shall carefully examine the relevant documents (e.g., the Form CMS-855, limited partnership agreement) to see if the limited partnership has undergone a CHOW.

3. Corporation

(For purposes of this section 10.6.1.1.2 only, and unless stated otherwise: (1) the term "corporation" includes LLCs; and (2) the term "stock" includes LLC ownership interests. Thus, a reference to the merger of two corporations could include, for instance, the merger of an LLC with a corporation to create a brand new LLC or corporation.)

A merger of one or more corporations into the surviving Medicare-participating provider corporation (i.e., a merger "into" the participating corporation) is not recognized as a CHOW of the surviving corporation. However:

- If the corporation that survives is not the former owner of the provider entity, there is a CHOW; and

- Consolidation or merger of two or more corporations that results in the creation of a new corporate entity having ownership/control over a provider organization constitutes a CHOW.

4. Leasing

When all or part of a provider facility is leased, it constitutes a CHOW. If only part of the provider is leased, the original provider agreement remains in effect only with respect to the unleased portion. The lease of part of the facility constitutes a CHOW.

10.6.1.1.3.1 – Step 1 - Initial Review of the CHOW Application

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Process

Upon receipt of a Form CMS-855 CHOW application, the contractor shall undertake the following (in whichever order the contractor prefers):

(i) Ensure that all data validations otherwise required per this chapter have been performed.

(ii) Ensure that the submitted application(s) is complete consistent with the instructions in this chapter.

(iii) Ensure that the provider has submitted all documentation otherwise required per this chapter. For CHOW purposes, this also includes the following:

(a) Legal Documentation of CHOW - The legal documents that governed the transaction, such as a sales agreement, bill of sale, or transfer agreement. (See section 10.6.1.1.3.1.1 below for more information on such documents.)

(b) Form CMS-1561 (Health Insurance Benefit Agreement). (In lieu of the Form CMS-1561, rural health clinics (RHCs) must submit the Form CMS-1561A and ambulatory surgical centers (ASCs) must submit the Form CMS-370.) (See https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List for more information.) These forms are generally known as "provider agreements" and "supplier agreements," as applicable.

(c) Evidence of state licensure, if applicable. (This can be furnished consistent with existing instructions in this chapter concerning submission of evidence of state licensure.)

(d) Evidence of successful electronic submission of the Form HHS-690 through the Office of Civil Rights (OCR) portal, as applicable. (Evidence should be either written or electronic documentation.) (See https://www.hhs.gov/sites/default/files/forms/hhs-690.pdf for more information.)

(e) Applicable CMS Form that requests certification in Medicare. (These include, for example, CMS-377 for ASCs, CMS-3427 for end-stage renal disease (ESRD) facilities, etc.) (See https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List for more information.)

(f) Form CMS-1539 - Medicare/Medicaid Certification and Transmittal (https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS011722).

(g) Form CMS-2567 – Statement of Deficiencies and Plan of Correction (https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS008860).

(h) For skilled nursing facilities (SNFs), a signed patient transfer agreement. (See https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/Facility-Transfer-Agreement-Example.pdf for an example.)

(The provider must complete, sign, date, and include the applicable CMS forms described in this subsection (A)(iii); the provider need not, of course, complete those sections of the forms that are reserved for CMS. For organizational providers, an authorized official (as defined in § 424.502) must sign the forms; for sole proprietorships, the sole proprietor must sign.)

Notwithstanding the foregoing, if any document in subsection (A)(iii)(b), (d), (e), (f), (g), or (h) above is missing, unsigned, undated, or otherwise incomplete, the contractor need not develop for the form(s) or the information thereon; the contractor shall instead notify the state in its recommendation letter which document(s) was/were missing or otherwise incomplete. For all other missing or incomplete required documentation, the contractor shall follow the normal development instructions in this chapter.

Note that if the application is rejected and this results in the expiration of the applicable time period for reporting the change (e.g., 30 days), the contractor shall e-mail its PEOG BFL notifying *the latter* of the rejection. PEOG will determine whether the provider's/supplier's billing privileges should be deactivated under § 424.540(a)(2) or § 424.550(b)(2) or revoked under § 424.535(a)(1) or (a)(9). PEOG will notify the contractor of its decision.

(iv) Ascertaining whether a formal § 489.18 CHOW has occurred – This involves performing all necessary background research, which can include:

- Reviewing the sales or lease agreement
- Reviewing the ownership information in Sections 2, 5, and 6 of the Form CMS-855A (or Sections 5 and 6 of the Form CMS-855B)
- Reviewing whether the provider checked "Yes" or "No" to the question in Section 2 of the Form CMS-855A concerning the acceptance of assignment of the provider agreement.
- Contacting the provider(s) to request clarification of the sales agreement, etc. (Unless otherwise stated in this chapter, the provider must furnish any such clarification in writing; e-mail (including the PCV) is acceptable.)

(v) As applicable, take into account the supplemental instructions in sections 10.6.1.1.3.1(B), 10.6.1.1.3.1.1 and 10.6.1.1.4 of this chapter.

B. Additional Instructions

1. TIN Change - While a CHOW is typically accompanied by a TIN change, this is not always the case. On occasion, the TIN remains the same; conversely, sometimes the provider is changing its TIN but not its ownership. In short, while a change of TIN (or lack thereof) is evidence that a CHOW may or may not have occurred, it is not the most important factor; rather, the change in the provider's ownership arrangement is the central issue. Hence, the contractor shall review the sales/lease agreement closely, for this will help indicate whether a CHOW has occurred. Again, CMS stresses that the terms and conditions of the sales agreement are the primary indicator of the existence or non-existence of a CHOW.

2. Request for Information and/or Clarification – If, after its initial review under subsection (A), the contractor remains uncertain as to whether a CHOW has taken place, the contractor: (i) reserves the right to request any clarifying information from the provider (e.g., additional documentation concerning the sale); and/or (ii) may contact its PEOG BFL or the SOG Location for assistance. (This may include situations where, for instance, (i) the provider believes that the transaction is merely a stock transfer but the contractor disagrees, and (ii) the contractor is uncertain whether the provider is accepting assignment.)

3. Acceptance of Assignment – Regardless of the provider's response to the Form CMS-855 question concerning whether the provider accepts assignment, the contractor shall review the sales/transfer agreement and any other documentation to confirm whether the provider's response is consistent with the agreement. (For example, if the provider responds "no" to the question, the contractor shall review the sales agreement to ensure consistency.) If an inconsistency is discovered, the contractor shall contact the provider for clarification.

4. Situations Requiring Referral to PEOG – The contractor shall refer the case and all supporting documentation (e.g., sales agreement) to its PEOG BFL in either of the following situations:

- The provider reports a CHOW based strictly on a relinquishment by the owner of all authority and responsibility for the provider organization without a § 489.18-level change of ownership. (For instance, the sales agreement indicates that the provider is selling only 10% of its ownership stake but the provider claims the transaction is a CHOW because it is relinquishing all control of the provider to the party to which its 10% ownership share is being sold.)
- It appears the owner of a provider is entering into a franchise agreement with a corporate chain (and thus uses the chain's name).

10.6.1.1.3.1.1 – Special Processing Instructions and Considerations for the Initial Review Process

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Form CMS-855A – Old and New Owner Applications

Unless stated otherwise in this chapter:

- The contractor shall ensure that all applicable sections of the Form CMS-855A for both the old and new owner are completed in accordance with the instructions on the Form CMS-855A.

- The instructions in this section 10.6.1.1.3.1.1(A) apply only to the Form CMS-855A.

1. Previous Owner(s)

The previous owner's Form CMS-855A CHOW application does not require a recommendation for approval. Any recommendations will be based on the CHOW application received from the new owner.

If the previous owner's Form CMS-855A is available at the time of review, the contractor shall examine the information therein against the new owner's Form CMS-855A to ensure consistency (e.g., same names). If the previous owner's Form CMS-855A has not been received, the contractor shall contact the previous owner and request it. However, the contractor may begin processing the new owner's application without waiting for the arrival of the previous owner's application. It may also make its CHOW recommendation to the state without having received the previous owner's Form CMS-855A.

If a certification statement is not on file for the individual signing the previous owner's application, the contractor shall request that the Individual Ownership and/or Managing Control section of the Form CMS-855A be completed for said person.

Note that the previous owner's Form CMS-855A CHOW application is essentially the equivalent of a Form CMS-855A voluntary termination submission; this is because the old owner is voluntarily leaving the Medicare program. As such, the contractor shall not require the old owner to submit a separate Form CMS-855A voluntary termination along with its Form CMS-855A CHOW application.

2. New Owner

If a Form CMS-855A is not received from the new owner within 14 calendar days of receipt of the old owner's Form CMS-855A, the contractor shall contact the new owner. If, within 30 calendar days after the contractor contacted it, the new owner fails to (1) submit a Form CMS-855A and (2) indicate that it accepts assignment of the provider agreement, the contractor shall send an e-mail to its PEOG BFL notifying *the latter* of the situation. PEOG will determine whether the provider's billing privileges should be deactivated under § 424.540(a)(2) or § 424.550(b) or revoked under § 424.535(a)(1) or (a)(9). PEOG will notify the contractor of its decision.

In the situations described in the previous paragraph where the contractor is awaiting the new owner's application after received the old owner's, the contractor shall: (1) begin processing the old owner's application; and (2) if possible, ascertain whether a CHOW has taken place.

3. Order of Processing of Old/New Owner Applications

To the maximum extent practicable, Form CMS-855A applications from the previous and new owners in a CHOW should be processed as they arrive. However, unless the instructions in this chapter indicate otherwise, the contractor should attempt to send the previous and new owners' applications to the state simultaneously, rather than as soon as they are processed. For instance, suppose the previous owner submits an application on March 1. The contractor should begin processing the application immediately without waiting for the arrival of the new owner's application. Yet the contractor should avoid sending the previous owner's application to the state until the new owner's application is processed. (For acquisition/mergers and consolidations (as those terms are described on the Form CMS-855A), the contractor may send the applications to the state separately.)

4. Form CMS-855A: CHOWs Involving Subtypes

a. Separate Reporting

Any subunit that has a separate provider agreement must report its CHOW on a separate Form CMS-855A. It cannot report the CHOW via the main provider's Form CMS-855A. If the subunit does not have a separate provider agreement (e.g., hospital psychiatric unit), the CHOW can be disclosed on the main provider's Form CMS-855A; this is because the subunit is a practice location of the main provider and not a separately enrolled entity.

b. Change in Subtype

A CHOW may occur in union with a change in the facility's provider subtype. This can happen, for instance, when a hospital undergoes a CHOW and changes from a general hospital to another type of hospital, such as a psychiatric hospital. Although a change in hospital type is considered a change of information (COI), the provider need not submit separate applications – one for the COI and one for the CHOW. Instead, all information (including the change in hospital type) should be reported on the CHOW application; the entire application should then be processed as a CHOW (assuming it indeed qualifies as such). However, if the facility is changing from one main provider type to another (e.g., hospital converting to a skilled nursing facility) and also undergoing a CHOW, the provider must submit its application as an initial enrollment. The contractor shall notify the provider of this and return the application.

(NOTE: For Medicare purposes, a critical access hospital (CAH) is a separately-recognized provider type. Thus, a general hospital undergoing a CHOW while converting to a CAH must submit its Form CMS-855A as an initial enrollment, not as a CHOW.)

5. Transitioning to Provider-Based Status (Form CMS-855A Submissions Only)

Consistent with existing CMS policy, a provider undergoing a CHOW pursuant to 42 CFR § 489.18 may be assigned to a new contractor jurisdiction only if the provider is transitioning from freestanding to provider-based status. In such cases, the contractor for the new jurisdiction (the "new contractor") shall process both the old and new owner's Form CMS-855A applications. Should the "old/previous" (or current) contractor receive the old and/or new owner's Form CMS-855A applications, it shall (a) forward the

application to the new contractor within 5 business days of receipt and (b) notify the new contractor within that same timeframe that the application was sent.

B. Sales and Lease Agreements

Except as indicated otherwise, this subsection (B) applies to Form CMS-855A and Form CMS-855B applications.

1. Verification of Terms

The contractor shall ascertain whether: (1) the sales/lease agreement includes the signatures of the old and new owners, for the agreement must contain the signatures of both parties to the transaction (if it does not, the contractor shall develop for an agreement containing both signatures); (2) the information contained in the sales agreement is consistent with that reported on the new owner's Form CMS-855A or the submitted Form CMS-855B (e.g., same names, effective date); (3) the terms of the contract indicate that the new owner will accept assignment of the provider agreement; and (4) the transaction falls within the scope of organizational transactions covered under § 489.18 and this section 10.6.1.1 et seq.

(Note that a bill of sale/lease agreement/sales transfer agreement is a sales/lease business document and should not be confused with a patient transfer agreement.)

A sales/lease agreement often will not specifically refer to the Medicare provider agreement, assets, and liabilities. However, if (1) the box in the Change of Ownership (CHOW) Information section of the Form CMS-855A is checked "Yes" and (2) the sales/lease agreement either confirms that the new owner will accept assignment or is relatively silent on the matter, the contractor can proceed as normal. If the agreement indicates that assignment will not be accepted, however, the contractor shall follow the instructions in section 10.6.1.1.3.2(A) below.

As previously mentioned, any clarifying data must be furnished in writing (e.g., additional legal documentation, letter, e-mail). If the clarification – for whatever reason - requires an update to the supplier's Form CMS-855 application, the contractor shall request the submission of said update. In addition, if the contractor discovers discrepancies between the data in the sales agreement and that on the Form CMS-855, the contractor shall seek clarifying information and, if necessary, obtain an updated Form CMS-855.

2. Form of Sales/Lease Agreement

There are instances where the parties in a CHOW did not sign a "sales" or "lease" agreement in the conventional sense of the term; the parties, for example, might have documented their agreement via a "bill of sale." The contractor can accept such documentation in lieu of a sales/lease agreement so long as (1) the document addresses the transaction's terms and (2) the information in the agreement is consistent with that on the Form CMS-855 (as discussed above).

3. Submission of Sales/Lease Agreement

a. General Requirements – Unless specified otherwise in this chapter: (i) both the previous and new owners in a Form CMS-855A CHOW situation must submit copies of the interim and final

sales/lease agreements; and (ii) copies of the interim and final sales/lease agreement must be submitted in Form CMS-855B CHOW situations.

b. Forwarding to State - The contractor shall not forward a copy of the application to the state until it has received and reviewed the final sales/lease agreement. However, the contractor need not reverify the information on the Form CMS-855 while waiting for the final agreement, even if the data therein may be somewhat outdated by the time the final agreement is received.

c. Failure to Submit - If a final sales/lease agreement is not submitted within 30 days after the contractor's receipt of the new owner's application, the contractor shall reject the application. Though the contractor must wait until the 30th day to reject the application, the contractor may proceed with rejection regardless of how many times it contacted the new owner or what types of responses (short of the actual receipt of the agreement) were received.

C. Relocation of Entity

A new owner may intend to relocate the provider concurrent with a CHOW. If the relocation is to a site in a different geographic area serving different clients than previously served and employing different personnel to serve those clients, the contractor shall notify the state via e-mail immediately. If the state believes that this situation has resulted in the effective creation of a new provider, the contractor shall return the application and notify the new owner that a new, initial enrollment application must be submitted. The provider must also notify the state or, if applicable, accreditation agency.

D. Intervening Change of Ownership

In situations where the provider (1) submits a Form CMS-855 initial application or CHOW application and (2) subsequently submits a Form CMS-855 CHOW application before the contractor has finalized the first application, the contractor shall adhere to the following:

Situation 1 – The provider submitted an initial application followed by a CHOW application, and a recommendation for approval to the state has not yet been made for the initial application: The contractor shall return both applications and require the provider to re-submit an initial application with the new owner's information.

Situation 2 - The provider submitted a CHOW application followed by another CHOW application, and a recommendation for approval to the state has not yet been made for the first CHOW application: The contractor shall process both applications – preferably in the order they were received – and shall, if recommendations for approval are warranted, refer both applications to the state in the same package. The accompanying notice/letter to the state shall explain the situation.

Situation 3 - The provider submitted an initial application followed by a CHOW application, and a recommendation for approval of the initial application has been made to the state – The contractor shall:

- Return the CHOW application.

- Notify the state via e-mail that a change of ownership has occurred (the new owner should be identified) and that the contractor will require the new provider to resubmit a new initial application containing the new owner's information.

- Request via letter that the provider submit a new initial Form CMS-855 application containing the new owner's information within 30 days of the date of the letter. If the provider fails to do so, the contractor shall return the originally submitted initial application and notify the provider and the state of this via letter. If the provider submits the requested application, the contractor shall process it as normal and, if a recommendation for approval is made, send the revised application package to the state with an explanation of the situation; the originally submitted initial application becomes moot. If the newly submitted/second initial application is denied, however, the first submitted application is denied as well; the contractor shall notify the provider and the state accordingly.

Situation 4 - The provider submitted a CHOW application followed by another CHOW application, and a recommendation for approval has been made for the first application - The contractor shall:

- Notify the state via e-mail that (1) a subsequent change of ownership has occurred (the new owner should be identified) and (2) the contractor will require the provider to resubmit a new CHOW application containing the subsequent/second new owner's information.

- Process the new/second CHOW application as normal. If a recommendation for approval is made, the contractor shall send the revised CHOW package to the state with an explanation of the situation; the first CHOW application becomes moot. If the newly submitted/second CHOW application is returned per section 10.6.1.1.3.2 below, the first application should, too, be returned. The contractor shall notify the provider and the state accordingly.

E. Potential CHOW

On occasion, a provider or supplier submits a Form CMS-855 change of information to report a large-scale stock transfer or other significant ownership change that the provider does not believe is (or report as) a CHOW. If the contractor suspects that the transaction in question might indeed be a CHOW, it shall request clarifying information (e.g., copy of the stock transfer agreement).

F. Entry into PECOS - Paper Applications Only

If it appears that the new owner will be accepting assignment and that the transaction falls within the scope of § 489.18, the contractor shall enter the CHOW information into the new enrollment record that shall be created for the new owner. (If the state recommends approval of the CHOW (see section 10.6.1.1.3.3 below), the Part A provider's CCN will be maintained in the new owner's enrollment record once the record is switched to an approved status.)

A new enrollment record must be created if a new TIN is established pursuant to the CHOW.

(For PECOS applications, PECOS will automatically perform the enrollment record activities described in this subsection (F).)

10.6.1.1.4 – Additional CHOW Processing Policies

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

Except as otherwise stated, the instructions in this section 10.6.1.1.4 apply to the Form CMS-855A and Form CMS-855B.

A. Payment Changes - In a CHOW, the contractor shall continue to pay the old owner until it receives from PEOG the e-mail, effective date, and signed provider agreement referenced in Section 10.6.1.1.3.3(B). Hence, any application from the old owner or new owner to change the EFT account or special payment address to that of the new owner shall be returned. It is ultimately the responsibility of the old and new owners to coordinate any payment arrangements between themselves while the contractor and the state are reviewing the CHOW. It is recommended that the contractor notify the new owner of this while processing the application.

B. National Provider Identifiers (NPI) - Depending on the sale's terms, the new owner may obtain a new NPI or maintain the existing NPI. Once CHOW processing is complete, the old owner is prohibited from billing for services (i.e., services furnished after CHOW processing is complete); only the new owner may submit claims using the existing CCN. As already stated, the old owner and new owner must arrange between themselves any payment matters regarding claims for services furnished during the CHOW processing period.

C. CHOW Pre-Approval Changes of Information

1. Old Owner

If – prior to receiving an approval recommendation from the state -– the contractor receives from the old owner a Form CMS-855 request to change any of the provider's enrollment data, the contractor shall return the change request if the information involves changing the provider's:

i. EFT or special payment address information to that of the new owner (as described in section 10.6.1.1.4(A) above);

ii. Practice location or base of operations to that of the new owner;

iii. Ownership or managing control to that of the new owner;

iv. Legal business name, TIN, or "doing business as" name to that of the new owner.

All other "pre-state recommendation" Form CMS-855 change requests from the old owner can be processed normally.

2. New Owner

If – prior to receiving an approval recommendation from the state - the contractor receives from the new owner a Form CMS-855 request to change any of the provider/supplier's existing enrollment information, the contractor shall return the change request. This is because the old owner remains the owner of record at this time; the new owner therefore has no standing to submit Form CMS-855 changes on behalf of the provider.

D. Change of Transaction Type in PECOS - There may be instances where the contractor enters a transaction into PECOS as a CHOW, but it turns out that the transaction was not a CHOW (e.g., was a stock transfer; was an initial enrollment because the new owner refused to accept assignment). If the contractor cannot change the transaction type in PECOS, it can leave the record in a CHOW status; however, it should note in PECOS that the transaction was not a CHOW.

E. Unreported CHOW - If the contractor learns via any means (including from the state or SOG Location) that an enrolled provider has been purchased by another entity or has purchased another Medicare-enrolled provider, the contractor shall immediately request Form CMS-855A CHOW applications from both the previous and new owners (or request a Form CMS-855B CHOW application from the ASC or PXRS). If the new owner fails to submit a Form CMS-855 within the latter of (1) the date of acquisition or (2) 30 days after the request, the contractor shall send an e-mail to its PEOG BFL notifying *the latter* of the situation. PEOG will determine whether the provider's billing privileges should be deactivated under § 424.540(a)(2) or § 424.550(b) or revoked under § 424.535(a)(1) or (a)(9). PEOG will notify the contractor of its decision.

F. Precise Time of CHOW - In general, a Medicare CHOW is considered to have taken place at 12:01 a.m. on the date specified (i.e., in the first minute of the 24-hour day). Legal responsibility and the right to payment changes when the clock moves past midnight into the CHOW effective date.

G. Termination of CCN - If the new owner rejects assignment, the CCN associated with that agreement (the old owner's) also terminates on the date of the ownership transfer.

H. Clock Stoppages and Processing Alternatives - While awaiting PEOG's reply on any matter in this section 10.6.1.1 et seq. in which the contractor is required to refer a matter to PEOG - and beginning on the date following the sending of the e-mail referenced therein - the application processing time clock is stopped. It resumes on the date on which the contractor receives PEOG's final response. Communication between the contractor and PEOG during this "waiting period" (e.g., PEOG request for additional information from the contractor) does not restart the clock.

In addition, nothing in this section 10.6.1.1 et seq. negates other permissible clock stoppages and processing alternatives outlined in this chapter that can apply to the applications addressed in this section 10.6.1.1 et seq.

10.6.1.1.5 – HHA and Hospice Ownership Changes

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Background – 36-Month Rule

1. General Principles

In accordance with 42 CFR § 424.550(b)(1), if there is a change in majority ownership of an HHA or hospice by sale (including asset sales, stock transfers, mergers, and consolidations) within 36 months after the effective date of the HHA's or hospice's initial enrollment in Medicare or within 36 months after the HHA's or hospice most recent change in majority ownership, the provider agreement and Medicare billing privileges do not convey to the new owner. The prospective provider/owner of the HHA or hospice must instead:

- Enroll in the Medicare program as a new (initial) HHA or hospice under the provisions of § 424.510, and

- Obtain a state survey or an accreditation from an approved accreditation organization.

For purposes of § 424.550(b)(1), a "change in majority ownership" (as defined in 42 CFR § 424.502) occurs when an individual or organization acquires more than a 50 percent direct ownership interest in an HHA or hospice during the 36 months following the HHA's or hospice's initial enrollment into the Medicare program or the 36 months following the HHA's or hospice's most recent change in majority ownership (including asset sales, stock transfers, mergers, or consolidations). This includes an individual or organization that acquires majority ownership in an HHA or hospice through the cumulative effect of asset sales, stock transfers, consolidations, or mergers during the 36-month period after Medicare billing privileges are conveyed or the 36-month period following the HHA's or hospice's most recent change in majority ownership.

2. Exceptions

There are several exceptions to § 424.550(b)(1). Specifically, the requirements of § 424.550(b)(1) do not apply if:

- The HHA or hospice has submitted 2 consecutive years of full cost reports since initial enrollment or the last change in majority ownership, whichever is later. (For purposes of this exception, low utilization or no utilization cost reports do not quality as full cost reports.)

- The HHA's or hospice's parent company is undergoing an internal corporate restructuring, such as a merger or consolidation.

- The HHA or hospice is changing its existing business structure – such as from a corporation, a partnership (general or limited), or a limited liability company (LLC) to a corporation, a partnership (general or limited) or an LLC - and the owners remain the same.

- An individual owner of the HHA or hospice dies.

In addition, § 424.550(b)(1) does not apply to "indirect" ownership changes. For purposes of the 36-month rule's application, an indirect owner is a party that owns a direct or indirect owner of the provider. Consider the following illustrations:

EXAMPLE 1: Smith Hospice is established as a corporation. It is listed as the provider in Section 2 of the Form CMS-855A. The corporation has four shareholders (W, X, Y, and Z), each of which own 25% of Smith. Since Smith is the enrolling provider and W, X, Y, Z own Smith's stock, W, X, Y, and Z are considered direct owners of Smith. Thus, if W, X, and Y sell their 25% shares to Jones, Jones now directly owns 75% of Smith. A change in majority enrollment under § 424.550(b)(1) has occurred.

EXAMPLE 2: Smith Hospice is established as an LLC. It is listed as the provider in Section 2 of the Form CMS-855A. The corporation has two owners, Company X and Company Y. X owns 80% of Smith, and Y owns 20%. X and Y are accordingly direct owners of Smith. Company Z owns 100% of X, making Z an indirect owner of Smith. Now suppose that Company V purchases Z in its entirety. Since the transaction involves a sale of one of Smith indirect owners, § 424.550(b)(1) is not invoked.

To the extent this previously occurred, hospices and HHAs should not assume that – using the above examples: (1) the corporation is the direct owner of Smith; (2) W, X, Y, and Z were therefore merely indirect owners of Smith; and (3) the sale of W/X/Y's shares to Jones is an indirect ownership change that does not trigger the 36-month rule. To the contrary, the corporation – as Smith Hospice – IS the provider, hence making W/X/Y/Z direct owners of Smith.

3. Timing of 36-Month Period for Hospices

The provisions of 42 CFR § 424.550(b)(1) and (2) with respect to hospices (as enacted in "CMS-1780-F, Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2024") became effective January 1, 2024. This means these provisions impact only those hospice ownership transactions whose effective date is on or after January 1, 2024. However, the provisions can apply irrespective of when the hospice first enrolled in Medicare. Consider the following illustrations:

- Example 1 – Smith Hospice initially enrolled in Medicare effective February 1, 2022. Smith undergoes a change in majority ownership effective February 1, 2024. The provisions of § 424.550(b)(1) apply to Smith because it underwent a change in majority ownership within 36 months of its initial enrollment.

- Example 2 – Jones Hospice initially enrolled in Medicare effective February 1, 2016. Jones undergoes its first change in majority ownership effective February 1, 2024. Section 424.550(b)(1) does not apply to this transaction because it occurred more than 36 months after Jones's initial enrollment. Suppose, however, that Jones undergoes another change in majority ownership effective February 1, 2025. Section 424.550(b)(1) applies to this transaction because it took place within 36 months after Jones's most recent change in majority ownership (i.e., on February 1, 2024).

- Example 3 – Davis HHA initially enrolled in Medicare effective February 1, 2012. It underwent its first change in majority ownership effective February 1, 2016. This change was not affected by § 424.550(b)(1) because it occurred more than 36 months after Davis's initial enrollment. Davis underwent another change in majority ownership effective February 1, 2023. This change, too, was unaffected by § 424.550(b)(1), for it occurred more than 36 months after the HHA's most recent change in majority ownership (i.e., on February 1, 2016). Davis underwent another majority ownership change on February 1, 2025. This change is impacted by § 424.550(b)(1), since it occurred within 36 months of the HHA's most recent change in majority ownership (i.e., on February 1, 2023).

B. Determining the 36-Month Rule's Applicability

If the contractor receives a Form CMS-855A application reporting an HHA or hospice ownership change (and unless a CMS instruction or directive states otherwise), it shall undertake the following steps:

Step 1 – Change in Majority Ownership

The contractor shall determine whether a change in direct majority ownership has occurred. Through its review of the transfer agreement, sales agreement, bill of sale, etc., the contractor shall verify whether:

- The ownership change was a direct ownership change and not a mere indirect ownership change, and

- The change involves a party assuming a greater than 50 percent ownership interest in the HHA or hospice.

Assumption of a greater than 50 percent direct ownership interest can generally occur in one of three ways. First, an outside party that is currently not an owner can purchase more than 50 percent of the business in a single transaction. Second, an existing owner can purchase an additional interest that brings its total ownership stake in the business to greater than 50 percent. For instance, if a 40 percent owner purchased an additional 15 percent share of the HHA or hospice, this would constitute a change in majority ownership. This is consistent with the verbiage in the above-mentioned definition of "change in majority ownership" regarding the "cumulative effect" of asset sales, transfers, etc. Another example of a change in majority ownership would be if a 50 percent owner obtains any additional amount of ownership (regardless of the percentage) and hence becomes a majority owner; thus, for instance, if a 50 percent owner were to acquire an additional .001 percent ownership stake, *the owner* becomes a majority owner and the transaction involves a change in majority ownership.

If the transfer does not qualify as a change in majority ownership, the contractor can process the application normally (which will typically be as a change of information under 42 CFR § 424.516(e)). If it does qualify, the contractor shall proceed to Step 2:

Step 2 – 36-Month Period

The contractor shall determine whether the effective date of the transfer is within 36 months after the effective date of the HHA's or hospice's (1) initial enrollment in Medicare or (2) most recent change in majority ownership. The contractor shall verify the effective date of the reported transfer by reviewing a copy of the transfer agreement, sales agreement, bill of sale, etc., rather than relying upon the date of the sale as listed on the application. It shall also review its records – and, if necessary, request additional information from the HHA or hospice – regarding the effective date of the HHA's or hospice's most recent change in majority ownership, if applicable.

If the effective date of the transfer does not fall within either of the aforementioned 36-month periods, the contractor may process the application normally; specifically, the contractor shall, as applicable and depending upon the facts of the case, process the application as a change of information under 42 CFR § 424.516(e) or as a potential change of ownership under 42 CFR § 489.18.

If the transfer's effective date falls within one of these 36-month timeframes, the contractor shall proceed to Step 3.

Step 3 – Applicability of Exceptions

If the contractor determines that a change in majority ownership has occurred within either of the above-mentioned 36-month periods, the contractor shall determine whether any of the exceptions in § 424.550(b)(2) apply. As alluded to earlier, the exceptions are as follows:

i. The HHA or hospice has submitted 2 consecutive years of full cost reports.

(A) For purposes of this exception, low utilization or no utilization cost reports do not qualify as full cost reports. (See 42 CFR § 413.24(h) for a definition of low Medicare utilization.)

(B) The cost reports must have been: (1) consecutive, meaning that they were submitted in each of the 2 years preceding the effective date of the transfer; and (2) accepted by the contractor.

ii. The HHA's or hospice's parent company is undergoing an internal corporate restructuring, such as a merger or consolidation.

iii. The HHA or hospice is changing its existing business structure – such as from a corporation, a partnership (general or limited), or an LLC to a corporation, a partnership (general or limited) or an LLC - and the owners remain the same.

(A) If the HHA or hospice is undergoing a change in business structure other than those which are specifically mentioned in this exemption (e.g., corporation to an LLC), the contractor shall contact its PEOG Business Function Lead (BFL) for guidance.

(B) For the exemption to apply, the owners must remain the same.

iv. An individual owner of the HHA or hospice dies – regardless of the percentage of ownership the person had in the HHA or hospice.

Step 4 - Determination

If the contractor concludes that one of the aforementioned exceptions applies (and unless a CMS instruction or directive states otherwise), it may process the application normally; specifically, the contractor shall, as applicable and depending upon the facts of the case, process the application as a change of information under 42 CFR § 424.516(e) (via the instructions in section 10.6.1.2 of this chapter) or as a potential change of ownership under 42 CFR § 489.18 (via the instructions in section 10.6.1.1 of this chapter).

If no exception applies, the contractor shall refer the case to its PEOG BFL for review. Under no circumstances shall the contractor apply the 36-month rule to the HHA or hospice and require an initial enrollment based thereon without the prior approval of PEOG. If PEOG agrees with the contractor's determination:

(1) PEOG will terminate the seller in ASPEN.

(2) The contractor shall identify the voluntary termination action in PECOS as a deactivation ---- and hence shall deactivate the HHA's or hospice's billing privileges pursuant to § 424.540(a)(8) --- with a status reason of "Voluntarily Withdrawal from the Medicare Program." Per § 424.540(d)(1)(ii)(E), the effective date of the deactivation shall be the date of the sale.

(3) The contractor shall send to the HHA or hospice the "36-Month Rule Voluntary Termination Letter" in section 10.7.5.1. This letter will include, among other things, rebuttal rights regarding the deactivation as well as language stating that, as a result of § 424.550(b)(1), the HHA or hospice must:

- Enroll as an initial applicant; and

- Obtain a new state survey or accreditation survey after it has submitted its initial enrollment application and the contractor has made a recommendation for approval to the state.

(In preparing this letter, the contractor may, if applicable to the situation, change any reference therein to "HHA" or "home health agency" to "hospice.")

(4) The HHA or hospice need not submit a Form CMS-855A voluntary termination application.

Providers and/or their representatives (e.g., attorneys, consultants) shall contact their local MAC with any questions concerning (1) the 36-month rule in general and (2) whether the rule and/or its exceptions apply in a particular provider's case.

C. Additional Notes

The contractor is advised of the following:

1. If the contractor learns of an HHA or hospice ownership change by means other than the submission of a Form CMS-855A application, it shall notify its PEOG BFL immediately.

2. If the contractor determines, under Step 3 above, that one of the § 424.550(b)(2) exceptions is applicable, the ownership transfer still qualifies as a change in majority ownership for purposes of the 36-month clock. To illustrate, assume that an HHA initially enrolled in Medicare effective July 1, 2010. It underwent a change in majority ownership effective February 1, 2012. The contractor determined that the transaction was exempt from § 424.550(b)(1) because the HHA submitted full cost reports in the previous 2 years. On February 1, 2014, the HHA underwent another change in majority ownership that did not qualify for an exception. The HHA thus had to enroll as a new HHA under § 424.550(b)(1) because the transaction occurred within 36 months of the HHA's most recent change in majority ownership - even though the February 2012 change was exempt from § 424.550(b)(1).

10.6.1.2 – Changes of Information – Transitioned Certified Providers and Suppliers

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

(Until further notice from CMS, the instructions in this section 10.6.1.2 apply only to certified provider and certified supplier types that have officially "transitioned" as part of the transition of various certification activities from the SOG Location to the states, the contractors, and PEOG. These provider/supplier types include SNFs, HHAs, CMHCs, CORFs, FQHCs, Part A OPT/OSP providers, ASCs, PXRSs, hospitals, hospices, and ESRD facilities. The contractor shall continue to use the existing change of information instructions--now in section 10.6.22.1 of this chapter--for all non-transitioned certified provider/supplier types.

When executing the instructions in this section 10.6.1.2, the contractor can disregard directives that obviously do not apply to the transitioned provider/supplier type in question (e.g., references to hospitals).

All references to the SOG Location (formerly the "RO") in this section 10.6.1.2 refer to the applicable CMS Regional Office's Survey & Operations Group (SOG) Location. Also, and except as otherwise indicated, all references to "provider" include certified suppliers (e.g., ambulatory surgical centers, portable x-ray suppliers).

The instructions in this section 10.6.1.2 address the handling of changes of information involving certified providers and certified suppliers. With the transition of certain functions from the SOG Locations to the contractors and the Provider Enrollment & Oversight Group (PEOG), the processing instructions for these changes of information are slightly different from previous guidance. In particular: (1) the SOG Locations will be much less involved in the process; (2) tie-in and tie-out notices will no longer be issued; (3) the contractor will be responsible for finalizing changes previously requiring SOG Location approval; and (4) recommendations of approval will be made to (and reviewed by) the state agency (hereafter occasionally referenced simply as "state") only and not the SOG Location.

Except as stated otherwise:

(1) Any provider-specific instructions in section 10.2.1 et seq. of this chapter pertaining to changes of information (e.g., relocation of a federally qualified health clinic site; addition or deletion of an OPT/OSP extension site) take precedence over those in this section 10.6.1.2.

(2) Any instructions pertaining to ownership changes in section 10.6.1.1 et seq. of this chapter take precedence over those in this section 10.6.1.2.

(3) Any instructions pertaining to voluntary terminations of entire enrollments and/or provider agreements in section 10.6.1.3 of this chapter take precedence over those in this section 10.6.1.2.

(4) Any instructions in this section 10.6.1.2 concerning the voluntary termination of a branch, sub-unit, or other practice location that does not involve the termination of the entire enrollment and/or provider agreement take precedence over those in section 10.6.1.3. For instance, suppose a certified provider's Form CMS-855A enrollment has three practice locations and/or sub-units. The provider is voluntarily terminating one of them. Here, the contractor shall use the instructions in section 10.6.1.2 when processing this transaction. Now assume that a provider is of a type that must individually and separately enroll each location. The provider has three separately enrolled locations with three separate provider agreements. The provider seeks to terminate one of these locations. Since this will involve the termination of an individual/entire enrollment and corresponding provider agreement, the instructions in section 10.6.1.3 apply.

A. Changes of Information Requiring Recommendation to the State

1. Types

The following Form CMS-855 transactions require an approval recommendation to (and review by) the state prior to approval:

- Addition or relocation/change of outpatient physical therapy/outpatient speech pathology extension site
- Addition of HHA branch
- Addition or deletion of a prospective payment system (PPS)-excluded psychiatric unit, rehabilitation unit, or transplant program.
- Addition or deletion of swing-bed approval (see Section 2A2 of the Form CMS-855A)
- Conversion of a hospital from one type to another (e.g., acute care to psychiatric)
- Addition, deletion, or relocation of a hospice practice location
- Addition, change, and/or relocation of a hospital practice location when a survey of the new site may be required. (If the contractor is uncertain as to whether the state will perform a survey, it may (1) contact the state for guidance or (2) make the referral based on the contractor's experience with these types of changes and with the practices

of the state in question. Note that a survey often may be required if the location is shifting outside of the existing geographic area.)

- Addition of PXRS practice location

2. Initial Contractor Review and Recommendation

The contractor shall process the change request consistent with the instructions in this chapter (e.g., verification of data, developing for missing or conflicting data). If the contractor determines that the change/addition should be approved, it shall send the appropriate recommendation letter (see section 10.7 et seq.) to the state with all applicable documentation that the contractor currently sends in such situations. The SOG Location need not be copied on the letter.

Nothing in this section 10.6.1.2(A)(2):

- Prohibits the contractor from returning or rejecting the application if grounds for doing so exist.
- Supersedes any applicable requirement for performing a site visit (including the timing of such visits).

3. State Review and Contractor Receipt of Recommendation

The state will review the recommendation of approval, the application, and any other pertinent information. If the state decides to perform a survey, it will do so and notify the contractor thereof.

a. State Recommends Approval

If the state concludes that the change/addition should be approved, it will make a recommendation to this effect to the contractor, typically via a Form CMS-1539 and/or similar confirming documentation. No later than 5 business days after receipt of the recommendation, the contractor shall send an e-mail to MedicareProviderEnrollment@cms.hhs.gov containing general identifying data about the provider (including LBN, NPI, CCN, specialty, facility name and address), a copy of the Form CMS-1539 (or other similar documentation evidencing the state's approval recommendation, if available), the draft provider approval letter, and a description of the change to be made. If, to the contractor's knowledge, a new CCN is required, the name and address of the new entity requiring the CCN should be furnished along with the effective date. If a termination is involved (e.g., HHA branch), the contractor shall include the old CCN and the termination date in the e-mail.

Once PEOG responds to the contractor, the latter may finalize its processing of the application (e.g., sending copies of the provider notification of approval to the state and, if applicable, accrediting organization; switching the PECOS record from "approval recommended" to "approved").

b. State Does Not Recommend Approval

If the state does not recommend approval, the contractor shall refer the matter to MedicareProviderEnrollment@cms.hhs.gov for guidance. The e-*mail s*hall contain (1) the identifying data described in (3)(a) above; (2) a copy of the notification from the state declining to recommend approval; and (3) any other information the contractor deems pertinent. PEOG will review the matter and furnish the contractor additional instructions, which the contractor shall follow.

4. Additional Policies

a. Post-Recommendation Inquiries - Once the contractor has made its recommendation for approval to the state, any inquiry the contractor receives from the provider regarding the status of its change request shall be referred to the state.

b. Pending State Recommendation - So as not to keep the PECOS record in "approval recommended" status interminably, if the contractor does not receive the state's recommendation after 120 days, it may contact the state to see if its recommendation is forthcoming. The contractor may contact the state every 30 days thereafter to ascertain the recommendation's status.

c. State Practice - The PECOS record should not be switched to "Approved" until the contractor receives the state's approval recommendation. However, if the contractor knows that the state in question generally does not review this type of transaction, the contractor need not send the transaction to the state and shall instead follow the instructions in section 10.6.1.2(B) below.

B. Post-Approval State Notification Required

Form CMS-855 changes that do not mandate a recommendation to the state but do require post-approval correspondence with PEOG and the state (and, if applicable, the accrediting organization) include:

- Except as described in section 10.6.1.2(A), deletions/voluntary terminations of practice locations or hospital subunits. (Note that this scenario is different from cases where the provider is voluntary terminating its enrollment as a whole (per section 10.6.1.3 of this chapter) rather than simply terminating a single location or subunit within its enrollment.)

- LBN, TIN, or "doing business as name" changes that do not involve a CHOW.

- Except as described in section 10.6.1.2(A), address changes that generally do not require a survey of the new location.

- Addition, change, and/or relocation of a hospital practice location (including physician/practitioner group practice locations) for which a survey is not required.

- Deletion of an OPT/OSP extension site or practice location.

- Ownership changes that involve neither a 42 CFR § 489.18 CHOW nor a § 424.550(b) exempt or non-exempt change in HHA majority ownership (e.g., a 15 percent owner of a hospice sells *the 15 percent* ownership stake).

The contractor shall:

(1) Inform PEOG, the state, and the AO (if appropriate) of the changed information (via any mechanism it chooses, including copying PEOG/state/AO on the notification letter or e-mail to the provider) no later than 10 calendar days after it has completed processing the transaction. Such notice to the PEOG/state/AO shall specify the type of information that is changing. (Prior PEOG approval of the change is not required, though PEOG will update applicable national database as needed.)

(2) Switch the PECOS record to "Approved."

C. All Other Changes of Information

1. General Principle

For all Form CMS-855 change requests not identified in section 10.6.1.2(A)(1) and (B) above (and except as stated in subsection (C)(2) below), the contractor shall: (1) notify the provider via letter, fax, e-mail, or telephone that the change has been made; and (2) switch the PECOS record to "Approved." The contractor need not notify the state, SOG Location, or PEOG of the change.

2. FQHCs

If an FQHC is adding, deleting, or changing a Section 13 contact person , the contractor shall send an approval letter via e-mail and copy the MedicareProviderEnrollment@cms.hhs.gov mailbox (with "FQHC COI" in the subject line) thereon. (Aside from this exception, all other instructions in subsection (C)(1) apply to this scenario.) See section 10.2.1.4(D) of this chapter for more information on FQHC changes of information.

D. Revalidations, Reactivations, and Complete Form CMS-855 Applications

1. When Referral Required - In situations where the provider submits a (1) Form CMS-855 reactivation, (2) Form CMS-855 revalidation, or (3) full Form CMS-855 as part of a change of information (i.e., the provider has no enrollment record in PECOS), the contractor shall make a recommendation to the state and switch the PECOS record to "approval recommended" only if the application contains new/changed data falling within one of the categories in section 10.6.1.2(A)(1). For instance, if a revalidation application reveals a new hospital psychiatric unit that was never reported to CMS via the Form CMS-855, the contractor shall make a recommendation to the state and await the state's approval recommendation before switching the record to "Approved." In this situation, the contractor should forward the application to the state with a note explaining that the only matter the state needs to consider is the new hospital unit.

2. No Referral Required - If the application contains new/changed data falling within one of the categories in section 10.6.1.2(B), the contractor can switch the PECOS record to "Approved." It shall also inform the state of the changed information (via any mechanism it chooses, including copying the state on the notification letter or e-mail to the provider) no later than 10 calendar days after it has completed processing the transaction.

E. Unsolicited Notifications from State

If the contractor receives notice of a provider's change of information from the state but the provider never submitted the required Form CMS-855 change request to the contractor, the contractor shall: (1) alert the state of the situation; and (2) contact the provider and have it complete and submit the change request. However, if the data in question is not collected on the Form CMS-855, the contractor need not make this request.

F. Special ESRD Instructions

Notwithstanding any other contrary instruction in this chapter, if an ESRD change of information application results in the issuance of a new or additional CCN, the contractor shall copy the ESRD Network on the approval letter it sends to the provider. The contact information for the ESRD Network can be found at https://esrdnetworks.org/membership/esrd-networks-contact-information/.

G. Clock Stoppages and Processing Alternatives

While awaiting PEOG's reply on any matter in this section 10.6.1.2 in which the contractor is required to refer a matter to PEOG - and beginning on the date following the sending of the e-mail referenced therein - the application processing time clock is stopped. It resumes on the date on which the contractor receives PEOG's final response. Communication between the contractor and PEOG during this "waiting period" (e.g., PEOG request for additional information from the contractor) does not restart the clock.

In addition, nothing in this section 10.6.1.2 negates other permissible clock stoppages and processing alternatives outlined in this chapter that can apply to the applications addressed in this section 10.6.1.2.

10.6.1.3 – Voluntary Terminations

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

The CMS Provider Enrollment & Oversight Group (PEOG) and Medicare Administrative Contractors have assumed a number of enrollment-related functions previously handled by state agencies (hereafter occasionally referenced as "state") and CMS Survey & Operations Group Locations (SOG Locations) concerning certified provider and certified supplier voluntary terminations. This section 10.6.1.3 instructs the contractor on how to process such transactions. Unless stated otherwise, these instructions take precedence over those in section 10.4.3 of this chapter.

Except as stated otherwise in this chapter, this section does not apply to voluntary terminations pursuant to an HHA change in majority ownership under § 424.550(b)(1). Instructions concerning the handling of these transactions are in section 10.2.1.6.1 of this chapter.

A. Background

Consistent with the principles of 42 CFR § 489.52(a) (and except as otherwise required), a certified provider/supplier that wishes to terminate its agreement with Medicare must send written notice of its intention to the SOG Location, the state agency, or the contractor within the timeframes addressed in § 489.52. Under CMS Publication (Pub.) 100-07, chapter 2, section 2005F, the notice is a letter on letterhead with an authorized signature.

Submission of a Form CMS-855 voluntary termination application is not mandatory but is highly preferred. Providers and suppliers are encouraged to continue to submit this form.

Section 10.6.1.3(B) below discusses various scenarios that the contractor may encounter in processing certified provider/supplier voluntary terminations. These should be reviewed and considered in conjunction with the policies in section 10.6.1.3(C) below, particularly those in subsections (C)(2), (C)(3), (C)(6), and (C)(7).

B. Situations and Scenarios

1. Termination Reported to Contractor Via Form CMS-855 or Letter with No Prior Notice from State Agency or SOG Location

If the contractor receives a Form CMS-855 voluntary termination application or a voluntary termination letter (but not both) directly from a certified provider/supplier without having received any termination notification from the state/SOG Location, the following apply:

(i) The contractor shall: (a) process the application/letter consistent with the timeframes for voluntary terminations in section 10.4.3 of this chapter; and (b) as applicable, follow the instructions in section 10.6.1.3(C) below.

(NOTE: If the application/letter is from a skilled nursing facility (SNF), the contractor shall contact the state agency to determine whether the SNF complies with the requirements of 42 CFR §§ 483.15(c)(8) and 483.70(l). These two provisions address the SNF's required notice to the state of an impending closure and patient safety. If the state indicates that the SNF is not compliant, the contractor shall contact its PEOG Business Function Lead (BFL) for guidance; if compliance is confirmed, the contractor can proceed as normal.)

(ii) Prior to finalizing its processing of the Form CMS-855 or letter submission, the contractor shall e-mail a copy of the draft approval letter (see the applicable model letter in section 10.7.5.1) containing the appropriate termination effective date, reason for termination, and source of the termination notice (i.e., Form CMS-855 or letter) to PEOG at MedicareProviderEnrollment@cms.hhs.gov, with "S&C Voluntary Termination" in the e-mail's subject line.

(iii) PEOG will update the Automated Survey Process Environment (ASPEN) system, notify the contractor thereof, and, if the provider/supplier is deemed, provide the contractor the name and e-mail address of the applicable accreditation organization (AO).

(iv) Within 3 business days of receiving of the aforementioned notice from PEOG, the contractor shall: (1) e-mail a copy of the final signed approval letter to the provider/supplier, SOG Location, state agency, and AO (if the provider/supplier is deemed); and (2) deactivate the provider/supplier in the Provider Enrollment, Chain and Ownership System (PECOS) pursuant to the instructions/guidance in section 10.6.1.3(C)(9) below.

2. Termination Reported to Contractor Via Form CMS-855 and Letter with No Prior Notice from State Agency or SOG Location

If the contractor receives a Form CMS-855 voluntary termination application and a voluntary termination letter directly from a certified provider/supplier without having received any termination notification from the state/SOG Location, the following apply:

(i) If the Form CMS-855 and letter arrive either simultaneously or before the contractor begins processing one of them, the contractor has the discretion to determine which submission to process unless a Form CMS-855 was submitted via PECOS; in this latter case, the contractor shall process the Form CMS-855 rather than the letter. It need not process both of them; the submission that the contractor does not process may be returned (consistent with the instructions in this chapter) or placed in the provider/supplier file, and the contractor need take no further action thereon.

(ii) If the contractor receives both submissions and it has begun processing one of them, the contractor shall continue processing that document. The contractor can return the other submission (consistent with the instructions in this chapter) or place it in the provider/supplier file; no further action thereon is required.

(iii) Regardless of whether (2)(i) or (ii) applies, the contractor shall process the submission consistent with the instructions in section 10.6.1.3(B)(1) above.

3. Notice of Voluntary Termination Received from State Agency and/or SOG Location without the Contractor Having Received a Form CMS-855 or Letter Directly From the Provider/Supplier

Although many voluntary termination submissions from certified providers/suppliers are via the Form CMS-855, there are occasions where the provider/supplier will only notify the state agency and/or SOG Location. The contractor will typically learn of this when it receives a Form CMS-1539 ("Medicare/Medicaid Certification and Transmittal") and/or other written notification from the state/SOG Location. (The state uses the Form CMS-1539 to communicate findings to the SOG Location with respect to a facility's compliance with health and safety requirements.) In such situations, the following apply:

(i) The contractor may accept from the state/SOG Location written documentation other than the Form CMS-1539. This includes, for example, a Form CMS-2007 or even a voluntary termination letter of the type described in sections 10.6.1.3(B)(1) and (B)(2) above; indeed, the

provider/supplier sometimes sends its termination letter directly to the state/SOG Location and the latter simply forwards it to the contractor.

If the contractor has questions concerning said documentation, it shall contact the state/SOG Location for clarification. (This could include situations when it is unclear: (1) whether a termination is involved; (2) which provider/supplier is to be terminated; or (3) if the state forwards to the contractor a termination request that the state received from the provider, whether the state considers it to be a valid termination request.).

(ii) Upon receipt of the Form CMS-1539 (or other/additional state/SOG Location document), the contractor need not develop with the provider/supplier for a Form CMS-855A/B voluntary termination application or a letter. Instead:

(A) The contractor shall abide by the applicable instructions in section 10.6.1.3(C) below (e.g., section (C)(6) regarding effective dates; section (C)(7) concerning cessations of business). If the notice from the state was a voluntary termination letter from the provider/supplier (as described in section 10.6.1.3(B)(3)(i) above), the contractor shall pay particular attention to the instructions in section 10.6.1.3(C)(3) below.

(B) The contractor shall e-mail a copy of the draft approval letter (see section 10.7.5.1 of this chapter) containing the appropriate termination effective date, reason for termination, and source of the termination notice to MedicareProviderEnrollment@cms.hhs.gov, with "S&C Voluntary Termination" in the subject line.

(C) PEOG will update ASPEN, notify the contractor thereof, and, if the provider/supplier is deemed, provide the contractor the name and e-mail address of the applicable AO.

(D) Within 3 business days of receiving of the aforementioned notice from PEOG, the contractor shall: (1) e-mail a copy of the final signed letter to the provider/supplier, SOG Location, state agency, and AO (if the provider/supplier is deemed); and (2) deactivate the provider/supplier in PECOS pursuant to the instructions/guidance in section 10.6.1.3(C)(9)) below.

4. Notification of Termination Received from the State Agency and/or SOG Location and Directly from the Provider/Supplier Via the Form CMS-855 and/or Letter

The contractor shall adhere to the instructions in this section (B)(4) in the following situations:

(i) **The contractor receives notification of termination (i.e., via Form CMS-1539 or other documentation) from the state/SOG Location after the provider/supplier has been deactivated in PECOS pursuant to the latter's Form CMS-855/letter voluntary termination submission** - Within 10 calendar days of receiving the state/SOG Location notification, the contractor shall inform the state/SOG Location via e-mail that the provider/supplier has already been deactivated in PECOS and terminated in ASPEN. No further action by the contractor is necessary.

(ii) **The contractor receives notification of termination from the state/SOG Location while the contractor is processing a Form CMS-855/letter voluntary termination submission but before the provider/supplier has been deactivated in PECOS** – The contractor shall: (i)

continue processing the application/letter normally and to completion, consistent with the instructions in this section 10.6.1.3; and (ii) e-mail a copy of the final signed letter to the provider/supplier, SOG Location, state agency, and AO (if the provider/supplier is deemed) after the provider/supplier has been deactivated in PECOS.

(iii) **The contractor receives notification of termination (i.e., via Form CMS-1539 or other documentation) from the state/SOG Location before the contractor received or began processing the provider's/supplier's Form CMS-855/letter voluntary termination submission** – The contractor:

(A) Shall follow the instructions in section 10.6.1.3(B)(3) above

(B) Need not contact the provider/supplier about its Form CMS-855/letter submission prior to the completion of all of the steps in section 10.6.1.3(B)(3)(ii) above

(C) Either in the termination approval letter (which the contractor may modify for the purpose) sent to the provider/supplier or via a simultaneous or separate e-mail to the provider/supplier, the contractor shall notify the provider/supplier that its submission to the contractor was not processed due to the provider/supplier's prior notification to the state/SOG Location. (If this communication is sent separately from the approval letter or the e-mail containing the letter, the contractor shall send the separate e-mail no later than 10 calendar days after sending the letter.)

(iv) The contractor receives notification of termination from the state/SOG Location and a separate voluntary termination Form CMS-855/letter from the provider/supplier without having begun the processing of either – The contractor has the discretion to determine which submission to process unless a Form CMS-855 was submitted via PECOS; in this latter case, the contractor shall process the Form CMS-855. It need not process both of them; the submission that the contractor does not process may be returned (consistent with the instructions in this chapter) or placed in the provider/supplier file, and the contractor need take no further action thereon.

C. Additional Certified Provider/Supplier Voluntary Termination Policies

1. Completion of Form CMS-1539 – The state completes the Form CMS-1539. In Part II thereof, the following fields contain: (i) 26-Termination Action "00"; Code for a voluntary termination; and (ii) 28 –Termination Date; this is the effective date of the voluntary termination.

2. Required Contents of Voluntary Termination Letter Received Directly from Provider/Supplier – If the contractor is processing a voluntary termination letter it received directly from the provider/supplier (as opposed to receiving it from the state/SOG Location), the contractor shall ensure that the letter:

- Is on the provider/supplier's letterhead
- Contains the provider/supplier's legal business name, NPI, and CMS Certification Number (CCN)
- States with sufficient clarity (in the contractor's judgment) that the provider/supplier wishes to terminate its Medicare provider/supplier agreement and/or enrollment. (No exact,

uniform, standard language from the provider/supplier is necessary; the letter must merely furnish adequate notice of the provider/supplier's intentions).

- Is signed and dated by an authorized representative of the provider/supplier. This person need not be on file as an authorized or delegated official of the provider/supplier. The contractor shall accept the *individual's* signature if it has no reason to suspect that the *individual lacks* the authority to act on the provider/supplier's behalf. If it has doubts, however, it may contact its PEOG for guidance.

(The applicable regulations do not require that the letter contain the termination effective date or the reason for the termination. For purposes of ascertaining the effective date and reason, the contractor shall follow the instructions in section 10.1.3(C)(6).)

If the letter does not meet all of the above requirements, the contractor shall develop with the provider/supplier for the missing or deficient information. Development shall be consistent with the general developmental instructions in this chapter (e.g., 30 days for provider/supplier to respond) except as follows:

- The contractor may develop for the missing or clarifying information via any means, even by telephone. No application development letter is required.
- Except as stated in sections 10.6.1.3(C)(3) and (C)(6) below, all missing or clarifying data must be furnished via a new letter signed by an authorized representative (who need not be the same person who signed the original letter).

If the provider/supplier fails to respond fully and completely to the aforementioned request within the required timeframe, the contractor shall contact its PEOG BFL for guidance and include a copy of the initial provider/supplier letter in the e-mail to PEOG.

(See section 10.6.1.3(C)(3) below for instances where the guidance in this section 10.6.1.3(C)(2) may apply to voluntary termination letters submitted to the state/SOG Location rather than to the contractor.)

1. Provider/Supplier's Voluntary Termination Letter Received Directly from the state/SOG Location Without the Contractor Having Received a Termination Notification from the Provider/Supplier – As explained in section 10.6.1.3(B)(3) above, the contractor may receive a provider/supplier's voluntary termination letter directly from the state/SOG Location without having received any termination notification (i.e., letter or Form CMS-855) from the provider/supplier. If the contractor encounters this situation, the contractor shall adhere to the following:

(i) Provider/Supplier Voluntary Termination Letter Received from State/SOG Location Without Other Confirming Documentation - If the letter is unaccompanied by a Form CMS-1539 or other documentation signifying that the state/SOG Location (1) considers the termination letter as valid or (2) otherwise accepts the termination request, the contractor shall contact the state via e-mail for clarification on these issues. If the state indicates that it considers the provider/supplier as having terminated its provider/supplier agreement, the contractor shall process the termination consistent with the instructions in section 10.6.1.3(B)(3); any missing or unclear information (e.g., reason for the termination, effective date, CCN) shall be obtained from the state and/or

SOG Location. If the state is merely forwarding the provider/supplier letter to the contractor for processing without making any determination as to whether the termination is valid, the contractor shall process the letter consistent with the instructions in section 10.6.1.3(B)(1) and (C)(2).

(ii) Provider/Supplier Voluntary Termination Letter Received from State/SOG Location With Additional Documentation Confirming that the State Considers the Provider/Supplier As Having Terminated Its Agreement - The contractor shall process the termination consistent with the instructions in section 10.6.1.3(B)(3).

4. Tie-Out Notices – SOG Locations no longer issue tie-out notices (Form CMS-2007) for voluntary terminations.

5. Special Payments - Upon receipt of a Form CMS-855 voluntary termination application or a voluntary termination letter directly from the provider/supplier per the instructions in this section 10.6.1.3, the contractor may (but is not required to) ask the provider/supplier to complete or update the "Special Payments" portion of Section 4 of the Form CMS-855 so that future payments can be sent thereto. If the provider/supplier is adding a special payment address, it should be included in the same transaction as the voluntary termination action (i.e., one transaction incorporating both items). If the provider/supplier is changing its existing special payments address, the transaction constitutes a separate change request (i.e., one termination and one change request). The provider/supplier is not required to submit a Form CMS-588 in conjunction with a termination.

6. Termination Effective Dates and Termination Reasons – As noted previously, § 489.52(b) outlines the applicable effective dates for voluntary terminations. The contractor shall adhere to the following instructions regarding these dates as well as certain situations pertaining to termination reasons:

(i) The contractor receives a Form CMS-855 or voluntary termination letter per section 10.6.1.3(B)(1) or (B)(2) (i.e., the contractor receives a termination submission from the provider/supplier before receiving notification from the state/SOG Location):

(A) If the provider/supplier's submission is missing either the effective date of termination or the reason for the termination (or if either data element is not sufficiently clear to the contractor), the contractor shall develop with the provider/supplier for the missing/unclear data. The contractor may develop for the information via any means, even by telephone; no development letter is required. The provider/supplier must furnish the data via e-mail or other written format, but a new letter is not required. If the provider/supplier fails to submit the requested data within 30 days, the contractor shall contact its PEOG BFL for guidance. If the provider/supplier submits the data, the following effective dates apply:

(1) The termination reason is that the provider/supplier has ceased business (which includes non-operational status) – The termination effective date in ASPEN is that on which the provider/supplier stopped providing services to the community. (See section 10.6.1.3(C)(6)(i)(C) below for additional instructions concerning cessations of business.)

(2) The termination reason does not involve a cessation of business or non-operational status (e.g., the provider simply wishes to depart Medicare without closing its business; the provider elects not to renew its state license) – The contractor shall include on the draft approval letter the termination effective date the provider/supplier furnished. However, the contractor shall include in its e-mail to PEOG (see section 10.6.1.3(B)(1)(ii) above) notification as to whether this effective date is less than 6 months from the date on which the contractor first received the provider/supplier's Form CMS-855/letter. If it is less than 6 months, PEOG will determine whether this termination effective date is acceptable.

(B) If the provider/supplier's initial submission contains the termination effective date and reason, and no development on these issues is needed, the contractor shall proceed as instructed per, as applicable, sections 10.6.1.3(B)(1), (B)(2), and (C)(6)(i)(A) above.

(C) In cases where a cessation of business (including non-operational status) is involved, a retroactive termination effective date is permissible if there were no Medicare beneficiaries receiving services from the facility on or after the requested termination date. The contractor shall confirm this via a claims review prior to forwarding the e-mail and approval letter to PEOG per section 10.6.1.3(B)(1)(ii). If claims were submitted, the contractor shall contact the provider/supplier via e-mail to confirm that services were indeed rendered and adjust the termination date with the provider/supplier; if no adjustment is made or contact cannot be made, an overpayment request must be issued.

(ii) <u>The contractor is processing a Form CMS-1539 or other documentation received from the state/SOG Location other than the provider/supplier's voluntary termination letter</u> – The contractor shall use the termination date listed on the Form CMS-1539 or other documentation as the termination effective date, even if a subsequent submission from the provider/supplier (e.g., Form CMS-855) uses a different date. If no termination date is listed on the submission from the state/SOG Location, the contractor shall contact the state agency for guidance.

Except as otherwise stated in this section 10.6.1.3 or unless directed otherwise by PEOG, the contractor: (1) shall use/apply the termination effective date listed on whichever submission it is processing (e.g., the contractor is processing the provider's Form CMS-855 voluntary termination application before receiving any documentation from the state); and (2) need not alter this termination effective date based on a subsequent submission from provider/supplier or the state/SOG Location.

7. <u>State Agency Performs Survey Based on Cessation of Business</u>

(i) Solicitation of Information

Situations may arise where the state (i) performs a survey of a certified provider/supplier based on a compliant or a cessation of business and (ii) finds that the provider/supplier is no longer operational and/or has vacated the practice location. The state will notify the contractor of its findings via the Form CMS-1539 or other documentation. Upon receipt of this documentation, the contractor shall send to the provider/supplier the applicable notice in section 10.7.2 of this chapter requesting that the provider/supplier: (1) provide evidence to the contractor (with a copy to the state) that it is still operational; (2) submit a request to the contractor (either via letter or a Form CMS-855) to voluntarily terminate its enrollment; or (3) submit a Form CMS-855 change

of information application to report a changed practice location address (and any other changed data). The contractor shall copy the state and SOG Location on the notice and give the provider/supplier 10 calendar days from the date the notice is sent to respond to the request.

(ii) Potential Outcomes

(A) The provider/supplier timely furnishes evidence to the contractor and the state that it is still operational at the same location – The contractor need take no additional action on the matter until it receives confirmation from the state concerning the latter's review. (If the contractor receives evidence from the provider/supplier more than 10 days after the request was made, it shall contact the state for guidance.)

While the contractor may forward the provider/supplier's evidence to the state to ensure that the latter received it, the contractor is not required to do so. It is ultimately (1) the provider/supplier's responsibility to copy the state on its submission to the contractor and (2) up to the state to determine whether the evidence of operational status the provider/supplier submitted is sufficient.

Upon receiving notice from the state as to the review's results, the contractor shall follow the applicable instructions in this section 10.6.1.3 if the provider/supplier is to be terminated (e.g., the state sends a Form CMS-1539 to the contractor). If the provider/supplier was indeed found operational, the contractor need take no further action.

(B) The provider/supplier submits a Form CMS-855 voluntary termination and/or a voluntary termination letter in response to the contractor's aforementioned solicitation - The contractor shall process the submission consistent with the instructions in section 10.6.1.3(B)(1) and/or (B)(2), as applicable. Notwithstanding any instruction to the contrary in this section 10.6.1.3, the contractor shall use the termination effective date listed on the Form CMS-1539 or other documentation from the state (rather than the date on the Form CMS-855/letter) as the termination effective date.

(C) The provider/supplier timely submits a Form CMS-855 to change its address – The contractor shall process the change request to completion, notify the provider/supplier thereof via the applicable instructions in this chapter 10, and forward a copy of the change request via e-mail to the state and SOG Location via e-mail. In this e-mail, the contractor shall: (1) notify the state/SOG Location of the new address; (2) reference the Form CMS-1539 (or other documentation) that the state had sent to the contractor; and (3) notify the state if PECOS indicated any addresses other than the "old" or "new" address at which the provider/supplier might be located.

(D) The provider/supplier fails to respond to the contractor's solicitation - The contractor shall process the voluntary termination consistent with the instructions in section 10.6.1.3(B)(3) above.

8. Clock Stoppages – In any circumstance where the contractor is required under section 10.6.1.3 to contact PEOG (including sending a termination to PEOG for approval) or the state/SOG Location for a determination, approval, or guidance of some type, the application processing time clock is stopped. It resumes on the date on which the contractor receives

PEOG/state/SOG Location's decision, resolution, determination, or final guidance, as applicable. Interim communication between the contractor and PEOG/state/SOG Location during such "waiting periods" (e.g., PEOG request for additional information from the contractor) does not restart the clock. Optional communications---that is, communications with PEOG/state/SOG Location that are not specifically directed under this section 10.6.1.3---do not stop the processing clock.

9. PECOS Deactivation Date

a. Matching Dates - As indicated previously, the termination effective date will be entered into ASPEN. The date of deactivation in PECOS (and except if PEOG instructs otherwise) should match the termination effective date with the exception of certified suppliers paid via MCS, in which case the PECOS deactivation date shall be the day after the termination date.

b. Already Deactivated – If the provider/supplier is already deactivated in PECOS pursuant to 42 CFR § 424.540(a)(1) through (a)(6) (i.e., the provider/supplier's billing privileges are merely stopped) and the provider/supplier is now voluntarily terminating enrollment, no change in the deactivation effective date in PECOS is needed (notwithstanding any contrary instruction in this chapter).

c. Seller CHOW - Notwithstanding paragraph (9)(b) above, the deactivation effective date in PECOS---as well as the voluntary termination date---is the day before the date of the sale. For certified suppliers paid via MCS, however, the deactivation effective date shall be the date of the sale. (Note that this paragraph (9)(c) does not apply to HHA changes in majority ownership for which no exception applies; see section 10.2.1.6.1(B) of this chapter for more information.)

10.6.2 – Establishing Effective Dates

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

In reviewing this section 10.6.2, it is important that the contractor keep in mind the distinctions between: (1) the date of enrollment/approval; (2) the effective date of billing privileges under 42 CFR § 424.520(d); and (3) the date from which the supplier may retrospectively bill for services under § 424.521(a).

(Note that the date of receipt of a PECOS application is the date on which the contractor received it, not the date on which the application required the contractor's manual intervention per section 10.3.)

A. Date of Enrollment/Approval

This section 10.6.2(A) does not apply to the application of § 424.535(g)(3). See section 10.4.7.2(A)(3) for more information.

For suppliers other than ambulatory surgical centers and portable x-ray suppliers, the date of enrollment is the date the contractor approved the application. The enrollment date cannot be made retroactive. To illustrate, suppose a practitioner met all the requirements needed to enroll in Medicare (other than the submission of a Form CMS-855I) on January 1. The *practitioner*

submits *a* Form CMS-855I to the contractor on May 1, and the contractor approves the application on June 1. The date of enrollment is June 1, not January 1.

B. Establishing Effective Dates of Billing Privileges for Certain Suppliers Under 42 CFR § 424.520(d)

1. Applicability

This section 10.6.2(B) applies to the following individuals and organizations:

a. Physicians; physician assistants; nurse practitioners; audiologists; clinical nurse specialists; certified registered nurse anesthetists; anesthesiology assistants; certified nurse- midwives; clinical social workers; clinical psychologists; independently billing psychologists, registered dietitians or nutrition professionals; physical therapists; occupational therapists; speech-language pathologists; mental health counselors; marriage and family therapists; and physician and non-physician practitioner organizations (e.g., group practices) consisting of any of the categories of individuals identified above.

b. Ambulance suppliers

c. Part B hospital departments

d. CLIA labs

e. Opioid treatment programs.

f. Mammography centers

g. Mass immunizers/pharmacies

h. Radiation therapy centers

i. Home infusion therapy suppliers

(See 42 CFR §§ 424.520(d)(2) and 424.521(a)(2) for the regulatory listing of these providers/suppliers.)

2. Background

In accordance with 42 CFR § 424.520(d)(1), the effective date of billing privileges for the individuals and organizations identified in § 424.520(d)(2) (and section 10.6.2(B)(1) above) is the later of:

(i) The date the supplier filed an enrollment application that was subsequently approved, or

(ii) The date the supplier first began furnishing services at a new practice location.

NOTE: The date of filing for Form CMS-855 applications is the date on which the contractor received the application, regardless of whether the application was submitted via paper or Internet-based PECOS.

3. Retrospective Billing Under 42 CFR § 424.521(a)

Consistent with 42 CFR § 424.521(a)(1), the individuals and organizations identified in § 424.521(a)(2) (and section 10.6.2(B)(1) above) may retrospectively bill for services when:

(i) The supplier has met all program requirements, including state licensure requirements; and

(ii) The services were provided at the enrolled practice location for up to—

(A) 30 days prior to the effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries, or

(B) 90 days prior to the effective date if a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§5121-5206 (Stafford Act) precluded enrollment in advance of providing services to Medicare beneficiaries.

The contractor shall interpret the above-mentioned phase "circumstances precluded enrollment" to mean that the supplier meets all program requirements (including state licensure) during the 30-day period before an application was submitted and no final adverse action (as that term is defined in § 424.502) precluded enrollment. If a final adverse action precluded enrollment during this 30-day period, the contractor shall only establish an effective billing date the day after the date that the final adverse action was resolved--so long as it is not more than 30 days prior to the date on which the application was submitted.

If the contractor believes that the aforementioned Presidentially-declared disaster exception may apply in a particular case, it shall contact its CMS Provider Enrollment & Oversight Group Business Function Lead for a determination on this issue.

4. Summarizing the Distinction Between Effective Date of Billing Privileges and Retrospective Billing Date

As already discussed, the effective date of billing privileges is "the later of the date of filing or the date (the supplier) first began furnishing services at a new practice location." The retrospective billing date, however, is "up to…30 days prior to (the supplier's) effective date (of enrollment)." To illustrate, suppose that a non-Medicare enrolled physician begins furnishing services at an office on March 1. A Form CMS-855I initial enrollment application *is submitted* on May 1. The application is approved on June 1 (which, as discussed in section 10.6.2(A) above, is the date of enrollment). The physician's effective date of billing privileges is May 1, which is the later of: (1) the date of filing, and (2) the date *the physician* began furnishing services. The retrospective billing date is April 1 (or 30 days prior to the effective date of billing privileges), assuming the requirements of 42 CFR § 424.521(a) are met. The effective date entered in PECOS and the Multi-Carrier System will be April 1; claims submitted for services provided before April 1 will not be paid.

C. Effective Date of Reassignment

Consistent with 42 CFR § 424.522(a), the effective date of the reassignment is 30 days before the reassignment application is submitted if all applicable requirements during that period were otherwise met. However, and except as otherwise stated in this section 10.6.2(C), an additional retroactive reassignment period of:

- 30 days shall be applied per § 424.521(a)(1)(i); or
- 90 days shall be applied if a Presidentially declared disaster applies per § 424.521(a)(1)(ii)

(For purposes of this section 10.6.2(C), the dates described in the previous paragraph and bullets will be collectively referenced as the "§ 424.522(a) date.")

Under this, therefore, the retroactive billing period would be 60 days (or 30 days under § 424.522(a) + 30 days per § 424.521(a)(1)(i)) or 120 days (30 days under § 424.522(a) + 90 days if § 424.521(a)(1)(ii) applies). This applies to initial reassignments as part of an initial enrollment or involving an enrolled supplier that is adding a new reassignment.

As noted elsewhere in this chapter, individual physicians and practitioners who wish to reassign benefits must now complete Section 4(F) of the Form CMS-855I rather than the discontinued Form CMS-855R. With this, the following scenario occasionally arises:

(1) The physician or practitioner submits a Form CMS-855I to reassign benefits;
(2) Section 4(F) is either blank or incomplete;
(3) The contractor develops for a completed Section 4(F); and
(4) The physician or practitioner submits Section 4(F).

The reassignment effective date in this situation -- assuming the application and Section 4(F) are ultimately approved and all applicable requirements were met during this timeframe -- should be based on the date on which the Form CMS-855I was initially submitted and not the date on which the physician or practitioner finally submitted Section 4(F). For instance, suppose a reassigning physician submits a Form CMS-855I on March 1 with Section 4(F) incomplete. The physician later submits Section 4(F) on March 14. The reassignment effective date is predicated on the March 1 date and not March 14. This means that the extra 30-day or 90-day period goes back from March 1.

The policies in this section 10.6.2(C) apply to: (1) initial reassignments as part of an initial enrollment; and (2) enrolled suppliers that are adding a new reassignment.

D. Effective Date for Certified Providers and Certified Suppliers

Note that 42 CFR § 489.13 governs the determination of the effective date of a Medicare provider agreement or supplier approval for health care facilities that are subject to survey and certification. Section 489.13 has been revised to state that: (1) the date of a Medicare provider agreement or supplier approval may not be earlier than the latest date on which all applicable

federal requirements have been met; and (2) such requirements include the contractor's review and verification of an application to enroll in Medicare.

E. Effective Date for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

Per § 424.57(b), DMEPOS suppliers must meet, among other requirements, the following conditions to be eligible to receive payment for a Medicare-covered item:

(1) The supplier has submitted a completed application to CMS to furnish Medicare-covered items including required enrollment forms. (The supplier must enroll separate physical locations it uses to furnish Medicare-covered DMEPOS excluding locations that it uses solely as warehouses or repair facilities.)

(2) The item was furnished on or after the date CMS issued to the supplier a DMEPOS supplier number conveying billing privileges. (CMS issues only one supplier number for each location.) This requirement does not apply to items furnished incident to a physician's service.

The contractor shall indicate the supplier's status as approved in PECOS upon the contractor making the determination the supplier meets all of the supplier standards found at § 424.57(c). The date the supplier was approved in PECOS shall be the supplier's effective date.

F. Form CMS-855O Effective Dates

Notwithstanding any other instruction in the chapter to the contrary, the effective date of a Form CMS-855O enrollment per 42 CFR § 424.522 is the date on which the Medicare contractor received the Form CMS-855O application if all other requirements are met --- meaning the Form CMS-855O was processed to approval.

G. Effective Date for Medicare Diabetes Prevention Program (MDPP) Suppliers

In accordance with 42 CFR § 424.205(f), the effective date of billing privileges for MDPP suppliers is the later of:

- The date the supplier filed an enrollment application that was subsequently approved,
- The date the supplier filed a corrective action plan that was subsequently approved by a Medicare contractor, or
- The date the supplier first began furnishing services at a new administrative location that resulted in a new enrollment record or Provider Transaction Access Number. (For PECOS applications, see section 10.3 of this chapter for information about what constitutes an enrollment record in PECOS.)

Under no circumstances should an effective date for billing privileges be prior to April 1, 2018. For any Form CMS-20134 submitted prior to April 1, 2018, and subsequently approved, the

contractor shall note April 1, 2018, as the MDPP supplier's effective date, even if this date is in the future.

NOTE: The date of filing for paper Form CMS-20134 applications is the date on which the contractor received the application. For Internet-based PECOS applications, the date of filing is the date that the contractor received an electronic version of the enrollment application and a signed certification statement submitted via paper or electronically.

H. Future Effective Dates

If the contractor cannot enter an effective date into PECOS because the provider/supplier, its practice location, etc., is not yet established, the contractor may use the authorized official's date of signature as the temporary effective date. Once the provider/supplier and the effective date are established (e.g., notification from the state is received), the contractor shall change the effective date in PECOS.

10.6.4 – Provider and Supplier Business Structures

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

This section explains the legalities of various types of business organizations that may enroll, including sole proprietorships. Note that the provider's or supplier's (hereafter occasionally referred to collectively as "provider") organizational structure can have a significant impact on the type of information it must furnish on the Form CMS-855 or CMS-20134.

Business organizations are generally governed by state law. Thus, State X may have slightly different rules than State Y regarding certain entities. (In fact, X may permit the creation of certain types of legal entities that Y does not.) The discussion below gives only a broad overview of the principal types of business entities and does not take into account different state nuances.

Since CMS issues a 1099 based on an enrolled entity's business structure, providers should consult their accountant or legal advisor to ensure that they are establishing the correct business structure.

A. Sole Proprietorships

A business is a sole proprietorship if it meets all of the following criteria:

- It files a Schedule C (1040) with the Internal Revenue Service (this form reports the business's profits/losses);
- One person owns all of the business's assets; and
- It is not incorporated.

A sole proprietorship is not a corporation. Suppose a physician operates *a* business as a home health agency. If *it is* incorporated, the business becomes a corporation (even though

the physician is the only stockholder). The frequently used term "unincorporated sole proprietorship" is therefore a misnomer because sole proprietorships by definition are unincorporated. In addition, merely because the sole proprietor hires employees does not mean the business is no longer a sole proprietorship. Assume that W is a sole proprietor and hires X, Y, and Z as employees. W's business is still a sole proprietorship because *W* remains the 100% owner of the business. If, however, W had sold parts of *the* sole proprietorship to X, Y, and Z, the business would no longer be a sole proprietorship because there is now more than one owner.

Note that professional associations (PAs) are generally not considered to be sole proprietorships; the PA designation is typically used in states that do not allow individuals to incorporate and form professional corporations. The PA will have its own employer identification number and is considered (like a professional corporation) to be a legal entity that is separate and distinct from the individual.

B. Processing Enrollments for Sole Proprietorships

1. Application Form Sections

If the provider indicates in the Identifying Information/Business Information section of the Form CMS-855A, CMS-855B, CMS-855I, CMS-855S or CMS-20134 that the *provider* is a sole proprietor, the contractor shall adhere to the following:

- The legal business name (LBN) in the Business Information section should list the person's (the sole proprietor's) legal name.

- The tax identification number (TIN) in the Business Information section should list the person's social security number.

- The Final Adverse Legal Actions/Convictions section of the Form CMS-855A, CMS-855B, CMS-855I, CMS-855S or CMS-20134 must be completed with information about the individual's final adverse action history.

- The Organizational Ownership and/or Managing Control section of the Form CMS-855A, CMS-855B, CMS-855I, CMS-855S or CMS-20134 will not apply unless the person has hired an entity to exercise operational or managerial control over the business (i.e., no owners will be listed in the section, for the sole owner has already reporte*d p*ersonal information in the Identifying Information and Adverse Legal Actions sections).

- No owners, partners, or directors/officers need to be reported in the Individual Ownership and/or Managing Control section. However, all managing employees (whether W-2 or not) must be listed.

- If the sole proprietor is not enrolling as a physician or non-physician practitioner via the Form CMS-855I, *the individual* may have authorized and delegated officials.

Since most sole proprietorships that complete the Form CMS-855A, CMS-855B, CMS-855I, CMS-855S or CMS-20134 will also have an EIN, the contractor shall request from the provider a copy of its CP-575, any federal tax department tickets, or any other preprinted information from the IRS containing the provider's EIN.

2. Reassignments of Benefits

If a physician or non-physician practitioner who is currently reassigning all *b*enefits attempts to enroll as a sole proprietorship or the sole owner of *a* professional corporation, professional association, or limited liability company, the contractor shall call or e-mail the old practice location to determine if the physician or non-physician practitioner is still employed there; if *the individual* is not, the contractor shall contact the practitioner to verify that *the latter* is indeed attempting to enroll as a sole proprietorship or sole owner.

C. Partnerships

A partnership is an association of two or more persons/entities who carry on a business for profit. Each partner in a partnership is an owner. If A and B form the "Y Partnership" and each contributes $50,000 to start the business, each partner owns one-half of Y.

In several respects, a partnership is the opposite of a corporation:

- Each partner is liable for all the debts of the partnership. Using the example above, suppose the Y Partnership breached a contract it had with X, who now sues for $10,000. Since each partner is liable for all debts, X can collect the entire $10,000 from A, or from B, or $5,000 from each, etc. This is because, unlike a corporation, a partnership is not really a separate and distinct entity from its partners/owners; the partners are the partnership. If Y had been a corporation, the owners (A and B) would likely have been shielded from liability.

- There is no "double taxation" with partnerships. The partnership itself does not pay taxes, although each partner pays taxes on any income *the partner* earns from the business.

- Unlike a corporation, a partnership generally does not file with the state upon its creation documents similar to articles of incorporation. Instead, a partnership has a "partnership agreement," which amounts to a contract between the partners outlining duties, responsibilities, powers, etc.

- Each partner has the right to participate in running the business's day-to-day operations, unless the partnership agreement dictates otherwise.

  An alternative type of partnership is a limited partnership (as opposed to a "general partnership," described above). While possessing many of the characteristics of a general partnership, there are some key differences. First, a limited partnership (LP) must file formal documents with the state. Second, a LP has two types of partners – general and limited. The general partner(s) runs the business yet is personally

responsible for all of the LP's debts; the limited partner(s) has limited liability yet cannot participate in the management of the business.

D. Limited Liability Companies

A limited liability company (LLC) is a legal entity that is neither a partnership nor a corporation but has characteristics of both. Its owners have limited liability (as with stockholders in a corporation). Also, the LLC does not pay federal taxes (similar to a partnership), although its owners – usually labeled "members" - must pay taxes on any dividends they earn.

An LLC should not be confused with a limited liability corporation, which is a type of corporation in some states. A limited liability company is not a corporation or partnership but a distinct legal entity created and regulated by special state statutes.

Note that certain Form CMS-855 or Form CMS-20134 information is required of different entities. The primary example of this is in the Individual Ownership and/or Managing Control section. If the provider is a corporation, it must list its officers and directors on the form. Partnerships and LLCs, on the other hand, do not have officers or directors and therefore need not list them.

E. Joint Ventures

A joint venture is when two or more persons/entities combine efforts in a business enterprise and agree to share profits and losses. It is similar to a partnership and is treated as a partnership for tax purposes. The core difference is that while a partnership is an ongoing business, a joint venture is a temporary, one-time business undertaking. A joint venture, therefore, is to some extent a "temporary partnership."

F. Corporations

A corporation is an entity that is separate and distinct from its owners (called stockholders, or shareholders). To form a corporation, various documents – such as articles of incorporation – must be filed with the state in which the business will incorporate. The principal elements of a corporation are:

- Limited Liability – This is the main reason for a business's decision to operate as a corporation. Suppose Corporation X has ten stockholders, each owning 10% of the business. X breached a contract it had with Company Y, which now wants to sue X's owners. Unfortunately for Y, it can generally only sue X itself; it cannot sue X's shareholders. The corporation's owners are essentially shielded from liability for the corporation' actions because, as stated above, a corporation is separate and distinct from its owners.

  Despite the concept of limited liability, there may be isolated instances where a corporation's owners/stockholders can be held personally liable for the corporation's debts. This is known as "piercing the corporate veil."

- "Double" Taxation – This is the principal reason for a business's decision not to be a corporation. "Double" taxation means that: (1) the corporation itself must pay taxes; and (2) each shareholder must pay taxes on any dividends the *shareholder* receives from the business.

- Board of Directors – Most corporations are run by a governing body, typically called a board of directors.

  (As discussed in section 10.6.7.2 of this chapter, there is an important difference between the term "director" in the context of board members and someone who has "director" in *the person's* job title (e.g., "Director of Finance"). Simply because an individual works for a corporation as a director of a department, unit, etc., does not automatically mean *the person* is a member of the board of directors. If the entity is a corporation, and for purposes for the Individual Ownership and/or Managing Control section of the Form CMS-855 and Form CMS-855, the term "director" means board members.

Two special types of corporations that contractors may encounter are:

- "Professional Corporation" (PC) - In general, a PC (1) is organized for the sole purpose of rendering professional services (such as medical or legal), and (2) all stockholders in a PC must be licensed to render such services. Thus, if A, B, and C want to form a physician practice (each is a 1/3 stockholder) and only A is a medical professional, a PC probably cannot be formed (depending, though, on what the applicable state PC statute says). A PC's title will usually end in "PC," "PA" (Professional Association), or "Chartered."

- "Close" Corporation (CC) (or "closely-held" corporation) – This type of corporation has a very limited number of stockholders. Unlike most corporations, a CC's board of directors generally does not run the business; rather, the shareholders do. The stock is typically not sold to outsiders.

Although PCs and CCs are considered "corporations" for enrollment purposes, state laws governing these entities are often different from those that govern "regular" corporations (i.e., states have separate statutes for "regular" corporations and for PCs/CCs.) In many cases, an entity must specifically elect to be a PC or CC when filing its paperwork with the state.

G. Non-Profit Organizations

The term "non-profit organization" (NPO) can be misleading. It does not signify an organization that is prohibited from making a profit. Rather, it means that all of the organization's profits are put back into the entity to promote its goals, which are usually political, social, religious, or charitable in nature; an NPO is not organized primarily for profit but instead to further some other goal. An entity can acquire NPO status by obtaining

an IRS 501(c)(3) certification from the IRS (meaning it is tax-exempt) or by acquiring such status from the state in which it is located.

NPOs are typically operated and/or managed by a board of trustees or other governing body. NPO status is important for enrollment purposes because NPOs generally do not have owners. (See section 10.6.4(D)(3) of this chapter for more information on NPO reporting requirements.)

H. Government-Owned Entities

For purposes of enrollment, a government-owned entity (GOE) exists when a particular government body (e.g., federal, state, city or county agency) will be legally and financially responsible for Medicare payments received. For example, suppose Smith County operates Hospital X. Medicare overpaid X $100,000 last year. If Smith County is the party responsible for reimbursing Medicare this amount, X is considered a government-owned entity.

Note that--

- GOEs do not have "owners." Thus, the Organizational Ownership and/or Managing Control sections of the Form CMS-855 or CMS-20134 need only contain the name of the government body in question. Using our example above, this would be Smith County.

- For the Individual Ownership and/or Managing Control section of the Form CMS-855 or CMS-20134, the only people that must be listed are "managing employees." This is because GOEs do not have corporate officers or directors.

The provider must submit a letter from the government body certifying that the government entity will be responsible for any Medicare payments.

10.6.6 – Final Adverse Actions

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

Unless stated otherwise, the instructions in this section 10.6.6 apply to the following sections of the Form CMS-855 and Form CMS-20134:

- Final Adverse Actions/Convictions (Section 3 of the Form CMS-855A, Form CMS-855B, Form CMS-855I, Form CMS-855O, and Form CMS-20134, and Section 7 of the Form CMS-855S)

- Business Information section/Private Practice Business Information section of the Form CMS-855I

- Organizational Ownership and/or Managing Control Final Adverse Legal Action History Section (Section 5 of the Form CMS-855A, Form CMS-855B, and Form CMS-20134, and Section 8 of the Form CMS-855S)

- Individual Ownership and/or Managing Control Final Adverse Legal Action History Section (Section 6 of the Form CMS-855A, Form CMS-855B, Form CMS-855I, and Form CMS-20134, and Section 9 of the Form CMS-855S)

For purposes of this section 10.6.6, the terms "final adverse action" and "adverse legal action" (as those terms are explained in section 10.6.6(F) of this chapter) will be collectively referred to as "ALA(s)", unless otherwise noted.

A. Prior Approval

The contractor shall send the application (if applicable) and ALA information to CMS (in accordance with section 10.6.6(I) below) for review for potential administrative action if:

- If the provider/supplier discloses its ALA on the Form CMS-855 or Form CMS-20134;

- If the provider/supplier discloses the ALA of an associated individual/entity on the Form CMS-855 or Form CMS-20134; or

- The contractor discovers---on its own volition and regardless of whether the provider/supplier is submitting a Form CMS-855 or Form CMS-20134---a provider's/supplier's ALA or that of an associated individual or entity of the provider/supplier.

In this chapter, and unless otherwise noted, "associated" individuals/entities refer to parties listed under the "Ownership Interest and/or Managing Control Information" sections of the Form CMS-855 or Form CMS-20134.

B. Review of the Provider Enrollment, Chain and Ownership System (PECOS)

If the contractor is reviewing a provider's/supplier's Form CMS-855 or Form CMS-20134 application for potential denial or revocation based on an ALA, the contractor shall search PECOS to determine whether the individual/entity with the ALA has any other associations (e.g., is listed in PECOS as an owner or managing employee of three Medicare-enrolled providers). This review requires searching the tax identification number (TIN) of the individual/entity and clicking "Associates w/ Connections" in PECOS. The TIN is the social security number or employer identification number (EIN).

If the contractor finds such an association and there are grounds to revoke the associated enrollment(s) of other provider(s)/supplier(s), the contractor shall submit the revocation referral(s) to CMS at ProviderEnrollmentRevocations@cms.hhs.gov.

C. Chain Home Offices, Billing Agencies, and Home Health Agency Nursing Registries

If the contractor discovers that an entity listed in Section 7 of the Form CMS-855A, Section 8 of the Forms CMS-855A/B/I/20134, or Section 12 of the Form CMS-855A has had an ALA imposed against it, the contractor shall contact its Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL) for guidance if needed. For any ALA against individuals

listed in Section 7 of the Form CMS-20134, the contractor shall refer to section 10.3.2.7 of this chapter, where this process is outlined in detail.

D. Review of the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) Online Searchable Database and the System for Award Management (SAM)

(NOTE: The required reviews described in this subsection (D) do not apply to (a) voluntary termination submissions and (b) associated individuals/entities being deleted/removed on the Form CMS-855 or Form CMS-20134. Moreover, the review requirement only applies to data that is reported via an **actual submission**. Data that has previously been reported (and thus is not part of the submission in question) need not be reviewed. To illustrate, suppose a provider has 20 managing employees on file in PECOS. It submits a change request to add two more managing officials. The contractor need only review the two officials. It need not check the other 20.)

Except as otherwise stated in this section 10.6.6, the contractor shall review each submission of a Form CMS-855 or Form CMS-20134 for (1) any exclusion(s) by HHS OIG of the provider/supplier and (2) exclusion(s) of any associated individuals/entities listed in the "Ownership Interest and/or Managing Control Information" Sections (e.g., an owner, managing employee, or authorized official), regardless of whether the provider/supplier reported the exclusion on the application (as applicable).

The OIG Online Searchable Database is located at exclusions.oig.hhs.gov; it includes all active exclusions for an individual or entity. The contractor shall verify the exclusion by entering the TIN of the excluded individual/entity and shall save that screenshot of the exclusion. (No screenshot is needed if no exclusion is involved.) The contractor shall also search for (1) any waivers to the HHS OIG exclusion and (2) any conviction(s) that may be tied to an exclusion (see section 10.6.6(G) and the applicable Decision Tree tables in section 10.6.6(I) for more details. In addition, if PECOS shows any associated enrollments (by TIN) of the excluded individual/entity that are not voluntarily withdrawn from Medicare, the contractor shall include this information in the ALA referral to CMS (as well as indicate whether CMS can take administrative action on the associated enrollment(s)).

In addition---and except as otherwise stated in this section 10.6.6---the contractor shall review each submission of a Form CMS-855 or Form CMS-20134 and search the SAM (i.e., at SAM.gov; formerly, the General Services Administration Excluded Parties List System) for exclusions/debarments if there is no HHS OIG exclusion—as identified on the OIG Online Searchable Database—for the provider/supplier and for any associated individuals/entities listed under the "Ownership Interest and/or Managing Control Information" Sections (e.g., an owner, managing employee, or authorized official). Only if SAM populates an exclusion/debarment—that the OIG Online Searchable Database does not populate—shall the contractor save that SAM screenshot when sending the ALA referral to CMS (even if the contractor learns from OIG that the exclusion is not active).

When an entity or individual is listed as debarred in the SAM (i.e., at SAM.gov), the SAM record may identify associated entities and persons that are also debarred. To illustrate, suppose

Smith is identified as debarred. The SAM record may also list individuals and entities associated with Smith that are debarred as well, such as *"S*mith Company" and "Smith *Consulting".*

If the contractor learns via the Form CMS-855 or Form CMS-20134 verification process, a Unified Program Integrity Contractor (UPIC) referral, or other similar means that a particular individual/entity is debarred or excluded, the contractor shall search the individual/entity in the SAM to see if the SAM record discloses any associated parties that are debarred or excluded. If associated parties are listed, the contractor – after verifying, via the instructions in this chapter, that the associated party is indeed debarred – shall check PECOS to determine whether the party is listed in any capacity. If the party is listed, the contractor shall take all applicable steps outlined in this chapter with respect to revocation proceedings against the party and against any persons/entities with whom the party is associated. For instance, using our example above, if the contractor confirms tha*t S*mith is debarred and PECOS show*s S*mith as an owner of Entity X, the contractor shall, as applicable, send an ALA referral to CMS for review for potential administrative action against X as outlined in this section 10.6.6.

In instances where an HHS OIG exclusion populates SAM but not the OIG Online Searchable Database, this could mean that the provider/supplier (or associated individual/entity) has been reinstated but the SAM has not been accordingly updated. In such cases, the contractor shall contact the appropriate OIG official to (1) verify whether the exclusion is still active, (2) determine the date of reinstatement (if applicable), and (3) request the reinstatement letter from HHS OIG (if applicable). The contractor can find the appropriate OIG official on the Exclusion Record of an individual/entity on SAM by clicking on the respective Excluding Agency (as the respective contact information would populate there). The contractor shall, as applicable, include this information and the reinstatement letter (if available) when sending the ALA referral to CMS.

E. Disclosure of ALA

This section 10.6.6(E) discusses the disclosure and non-disclosure of ALAs on the Form CMS-855 and Form CMS-20134 as well as required documentation.

1. ALA Disclosed

a. Non-Felonies

If the provider/supplier discloses a non-felony ALA on the Form CMS-855/20134, the provider/supplier must furnish documentation concerning (i) the type of reported non-felony ALA, (ii) the date the non-felony ALA occurred, and (iii) what court or governing/administrative body imposed the action. (This documentation is referenced in Section 3 of the Form CMS-855/20134.) The provider/supplier must furnish the documentation regardless of whether the non-felony ALA occurred in a state different from that in which the provider/supplier seeks enrollment or is enrolled. The contractor shall develop for any such documentation that the provider/supplier fails to submit using the general developmental procedures outlined in this chapter.

b. Felony Convictions

(As a reminder, this subsection (E)(1)(b) applies only if the felony was disclosed.)

(i) Acquisition

For felony conviction documentation (and except as stated in subsection (E)(1)(b)(ii) below), the contractor shall:

- Develop for any required documentation (as described in subsection (E)(1)(a)(i) through (iii) above and on Section 3 of the Form CMS-855) that the provider/supplier fails to submit using the general developmental procedures outlined in this chapter; and

- Follow the instructions in subsection (E)(3) regarding the acquisition of the felony-specific documentation discussed therein.

(ii) Potential Overlap

In all instances discussed in this subsection (E)(1)(b), the contractor shall secure the mandatory documentation subsection (E)(3)(b) below. If the mandatory documentation captures the same information described in subsection (E)(1)(a)(i) through (iii) above, however, the contractor need not obtain the separate/additional (E)(1)(a)(i) through (iii) documentation. For instance, suppose the mandatory documentation identifies the court that imposed the action. The contractor need not obtain additional documentation verifying this data (as stated in subsection (E)(1)(a)(i) through (iii) above and Section 3 of the Form CMS-855). If, however, the mandatory documentation does not contain the data in subsection (E)(1)(a)(i) through (iii), the contractor shall develop for this information if the felony was reported.

2. ALA Is Not Disclosed

This section (E)(2) applies to situations where the contractor discovers an ALA that was not reported on the Form CMS-855/20134.

a. Non-Felonies

For ALAs other than felony convictions, the contractor need not develop for ALA documentation unless CMS instructs otherwise.

b. Felony Conviction

For felony conviction documentation, the contractor shall follow the instructions in section 10.6.6(E)(3).

3. Special Requirements Concerning Felony Documentation

a. Introduction

(This subsection (E)(3) applies (i) only to felony convictions and (ii) regardless of whether the felony conviction was reported on the Form CMS-855/20134.)

If, in felony conviction situations, the provider/supplier does not submit the mandatory documentation described in section 10.6.6(E)(3)(b) below (and, as applicable, the documentation in subsection (E)(1)(a)(i) through (iii) above), the contractor shall directly develop for the documentation with the provider/supplier using the existing development procedures outlined in this chapter; prior approval or instruction from CMS to develop in this scenario is not needed. After obtaining the documents (or after an unsuccessful attempt), the contractor shall submit the felony referral, application, and any supporting document(s) to CMS for review. The provider/supplier must fully submit all of the requested documentation within 30 calendar days of the date of the development request. If the provider/supplier fails to do so, the contractor shall reject the application, upon PEOG approval; PEOG will then determine, if applicable, whether a revocation is warranted.

b. Documentation to Be Submitted

Mandatory – When sending the felony referral for review (and except as otherwise stated in this chapter), the contractor shall obtain from the provider/supplier and submit to CMS the following documentation:

- Judgment and/or sentencing order (as applicable);
- Any amended judgment and/or amended sentencing order (if applicable); and
- Jury verdict form or guilty plea acceptance document (as applicable; availability may vary from court to court). Note that some courts may incorporate the jury verdict or guilty plea entry/acceptance directly into the judgment and/or sentencing order. Also, some courts may not have a separate jury verdict form or guilty plea entry/acceptance, in which case the judgment and/or sentencing order suffices.

Not Required but Encouraged – The following documentation is optional, though the contractor is encouraged to, if possible, secure and submit this material to CMS; the data below could help furnish valuable background and context to CMS regarding the case.

- Any document showing the court's dismissal of charges (if applicable)
- Plea agreement (if applicable)
- Docket report/case summary
- Information or indictment
- Any amended information document(s) or superseding indictment(s)
- Police criminal complaint and/or affidavit of probable cause

4. Additional Policies

a. Reinstatements - If the individual or entity in question was excluded or debarred but has since been reinstated, the contractor shall confirm the reinstatement through HHS OIG or, in the case of debarment, through the federal agency that took the action. The appropriate OIG contact for such reinstatement verification requests is sanction@oig.hhs.gov. SAM.gov provides the appropriate contact for the federal agency that took debarment action on the screenshot page of that action (when searching the individual/entity).

b. Scope of Disclosure – All ALAs that occurred under the legal business name (LBN) and TIN of the disclosing entity (e.g., applicant, Section 5 owner) must be reported.

Example (A) - Smith Pharmacy, Inc. had 22 separately enrolled locations in 2017. Each location was under Smith's LBN and TIN. In 2018, two locations were excluded by the OIG and then subsequently revoked by CMS. Smith submits a Form CMS-855S application for a new location on Jones Street. Suppose, however, that each of Smith's locations had its own LBN and TIN. The Jones Street application need not disclose the two revocations from 2018.

Example (B) – A home health agency (HHA), hospice, and hospital are enrolling under Corporation X's LBN and TIN. X is listed as the provider in Section 2 of each applicant's Form CMS-855A. All three successfully enroll. Six months later, Company X's enrollment for the HHA is revoked due to an OIG exclusion. Both the hospice and the hospital must report that X was excluded on a Form CMS-855A change request because X is under the provider's LBN and TIN. Assume now that X seeks to enroll an ambulatory surgical center (ASC) under X's LBN and TIN. The exclusion would have to be reported in Section 3 of the ASC's initial Form CMS-855B.

Example (C) – Company Y is listed as the provider/supplier for two HHAs and two suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). These four providers/suppliers are under Y's LBN and TIN. Each provider/supplier is located in a different state. All are enrolled. Y's enrollment for one of the DMEPOS suppliers is revoked due to a felony conviction. Y now seeks to enroll an ASC in a fifth state. Y must disclose its felony conviction even though the felony conviction occurred in a state different from that in which the ASC is located.

c. Timeframe – With the exception of felony and misdemeanor convictions (and unless stated otherwise in this chapter), all ALAs must be reported in the final adverse legal action section of the Form CMS-855 or Form CMS-20134 regardless of when the final adverse legal action occurred.

d. Evidence to Indicate ALA – There may be instances where the provider or supplier states on the Form CMS-855 or Form CMS-20134 that the person or entity has never had an ALA imposed against *the person or entity*, but the contractor finds evidence to indicate otherwise. In such cases, the contractor shall follow the decision tree in section 10.6.6(I) below.

e. MDPP Coaches - MDPP suppliers enrolling via the Form CMS-20134 are not required to report any ALA as it relates to MDPP coaches submitted on Section 7 of that form.

F. Scope of a Reportable ALA

Providers and suppliers shall disclose all reportable ALAs on their enrollment applications. To satisfy the reporting requirement, the provider/supplier shall complete the Final Adverse Legal Action section(s) (Form CMS-855 or Form CMS-20134) in its entirety and attach all applicable documentation concerning the ALA to the application. All ALAs must be reported, regardless of whether any records have been expunged or sealed or any appeals are pending.

ALAs that must be disclosed on the Form CMS-855 or Form CMS-20134 include:

1. Felony conviction(s) within 10 years

a. Reporting – Providers/suppliers are required to report a felony (federal or state) when: (1) a conviction has occurred; and (2) the felony conviction date (e.g., the date of a court's acceptance of a guilty plea or the date of a jury verdict) is within 10 years from the submission date of a Form CMS-855 or Form CMS-20134 application.

b. When a Conviction Occurs - A conviction (as the term 'convicted' is defined in 42 CFR 1001.2) has occurred when:

(A) A judgment of conviction has been entered against an individual or entity by a federal, state, or local court, regardless of whether:

(1) There is a post-trial motion or an appeal pending, or

(2) The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;

(B) A federal, state, or local court has made a finding of guilt against an individual or entity;

(C) A federal, state, or local court has accepted a plea of guilty or nolo contendere by an individual or entity; or

(D) An individual or entity has entered into participation in a first offender, deferred adjudication, or other program or arrangement where judgment of conviction has been withheld.

A felony conviction shall be reported by the provider/supplier even if the conviction has been sealed or expunged or there is an appeal or post-trial motion pending. Furthermore, in instances where the defendant pleads guilty to a felony and a court orders deferred adjudication/adjudication withheld/treatment in lieu of conviction/probation with a suspended imposition of sentence/pre-trial diversion, these dispositions generally fall under 42 CFR 1001.2's definition of 'convicted.' Consequently, the provider/supplier shall report these types of convictions on the Form CMS-855 or Form CMS-20134.

c. Additional Information

For any submission of a Form CMS-855 or Form CMS-20134 for initial enrollment, reactivation, change of information, or revalidation---and except as stated in the following paragraph---the contractor shall review and use APS as a resource to determine if there are any felony convictions on which CMS can take administrative action. The contractor shall include any felony conviction(s) and/or ongoing criminal case(s) listed on APS in its referral email to CMS.

(NOTE: The aforementioned APS review is not required for (a) voluntary termination submissions, (b) associated individuals/entities being deleted/removed on the Form CMS-855, and (c) any individuals and entities listed on the application who have previously been reviewed against APS as part of any prior application submission. Moreover, the APS review requirement only applies to data that is reported via an actual submission. Data that has previously been reported (and thus is not part of the submission in question) need not be reviewed.)

The aforementioned APS review would be to determine whether (a) the provider/supplier submitting the Form CMS-855 or Form CMS-20134 or (b) any associated individual/entity (e.g., owner or managing employee) listed in the "Ownership Interest and/or Managing Control Information" sections of the provider/supplier's Form CMS-855 or Form CMS-20134 has a felony conviction.

2. Misdemeanor conviction within 10 years

- Report a misdemeanor conviction (federal or state) when—
    - A conviction has occurred;
    - The misdemeanor conviction date (e.g., the date of a court's acceptance of a guilty plea, or the date of a jury verdict) is within 10 years from the submission date of a Form CMS-855 or Form CMS-20134 application; and
    - The misdemeanor is related to any of the following:
        - The delivery of an item/service under Medicare or a state health care program;
        - The abuse or neglect of a patient in connection with the delivery of a health care item or service;
        - Theft, fraud, embezzlement, breach of fiduciary duty or other financial misconduct in connection with the delivery of a health care item/service;
        - The interference with or obstruction of any investigation into any criminal offense described under 42 CFR 1001.101 or 1001.201; or
        - The unlawful manufacture, distribution, prescription or dispensing of a controlled substance.
- A conviction has occurred when any of the criteria in 42 CFR 1001.2 (and as described in the second in bullet in (F)(1)(b) above) are met.
- A misdemeanor conviction shall be reported even if the conviction has been sealed, expunged, or there is an appeal or post-trial motion pending.

3. Current or past suspension(s)/revocations(s)/voluntary surrender(s) in lieu of further disciplinary action of a medical license(s)

- A medical license board suspends or revokes a medical license for any period of time; or the provider voluntarily surrenders her/his medical license in lieu of further disciplinary action.

4. Current or past suspensions(s)/revocation(s) of an accreditation -- An accrediting body suspends or revokes an accreditation for any period of time.

5. Current or past exclusion(s) imposed by HHS OIG -- Items/services furnished, ordered, or prescribed by a specified individual/entity are not reimbursed under Medicare, Medicaid, and/or all other federal health care programs until the individual or entity is reinstated by the HHS OIG.

6. Current or past debarment(s) from participation in any federal executive branch procurement or non-procurement program -- An individual or entity is suspended throughout the executive branch of the federal government, as it applies to procurement and non-procurement programs. An individual or entity will not be solicited from, contracts will not be awarded to, or existing contracts will not be renewed or otherwise extended to those individuals or entities with a debarment (e.g., GSA debarment).

7. Medicaid exclusion(s), revocation(s) or termination(s) of any billing number -- A state terminates an active provider agreement or prohibits a provider from enrolling in the Medicaid program. Any Medicaid terminations shall be forwarded to ProviderEnrollmentRevocations@cms.hhs.gov for review by PEOG.

G. Reviewing for ALAs

The contractor shall address the reporting of ALA in its review of initial enrollment, revalidation, reactivation, or change of information applications submitted by a provider or supplier. The contractor may receive information of ALAs not yet reported by the provider or supplier from CMS or other contractors via the application screening process. The contractor shall consider this information and take action as described in (but not limited to) this section 10.6.6 and other applicable sections of this chapter.

Providers and suppliers shall include all reportable ALAs on their enrollment applications. This information must be reported by the provider/supplier on the initial/revalidation application and pursuant to the reporting requirements specified in 42 CFR § 424.516 and section 10.4(J) of this chapter. Reportable ALAs are listed in section 10.6.6(F) above. All applicable ALAs shall be reported, regardless of whether any (1) records were expunged or sealed, (2) appeals are pending, or (3) waivers were granted.

Notwithstanding any other instruction to the contrary in this chapter, the contractor need not send an ALA referral to CMS/PEOG for review if:

- The provider/supplier previously disclosed that same reportable ALA on a Form CMS-855 or Form CMS-20134 application and CMS/PEOG had already reviewed it; or
- The provider/supplier discloses a non-reportable ALA along with a reportable one. In this case, the non-reportable ALA need not be referred to CMS/PEOG in conjunction with the reportable ALA.

H. Non-Reportable ALAs

Non-reportable ALAs include but are not limited to: license probations in which the state board does not prohibit the practice of medicine; malpractice suits; false claims act civil judgments; and felony or misdemeanor convictions that are not within the previous 10 years from the submission date of a Form CMS-855 or Form CMS-20134 application.

The contractor need not send an ALA referral to CMS for review if the provider/supplier previously reported that same non-reportable ALA on a Form CMS-855 or Form CMS-20134 application that CMS had already reviewed.

I. ALA Decision Tree

To assist the contractor in determining what actions to take when an ALA is involved, CMS has produced an ALA Decision Tree (see below) for the contractor to use as a guide. Except as otherwise stated in this section 10.6.6, chapter 10 itself, or another CMS directive, the contractor: (1) shall follow the ALA Decision Tree when it receives ALA information regarding a provider or supplier (or discovers an ALA through independent research or other means); and (2) shall not develop with the provider or supplier for reported or unreported ALA(s). Note that the term "provider" in the Decision Tree includes "supplier" unless noted otherwise.

The instructions in the Decision Tree take precedence over all others in this chapter.

TABLE 1 -- INITIAL/REACTIVATION APPLICATIONS – LICENSE OR ACCREDITATION CURRENTLY SUSPENDED / REVOKED / VOLUNTARILY SURRENDERED IN SAME STATE – REPORTED

Licensure Scenario	Did the provider report the ALA taken on their license / accreditation?	MAC Action	Notes
Provider's accreditation/medical license is currently suspended / revoked / voluntarily surrendered in lieu of further disciplinary action by a state licensing authority, where the licensure action is in the same state in which the provider is enrolling.	Yes	The contractor shall send the application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision under 42 CFR § 424.530(a)(1) and any other applicable denial reasons. Refer to Tables 3 – 13.	The contractor shall read board orders thoroughly to determine if there is any other ALA associated with the license suspension, revocation, or voluntary surrender in lieu of

TABLE 1 -- INITIAL/REACTIVATION APPLICATIONS – LICENSE OR ACCREDITATION CURRENTLY SUSPENDED / REVOKED / VOLUNTARILY SURRENDERED IN SAME STATE – REPORTED			
Licensure Scenario	**Did the provider report the ALA taken on their license / accreditation?**	**MAC Action**	**Notes**
			further disciplinary action (e.g., a felony conviction). If the board order mentions another license suspension / revocation / voluntary surrender from another state, the contractor shall include this information in its referral to CMS and note whether revocation action is appropriate for any other enrollment. The contractor shall not refer to CMS/PEOG under 42 CFR § 424.530(a)(1) if the licensure action is any of the following: (i) a

TABLE 1 -- INITIAL/REACTIVATION APPLICATIONS – LICENSE OR ACCREDITATION CURRENTLY SUSPENDED / REVOKED / VOLUNTARILY SURRENDERED IN SAME STATE – REPORTED			
Licensure Scenario	**Did the provider report the ALA taken on their license / accreditation?**	**MAC Action**	**Notes**
			suspension is "stayed" in its entirety; (ii) the license is placed on probation but is otherwise still active for the practice of medicine; (iii) advertising/ administrative penalties; or (iv) fines, violations, stipulations, reprimands.

TABLE 2 -- INITIAL/REACTIVATION APPLICATIONS – LICENSE OR ACCREDITATION CURRENTLY OR PREVIOUSLY SUSPENDED/REVOKED/VOLUNTARILY SURRENDERED IN SAME STATE – NOT REPORTED			
Licensure Scenario	**Did the provider report the ALA taken on their license or accreditation?**	**MAC Action**	**Notes**
Provider's accreditation /medical license is currently or was previously suspended / revoked / voluntarily surrendered in lieu of further disciplinary action by a state licensing authority, where the licensure action is in the same state in which the provider is enrolling.	No	The contractor shall send the application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision under 42 CFR § 424.530(a)(1), § 424.530(a)(4) and/or any other applicable denial reasons. Refer to Tables 1 and 3 – 14.	424.530 (a)(4) shall ONLY be included as a denial reason if the provider has never reported this ALA. The contractor shall read board orders thoroughly to determine if there is any other ALA associated with the license suspension / revocation / voluntarily surrendered in lieu of further disciplinary action. If the board order mentions another license suspension / revocation / voluntary surrendered in lieu of further disciplinary action. from another state, the contractor shall include this information in its referral to CMS under § 424.530(a)(4) and any other applicable denial reasons; the contractor shall note whether revocation action is appropriate for any other enrollment. There is no reporting requirement for/if: (i) a suspension is "stayed" in its entirety; (ii) the license is on probation but otherwise is still active for the practice of medicine; (iii) advertising / administrative penalties; or (iv) fines, violations, stipulations, reprimands.

TABLE 3 -- INITIAL/REACTIVATION APPLICATIONS – LICENSE CURRENTLY SUSPENDED OR REVOKED IN DIFFERENT STATE – REPORTED			
Licensure Scenario	**Did the provider report the ALA taken on their license?**	**MAC Action**	**Notes**
Provider's medical license currently suspended / revoked / in a state different from that in which the provider is enrolling.	Yes or No	The contractor shall send the application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision under 42 CFR § 424.530(a)(14) and any other applicable denial reasons. Refer to Tables 1-2 and 4-14.	Denial under 42 CFR § 424.530(a)(14) is appropriate only if the license suspension/revocation action in the different state (i.e., the state other than that in which the provider is enrolling) occurred on or after March 17, 2020. The contractor shall read board orders thoroughly to determine if there is any other ALA associated with the license suspension or revocation (e.g., a felony conviction). The contractor shall note whether revocation action is appropriate for any other enrollment. Note that voluntary surrenders in lieu of further disciplinary action do not give rise to denial under 42 CFR § 424.530(a)(14).

TABLE 4 -- INITIAL/REACTIVATION APPLICATIONS – FELONIES			
Felony	**Did the provider report the felony conviction ?**	**MAC Action**	**Notes**
Provider or an individual/entity listed on the application as a 5 percent or greater owner, partner, managing employee, corporate director, corporate officer, or managing organization has been adjudged guilty of a felony.	Yes or No	The contractor shall send the application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision under 42 CFR § 424.530(a)(3) and any other applicable denial reasons. Refer to Tables 1-3 and 5-14.	A felony is defined as a crime that has a maximum penalty—as specified in the criminal statute—by imprisonment for a period of more than one year. All felony convictions within the preceding 10 years of the submission date of a Form CMS-855 or Form CMS-20134 application shall be forwarded to CMS for review and decision unless CMS instructs otherwise.

TABLE 5 -- INITIAL/REACTIVATION APPLICATIONS – MISDEMEANORS			
Misdemeanor	**Did the provider report the misdemeanor conviction?**	**MAC Action**	**Notes**
Provider or an individual/entity listed on the application as a 5 percent or greater owner, partner, managing employee, corporate director, corporate officer, or managing organization has been adjudged guilty of a misdemeanor related to health care abuse or neglect of a patient; financial misconduct; interference with a criminal investigation; or unlawful manufacture, distribution, or dispensing of a controlled substance.	Yes or No	Process application unless another reported or unreported ALA precludes processing. Refer to Tables 1 – 4 and 6 – 14.	A misdemeanor is defined as a crime that has a maximum penalty—as specified in the criminal statute—by imprisonment for a period of not more than a year (i.e., one year or less).

TABLE 6 -- INITIAL/REACTIVATION APPLICATIONS – ACTIVE EXCLUSION/DEBARMENT - REPORTED			
Current Exclusion or Debarment	**Did the provider report the exclusion or debarment?**	**MAC Action**	**Notes**
Provider or an individual/entity listed on the application as a 5 percent or greater owner, partner, managing employee, corporate director, corporate officer, managing organization, authorized official, delegated official, medical director, supervising physician, or other health care or administrative or management services personnel has an active OIG exclusion or SAM debarment.	Yes	Send application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision under 42 CFR § 424.530(a)(2) and any other applicable denial reasons. Refer to Tables 1 – 5 and 7-14.	A waiver does not guarantee automatic enrollment into the Medicare program. All waivers shall be sent to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision, along with the corresponding ALA information and application.

TABLE 7 -- INITIAL/REACTIVATION APPLICATIONS – ACTIVE EXCLUSION/DEBARMENT – NOT REPORTED			
Current Exclusion or Debarment	**Did the provider report the exclusion or debarment?**	**MAC Action**	**Notes**
Provider or an individual/entity listed on the application as a 5 percent or greater owner, partner, managing employee, corporate director, corporate officer, managing organization, authorized official, delegated official, medical director, supervising physician, or other health care or administrative or management services personnel has an active OIG exclusion or SAM debarment.	No	Send application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision under 42 CFR § 424.530(a)(2), § 424.530(a)(4), and/or any other applicable denial reasons. Refer to Tables 1 – 6 and 8 – 14.	Note that (a)(4) shall ONLY be included as a denial reason if the provider has never reported this ALA. A waiver does not guarantee automatic enrollment into the Medicare program. All waivers shall be sent to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision, along with the corresponding ALA information and application.

TABLE 8 -- INITIAL/REACTIVATION APPLICATIONS – EXPIRED EXCLUSION/DEBARMENT - REPORTED			
Exclusion Period/Debarment Period Has Expired	**Did the provider report the past exclusion or debarment?**	**MAC Action**	**Notes**
Provider or an individual/entity listed on the application as a 5 percent or greater owner, partner, managing employee, corporate director, corporate officer, managing organization, authorized official, delegated official, medical director, supervising physician, or other health care or administrative or management services personnel had an OIG exclusion or a federal/SAM debarment (or an exclusion by a federal agency other than OIG) and has been reinstated by HHS and/or OIG and/or the federal agency in question.	Yes	Process application unless there is another reported or unreported ALA that precludes processing the application. Refer to Tables 1 – 7 and 10 – 14.	

TABLE 9 -- INITIAL/REACTIVATION APPLICATIONS – EXPIRED EXCLUSION/DEBARMENT – NOT REPORTED			
Exclusion Period/Debarment Period Has Expired	**Did the provider report the past exclusion or debarment?**	**MAC Action**	**Notes**
Provider or an individual/entity listed on the application as a 5 percent or greater owner, partner, managing employee, corporate director, corporate officer, managing organization, authorized official, delegated official, medical director, supervising physician, or other health care or administrative or management services personnel had an OIG exclusion or a federal/SAM debarment (or an exclusion by a federal agency other than OIG) and has been reinstated by HHS and/or OIG and/or the federal agency in question.	No	Send application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision under 42 CFR § 424.530(a)(4) and any other applicable denial reasons. Refer to Tables 1 – 7 and 10-14.	Note that (a)(4) shall ONLY be included as a denial reason if the provider has never reported this ALA. A waiver does not guarantee automatic enrollment into the Medicare program. All waivers shall be sent to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision, along with the corresponding ALA information and application. If CMS previously revoked this provider due to that prior OIG exclusion, debarment, or other federal action--and the provider or associated individual/entity has been reinstated by OIG/HHS/federal agency--the contractor shall process the application unless there is another reported or unreported ALA that precludes processing the application.

TABLE 10 -- INITIAL/REACTIVATION APPLICATIONS – MEDICARE PAYMENT SUSPENSION – CURRENT OR PAST			
Medicare Payment Suspension Status	**Did the provider report the Medicare payment suspension?**	**MAC Action**	**Notes**
Current Medicare payment suspension	Yes or No	Process application unless there is another reported or unreported ALA that precludes processing the application. Refer to Tables 1 – 9 and 11 – 14.	Providers are NOT required to report current Medicare payment suspensions to CMS. The contractor shall consider whether other denial reasons exist. Refer to Tables 1 – 9 and 11 – 14.
Past Medicare payment suspension	Yes or No	Process application unless there is another reported or unreported ALA that precludes processing the application. Refer to Tables 1 – 9 and 11 – 14.	Providers are NOT required to report past Medicare payment suspensions to CMS. The contractor shall consider whether other denial reasons exist. Refer to Tables 1 – 9 and 11 – 14.

TABLE 11 -- INITIAL/REACTIVATION APPLICATIONS – MEDICARE REVOCATION – ALL PRIOR ENROLLMENT BAR(S) EXPIRED			
Medicare Revocation	**Did the provider report the Medicare revocation?**	**MAC Action**	**Notes**
All prior enrollment bar(s) have expired.	Yes or No	Process application unless there is another reported or unreported ALA that precludes processing the application. Refer to Tables 1 – 10 and 12-14.	Providers are NOT required to report current or past Medicare revocations to CMS. The contractor shall consider whether other denial reasons exist. Refer to Tables 1 – 10 and 12-14. Under 42 CFR § 424.530(a)(3), CMS can still deny an application if there is a felony conviction within the preceding 10 years by a provider/supplier or by an individual/entity listed on the application as a 5 percent or greater owner, managing employee, partner, corporate director, corporate officer, or managing organization. This denial authority is still applicable and should be considered by the contractor even if the previous Medicare revocation had a 3-year re-enrollment bar and the bar has expired. In such instances, the contractor shall send the ALA information and application to CMS for review and decision at ProviderEnrollmentRevocaions@cms.hhs.gov.

TABLE 12 -- INITIAL/REACTIVATION APPLICATIONS – MEDICARE REVOCATION – ACTIVE REENROLLMENT BAR			
Medicare Revocation	**Did the provider report the Medicare revocation?**	**MAC Action**	**Notes**
Enrollment bar is active (in the state in which the provider is enrolling or in another state)	Yes or No	If the application is for an enrollment that has an active reenrollment bar on the enrollment itself, the application should be returned.	

TABLE 13 -- INITIAL/REACTIVATION APPLICATIONS - OTHER PROGRAM TERMINATION – CURRENT			
Other Program Termination	**Did the provider report the other program termination?**	**MAC Action**	**Notes**
The provider is currently terminated or suspended (or otherwise barred) from participation in a state Medicaid program or any other federal health care program.	Yes	Send application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision under 42 CFR § 424.530(a)(14) and any other applicable denial reasons. Refer to Tables 1 – 12 and 14.	Denial may be appropriate under 42 CFR § 424.530(a)(14) if the provider is currently terminated/suspended/barred from participation in a state Medicaid program or any other federal health care program (e.g., TRICARE). The termination or suspension must occur by letter dated on or after March 17, 2020.

TABLE 14- INITIAL/REACTIVATION APPLICATIONS – FALSE CLAIMS ACT (FCA) CIVIL JUDGMENTS			
False Claims Act (FCA) Civil Judgments	**Did the provider report the False Claims Act (FCA) Civil Judgment?**	**MAC Action**	**Notes**
Provider or any individual/entity listed as a 5 percent or greater owner, partner managing employee or organization, corporate officer, or corporate director thereof has had a civil judgment under the FCA imposed against them within the previous 10 years.	Yes or No	Send application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision under 42 CFR § 424.530(a)(17) and any other applicable denial reasons. Refer to Tables 1 – 13.	The FCA (31 U.S.C. 3729–3733) is the federal government's principal civil remedy for addressing false or fraudulent claims for federal funds. Section 3729(a)(1) of the FCA lists specific actions that can result in an FCA judgment against a defendant. Denial may be appropriate under 42 CFR § 424.530(a)(17) if the FCA civil judgment is within the preceding 10 years of the submission date of a Form CMS-855 or Form CMS-20134. FCA civil judgments must occur on or after January 1, 2024. Note that the term ''civil judgment'' is not inclusive of FCA settlement agreements and should not be referred to CMS for review. Providers are NOT required to report FCA civil judgments to CMS.

TABLE 15 – REVALIDATIONS/CHANGE OF INFORMATION APPLICATIONS – PREVIOUS LICENSURE OR ACCREDITATION – SAME STATE – REPORTED

If the contractor discovers an ALA that has not been reported by a provider, the contractor shall, upon CMS' approval, record the ALA in the PECOS Final Adverse Legal Actions Section ~~and/~~or PECOS profile for the associated individual/entity (as appropriate).

- If the contractor is inputting the ALA which has not been reported by the provider—and if CMS does not take administrative action due to that ALA—the contractor shall select "No" for the "Display in PI" field, thereby making this ALA not visible in the provider interface (as applicable).

- If the contractor is inputting the ALA which has not been reported by the provider—and if CMS does take administrative action due to that ALA—the contractor shall select "Yes" for the "Display in PI" field, thereby making the ALA visible in the provider interface.

Unless otherwise stated, the foregoing statements apply to Tables 15 through 26.

Provider holds a valid accreditation / medical license in the state in which it is revalidating or changing information	**Did the provider report the ALA taken on their license/ accreditation?**	**MAC Action**	**Notes**
Provider's accreditation/ medical license was previously suspended/revoked/ voluntarily surrendered in lieu of further disciplinary action by a state licensing authority but is currently active for the practice of medicine AND where the licensure action is in the same state in which the provider is currently enrolled.	Yes	The contractor shall check whether the provider billed for dates of service during the period of license susp/rev/vol surrender in lieu of further disciplinary action. If the provider billed for dates of service during this period, the contractor shall send the application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision for potential revocation action under 42 CFR § 424.535(a)(8). The contractor shall note this information when sending a referral to CMS for review. If the provider did not bill during the period of license susp/rev/vol surrender in lieu of further disciplinary action, the application shall be processed unless there is another reported or	The contractor shall read board orders thoroughly to determine if there is any other ALA (e.g., a felony conviction) associated with the license susp/rev/vol surrender in lieu of further disciplinary action. If the board order mentions another license susp/rev/vol surrender in lieu of further disciplinary action from another state, the contractor shall include this information in its referral to CMS and note whether revocation action is appropriate for any other enrollment. The contractor shall not refer to CMS/PEOG for

		unreported ALA that precludes processing. Refer to Tables 17 – 27.	revocation under 42 CFR § 424.535(a)(1) if the licensure action is any of the following: (i) a suspension is "stayed" in its entirety; (ii) the license is placed on probation but otherwise is active for the practice of medicine; (iii) advertising / administrative penalties; or (iv) fines, violations, stipulations, reprimands.

TABLE 16 – REVALIDATION/CHANGE OF INFORMATION APPLICATIONS – LICENSE PREVIOUSLY SUSPENDED/REVOKED/VOLUNTARY SURRENDERED - SAME STATE – NOT REPORTED			
Provider holds a valid accreditation/ medical license in the state in which it is revalidating or changing information	**Did the provider report the ALA taken on its license or accreditation?**	**MAC Action**	**Notes**
Provider's accreditation/ medical license was previously suspended / revoked / voluntarily surrendered in lieu of further disciplinary action by a state licensing authority but is now active AND the licensure action is in the same state in which the provider is enrolling.	No	The contractor shall send the application and ALA information to ProviderEnrollment Revocations@cms.hhs.gov for review and decision under § 424.535(a)(4) and any other applicable revocation reasons. Refer to Tables 17 – 27. Note that § 424.535 (a)(4) shall ONLY be included as a revocation reason if the provider has never reported this ALA and CMS did not previously revoke the provider for that ALA.	The contractor shall check whether the provider billed for dates of service during the period of license susp/rev/vol surrender in lieu of further disciplinary action. If the provider billed for dates of service during this period, there may be potential revocation action under 42 CFR § 424.535(a)(8). The contractor shall note this information when sending a referral to CMS for review. The contractor shall read board orders thoroughly to determine if there is any other ALA associated with the license susp/rev/vol surrender in lieu of further disciplinary action. If the board order mentions another license susp/rev/vol surrender in lieu of further disciplinary action from another state, the contractor shall include this information in its referral to CMS and note whether revocation action is appropriate for any other enrollment. There is no reporting requirement for/if: (i) a suspension is "stayed" in its entirety; (ii) if license is on probation but otherwise is active for the practice of medicine; (iii) advertising / administrative penalties; or (iv) fines, violations, stipulations, reprimands.

TABLE 17 – REVALIDATIONS/CHANGE OF INFORMATION APPLICATIONS – CURRENT LICENSURE OR ACCREDITATION – SAME STATE – REPORTED			
Provider holds a valid accreditation / medical license in the state in which it is revalidating or changing information	**Did the provider report the ALA taken on their license/ accreditation?**	**MAC Action**	**Notes**
Provider's accreditation/ medical license is currently suspended/revoke d/ voluntarily surrendered in lieu of further disciplinary action by a state licensing authority where the licensure action is in the same state in which the provider is currently enrolled.	Yes	The contractor shall send the application and ALA information to ProviderEnrollment Revocations@cms.hhs.gov for review and decision under 42 CFR § 424.535(a)(1) and any other applicable revocation reasons. Refer to Tables 15-16 and 18- 27.	The contractor shall check whether the provider billed for dates of service during the period of license susp/rev/vol surrender in lieu of further disciplinary action. If the provider billed for dates of service during this period, there may be potential revocation action under 42 CFR § 424.535(a)(8). The contractor shall note this information when sending a referral to CMS for review. The contractor shall read board orders thoroughly to determine if there is any other ALA associated with the license susp/rev/vol surrender in lieu of further disciplinary action. If the board order mentions another license susp/rev/vol surrender in lieu of further disciplinary action from another state, the contractor shall include this information in its referral to CMS and note whether revocation action is appropriate for any other enrollment. There is no reporting requirement for/if: (i) a suspension is "stayed" in its entirety; (ii) if license is on probation but is otherwise active for the practice of medicine; (iii) advertising / administrative penalties; or (iv)

TABLE 17 – REVALIDATIONS/CHANGE OF INFORMATION APPLICATIONS – CURRENT LICENSURE OR ACCREDITATION – SAME STATE – REPORTED			
			fines, violations, stipulations, reprimands.

TABLE 18 -- REVALIDATION/CHANGE OF INFORMATION APPLICATIONS – FELONIES			
Felony	**Did the provider report the felony conviction ?**	**MAC Action**	**Notes**
Provider or an individual/entity listed on the application as a 5 percent or greater owner, partner, managing employee, corporate director, corporate officer, or managing organization has been adjudged guilty of a felony.	Yes or No	Send application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision under § 424.535(a)(3) and any other applicable revocation reasons. Refer to Tables 15-17 and 19 – 27.	A felony is defined as a crime that has a maximum penalty—as specified in the criminal statute—by imprisonment for a period of more than one year. All felony convictions within the preceding 10 years of the submission date of a Form CMS-855 or Form CMS-20134 application shall be forwarded to CMS for review and decision unless CMS instructs otherwise.

TABLE 19 – REVALIDATION/CHANGE OF INFORMATION APPLICATIONS – MISDEMEANORS			
Misdemeanor	**Did the provider report the misdemeanor conviction?**	**MAC Action**	**Notes**
Provider or an individual/entity listed on the application as a 5 percent or greater owner, partner, managing employee, corporate director, corporate officer, or managing organization has been adjudged guilty of a misdemeanor that is related to health care abuse or neglect of a patient; financial misconduct; interference with a criminal investigation; or unlawful manufacture, distribution, or dispensing of a controlled substance.	Yes or No	Process application unless there is another reported or unreported ALA that precludes processing the application. Refer to Tables 15 – 18 and 20 – 27.	A misdemeanor is defined as a crime that has a maximum penalty—as specified in the criminal statute—by imprisonment for a period of not more than a year (i.e., one year or less).

TABLE 20 – REVALIDATION/CHANGE OF INFORMATION APPLICATIONS – ACTIVE OIG EXCLUSION OR SAM DEBARMENT - REPORTED			
Current Exclusion or Debarment	**Did the provider report the exclusion?**	**MAC Action**	**Notes**
Provider or an individual/entity listed on the application as a 5 percent or greater owner, partner, managing employee, corporate director, corporate officer, managing organization, authorized official, delegated official, medical director, supervising physician, or other health care or administrative or management services personnel has an active OIG exclusion or SAM debarment.	Yes	Send application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision under § 424.535(a)(2) and any other applicable revocation reasons. Refer to Tables 15-19 and 21 – 27.	A waiver does not guarantee automatic enrollment into the Medicare program. All waivers shall be sent to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision, along with the corresponding ALA information and application.

TABLE 21 -- REVALIDATION/CHANGE OF INFORMATION APPLICATIONS – ACTIVE OIG EXCLUSION OR SAM DEBARMENT – NOT REPORTED			
Current Exclusion or Debarment	**Did the provider report the exclusion?**	**MAC Action**	**Notes**
Provider or an individual/entity listed on the application as a 5 percent or greater owner, partner, managing employee, corporate director, corporate officer, managing organization, authorized official, delegated official, medical director, supervising physician, or other health care or administrative or management services personnel has an active OIG exclusion or SAM debarment.	No	Send application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision under 42 CFR § 424.535(a)(2), 42 CFR § 424.535(a)(4) and/or any other applicable revocation reasons. Refer to Tables 15 – 20 and 22 – 27.	Note (a)(4) shall ONLY be included as a revocation reason if the provider has never reported this ALA. A waiver does not guarantee automatic enrollment into the Medicare program. All waivers shall be sent to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision, along with the corresponding ALA information and application.

TABLE 22 – REVALIDATION/CHANGE OF INFORMATION APPLICATIONS – EXCLUSION/DEBARMENT – EXPIRED - REPORTED			
Exclusion or Debarment Status	**Did the provider report the exclusion or debarment?**	**MAC Action**	**Notes**
Provider or an individual/entity listed on the application as a 5 percent or greater owner, partner, managing employee, corporate director, corporate officer, managing organization, authorized official, delegated official, medical director, supervising physician, or other health care or administrative or management services personnel had an OIG exclusion or a federal/SAM debarment (or an exclusion by a federal agency other than OIG) and has been reinstated by OIG and/or HHS and/or the other federal agency.	Yes	Process application unless there is another reported or unreported ALA that precludes processing the application. Refer to Tables 15 – 20 and 23 – 27.	

TABLE 23 – REVALIDATION/CHANGE OF INFORMATION APPLICATIONS – EXCLUSION/DEBARMENT – EXPIRED – NOT REPORTED			
Exclusion or Debarment Status	**Did the provider report the exclusion or debarment?**	**MAC Action**	**Notes**
Provider or an individual/entity listed on the application as a 5 percent or greater owner, partner, managing employee, corporate director, corporate officer, managing organization, authorized official, delegated official, medical director, supervising physician, or other health care or administrative or management services personnel had an OIG exclusion or a federal/SAM debarment (or an exclusion by a federal agency other than OIG) and has been reinstated by OIG and/or HHS and/or other federal agency.	No	Send application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision under 42 CFR § 424.535(a)(4) and any other applicable revocation reasons. Refer to Tables 15 – 21 and 24 – 27.	Note that (a)(4) shall ONLY be included as a revocation reason if the provider has never reported this ALA. If CMS previously revoked this provider due to the prior OIG exclusion and the provider or associated individual/entity has been reinstated by OIG, the contractor shall process the application unless there is another reported or unreported ALA that precludes processing.

TABLE 24 - REVALIDATION/CHANGE OF INFORMATION APPLICATIONS – MEDICARE PAYMENT SUSPENSION – CURRENT OR PAST			
Medicare Payment Suspension Status	**Did the provider report the Medicare payment suspension?**	**MAC Action**	**Notes**
Current Medicare payment suspension	Yes or No	Process application unless there is another reported or unreported ALA that precludes processing the application. Refer to Tables 15 – 22 and 25 – 27.	Providers are NOT required to report current or past Medicare payment suspensions to CMS.
Past Medicare payment suspension	Yes or No	Process application unless there is another reported or unreported ALA that precludes processing the application. Refer to Tables 15 – 22 and 25 – 27.	Providers are NOT required to report current or past Medicare payment suspensions to CMS.

TABLE 25 -- REVALIDATION/CHANGE OF INFORMATION APPLICATIONS – MEDICARE REVOCATION – ACTIVE ENROLLMENT BAR			
Status	**Did the provider report the Medicare revocation?**	**MAC Action**	**Notes**
Enrollment bar is active in the state in which the provider is submitting this application, or the enrollment bar is active in another state.	Yes or No	If the application is for an enrollment that has an active reenrollment bar on the enrollment itself, the application should be returned.	.

TABLE 26 -- REVALIDATION/CHANGE OF INFORMATION APPLICATIONS – OTHER PROGRAM TERMINATION (CURRENT)			
Other Program Termination	**Did the provider report the other program termination?**	**MAC Action**	**Notes**
The provider/supplier is currently terminated or suspended (or otherwise barred) from participation in a state Medicaid program or any other federal health care program.	Yes	Send application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision under 42 CFR § 424.535(a)(12) and any other applicable revocation reasons. Refer to Tables 15-25 and 27.	Revocation may be appropriate under 42 CFR § 424.535(a)(12) if the provider/supplier is currently terminated/suspended/barred from participation in a state Medicaid program or any other federal health care program (e.g., TRICARE). The state Medicaid program termination or suspension must occur by letter dated on or after January 1, 2011. Any other federal health care program (e.g., TRICARE) termination or suspension must occur by letter dated on or after March 17, 2020.

TABLE 27- REVALIDATION/CHANGE OF INFORMATION APPLICATIONS – FALSE CLAIMS ACT (FCA) CIVIL JUDGMENTS			
FCA Civil Judgments	**Did the provider report the FCA Civil Judgment?**	**MAC Action**	**Notes**
Provider, or any individual/entity listed as a 5 percent or greater owner, partner managing employee or organization, corporate officer, or corporate director thereof, has had a civil judgment under the FCA imposed against them within the previous 10 years.	Yes or No	Send application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision under 42 CFR § 424.535(a)(15) and any other applicable revocation reasons. Refer to Tables 15 – 26.	The FCA (31 U.S.C. 3729–3733) is the federal government's principal civil remedy for addressing false or fraudulent claims for federal funds. Section 3729(a)(1) of the FCA lists specific actions that can result in an FCA judgment against a defendant. Revocation may be appropriate under 42 CFR § 424.535(a)(15) if the FCA civil judgment is within the preceding 10 years of the submission date of a Form CMS-855 or Form CMS-20134. FCA civil judgments must occur on or after January 1, 2024. Note the term ''civil judgment'' is not inclusive of FCA settlement agreements and should not be referred to CMS for review. Providers are NOT required to report FCA civil judgments to CMS.

10.6.7.2 – Individual Owning and Managing Information

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

(See section 10.6.7.1 for more detailed information on ownership/managerial disclosures.)

A. Owning and Managing Individuals Who Must Be Listed in this Section

All individuals who have any of the following must be listed in this section:

(i) Ownership - A 5 percent or greater direct or indirect ownership interest in the provider.

(ii) Mortgage/Security Interest - A 5 percent or greater mortgage or security interest in the provider.

(iii) Partnership Interests

(a) General partnerships - Any general partnership interest in the provider, regardless of the percentage.

(b) For limited partnerships: All general partnership and limited partnership interests, regardless of the percentage.

(iv) Managing Control of the Provider - For purposes of enrollment, such a person is considered a "managing employee." A managing employee is any individual, including a general manager, business manager, office manager or administrator, who exercises operational or managerial control over the provider's business, or who conducts the day-to-day operations of the business. A managing employee also includes any individual who is not an actual W-2 employee but who, either under contract or through some other arrangement, manages the day-to-day operations of the business.

Hospice and SNF medical directors and administrators are considered managing employees under § 424.502. If a hospice or SNF fails to list its medical director and administrator on an initial, revalidation, reactivation, or CHOW Form CMS-855A application, the contractor shall develop for this information. This includes listing "medical director" or "administrator" in the "Title" box.

(v) Corporate Officers and Directors/Board Members

Officers and directors/board members must be listed in the Individual Ownership and/or Managing Control section if – and only if - the applicant is a corporation. (For-profit and non-profit corporations must list all their officers and directors. If a non-profit corporation has "trustees" instead of officers or directors, these trustees must be listed in this section of the Form CMS-855A, CMS-855B, CMS-855S and CMS-20134.)

Only the enrolling provider's officers and directors must be reported. Board members of the provider's indirect owners need not be disclosed to the extent they are not otherwise required to be reported (e.g., as an owner or managing employee) in this section. However, there may be situations where the officers and directors/board members of the enrolling provider's corporate owner/parent also serve as the enrolling provider's officers and directors/board members. In such cases – and again assuming that the provider is a corporation – the indirect owner's officers and directors/board members would have to be disclosed as the provider's officers and directors/board members in this section.

With respect to corporations, the term "director" refers to members of the board of directors. If a corporation has, for instance, a Director of Finance who nonetheless is not a member of the board of directors, *the individual* would not need to be listed as a director/board member in this section. However, *the individual* may need to be listed in this section as a managing employee.

(See sections 10.6.7.1(A) of this chapter for more information on direct and indirect ownership, mortgage and security interests, and partnerships.)

Officers and directors can also include persons who serve in a voluntary or ceremonial capacity. CMS re-emphasizes, however, that officers and directors apply only to corporations.

B. Specific Reporting Policies

1. Proof of Owning/Managing Control and Percentages –- Proof of ownership interest, partnership interest, managerial control (including W-2s and other proof of employment), security interest, percentage of ownership or control, etc., need not be submitted unless the contractor requests it. This also means that articles of incorporation, partnership agreements, etc., need not be submitted absent a contractor's request.

2. Government Entities – Government entities need only report their managing employees, for they do not have owners, partners, corporate officers, or corporate directors.

3. Minimum Number of Managing Employees - The provider must report all managing employees but must have at least one if it is completing the Form CMS-855A, CMS-855B, CMS-855S, or CMS-20134. An individual completing the Form CMS-855I need not list a managing employee if one *does not exist.*

4. Practice Locations on the Form CMS-855I - All managing employees at all practice locations listed in the Business Information/Practice Location Information section of the Form CMS-855I must be reported in the Managing Employee Information section. The only exceptions to this are individuals who are (a) employed by hospitals, health care facilities, or other organizations shown in the Business Information/Practice Location Information section (e.g., the chief executive officer of a hospital listed in this section) or (ii) managing employees of any group/organization to which the practitioner will be reassigning *b*enefits; these persons need not be reported.

5. Partnership Interests Involving Indirect Owners - Only partnership interests in the enrolling provider need be disclosed. Partnership interests in the provider's indirect owners need not be reported. However, if the partnership interest in the indirect owner results in a greater than 5 percent indirect ownership interest in the enrolling provider, this indirect ownership interest would have to be reported.

6. Ownership Disclosures – Concerning ownership disclosures, the contractor shall adhere to the instructions in section 10.6.7.1(D)(6).

10.6.11 – Participation (Par) Agreements and the Acceptance of Assignment – General Information

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

All providers/suppliers must choose to be either Par or Non-Par when initially enrolling and must maintain the same Par status across all lines of business.

Individual physicians and non-physician practitioners who reassign benefits to a clinic/group practice inherit the Par status established by the clinic/group practice. However, if the individual physician or non-physician practitioner maintains a private practice (separate from the reassignment of benefits agreement), *the physician/practitioner* may designate *the physician/practitioner's* own Par status. See Publication 100-04, chapter 1, section 30 for guidance on applying the correct Par status to clinic/group practices, organizations, and individuals in private practice.

The contractor shall follow the instructions in CMS Publication 100-04, chapter 1, sections 30 through 30.3.12.3 when handling issues related to par agreements and assignment. Queries related to the interpretation of such instructions shall be referred to the responsible CMS component.

Physicians and Part B organizations should be entered as Par in PECOS based on the submission of a signed Form CMS-460 (Medicare Participating Physician or Supplier Agreement) upon initial enrollment or during a change to their Par status during the annual Medicare Open Enrollment period. Non-Physician Practitioners that are considered mandatory participation and individual physicians and non-physician practitioners that reassign all of their benefits to a Par organization should not be entered as Par in PECOS.

10.6.12 – Opting-Out of Medicare

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

Physicians and practitioners are typically required to submit claims on behalf of beneficiaries for all items and services they provide for which Medicare payment may be made under Part B. They are also not permitted to charge beneficiaries in excess of the limits on charges that apply to the item or service being furnished. However, certain types of physicians and practitioners may "opt-out" of Medicare. A physician or practitioner who opts-out is not required to submit claims on behalf of beneficiaries and also is excluded from limits on charges for Medicare-covered services. Medicare does not pay anyone for services (except for certain emergency and urgent care services) furnished by an opt-out physician or practitioner. Instead, opt-out physicians and practitioners sign private contracts with beneficiaries. Please refer to CMS Pub. 100-02, Chapter 15, sections 40 - 40.39 for more information regarding the maintenance of opt-out affidavits and the effects of improper billing of claims during an opt-out period.

The instructions in this section 10.6.12 address the contractor's processing of opt-out affidavits. (See Pub. 100-02, chapter 15, section 40.8 for private contract definitions and requirements.)

A. Who May Opt-Out of Medicare

Only the following physicians and practitioners (sometimes collectively referenced as "eligible practitioners" in this section) can "opt-out" of Medicare:

Physicians who are:

- Doctors of medicine or osteopathy,
- Doctors of dental surgery or dental medicine,
- Doctors of podiatry, or
- Doctors of optometry who are legally authorized to practice dentistry, podiatry, optometry, medicine, or surgery by the state in which such function or action is performed.

Non-physician practitioners who are:

- Physician assistants,
- Nurse practitioners,
- Clinical nurse specialists,
- Certified registered nurse anesthetists,

- Certified nurse midwives,
- Clinical psychologists,
- Clinical social workers,
- Registered dietitians or nutrition professionals who are legally authorized to practice by the state and otherwise meet Medicare requirements,
- Mental health counselors, or
- Marriage and family therapists

(Organizations are not permitted to opt-out of Medicare.)

This means that neither the eligible practitioner nor the beneficiary submits the bill to Medicare for services performed. Instead, the beneficiary pays the eligible practitioner out-of-pocket and neither party is reimbursed by Medicare. In fact, a private contract is signed between the eligible practitioner and the beneficiary that states, in essence, that neither can receive payment from Medicare for the services performed. (The contract, though, must be signed before the services are provided so the beneficiary is fully aware of the eligible practitioner's opt-out status.) Moreover, the eligible practitioner must submit an affidavit to Medicare expressing *a* decision to opt-out of the program. The contractor's provider enrollment unit must process these affidavits.

Eligible practitioners who opt-out of Medicare are not the same as non-participating physicians/suppliers. The latter are enrolled in Medicare and choose on a claim-by-claim basis whether they want to accept assignment unless the service can only be paid on an assignment-related basis as required by law (e.g., for drugs, ambulance services, etc.). Non-participating physicians/suppliers must therefore comply with Medicare's mandatory claim submission, assignment, and limiting charge rules. Opt-out eligible practitioners, on the other hand, are excused from the mandatory claim submission, assignment, and limiting charge rules, though **only** when they maintain compliance with all of the requirements for opting out.

In an emergency care or urgent care situation, an eligible practitioner who has opted-out may treat a Medicare beneficiary with whom *the eligible practitioner* does not have a private contract. In those circumstances, the eligible practitioner must complete a Form CMS-855 application.

B. Requirements for an Opt-out Affidavit

1. Affidavit Contents

As stated in Pub. 100-02, chapter 15, section 40.9, the affidavit shall state that, upon signing the affidavit, the eligible practitioner agrees to the following requirements:

- Except for emergency or urgent care services, during the opt-out period the eligible practitioner will provide services to Medicare beneficiaries only through private contracts, but for their provision under a private contract, would have been Medicare-covered services;

- The eligible practitioner will not submit a claim to Medicare for any service furnished to a Medicare beneficiary during the opt-out period, nor will the eligible practitioner permit any entity acting on the eligible practitioner's behalf to submit a claim to Medicare for services furnished to a Medicare beneficiary;

- During the opt-out period, the eligible practitioner understands that the *eligible practitioner* may receive no direct or indirect Medicare payment for services that the eligible practitioner furnishes to Medicare beneficiaries with whom the eligible practitioner has privately contracted, whether as an individual, an employee of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare beneficiary under a Medicare Advantage plan;

- An eligible practitioner who opts out of Medicare acknowledges that, during the opt-out period, the eligible practitioner's services are not covered under Medicare and that no Medicare payment may be made to any entity for the eligible practitioner's services, directly or on a capitated basis;

- On acknowledgment by the eligible practitioner to the effect that, during the opt- out period, the eligible practitioner agrees to be bound by the terms of both the affidavit and the private contracts that the eligible practitioner has entered into;

- Acknowledge that the eligible practitioner recognizes that the terms of the affidavit apply to all Medicare-covered items and services furnished to Medicare beneficiaries by the eligible practitioner during the opt-out period (except for emergency or urgent care services furnished to the beneficiaries with whom the eligible practitioner has not previously privately contracted) without regard to any payment arrangements the eligible practitioner may make;

- With respect to an eligible practitioner who has signed a Part B participation agreement, acknowledge that such agreement terminates on the effective date of the affidavit;

- Acknowledge that the eligible practitioner understands that a beneficiary who has not entered into a private contract and who requires emergency or urgent care services may not be asked to enter into a private contract with respect to receiving such services;

- Identify the eligible practitioner sufficiently so that the Medicare contractor can ensure that no payment is made to the eligible practitioner during the opt-out period; and

- Be filed with all MACs that have jurisdiction over claims the eligible practitioner would otherwise file with Medicare; the initial two-year opt-out period will begin the date on which the affidavit meeting the requirements of 42 C.F.R. § 405.420 is signed, provided the affidavit is filed within 10 days after the eligible practitioner signs *the latter's* first private contract with a Medicare beneficiary.

(See Pub. 100-02, chapter 15, section 40.9 for more information on the requirements of opt-out affidavits. See also section 10.6.12(B)(5) below for acceptable opt-out formats.)

The contractor shall review initial opt-out affidavits to ensure that they contain the following information about the eligible practitioner to create an affidavit record in PECOS:

- Full name (first, middle and last),
- Birthdate,

- Address, telephone number, and e-mail address
- License information,
- NPI (if one has been obtained),
- SSN (if no NPI has been issued, though note that this cannot be an individual tax identification number (ITIN)), and
- Contact person name, telephone number, and e-mail address (if different from the opting-out physician or practitioner)

If, to create a PECOS affidavit record, the contractor needs to obtain data that is missing from an affidavit, it may (1) obtain this information from other sources (such as the state license board) or (2) contact the eligible practitioner only **one time** directly. The contractor shall **not** use Internet-based PECOS or the Form CMS-855 to secure the data from the eligible practitioner, for the eligible practitioner **is not** enrolling in Medicare. If the eligible practitioner is requested to submit missing information to permit the processing of the affidavit and fails to do so within 30 days, the contractor shall reject the opt-out affidavit.

2. Opting-Out and Ordering/Certifying/Referring

If an eligible practitioner who wishes to opt-out elects to order/certify/refer Medicare items or services, the contractor shall develop for the date of birth (if not provided on the affidavit):

If this information is requested but not received, the eligible practitioner's affidavit can still be processed; however, *the eligible practitioner* cannot be listed as an ordering/certifying/referring provider.

3. Adverse Actions

The contractor shall review the List of Excluded Individuals and Entities (LEIE) and the System for Award Management (SAM) for all eligible practitioners who submit opt-out affidavits. Excluded eligible practitioners may opt-out of Medicare but cannot order certify/refer.

As noted in 42 CFR § 405.425(i) and (j), individuals who are revoked from Medicare cannot order, certify, or refer Part A or B services or items to Medicare beneficiaries if they opt-out of Medicare after revocation.

4. No Dual Status

a. Form CMS-855O - Eligible practitioners cannot be enrolled via the Form CMS-855O and actively opted-out simultaneously. Prior to processing an initial Form CMS-855O or opt-out affidavit submission, therefore, the contractor shall confirm that an approved Form CMS-855O enrollment or valid opt-out affidavit does not exist in PECOS. If an approved enrollment or affidavit indeed exists, the contractor shall return the pending application.

b. Form CMS-855I – A Form CMS-855I enrollment can simultaneously exist with a valid opt-out affidavit **only** if the Form CMS-855I is to bill for emergency services. If a Form CMS-855I is received **and** an opt-out affidavit is active, the contractor shall contact the eligible practitioner (via any means) to clarify if *the latter* submitted the application to solely bill for emergency

services provided to a beneficiary. If so, the application shall be processed via normal procedures. If not, the application may be returned. (See Pub. 100-02, chapter 15, section 40.28 for more information on emergency and urgent care services.)

An eligible practitioner who has opted out of Medicare need not also enroll via the Form CMS-855O if *the eligible practitioner* wishes to order/refer/certify (e.g., providing the necessary information on *the a*ffidavit per this section 10.6.12).

5. Acceptable Opt-Out Affidavit Formats

The contractor may provide a sample opt-out affidavit form for eligible practitioners to complete. The opt-out affidavit form must provide spaces for the eligible practitioners to furnish their personal information.

Eligible practitioners may also create their own affidavit. If *the eligible practitioner* elects to do so, *the affidavit* should include information found in section 10.6.12(B)(1) to ensure timely processing of the opt-out affidavit.

The contractor and eligible practitioners may use the information below as an opt-out affidavit form.

I, {Enter Physician/Non-Physician Practitioner Name}, being duly sworn, depose and say:

- Opt-out is for a period of two years. At the end of the two-year period, my opt-out status will automatically renew. If I wish to cancel the automatic extension, I understand that I must notify my Medicare Administrative Contractor (MAC) in writing at least 30 days prior to the start of the next two-year opt-out period.

- Except for emergency or urgent care services (as specified in the Medicare Benefit Policy Manual Publication 100-02, Chapter 15 §40.28), during the opt-out period I will provide services to Medicare beneficiaries only through private contracts that meet the criteria of §40.8 for services that, but for their provision under a private contract, would have been Medicare-covered services.

- I will not submit a claim to Medicare for any service furnished to a Medicare beneficiary during the opt-out period, nor will I permit any entity acting on my behalf to submit a claim to Medicare for services furnished to a Medicare beneficiary, except as specified in § 40.28.

- During the opt-out period, I understand that I may receive no direct or indirect Medicare payment for services that I furnish to Medicare beneficiaries with whom I have privately contracted, whether as an individual, an employee of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare beneficiary under Medicare Advantage.

- I acknowledge that during the opt-out period, my services are not covered under Medicare and that no Medicare payment may be made to any entity for my services, directly or on a capitated basis.

- I acknowledge and agree to be bound by the terms of both the affidavit and the private contracts that I have entered into during the opt-out period.

- I acknowledge and understand that the terms of the affidavit apply to all Medicare-covered items and services furnished to Medicare beneficiaries by myself during the opt-out period (except for emergency or urgent care services furnished to the beneficiaries with whom I have not previously privately contracted) without regard to any payment arrangements I may make.

- I acknowledge that if I have signed a Part B participation agreement, that such agreement terminates on the effective date of this affidavit.

- I acknowledge and understand that a beneficiary who has not entered into a private contract and who requires emergency or urgent care services may not be asked to enter into a private contract with respect to receiving such services and that the rules of §40.28 apply if I furnish such services.

- I have identified myself sufficiently so that the MAC can ensure that no payment is made to me during the opt-out period. If I have already enrolled in Medicare, I have included my Medicare PTAN, if one has been assigned. If I have not enrolled in Medicare, I have included the information necessary to opt-out.

- I will file this affidavit with all MACs who have jurisdiction over claims that I would otherwise file with Medicare and the initial two- year opt-out period will begin the date the affidavit meeting the requirements of 42 C.F.R. §405.420 is signed, provided the affidavit is filed within 10 days after the physician/practitioner signs *the latter's* first private contract with a Medicare beneficiary.

Eligible practitioners should also be encouraged to include the following information (to complete an affidavit record in PECOS): Medicare Identification Number (if issued); date of birth; specialty; e-mail address; any request to order/certify/refer.

C. Effective Date of an Opt-Out Period

As noted in Pub. 100-02, chapter 15, section 40.17, eligible practitioners receive effective dates based on their participation status.

1. Eligible Practitioners Who Have Never Enrolled In Medicare

Eligible practitioners need not enroll prior to opting-out of Medicare. If a non-enrolled eligible practitioner submits an opt-out affidavit, the effective date of the opt-out period begins the date the affidavit is signed by the eligible practitioner.

2. Non-Participating Practitioners

If an eligible practitioner who is a non-participating provider decides to terminate *an* active Medicare billing enrollment and instead opt-out of Medicare, the effective date of the opt-out period begins the date the affidavit is signed by the eligible practitioner.

3. Participating Practitioners

If an eligible practitioner who is a participating provider (one who accepts assignment for *all M*edicare claims) decides to terminate *an* active Medicare billing enrollment and opt-out of Medicare, the effective date of the opt-out period begins the first day of the next calendar quarter. Per 42 CFR § 405.410(d), an eligible practitioner may opt-out of Medicare at the beginning of any calendar quarter, provided that the affidavit described in 42 CFR § 405.420 is submitted to the applicable contractor(s) at least 30 days before the beginning of the selected calendar quarter. (The contractor shall, however, add 5 calendar days to the 30-day period to allow for mailing.) An opt-out affidavit must therefore be submitted at least 30 days before the first day of the calendar quarter in order to receive January 1, April 1, July 1 or October 1 as the effective date. If the opt-out affidavit is submitted within 30 days prior to January 1, April 1, July 1 or October 1, the effective date would be the first day of the next calendar quarter. (For example, an enrolled participating eligible practitioner's opt-out affidavit was submitted on December 10. The eligible practitioner's effective date could not be January 1, for the affidavit was not submitted at least 30 days prior to January 1. The effective date would be April 1.) The eligible practitioner would need to remain enrolled as a participating supplier until the end of the next calendar quarter so that claims can be properly submitted until the opt-out period begins.

4. Opt-Out After Enrollment

(This section 10.6.12(C)(4) applies notwithstanding any instruction to the contrary in this chapter.)

If an enrolled physician or eligible practitioner is now opting-out, the existing PECOS enrollment record shall be end-dated the same day as the affidavit effective date.

D. Emergency and Urgent Care Services

If an eligible practitioner who has opted-out provides emergency or urgent care services, *the eligible practitioner* must apply for enrollment via the Form CMS-855I. Once *the eligible practitioner* receives *a* PTAN, *the eligible practitioner* must submit the claim(s) for any emergency or urgent care service furnished. The contractor shall contact its PEOG BFL for additional guidance when this type of situation arises. (See Pub. 100-02, chapter 15, section 40.28 for more information on emergency and urgent care services.)

E. Termination of an Opt-Out Affidavit

As noted in Pub. 100-02, chapter 15, section 40.35, an eligible practitioner who has not previously opted-out may terminate *an* opt-out period early. However, *the eligible practitioner* must submit written notification thereof (with *the eligible practitioner's* signature) no later than 90 days after the effective date of the initial 2-year opt-out period. To properly terminate an affidavit, moreover, the eligible practitioner must:

1. Not have previously opted-out of Medicare (the eligible practitioner cannot terminate a renewal of *the* opt-out);
2. Notify all the MACs that the eligible practitioner has filed an affidavit no later than 90 days after the effective date of the affidavit;
3. Notify all beneficiaries (or their legal representation) with whom the eligible practitioner entered into private contracts of the eligible practitioner's decision to terminate *an* opt-out and of the beneficiaries' right to have claims filed on their behalf with Medicare for the services furnished during the period between the effective date of the opt-out and the effective date of the termination of the opt-out period and;
4. Refund to each beneficiary with whom the physician or practitioner has privately contracted all payments collected in excess of the Medicare limiting charge or deductibles and coinsurance.

For eligible practitioners who were previously enrolled to bill Medicare for services, the contractor shall reactivate the eligible practitioner's enrollment record in PECOS and reinstate *the* PTAN as if no opt-out affidavit existed. The eligible practitioner may bill for services provided during the opt-out period.

For eligible practitioners who were not previously enrolled to bill Medicare for services, the contractor shall remove the affidavit record from PECOS; this will help ensure that the eligible practitioner can submit the appropriate application(s) (via PECOS or paper Form CMS-855 for individual and/or reassignment enrollment) in order to establish an enrollment record in PECOS and thus bill for services rendered during the opt-out period.

F. Opt-Out Period Auto-Renewal and Cancellation of the Opt-Out Affidavit

1. General Policies

Eligible practitioners who initially opted-out or renewed an affidavit on or after June 16, 2015 need not submit a renewal of their affidavit. The opt-out will be automatically renewed for another 2-year period. Yet if the eligible practitioner decides to cancel *the* opt-out, the *eligible practitioner* must submit a written notice to each contractor to which would file claims (absent the opt-out) not later than 30 days before the end of the current 2 year opt-out period.

If the eligible practitioner decides to enroll in Medicare after *an* opt-out is canceled, the *eligible practitioner* must submit a Form CMS-855I application. The effective date of enrollment, however, cannot be before the cancellation date of the opt-out period. (For example, suppose an eligible practitioner submits a cancellation *of o*pt-out to end the period on March 31, which is two years from the eligible practitioner's opt-out affidavit effective date. *The eligible practitioner's* requested effective date of enrollment cannot be before April 1.)

If the eligible practitioner submits a cancellation request within 30 days of the end of the current opt-out period or after the opt-out period automatically renews, the contractor shall return the cancellation request to the eligible practitioner and provide appeal rights.

2. Auto-Renewal Report and Opt-Out Renewal Alert

The contractor shall issue an Opt-Out Renewal Alert Letter (found in section 10.7.14(E) of this chapter) to any eligible practitioner whose opt-out period is set to auto-renew. For this purpose, CMS will provide a monthly opt-out report to all contractors via the Share Point Ensemble site. The contractor shall access the report monthly through the Share Point Ensemble site. The contractor shall also review the opt-out report for opted-out eligible practitioners that will auto-renew in the next three-and-a-half months. In addition, the contractor shall issue an Auto-Renewal Alert Letter to eligible practitioners at least 90 days prior to the auto-renewal date; the eligible practitioner will thus have at least 60 days prior to the date a cancellation notice must be submitted to cancel the current opt-out.

The Opt-out Auto-Renewal Alert Letter will provide (1) the date on which the current opt-out period will be auto renewed and (2) the date by which the eligible practitioner will need to submit a cancellation request. The letter will also furnish the eligible practitioner appeal rights if *the latter* fails to submit a cancellation request and the opt-out renews.

The contractor shall (1) complete the Opt-Out Renewal Alert Letter Report to include the date the Alert Letter was issued, (2) post its reports no later than the 15th of the following month to the Share Point Ensemble site, and (3) email its PEOG BFL when the report has been posted.

If an opted-out eligible practitioner submits a Form CMS-855I without submitting a cancellation request of *the* opt-out, the contractor shall develop for the cancellation notice. Once the cancellation notice is received, the contractor shall then process the application(s).

If the eligible practitioner submits a cancellation request within 30 days of the end of the current opt-out period or after the opt-out period automatically renews, the contractor shall return the cancellation request to the eligible practitioner and provide appeal rights using the Late Cancellation Request return letter. In addition, if the eligible practitioner submits a cancellation request more than 90 days prior to the auto-renewal date, the contractor shall return the cancellation request to the eligible practitioner using the Cancellation Request Received Too Early return letter.

G. Failure to Properly Cancel or Terminate Opt-Out

Eligible practitioners who fail to properly cancel or terminate their opt-out may appeal the decision to continue (1) the auto-renewal of the opt-out or (2) the eligible practitioner's initial opt-out period.

Opt-out approval letters include appeal rights for eligible practitioners who initially opt-out and fail to properly terminate the opt-out within 90 days of the approval.

10.6.15 – Risk-Based Screening

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

Consistent with 42 CFR § 424.518, newly-enrolling and existing providers and suppliers will, beginning on March 25, 2011, be placed into one of three levels of categorical screening: limited, moderate, or high. The risk levels denote the level of the contractor's screening of the provider

when it initially enrolls in Medicare, adds a new practice location, revalidates its enrollment information, or, in certain circumstances, changes all or part of its ownership.

A. Specific Screening Categories

1. Limited Risk

The "limited" level of categorical screening consists of the following provider and supplier types:

- Physicians
- Non-physician practitioners other than physical therapists
- Physician group practices
- Non-physician group practices other than physical therapist group practices
- Ambulatory surgical centers
- Competitive Acquisition Program/Part B Vendors
- End-stage renal disease facilities
- Federally qualified health centers
- Histocompatibility laboratories
- Home infusion therapy suppliers
- Hospitals (including critical access hospitals, rural emergency hospitals, Department of Veterans Affairs hospitals, and other federally-owned hospital facilities.
- Health programs operated by an Indian Health Program (as defined in section 4(12) of the Indian Health Care Improvement Act) or an urban Indian organization (as defined in section 4(29) of the Indian Health Care Improvement Act) that receives funding from the Indian Health Service pursuant to Title V of the Indian Health Care Improvement Act
- Mammography screening centers
- Mass immunization roster billers
- Organ procurement organizations
- Outpatient physical therapy/outpatient speech pathology providers enrolling via the Form CMS-855A
- Pharmacies that are newly enrolling or revalidating via the Form CMS-855B application
- Radiation therapy centers
- Religious non-medical health care institutions
- Rural health clinics

For providers and suppliers in the "limited" category, the contractor shall process initial, revalidation, and new location applications in accordance with existing instructions.

2. Moderate Risk

a. General Information

The "moderate" level of categorical screening consists of the following provider and supplier types:

- Ambulance service suppliers
- Community mental health centers (CMHCs)
- Comprehensive outpatient rehabilitation facilities (CORFs)
- Independent clinical laboratories
- Independent diagnostic testing facilities
- Physical therapists enrolling as individuals or as group practices
- Portable x-ray suppliers (PXRSs)
- Newly Enrolling Opioid Treatment Program (OTP) that were SAMSHA certified prior to October 24, 2018
- Revalidating home health agencies (HHAs)
- Revalidating hospices
- Revalidating DMEPOS suppliers
- Revalidating MDPP suppliers
- Revalidating OTP providers
- Revalidating SNFs
- Pursuant to § 424.518(b)(1)(ix), revalidating OTPs that have not been fully and continuously certified by SAMHSA since October 23, 2018, revalidating DMEPOS suppliers, revalidating MDPP suppliers, revalidating HHAs, revalidating SNFs, and revalidating hospices to which CMS applied the fingerprinting requirements outlined in § 424.518(c)(2)(ii) upon the provider's or supplier's—
    - New/initial enrollment; or
    - Revalidation after CMS waived the fingerprinting requirements, under the circumstances described in § 424.518(c)(1)(viii), when the provider or supplier initially enrolled in Medicare. (See subsection (A)(5) below for more information.)

For providers and suppliers in the "moderate" level of categorical screening, the contractor shall (unless section 10.6.15(A)(4) of this chapter or another CMS directive applies): (1) process initial, revalidation, and new location applications in accordance with existing instructions; and (2) order an NSVC site visit through PECOS consistent with subsection 2(b) below. (Unless stated otherwise in this chapter, the scope of the site visit shall be consistent with existing instructions.)

b. Provider/Supplier-Specific Information

(i) <u>Ambulance suppliers, independent clinical laboratories, physical therapists, and physical therapist groups</u>

If the supplier submits an initial application, revalidation application, or application to add a new practice location, the contractor shall order a site visit. (For new location additions, the site visit shall be of the new location.) The contractor shall not make a final decision regarding the application (or, for initial applications, shall not convey Medicare billing privileges) prior to the completion of the NSVC's site visit and the contractor's review of the results.

(ii) <u>CMHCs, CORFs, Hospices and PXRSs</u>

For site visits regarding these four provider/supplier types, the contractor shall adhere to the site visit instructions in, respectively, sections 10.2.1.1, 10.2.1.2, 10.2.1.7, and 10.2.2.8 of this chapter.

(iii) IDTFs

Initial applications - The NSVC will conduct site visits of initially enrolling IDTFs consistent with section 10.2.2(O)(15) of this chapter.

Revalidations - The NVSC will conduct site visits of revalidating IDTFs (prior to the contractor's final decision regarding the revalidation application) consistent with section 10.2.2(I)(15) of this chapter.

IDTF Code Changes - The NSVC will conduct site visits for IDTF code changes as specified in section 10.2.2(I)(17) of this chapter.

(iv) Revalidating HHAs and SNFs

For site visits regarding revalidating HHAs and SNFs, the contractor shall adhere to the site visit instructions in, respectively, sections 10.2.1.6 and 10.2.1.14 of this chapter.

(v) Revalidating DMEPOS Suppliers

A site visit of the DMEPOS supplier shall be conducted prior to the NSC making a final decision regarding the revalidation application.

(vi) Revalidating MDPP Suppliers

If an MDPP supplier submits a revalidation application, the contractor shall order a site visit. The contractor shall not make a final decision regarding the revalidation application prior to the completion of the NSVC's site visit and the contractor's review of the results.

(vii) Revalidating OTP Providers

If an OTP provider submits a revalidation application, the contractor shall order a site visit. The contractor shall not make a final decision regarding the revalidation application prior to the completion of the NSVC's site visit and the contractor's review of the results.

3. High Risk

a. General Information

Pursuant to 42 CFR § 424.518, the "high" level of categorical screening consists of the following provider and supplier types:

- Newly enrolling DMEPOS suppliers
- Newly enrolling HHAs (including HHAs that must submit an initial enrollment application

pursuant to § 424.550(b)(1))
- Newly enrolling hospices
- Newly enrolling MDPP suppliers
- Newly enrolling OTP providers that were SAMSHA certified after October 24, 2018
- Newly enrolling SNFs
- DMEPOS suppliers, HHAs, MDPP suppliers, OTP providers that were SAMSHA certified after October 24, 2018, SNFs, and hospices submitting either: (i) a change of ownership application pursuant to 42 CFR § 489.18; or (ii) an application to report any new owner (regardless of ownership percentage, though consistent with the definition of owner in section 10.1.1 of this chapter) pursuant to a change of information or other enrollment transaction under title 42.
- Except as stated in § 424.518(b)(1)(ix), revalidating OTPs that have not been fully and continuously certified by SAMHSA since October 23, 2018, revalidating DMEPOS suppliers, revalidating MDPP suppliers, revalidating HHAs, revalidating SNFs, and revalidating hospices for which, upon their new/initial enrollment, CMS waived the fingerprinting requirements outlined in paragraph (c)(2)(ii) of this section pursuant to applicable legal authority due to a national, state, or local emergency declared under existing law. (See subsection (A)(5) below for more information.)

For newly enrolling providers and suppliers in the "high" level of categorical screening:

(i) The contractor shall process the application in accordance with existing instructions.

(ii) The NSVC will perform a site visit. The contractor shall not switch the provider's enrollment record to "Approved" prior to the completion of the site visit and the contractor's review of the results.

(iii) Their 5 percent or greater direct and indirect owners must undergo fingerprint-based criminal background checks. The contractor shall not switch the provider's enrollment record to "Approved" prior to the completion of fingerprinting and the contractor's review of the results.

(iv) The contractor shall, upon switching the provider's or supplier's enrollment record to "Approved," enter the provider's risk category as "moderate" into PECOS.

b. Additional Considerations

(i) Enrolled DMEPOS suppliers that are adding another location will be classified as "high" for screening purposes.

(ii) The addition of a new HHA branch falls within the "moderate" level of categorical screening. A site visit of the branch shall thus be performed consistent with the instructions in this chapter (including those in section 10.2.1.6).

(iii) The addition of a new MDPP supplier administrative location that does not result in a new PTAN does not require an additional site visit. Any additional MDPP supplier administrative location that results in a new PTAN, either due to being in a new jurisdiction or because of a new CDC organizational code, the contractors shall order a site visit of the location through PECOS.

This is to ensure that the supplier is in compliance with CMS's enrollment requirements. The scope of the site visit will be consistent with section 15.19.2.2(B) of this chapter. The NSVC will perform the site visit. The contractor shall not switch the provider's enrollment record to "Approved" prior to the completion of the NSVC's site visit and the contractor's review of the results.

c. Changes of/in Ownership

As explained above and in more detail in section 10.6.21(E)(3), the "high" screening category includes DMEPOS suppliers, HHAs, MDPP suppliers, OTP providers that were SAMSHA certified after October 24, 2018, SNFs, and hospices submitting either: (i) a change of ownership application pursuant to 42 CFR § 489.18; or (ii) an application to report any new owner (regardless of ownership percentage, though consistent with the definition of owner in section 10.1.1 of this chapter) pursuant to a change of information or other enrollment transaction under title 42. Accordingly, any change of/in ownership that meets all of the following criteria would fall under (i) or (ii) above:

- Does not involve the triggering of an initial enrollment (e.g., an HHA or hospice change in majority ownership for which no exception applies requires a new enrollment); and
- The change reports either:

    - For partnerships: A new partner (general or limited) who owns any percentage (even 1 percent) of the provider/supplier; or
    - Excluding partnerships: A new direct or indirect owner of at least 5 percent of the provider/supplier.

Upon receipt of an application described above, the contractor shall process it consistent with the instructions in this chapter and this section 10.6.15. This includes requesting fingerprints from the new owner(s) if the owner has a 5 percent or greater direct or indirect ownership interest. However, the contractor need not also solicit them from the provider/supplier's existing owners; only the new owner(s) need be fingerprinted.

(Note that if a new partner is being reported but the partner owns less than 5 percent of the provider/supplier, the provider/supplier's application must still be processed at the high screening level. However, the new partner need not be fingerprinted. This is because fingerprinting only applies to 5 percent or greater direct or indirect owners. It is therefore possible that, in such a change of ownership transaction, no fingerprinting will have to be conducted at all.)

The contractor shall also order a site visit of the provider/supplier consistent with existing instructions. In terms of the timing of the HHA, SNF, or hospice site visit, however, the contractor shall adhere to the following:

- No State/SOG Location Approval Required – If the ownership change does not require state or SOG Location approval under existing CMS instructions (see sections 10.6.1.1, 10.6.1.2, 10.6.22, and 10.6.22.1 of this chapter for more information on this topic), the site visit shall be ordered and performed prior to the contractor's final decision regarding the application.

- State/SOG Location Approval Required - If the ownership change requires state or SOG Location approval under existing CMS instructions, the site visit shall be ordered and performed no later than 5 business days after the contractor receives notice of approval from the state or SOG Location but before the contractor switches the provider/supplier's enrollment record to an "Approved" status.

(See section 10.6.21(E)(3) of this chapter for more information.)

4. Elevating Existing Providers and Suppliers into the High-Risk Screening Category

a. Criteria for Raising Providers/Suppliers to High-Risk

Under § 424.518(c)(3), CMS may adjust (or "bump up") a particular provider or supplier's screening level from "limited" or "moderate" to "high" if any of the following occur:

(i) CMS imposes a payment suspension on a provider or supplier at any time within the last 10 years;

(ii) The provider or supplier:

- Has been excluded from Medicare by the Office of Inspector General;
- Had its billing privileges revoked by a Medicare contractor within the previous 10 years and is attempting to establish additional Medicare billing privileges by: (A) enrolling as a new provider or supplier; or (B) obtaining billing privileges for a new practice location;
- Has been terminated or is otherwise precluded from billing Medicaid;
- Has been excluded from any federal health care program; or
- Has been subject to any final adverse action (as defined in § 424.502) within the previous 10 years.

(iii) CMS lifts a temporary moratorium for a particular provider or supplier type, and a provider or supplier that was prevented from enrolling based on the moratorium applies for enrollment as a Medicare provider or supplier at any time within 6 months from the date the moratorium was lifted.

b. Extension of Application of a Provider/Supplier's "Bump-Up"

Effective January 6, 2023 (and pursuant to § 424.518(c)(4)), any screening level adjustment under § 424.518(c)(3) also applies to all other enrolled and prospective providers and suppliers that have the same legal business name (LBN) and tax identification number (TIN) as the provider or supplier for which the screening level under § 424.518(c)(3) was originally raised. To illustrate, suppose an entity is enrolled as an ambulance supplier, a CORF, and a home infusion therapy (HIT) supplier. All three providers/suppliers are under the entity's TIN and LBN. The HIT supplier is under a payment suspension and is thus bumped-up to "high." Pursuant to § 424.518(c)(4), the ambulance supplier and CORF will also be moved to "high" because they have the same LBN and TIN as the HIT supplier.

c. List of Bumped-Up Providers/Suppliers

The CMS makes available to the contractor on a bi-monthly basis a list of current and former Medicare providers and suppliers within the contractor's jurisdiction that have been "bumped-up" pursuant to § 424.518(c)(3) and (c)(4). Upon receipt of an initial or revalidation application from a provider or supplier that otherwise falls within the limited or moderate screening category (and after the appropriate fee has been paid, etc.), the contractor shall determine whether the provider or supplier is on the bi-monthly "high" screening list. If the provider or supplier is not on said list, the contractor shall process the application in accordance with existing instructions. If the provider or supplier is on the list, the contractor shall process the application using the procedures in the "high" screening category unless the provider is on the list solely because *of a revocation* for failing to timely respond to a revalidation request. If such is the case, the contractor shall contact its CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL) for guidance as to how the situation should be handled.

d. Post-Moratorium Applications

If the contractor receives an initial or new location application from a provider or supplier: (a) that is of a provider or supplier type that was subject to a moratorium and (b) within 6 months after the applicable moratorium was lifted, the contractor shall process the application using the procedures in the "high" screening category.

5. Prior Waiver from Fingerprinting

During the recent COVID-19 public health emergency (PHE), CMS temporarily waived the requirement for fingerprint-based criminal background checks (FBCBCs) for 5 percent or greater owners of newly enrolling providers and suppliers falling within the high-risk screening category in § 424.518(c). CMS seeks to perform FBCBCs for high-risk providers and suppliers that initially enrolled during the PHE upon their revalidation once the PHE ends. This was not previously possible under our prior regulations because the revalidation applications would only be screened at the moderate-risk level. Pursuant to our regulatory revisions in the CMS CY 2024 Home Health Prospective Payment System final rule, however, CMS --- effective January 1, 2024 ---- may fingerprint the 5 percent or greater direct/indirect owners of these providers/suppliers. Specifically:

(i) Revalidating OTPs that have not been fully and continuously certified by SAMHSA since October 23, 2018, revalidating DMEPOS suppliers, revalidating MDPP suppliers, revalidating HHAs, revalidating SNFs, and revalidating hospices for which, upon their new/initial enrollment, CMS waived the fingerprinting requirements pursuant to a legally declared national, state, or local emergency declared under existing law --- These providers/suppliers fall within the high-risk screening category and are subject to the fingerprinting requirement as part of their revalidation requirement.

(ii) Once the providers/suppliers in (i) have been fingerprinted, they fall within the moderate-risk category.

Upon receipt of an application from a revalidating OTP that has not been fully and continuously certified by SAMHSA since October 23, 2018, revalidating DMEPOS supplier, revalidating

HHA, revalidating MDPP supplier, revalidating SNF, or revalidating hospice, the contractor shall determine whether the provider/supplier was waived from the fingerprinting requirement pursuant to applicable legal authority due to a national, state, or local emergency declared under existing law. If the provider/supplier was waived and has not yet been undergone fingerprinting, the contractor shall process the revalidation using the high-risk screening procedures. If the provider/supplier was not so waived or has otherwise undergone fingerprinting after a waiver, the revalidation application shall be processed consistent with the moderate-risk screening procedures.

Note that any such waiver must have been directed by CMS.

B. Changes of Information (Including Additions and Changes of Practice Locations)

(This subsection (B) does not apply to ownership changes that qualify as a mere change of information (e.g., reporting a new 10 percent owner).) These transactions are addressed in subsection (C) below.)

1. Limited

Changes of information (including additions of practice locations) submitted by providers/suppliers in the "limited" level of categorical screening shall be processed consistent with existing instructions.

2. Moderate

Changes of information submitted by providers/suppliers in the "moderate" level of categorical screening shall be processed consistent with existing instructions, although practice location additions and changes in a practice location's physical location also require a site visit as described in this section 10.6.15. The site visit shall be performed consistent with the applicable instructions in this chapter (e.g., section 10.2.1.2 for CORFs). The contractor shall not make its final decision regarding the application prior to the completion of the site visit and the contractor's review of the results.

3. High

Except as stated below, changes of information submitted by providers/suppliers in the "high" level of categorical screening shall be processed consistent with existing instructions, although practice location additions and changes in a practice location's physical location also require a site visit as described in this section 10.6.15. The site visit shall be performed consistent with the applicable instructions in this chapter. The contractor shall not make its final decision regarding the application prior to the completion of the site visit and the contractor's review of the results.

For purposes of this requirement:

- A change of location includes situations in which the provider/supplier is switching suite numbers or floors within a building. A site visit is required.

- If the provider/supplier's physical location is not changing (e.g., the provider's street name is changing but its actual office space is not), no site visit is required.

- A DMEPOS supplier that is adding a new practice location falls within the "high" screening category. This is because each location must be separately enrolled. The enrollment of a new location thus constitutes an initial enrollment.

- A DMEPOS supplier undergoing a change in TIN with no change in ownership falls within the "moderate screening category.

C. Change of Ownership

1. **Limited**

Changes of ownership (regardless of whether a new TIN is triggered) shall be processed consistent with existing instructions.

2. Moderate

If a provider or supplier is undergoing a change of ownership resulting in a new TIN, the contractor shall:

a. Process the application consistent with existing instructions, and

b. Order a site visit through PECOS in accordance with the following:

- For ownership changes that must be approved by the state or SOG Location under current CMS instructions (see sections 10.6.1.1, 10.6.1.2, 10.6.22, and 10.6.22.1) of this chapter), the site visit shall be ordered and performed after the contractor receives notice of approval from the state or SOG Location but before the contractor switches the provider/supplier's enrollment record to an "Approved" status. The contractor shall not switch the provider/supplier's enrollment record to "Approved" prior to the completion of the NSVC's site visit and the contractor's review of the results.

- For ownership changes that do not require state or SOG Location approval under current CMS instructions, the site visit shall be ordered and performed prior to the contractor's final decision regarding the application.

3. High

See subsection (A)(3)(c) for information on processing changes of/in ownership applications from DMEPOS suppliers, HHAs, MDPP suppliers, OTPs that have not been continuously SAMSHA-certified since October 24, 2018, SNFs, and hospices.

D. Reactivations

a. Limited

Form CMS-855 reactivation applications submitted by providers and suppliers in the "limited" level of categorical screening shall be processed in accordance with existing instructions.

b. Moderate

Form CMS-855 reactivation applications submitted by providers and suppliers in the "moderate" level of categorical screening – including existing DMEPOS suppliers, HHAs, MDPP suppliers, OTPs that have not been continuously SAMSHA-certified since October 24, 2018, and SNFs – shall be processed in accordance with the screening procedures for this category. A site visit will therefore be needed prior to the contractor's final decision regarding the application.

c. High

Form CMS-855 reactivation applications submitted by providers and suppliers in the "high" level of categorical screening shall be processed in accordance with the screening procedures for this category. A site visit will therefore be needed prior to the contractor's final decision regarding the application.

10.6.17 – Deceased Practitioners

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Reports of Death from the Social Security Administration (SSA)

Contractors, including DME MACs, will receive from CMS a monthly file that lists individuals who have been reported as deceased to the SSA. To help ensure that Medicare maintains current enrollment and payment information and to prevent others from utilizing the enrollment data of deceased individuals, the contractor shall undertake the activities in this section 10.6.17.

B. Erroneous Report of Death

In the event of an erroneous report of death, the contractor shall contact its PEOG BFL for guidance.

C. Verification Activities for Individuals Other than Physicians, Non-Physician Practitioners, and/or DMEPOS Suppliers

(If the person is an owner, sole owner of *a* professional corporation or professional association, managing employee, director, officer, authorized official, etc., the contractor shall verify and document in PECOS that the person is deceased using the process described in section 10.6.17(D)(1).)

Once the contractor verifies the report of death, it shall notify the provider or supplier organization with which the individual is associated that it needs to submit a Form CMS-855 change request that deletes the individual from the provider or supplier's enrollment record. If the provider fails to submit this information within 90 calendar days of the contractor's request, the contractor shall deactivate the provider's Medicare billing privileges in accordance with 42 CFR § 424.540(a)(2). (For DMEPOS Suppliers - If a DMEPOS supplier fails to submit this

information within 30 calendar days of the contractor's request, the contractor shall deactivate the supplier's billing privileges in accordance with 42 CFR § 424.57(c)(2).) The contractor need not, however, solicit a Form CMS-855 change request if the organization is enrolled with another contractor. Instead, the contractor shall notify (via fax or e-mail) the contractor with which the organization is enrolled of the situation, at which time the latter contractor shall take actions consistent with this section 10.6.17.

D. Reports of Death from Third-Parties

1. Verification of Death

If a contractor (including DME MACs) receives a report of death from a third-party (e.g., state provider association, state medical society, academic medical institution, etc.), the contractor shall verify that the physician, non-physician practitioner, or DMEPOS supplier is deceased by:

- Obtaining oral or written confirmation of the death from an authorized or delegated official of the group practice to which the physician, non-physician practitioner or DMEPOS supplier had reassigned *b*enefits;

- Obtaining an obituary notice from the newspaper;

- Obtaining oral or written confirmation from the state licensing board (e.g., telephone, e-mail, computer screen printout);

- Obtaining oral or written confirmation from the State Bureau of Vital Statistics; or

- Obtaining a death certificate, Form SSA-704, or Form SSA-721 (Statement of Funeral Director).

All verification shall be documented in PECOS per section 10.6.19(I) (and, as applicable, section 10.3) of this chapter; in addition, any documents that were used to confirm the death (e.g., obituary notice) shall be uploaded into PECOS.

2. Deceased Individuals: Post-Confirmation Actions

Once the contractor verifies the death, it shall:

a. Undertake all actions normally associated with the deactivation of a supplier's billing privileges.

b. Search PECOS to determine whether the individual is listed therein as an owner, managing employee, director, officer, partner, authorized official, or delegated official of another supplier.

c. If the person is not in PECOS, no further action with respect to that individual is needed.

d. If the supplier is indeed identified in PECOS as an owner, sole owner of *a* professional corporation or professional association, officer, etc., the contractor shall notify the organization

with which the person is associated that it needs to submit a Form CMS-855 change request that deletes the individual from the entity's enrollment record. If a provider fails to submit this information within 90 calendar days of the contractor's request, the contractor shall deactivate the provider's billing privileges in accordance with § 424.540(a)(2). (For DMEPOS Suppliers - If a DMEPOS supplier fails to submit this information within 30 calendar days of the contractor's request, the contractor shall deactivate the supplier's billing privileges in accordance with § 424.57(c)(2).) The contractor need not, however, ask for a Form CMS-855 change request if the organization is enrolled with another contractor. Instead, the contractor shall notify (via fax or e-mail) the contractor with which the organization is enrolled of the situation, at which time the latter contractor shall take actions consistent with this section 10.6.17.

E. Deceased Individuals: Education & Outreach

Contractors (including DME MACs) shall conduct outreach to state provider associations, state medical societies, academic medical institution, and group practices, etc., regarding the need to promptly inform contractors of the death of physicians and non-physician practitioners participating in the Medicare program.

F. Process to Deactivate NPI Due to a Death

1. Trustees/Legal Representatives

The trustee/legal representative of a deceased physician, non-physician practitioner, or DMEPOS supplier's estate may deactivate the NPI of the deceased provider by providing written documentation to the NPI enumerator.

2. Special Payment Address: Process to Update to an Estate Upon a Death

In situations where a physician, non-physician practitioner, or DMEPOS supplier has died, the contractor can make payments to the individual's estate per the instructions in Pub. 100-04, chapter 1. When the contractor receives a request from the trustee or other legally-recognized representative of the physician, non-physician practitioner, or DMEPOS supplier's estate to change the deceased's special payment address, the contractor shall, at a minimum, ensure that the following information is furnished:

- Form CMS-855 change of information request that updates the "Special Payment" address in the application. The Form CMS-855 can be signed by the trustee/legal representative.

- Any evidence – within reason - verifying that the physician, non-physician practitioner, or DMEPOS supplier is in fact deceased.

- Legal documentation verifying that the trustee/legal representative has the legal authority to act on behalf of the provider, non-physician practitioner, or DMEPOS supplier's estate.

The policies in this section 10.6.17(F) and (G) apply only to physicians, non-physician practitioners. and DMEPOS suppliers who operated their business as sole proprietors. It does

not apply to solely-owned corporations, limited liability companies, etc., nor to situations in which the physician or non-physician practitioner reassigned benefits to another entity.

All verification shall be documented in PECOS per section 10.6.19(I) of this chapter; in addition, any documents that were used to confirm the death (e.g., obituary notice) shall be uploaded into PECOS.

G. Other Enrollment Information

1. Reassignment and Revoked/Deceased Physicians and Non-Physician Practitioners

There are situations where a physician/non-physician practitioner (the "owning physician/practitioner") owns 100% of a practice, employs another physician (the "employed physician/practitioner") to work with the employing physician/non-physician practitioner, and accepts reassigned benefits from the employed physician/practitioner. Should the sole proprietor or sole owner die or have billing privileges revoked and the provider/supplier fails to submit an updated Form CMS-855 within 90 days, the practice is automatically dissolved for purposes of Medicare enrollment and all reassignments to the practice are automatically terminated as well. Neither the owning physician/practitioner nor the practice is enrolled in Medicare any longer and the enrollments for both shall be deactivated in accordance with the deactivation procedures outlined in this chapter. (It is immaterial whether the practice was established as a sole proprietorship, a professional corporation, a professional association, or a solely-owned limited liability company.) In addition, the contractor shall end-date the reassignment using, as applicable, the date of death or the effective date of the revocation.

Besides deactivating the enrollments of the owning physician/practitioner and the practice, the contractor shall notify the employed physician/practitioner that:

a. The practice's billing privileges have been deactivated;

b. Any services furnished by the physician/practitioner on behalf of the practice after the date of the owning physician/practitioner's death or date of revocation or deactivation will not be paid; and

c. If the employed physician/practitioner wishes to provide services at the former practice's location, the individual must submit a Form CMS-855I change of information request to add the owning physician/practitioner's practice location as a new location of the employed physician/practitioner. For purposes of this section 10.6.17(G)(1)(c) only, submission of an initial Form CMS-855I and a terminating Form CMS-855R application are not required – even if the employed physician/non-physician practitioner had reassigned all benefits to the practice.

H. Proof of Life Documentation

On rare occasions, erroneous death information may be received through the DMF process that results in systematic enrollment deactivations in PECOS or records populated on the Deceased Associates reports in PECOS for contractor deactivation actions. In order for the providers/suppliers to reactivate their enrollments and have the date of death removed from their PECOS records, the contractor shall request documentation that supports "proof of life" (for

example, Retirement, Survivors, and Disability Insurance document issued by SSA). If the provider/supplier is unable to obtain such documentation, the contractor shall submit a request to *its* PEOG BFL containing the provider/supplier's name, date of birth, and SSN so that CMS can confirm proof of life with SSA.

10.6.18 – Appeals Process

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

This section contains instructions for how the Medicare Administrative Contractors (hereinafter, "MACs" or "Contractors") shall process provider enrollment corrective action plans (hereinafter, "CAPs") and reconsideration requests. CAPs and reconsideration requests are collectively referred to as "appeals".

A. Review Procedures for Determinations that Affect Participation in the Medicare Program

1. Background

This review process of initial determinations applies to all providers/suppliers and ensures that all current and prospective providers/suppliers receive a fair and full opportunity to be heard. With the implementation of the appeals provision of Section 936 of the Medicare Prescription Drug Modernization and Improvement Act (MMA), all providers/suppliers that wish to appeal will be given the opportunity to request Administrative Law Judge (ALJ) review of a reconsideration decision within the Civil Remedies Division of the Departmental Appeals Board (CRD DAB). Providers/suppliers may thereafter seek review of the ALJ decision in the Appellate Division of the Departmental Appeals Board (DAB) and may then request judicial review in Federal District Court.

For purposes of this chapter, in accordance with 42 C.F.R. § 498.3, an initial determination includes: (1) the denial of enrollment in the Medicare program; (2) the revocation of a provider's or supplier's Medicare billing privileges; (3) the effective date of participation in the Medicare program; and (4) whether a physician or practitioner has failed to properly opt-out, failed to maintain opt-out, failed to timely renew opt-out, failed to privately contract, or failed to properly terminate opt-out.

Any CAP or reconsideration request that purports to challenge an enrollment action other than the initial determinations identified above (including inclusion on the CMS Preclusion List) shall be forwarded to CMS at ProviderEnrollmentAppeals@cms.hhs.gov for review within 10 business days of the date of receipt. The MAC shall take no action on the provider's or supplier's information on its enrollment record regarding an appeal submission for revocations forwarded to CMS for processing unless otherwise instructed by the Provider Enrollment and Oversight Group (PEOG).

A provider/supplier dissatisfied with the initial determinations referenced above may challenge the determination. All properly submitted requests shall be reviewed at the enrollment level. As a result, if one letter attempts to challenge the initial determination for a group enrollment in addition to individual practitioner enrollment(s), each enrollment shall receive a separate

decision. All submissions shall be processed in the order in which they are received. All CAPs and/or reconsideration requests will be reviewed by an individual separate and apart from the individual involved in the implementation of the initial determination.

Depending on the regulatory authority under which an initial determination is issued, providers/suppliers may be entitled to submit a CAP and/or a reconsideration request. A CAP is a plan that allows a provider/supplier an opportunity to demonstrate compliance with all applicable Medicare requirements by correcting the deficiencies (if possible) that led to the initial determination, specifically either the denial of enrollment into the Medicare program under 42 C.F.R. § 424.530(a)(1) or the revocation of Medicare billing privileges pursuant to § 424.535(a)(1). While CAPs may only be submitted in response to a denial under § 424.530(a)(1) or a revocation under § 424.535(a)(1), all initial determinations allow for the submission of a reconsideration request. A reconsideration request allows the provider or supplier an opportunity to demonstrate that an error was made in the initial determination at the time the initial determination was implemented. In contrast to a CAP, a reconsideration request does not allow a provider/supplier the opportunity to correct the deficiencies that led to the initial determination.

Any CAPs and/or reconsideration requests received in response to initial determinations involving the following, either in whole or in part, shall be forwarded to CMS for review within 10 business days of the date of receipt. The CAP and/or reconsideration request shall be sent to the PEOG Provider Enrollment Appeals inbox at ProviderEnrollmentAppeals@cms.hhs.gov.

- All CAPs and reconsideration requests for certified providers/suppliers (as defined in Sections 10.2.1 and 10.2.2 of this chapter) and institutional providers/suppliers (as defined in Section 10.4.7.4(D) of this chapter), including those regarding effective dates, denials, and revocations;

- CAPs and reconsideration requests for Independent Diagnostic Testing Facilities (IDTFs);

- CAPs and reconsideration requests for Medicare Diabetes Prevention Programs (MDPPs);

- CAPs and reconsideration requests for Opioid Treatment Programs (OTPs);

- Reconsideration requests for enrollment denials pursuant, in whole or in part, to 42 C.F.R. § 424.530(a)(2), (3), (6), (11), (12), (13), (14), (15), and (17);

- Reconsideration requests for revocations pursuant, in whole or in part, to 42 C.F.R. § 424.535(a)(2), (3), (4), (7), (8), (10), (12), (13), (14), (15), (17), (18), (19), (20), (21), and (22);

- Requests for reversals of denials pursuant to 42 C.F.R. § 424.530(c) and/or revocations pursuant to § 424.535(e);

- CAPs and reconsideration requests for revocations pursuant, in whole or in part, to 42 C.F.R. § 424.535(j);

- CAPs and reconsideration requests challenging the addition of years to an existing re-enrollment bar;

- CAPs and reconsideration requests challenging whether an individual or entity other than the provider or supplier that is the subject of the second revocation was the actual subject of the first revocation; and

- Reconsideration requests challenging an individual or entity being included on the CMS Preclusion List as defined in 42 C.F.R. § 422.2 or § 423.100.

(NOTE: As indicated in section 10.4.7.4(D) of this chapter – and notwithstanding any other instruction to the contrary in this chapter (including in this section 10.6.18(A)(1)) -- the MAC shall make all reconsideration determinations for denials under § 424.530(a)(18) and revocations under § 424.535(a)(23).)

If the provider/supplier is denied enrollment or has its Medicare billing privileges revoked, under 42 C.F.R. § 424.530(a)(1) or § 424.535(a)(1), (5), (9), in conjunction with any denial or revocation reason(s) listed above, those CAPs and/or reconsideration requests should also be forwarded to CMS at ProviderEnrollmentAppeals@cms.hhs.gov for review within 10 business days of the date of receipt and the determination will be rendered by CMS. If the provider/supplier only submits a CAP for the noncompliance portion of any initial determinations listed above, the CAP must be sent to CMS at ProviderEnrollmentAppeals@cms.hhs.gov for review within 10 business days of the date of receipt, even if the provider/supplier does not submit a reconsideration request. The MAC shall not process the CAP if it is required to be forwarded to CMS. If the provider/supplier later submits a reconsideration request, the reconsideration request must also be sent to CMS at ProviderEnrollmentAppeals@cms.hhs.gov within 10 business days of the date of receipt.

All CAPs and reconsideration requests received by the MACs that are not specifically identified above as being required to be forwarded to CMS for review, shall be processed and a decision rendered by the MACs. However, CMS may exercise its discretion to review any CAP and/or reconsideration request and issue a decision regardless of the basis for the initial determination.

(**NOTE:** This includes all CAPs and reconsideration requests for DMEPOS suppliers that fit the criteria identified above. In addition, as also indicated above, CAPs may only be submitted for denials pursuant to 42 C.F.R. § 424.530(a)(1) and revocations pursuant to § 424.535(a)(1). However, in the event a CAP is submitted for revocations pursuant, in whole or in part, to §§ 424.535(a)(2), (3), (4), (7), (8), (10), (12), (13), (14), (15), (17), (18), (19), (20), (21), or (22) the submission should still be forwarded to CMS within 10 business days of the date of receipt to the PEOG Provider Enrollment Appeals inbox at ProviderEnrollmentAppeals@cms.hhs.gov.)

PEOG shall notify the MAC via email when it receives a CAP and/or reconsideration request for a provider/supplier that has not been previously forwarded to PEOG by the MAC. The MAC shall not take any action on a provider's or supplier's information on its enrollment record if there is a CAP and/or reconsideration request pending for a revocation action unless otherwise

instructed by PEOG. The MAC shall email ProviderEnrollmentAppeals@cms.hhs.gov with any inquiries, questions, or requests.

MACs shall save all documentation related to CAPs and reconsideration requests (including, but not limited to, the decisions) in PDF format. The date on the CAP and reconsideration request decisions shall be the same date as the date the decision is issued to the provider/supplier/representative.

2. Reopening and Revising CAP and Reconsideration Determinations

Once a CAP and/or reconsideration decision is issued, the MAC shall not reopen and revise a CAP and/or reconsideration decision without PEOG's prior written approval, even if the MAC rendered the CAP or reconsideration decision independently. The MAC shall send all requests to reopen and revise a CAP and/or reconsideration decision to ProviderEnrollmentAppeals@cms.hhs.gov and await further instruction before taking any action regarding the CAP and/or reconsideration decision.

3. Requests to the MACs

The MAC shall work with and provide PEOG and the Office of General Counsel (OGC), when applicable, all necessary documentation related to any and all CAPs, reconsideration requests, ALJ appeals, DAB appeals, or requests for judicial review.

The following are examples of information the MAC may be asked to provide. This is not an exhaustive list.

- A copy of the initial determination letter**;**
- A chronological timeline outlining: (1) the processing of applications; (2) the date the provider/supplier began providing services at the newest assigned location; and (3) if there were development requests;
- The hearing officer's decision as well as the provider's or supplier's CAP and/or reconsideration request;
- A complete copy of all application Form CMS-855s, and any supporting documentation submitted with the provider's or supplier's application;
- All background information and investigative data the hearing officer used to make the decision, including any on-site visit reports, and the MAC's recommendation for administrative action based on the on-site visit; and
- Contact information for the person(s) who signed both the revocation and reconsideration decision letters.

The MAC shall supply PEOG or OGC with all requested documentation within 5 business days of receipt of the request, unless requested sooner.

All requested documentation shall be provided in PDF format (if possible) and saved with a file name that identifies the content of the document.

If a CAP and/or reconsideration decision requires the MAC to take action on a provider's or supplier's enrollment, such as reinstating the provider's or supplier's enrollment to an active status, the MAC shall complete all updates to the provider's or supplier's enrollment within 10 business days of the date the CAP and/or reconsideration decision is issued unless additional documentation is needed to update the enrollment. If a CAP or reconsideration decision requires the provider/supplier to submit further information before the enrollment can be updated (such as an enrollment application) the MAC shall allow 30 calendar days for the provider/supplier to submit the necessary information. The MAC shall complete all updates to the provider's or supplier's enrollment within 10 business days of the date of receipt of the additional information/documentation. If the provider/supplier does not submit the necessary information within 30 calendar days, the MAC shall contact PEOG by emailing ProviderEnrollmentAppeals@cms.hhs.gov for further instruction.

4. Timing of CAP and Reconsideration Request Submissions

A provider/supplier who wishes to submit a CAP must file its request in writing within 35 calendar days of the date of the initial determination. A provider/supplier must submit a reconsideration request in writing within 65 calendar days of the date of the initial determination. The date on which CMS or the MAC receives the submission is the date of filing. See section 10.6.18(D) if this chapter below for information on calculating timely submissions.

The mailing and email address for all CAPs and reconsideration requests to be rendered by CMS identified in section 10.6.18(A) is:

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop AR-19-51
Baltimore, MD 21244-1850

Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review and may result in the dismissal of any untimely submitted reconsideration request. Pursuant to 42 C.F.R. § 498.22(d), CMS may extend the time limit to submit a reconsideration request if "good cause" is shown. Good cause may be found when the record clearly shows (or the party alleges and the record does not negate) that the delay in filing was due to circumstances outside of the provider's or supplier's control such as the following:

- Unusual or unavoidable circumstances, the nature of which demonstrate that the individual could not reasonably be expected to have been aware of the need to file timely; or

- Destruction by fire, or other damage, of the individual's records when the destruction was responsible for the delay in filing.

The CMS will make the determination as to whether good cause exists. If a MAC receives an untimely CAP and/or reconsideration request that it believes is entitled to a good cause exception related to untimeliness, the hearing officer must request approval from PEOG by emailing ProviderEnrollmentAppeals@cms.hhs.gov before making a finding of good cause or taking any other action regarding the CAP and/or reconsideration request. The email shall include an explanation of why the MAC believes good cause exists. The MAC shall not take action on the CAP and/or reconsideration request until it receives a response from CMS regarding the good cause exception request.

5. Time Calculations

Per 42 C.F.R. § 498.22(b)(3), the date of receipt of an initial determination is presumed to be 5 calendar days after the date on the initial determination notice unless there is a showing that it was, in fact, received earlier or later. Therefore, a CAP must be received by the MAC or CMS within 35 calendar days of the date of the initial determination. A reconsideration request must be received by the MAC or CMS within 65 calendar days of the date of the initial determination. If the 35th day (for a CAP) or 65th day (for a reconsideration request), falls on a weekend, or Federally recognized holiday, the CAP and/or reconsideration request shall be considered timely filed if received on the next business day. In the case of an email submission of a CAP and/or reconsideration request, the filing date is presumed to be the date of receipt of the email. Consider the following example:

An initial determination letter is dated April 1, 2024. The provider is presumed to have received the initial determination on April 6, 2024. The provider submits a reconsideration request by mail that is received on June 5, 2024 -- 60 calendar days after April 6. This is considered timely because it is presumed that the provider did not receive the initial determination letter until April 6.

It is the provider's or supplier's responsibility to timely update its enrollment record to reflect any changes to the provider's or supplier's enrollment information, including its correspondence mailing address. Failure to timely update a correspondence address or other address included in the enrollment record does not constitute an "in fact" showing that an initial determination letter was received after the presumed date of receipt.

6. Signatures

A CAP and/or reconsideration request must be submitted in the form of a letter that is signed by the individual physician or practitioner, an authorized/delegated official, or a properly appointed representative, as defined in 42 C.F.R. § 498.10.

- If the representative is an attorney, the attorney must include a statement that *the attorney* has the authority to represent the provider/supplier. This statement is sufficient to constitute notice of appointment.
- If the representative is not an attorney, the provider/supplier must file written notice of

the appointment of a representative with CMS or the MAC. This notice of appointment must be signed by the individual physician or practitioner, or an authorized/delegated official. The signature need not be original and can be electronic.

- Authorized/delegated officials for groups cannot sign and submit a CAP and/or reconsideration request on behalf of a reassigned individual physician or practitioner without *the latter* submitting a signed statement authorizing that official from the group to act on *the reassigned physician's/practitioner's* behalf.

(**NOTE:** The Contact Person (as listed in Section 13 of the Form CMS- 855I, CMS-855A, CMS-855B, CMS-855S, or CMS-20134, or Section 6 of the Form CMS-855O) does not qualify as a "properly appointed representative" for purposes of signing a CAP and/or reconsideration request without a signed notice of appointment from the individual physician or practitioner, or an authorized/delegated official. See section 10.6.18(A)(7) of this chapter for additional information regarding representatives for CAPs and reconsideration requests.)

If the CAP and/or reconsideration request is not appropriately signed or if a statement from the attorney or written notice of representation is not included in the submission, the MAC shall send a development request for a proper signature or the missing statement/written notice (using the applicable model letter in section 10.7 of this chapter) before dismissing the CAP and/or reconsideration request. The MAC shall allow 15 calendar days from the date of the development request letter for the submitter to respond to the development request.

If the CAP and/or reconsideration request submission is not appropriately signed and no response is timely received to the development request, the MAC shall dismiss the CAP and/or reconsideration request using the applicable model dismissal letter from section 10.7 of this chapter.

7. Representative for CAP and/or Reconsideration Request

Per 42 C.F.R. § 498.10, a provider/supplier may appoint as *a* representative any individual that is not disqualified or suspended from acting as a representative in proceedings before the Secretary of the Department of Health and Human Services or otherwise prohibited by law to engage in the appeals process. If this individual is an attorney, *the latter's* statement that *the attorney has* the authority to represent the provider/supplier is sufficient to accept this individual as the representative. If the representative is not an attorney, the individual physician or practitioner, or authorized/delegated official must file written notice of the appointment of *a* representative with CMS or the MAC. Once a representative has been properly appointed, the representative may sign and/or submit a CAP, reconsideration request, request for reversal, or a request for good cause exception on behalf of the provider/supplier.

8. Submission of Enrollment Application while a CAP and/or Reconsideration Request is Pending/Submission Timeframe has not Expired

Pursuant to 42 C.F.R. § 424.530(b), if a provider's or supplier's enrollment application is denied, the provider/supplier must wait until the time period in which to submit a CAP and/or reconsideration request has ended before submitting a new enrollment application, change of information, or provide any additional information to update th*e e*nrollment record. If the MAC

receives an enrollment application, change of information, or additional information to update a provider's or supplier's enrollment record prior to the conclusion of the time period in which to submit a CAP and/or reconsideration request the MAC shall return the application, unless the application is received as part of *a* CAP and/or reconsideration request submission. The MAC shall not modify the enrollment record of a provider/supplier that currently has a pending CAP and/or reconsideration request or is still within the submission time period following a denial unless instructed by CMS to do so. If the MAC confirms that the provider/supplier submitted an enrollment application prior to the expiration of the time period in which it is entitled to appeal the denial of its previously submitted application, the MAC shall return the application, consistent with section 10.4.1.4.2(A) of this chapter.

B. Corrective Action Plans (CAPs)

1. Background

A CAP is a plan that allows a provider or supplier an opportunity to demonstrate compliance by correcting the deficiencies (if possible) that led to the initial determination. CAPs may only be submitted in response to enrollment denials pursuant to 42 C.F.R. § 424.530(a)(1) and revocation of Medicare billing privileges pursuant to 42 C.F.R. § 424.535(a)(1).

2. Requirements for CAP Submission

To be accepted a CAP submission:

a) Must contain, at a minimum, verifiable evidence that the provider/supplier is in compliance with all applicable Medicare requirements;
b) Must be received within 35 calendar days from the date of the initial determination (see section 10.6.18(A)(5) of this chapter for clarification on timing). The contractor shall accept a CAP via hard-copy mail, email, and/or fax;
c) Must be submitted in the form of a letter that is signed by the individual physician or practitioner, an authorized/delegated official, or a properly appointed representative;
d) Should include all documentation and information the provider/supplier would like to be considered in reviewing the CAP.
e) For denials, the denial must be based on 42 C.F.R. § 424.530(a)(1);
    i) For denials based on multiple grounds including § 424.530(a)(1), the CAP may only be accepted with respect to § 424.530(a)(1), but with respect to the other grounds. The other denial bases may only be reviewed as a reconsideration.
    ii) If the provider/supplier submits a CAP that does not comply with this paragraph, the MAC shall address this in the acknowledgement email or letter using the model acknowledgement letter (see section 10.7 of this chapter).
f) For revocations, the revocation must be based on 42 C.F.R. § 424.535(a)(1);
    i) Consistent with § 405.809, CAPs for revocations based on grounds other than § 424.535(a)(1) shall not be accepted.
    ii) For revocations based on multiple grounds of which one is § 424.535(a)(1), the CAP may be accepted with respect to § 424.535(a)(1), but not with respect to the other grounds. The other revocation bases may only be reviewed as a reconsideration.

iii) If the provider/supplier submits a CAP that does not comply with this paragraph, the MAC shall address this in the acknowledgment email or letter sent to the provider/supplier using the model acknowledgment letter

3. Receipt Acknowledgment of CAP

If the MAC receives an acceptable CAP for a provider/supplier, the MAC shall use the model acknowledgment letter in section 10.7 of this chapter to email (if a valid email address is available) and send a hard-copy letter to the address included on the CAP submission letter or if no address is listed on the CAP submission letter, then the return address on the envelope from which the CAP was submitted within 14 calendar days of the date of receipt of the CAP, informing the provider/supplier or *representative thereof* that a CAP decision will be rendered within 60 calendar days of the date of receipt of the CAP. If no address is listed in the CAP, then an acknowledgment letter should be sent to the correspondence mailing address on the provider's or supplier's enrollment record.

If the provider's or supplier's CAP cannot be accepted due to untimeliness, an improper signature (including a failure to respond to development for the required statement or signed declaration from a representative), or any other reason, the MAC shall **not** send the provider/supplier/representative an acknowledgment email or letter. Instead, the MAC shall dismiss the CAP using the applicable model dismissal letter in section 10.7 of this chapter.

4. Dismissing a CAP

A CAP shall be dismissed when the provider/supplier does not have the right to submit a CAP for the initial determination, or when the provider/supplier submitted the CAP improperly or untimely (see Section 10.6.18(B)(2) of this chapter). As a result, the CAP shall not be reviewed. The MAC shall use the model dismissal letter when dismissing a CAP. All unacceptable CAPs shall be dismissed as soon as possible.

If a provider/supplier concurrently submits a CAP and reconsideration request, but the initial determination being appealed does not afford CAP rights or the CAP submission is untimely, the MAC shall dismiss the CAP using the No CAP Rights Dismissal Model Letter or Untimely CAP Dismissal Model Letter in section 10.7 of this chapter and review the reconsideration request in accordance with the instruction in Section 10.6.18(C) of this chapter.

5. CAP Analysis

The MAC shall only review the CAP as it relates to denial of enrollment pursuant to 42 C.F.R. § 424.530(a)(1) or a revocation of billing privileges pursuant to § 424.535(a)(1). The MAC must determine whether or not the information and documentation submitted with the CAP establishes that the provider/supplier has demonstrated compliance with all applicable Medicare rules and requirements by correcting the deficiency that led to the initial determination.

If the MAC finds that the CAP corrects the deficiency that led to the initial determination, then the MAC shall overturn the initial determination as it relates to the denial reasons under § 424.530(a)(1) or revocation under § 424.535(a)(1). If the denial of enrollment is overturned completely, the MAC shall continue processing the previously denied enrollment application in

accordance with standard processing procedures. Pursuant to § 405.809(b), if the revocation is overturned completely, the MAC shall reinstate the provider's or supplier's enrollment to an approved status based on the date the provider/supplier came into compliance. Consider the following example:

> Example 1: Dr. Smith's enrollment is revoked under 42 C.F.R. § 424.535(a)(1) because *the* required license has been suspended. Dr. Smith timely submits a CAP with evidence that *the* licensure has been reinstated, effective June 1, 2024, and is currently active. After confirming the status of current licensure, the MAC renders a favorable CAP decision because the Dr. Smith has corrected the licensure issue that led to enrollment denial or revocation. Dr. Smith's enrollment is reinstated, effective June 1, 2024.

If the provider/supplier submitted a CAP for reasons in addition to 42 C.F.R. § 424.535(a)(1), the MAC shall include a statement in the decision letter that the CAP was reviewed only in regard to the denial under 42 C.F.R. § 424.535(a)(1).

If the provider/supplier does not submit information that establishes compliance with all applicable Medicare rules and requirements by correcting the deficiency that led to the initial determination, the MAC need not contact the provider/supplier for the missing information or documentation. The MAC shall instead deny the CAP. Under 42 C.F.R. § 405.809(a)(2), with respect to the revocation basis, the provider/supplier has only one opportunity to correct all deficiencies that served as the basis of its revocation through a CAP.

6. Processing and Approval of CAPs

The time to submit a reconsideration request continues to run even though the MAC has received a CAP and is reviewing the CAP. Therefore, the time period in which to submit a reconsideration request does not stop once a CAP is received and while the CAP is being reviewed. The provider/supplier must submit a reconsideration request within 65 days of the date of the initial determination, even if a CAP is timely submitted and accepted.

The hearing officer shall issue a written decision within 60 calendar days of the date of receipt of the accepted CAP. The hearing officer shall email and mail a hard copy of the CAP decision to the provider/supplier/representative, unless an email address is unavailable or the email is returned, then only a hard copy letter shall be mailed to the return address on the CAP/envelope or the correspondence mailing address on the provider's or supplier's enrollment record if no return address is included on the CAP. The MAC should also send the CAP decision letter via fax if a valid fax number is available.

If the MAC approves a CAP, it shall notify the provider/supplier/representative by issuing a favorable decision letter following the applicable model CAP letter in section 10.7 of this chapter. The MAC shall continue processing the enrollment application under standard processing timelines or restore billing privileges (as applicable) within 10 business days of the date of the CAP decision or the date of receipt of additional documentation, if needed.

For denials – and unless stated otherwise in another CMS directive or instruction – the effective date is the later of either the date of the filing of the enrollment application or the date on which services were first rendered. Consider the following examples:

a. Denials

Dr. Happy's initial enrollment application is denied on March 1, 2024. Dr. Happy submits a CAP showing that, as of March 20, 2024, they were in compliance with all Medicare requirements. If the MAC approves the CAP, the effective date for Dr. Happy's Medicare enrollment and billing privileges should be March 20, 2024, as that is the day on which Dr. Happy came into compliance with all Medicare requirements. The 30-day retrospective billing period under 42 C.F.R. § 424.521 should not be applied in this situation because § 424.521(a)(1) requires that the provider/supplier has met all program requirements during the 30-day period. That is not the case here. Dr. Happy was not in compliance with all Medicare requirements until March 20.

b. Revocations

Dr. Smile's medical license is suspended on June 3, 2024. Dr. Smile's Medicare enrollment is revoked under 42 C.F.R. § 424.535(a)(1) on June 15, 2024. Dr. Smile then submits a CAP showing that *the* license was reinstated as of July 1, 2024. Pursuant to § 405.809(b)(1)(i), if the MAC approves the CAP, the effective date for reactivation of the Dr. Smile's Medicare enrollment billing privileges will be July 1, 2024, as that is the date on which Dr. Smile came into compliance with all Medicare requirements. The 30-day retrospective billing period under § 424.521 does not apply in this situation.

The MAC shall ensure that the applicable CMS Regional Office is notified of the outcome of any CAP decision that involves the revocation of Medicare billing privileges for a certified provider or supplier.

If additional information/documentation is needed prior to reinstating the provider or supplier, the MAC shall document these next steps in *its* CAP decision letter. The MAC shall not reinstate the provider's or supplier's enrollment until the requested information is received and processed. If the additional information/documentation is not received within 30 calendar days of the date of the CAP decision letter, the MAC shall contact the provider or supplier via the applicable model letter to again request the additional information/documentation within 10 calendar days of not receiving a response. If no response is received within 30 calendar days of the second request for additional information/documentation, the MAC shall contact ProviderEnrollmentAppeals@cms.hhs.gov within 10 calendar days for further instruction

7. Withdrawal of CAP

The provider/supplier/representative who submitted the CAP may withdraw the CAP at any time prior to the mailing of the CAP determination. If submitted via mail, the request to withdraw the CAP must be postmarked prior to the CAP determination date. The request to withdraw the CAP must be made in writing, signed, and filed with the MAC or CMS. If the MAC receives a request to withdraw a CAP before the CAP determination is issued, it shall send a letter or e-mail to the provider/supplier/representative acknowledging receipt of the request to withdraw the CAP and advising that the CAP has been dismissed, utilizing the applicable model letter in section 10.7 of this chapter.

8. Concurrent Submission of CAP and Reconsideration Request

If a provider/supplier submits a CAP and a reconsideration request concurrently in response to any denial of enrollment under 42 C.F.R. § 424.530(a)(1) or a revocation of billing privileges under § 424.535(a)(1), the MAC shall first process and make a determination regarding the CAP, only as it relates to the denial and/or revocation under § 424.530(a)(1) or § 424.535(a)(1). If the MAC renders a favorable decision as it relates to § 424.530(a)(1) or § 424.535(a)(1), the MAC shall only render a reconsideration decision on the remaining authorities not addressed by the favorable CAP decision. Processing timelines still apply.

If a CAP and a reconsideration request (see Section 10.6.18(C)(8) of this chapter below) are submitted concurrently, the MAC shall coordinate the review of the CAP and reconsideration request to ensure that the CAP is reviewed and a CAP decision rendered before a reconsideration decision is rendered (if the initial determination is not resolved in its entirety by the CAP decision).

If the CAP is approved and resolves the basis for the initial determination in its entirety, the model CAP decision letter shall be sent to the provider/supplier/representative with a statement that the reconsideration request will not be evaluated because the initial determination has been overturned. If the CAP decision does not fully resolve the initial determination or results in a gap in the provider's or supplier's billing privileges, the MAC shall also process the reconsideration request.

If the CAP is denied:

- There are no further appeal rights; therefore, the CAP decision cannot be appealed. As a result, the MAC shall not include further appeal rights for a CAP only decision.

- The MAC shall notify the provider/supplier/representative of the denial of the CAP via the applicable CAP model letter in section 10.7 of this chapter.

- The provider/supplier may continue with the appeals process only if it has filed a reconsideration request or is preparing to timely submit such a request.

- The reconsideration request, if properly and timely submitted, shall be processed.

C. Reconsideration Requests

1. Background

A reconsideration request allows the provider/supplier an opportunity to demonstrate that an error was made in the initial determination at the time the initial determination was implemented. In contrast to a CAP, a reconsideration request **does not** allow a provider/supplier the opportunity to correct the deficiencies that led to the initial determination.

2. Requirements for Reconsideration Request Submission

To be accepted, a reconsideration request:

a. Must, at a minimum, state the issues and/or the findings of fact with which the affected party disagrees, and the reasons for disagreement;

b. Must be received within 65 calendar days from the date of the initial determination (see Section 10.6.18(A)(4)-(5) of this chapter for clarification on timing). The contractor shall accept a reconsideration request via hard-copy mail, email, and/or fax;

c. Must be submitted in the form of a letter;

d. Must be signed by the individual physician/practitioner, an authorized or delegated official, or a properly appointed representative; and

e. Should include all documentation and information the provider/supplier would like to be considered in reviewing the reconsideration request.

3. Receipt Acknowledgement of Reconsideration Request

Upon receipt of a properly submitted reconsideration request, the MAC shall send an email (if a valid email address is available) and hard-copy letter, to the individual that submitted the reconsideration request to acknowledge receipt of the reconsideration request using the applicable model acknowledgment letter in section 10.7 of this chapter within 14 calendar days of the date of receipt of the reconsideration request. The MAC shall send a hard-copy letter to the address listed in the reconsideration request submission or the return address listed on the reconsideration request submission envelope if no address is included on the reconsideration request letter. If no address is listed in the reconsideration request or on the envelope, then an acknowledgment letter should be sent to the correspondence mailing address on the provider's or supplier's enrollment record. In the acknowledgment letter/email, the MAC shall advise the requesting party that the reconsideration request will be reviewed, and a determination will be issued within 90 calendar days from the date of receipt of the reconsideration request. The MAC shall include a copy of the acknowledgment letter/email in the reconsideration file. If the reconsideration request should have been submitted to CMS, the MAC shall not send the provider/supplier/representative an acknowledgment letter/email. Instead, the MAC shall forward the appeal to CMS within 10 business days of the date of receipt of the reconsideration request (as specified in Section 10.6.18(A)(1) of this chapter).

If the reconsideration request cannot be accepted due to untimeliness, an improper signature (including a failure to respond to development for the required statement or signed declaration from a representative, or any other reason), the MAC shall not send the provider/supplier/representative an acknowledgment letter/email. Instead, the MAC shall dismiss the reconsideration request using the applicable model dismissal letter section 10.7 of this chapter.

4. Reconsideration Determination

The MAC shall review all documentation in the record relevant to the initial determination and issue a written determination within 90 calendar days of the date of receipt of the accepted reconsideration request.

A proper reconsideration request must be received by the MAC or CMS within 65 calendar days of the date of the initial determination. Refer to Section 10.6.18(A)(4)-(5) of this chapter for receipt date determinations. However, consistent with 42 C.F.R. § 498.24(a), the provider/supplier/representative may submit corrected, new, or previously omitted documentation or other facts in support of its reconsideration request at any time before reconsideration decision is issued. The hearing officer must determine whether an error was made in the initial determination at the time the initial determination was implemented, based on all of the evidence presented, including:

- The initial determination itself,
- The findings on which the initial determination was based,
- The evidence considered in making the initial determination, and
- Any other written evidence submitted under § 498.24(a), taking into account facts relating to the status of the provider/supplier subsequent to the initial determination.

If the appealing party (i.e. the provider/supplier) has additional information that it would like the hearing officer to consider during the reconsideration or, if necessary, an administrative law judge (ALJ) to consider during a hearing, the party must submit that information with its request for reconsideration. This is the party's only opportunity to submit information during the administrative appeals process; the party will not have another opportunity to do so unless an ALJ specifically allows the party to do so under 42 C.F.R. § 498.56(e).

5. Issuance of Reconsideration Determination

The hearing officer shall issue a written decision within 90 calendar days of the date of receipt of the accepted reconsideration request. The hearing officer shall email and mail a hard copy of the reconsideration decision to the provider/supplier/representative that submitted the reconsideration request, unless an email address is unavailable or the email is returned, then only a hard copy letter should be mailed to the return address on the reconsideration request/envelope or the correspondence mailing address on the provider's or supplier's enrollment record if no return address is included on the reconsideration request. The MAC should also fax the reconsideration decision letter if a valid fax number is available. The reconsideration letter shall follow the applicable model letter in section 10.7 of this chapter and include:

- The regulatory basis to support each reason for the initial determination;
- A summary of the documentation that the provider/supplier/representative provided, as well as any additional documentation reviewed as part of the reconsideration process;
- The re-stated facts and findings, including the regulatory basis for the action as determined by the contractor or CMS in its initial determination;

- A clear explanation of why the hearing officer is upholding or overturning the initial determination in sufficient detail for the provider/supplier/representative to understand the hearing officer's decision and, if applicable, the nature of the provider's or supplier's deficiencies. This explanation should reference the specific regulations and/or sub-regulatory guidance supporting the decision, as well as any documentation reviewed;

- An explanation of how the provider/supplier does not meet the Medicare enrollment criteria or requirements (if applicable);

- Further appeal rights, regardless of whether the decision is favorable or unfavorable, procedures for requesting an ALJ hearing, and the addresses to which the written appeal must be mailed or e-mailed. (Further appeal rights shall only be provided for reconsideration decisions. There are no further appeals rights related to CAP decisions.); and

- Information the provider/supplier/representative must include with its appeal:

    - name/legal business name;
    - provider transaction access number (PTAN) (if applicable);
    - tax identification number/employer identification number (TIN/EIN);
    - NPI; and
    - a copy of the reconsideration decision.

Consider the following example for a Site Visit Revocation:

> If a provider/supplier submits a reconsideration request in response to a revocation pursuant to 42 C.F.R. § 424.535(a)(5), the MAC shall determine if an error was made in the implementation of the initial determination (e.g., if an error was made during the site visit, or the site visit was conducted at the wrong location.). To do so the MAC shall review the (1) initial determination, the enrollment application preceding the site visit, the site investigation report(s), (2) the reconsideration request and supporting documentation, and (3) any other relevant information. If the MAC finds that an error was made during the site visit, the MAC shall order an additional site visit. If an additional site visit is ordered, the MAC shall await the findings of the site investigator, via the site visit report, before issuing a reconsideration decision. If the site visit report finds the provider/supplier to be operational then the MAC shall overturn the revocation of the provider's or supplier's Medicare billing privileges as it relates to § 424.535(a)(5) using the applicable model letter in section 10.7 of this chapter.

If the MAC overturns the initial determination, the MAC shall reinstate the provider's or supplier's enrollment and billing privileges to an approved status as of the effective date determined in the reconsidered determination and/or continue processing the enrollment

application (as applicable). Unless otherwise instructed by PEOG, the MAC shall only send the favorable reconsideration decision to the provider/supplier/representative at the return address included on the reconsideration request. The reconsideration decision is sufficient for providing notice to the provider/supplier of the enrollment action being taken. All enrollment updates shall be completed within 10 business days of the date the reconsideration decision was issued or the date of receipt of additional documentation, if needed.

For initial enrollments, the effective date of Medicare billing privileges is based on the date the provider/supplier is found to be in compliance with all Medicare requirements or the receipt date of the application – subject, of course, to any applicable retrospective billing provisions. (See Section 10.6.2 of this chapter for more information.) The MAC shall use the receipt date of the reconsideration request as the receipt date entered in the Provider Enrollment, Chain and Ownership System (PECOS). For DMEPOS suppliers, the effective date is the date awarded by the applicable contractor.

The MAC shall ensure that the applicable CMS Regional Office is notified of the outcome of any reconsideration decision that involves the revocation of Medicare billing privileges for a certified provider/supplier.

If additional information/documentation is needed prior to reinstating the provider or supplier, the MAC shall document these next steps in *its* reconsideration decision letter. The MAC shall not reinstate the provider's or supplier's enrollment until the requested information is received and processed. If the additional information/documentation is not received within 30 calendar days of the date of the reconsideration decision letter, the MAC shall contact the provider/supplier/representative via the applicable model letter to again request the additional information/documentation within 10 calendar days of the missed deadline. If no response is received within 30 calendar days of the second request for additional information/documentation, the MAC shall contact ProviderEnrollmentAppeals@cms.hhs.gov within 10 calendar days for further instruction. The email to PEOG shall include copies of the reconsideration decision and second request for additional information/documentation.

6. Withdrawal of Reconsideration Request

The provider/supplier/representative who submitted the reconsideration request may withdraw the reconsideration request at any time prior to the mailing of the reconsideration decision. If submitted via mail, the request to withdraw the reconsideration request must be postmarked prior to the reconsideration decision date. The request to withdraw the reconsideration request must be made in writing, signed, and filed with the MAC or CMS. If the MAC receives a request to withdraw a reconsideration request before the reconsidered determination is issued, it shall send a letter or e-mail to the provider/supplier/representative acknowledging receipt of the withdrawal request and advising that the reconsideration request has been dismissed, utilizing the applicable model letter in section 10.7 of this chapter.

7. Requests for Reversal under 42 C.F.R. § 424.530(c) and § 424.535(e)

Under 42 C.F.R. § 424.530(c) and § 424.535(e), a provider/supplier/representative may request reversal of a denial of enrollment or revocation of billing privileges if the denial or revocation was due to adverse activity (sanction, exclusion, or felony) against an owner, managing

employee, managing organization, officer, director, authorized or delegated official, medical director, supervising physician, or other health care or administrative or management services personnel furnishing services payable by a Federal health care program. The denial or revocation may be reversed, at the discretion of CMS, if the provider/supplier terminates and submits proof that it has terminated its business relationship with the individual or organization against whom the adverse action is imposed within 15 days of the revocation determination. (For reversal of denials, the timeframe within 30 days of the denial notification.) Information that may provide sufficient proof includes, but is not limited to, state corporate filings, IRS documentation, sales contracts, termination letters, evidence of unemployment benefits, board governance documents, and payroll records.

If the MAC receives a CAP and/or reconsideration request from a provider/supplier/representative to reverse a denial or revocation due to the termination of the business relationship, the MAC shall not take any action. The MAC shall forward the CAP and/or reconsideration request to ProviderEnrollmentAppeals@cms.hhs.gov within 10 business days of receipt. The MAC shall not take any action pursuant to the request until further instruction is provided by CMS.

8. Not Actionable CAPs and Reconsideration Requests

If the issue in the initial determination is resolved prior to a CAP and/or reconsideration decision being rendered, the basis of the initial determination may become moot and the CAP and/or reconsideration request will be not actionable. The MAC will be notified if an action has been taken that would render a CAP and/or reconsideration request not actionable. For example, CMS may contact the MAC to rescind the revocation or reinstate the provider's or supplier's Medicare billing privileges. If the MAC receives such a notification, then the MAC shall review to determine if a CAP and/or reconsideration request has become not actionable. If so, the MAC shall send a hard copy letter should be mailed to the return address on the CAP or reconsideration request, as well as the provider's or supplier's correspondence address using the applicable not actionable model letter in section 10.7 of this chapter. The MAC shall also send an email if a valid email address is available. The MAC may also send via fax if a valid fax number is available. The MAC shall attach a copy of the letter informing the provider/supplier/representative of the enrollment action which led to the CAP and/or reconsideration request becoming not actionable. If there is a scenario not captured in the not actionable model letter and the MAC believes a CAP and/or reconsideration request has become not actionable, the MAC should email ProviderEnrollmentAppeals@cms.hhs.gov for guidance.

9. Requesting Guidance Related to CAPs and Reconsideration Requests

If the MAC encounters a situation that is not addressed by these instructions, the MAC shall contact the ProviderEnrollmentAppeals@cms.hhs.gov inbox for guidance before taking any action.

10. Reconsideration Requests Related to Opt-Outs

a. General Instructions

The MACs shall process all reconsideration requests for initial determinations pertaining to opt-

outs, as described at 42 C.F.R. § 498.3(b)(19). Assuming all other requirements are met (e.g. timeliness, signature, etc.) MACs shall accept reconsideration requests related to all of the following:

- automatic renewal of opt-out status;
- untimely cancellation of opt-out auto-renewal;
- early cancellation of opt-out status;
- termination of opt-out status; and
- effective date of opt-out status.

When reviewing opt-out reconsideration request, particularly those that involve automatic renewal of the opt-out period, the MAC shall confirm that all notices were sent to the current address on file for the physician/practitioner within the timeframes required by CMS direction.

Reconsideration requests regarding opt-outs are subject to the same requirements discussed elsewhere in this chapter pertaining to proper signature. The MACs shall follow applicable instructions elsewhere in this chapter regarding receipt acknowledgement, development, and dismissal of opt-out reconsideration requests. The MACs shall use the appropriate Model Letters in Section 10.7 of this Chapter to issue letters regarding opt-outs reconsideration requests. The MACs shall include Further Appeal Rights in all reconsideration request decisions pertaining to opt-outs.

If the MAC encounters an opt-out appeal that is not addressed by these instructions or requires clarification, the MAC shall contact the ProviderEnrollmentAppeals@cms.hhs.gov inbox for guidance before taking any action, including acknowledging receipt of the reconsideration request.

b. Examples

Below are common examples of reconsideration requests that may be submitted.

Example 1 – Untimely Cancellation of Auto-Renewal.

Dr. Red is a licensed psychiatrist who initially opted-out of Medicare effective January 1, 2020. *Dr. Red's* opt-out status automatically renewed on January 1, 2022, and January 1, 2024. On February 10, 2024, the MAC receives a reconsideration request from Dr. Red *requesting* to cancel *the o*pt-out and enroll in the Medicare program as a supplier. The MAC accepts this reconsideration request as both a termination request and a cancellation request. The MAC confirms that the auto-renewal notices were sent to Dr. Red at *the* address of record at least 90 days before *the o*pt-out status renewed. Because Dr. Red's request was received more than 90 days after *the* initial effective date, the MAC determines that *Dr. Red* has failed to properly and timely terminate *the o*pt-out status. In addition, because it is more than 90 days before *the o*pt-out status will automatically renew (i.e. 90 days before January 1, 2026), the MAC also determines that Dr. Red has failed to properly and timely cancel the automatic renewal of th*e o*pt-out.

Example 2 – Untimely Termination Request

Dr. Orange is a licensed neurologist who has never previously enrolled in Medicare nor opted-out of Medicare. *Dr. Orange* submitted an opt-out affidavit to the MAC, which was signed on June 1, 2024. In a letter dated July 1, 2024, the MAC approves Dr. Orange's affidavit, effective June 1, 2024. The initial approval letters states that Dr. Orange has until August 30, 2024 to terminate their opt-out. On September 2, 2024, the MAC receives Dr. Orange's termination request. On September 3, 2024, the MAC returns the termination request as untimely. Dr. Orange responds on September 4, 2024 requesting reconsideration. The MAC accepts the reconsideration request and confirms that the approval letter was sent to Dr. Orange's address of record. Because Dr. Orange's termination request was received more than 90 days after the effective date of their opt-out status, the MAC determines that *Dr. Orange* failed to properly terminate their opt-out status. In addition, because it is more than 90 days before their opt-out status will automatically renew (i.e. 90 days before June 1, 2026), the MAC also determines that Dr. Orange has failed to properly and timely cancel the automatic renewal o*f the o*pt-out status.

Example 3 – Opt-out Effective Date Appeal

Dr. Yellow was enrolled in Medicare as an individual physician. With *the* initial CMS-855I enrollment application *submission*, Dr. Yellow included a form CMS-460 and was enrolled as a participating physician. *Dr. Yellow* submitted an opt-out affidavit to the MAC which was signed on August 12, 2024. In a letter dated September 2, 2024, the MAC approved Dr. Yellow's affidavit, effective August 12, 2024. On September 9, 2024, the MAC receives Dr. Yellow's reconsideration request to challenge the effective date of *the* opt-out approval. Dr. Yellow argues that *the* opt-out approval status should be October 1, 2024 because *Dr. Yellow was* previously enrolled as a participating physician. The MAC finds that Dr. Yellow submitted the opt-out affidavit more than 30 days before the start of the next calendar quarter (October 1, 2024). Therefore, the MAC issues a favorable reconsideration decision and changes Dr. Yellow's opt-out status effective date to October 1, 2024.

D. Further Appeal Rights for Reconsidered Determinations

1. Administrative Law Judge (ALJ) Hearing

CMS or a provider/supplier dissatisfied with a reconsidered determination is entitled to review by an ALJ with the CRD DAB. The ALJ has delegated authority from the Secretary of the Department of Health and Human Services (DHHS) to exercise all duties, functions, and powers relating to holding hearings and rendering decisions. Such an appeal must be filed, in writing, within 60 days from receipt of the reconsideration decision. To request final ALJ review, the provider or supplier must file an appeal with the CRD of the DAB within 60 calendar days after the date of receipt of this decision. A provider or supplier may file an appeal electronically at the DAB Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/.

To file a new appeal using DAB E-File, the provider or supplier must first register a new account by:

(a) Clicking Register on the DAB E-File home page;
(b) Entering the information requested on the "Register New Account" form; and
(c) Clicking Register Account at the bottom of the form. If the provider or supplier has more than one representative, each representative must register separately to use DAB E-File on

the provider's/supplier's behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which *the user* is a party or authorized representative.

Once registered, a provider or supplier may file an appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and

- Entering and uploading the requested information and documents on the "File New Appeal – Civil Remedies Division" form.

All documents must be submitted in PDF form. More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E-File Procedures link on the File New Appeal Screen for CRD appeals.

Pursuant to 42 C.F.R. § 405.809(a)(2), a provider or supplier may not appeal an adverse determination for a CAP, if one was made.

Failure to timely request an ALJ hearing is deemed a waiver of all rights to further administrative review.

Upon receipt of a request for an ALJ hearing, an ALJ at the CRD DAB will issue a letter by certified mail to the supplier, CMS and the OGC acknowledging receipt of an appeals request and detailing a scheduled pre-hearing conference. The OGC will assign an attorney to represent CMS during the appeals process; *the attorney* will also serve as the DAB point of contact. Neither CMS nor the Medicare contractor are required to participate in the pre-hearing conference but should coordinate among themselves and the OGC attorney prior to the pre-hearing to discuss any issues. The MAC shall work with and provide the OGC attorney with all necessary documentation. This includes compiling and sending all relevant case material to the OGC attorney upon the latter's request within 5 calendar days of said request. See section 10.6.18(A)(3) of this chapter for additional information.

Any settlement proposals, as a result of the pre-hearing conference, will be addressed with CMS. If CMS agrees to settle a provider enrollment appeal, CMS will notify the contractor of appropriate next steps (e.g., changing the effective date of billing privileges or reinstating a provider's billing privileges). This may result in PEOG providing specific instructions to the contractor to modify model letter language to appropriately notify the provider of changes to its enrollment status, revocation effective date, or effective date of billing privileges.

If an ALJ decision is rendered that overturns and/or modifies the initial determination establishing an effective date, revocation or denial of billing privileges, or remands a case back to CMS, this may also result in PEOG providing specific instructions to the contractor to draft and issue a revised reconsideration decision and/or modify the model letter language to appropriately notify the provider or supplier of changes to its enrollment status, revocation

effective date, or effective date of billing privileges.

The MAC shall complete all steps associated with the settlement or ALJ decision no later than 10 business days from the date it received PEOG's specific instructions.

2. Departmental Appeals Board (DAB) Hearing

The CMS or a provider/supplier dissatisfied with the ALJ hearing decision may request a Board review by the DAB. Such a request must be filed within 60 days after the date of receipt of the ALJ's decision. Failure to timely request a DAB review is deemed to be a waiver of all rights to further administrative review.

The DAB will use the information in the case file established at the reconsideration level and any additional evidence introduced at the ALJ hearing to make its determination. The DAB may admit additional evidence into the record if the DAB considers it relevant and material to an issue before it. Before such evidence is admitted, notice is mailed to the parties stating that evidence will be received regarding specified issues. The parties are given a reasonable time to comment and to present other evidence pertinent to the specified issues. If additional information is presented orally to the DAB, a transcript will be prepared and made available to any party upon request.

When CMS receives a decision or order from the DAB, as appropriate, PEOG will notify the MAC of appropriate next steps (i.e., changing an effective date or reinstating a provider's billing privileges). This may also result in PEOG providing specific instructions to the contractor to draft and issue a revised reconsideration decision and/or modify the model letter language to appropriately notify the provider of changes to its enrollment status, revocation effective date, or effective date of billing privileges.

The MAC shall complete all steps associated with the DAB decision no later than 10 business days from the date it received PEOG's specific instructions.

3. Judicial Review

A supplier dissatisfied with a DAB decision may seek judicial review by timely filing a civil action in a United States District Court. Such a request shall be filed within 60 days from receipt of the notice of the DAB's decision.

F. External Monthly Reporting Requirements for CAPs and Reconsideration Requests

Using the provider enrollment appeals reporting template, the Contractor shall complete all columns listed for all appeals (i.e. CAPs and reconsideration requests) except those submissions that are referred to CMS for processing. No column shall be left blank (except Column N). If the contractor is unable to complete all columns for a given appeal submission, the contractor shall contact ProviderEnrollmentAppeals@cms.hhs.gov within five business days of discovery to seek further guidance.

The reports shall use only the formats identified below. All dates shall be formatted as mm/dd/yyyy (e.g. 01/13/2021). The reports shall be sent to CMS via email at ProviderEnrollmentAppeals@cms.hhs.gov no later than the 15th of each month. If this day falls on a weekend or a holiday, the report shall be submitted the following business day. The report

shall include the prior month's appeal submissions, as well as outcomes for all appeals previously received that were not yet completed and reported to CMS (e.g., the February report shall cover all January appeals). **IMPORTANT:** All submissions shall remain on the monthly report until a final outcome/decision has been reported to CMS.

The response in Column A labeled, "Initial Determination Type," shall be one of the following:

- **Denial**
  CAP or Reconsideration Request that challenges the denial of a Medicare enrollment application pursuant to 42 C.F.R. § 424.530(a)(1)-(18).

- **Revocation**
  CAP or Reconsideration Request that challenges the revocation of Medicare billing privileges or provider/supplier number pursuant to 42 C.F.R. § 424.535(a)(1)-(23).

- **Effective Date**
  Reconsideration request that challenges an initial determination that establishes an effective date of participation in the Medicare program, including the effective date of reactivation after deactivation.

- **Opt-Out**
  Reconsideration request pertaining to an individual physician/practitioner opt-out status. If "Opt-Out" is listed, enter "405.450" in Column G.

- **Other**
  CAP or reconsideration request that does not fall under the three categories listed above. If "Other" is listed, an explanation shall be provided in the "Comments" column N and "N/A" in column G.

The response in Column B labeled, "Provider/Supplier Name" shall be the legal business name (LBN) of the provider/supplier exactly as it is spelled and formatted in the PECOS enrollment record (including capitalization, abbreviations, and punctuation). This column shall not be blank.

The response in Column C labeled, "NPI" shall be the provider's or supplier's NPI number. If a provider/supplier has multiple NPIs, each shall be separated with a semicolon followed by a space (e.g. "1234567890; 1123456789"). This column shall not be blank.

The response in Column D labeled, "EID" shall be the provider's or supplier's PECOS enrollment identification number (EID) as it appears in PECOS. On the rare occasion that no EID is available, the contractor shall enter "N/A". This column shall not be blank.

The response in Column E labeled, "PTAN(s)" shall be the provider's or supplier's Provider Transaction Access Number(s) (PTAN(s)), or other Medicare ID number. If the provider/supplier has not yet been assigned a PTAN or Medicare ID, the contractor shall enter "N/A". If a provider/supplier has multiple PTANs or Medicare IDs, each shall be separated with a semicolon (e.g. "12AB345; ZZ2356"). This column shall not be blank.

The response in Column F labeled, “Contractor” shall be one of the following, as appropriate. This column shall not be blank. No other formats are acceptable.

- **CGS**
- **FCSO**
- **NGS JK**
- **NGS J6**
- **Palmetto JM**
- **Palmetto JJ**
- **NSC**
- **WPS J8**
- **WPS J5**
- **Noridian JE**
- **Noridian JF**
- **Novitas JL**
- **Novitas JH**
- **NPEast**
- **NPWest**

The response in Column G labeled, “Regulatory Authority,” shall be in the following formats. If none of these applies, the contractor shall enter “N/A” and provide an explanation in the Comments Column N. No other formats are acceptable. This column shall not be blank.

- **424.520**
  This exact format shall be used for all effective date appeals

- **405.450**
  This exact format shall be used for all opt-out appeals

- **424.530(a)([#])([#])**
  This format shall be used for denial appeals. The contractor shall enter the applicable section numbers [#], as appropriate. For example: 424.530(a)(1) or 424.530(a)(1)(9)

- **424.535(a)([#])([#])**
  This format shall be used for revocation appeals. The contractor shall enter the applicable section numbers [#], as appropriate. For example: 424.535(a)(5) or 424.535(a)(1)

The response in Column H labeled “Provider/Supplier Standards” shall be the regulatory citations for any provider/supplier standard(s) cited in the initial determination. For example, a denial for an IDTF may cite § 410.33(g)(4); the contractor would enter “410.33(g)(4)” in this column. If no provider/supplier standards were cited in the initial determination, the contractor shall enter “N/A”. This column shall not be blank.

The response in Column I labeled “CAP or Reconsideration” shall be one of the following. No other formats are acceptable. This column shall not be blank.

- **CAP**
- **Reconsideration**

The response in Column J labeled, "Date Received," shall be the date the contractor received the appeal from the provider/supplier or representative (in mm/dd/yyyy format); no other formats are acceptable. This column shall not be blank.

The response in Column K labelled, "Date Receipt Acknowledgement Sent," shall be one of the following:

- **[mm]/[dd]/[yyyy]**
  The date the receipt acknowledgement email/letter was sent to the provider/supplier or the representative, in "mm/dd/yyyy" format. No other date formats are acceptable.

- **Not Yet Sent**
  If a receipt acknowledgement email/letter has not been sent at the time the monthly report is sent to CMS.

- **N/A**
  If a receipt acknowledgement email/letter is not required for that case.

The response in Column L labelled, "Final Decision Result," shall be one of the following. If the appeal submission is referred to CMS for processing then the appeal shall not be included on the MAC Monthly Appeals Report.

- **Not Actionable**
  Appeal is no longer actionable (moot) because the basis for the initial determination has been resolved. (e.g.: Fingerprints have received a passed designation, initial determination has been reopened and revised, or CMS has instructed the Contractor to rescind the initial determination).

- **Favorable**
  Contractor has determined that an error was made in the implementation of the initial determination. Therefore, the initial determination was overturned and the enrollment record has been placed in approved status, the effective date modified, or application processing has continued.

- **Unfavorable**
  Contractor upholds the initial determination.

- **Dismissed**
  The appeal does not meet the appeal submission requirements. (Ex: incorrect signature, untimely, not appealable, etc.)

- **In Process**
  The final decision has not been issued.

- **Withdrawn**
  The provider/supplier or representative has submitted written notice of its intent to withdraw its appeal before the Contractor issued a final determination.

The response in Column M labelled, "Date Final Decision Issued," shall be either the date the final determination was issued (in mm/dd/yyyy format) or "In Process" (if a final decision has not been issued at the time the monthly report is sent to CMS). No other formats are acceptable. This column shall not be blank.

The response in Column N labelled, "Comments" shall be any comments the contractor has regarding the appeal case, including details about why a case is labelled as "Other" in Column A. This column may be blank.

The reports shall be sent to CMS via email at ProviderEnrollmentAppeals@cms.hhs.gov no later than the 15th of each month; the report shall include the prior month's appeal submissions, as well as outcomes for all submissions previously received that were not yet completed and reported to CMS (e.g., the February report shall cover all January CAPs/reconsideration requests). All submissions shall remain on the monthly report until a final outcome/decision has been reported to CMS. If this day falls on a weekend or a holiday, the report must be submitted the following business day.

10.6.19 – Other Medicare Contractor Duties

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

(The contractor also shall review section 10.3 of this chapter regarding the topics in this section 10.6.19. In the event of a conflict, those instructions take precedence over those in this section 10.6.19.)

The contractor shall adhere to all instructions in this chapter and other CMS provider enrollment directives (e.g., technical direction letters). The contractor shall also assign the appropriate number of staff to the Medicare enrollment function to ensure that all such instructions and directives - including application processing timeframes and accuracy standards - are complied with and met.

A. Training

The contractor shall provide (1) training to new employees, and (2) refresher training (as necessary) to existing employees to ensure that each employee processes enrollment applications in a timely, consistent, and accurate manner. Training shall include, at a minimum:

- An overview of the Medicare program
- A review of all applicable regulations, manual instructions, and other CMS guidance
- A review of the contractor's enrollment processes and procedures
- Training regarding PECOS.

For new employees, the contractor shall also:

- Provide side-by-side training with an experienced provider enrollment analyst
- Test the new employee to ensure that *the latter* understands Medicare enrollment policy and contractor processing procedures, including the use of PECOS
- Conduct end-of-line quality reviews for 6 months after training or until the analyst demonstrates a clear understanding of Medicare enrollment policy, contractor procedures, and the proper use of PECOS.

For existing employees, the contractor shall perform periodic quality reviews and refresher trainings.

B. PECOS

The contractor shall:

- Process all enrollment actions (e.g., initials, changes, revalidations, revocations, appeals, denials) through PECOS
- Deactivate or revoke the provider or supplier's Medicare billing privileges in the Multi-Carrier System or the Fiscal Intermediary Shared System only if the provider or supplier is not in PECOS; if the provider does not exist in MCS or FISS, the contractor shall contact its PEOG BFL prior to taking action.
- Close or delete any aged logging and tracking (L & T) records older than 120 days for which there is no associated enrollment application
- Participate in user acceptance testing for each PECOS release
- Attend scheduled PECOS training when requested
- Report PECOS validation and production processing problems through the designated tracking system for each system release
- Develop (and update as needed) a written training guide for new and current employees on the proper processing of Form CMS-855 and Form CMS-20134 applications, opt-out affidavits, and the appropriate entry of data into PECOS.

C. Customer Service

1. Responding to Provider Enrollment Inquiries

The contractor's customer service unit may handle provider enrollment inquiries that do not involve complex enrollment issues. Examples of inquiries that can be processed by customer service units include:

- Application status checks (e.g., "Has the contractor finished processing my application?") (The contractor may wish to establish electronic mechanisms by which providers can obtain updates on the status of their enrollment applications via the contractor's web site or automated voice response (AVR).

- Furnishing information on where to access Form CMS-855 or Form CMS-20134 applications (and other general enrollment information) online

- Explaining to providers/suppliers which Form CMS-855 or CMS-20134 applications should be completed.

2. Contractor's Responsiveness to Inquiries

Excluding matters pertaining to application processing (e.g., development for missing data) and appeals (e.g., appeal of revocation), the contractor is encouraged to respond to all enrollment-related provider/supplier correspondence (e.g., e-mails, letters, telephone calls) within 30 business days of receipt.

D. Contractor Outreach to Providers

The contractor is strongly encouraged to establish e-mail "list serves" with the provider community to disseminate important information thereto, such as contractor address changes, new CMS enrollment policies or internal contractor procedures, reminders about existing policies, etc. By being proactive in distributing information to its providers and suppliers on a regular basis (e.g., weekly, bi-weekly), the contractor can reduce the number of policy inquiries it receives and help facilitate the submission of complete and accurate Form CMS-855 and Form CMS-20134 applications.

E. Encouraging Use of Internet-based PECOS

When a prospective provider or supplier contacts the contractor to obtain a paper enrollment Form CMS-855 or Form CMS-20134, the contractor shall encourage the provider or supplier to submit the application using Internet-based PECOS. The contractor shall also notify the provider or supplier of:

- The CMS Web site at which information on Internet-based PECOS can be found and at which the paper applications can be accessed (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index?redirect=/MedicareProviderSupEnroll/).
- The contractor's address so that the applicant knows where to return the paper application.
- Any supporting documentation required for the applicant's provider/supplier type.

- Other required forms as described in sections above. Notification can be given in any manner the contractor chooses.

F. Adherence to Responsibilities Based Upon Jurisdiction - Audit and Claims Contractors

1. Background

For purposes of enrollment via the Form CMS-855A, there are generally two categories of contractors: audit contractors and claims contractors. The audit contractor enrolls the provider, conducts audits, etc. The claims contractor pays the provider's claims. In most cases, the provider's audit contractor and claims contractor will be the same. On occasion, though, they will differ. This can happen, for instance, with provider-based entities, whereby the parent provider's contractor (audit contractor) will process the provider's enrollment application and a different contractor will pay the provider's claims (claims contractor).

Should the audit and claims contractors differ, the audit contractor shall process all changes of information, including all Form CMS-588 changes. The audit contractor shall notify the applicant during the initial enrollment process that all future changes of information must be sent to the audit contractor, not the claims contractor. If the provider inadvertently sends a change request to the claims contractor, the latter shall return the application per the instructions in this chapter.

2. Process

If the audit contractor approves the Form CMS-855A transaction in question (e.g., initial enrollment), it shall:

(i) Send an e-mail to the claims contractor identifying the specific Form CMS-855A transaction involved and confirming that the information has been updated in PECOS. Pertinent identifying information, such as the provider name, CCN, and NPI, shall be included in the e-mail notification. The audit contractor need not include any supporting documentation in the e-mail because PECOS will contain any documents (e.g., approval letters from the state).

(ii) As applicable, fax, mail, or email an encrypted copy of the submitted Form CMS-588 to the appropriate claims contractor.

Upon receipt of the e-mail notification, the claims contractor shall access PECOS, review the enrollment record, and, as needed, update its records accordingly.

The audit contractor shall ensure that all original copies of Form CMS-855A paperwork and supporting documentation (including all Form CMS-588s), approval letters from the state, and other written documents related to the application are uploaded in PECOS.

If the provider's audit contractor and claims contractor are different, the audit contractor shall e-mail or fax a copy of all SOG Location approval/denial notices/letters it receives to the claims contractor. This is to ensure that the claims contractor is fully aware of the SOG Location's action, as some may only send copies of the approval letters to the audit contractor. If the audit

contractor chooses, it can simply contact the claims contractor by phone or e-mail and ask if the latter received the tie-in notice.

It is imperative that audit and claims contractors effectively communicate and coordinate with each other in all payment-related and program integrity matters involving the provider.

G. Online Presence – Web Sites

The contractor must provide a link to CMS' provider/supplier enrollment Web site located at https://www.cms.gov/medicare/provider-enrollment-and-certification/medicareprovidersupenroll/index.html?redirect=/medicareprovidersupenroll/ . The link shall: (1) be available on the contractor's existing provider outreach Web site (which should be an established sub-domain of the contractor's current commercial Web site), and (2) comply with the guidelines stated in the Provider/Supplier Information and Education Web site section (Activity Code 14101) under the Provider Communications (PCOM) Budget and Performance Requirements (BPRs). Bulletins, newsletters, seminars/workshops and other information concerning provider enrollment issues shall also be made available on the existing provider outreach Web site. All contractor web sites must comply with section 508 of the Rehabilitation Act of 1973 in accordance with, 36 CFR §1194 and with CMS' Contractor Website Standards and Guidelines posted on CMS's web site.

The CMS Provider/Supplier Enrollment Web site gives users access to provider/supplier enrollment forms, specific requirements for provider/supplier types, manual instructions, frequently asked questions (FAQs), contact information, hot topics, and other pertinent provider/supplier information. The contractor shall not duplicate content already provided at the CMS provider/supplier enrollment website and shall not reproduce the forms or establish the contractor's own links to forms. It shall, however, have a link on its website that goes directly to the forms section of the CMS provider/supplier enrollment site.

On a quarterly basis (specifically, no later than the 15th day of January, April, July, and October), each contractor shall review and provide updates regarding its contact information shown at URL: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf. If the contractor services several states with a universal address and telephone number, the contractor shall report that information. In situations where no updates are needed, a response from the contractor is still required (i.e., the contact information is accurate). In addition, only such information that pertains to provider enrollment activity for the contractor's jurisdiction is to be reported. All updates shall be sent directly via e-mail to the contractor's PEOG BFL.

H. Document Uploading and Retention

1. Introduction

To ensure that proper internal controls are maintained and that important information is recorded in case of potential litigation, the contractor shall maintain documentation as outlined in this section 10.6.19(H) and, as applicable, section 10.3. CMS cannot stress enough how crucial it is for contractors to document their actions as carefully and thoroughly as possible.

The requirements in this section 10.6.19(H) are in addition to, and not in lieu of, all other documentation or document maintenance requirements that CMS has mandated.

The contractor shall maintain and store all documents relating to the enrollment of a provider into Medicare. These documents include, but are not limited to, Medicare enrollment applications and all supporting documents, attachments, correspondence, and correspondence tracking documentation, and appeals submitted in conjunction with an initial enrollment, reassignment, change of enrollment, revalidation, etc.

Supporting documentation includes, but is not limited to:

- Copies of federal, state and/or local (city/county) professional licenses, certifications and/or registrations;
- Copies of federal, state, and/or local (city/county) business licenses, certifications and/or registrations;
- Copies of professional school degrees or certificates or evidence of qualifying course work;
- Copies of CLIA certificates and FDA mammography certificates;
- Copies of any entry found on the MED report that leads to a provider or supplier's revocation, and;
- Copies of Centers for Disease Control and Prevention (CDC) Diabetes Prevention Recognition Program (DPRP) recognition letters or certificates indicating full or MDPP preliminary recognition.

See section 10.6.19(I) below for additional document uploading requirements.

2. Document Disposal

The contractor shall dispose of the aforementioned records as described below:

i. Provider/Supplier and Durable Medical Equipment Supplier Application

a. Rejected applications as a result of provider failing to provide additional information

Disposition: Destroy when 7 years old.

b. Approved applications of provider/supplier

Disposition: Destroy 15 years after the provider/supplier's enrollment has ended.

c. Denied applications of provider/supplier

Disposition: Destroy 15 years after the date of denial.

d. Approved application of provider/supplier, but the billing number was subsequently revoked

Disposition: Destroy 15 years after the billing number is revoked.

e. Voluntary deactivation of billing number

Disposition: Destroy 15 years after deactivation.

f. Provider/Supplier dies

Disposition: Destroy 7 years after date of death.

ii. Electronic Mail and Word Processing System Copies

a. Copies that have no further administrative value after the recordkeeping copy is made. These include copies maintained by individuals in personal files, personal electronic mail directories, or other personal directories on hard disk or network drives, and copies on shared network drives that are used only to produce the recordkeeping copy.

Disposition: Delete within 180 days after the recordkeeping copy has been produced.

b. Copies used for dissemination, revision or updating that are maintained in addition to the recordkeeping copy.

Disposition: Delete when dissemination, revision, or updating is complete.

I. Keeping Record of Activities

As with document retention as described in subsection (H) above, it is important that the contractor maintains records of its written and telephonic communications. The contractor shall thus adhere to the instructions in this subsection (I).

1. Written Communications

(For purposes of this section 10.6.19(I)(1), "written correspondence" includes mailed, faxed, and e-mailed correspondence. Note that this is different from supporting documentation accompanying an enrollment application, the requirements for which are addressed in subsection (H) above.)

Except as stated in this subsection (I)(1), the contractor shall:

- Retain copies of all written correspondence pertaining to the provider, regardless of whether the correspondence was initiated by the contractor, the provider, CMS, state officials, etc.

- Document when it sends written correspondence to providers. For instance, if the contractor crafts an approval letter to the supplier dated March 1 but sends it out on March 3, the contractor shall note this in PECOS.

- Document all referrals to CMS, the UPIC, or the OIG

In cases where the written correspondence is sent directly via or to PECOS (e.g., PCV), the contractor need not separately document this; PECOS will retain this information (date, time, etc.). For all other written correspondence not sent via or to PECOS, the contractor (1) shall upload a copy of the correspondence into PECOS (e.g., fax, a printed copy of the e-mail) and (2) shall note in PECOS:

- The type of correspondence (e.g., approval letter)
- The form of correspondence (e.g., fax, e-mail)
- The date and time the correspondence was sent
- The party to whom the correspondence was sent (e.g. provider name, contact person)

2. Telephonic or Face-to-Face Contact

(Telephonic or face-to-face contact is hereafter referred to as "oral communication.")

The contractor shall document any and all actual or attempted oral communication with the provider, any representative thereof, or any other person or entity regarding a provider. This includes, but is not limited to, the following situations:

- Telephoning a provider about its application. (Even if the provider official was unavailable and a voice mail message was left, this must be documented.)

- Requesting information from the state or another contractor concerning the applicant or enrollee

- Contacting the UPIC for an update concerning a particular case

- Phone calls from the provider

- Conducting a meeting at the contractor's headquarters/offices with officials from a hospital concerning problems with its application

- Telephoning PEOG, the state agency, or the SOG Location and receiving instructions therefrom about a problem the contractor is having with an applicant or an existing provider

- Telephoning the provider's billing department with a question about the provider.

When documenting oral communications, the contractor shall indicate (1) the time and date of the call or contact, (2) who initiated the contact, (3) who was spoken with, and (4) what the conversation pertained to. Concerning the last requirement, the contractor need not write down every word that was said during the conversation. Rather, the documentation should merely be adequate to reflect the contents of the conversation.

The documentation requirements in this subsection (I)(2) only apply to enrolled providers and to providers that have already submitted an enrollment application. In other words, these documentation requirements go into effect only after the provider submits an initial application. To illustrate, if a hospital contacts the contractor requesting information concerning how it should enroll in the Medicare program, this need not be documented because the hospital has not yet submitted an enrollment application.

All oral communications addressed in this subsection (I)(2) shall be documented in PECOS.

If an application is returned, the contractor shall document this. The manner of documentation lies within the contractor's discretion.

J. Documenting Verification of Data Elements

Once the contractor has completed its review of the Form CMS-855 and Form CMS-20134 applications (e.g., approved/denied application, approved change request) as well as opt-out affidavits, it shall document that it has: (1) verified all data elements on the application, and (2) reviewed all applicable names on the above- mentioned forms against the OIG/LEIE and the System for Access Management (SAM). It can be drafted in any manner the contractor chooses so long as it certifies that the above-mentioned activities were completed.

For each person or entity that appeared on the OIG/LEIE or SAM, the contractor shall document any positive findings via a screen printout and upload it into PECOS. In all other situations, the contractor is not encouraged to document *its* reviews via screen printouts. Simply using the verification statement described above is sufficient. Although the contractor has the discretion to use screen prints if it so chooses, the aforementioned verification statement is still required.

K. Release of Information

On October 13, 2006, CMS published System of Records Notice for PECOS in the Federal Register. Consistent with this notice, once the provider has submitted an enrollment application (as well as after it has been enrolled), the contractor shall not release – either orally or in writing - provider-specific data to any outside person or entity unless specified otherwise in this chapter. (Provider-specific data includes, but are not limited to, owners/managers, adverse legal history, practice locations, group affiliations, effective dates, etc.) Examples of outside persons or entities include, but are not restricted to, national or state medical associations or societies, clearinghouses, billing agents, provider associations, or any person within the provider's organization other than the provider's authorized official(s), delegated official(s), or contact persons. The only exceptions to this policy are:

- A routine use found in the aforementioned System of Records applies.

- The provider (or, in the case of an organizational provider, an authorized or delegated official): (1) furnishes a signed written letter on the provider's letterhead stating that the release of the provider data is authorized; and (2) the contractor has no reason to question the authenticity of the person's signature. The letter can be mailed, faxed, or e-mailed to the contractor. The contractor shall upload the letter in PECOS.

- The release of the data is specifically authorized in some other CMS instruction or directive.

(These provisions also apply in cases where the provider requests a copy of any Form CMS-855 or CMS-20134 paperwork the contractor has on file that the provider does not already have access to in PECOS. For instance, if the provider already uses PECOS for application submissions, the contractor can simply refer the provider to PECOS if the document in question is in PECOS. If the provider does not use PECOS, the contractor shall not require the provider to do so in order to access the document(s) but shall follow the above instructions; the latter shall also be followed if the provider uses PECOS but the requested document is not in PECOS.)

It is recommended that the contractor notify the provider of the broad parameters of the aforementioned policy as early in the enrollment process as possible.

The following information shall be made available over-the-phone to a caller who is able to provide a provider/supplier's name, PTAN, TIN/SSN, and NPI number; the caller need not be listed on the provider/supplier's enrollment record as a contact person:

- Revalidation status (i.e., whether or not a provider/supplier has been revalidated)

- Revalidation due date

- Revalidation approval date

- The specific information related to a revalidation development request

- The date a provider/supplier was deactivated due to non-response to a revalidation or non-response to a development request.

In addition:

- When sending emails, the contractor shall not transmit sensitive data, such as SSNs or EINs, without first encrypting the email.

- The contractor may not send PECOS screen printouts to the provider.

- With the exception of Form CMS-855S applications, if any contact person listed on the provider's enrollment record requests a copy of a provider's Medicare approval letter or revalidation notice and the contact person does not have access to PECOS, the contractor

shall send to the contact person via email, fax or mail. (This excludes certification Letters from the state agency, for the contractor does not generate these approvals.) If the contact person has access to PECOS, the contractor can simply refer *the individual* to PECOS. If the contact person does not use PECOS, the contractor shall not require the contact person to do so in order to access the document(s) but shall follow the above instructions; the latter shall also be followed if the contact person uses PECOS but the requested document is not in PECOS.)

L. Security

The contractor shall ensure that the highest level of security is maintained for all systems and its physical and operational processes in accordance with the CMS/Business Partners Systems Security Manual (BPSSM) and the Program Integrity Manual.

Applications shall never be removed from the controlled area to be worked on at home or in a non-secure location. Also, provider enrollment staff must control and monitor all applications accessed by other contractor personnel.

All contractor staff shall be trained on security procedures as well as relevant aspects of the Privacy Act and the Freedom of Information Act. This applies to all management, users, system owners/managers, system maintainers, system developers, operators and administrators - including contractors and third parties - of CMS information systems, facilities, communication networks, and information.

Note that these instructions are in addition to, and not in lieu of, all other CMS instructions regarding security.

M. Establishment of Relationships

To the maximum extent possible, and to help ensure it becomes aware of recent felony convictions of practitioners and owners of health care organizations, the contractor shall establish relationships with appropriate state government entities – such as, but not limited to, Medicaid fraud units, state licensing boards, and criminal divisions –to facilitate the flow of felony information from the state to the contractor. For instance, the contractor can request that the state inform it of any new felony convictions of health care practitioners.

N. Monitoring Information from State Licensing Boards

To help ensure that only qualified physicians and non-physician practitioners are enrolled in Medicare, the contractor shall undertake the activities described below. (For purposes of this section, the term "practitioner" includes both physicians and non-physician practitioners. In addition, the instructions in this section, apply only to these practitioners.)

No later than the 15th day of each month, the contractor shall review state licensing board information for each state within its jurisdiction to determine whether any of its currently enrolled practitioners have, within the previous 60 days:

- Had *a* medical license revoked, suspended, or inactivated (due to retirement, death, or voluntary surrender of license);

- Otherwise lost *a* medical license or have had *a* license expire.

For those practitioners who no longer have a valid medical license, the contractor shall take the necessary steps pursuant to this chapter.

The mechanism by which the contractor performs these monthly licensure reviews lies within its discretion, though the most cost-effective method shall be used.

O. Regarding Potential Identity Theft or Other Fraudulent Activity

If --when conducting the verification activities described in this chapter -- the contractor believes that a case of identity theft or other fraudulent activity likely exists, the contractor shall notify its PEOG BFL immediately; the BFL will instruct the contractor as to what, if any, action shall be taken (For example, a physician indicates that *the physician* is not establishing a new practice location or changing *E*FT information and that the application submitted in *the physician's* name is false.)

10.6.22 - Non-Transitioned Certified Provider/Supplier Changes of Ownership

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

(Until further notice, the contractor shall continue to follow these instructions for CHOWs involving those certified provider and certified supplier types that have not "transitioned" as described in section 10.6.1.1 of this chapter.)

All references to the SOG Location (formerly the "RO") in this section 10.6.22 refer to the applicable CMS Regional Office's Survey & Operations Group (SOG) Location. Also, and except as otherwise indicated, all references to "provider" include certified suppliers (e.g., ambulatory surgical centers, portable x-ray suppliers).

Changes of ownership (CHOWs) are officially defined in and governed by 42 CFR § 489.18 and Publication 100-07, chapter 3, sections 3210 through 3210.5(C). The SOG Location – not the contractor – makes the determination as to whether a CHOW has occurred (unless this function has been delegated).

Except as otherwise specified, the term "CHOW" - as used in this section 10.6.22 - includes CHOWs, acquisitions/mergers, and consolidations.

Though the Change of Ownership (CHOW) Information section of the Form CMS-855A separates the applicable transactions into CHOWs, acquisition/mergers and consolidations for ease of disclosing and reporting, they fall within the general CHOW category under 42 CFR § 489.18 (e.g., an acquisition/merger is a type of CHOW under § 489.18).

A. Definitions for CHOWs

For purposes of provider enrollment only, there are three main categories of CHOWs captured on the Form CMS-855A application:

1. "Standard" CHOW

This occurs when a provider's CMS Certification Number (CCN) and provider agreement are transferred to another entity as a result of the latter's purchase of the provider. To illustrate, suppose Entity A is enrolled in Medicare, but Entity B is not. B acquires A. Assuming all regulatory requirements are met, A's provider agreement and CCN number will transfer to B.

This is the most frequently encountered change of ownership scenario. As explained in this section 10.6.22, even though it is technically an acquisition (i.e., B bought/acquired A) under § 489.18, this situation falls under the "CHOW" category – as opposed to the "Acquisition/Merger" category – on the Form CMS-855A.

2. Acquisition/Merger

In general, this occurs when two or more Medicare-enrolled entities combine, leaving only one remaining CCN number and provider agreement. For instance, Entity A and Entity B are both enrolled in Medicare, each with its own CCN number and provider agreement. The two entities decide to merge. Entity B's CCN number and provider agreement will be eliminated (leaving only Entity A's CCN number and provider agreement).

If the acquisition results in an existing provider having new owners but keeping its existing provider number, the applicant should check the CHOW box in the Basic Information section of the Form CMS-855A.

Unlike the new owner in a CHOW or consolidation, the new owner in an acquisition/merger need not complete the entire Form CMS-855A. This is because the new owner is already enrolled in Medicare. As such, the provider being acquired should be reported as a practice location in the Practice Location Information section of the new owner's Form CMS-855A.

3. Consolidations

This occurs when the merger of two or more Medicare-enrolled entities results in the creation of a brand new entity. To illustrate, if Entities A and B decide to combine and, in the process, create a new entity (Entity C), the CCN numbers and provider agreements of both A and B will be eliminated. Entity C will have its own CCN number and provider agreement.

Note the difference between acquisitions/mergers and consolidations. In an acquisition/merger, when A and B combine there is one surviving entity. In a consolidation, when A and B combine there are no surviving entities. Rather, a new entity is created – Entity C.

Under 42 CFR § 489.18(a)(4), the lease of all or part of a provider facility constitutes a change of ownership of the leased portion. If only part of the provider is leased, the original provider agreement remains in effect only with respect to the un-leased portion. (See Pub. 100-07, chapter 3, section 3210.1D (4) for more information.)

Note that a provider may undergo a financial or administrative change that it considers to be a CHOW, but does not meet the regulatory definition identified in §489.18.

B. Examining Whether a CHOW May Have Occurred

As stressed previously, the SOG Location – not the contractor – determines whether a CHOW has occurred (unless this function has been delegated). However, in processing the application, the contractor shall perform all necessary background research regarding whether: (1) a CHOW may have occurred, and/or (2) the new owner is accepting assignment of the Medicare assets and liabilities of the old owner. Such research may include reviewing the sales agreement or lease agreement, contacting the provider(s) to request clarification of the sales agreement, etc. (A CHOW determination by the SOG Location is usually not required prior to the contractor making its recommendation.)

While a CHOW is usually accompanied by a tax identification number (TIN) change, this is not always the case. There may be isolated instances where the TIN remains the same. Conversely, there may be cases where a provider is changing its TIN but not its ownership. In short, while a change of TIN (or lack thereof) is evidence that a CHOW may or may not have occurred, it is not the most important factor; rather, the change in the provider's ownership arrangement is. Hence, the contractor should review the sales/lease agreement closely, as this will help indicate whether a CHOW may or may not have occurred.

In addition:

(a) If the provider claims that the transaction in question is a stock transfer and not a CHOW, the contractor reserves the right to request any information from the provider to verify this (e.g., copy of the stock transfer agreement).

If – after performing the necessary research – the contractor remains unsure as to whether a CHOW has occurred and/or whether the new owner is accepting assignment, the contractor may refer the matter to the SOG Location for guidance. Such referrals to the SOG Location should only be made if the contractor is truly uncertain as to whether a CHOW and/or acceptance of assignment may have taken place and should not be made as a matter of course. A SOG Location CHOW determination is usually not required prior to the contractor making its recommendation.

(b) There may be instances where the contractor enters a particular transaction into PECOS as a CHOW, but it turns out that the transaction was not a CHOW (e.g., was a stock transfer; was an initial enrollment because the new owner refused to accept the Medicare liabilities). If the contractor cannot change the transaction type in PECOS, it can leave the record in a CHOW status; however, it should note in the provider's file that the transaction was not a CHOW.

C. Processing CHOW Applications

Unless stated otherwise in this chapter, the contractor shall ensure that all applicable sections of the Form CMS-855A for both the old and new owners are completed in accordance with the instructions on the Form CMS-855A.

1. Previous Owner(s)

The previous owner's Form CMS-855A CHOW application does not require a recommendation for approval. Any recommendations will be based on the CHOW application received from the new owner.

If the previous owner's Form CMS-855A is available at the time of review, the contractor shall examine the information therein against the new owner's Form CMS-855A to ensure consistency (e.g., same names). If the previous owner's Form CMS-855A has not been received, the contractor shall contact the previous owner and request it. However, the contractor may begin processing the new owner's application without waiting for the arrival of the previous owner's application. It may also make its recommendation to the state agency without having received the previous owner's Form CMS-855A. The contractor, of course, shall not make a recommendation for approval unless the new owner has checked on the form that it will assume the provider agreement and the terms of the sales agreement indicate as such.

If a certification statement is not on file for the previous owner, the contractor shall request that the Individual Ownership and/or Managing Control section be completed for the individual who is signing the certification statement.

Note that a previous owner's Form CMS-855A CHOW application is essentially the equivalent of a Form CMS-855 voluntary termination submission, as the seller is voluntarily leaving the Medicare program. As such, the contractor shall not require the seller to submit a separate Form CMS-855 voluntary termination along with its Form CMS-855A CHOW application.

2. New Owner(s)

If a Form CMS-855A is not received from the new owner within 14 calendar days of receipt of the previous owner's Form CMS-855A, the contractor shall contact the new owner. If, within 30 calendar days after the contractor contacted it, the new owner fails to (1) submit a Form CMS-855A and (2) indicate that it accepts assignment of the provider agreement, the contractor shall send an e-mail to its PEOG BFL notifying *the latter* of the situation. PEOG will determine whether the provider's billing privileges should be deactivated under § 424.540(a)(2) or § 424.550(b) or revoked under § 424.535(a)(1) or (a)(9). PEOG will notify the contractor of its decision.

3. Order of Processing

To the maximum extent practicable, Form CMS-855A applications from the previous and new owners in a CHOW should be processed as they come in. The contractor should not wait for applications from both the previous and new owner to arrive before processing them. However, unless the instructions in this chapter indicate otherwise, the contractor should attempt to send the previous and new owners' applications to the state simultaneously, rather than as soon as they are processed. For instance, suppose the previous owner submits an application on March 1. The contractor should begin processing the application immediately, without waiting for the arrival of the new owner's application. Yet it should avoid sending the previous owner's application to the state until the new owner's application is processed. (For acquisition/mergers

and consolidations, the contractor may send the applications to the SOG Location separately, since one number is going away.)

4. Sales and Lease Agreements

The contractor shall abide by the following:

(i) Verification of Terms - The contractor shall determine whether: (1) the sales/lease agreement includes the signatures of the buyer and seller and the information contained within is consistent with that reported on the new owner's Form CMS-855A (e.g., same names, effective date), and (2) the terms of the contract indicate that the new owner will assume the provider agreement. In many cases, the sales/lease agreement will not specifically refer to the Medicare provider agreement. Clearly, if the box in the Change of Ownership (CHOW) Information section is checked "Yes" and the sales/lease agreement either confirms that the new owner will assume the agreement or is relatively silent on the matter, the contractor can proceed as normal. Conversely, if the agreement indicates that the assets and liabilities will not be accepted, the contractor should deny the application.

(Note that--

- A bill of sale/lease agreement/sales transfer agreement is a sales/lease business document and should not be confused with a patient transfer agreement.
- The agreement must contain the signatures of both parties to the transaction. If it does not, the contractor shall develop for an agreement containing both signatures.)

(ii) Form of Sales/Lease Agreement - There may be instances where the parties in a CHOW did not sign a “sales” or “lease” agreement in the conventional sense of the term; the parties, for example, may have documented their agreement via a “bill of sale.” The contractor may accept this documentation in lieu of a sales/lease agreement so long as the document furnishes clear verification of the terms of the transaction and the information is consistent with that contained in the Form CMS-855A as discussed above.

(iii) Submission of Final Sales/Lease Agreement - The contractor shall not forward a copy of the application to the state until it has received and reviewed the final sales/lease agreement. It need not revalidate the information on the Form CMS-855A, even if the data therein may be somewhat outdated by the time the final agreement is received.

If a final sales/lease agreement is not submitted within 30 days after the contractor’s receipt of the new owner’s application, the contractor shall reject the application. Though the contractor must wait until the 30th day to reject the application, the contractor may do so regardless of how many times it contacted the new owner or what types of responses (short of the actual receipt of the agreement) were obtained.

Unless specified otherwise in this chapter, both the previous and new owners must submit separate Form CMS-855A applications, as well as copies of the interim and final sales/lease agreements.

5. CHOWs Involving Subtypes

On occasion, a CHOW may occur in conjunction with a change in the facility's provider subtype. This frequently happens when a hospital undergoes a CHOW and changes from a general hospital to another type of hospital, such as a psychiatric hospital. Although a change in hospital type is considered a change of information (COI), it is not necessary for the provider to submit separate applications – one for the COI and one for the CHOW. Instead, all information (including the change in hospital type) should be reported on the CHOW application; the entire application should then be processed as a CHOW. However, if the facility is changing from one main provider type to another (e.g., hospital converting to a skilled nursing facility) and also undergoing a CHOW, the provider must submit its application as an initial enrollment.

NOTE: For Medicare purposes, a critical access hospital (CAH) is a separately-recognized provider type. Thus, a general hospital that undergoes a CHOW while converting to a CAH must submit its Form CMS-855A as an initial enrollment, not as a CHOW.

6. Unreported CHOW

If the contractor learns via any means (including receipt of a tie-in notice or other SOG Location or state notice) that an enrolled provider (1) has been purchased by another entity or has purchased another Medicare enrolled provider, the contractor shall immediately request Form CMS-855A applications from both the previous and new owners. If the new owner fails to submit a Form CMS-855A within the latter of (1) the date of acquisition or (2) 30 days after the request, the contractor shall stop payments to the provider. Payments may be resumed upon receipt of the completed Form CMS-855A.

7. Relocation of Entity

A new owner may propose to relocate the provider concurrent with the CHOW. If the relocation is to a site in a different geographic area serving different clients than previously served and employing different personnel to serve those clients, the contractor shall notify the SOG Location immediately. Unless the SOG Location dictates otherwise, the provider shall - per CMS Publication 100-07, chapter 3, section 3210.1(B)(5) - treat the transaction as an initial enrollment (and the provider as a new applicant), rather than as an address change of the existing provider.

8. Transitioning to Provider-Based Status

Consistent with existing CMS policy, a provider undergoing a CHOW pursuant to 42 CFR § 489.18 may be assigned to a new contractor jurisdiction only if the provider is transitioning from freestanding to provider-based status. In such cases, the contractor for the new jurisdiction (the "new contractor") shall process both the buyer's and seller's Form CMS-855A applications. Should the "old/previous" (or current) contractor receive the buyer's and/or seller's Form CMS-855A application, it shall: (a) forward the application to the new contractor within 5 business days of receipt, and (b) notify the new contractor within that same timeframe that the application was sent.

9. Intervening Change of Ownership (CHOW)

(This section does not apply to home health agencies.)

In situations where (1) the provider submits a Form CMS-855A initial application or CHOW application and (2) a Form CMS-855A CHOW application is subsequently submitted but before the contractor has received the tie-in notice from the SOG Location, the contractor shall abide by the following:

Situation 1 – The provider submitted an initial application followed by a CHOW application, and a recommendation for approval has not yet been made with respect to the initial application – The contractor shall return both applications and require the provider to re-submit an initial application with the new owner's information.

Situation 2 - The provider submitted a CHOW application followed by another CHOW application, and a recommendation for approval has not been made for the first application - The contractor shall process both applications – preferably in the order in which they were received – and shall, if recommendations for approval are warranted, refer both applications to the state/SOG Location in the same package. The accompanying notice/letter to the state/SOG Location shall explain the situation.

Situation 3 - The provider submitted an initial application followed by a CHOW application, and a recommendation for approval of the initial application has been made – The contractor shall:

(i) Return the CHOW application.

(ii) Notify the state/SOG Location via letter (sent via mail or e-mail) that there has been a change of ownership (the new owner should be identified) and that the contractor will be requiring the provider to resubmit a new initial application containing the new owner's information.

(iii) Request via letter that the provider submit a new initial Form CMS-855A application containing the new owner's information within 30 days of the date of the letter. If the provider fails to do so, the contractor shall return the initial application and notify the provider and the state/SOG Location of this via letter. If the provider submits the application, the contractor shall process it as normal and, if a recommendation for approval is made, send the revised application package to the state/SOG Location with an explanation of the situation; the initially submitted application becomes moot. If the newly submitted application is denied, however, the initially submitted application is denied as well; the contractor shall notify the provider and the state/SOG Location accordingly.

Situation 4 - The provider submitted a CHOW application followed by another CHOW application, and a recommendation for approval has been made for the first application - The contractor shall:

(i) Notify the state/SOG Location via e-mailed letter that there has been a change of ownership (the new owner should be identified) and that the contractor will be requiring the provider to resubmit a new initial application containing the new owner's information.

(ii) Process the new CHOW application as normal. If a recommendation for approval is made, the contractor shall send the revised CHOW package to the state/SOG Location with an explanation of the situation; the first CHOW application becomes moot. If the newly submitted CHOW application is denied, the first application is denied as well; the contractor shall notify the provider and the state/SOG Location accordingly.

10. CHOWs and Address Changes

A new owner may propose to relocate the supplier concurrent with a CHOW. If the relocation is to a site in a different geographic area serving different clients than previously served and employing different personnel to serve those clients, the contractor shall notify the SOG Location immediately. Unless the SOG Location dictates otherwise, the supplier shall - per Pub. 100-07, chapter 3, section 3210.1(B)(5) - treat the transaction as an initial enrollment (and the supplier as a new applicant), rather than as an address change of the existing supplier.

D. Form CMS-855A - Entry into PECOS

If the new owner will or will not be accepting assignment as well as the assets and liabilities of the old owner, the contractor shall enter the CHOW information into the new enrollment record that shall be created for the CHOW buyer. If the SOG Location approves the CHOW and sends the tie-in/approval notice to the contractor, the supplier's CCN will be maintained in the new owner's enrollment record once the record is switched to an approved status.

If the CHOW is for a Part B certified supplier, a new enrollment record must be created if a new TIN is created in the CHOW.

E. Form CMS-855A - Electronic Funds Transfer (EFT) Payments and CHOWs

In a CHOW, the contractor shall continue to pay the old owner until it receives the tie-in/approval notice from the SOG Location. Hence, any application from the old or new owner to change the EFT account or special payment address to that of the new owner shall be rejected. It is the responsibility of the old and new owners to work out any payment arrangements between themselves while the contractor and SOG Location are processing the CHOW. It is advisable that the contractor notify the new owner of this while the application is being processed.

In a CHOW, the existing provider agreement is automatically assigned to the buyer/transferee. If the buyer/transferee does not explicitly reject automatic assignment before the transfer date, the provider agreement is automatically assigned, along with the CCN, effective on the transfer date. The assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued. Among other things, this means that the contractor will continue to adjust payments to the provider to account for prior overpayments and underpayments, even if they relate to services provided before the sale/transfer. If the buyer rejects assignment of the provider agreement, the buyer must file an initial application to participate in the Medicare program. In this situation, Medicare will **never** pay the applicant for services the prospective provides before the date on which the provider qualifies for Medicare participation as an initial applicant.

Depending on the terms of the sale, the buyer/transferee may obtain a new NPI or maintain the existing NPI. After CHOW processing is complete, the seller/transferor will no longer be allowed to bill for services (i.e., services furnished after CHOW processing is complete) and only the buyer is permitted to submit claims using the existing CCN. It is ultimately the responsibility of the old and new owners to work out between themselves any payment arrangements for claims for services furnished during the CHOW processing period.

F. Form CMS-855A CHOW: Pre-Approval Changes of Information

1. CHOW: Regarding Seller

If – prior to the issuance of the tie-in notice – the contractor receives from the seller a Form CMS-855 request to change any of the provider's enrollment data, the contractor shall reject the change request if the information in question involves changing the provider's:

i. EFT or special payment address information to that of the buyer

ii. Practice location or base of operations to that of the buyer

iii. Ownership or managing control to that of the buyer

iv. Legal business name, TIN, or "doing business as" name to that of the buyer

All other "pre-tie-in notice" Form CMS-855 change requests from the seller can be processed normally.

2. CHOW: Regarding Buyer

If – prior to the issuance of the tie-in notice – the contractor receives from the buyer a Form CMS-855 request to change any of the provider's existing enrollment information, the contractor shall reject the change request. Until the tie-in notice is issued, the seller remains the owner of record. Hence, the buyer has no standing to submit Form CMS-855 changes on behalf of the provider.

10.7.4 – DME Approval Letter Templates

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Approval – Change of Information (DME)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] approved your Change of Information (COI) application.

Medicare Enrollment Information

Supplier Legal Business Name (LBN)	
Doing Business As (DBA)	
Physical Location Address	
Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
PTAN Effective Date	
Changed Information	Include detailed changes or section titles, as applicable.

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Filing claims electronically? Contact the Common Electronic Data Exchange (CEDI) Contractor at www.ngscedi.com or (866) 311-9184.

Subscribe to receive timely listserv messages regarding Medicare billing policies at:

- Jurisdiction A – Noridian Healthcare Solutions, med.noridianmedicare.com/web/jadme
- Jurisdiction B – CGS, www.cgsmedicare.com
- Jurisdiction C – CGS, www.cgsmedicare.com
- Jurisdiction D – Noridian Healthcare Solutions, med.noridianmedicare.com/web/jddme

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR § 424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

B. Approval – Initial (DME)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] approved your initial enrollment application.

Medicare Enrollment Information

Supplier Legal Business Name (LBN)	
Doing Business As (DBA)	
Physical Address Location	
Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
PTAN Effective Date	
Participation Status	

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Filing claims electronically? Contact the Common Electronic Data Exchange (CEDI) Contractor at www.ngscedi.com or (866) 311-9184.

Subscribe to receive timely listserv messages regarding Medicare billing policies at:

- Jurisdiction A – Noridian Healthcare Solutions, med.noridianmedicare.com/web/jadme
- Jurisdiction B – CGS, www.cgsmedicare.com
- Jurisdiction C – CGS, www.cgsmedicare.com
- Jurisdiction D – Noridian Healthcare Solutions, med.noridianmedicare.com/web/jddme

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR §424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

[Name of MAC]
[Address]
[City], ST [Zip]

or

[Centers for Medicare & Medicaid Services]
[Center for Program Integrity]
[Provider Enrollment & Oversight Group]
[ATTN: Division of Provider Enrollment Appeals]
[7500 Security Blvd.]
[Mailstop: AR-19-51]
[Baltimore, MD 21244-1850]

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

C. Approval – Reactivation (DME)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] approved your reactivation application.

Medicare Enrollment Information

Supplier Legal Business Name (LBN)	
Doing Business As (DBA)	
Physical Address Location	
Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
PTAN Effective Date	
Participation Status	

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

To file claims electronically, please contact the Common Electronic Data Exchange (CEDI) Contractor at www.ngscedi.com or (866) 311-9184.

Subscribe to receive timely listserv messages regarding Medicare billing policies at:

- Jurisdiction A – Noridian Healthcare Solutions, med.noridianmedicare.com/web/jadme
- Jurisdiction B – CGS, www.cgsmedicare.com
- Jurisdiction C – CGS, www.cgsmedicare.com
- Jurisdiction D – Noridian Healthcare Solutions, med.noridianmedicare.com/web/jddme

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov..

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR §424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

[Name of MAC]
[Address]
[City], ST [Zip]

or

[Centers for Medicare & Medicaid Services]
[Center for Program Integrity]
[Provider Enrollment & Oversight Group]
[ATTN: Division of Provider Enrollment Appeals]
[7500 Security Blvd.]
[Mailstop: AR-19-51]
[Baltimore, MD 21244-1850]

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

D. Approval – Revalidation (DME)

[Month, Day, Year]

[Provider/Supplier Name]
[Address]

[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] approved your revalidation application.

Medicare Enrollment Information

Supplier Legal Business Name (LBN)	
Doing Business As (DBA)	
Physical Address Location	
Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
PTAN Effective Date	
Changed Information	Include detailed changes or section titles, as applicable.

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

To file claims electronically, please contact the Common Electronic Data Exchange (CEDI) Contractor at www.ngscedi.com or (866) 311-9184.

Subscribe to receive timely listserv messages regarding Medicare billing policies at:

- Jurisdiction A – Noridian Healthcare Solutions, med.noridianmedicare.com/web/jadme
- Jurisdiction B – CGS, www.cgsmedicare.com
- Jurisdiction C – CGS, www.cgsmedicare.com
- Jurisdiction D – Noridian Healthcare Solutions, med.noridianmedicare.com/web/jddme

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR §424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

[Name of MAC]		[Centers for Medicare & Medicaid Services]
[Address]	or	[Center for Program Integrity]

[City], ST [Zip]

[Provider Enrollment & Oversight Group]
[ATTN: Division of Provider Enrollment Appeals]
[7500 Security Blvd.]
[Mailstop: AR-19-51]
[Baltimore, MD 21244-1850]

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

E. Approval – Voluntary Termination (DME)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] completed your application to voluntarily disenroll from the Medicare program.

Medicare Enrollment Information

Supplier Legal Business Name (LBN)	
Doing Business As (DBA)	
Physical Address Location	
Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Effective Date of Termination and Deactivation	

Medicare will not reimburse you for any claims with dates of service on or after your effective date of termination.

With this voluntary termination, your billing privileges are also being deactivated effective on the aforementioned date of the termination pursuant to 42 C.F.R. § 424.540(a)(7).

REBUTTAL RIGHTS:

If you believe that this deactivation determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.545(b). The rebuttal must be received by this office in writing within 15 calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.

The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative. Please be advised that authorized or delegated officials for groups cannot sign and submit a rebuttal on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on the *reassigned provider's/supplier's* behalf.

If the provider/supplier wishes to appoint a legal representative that is not an attorney to sign the rebuttal, the provider/supplier must include with the rebuttal a written notice authorizing the legal representative to act on the provider/supplier's behalf. The notice should be signed by the provider/supplier.

If the provider/supplier has an attorney sign the rebuttal, the rebuttal must include a statement from the attorney that *the attorney has* the authority to represent the provider/supplier.

If you wish to receive communication regarding your rebuttal via email, please include a valid email address in your rebuttal submission.

The rebuttal should be sent to the following:
[Contractor Rebuttal Receipt Address]
[Contractor Rebuttal Receipt Email Address]
[Contractor Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM ET/CT/MT/PT] and [x:00 AM/PM ET/CT/MT/PT].

Sincerely,

[Name]
[Title]
[Company]

10.7.5 – Part A/B Certified Provider and Supplier Approval Letter Templates

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Approval – Change of Information (Part A/B Certified Org, No Referral to State Required)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] has approved your Change of Information (COI) application.

Medicare Enrollment Information

Legal Business Name (LBN)	
Doing Business As (DBA)	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Changed Information	Include detailed changes or section titles, as applicable.

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR §424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

    - If the authorized representative is an attorney, the attorney's statement that the *attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on the *reassigned provider's/supplier's* behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted; and
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 CFR Part 498.

The reconsideration request should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Blvd.
Mailstop: AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

[CC: SOG Location and State]

B. Approval - Post Tie-In Change of Information (Part A/B Certified)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] has processed the Medicare Tie in Notice approving your change of information application.

Medicare Enrollment Information

Legal Business Name (LBN)	
Doing Business As (DBA)	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Changed Information	Include detailed changes or section titles, as applicable.

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR §424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement; and
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted; and
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 CFR Part 498.

The reconsideration request should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Blvd.
Mailstop: AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

C. Approval - Post Tie-In Change of Ownership (Part A/B Certified)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] has processed the Medicare Tie in Notice approving your change of ownership application.

Medicare Enrollment Information

Legal Business Name (LBN)	
Doing Business As (DBA)	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	

PTAN Effective Date	
CHOW Effective Date	
Medicare Year-End Cost Report Date (Part A CHOWs only)	

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Contact our electronic data interchange (EDI) department for enrollment and further instructions on electronic claims filing at [phone number].

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR §424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement; and
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted; and
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Blvd.
Mailstop: AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

D. Approval - Post Tie-In/Initial (Part A/B Certified)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] has processed the Medicare Tie in Notice approving your initial enrollment application.

Medicare Enrollment Information

Legal Business Name (LBN)	
Doing Business As (DBA)	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
PTAN Effective Date	
Medicare Year-End Cost Report Date (Part A only)	

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Contact our electronic data interchange (EDI) department for enrollment and further instructions on electronic claims filing at [phone number].

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR §424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement; and

- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted; and
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Blvd.
Mailstop: AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

E. Forwarded to State - Initial (Part A/B Certified)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

This letter updates you on the status of your initial enrollment application. Your application is required to go through a multi-step review process.

[Contractor Name] is a CMS Medicare Administrative Contractor (MAC) charged with enrolling providers and suppliers in the Medicare program. We have assessed your enrollment application and forwarded it to the [Enter State Agency] for the next step in the process. The State Agency will conduct a review for further compliance with the applicable Federal, State, and local requirements. Once the State Agency's review is complete, CMS will conduct a final review and issue a decision.

We will contact you when your application has completed all stages of review and a decision has been made.

Medicare Enrollment Information	
Legal Business Name (LBN)	
Doing Business As (DBA)	
National Provider Identifier (NPI)	
Provider/Supplier Type	
Medicare Year-End Cost Report Date (Part A only)	

For questions concerning the application's review at this stage, contact [Insert State] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

F. Forwarded to State – Change of Information or Change of Ownership (Part A/B Certified)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

This letter updates you on the status of your [change of information or change of ownership enrollment] application. Your application is required to go through a multi-step review process.

[Contractor Name] is a CMS Medicare Administrative Contractor (MAC) charged with enrolling providers and suppliers in the Medicare program. We have assessed your enrollment application and forwarded it to the [Enter State Agency] for the next step in the process. The State Agency will conduct a review for further compliance with the applicable Federal, State, and local requirements. Once the State Agency's review is complete, CMS will conduct a final review and issue a decision.

We will contact you when your application has completed all stages of review and a decision has been made.

Medicare Enrollment Information

Legal Business Name (LBN)		
Doing Business As (DBA)		
Provider/Supplier Type		
National Provider Identifier (NPI)		
Provider Transaction Access Number (PTAN)		
Medicare Year-End Cost Report Date (Part A only)		
Requested Changes (applicable to COI and CHOW, remove if doesn't apply)	Existing	
	New	
	Effective Date	

For questions concerning the application's review at this stage, contact [Insert State] at [contact information].

Sincerely,

[Name]

[Title]
[Company]

CC: State Agency [and AO, if applicable]

G. Approval – Revalidation (Part A/B Certified Org)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] has [approved your revalidation application/assessed your revalidation application and forwarded it to the Centers for Medicare & Medicaid Services (CMS) [City] SOG for a final review].

Medicare Enrollment Information

Legal Business Name (LBN)	
Doing Business As (DBA)	
Provider/Supplier Type	
Provider/Supplier National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
PTAN Effective Date	
Changed Information	Include detailed changes or section titles, as applicable.

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR §424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement; and
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted; and
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

Centers for Medicare & Medicaid Services

Center for Program Integrity
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Blvd
Mailstop: AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

H. Approval – Voluntary Termination (Part A/B Certified Org)

[Month, Day, Year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] completed your application to voluntarily disenroll from the Medicare program.

Medicare Enrollment Information

Legal Business Name (LBN)	
Doing Business As (DBA)	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Effective Date of Termination and Deactivation	

Medicare will not reimburse you for any claims with dates of service on or after your effective date of termination. With this voluntary termination, your billing privileges are also being

deactivated effective on the aforementioned date of the termination pursuant to 42 C.F.R. § 424.540(a)(7).

REBUTTAL RIGHTS:

If you believe that this deactivation determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.545(b). The rebuttal must be received by this office in writing within 15 calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.

The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative. Please be advised that authorized or delegated officials for groups cannot sign and submit a rebuttal on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

If the provider/supplier wishes to appoint a legal representative that is not an attorney to sign the rebuttal, the provider/supplier must include with the rebuttal a written notice authorizing the legal representative to act on the provider/supplier's behalf. The notice should be signed by the provider/supplier.

If the provider/supplier has an attorney sign the rebuttal, the rebuttal must include a statement from the attorney that *the attorney has* the authority to represent the provider/supplier.

If you wish to receive communication regarding your rebuttal via email, please include a valid email address in your rebuttal submission.

The rebuttal should be sent to the following:

[Contractor Rebuttal Receipt Address]
[Contractor Rebuttal Receipt Email Address]
[Contractor Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM ET/CT/MT/PT] and [x:00 AM/PM ET/CT/MT/PT].

Sincerely,

[Name]
[Title]
[Company]

[CC: SOG Location and State for Certified Providers/Suppliers]

I. Approval – Reactivation (Part A/B Certified Org)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] approved your reactivation enrollment application.

Medicare Enrollment Information

Legal Business Name (LBN)	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
PTAN Effective Date	
Participation Status	

Include if applicable: [While your PTAN(s) and effective date(s) remain the same, you will have a gap in billing privileges from [deactivation date] through [reactivation date] for failing to fully revalidate during a previous revalidation cycle. You will not be reimbursed for services provided to Medicare beneficiaries during this time period since you were not in compliance with Medicare requirements.]

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Contact our electronic data interchange (EDI) department for enrollment and further instructions on electronic claims filing at [phone number].

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR §424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement; and
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted; and
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group

ATTN: Division of Provider Enrollment Appeals
7500 Security Blvd.
Mailstop: AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

10.7.5.1 – Part A/B Certified Provider and Supplier Letter Templates – Post-Transition

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

The model letters in this section 10.7.5.1 pertain to certain enrollment transactions involving certified providers and certified suppliers. Except as otherwise stated, the contractor shall begin utilizing these letters (instead of those in section 10.7.5) upon completion of the transition of the applicable CMS Survey & Operations Group (SOG) function to the contractor and the CMS Provider Enrollment & Oversight Group (PEOG). In other words, once a provider specialty, provider agreement, or provider enrollment transaction type (for example, voluntary terminations) has been transitioned, the contractor shall commence using the section 10.7.5.1 letter(s) pertaining to said transaction. CMS will notify contractors once a particular transition has occurred.

For certified provider/supplier transactions (and transaction outcomes) not specifically addressed in this section 10.7.5.1, the contractor shall continue to use the existing model letters in section 10.7 et seq. (even after the above-mentioned transition).

In addition:

(i) Most of the documents in this section 10.7.5.1 identify parties that must receive a copy of the letter in question. If an inconsistency exists between said copied parties and those listed elsewhere in this chapter concerning a particular letter, the parties identified in this section 10.7.5.1 take precedence. To illustrate, suppose another section of this chapter requires X, Y, and Z to be copied on a certain letter while section 10.7.5.1 only requires X to be copied. The contractor in this situation need only copy X.

(ii) The contractor need only copy an accrediting organization (AO) on a particular letter if the provider/supplier has an AO for the identified provider/supplier specialty. The contractor can typically ascertain this by checking PECOS (for currently enrolled providers/suppliers) or

reviewing the application (for initial enrollments) to see if an AO is disclosed. Also, PEOG will often identify an AO (if one exists) in cases where it must review the transaction before notifying the contractor of its final approval (e.g., CHOWs, certain changes of information, voluntary termination).

(iii) See section 10.7.5.1(P) below for the applicable e-mail addresses of the SOG Locations. The contractor shall insert the relevant e-mail address into any letter in section 10.7.5.1 that addresses the provider/supplier's right to a reconsideration of a provider agreement determination.

(iv) Any data element boxes that the contractor cannot complete because the information is unavailable or inapplicable (e.g., CMS Certification Number (CCN) in certain instances) can be: (1) left blank; (2) denoted with "N/A," "Not applicable," or any similar term; or (3) removed altogether.

(v) The Provider Transaction Access Number (PTAN) box should contain the CCN for all provider/supplier types other than ASCs and PXRSs; the PTAN for the latter two supplier types will be that which the contractor assigns or has assigned.

(vi) The Primary Practice Location Address box shall include the suite number if one was/is listed on the application.

(vii) For the Denial letter in section 15.7.5.1(H), the contractor shall indicate (in any manner it chooses) whether the denial pertains to the buyer's or the seller's application if a prospective CHOW was involved.

(viii) In cases where provider/supplier data has changed and the contractor must list "detailed information or application section titles (as applicable)", the contractor has the discretion to list either (i.e., the info or the section titles).

(ix) Note that some provider/supplier types, such as PXRSs, do not have provider/supplier agreements. In such cases, and as shown in the section 10.7.5.1 model letters, the contractor shall remove references to provider/supplier agreements from these letters. For example, if no provider/supplier agreement is involved, the contractor shall:

- Change the data box heading "Provider/Supplier Agreement-Specific Information" to "Other Information".
- Remove the section regarding provider/supplier agreement appeal rights.

(Quotation marks, of course, should be removed.)

A. Approval – Change of Information (Part A/B Certified Org; No Referral to State Was Required)

[Month, Day, Year]

[Provider/Supplier Name]

[Address]
[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and Contractor number]] has approved your Change of Information (COI) application.

Medicare Enrollment Information	
Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Changed Information	Include detailed changes or application section titles, as applicable.

["Provider/Supplier Agreement-Specific" OR "Other", as applicable] Information	
CMS Certification Number (CCN)	
CCN Effective Date	

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Enroll, make changes, or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR § 424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations, at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement; and
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

    - If the authorized representative is an attorney, the attorney's statement that *the attorney has* the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted; and
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 CFR Part 498.

The reconsideration request should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Blvd.
Mailstop: AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [& Accrediting Organization (AO), if applicable]

Attachments: [Include any attachments that the contractor must send to the provider/supplier, the state agency, and/or the AO per the instructions in this chapter 10.]

B. Approval - State Agency Approved Change of Information (Part A/B Certified; Referral to State Was Required)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and Contractor number]] has received a response from the Medicare State Agency. Your change of information application is now approved.

Medicare Enrollment Information	
Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Changed Information	Include detailed changes or application section titles, as applicable

[“Provider/Supplier Agreement Specific” OR “Other”, as applicable] Information	
CMS Certification Number (CCN)	
CCN Effective Date	

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Enroll, make changes, or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR § 424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement; and
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the

administrative appeals process unless an ALJ allows additional information to be submitted; and

- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 CFR Part 498.

The reconsideration request should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Blvd.
Mailstop: AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

Attachments: [Include any attachments that the contractor must send to the provider/supplier, the state agency, and/or the AO per the instructions in this chapter 10.]

C. Approval - State Agency Approved Change of Ownership (Part A/B Certified Excluding FQHCs)

[Month, Day, Year]

[Provider/Supplier Name]
[Address]
[City, State, Zip]
Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and Contractor number]] has received a response from the State Agency. Your change of ownership application is now approved. [If the provider/supplier type has a provider/supplier agreement, insert "The corresponding executed [insert provider/supplier agreement type] is enclosed/attached"]. Your enrollment and [insert provider/supplier agreement-specific OR "other", as applicable] information is outlined below:

Medicare Enrollment Information	
Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	

["Provider/Supplier Agreement Specific" OR "Other", as applicable] Information	
CMS Certification Number (CCN)	
CCN Effective Date (use effective date of seller's CCN)	
CHOW Effective Date	

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Contact our electronic data interchange (EDI) department for enrollment and further instructions on electronic claims filing at [phone number].

Enroll, make changes, or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR § 424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations, at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement; and
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted; and
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 CFR Part 498.

The reconsideration request should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Blvd.
Mailstop: AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

[Insert the following language if provider/supplier type has a provider/supplier agreement:

And

If you are also requesting a reconsideration of the provider/supplier agreement determination, you must submit a separate Reconsideration Request. Your requests must be e-mailed to: [Insert: Name and e-mail address of CMS Location Office]/

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

Attachments: [Include any attachments that the contractor must send to the provider/supplier, the state agency, and/or the AO per the instructions in this chapter 10.]

D. Approval - State Agency Approved Initial (Part A/B Certified)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and Contractor number]] received a response from the Medicare State Agency. Your initial enrollment application [if applicable to the provider/supplier type, insert "and [provider/supplier agreement"]] [is /are] approved. [If applicable, insert "Your executed [if applicable, insert provider/supplier agreement name] is enclosed/attached."] The effective date is the date you met all federal requirements.

Medicare Enrollment and [insert "Provider/Supplier Specific Participation Agreement" OR "Other" Information]

Medicare Enrollment Information	
Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type	

National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Enrollment Effective Date	

[“Provider/Supplier Agreement Specific” OR “Other”, as applicable] Information	
CMS Certification Number (CCN)	
CCN Effective Date	
Medicare Year-End Cost Report Date	

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Contact our electronic data interchange (EDI) department for enrollment and further instructions on electronic claims filing at [phone number].

Enroll, make changes, or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR § 424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations, at [insert contractor’s web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement; and
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

    - If the authorized representative is an attorney, the attorney’s statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.

- If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
- Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted; and
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 CFR Part 498.

The reconsideration request should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Blvd.
Mailstop: AR-19-51
Baltimore, MD 21244-1850

Or emailed to: ProviderEnrollmentAppeals@cms.hhs.gov

[Insert the following language if provider/supplier type has a provider/supplier agreement:

And

If you are also requesting a provider/supplier agreement reconsideration, you must submit a separate Reconsideration Request. Your requests must be e-mailed to:

[Insert: Name and e-mail address of CMS Location Office]

Your e-mail must include the following in the subject line: "Subject: Medicare Provider/Supplier Agreement Reconsideration Request"*]*

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

Attachments: [Include any attachments that the contractor must send to the provider/supplier, the state agency, and/or the AO per the instructions in this chapter 10.]

E. Forwarded to State - Initial (Part A/B Certified)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

This letter updates you on the status of your initial enrollment application. Your application is required to go through a multi-step review process.

[Contractor Name] is a CMS Medicare Administrative Contractor (MAC) charged with enrolling providers and suppliers in the Medicare program. We have assessed your enrollment application and forwarded it to the [Enter State Agency] for the next step in the process. The State Agency will conduct a review for further compliance with the applicable Federal, State, and local requirements. If you have elected to use a CMS approved accreditation organization (AO), the AO will conduct the survey and recommend approval to the State Agency to finalize your certification. Once the State Agency's review is complete, CMS will conduct a final review and issue a decision.

We will contact you when your application has completed all stages of review and a decision has been made.

Medicare Enrollment Information	
Legal Business Name (LBN)	
Doing Business As (DBA)	
National Provider Identifier (NPI)	
Provider/Supplier Type	
Practice Location Address	
Medicare Year-End Cost Report Date (Part A only)	

For questions concerning the application's review at this stage, contact [Insert State] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

F. Forwarded to State – Change of Information, Change of Ownership, Revalidation, or Reactivation Containing Changed New/Changed Data that the State Must Review (if applicable) (Part A/B Certified)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

This letter updates you on the status of your [list type of transaction] enrollment application. Your application is required to go through a multi-step review process.

[Contractor Name] is a CMS Medicare Administrative Contractor (MAC) charged with enrolling providers and suppliers in the Medicare program. We have assessed your enrollment application and forwarded it to the [Enter State Agency] for the next step in the process. The State Agency will conduct a review for further compliance with the applicable Federal, State, and local requirements. Once the State Agency's review is complete, CMS will conduct a final review and issue a decision.

We will contact you when your application has completed all stages of review and a decision has been made.

Medicare Enrollment Information	
Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	

["Provider/Supplier Agreement-Specific" OR "Other" Information [as applicable]]		
CMS Certification Number (CCN)		
Requested Changes (applicable to COI, CHOW, or Revalidation; remove if inapplicable)	Existing	Seller
	New	Buyer
	Effective Date	

For questions concerning the application's review at this stage, contact [Insert State] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

G. Approval Revalidation (Part A/B Certified Org)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and add Contractor number]] has approved your revalidation application [include if the application was sent to the state: "and forwarded it to the State Agency. The State Agency review has also been completed"]. Your Medicare enrollment information is provided below.

Medicare Enrollment Information

Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
PTAN Effective Date	

Changed Information	Include detailed changes or application section titles, as applicable.

["Provider/Supplier Agreement-Specific" OR "Other" Information [as applicable]]		
CMS Certification Number (CCN)		
Requested Changes (applicable to COI, CHOW, or Revalidation; remove if inapplicable)	Existing	Seller
	New	Buyer
	Effective Date	

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR § 424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations, at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement; and
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

    - If the authorized representative is an attorney, the attorney's statement that the *attorney has the* authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.

- Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted; and
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 CFR Part 498.

The reconsideration request should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Blvd
Mailstop: AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

[Insert the following language if provider/supplier type has a provider/supplier agreement:

And

If you are also requesting a provider/supplier agreement reconsideration, you must submit a separate Reconsideration Request. Your requests must be e-mailed to:

[Insert: Name and e-mail address of CMS Location Office]

Your e-mail must include the following in the subject line: "Subject: Medicare Provider/Supplier Agreement Reconsideration Request"*]*

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

H. Denial Letter – Post-1539 (Or Other Similar Notice) Received from State Agency for the following application types—Initials, COIs, CHOWs, Revalidations, and Reactivations

(This letter only applies in cases where:

(1) A recommendation to the state was required per the instructions in this chapter (e.g., the application contained information/changes requiring state review), and
(2) The state sends notification to the contractor (e.g., via the 1539 or other notice) that the application should be denied and/or, if applicable, the provider/supplier agreement should be terminated.

As explained in this chapter, certain changes of information and revalidation applications can result in an enrollment revocation and provider agreement termination, though most do not. Accordingly, the contractor shall insert the applicable review result language (e.g., see bracketed options below) in the first paragraph of the letter.)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[The [insert name of State Agency] completed its evaluation of your [initial application] or [change of information] or [change of ownership] or [revalidation] or [reactivation]. [Insert the following language based on the situation involved and the specific result of the state's review:

[INITIAL ENROLLMENT: Your participation in the Medicare Program and your enrollment in the Medicare Program is [denied] for the following reasons]:

[NO REVOCATION AND/OR PROVIDER AGREEMENT TERMINATION INVOLVED: Your application for [insert] is denied for the following reasons]:

[REVOCATION AND/OR PROVIDER AGREEMENT TERMINATION RESULTING FROM THE APPLICATION SUBMISSION. As a result of the state's review, your provider/supplier

agreement for participation in the Medicare program is terminated and your enrollment in the Medicare program is revoked for the following reason(s]:

[**INSERT DENIAL OR TERMINATION REASON GIVEN BY THE STATE AGENCY**]

Information about your [if applicable, "provider/supplier agreement" and your] Medicare enrollment [are/is] are outlined in the text box below.

Medicare Administrative Contractor Name & Contractor Number	
Medicare Enrollment Determination	
Status	**DENIED [OR REVOKED]**
Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Provider/Supplier Agreement Determination [include this title and the two data elements below only if the provider/supplier type is one that has a provider/supplier agreement]	
Provider/Supplier Agreement	**DENIED [OR TERMINATED]**
CMS Certification Number (CCN)	

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement; and
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

    - If the authorized representative is an attorney, the attorney's statement that *the attorney has* the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider,

supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.

- Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted; and
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

RECONSIDERATIONS REQUEST—MAILING ADDRESSES:

Requests for Reconsideration: Medicare Provider Enrollment: The reconsideration request regarding your Medicare enrollment may be submitted electronically via e-mail to: ProviderEnrollmentAppeals@cms.hhs.gov or addressed as follows:

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Blvd.
Mailstop: AR-19-51
Baltimore, MD 21244-1850

[Insert the following language if provider/supplier type has a provider/supplier agreement:

And

Requests for Reconsideration: Medicare Provider/Supplier Agreement: For reconsideration of the Provider/Supplier Agreement determination, you must submit a separate Reconsideration Request. Your requests must be e-mailed to:

[Insert: Name and e-mail address of CMS Location Office]

Your e-mail must include the following in the subject line: "Subject: Medicare Provider/Supplier Agreement Reconsideration Request"]

[If a failed survey was involved, the contractor shall include the following language here: "Note that any survey deficiencies may only be addressed as part of the provider/supplier agreement reconsideration process."]

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

I. Approval – Voluntary Termination (Part A/B Certified Org)

[Month, Day, Year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and Contractor number]] has received notification from the State Agency that you are voluntarily terminating your provider/supplier agreement **or** [Insert Contractor name [and Contractor number]] has completed processing your application [or letter] to voluntarily disenroll from the Medicare program. Therefore, [if applicable to the provider/supplier type, insert "your provider/supplier agreement has been voluntarily terminated and"] your enrollment in the Medicare program has been voluntarily terminated effective on the date[s] shown below.

Medicare Enrollment [if applicable to the provider/supplier type, add "and Provider/Supplier Agreement"] Information

Medicare Enrollment Termination and Deactivation of Billing Privileges	
Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type	

Medicare Enrollment Termination and Deactivation of Billing Privileges	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Effective Date of Enrollment Termination and Deactivation	

Provider/Supplier Agreement Termination *[include this title and the three data elements below only if the provider/supplier type is one that has a provider/supplier agreement]*	
CMS Certification Number (CCN)	
Effective Date of CCN Termination	
Reason for Termination	

In accordance with 42 CFR § 489.52, Medicare will not reimburse you for any claims with dates of service on or after your effective date of termination. With this termination, your billing privileges are also being deactivated effective on the aforementioned date of the termination pursuant to 42 C.F.R. § 424.540(a)(7).

REBUTTAL RIGHTS:

If you believe that this deactivation determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.545(b). The rebuttal must be received by this office in writing within 15 calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.

The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative. Please be advised that authorized or delegated officials for groups cannot sign and submit a rebuttal on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

If the provider/supplier wishes to appoint a legal representative that is not an attorney to sign the rebuttal, the provider/supplier must include with the rebuttal a written notice authorizing the legal representative to act on the provider/supplier's behalf. The notice should be signed by the provider/supplier.

If the provider/supplier has an attorney sign the rebuttal, the rebuttal must include a statement from the attorney *that the attorney has* the authority to represent the provider/supplier.

If you wish to receive communication regarding your rebuttal via email, please include a valid email address in your rebuttal submission.

The rebuttal should be sent to the following:
[Contractor Rebuttal Receipt Address]
[Contractor Rebuttal Receipt Email Address]
[Contractor Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM ET/CT/MT/PT] and [x:00 AM/PM ET/CT/MT/PT].

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

J. Approval – Reactivation (Part A/B Certified Org)

(This letter should be used for reactivation approvals regardless of whether the application was referred to the state agency for review.)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and add Contractor number]] has approved your reactivation enrollment application.

Medicare Enrollment Information

Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
PTAN Effective Date	

["Provider/Supplier Agreement Specific" OR "Other" Information [as applicable]]	
CMS Certification Number (CCN)	
CCN Effective Date	

Include if applicable: [While your PTAN(s) and effective date(s) remain the same, you will have a gap in billing privileges from [deactivation date] through [reactivation date] for failing to fully revalidate during a previous revalidation cycle. You will not be reimbursed for services provided to Medicare beneficiaries during this time period since you were not in compliance with Medicare requirements.]

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Contact our electronic data interchange (EDI) department for enrollment and further instructions on electronic claims filing at [phone number].

Enroll, make changes, or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR § 424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations, at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement; and
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.

- If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
- Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted; and
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 CFR Part 498.

The reconsideration request should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Blvd.
Mailstop: AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

[Insert the following language if provider/supplier type has a provider/supplier agreement:

And

Requests for Reconsideration: Medicare Provider/Supplier Agreement: For reconsideration of the Provider/Supplier Agreement determination, you must submit a separate Reconsideration Request. Your requests must be e-mailed to:

[Insert: Name and e-mail address of CMS Location Office]

Your e-mail must include the following in the subject line: "Subject: Medicare Provider/Supplier Agreement Reconsideration Request"]

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

(Note: No CC: to State Agency/AO required. Deactivations do not impact certified provider CCN participation status.)

K. Voluntary Termination: Failure to Respond to Request for Information

Month, Day, Year

PROVIDER/SUPPLIER NAME
ADDRESS
CITY, STATE, ZIP

Reference # Application ID

Dear Provider Name (LBN),

[Insert Contractor name [and Contractor number]] has received notification from the State Agency that you are no longer operational. We have not received a response to the request sent on Month DD, YYYY to update your enrollment information. Therefore, we have disenrolled you from the Medicare program. [Include if provider/supplier type has a provider/supplier agreement: "Your [provider/supplier agreement] has also been terminated."]

Medicare Enrollment [add if applicable "and Provider/Supplier Agreement"] Information

Medicare Enrollment Termination and Deactivation of Billing Privileges Information	
Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type/Specialty	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Effective Date of Enrollment Deactivation	

[“Provider/Supplier Agreement” OR “Other”, as applicable] Termination Information	
CMS Certification Number (CCN)	
Effective Date of CCN Termination	

In accordance with 42 CFR § 489.52, Medicare will not reimburse you for any claims with dates of service on or after your effective date of termination. With this termination, your billing privileges are also being deactivated effective on the aforementioned date of the termination pursuant to 42 C.F.R. § 424.540(a)(7).

REBUTTAL RIGHTS:

If you believe that this deactivation determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.545(b). The rebuttal must be received by this office in writing within 15 calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.

The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative. Please be advised that authorized or delegated officials for groups cannot sign and submit a rebuttal on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider’s/supplier’s* behalf.

If the provider/supplier wishes to appoint a legal representative that is not an attorney to sign the rebuttal, the provider/supplier must include with the rebuttal a written notice authorizing the legal representative to act on the provider/supplier’s behalf. The notice should be signed by the provider/supplier.

If the provider/supplier has an attorney sign the rebuttal, the rebuttal must include a statement from the attorney *that the attorney has* the authority to represent the provider/supplier.

If you wish to receive communication regarding your rebuttal via email, please include a valid email address in your rebuttal submission.

The rebuttal should be sent to the following:

[Contractor Rebuttal Receipt Address]
[Contractor Rebuttal Receipt Email Address]
[Contractor Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM ET/CT/MT/PT] and [x:00 AM/PM ET/CT/MT/PT].

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

L. Voluntary Termination Cessation of Business

[Month, Day, Year]

PROVIDER/SUPPLIER NAME
ADDRESS
CITY, STATE, ZIP

Reference Number:

Dear Provider/Supplier Name:

[Insert Contractor name [and Contractor number]] was notified by State Agency Name that on MONTH DD, YYYY, the State Agency attempted to verify if your Type of Provider is operational. The State Agency has reported that your facility was closed, not operational, and/or ceased business at your address of record.

Pursuant to 42 CFR § 489.52(b)(3), CMS considers a cessation of business and providing services to the community to constitute a voluntary withdrawal from the Medicare program.

If you believe that our determination is incorrect and your Type of Provider facility remains operational, you must notify the State Agency and copy this office within 10 days from your receipt of this notice that your facility is still operational and participating in the Medicare program. You must provide the State Agency and this office with information to clarify why your facility was not functional at the address of record at the time the State Agency performed the site survey.

STATE AGENCY NAME
ADDRESS
CITY, STATE, ZIP

We request that you complete and submit a CMS-855 or an application via the Internet-Based Provider Enrollment Chain and Ownership System (PECOS) for a change of information to indicate that your facility/practice location remains open and operational or to request a voluntary termination of your enrollment.

If we do not hear from you, your Medicare enrollment [add if applicable "and corresponding provider/supplier agreement"] will be terminated pursuant to 42 CFR § 489.52(b)(3). With this termination, your billing privileges will also be deactivated effective on the aforementioned date of the termination pursuant to 42 C.F.R. § 424.540(a)(7).

If you have any questions, please contact our office at:

Sincerely,

[Name]
[Title]
[Company]

M. Approval – Seller CHOW (Part A/B Certified Org)

[Month, Day, Year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and Contractor number]] has received notification from the [use "State Agency" or "CMS Survey & Operations Group Location", as appropriate] that the change of ownership involving [insert seller name] is now approved. Therefore, you have been disenrolled from the Medicare program effective on the date shown below.

Medicare Enrollment [add if applicable "and Provider/Supplier Agreement"] Termination Information

Medicare Enrollment Termination	
Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Effective Date of Enrollment Termination	

["Provider/Supplier Agreement" OR "Other"] Information	
CMS Certification Number (CCN)	

Effective Date of CCN Termination	

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

N. Federally Qualified Health Centers (FQHCs) – Initial Enrollment Approval Letter

Notwithstanding any other instruction to the contrary in this chapter, the contractor shall use this letter (which was formerly in section 10.7.19 of this chapter) for all FQHC initial enrollment approvals. For all other FQHC transactions (e.g., revalidations), the contractor may use the applicable letters in either 10.7.5 or 10.7.5.1.

[Month, Day, Year]

[FQHC Name]
[Address]
[City, State, Zip]

Reference # (Application Tracking Number)

Dear [FQHC],

[Insert Contractor] has approved your enrollment as a federally qualified health center (FQHC).

Medicare Enrollment Information

Legal Business Name (LBN)	
Doing Business As (DBA)	
Physical Location Address	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)/CMS Certification Number (CCN)	
PTAN/CCN Effective Date	
Medicare Year-End Cost Report Date	

Provider/Supplier Agreement Information	
CMS Certification Number (CCN)	
Effective Date of CCN	

Included with this letter is a copy of your "Attestation Statement for Federal Qualified Health Center" (Exhibit 177), which CMS has signed.

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Contact our electronic data interchange (EDI) department for enrollment and further instructions on electronic claims filing at [phone number].

Enroll, make changes to, or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR § 424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement; and
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney has* the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted; and
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Compliance & Appeals
7500 Security Blvd.
Mailstop: AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

O. Approval – FQHC Change of Ownership

[Month, Day, Year]

[Provider/Supplier Name]
[Address]
[City, State, Zip]
Reference # (Application Tracking Number)

Dear [Provider/Supplier],

Your change of ownership application is now approved. The corresponding executed "Attestation Statement for Federal Qualified Health Center" (Exhibit 177), which CMS has signed, is enclosed/attached. Your enrollment and Exhibit 177 information is outlined below:

Medicare Enrollment Information	
Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	

Provider Agreement Specific Information	
CMS Certification Number (CCN)	
CCN Effective Date (use effective date of seller's CCN)	
CHOW Effective Date	

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Contact our electronic data interchange (EDI) department for enrollment and further instructions on electronic claims filing at [phone number].

Enroll, make changes, or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR § 424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations, at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.

- State the issues or findings of fact with which you disagree and the reasons for disagreement; and
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

    - If the authorized representative is an attorney, the attorney's statement that *the attorney has* the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

You may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted; and
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 CFR Part 498.

The reconsideration request should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Blvd.
Mailstop: AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

Attachments: [Include any attachments that the contractor must send to the provider/supplier, the state agency, and/or the AO per the instructions in this chapter 10.]

P. 36-Month Rule Voluntary Termination Letter

[Month, Day, Year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (Application Tracking Number)

Dear [HHA or Hospice Seller],

[Insert Contractor name] has [Insert appropriate situation (e.g., reviewed [insert HHA's *or* hospice's current name] change of ownership application; learned that [insert HHA's or hospice's current name] may have undergone a change in majority ownership pursuant to 42 C.F.R. § 424.550(b)(1); etc.]. After our review, [Insert Contractor name] has determined that [insert HHA's or hospice's current name] has undergone a change in majority ownership under 42 C.F.R. § 424.550(b)(1) and that none of the exceptions described in 42 C.F.R. § 424.550(b)(2) apply to this situation. Pursuant to 42 C.F.R. § 424.550(b)(1), therefore, [insert HHA's or hospice's current name] provider agreement and Medicare billing privileges do not convey to the new owner. The prospective provider/owner of [insert HHA's or hospice's current name] must instead:

- Enroll in the Medicare program as a new (initial) [insert home health agency or hospice, as applicable] under the provisions of 42 C.F.R § 424.510; and
- Obtain a state survey or an accreditation from an approved accreditation organization.

Consistent with the foregoing, [insert HHA's or hospice's current name] provider agreement [will be/has been] voluntarily terminated and its Medicare billing privileges [will be/have been] deactivated pursuant to 42 C.F.R § 424.540(a)(8) effective [Insert date(s)].

Medicare Enrollment and Provider Agreement Information

Medicare Enrollment Deactivation	
Legal Business Name (LBN)	
Doing Business As Name	

Medicare Enrollment Deactivation	
Primary Practice Location Address	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Effective Date of Enrollment Deactivation	

Provider Agreement Termination	
CMS Certification Number (CCN)	
Effective Date of CCN Termination	
Reason for Termination	

In accordance with 42 CFR § 489.52, Medicare will not reimburse you for any claims with dates of service on or after your effective date of termination.

REBUTTAL RIGHTS:

If you believe that this deactivation determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.545(b). The rebuttal must be received by this office in writing within 15 calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.

The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative. Please be advised that authorized or delegated officials for groups cannot sign and submit a rebuttal on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

If the provider/supplier wishes to appoint a legal representative that is not an attorney to sign the rebuttal, the provider/supplier must include with the rebuttal a written notice authorizing the legal representative to act on the provider/supplier's behalf. The notice should be signed by the provider/supplier.

If the provider/supplier has an attorney sign the rebuttal, the rebuttal must include a statement from the attorney that *the attorney has* the authority to represent the provider/supplier.

If you wish to receive communication regarding your rebuttal via email, please include a valid email address in your rebuttal submission.

The rebuttal should be sent to the following:

[Contractor Rebuttal Receipt Address]
[Contractor Rebuttal Receipt Email Address]
[Contractor Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM ET/CT/MT/PT] and [x:00 AM/PM ET/CT/MT/PT].

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

Q. Applicable SOG Location E-mail Boxes

CMS Locations Corporate Email Addresses		
CMS LOCATION	**BRANCH**	**EMAIL Address**
CMS Boston Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	ACC & LTC	BostonRO-DSC@cms.hhs.gov
CMS Philadelphia Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia	ACC & LTC	ROPHIDSC@cms.hhs.gov
CMS New York New Jersey, New York, Puerto Rico, Virgin Islands	ACC & LTC	RONYdsc@cms.hhs.gov
CMS Atlanta Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	ACC & LTC	ROATLHSQ@cms.hhs.gov
CMS Chicago Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	ACC & LTC	ROCHISC@cms.hhs.gov
CMS Kansas City	ACC & LTC	ROkcmSCB@cms.hhs.gov

Iowa, Kansas, Missouri, Nebraska		
CMS Denver	ACC & LTC	CMSKC_DEN_SOG@cms.hhs.gov
Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming		
CMS Dallas	ACC & LTC	RODALDSC@cms.hhs.gov
Arkansas, Louisiana, New Mexico, Oklahoma, Texas		
CMS San Francisco	ACC & LTC	ROSFOSO@cms.hhs.gov
Arizona, California, Hawaii, Nevada, Pacific Territories		
CMS Seattle	ACCB	CMS_RO10_CEB@cms.hhs.gov
Alaska, Idaho, Oregon, Washington	LTC	Seattle_LTC@cms.hhs.gov

10.7.6 – Part B Non-Certified Provider and Supplier Approval Letter Templates

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Approval – Change of Information (Part B Sole Proprietor)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] has approved your Change of Information (COI) application.

Medicare Enrollment Information

Individual Name	
Individual Specialty	
Individual National Provider Identifier (NPI)	
Individual Provider Transaction Access Number (PTAN)	

Changed Information	

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

You must include your NPI, as the billing and rendering provider, on all Medicare claim submissions.

Contact our electronic data interchange (EDI) department for enrollment and further instructions on electronic claims filing at [phone number].

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR §424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

B. Approval – Change of Information (Part B Physician Assistant)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] has approved your Change of Information (COI) application.

Medicare Enrollment Information

Individual Name	
Individual Specialty	Physician Assistant
Individual National Provider Identifier (NPI)	
Individual Provider Transaction Access Number (PTAN)	
Individual PTAN Effective Date	
Employer Legal Business Name (LBN)	
Employer National Provider Identifier (NPI)	
Employer Provider Transaction Access Number (PTAN)	
Changed Information	

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

You must include your NPI, as the rendering provider, on all Medicare claims submissions.

Contact our electronic data interchange (EDI) department for enrollment and further instructions on electronic claims filing at [phone number].

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR §424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

C. Approval – Change of Information (Part B Org or Part B Sole Owner)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] has approved your Change of Information (COI) application.

Medicare Enrollment Information

Legal Business Name (LBN)	
Doing Business As (DBA)	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Changed Information	

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Contact our electronic data interchange (EDI) department for enrollment and further instructions on electronic claims filing at [phone number].

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at [42 CFR §424.516 or 42 CFR§424.205]. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

D. Approval – Change of Information (Part B Reassignment for Existing Physician or Non-Physician Practitioner)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] has approved your Change of Information (COI) application.

Medicare Enrollment Information

Individual Name	
Individual Specialty	
Individual National Provider Identifier (NPI)	
Individual Provider Transaction Access Number (PTAN)	
Group Legal Business Name (LBN)	
Group NPI	
Group PTAN	
Reassignment Effective Date	
Changed Information	

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

You must include your NPI, as the rendering provider, on all Medicare claim submissions.

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR §424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

E. Approval – Change of Information (Part B Reassignment to CAH)

[Month, Day, Year]

[Provider/Supplier Name]

[Address]
[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] has approved your Change of Information (COI) application.

Medicare Enrollment Information

Individual Name	
Individual Specialty	
Individual National Provider Identifier (NPI)	
Provider/Supplier Legal Business Name (LBN)	
Provider/Supplier Type	Critical Access Hospital (CAH)
Provider/Supplier NPI	
Provider/Supplier PTAN	
Reassignment Effective Date	
Changed Information	

This action establishes a relationship between the above named individual and the Critical Access Hospital (CAH) facility, in PECOS, for enrollment purposes only. This does not constitute approval of the election of this facility or individual for Method II Billing, as identified in Section 1834(g)(2) of the Act.

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR §424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

F. Approval – Initial/Reactivation Reassignment (Part B CAH)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] approved your [initial or reactivation] enrollment application.

Medicare Enrollment Information

Individual Name	
Individual Specialty	
Individual National Provider Identifier (NPI)	
Provider/Supplier Legal Business Name (LBN)	
Provider/Supplier Type	Critical Access Hospital (CAH)
Provider/Supplier NPI	
Provider/Supplier PTAN	
Reassignment Effective Date	

This action establishes a relationship between the above named individual and the Critical Access Hospital (CAH) facility, in PECOS, for enrollment purposes only. This does not constitute approval of the election of this facility or individual for Method II Billing, as identified in Section 1834(g)(2) of the Act.

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR §424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney has* the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Name of MAC]
[Address]
[City], ST [Zip]

Or emailed to:

[Insert MAC email address]

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

G. Approval – Initial/Reactivation (Part B Order and Certify)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] approved your [initial or reactivation] enrollment application to solely order and certify items and services for Medicare beneficiaries. You may not send billed services claims to [Insert Contractor].

Medicare Enrollment Information

Individual Name	
Individual Specialty	
Individual National Provider Identifier (NPI)	
Effective Date	

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR §424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney has* the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Name of MAC]
[Address]
[City], ST [Zip]

Or emailed to:

[Insert MAC email address]

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

H. Approval – Change of Information (Part B Order and Certify)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] has approved your Change of Information (COI) application.

Medicare Enrollment Information

Individual Name	
Individual Specialty	
Individual National Provider Identifier (NPI)	
Changed Information	

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR §424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

I. Approval – Initial/Reactivation (Part B Org)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] approved your [initial or reactivation] enrollment application.

Medicare Enrollment Information

Legal Business Name (LBN)	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
PTAN Effective Date	
Participation Status	

Include if applicable: [While your PTAN(s) and effective date(s) remain the same, you will have a gap in billing privileges from [deactivation date] through [reactivation date] for failing to fully revalidate during a previous revalidation cycle. You will not be reimbursed for services provided to Medicare beneficiaries during this time period since you were not in compliance with Medicare requirements.]

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Contact our electronic data interchange (EDI) department for enrollment and further instructions on electronic claims filing at [phone number].

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at [42 CFR §424.516 or 42 CFR§424.205]. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

[Name of MAC]
[Address]
[City], ST [Zip]

or

[Centers for Medicare & Medicaid Services]
[Center for Program Integrity]
[Provider Enrollment & Oversight Group]
[ATTN: Division of Provider Enrollment Appeals]
[7500 Security Blvd.]
[Mailstop: AR-19-51]
[Baltimore, MD 21244-1850]

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

J. Approval – Initial/Reactivation (Part B Physician Assistant)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] approved your [initial or reactivation] enrollment application.

Medicare Enrollment Information

Individual Name	
Individual Specialty	Physician Assistant
Individual National Provider Identifier (NPI)	
Individual Provider Transaction Access Number (PTAN)	
Individual PTAN Effective Date	
Employer Legal Business Name (LBN)	
Employer National Provider Identifier (NPI)	
Employer Provider Transaction Access Number (PTAN)	

Include if applicable: [While your PTAN(s) and effective date(s) remain the same, you will have a gap in billing privileges from [deactivation date] through [reactivation date] for failing to fully revalidate during a previous revalidation cycle. You will not be reimbursed for services provided to Medicare beneficiaries during this time period since you were not in compliance with Medicare requirements.]

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Contact our electronic data interchange (EDI) department for enrollment and further instructions on electronic claims filing at [phone number].

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR §424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the

provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Name of MAC]
[Address]
[City], ST [Zip]

Or emailed to:

[Insert MAC email address]

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

K. Approval – Initial/Reactivation (Part B Sole Owner)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] approved your [initial or reactivation] enrollment application.

Medicare Enrollment Information

Individual Name	
Individual Specialty	
Individual National Provider Identifier (NPI)	
Individual Provider Transaction Access Number (PTAN)	
Individual PTAN Effective Date	
Group Legal Business Name (LBN)	
Group Specialty	
Group NPI	
Group PTAN	
Group PTAN Effective Date	
Participation Status	

Include if applicable: [While your PTAN(s) and effective date(s) remain the same, you will have a gap in billing privileges from [deactivation date] through [reactivation date] for failing to fully revalidate during a previous revalidation cycle. You will not be reimbursed for services provided to Medicare beneficiaries during this time period since you were not in compliance with Medicare requirements.]

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

You must include the individual provider's NPI as the rendering provider and the organizational provider's NPI as the billing provider on all Medicare claim submissions.

Contact our electronic data interchange (EDI) department for enrollment and further instructions on electronic claims filing at [phone number].

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR §424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Name of MAC]
[Address]

[City], ST [Zip]

Or emailed to:

[Insert MAC email address]

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

L. Approval – Initial/Reactivation (Part B Sole Proprietor)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] approved your [initial or reactivation] enrollment application.

Medicare Enrollment Information

Individual Name	
Individual Specialty	
Individual National Provider Identifier (NPI)	
Individual Provider Transaction Access Number (PTAN)	
PTAN Effective Date	
Participation Status	

Include if applicable: [While your PTAN(s) and effective date(s) remain the same, you will have a gap in billing privileges from [deactivation date] through [reactivation date] for failing to fully revalidate during a previous revalidation cycle. You will not be reimbursed for services provided to Medicare beneficiaries during this time period since you were not in compliance with Medicare requirements.]

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

You must include your NPI, as the billing and rendering provider, on all Medicare claim submissions.

Contact our electronic data interchange (EDI) department for enrollment and further instructions on electronic claims filing at [phone number].

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR §424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing

Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.

- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Name of MAC]
[Address]
[City], ST [Zip]

Or emailed to:

[Insert MAC email address]

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

M. Approval – Initial/Reactivation with Reassignment (Part B Ind)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] approved your [initial or reactivation] enrollment and reassignment application(s).

Medicare Enrollment Information

Individual Name	
Individual Specialty	
Individual National Provider Identifier (NPI)	
Individual Provider Transaction Access Number (PTAN)	
Group Legal Business Name (LBN)	
Group NPI	
Group PTAN	
Reassignment Effective Date	

Include if applicable: [While your PTAN(s) and effective date(s) remain the same, you will have a gap in billing privileges from [deactivation date] through [reactivation date] for failing to fully revalidate during a previous revalidation cycle. You will not be reimbursed for services provided to Medicare beneficiaries during this time period since you were not in compliance with Medicare requirements.]

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.
You must include your NPI, as the billing and rendering provider, on all Medicare claim submissions.

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR §424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.

- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Name of MAC]
[Address]
[City], ST [Zip]

Or emailed to:

[Insert MAC email address]

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

N. Approval – Revalidation (Part B Ind with Reassignment)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] has approved your revalidation application.

Medicare Enrollment Information

Individual Name	
Individual Specialty	
Individual National Provider Identifier (NPI)	
Individual Provider Transaction Access Number (PTAN)	
Group Legal Business Name (LBN)	
Group NPI	
Group PTAN	
PTAN Effective Date	
Changed Information	

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR §424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Name of MAC]
[Address]
[City], ST [Zip]

Or emailed to:

[Insert MAC email address]

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

O. Approval – Revalidation (Part B Sole Proprietor)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] approved your revalidation enrollment application.

Medicare Enrollment Information

Individual Name	
Individual Specialty	
Individual National Provider Identifier (NPI)	
Individual Provider Transaction Access Number (PTAN)	
PTAN Effective Date	
Changed Information	

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR §424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Name of MAC]

[Address]
[City], ST [Zip]

Or emailed to:

[Insert MAC email address]

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

P. Approval – Revalidation (Part B Physician Assistant)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] has approved your revalidation application.

Medicare Enrollment Information

Individual Name	
Individual Specialty	Physician Assistant
Individual National Provider Identifier (NPI)	
Individual Provider Transaction Access Number (PTAN)	
Individual PTAN Effective Date	
Employer Legal Business Name (LBN)	
Employer National Provider Identifier (NPI)	
Employer Provider Transaction Access Number (PTAN)	
Changed Information	

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR §424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.

- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Name of MAC]
[Address]
[City], ST [Zip]

Or emailed to:

[Insert MAC email address]

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

Q. Approval – Revalidation (Part B Non-Certified Org or Part B Sole Owner)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] has approved your revalidation application.

Medicare Enrollment Information

Legal Business Name (LBN)	
Doing Business As (DBA)	
Provider/Supplier Type	
Provider/Supplier National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	

PTAN Effective Date	
Changed Information	

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at [42 CFR §424.516 or 42 CFR§424.205]. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

[Name of MAC]		[Centers for Medicare & Medicaid Services]
[Address]		[Center for Program Integrity]
[City], ST [Zip]	or	[Provider Enrollment & Oversight Group]
		[ATTN: Division of Provider Enrollment Appeals]
		[7500 Security Blvd.]
		[Mailstop: AR-19-51]
		[Baltimore, MD 21244-1850]

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

R. Approval – Voluntary Termination (Part B Sole Proprietor)

[Month, Day, Year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] completed your application to disenroll from the Medicare program.

Medicare Enrollment Information

Individual Name	
Individual Specialty	
Individual National Provider Identifier (NPI)	
Individual Provider Transaction Access Number (PTAN)	
Effective Date of Termination	

Medicare will not reimburse you for any claims with dates of service on or after your effective date of termination.

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

S. Approval – Voluntary Termination (Part B Physician Assistant)

[Month, Day, Year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] completed your application to disenroll from the Medicare program.

Medicare Enrollment Information

Individual Name	
Individual Specialty	Physician Assistant
Individual National Provider Identifier (NPI)	
Individual Provider Transaction Access Number (PTAN)	

Employer Name	
Employer National Provider Identifier (NPI)	
Employer Provider Transaction Access Number (PTAN)	
Effective Date of Termination	

Medicare will not reimburse you for any claims with dates of service on or after your effective date of termination.

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

T. Approval – Termination of Reassignment (Part B Ind)

[Month, Day, Year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] completed your application to disenroll from the Medicare program.

Medicare Enrollment Information

Individual Name	
Individual Specialty	
Individual National Provider Identifier (NPI)	
Individual Provider Transaction Access Number (PTAN)	
Group Name	
Group National Provider Identifier (NPI)	
Group Provider Transaction Access Number (PTAN)	
Effective Date of Termination	

Medicare will not reimburse you for any claims with dates of service on or after your effective date of termination.

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

U. Approval – Termination of Reassignment (Part B CAH)

[Month, Day, Year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] completed your application to disenroll from the Medicare program.

Medicare Enrollment Information

Individual Name	
Individual Specialty	
Individual National Provider Identifier (NPI)	
Provider/Supplier Legal Business Name (LBN)	
Provider/Supplier Type	Critical Access Hospital (CAH)
Provider/Supplier NPI	
Provider/Supplier PTAN	
Effective Date of Termination	

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

V. Approval – Voluntary Termination (Part B Non-Certified Org or Part B Sole Owner)

[Month, Day, Year]

[Provider/Supplier Name]
[Address]

[City] ST [Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] completed your application to disenroll from the Medicare program.

Medicare Enrollment Information

Legal Business Name (LBN)	
Doing Business As (DBA)	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Effective Date of Termination	

Reassignments and any physician assistant employment arrangements are also deactivated.

Medicare will not reimburse you for any claims with dates of service on or after your effective date of termination.

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

10.7.8 – Denial Model Letters

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Denial Letter Guidance

The contractor must submit one or more of the denial citations as found in Section 10.4.2 et seq. of this chapter into the appropriate section on the Model Denial Letter. Only the CFR citation and a short heading shall be cited for the primary denial reason.

- The contractor may submit one or more denial reason, as appropriate. The denial reason(s) should state sufficient details so it is clear as to why the provider or supplier is being denied.

- Specific Denial Reasons may contain one or more of the following items:

    - A specific regulatory (CFR) citation.

- Dates (of actions, suspensions, convictions, receipt of documents, etc.)
- Pertinent details of action(s)

DMEPOS supplier-only language. All denial letters for DMEPOS suppliers shall replace the 1st paragraph of the model denial letter with the following text:

Your application to enroll in Medicare is denied. After reviewing your submitted application document(s), it was determined that per 42 CFR § 405.800, 42 CFR § 424.57, and 42 CFR § 498.22, that you do not meet the conditions of enrollment or meet the requirements to qualify as a Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) provider or supplier for the following reason(s):

(Exclusions and sanctions – the following two sentences should be REMOVED for all denial letters that DO NOT involve an exclusion or sanction action:

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.)

For IDTF, DMEPOS, and MDPP providers and suppliers, each regulatory citation needs to be listed along with the specific regulatory language. For IDTF, the standards are found in 42 CFR § 410.33(g). For DMEPOS providers and suppliers, the standards are found in 42 CFR § 424.57(c)(1) through (30). For MDPP suppliers, the standards are found in 42 CFR § 424.205(d).

If a provider is being added to the CMS Preclusion List, the following should be inserted to the denial letter (should PEOG instruct the contractor to do so:

> The Centers for Medicare & Medicaid Services (CMS) has been made aware of [Provider Name]'s [Date], felony conviction, as defined in 42 C.F.R. § 1001.2, for [reason] in violation of [Code] in the Court Name]. After reviewing the specific facts and circumstances surrounding [Doe]'s felony conviction, CMS has determined that [Provider Name]'s felony conviction is detrimental to the best interests of the Medicare program and its beneficiaries.
>
> Additionally, [Provider Name] will be placed on the CMS Preclusion List because [*Provider Name*] has been convicted of a felony, as described above, under Federal or State law, within the previous 10 years, that CMS deems detrimental to the best interests of the Medicare program. CMS may take this action regardless of whether you are or were enrolled in the Medicare program. This action is being taken pursuant to 42 C.F.R. §§ 422.2, 422.222, 423.100, and 423.120(c)(6).
>
> The effective date of your inclusion on the Preclusion List is dependent upon the submission or non-submission of a reconsideration request (see below). If you do submit a reconsideration request and your inclusion on the Preclusion List is upheld, you will be added to the Preclusion List on the date of the reconsideration decision. If you do not submit a reconsideration request, you will be included on the Preclusion List 65 days after the date of this letter.

During the time period that your name will be included on the Preclusion List as listed above, any claims you submit for health care items or services furnished under a Medicare Advantage (MA) benefit may be denied. Additionally, any pharmacy claims submitted for Medicare Part D drugs that you prescribe may be rejected or denied. This means that your patients may not be able to receive coverage of their prescriptions using their Part D benefit at the pharmacy.

The below appeal rights apply to both your denial and preclusion. If you choose to appeal, you **must** file an appeal to the denial and preclusion jointly.

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination.

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.

- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

B. Model Denial Letter

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your application to enroll in Medicare is denied for the following reason(s):

xx CFR §xxx.(x) [heading]
[Specific reason]

xx CFR §xxx.(x) [heading]
[Specific reason]

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if denied under 42 C.F.R. § 424.530(a)(1))

You may submit a corrective action plan (CAP) in response to the denial of an enrollment application under 42 C.F.R. § 424.530(a)(1). You may also request a reconsideration (described below). If your enrollment application was denied under authorities other than 42 C.F.R. § 424.530(a)(1), you may **only** submit a reconsideration request in response to those denial bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to enroll in the Medicare program. (Optional Coversheet

sentence: [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]) The CAP must--

- Be received in writing within 35 calendar days of the date of this letter and mailed to the address below or emailed to the address below;
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney has* the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.
- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

Please note that CAPs may not be appealed further to the Departmental Appeals Board. Further appeal rights do exist for reconsideration requests (described below). CAP requests should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for reviewing the CAP)

[Name of MAC]
[Address]
[City], ST [Zip]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate

the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney has* the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If denied under 42 C.F.R. § 424.530(a)(2)) Please note that 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 a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

[Name of MAC]
[Address]
[City], ST [Zip]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

C. Denial Example Letters

Note that each example contains appeal rights for both CMS and the MAC, regardless of the example reason, so that the contractors may include the appropriate appeal address based on the provider or supplier type that has been denied.

1. Discipline Not Eligible Example

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your application to enroll in Medicare is denied for the following reason(s):

42 CFR §424.530(a)(1) – Not in Compliance with Medicare Requirements
There is no statutory or regulatory basis which permits a Marriage and Family Therapist to enroll or receive payment in the Medicare Program.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if denied under 42 C.F.R. § 424.530(a)(1))

You may submit a corrective action plan (CAP) in response to the denial of an enrollment application under 42 C.F.R. § 424.530(a)(1). You may also request a reconsideration (described below). If your enrollment application was denied under authorities other than 42 C.F.R. § 424.530(a)(1), you may **only** submit a reconsideration request in response to those denial bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to enroll in the Medicare program. (Optional Coversheet sentence: [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]) The CAP must--

- Be received in writing within 35 calendar days of the date of this letter and mailed to the address below or emailed to the address below;
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.
- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

Please note that CAPs may not be appealed further to the Departmental Appeals Board. Further appeal rights do exist for reconsideration requests (described below). CAP requests should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for reviewing the CAP)

[Name of MAC]
[Address]
[City], ST [Zip]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney has* the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If denied under 42 C.F.R. § 424.530(a)(2)) Please note that 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 a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

[Name of MAC]
[Address]
[City], ST [Zip]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,
[Name]

[Title]
[Company]

2. Criteria for Eligible Discipline Not Met Example

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your application to enroll in Medicare is denied for the following reason(s):

42 CFR §424.530(a)(1) - Not in Compliance with Medicare Requirements
Per 42 CFR §410.75(b)(1)(i), the provider or supplier is not certified by a recognized national certifying body that has established standards for nurse practitioners.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if denied under 42 C.F.R. § 424.530(a)(1))

You may submit a corrective action plan (CAP) in response to the denial of an enrollment application under 42 C.F.R. § 424.530(a)(1). You may also request a reconsideration (described below). If your enrollment application was denied under authorities other than 42 C.F.R. § 424.530(a)(1), you may **only** submit a reconsideration request in response to those denial bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to enroll in the Medicare program. (Optional Coversheet sentence: [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]) The CAP must--

- Be received in writing within 35 calendar days of the date of this letter and mailed to the address below or emailed to the address below;
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.
- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

Please note that CAPs may not be appealed further to the Departmental Appeals Board. Further appeal rights do exist for reconsideration requests (described below). CAP requests should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for reviewing the CAP)

[Name of MAC]
[Address]
[City], ST [Zip]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Provider Enrollment Appeals
7500 Security Boulevard

Mailstop AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If denied under 42 C.F.R. § 424.530(a)(2)) Please note that 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 a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

[Name of MAC]
[Address]
[City], ST [Zip]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,
[Name]

[Title]
[Company]

3. Provider Standards Not Met Example

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (Contractor Control Number or NPI)

Dear IDTF Services, Inc.:

Your application to enroll in Medicare is denied for the following reason(s):

42 CFR §424.530(a)(5) - On-site Review - Requirements Not Met

Specifically, the following standards were not met:

42 CFR §410.33(g) 4 - Have all applicable diagnostic testing equipment available at the physical site excluding portable diagnostic testing equipment. A catalog of portable diagnostic equipment, including diagnostic testing equipment serial numbers, must be maintained at the physical site. In addition, portable diagnostic testing equipment must be available for inspection within two business days of a CMS inspection request. The IDTF must maintain a current inventory of the diagnostic testing equipment, including serial and registration numbers, provide this information to the designated fee-for-service contractor upon request, and notify the contractor of any changes in equipment within 90 days.

42 CFR §410.33(g) 9 - Openly post these [IDTF] standards for review by patients and the public

42 CFR §410.33(g) 11 - Have its testing equipment calibrated and maintained per equipment instructions and in compliance with applicable manufacturers suggested maintenance and calibration standards.

42 CFR §410.33(g) 12 - Have technical staff on duty with the appropriate credentials to perform tests. The IDTF must be able to produce the applicable Federal or State licenses or certifications of the individuals performing these services.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if denied under 42 C.F.R. § 424.530(a)(1))

You may submit a corrective action plan (CAP) in response to the denial of an enrollment application under 42 C.F.R. § 424.530(a)(1). You may also request a reconsideration (described below). If your enrollment application was denied under authorities other than 42 C.F.R. § 424.530(a)(1), you may **only** submit a reconsideration request in response to those denial bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to enroll in the Medicare program. (Optional Coversheet sentence: [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]). The CAP must--

- Be received in writing within 35 calendar days of the date of this letter and mailed to the address below or emailed to the address below;
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.

- Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

Please note that CAPs may not be appealed further to the Departmental Appeals Board. Further appeal rights do exist for reconsideration requests (described below). CAP requests should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for reviewing the CAP)

[Name of MAC]
[Address]
[City], ST [Zip]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration

request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If denied under 42 C.F.R. § 424.530(a)(2)) Please note that 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 a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

[Name of MAC]
[Address]
[City], ST [Zip]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,
[Name]

[Title]
[Company]

4. Business Type Not Met Example

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:
Your application to enroll in Medicare is denied for the following reason(s):

42 CFR §424.530(a)(1) - Not in Compliance with Medicare Requirements
42 CFR §410.62(c)(ii) states that speech language pathologists in private practice must be engaged in one of the following practice types if allowed by State and local law: (A) An unincorporated solo practice; (B) An unincorporated partnership or unincorporated group practice; (C) An employee in an unincorporated solo practice, partnership, or group practice, or a professional corporation or other incorporated speech-language pathology practice; (D) An employee of a physician group (includes certain Non-Physician Practitioners [NPPs], as appropriate); or (E) An employee of a group that is not a professional corporation.

Your current private practice status is an incorporated solo practice; therefore, you do not qualify as a Medicare provider or supplier.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if denied under 42 C.F.R. § 424.530(a)(1))

You may submit a corrective action plan (CAP) in response to the denial of an enrollment application under 42 C.F.R. § 424.530(a)(1). You may also request a reconsideration (described below). If your enrollment application was denied under authorities other than 42 C.F.R. § 424.530(a)(1), you may **only** submit a reconsideration request in response to those denial bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to enroll in the Medicare program. (Optional Coversheet sentence: [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]). The CAP must--

- Be received in writing within 35 calendar days of the date of this letter and mailed to the address below or emailed to the address below;
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

- If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
- If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
- Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

Please note that CAPs may not be appealed further to the Departmental Appeals Board. Further appeal rights do exist for reconsideration requests (described below). CAP requests should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for reviewing the CAP)

[Name of MAC]
[Address]
[City], ST [Zip]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

- If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
- If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
- Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If denied under 42 C.F.R. § 424.530(a)(2)) Please note that 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 a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

[Name of MAC]
[Address]
[City], ST [Zip]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,
[Name]

[Title]
[Company]

5. Existing or Delinquent Overpayments Example

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your application to enroll in Medicare is denied for the following reason(s):

42 CFR §424.530(a)(6) – Existing Overpayment at Time of Application

The current owner (as defined in § 424.502), physician or non-physician practitioner has an existing overpayment at the time of filing an enrollment application.

Dates: (enter date of existing or delinquent overpayment period)

Pertinent details of action(s) (Whether the person or entity is on a Medicare-approved plan of repayment of payments are currently being offset: Whether the overpayment is currently being appealed; the reason for the overpayment)

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if denied under 42 C.F.R. § 424.530(a)(1))

You may submit a corrective action plan (CAP) in response to the denial of an enrollment application under 42 C.F.R. § 424.530(a)(1). You may also request a reconsideration (described below). If your enrollment application was denied under authorities other than 42 C.F.R. § 424.530(a)(1), you may **only** submit a reconsideration request in response to those denial bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to enroll in the Medicare program. (Optional Coversheet sentence: [To facilitate the processing of your CAP, please utilize and include the [attached]

coversheet [also found at [[insert web address for coversheet]] with your submission.]). The CAP must--

- Be received in writing within 35 calendar days of the date of this letter and mailed to the address below or emailed to the address below;
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney has* the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.
- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

Please note that CAPs may not be appealed further to the Departmental Appeals Board. Further appeal rights do exist for reconsideration requests (described below). CAP requests should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for reviewing the CAP)

[Name of MAC]
[Address]
[City], ST [Zip]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If denied under 42 C.F.R. § 424.530(a)(2)) Please note that 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 a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

[Name of MAC]
[Address]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity

[City], ST [Zip]

Provider Enrollment & Oversight Group
Attn: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,
[Name]

[Title]
[Company]

6. MDPP Supplier Standards Not Met – Ineligible Coach Example

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your application to enroll in Medicare is denied for the following reason(s):
42 CFR §424.530(a)(1) - Not in Compliance with Medicare Requirements

Specifically, the following standards were not met:

42 CFR §424.205(d)(3) - The MDPP supplier must not include on the roster of coaches nor permit MDPP services to be furnished by any individual coach who meets any of ineligibility criteria.
42 CFR §424.205(e)(v)(a) specifies that an individual with a state or federal felony conviction in the previous 10 years of any crime against persons, such as murder, rape, assault, and other similar crimes, would not meet the eligibility criteria to be an MDPP coach.

The following coach included on Section 7 of your Form CMS-20134 or its electronic equivalent meets this ineligibility criteria:

B. Doe | DOB: June 19, 1991 | NPI: 1234567

Please see attached documentation of the felony conviction.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if denied under 42 C.F.R. § 424.530(a)(1))

You may submit a corrective action plan (CAP) in response to the denial of an enrollment application under 42 C.F.R. § 424.530(a)(1). You may also request a reconsideration (described below). If your enrollment application was denied under authorities other than 42 C.F.R. § 424.530(a)(1), you may **only** submit a reconsideration request in response to those denial bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to enroll in the Medicare program. (Optional Coversheet sentence: [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]). The CAP must--

- Be received in writing within 35 calendar days of the date of this letter and mailed to the address below or emailed to the address below;
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.
- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

Please note that CAPs may not be appealed further to the Departmental Appeals Board. Further appeal rights do exist for reconsideration requests (described below). CAP requests should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for reviewing the CAP)

[Name of MAC]
[Address]
[City], ST [Zip]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Provider Enrollment Appeals
7500 Security Boulevard

Mailstop AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If denied under 42 C.F.R. § 424.530(a)(2)) Please note that 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 a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

[Name of MAC]
[Address]
[City], ST [Zip]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,
[Name]

[Title]
[Company]

10.7.9 – Revocation Letters

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Revocation Letter Guidance

The contractor--

- Must submit one or more of the Primary Revocation Reasons as found in section 10.4.7.3 into the appropriate section on the specific Revocation Letter. Only the CFR citation and a short heading shall be cited for the primary revocation reason.

- Shall include sufficient details to support the reason for the provider or supplier's revocation;

- Shall issue all revocation letters via certified letter, per regulations found in 42 CFR 405.800(b)(1); and

- Shall issue two revocation letters to any solely owned organizations, one for the individual and the other for the organization.

B. Model Revocation Letters

1. Revocation Example - Letter for DMEPOS Suppliers

[month] [day], [year]

[Supplier Name]
[Address]
[City] ST [Zip]

Reference # (PTAN #, Enrollment #, Case #, etc.)

Certified mail number: [number]
Returned receipt requested

Dear [Supplier Name]:

The purpose of this letter is to inform you that pursuant to 42 CFR §§ 405.800, 424.57(x), 424.535(g), and 424.535(a)[(x)], your Medicare supplier number [xxxxxxxxxx], Medicare enrollment, and Medicare billing privileges for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS),

[will be revoked effective 30 days from the postmarked date of this letter]

[are revoked. The effective date of this revocation has been made retroactive to [month] [day], [year], which is the date [revocation reason]]

[The Supplier Audit and Compliance Unit (SACU) reviewed and evaluated the documents you submitted in response to the developmental letter dated [date]. This letter allowed you to demonstrate your full compliance with the DMEPOS supplier standards and/or to correct the deficient compliance requirement(s).]

[The Supplier Audit and Compliance Unit (SACU) has not received a response to the developmental letter sent to you on [date]. This letter allowed you to demonstrate your full compliance with the DMEPOS supplier standards and/or to correct the deficient compliance requirement(s)]

[[Contractor Name] has not received a response to the developmental letter sent to you on [date] informing you that the request for a hardship exception for the required application fee was denied. The notification afforded you the opportunity to pay the mandatory application fee for processing your enrollment application and an appeal period which you did not select.]

[[Contractor Name] has not received a response to the developmental letter sent to you on [date] informing you that the application fee was not paid at the time you filed the Form CMS-855S enrollment application. The 30-day notification afforded you the opportunity to pay the mandatory application fee for processing your enrollment application]

We have determined that you are not in compliance with the supplier standards noted below:

42 CFR §424.57(c) [1-30] [Insert the specific performance standard not met]

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)(A)(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 money penalties.

Pursuant to 42 CFR § 424.535(c), you are barred from reenrolling in the Medicare program for a period of [number of years] year(s) from the effective date of the revocation. To reenroll after the reenrollment bar has expired, you must meet all requirements for your supplier type. In addition, if submitting a Form CMS-855S application after the reenrollment bar's expiration, 42 C.F.R. § 424.57(d)(3)(ii) states that suppliers are required to maintain an elevated surety bond amount of $50,000 for each final adverse action (which includes a Medicare revocation) imposed. Therefore, if you do not request a reconsideration of this revocation decision or receive an unfavorable decision through the administrative review process, you must submit an elevated surety bond with any application to reenroll in Medicare. Please note that this amount is in addition to, and not in lieu of, the base $50,000 amount that must be maintained.

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.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if revoked under 42 C.F.R. § 424.535(a)(1))

You may submit a corrective action plan (CAP) in response to an enrollment revocation under 42 C.F.R. § 424.535(a)(1). You may also request a reconsideration (described below). If your enrollment was revoked under authorities other than 42 C.F.R. § 424.535(a)(1), you may **only** submit a reconsideration request in response to those revocation bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to enroll in the Medicare program. (Optional Coversheet sentence: [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]). The CAP must--

- Be received in writing within 35 calendar days of the date of this letter and mailed to the address below or emailed to the address below;
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.
- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

Please note that CAPs may not be appealed further to the Departmental Appeals Board. Further appeal rights do exist for reconsideration requests (described below). CAP requests should be sent to:

Chags Health Information
Technology LLC
P.O. Box 45266
Jacksonville, FL 32232

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

[PEARC@c-hit.com] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If revoked under 42 C.F.R. § 424.535(a)(2)) Please note that 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 a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

(Insert correct address based on whether C-HIT or CMS is responsible for handling the reconsideration.

Chags Health Information Technology LLC
P.O. Box 45266
Jacksonville, FL 32232

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Provider Enrollment Appeals

7500 Security Boulevard
Mailstop AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

[PEARC@c-hit.com] or [ProviderEnrollmentAppeals@cms.hhs.gov]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

2. Model Revocation Letter for Part B Suppliers and Certified Providers and Suppliers

[Month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your Medicare enrollment and Medicare billing privileges are being revoked effective [Date of revocation] for the following reasons:

xx CFR §xxx.(x) [heading]
[Specific reason]

xx CFR §xxx.(x) [heading]
[Specific reason]

(For certified providers and certified suppliers only: Pursuant to 42 CFR §424.535(b), this action will also terminate your corresponding (provider or supplier) agreement.)

Pursuant to 42 CFR §424.535(c), CMS is establishing a re-enrollment bar for a period of [Insert amount of time] that shall begin 30 days after the postmark date of this letter. This re-enrollment bar only applies to your ability to submit a new enrollment application to the Medicare program. In order to re-enroll, you must meet all requirements for your provider or supplier type.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if revoked under 42 C.F.R. § 424.535(a)(1))

You may submit a corrective action plan (CAP) in response to the revocation of Medicare billing privileges under 42 C.F.R. § 424.535(a)(1). You may also request a reconsideration (described below). If your Medicare billing privileges were revoked under authorities other than 42 C.F.R. § 424.535(a)(1), you may **only** submit a reconsideration request in response to those revocation bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to maintain enrollment in the Medicare program. (Optional Coversheet sentence [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]). The CAP must--

- Be received in writing within 35 calendar days of the date of this letter and mailed or emailed to the address below;

- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.

    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.

    - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

        - Provide evidence to demonstrate that you are in compliance with Medicare requirements.

(Insert correct address based on whether the MAC or CMS is responsible for reviewing the CAP)

The CAP should be sent to:

[Name of MAC]
[Address]
[City], [ST] [Zip]

Or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop AR-19-51

Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If revoked under 42 C.F.R. § 424.535(a)(2)) Please note that 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 a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

[Name of MAC]
[Address]
[City], [ST] [Zip]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

C. Revocation Letter Examples

Note that each example contains instructions to send appeals to both CMS and the contractor, regardless of the example reason, so that the contractors may include the appropriate appeal address based on the provider or supplier type that has been revoked. In addition, note that the section advising the provider/supplier of the right to submit a CAP are only included in the examples of revocations based on 42 C.F.R. § 424.535(a)(1).

1. Abuse of Billing Revocation Letter Example

[month] [day], [year]

[Entity name]
[Address]
[City, State & ZIP Code]

Reference # (PTAN #, Enrollment #, Case #, etc.)

Dear [Provider/Supplier Name]:

Your Medicare enrollment and Medicare billing privileges are being revoked effective June 16, 2022 for the following reasons:

Revocation reason: 42 CFR § 424.535(a)(8)

Specifically, you submitted 186 claims to Medicare for services provided after the date of death of 15 beneficiaries.

Pursuant to 42 CFR §424.535(c), CMS is establishing a re-enrollment bar for a period of [Insert amount of time] that shall begin 30 days after the postmark date of this letter. This re- enrollment bar only applies to your ability to submit a new enrollment application to the Medicare program. In order to re-enroll, you must meet all requirements for your provider or supplier type.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If revoked under 42 C.F.R. § 424.535(a)(2)) Please note that 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 a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

[Name of MAC]
[Address]
[City], [ST] [Zip]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

2. DMEPOS Supplier Revocation Letter Example

[month] [day], [year]

[Entity name]
[Address]
[City], [ST] [Zip]

Reference #: [PTAN #, Enrollment #, Case #, etc.]
NPI: [xxxxxxxxxx]

Dear [Supplier Name]:

The purpose of this letter is to inform you that pursuant to 42 C.F.R. § 405.800, 42 C.F.R. §424.57(e), and 42 C.F.R. § 424.535(a)(5), your Medicare supplier number [xxxxxxxxxx], Medicare enrollment, and Medicare billing privileges for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) issued by [Contractor name) is revoked. The effective date of this revocation has been made retroactive to April 26, 2012, which is the date the Centers for Medicare & Medicaid Services (CMS) determined that your practice location is not operational.

We have determined that you are not in compliance with the supplier standards noted below:

42 C.F.R. § 424.57(c)(7) Maintain a physical facility on an appropriate site, accessible to the public and staffed during posted hours of business with visible signage.

Recently a representative of [Contractor name] attempted to conduct a visit of your facility on April 26, 2012. However, the visit was unsuccessful because your facility was closed, locked, and vacant. There was a "For Rent" sign on the window along with a sign directing customers to a nearby Rite Aid Pharmacy. Because we could not complete an inspection of your facility, we could not verify your compliance with the supplier standards. Based on a review of the facts, we have determined that your facility is not operational to furnish Medicare covered items and services. Thus, you are in violation of 42 CFR § 424.535(a)(5).

42 C.F.R. § 424.57(c)(26) must meet the surety bond requirements specified in 42 C.F.R. § 424.57(d).

We received a cancellation notice from Cook, Books & Hyde Surety indicating that the surety bond on file with the billing number 99999999 has been cancelled effective January 19, 2012. You failed to maintain a valid surety bond as required by law.

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 sections 1834(j)(4) and 1879(h) of the Social Security Act, you may be liable for Civil Monetary penalties.

(Delete the following paragraph if no reenrollment bar established.)[Pursuant to 42 C.F.R. § 424.535(c), CMS is establishing a reenrollment bar for a period of [Insert amount of time] that shall begin 30 days after the postmark date of this letter. This reenrollment bar only applies to your ability to submit a new enrollment application to the Medicare program. In order to reenroll, you must meet all requirements for your provider or supplier type.]

In addition, if submitting a Form CMS-855S application after the reenrollment bar's expiration, 42 C.F.R. § 424.57(d)(3)(ii) states that suppliers are required to maintain an elevated surety bond amount of $50,000 for each final adverse action (which includes a Medicare revocation) imposed. Therefore, if you do not request a reconsideration of this revocation decision or receive an unfavorable decision through the administrative review process, you must submit an elevated surety bond with any application to reenroll in Medicare. Please note that this amount is in addition to, and not in lieu of, the base $50,000 amount that must be maintained.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the implementation of the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the attached coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement *that the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

(Insert correct address based on whether the C-HIT or CMS is responsible for handling the reconsideration.

Chags Health Information
Technology LLC
P.O. Box 45266
Jacksonville, FL 32232

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

[PEARC@c-hit.com] or [ProviderEnrollmentAppeals@cms.hhs.gov]

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] years before resubmitting your CMS-855S application, per the re-enrollment bar cited above. Applications received by [Contractor name] prior to this timeframe will be returned.

If you have any questions, please contact our office at [Contractor call center phone number] between the hours of [x:00 AM/PM ET/CT/PT/MT] and [x:00 AM/PM ET/CT/PT/MT].

Sincerely,

[Name]
[Title]
[Company]

3. MDPP Supplier Use of an Ineligible Coach Revocation Letter Example

[month] [day], [year]

[Entity name]
[Address]
[City, State & ZIP Code]

Reference # (PTAN #, Enrollment #, Case #, etc.)

Dear [MDPP Supplier Name]:

Your Medicare enrollment and Medicare billing privileges are being revoked effective June 16, 2018 for the following reasons:

Revocation reason: 42 CFR §424.535(a)(1) – Not in Compliance with Medicare Requirements

Per 42 CFR §424.205(d)(3), MDPP suppliers must only use eligible coaches.

Revocation reason: 42 CFR §424.205(h)(v) – Use of an Ineligible coach

Specifically, you were notified on April 1, 2018 that Doe was ineligible to serve as an MDPP coach due to an assault conviction in June 2015. On April 15, 2018, you submitted a corrective action plan (CAP), which removed Doe from Section 7 of your Form CMS-20134. On June 1, 2018, you submitted a claim with the NPI of Doe for services rendered May 1st, after *Doe* was removed from your coach roster. This indicates knowingly use of an ineligible MDPP coach.

Revocations under 42 CFR §424.205(h)(v) are not eligible for CAP submission. The revocation becomes effective 30 days after the date of this notice.

Pursuant to 42 CFR §424.535(c), CMS is establishing a re-enrollment bar for a period of [Insert amount of time] that shall begin 30 days after the postmark date of this letter. This re- enrollment bar only applies to your ability to submit a new enrollment application to the Medicare program. In order to re-enroll, you must meet all requirements for your provider or supplier type.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if revoked under 42 C.F.R. § 424.535(a)(1))

You may submit a corrective action plan (CAP) in response to the revocation of Medicare billing privileges under 42 C.F.R. § 424.535(a)(1). You may also request a reconsideration (described below). If your Medicare billing privileges were revoked under authorities other than 42 C.F.R. § 424.535(a)(1), you may **only** submit a reconsideration request in response to those revocation bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to maintain enrollment in the Medicare program.

(Optional Coversheet sentence [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]) The CAP must--

- Be received in writing within 35 calendar days of the date of this letter and mailed or emailed to the address below;

- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

  - If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.

  - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.

  - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

(Insert correct address based on whether the MAC or CMS is responsible for reviewing the CAP)

[Name of MAC]
[Address]
[City], [ST] [Zip]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must--

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

    - If the authorized representative is an attorney, the attorney's statement *that the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If revoked under 42 C.F.R. § 424.535(a)(2)) Please note that 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 a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

[Name of MAC] [Address] [City], [ST] [Zip]	or	Centers for Medicare & Medicaid Services Center for Program Integrity Provider Enrollment & Oversight Group

Attn: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

10.7.10 – Corrective Action Plan (CAP) Model Letters

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. CAP Withdrawn Acknowledgement Template

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

1. Email Template

To: [Email address provided by the person who submitted the CAP]
Subject: Medicare Provider Enrollment CAP re: [Provider/Supplier Name]
Dear [Name of the person(s) who submitted the CAP]:
We are in receipt of your written withdrawal request in regard to your corrective action plan (CAP) received on [Month] [DD], [YYYY]. [MAC Name] has not yet issued a decision regarding your CAP. Therefore, [MAC Name] considers your CAP dated [Month] [DD], [YYYY] to be withdrawn. As a result, a decision will not be issued in response to your CAP.

If you have not yet filed a reconsideration request, please be advised that failure to timely submit a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,
[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

2. Hard-Copy Letter Template

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of CAP]
[Address] (Address from which the CAP was sent)
[City], [State] [Zip Code]

Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the CAP]:

We are in receipt of your written withdrawal request in regard to your corrective action plan (CAP) received on [Month] [DD], [YYYY]. [MAC Name] has not yet issued a decision regarding your CAP. Therefore, [MAC Name] considers your CAP dated [Month] [DD], [YYYY] to be withdrawn. As a result, a decision will not be issued in response to your CAP.

If you have not yet filed a reconsideration request, please be advised that failure to timely submit a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,
[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

B. CAP Receipt Acknowledgement Email Template to Provider/Supplier/ Representative

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

1. Email Template

To: [Email address provided by the person who submitted the CAP]
Subject: Medicare Provider Enrollment CAP re: [Provider/Supplier Name]
Dear [Name of the person(s) who submitted the CAP]:
We are in receipt of your corrective action plan (CAP) on behalf of [Provider/Supplier Name]. Please be advised that [MAC Name] has 60 calendar days to review your CAP and render a decision.

If you have additional information that you would like a hearing officer to consider during the CAP review, you must submit that information prior to a decision being issued.

Please be advised that failure to timely submit a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely

,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

2. Hard-Copy Letter Template

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of CAP]
[Address] (Address from which the CAP was sent)
[City], [State] [Zip Code]

Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the CAP]:

We are in receipt of your corrective action plan (CAP) on behalf of [Provider/Supplier Name]. Please be advised that [MAC Name] has 60 calendar days to review your CAP and render a decision.

If you have additional information that you would like a hearing officer to consider during the CAP review you must submit that information prior to a decision being issued.

Please be advised that failure to timely submit a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,
[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

C. CAP Decision Email Template to Provider/Supplier/Representative

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the CAP]
Subject: Medicare Provider Enrollment CAP re: [Provider/Supplier Name]
(Be sure to attach a copy of the final decision[s] in PDF format.)
Dear [Name of the person(s) who submitted the CAP]:

Please see the attached decision regarding your Medicare Provider Enrollment CAP.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

D. CAP Not Actionable (Moot) Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of CAP]
[Address] (Address from which the CAP was sent)
[City], [State] [Zip Code]

Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the CAP]:

This letter is in response to the CAP received by [MAC Name] based on the initial determination letter, dated [Month] [DD], [YYYY].

In correspondence dated [Month] [DD], [YYYY], the initial determination letter, dated [Month] [DD], [YYYY] informing you of the [denial of your Medicare enrollment application or revocation of your Medicare billing privileges] was [insert description] (describe action taken in regards to the initial determination, i.e. rescission of denial or revocation). For your convenience, a copy of the initial determination is included. Therefore, the issue set forth in the CAP is no longer actionable. This issue is moot, and we are unable to render a decision on the matter.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

E. Untimely CAP Dismissal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of CAP]
[Address] (Address from which the CAP was sent)
[City], [State] [Zip Code]

Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the CAP]:

This letter is in response to the CAP received by [MAC Name] based on the initial determination letter, dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your CAP as it was not timely submitted. The initial determination letter was dated [Month] [DD], [YYYY]. A CAP must be received within 35 calendar days of the date of the initial determination letter. Your CAP was not received until [Month] [DD], [YYYY], which is beyond the applicable submission time frame. [Provider/Supplier/Representative] failed to show good cause for its late request. Therefore, [MAC Name] is unable to render a decision in this matter.

Please refer to the initial determination letter, dated [Month] [DD], [YYYY], for instructions on how to properly file a reconsideration request. If you have already submitted a reconsideration request, you will receive further communication related to that submission. Failure to timely file a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]

[MAC Name]

F. Improperly Signed CAP Dismissal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of CAP]
[Address] (Address from which the CAP was sent)
[City], [State] [Zip Code]

Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the CAP]:

This letter is in response to the corrective action plan (CAP) received by [MAC Name] based on the initial determination letter, dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your CAP as it was not signed by an authorized or delegated official currently on file in your Medicare enrollment record, the individual provider or supplier, or a properly appointed representative. The signature requirement was stated in the initial determination letter, dated [Month] [DD], [YYYY], as well as in Chapter 10 of the Medicare Program Integrity Manual.

Please refer to the initial determination letter, dated [Month] [DD], [YYYY], for instructions on how to properly file a reconsideration request. If you have already submitted a reconsideration request, you will receive further communication related to that submission. Failure to timely file a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

G. No CAP Rights Dismissal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of CAP]
[Address] (Address from which the CAP was sent)
[City], [State] [Zip Code]

Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the CAP]:

This letter is in response to the corrective action plan (CAP) received by [MAC Name] based on the initial determination letter, dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your CAP. A provider or supplier may only submit a CAP if there has been a denial of enrollment in the Medicare program under 42 C.F.R § 424.530(a)(1) or the revocation of Medicare billing privileges under 42 C.F.R. § 424.535(a)(1). Your enrollment was not denied or revoked under one of the aforementioned authorities. Therefore, a CAP decision cannot be rendered based on this submission.

Please refer to the initial determination letter, dated [Month] [DD], [YYYY], for instructions on how to properly file a reconsideration request. If you have already submitted a reconsideration request, you will receive further communication related to that submission. Please be advised that failure to timely submit a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

H. Not Eligible to Submit CAP Dismissal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of CAP]
[Address] (Address from which the CAP was sent)
[City], [State] [Zip Code]

Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the CAP]:

This letter is in response to the [corrective action plan (CAP)] received by [MAC Name], based on the [Month] [DD], [YYYY] initial determination.

[MAC Name] is unable to accept your [CAP] submission because the action taken in regards to your Medicare enrollment is not an initial determination subject to administrative review. More specifically, an initial determination has not been made as described in 42 C.F.R. § 498.3(b). Under 42 C.F.R. § 498.5(l), appeal rights extend only to initial determinations related to the denial or revocation of Medicare billing privileges.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

I. CAP Signature Development Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of CAP]
[Address] (Address from which the CAP was sent)
[City], [State] [Zip Code]

Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the CAP]:

We are in receipt of your CAP submission, received on [Month] [DD], [YYYY].

(If the submission is not properly signed, use the following.) [Your submission is not appropriately signed, as stated in the initial determination letter and in the Medicare Program Integrity Manual, Ch. 10, Section 10.6.18. [MAC Name] is requesting that you submit a CAP that is properly signed by the individual provider, supplier, the authorized or delegated official, or a properly appointed representative. Your properly signed submission must be received within 15 calendar days of the date of this notice. If you do not timely respond to this request, your CAP submission may be dismissed.]

(If the submission is missing a statement by the attorney, use the following.) [Your submission is missing an attorney statement that *the attorney* has the authority to represent the provider or supplier. [MAC Name] is requesting that you submit a CAP that includes an attorney statement *that the attorney* has the authority to represent the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, your CAP submission may be dismissed.]

(If the submission is missing a signed written notice from the provider/supplier authorizing the representative to act on *the provider's/supplier's* behalf, use the following.) [Your submission is missing a written notice of the appointment of a

representative signed by the provider or supplier. [MAC Name] is requesting that you submit written notice of the appointment of a representative that is signed by the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, your CAP submission may be dismissed.]

Your submission should be sent to [MAC Appeal Receipt Email Address] or mailed to the following address:

[MAC Appeal Receipt Address] [MAC Fax number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

J. Favorable CAP Model Letter in Response to an Enrollment Denial

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of CAP]
[Address] (Address from which the CAP was sent)
[City], [State] [Zip Code]

Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the CAP]:

This letter is in response to the corrective action plan (CAP) received by [MAC Name] based on an enrollment denial. The initial determination letter was dated [Month] [DD], [YYYY] and the CAP was received on [Month] [DD], [YYYY]; therefore, this CAP is considered timely. (if the CAP is untimely, but good cause has been found to accept the CAP, use the following [This CAP was not timely submitted, but a good cause waiver has been granted.) The following decision is

based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DENIAL REASON:

- 42 C.F.R. § 424.530(a)(1)

OTHER APPLICABLE AUTHORITIES:

- (Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)

EXHIBITS:

- Exhibit 1: (Ex.: CAP, signed by Doe, dated [Month] [DD], [YYYY].)
- Exhibit 2: (Ex: Copy of a medical license for Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies and program instructions.

(Summarize the facts underlying the case which led up to the submission of the CAP.)

CORRECTIVE ACTION PLAN ANALYSIS:

[A [Provider/Supplier Name] may only submit a corrective action plan for noncompliance under 42 C.F.R. § 424.530(a)(1). If the initial determination was based on any other denial reasons other than 42 C.F.R. § 424.530(a)(1), this decision will not review those authorities.]

(A CAP is an opportunity to correct the deficiencies identified in the initial determination. This section should include: A clear explanation of why the denial was overturned in sufficient detail for the provider or supplier to understand the decision and; if applicable: the nature of the provider or supplier's deficiencies, the regulatory or other policy basis to support each reason for the denial, and an explanation of how the provider or supplier now meets the enrollment criteria or

requirements. This section shall not reference a CAP decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement. Approval date should be based on the date the provider or supplier came into compliance with all applicable Medicare requirements.)

(Ex: On [Month] [DD], [YYYY], Doe's medical license expired. However, on [Month] [DD], [YYYY] Smith submitted a copy of *the* renewed medical license, which was reinstated back to the date of expiration by the Wisconsin Medical Board. As a result, [MAC Name] finds that Doe came into compliance with the applicable Medicare requirements on [Month] [DD], [YYYY]. Therefore, [MAC Name] overturns the denial of Doe's Medicare enrollment application as it relates to 42 C.F.R. § 424.530(a)(1).

This decision is a **FAVORABLE DECISION**. To effectuate this decision, [MAC name] will continue processing the enrollment application.

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this CAP decision. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this decision letter.)

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

K. Favorable CAP Model Letter for Revocation Determination

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of CAP]
[Address] (Address from which the CAP was sent)
[City], [State] [Zip Code]

Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the CAP]:

This letter is in response to the corrective action plan (CAP) received by [MAC Name] based on a revocation of Medicare billing privileges. The initial determination letter was dated [Month] [DD], [YYYY] and the CAP was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the CAP is untimely, but good cause has been found to accept the CAP, use the following [This CAP was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, evidence in the file, and any information received before this decision was rendered.

REVOCATION REASON:

- 42 C.F.R. § 424.535(a)(1)

OTHER APPLICABLE AUTHORITIES:

- (Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)

EXHIBITS:

- Exhibit 1: (Ex.: CAP, signed by Doe, dated [Month] [DD], [YYYY].)
- Exhibit 2: (Ex: Copy of a medical license for Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the CAP.)

CORRECTIVE ACTION PLAN ANALYSIS:

[A [Provider/Supplier Name] may only submit a corrective action plan for noncompliance. If the initial determination was based on revocation reasons other than 42 C.F.R. § 424.535(a)(1), this decision will not review those authorities.]

(A CAP is an opportunity to correct the deficiencies identified in the initial determination. This section should include: A clear explanation of why the revocation is being upheld or overturned in sufficient detail for the provider or supplier to understand the decision and; if applicable: the nature of the provider or supplier's deficiencies, the regulatory basis to support the revocation for noncompliance, and an explanation of how the provider or supplier now meets the enrollment compliance criteria or requirements. This section shall not reference a CAP decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(Ex: On [Month] [DD], [YYYY], Doe's medical license was suspended. However, as part of *a* CAP, Doe submitted a revised order from the Wisconsin Medical Board, which reinstated *the* medical license back to the date of suspension. As a result, [MAC Name] finds that Doe came into compliance with the applicable Medicare requirements on [Month] [DD], [YYYY]. Therefore, [MAC Name] overturns the revocation of Doe's Medicare billing privileges as it relates to 42 C.F.R. § 424.535(a)(1).

This decision is a **FAVORABLE DECISION**. To effectuate this decision, [MAC name] [will reinstate/has reinstated] your Medicare billing privileges, effective [Month] [DD], [YYYY].

(The reinstatement date is based on chapter 10 of the MPIM and the date of the provider's or supplier's revocation or the date the provider's or supplier's license was reinstated if the revocation involves a licensure issue.)

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this CAP decision. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this decision letter.)

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

L. Unfavorable CAP Model Letter in Response to an Enrollment Denial

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of CAP]
[Address] (Address from which the CAP was sent)
[City], [State] [Zip Code]

Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the CAP]:

This letter is in response to the corrective action plan (CAP) received by [MAC Name] based on an enrollment denial. The initial determination letter was dated [Month] [DD], [YYYY] and the CAP was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the CAP is untimely, but good cause has been found to accept the CAP, use the following [This CAP was not timely submitted, but a good cause waiver has been granted.])The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DENIAL REASON:

- 42 C.F.R. § 424.530(a)(1)

OTHER APPLICABLE AUTHORITIES:

- (Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)

EXHIBITS:

- Exhibit 1: (Ex.: (Ex.: CAP, signed by Doe, dated [Month] [DD], [YYYY].)
- Exhibit 2: (Ex: Copy of a medical license for Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the CAP).

CORRECTIVE ACTION PLAN ANALYSIS:

[A [Provider/Supplier Name] may only submit a corrective action plan for noncompliance under 42 C.F.R. § 424.530(a)(1). If the initial determination was based on any other denial reasons other than 42 C.F.R. § 424.530(a)(1), this decision will not review those authorities.]

(A CAP is an opportunity to correct the deficiencies identified in the initial determination. This section should include: A clear explanation of why the denial is being upheld in sufficient detail for the provider or supplier to understand the decision and; if applicable: the nature of the provider or supplier's deficiencies, the regulatory or other policy basis to support each reason for the denial, and an explanation of how the provider or supplier now meets the enrollment criteria or requirements. This section shall not reference a CAP decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], Doe's medical license was suspended by the Wisconsin Medical Board. [MAC Name] has confirmed that Doe's medical license remains suspended. As a result, [MAC Name] upholds the denial of Doe's Medicare enrollment application under 42 C.F.R. § 424.530(a)(1).)

This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that the CAP does not correct the deficiencies that led to the denial of your Medicare enrollment. As a result, the denial of your Medicare enrollment is upheld.

Failure to timely file a reconsideration request is deemed a waiver of all further administrative review. However, if you have submitted a reconsideration request, a separate decision is forthcoming.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

M. Unfavorable CAP Model Letter for Revocation Determination

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of CAP]
[Address] (Address from which the CAP was sent)
[City], [State] [Zip Code]

Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)
Dear [Person(s) who submitted the CAP]:

This letter is in response to the corrective action plan (CAP) received by [MAC Name] based on a revocation of Medicare billing privileges. The initial determination letter was dated [Month] [DD], [YYYY] and the CAP was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the CAP is untimely, but good cause has been found to accept the CAP, use the following [This CAP was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

REVOCATION REASON:

- 42 C.F.R. § 424.535(a)(1)

OTHER APPLICABLE AUTHORITIES:

- (Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)

EXHIBITS:

- Exhibit 1: (Ex.: (Ex.: CAP, signed by Doe, dated [Month] [DD], [YYYY].)
- Exhibit 2: (Ex: Copy of a medical license for Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the CAP.)

CORRECTIVE ACTION PLAN ANALYSIS:

[A [Provider/Supplier Name] may only submit a corrective action plan for noncompliance. If the initial determination was based on revocation reasons other than 42 C.F.R. § 424.535(a)(1), this decision will not review those authorities.]

(A CAP is an opportunity to correct the deficiencies identified in the initial determination. This section should include: A clear explanation of why the revocation is being upheld in sufficient detail for the provider/supplier to understand

the decision and, if applicable: the nature of the provider/supplier's deficiencies, the regulatory or other policy basis to support compliance and how the provider/supplier now meets the enrollment criteria or requirements. This section shall not reference a CAP decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], Doe's medical license was suspended by the Wisconsin Medical Board. Doe has not submitted evidence to demonstrate that *the* medical license has been reinstated. In addition, [MAC Name] has confirmed that Doe's medical license remains suspended. As a result, [MAC Name] upholds the revocation of Doe's Medicare billing privileges under 42 C.F.R. § 424.535(a)(1).)

This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that the CAP did not correct the deficiencies noted in the implementation of the revocation. As a result, the revocation of your Medicare billing privileges is upheld.

Failure to timely file a reconsideration request is deemed a waiver of all further administrative review. However, if you have submitted a reconsideration request, a separate decision is forthcoming.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

N. CAP Further Information Required for Development Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the CAP.]
Subject: Medicare Provider Enrollment CAP re: [Provider/Supplier Name]
Dear [Name of the person(s) who submitted the CAP]
[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of CAP] (If submitted on behalf of an organization or group)
[Address] (Address from which the CAP was sent)
[City], [State] [Zip Code]

Re: CAP Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the CAP]:

On [Month] [DD]. [YYYY], [MAC Name] issued a CAP decision. As stated in the [Month] [DD], [YYYY] CAP decision letter, the approval of [Provider/Supplier Name]'s Medicare enrollment is contingent upon the submission of [list required documentation]. Please send the required documentation within 30 calendar days to:

[MAC CAP Receipt Address]

[MAC CAP Receipt Email Address] [MAC CAP Receipt Fax Number]
If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

10.7.11 – Reconsideration Request Model Letters

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

Instruction

For the following model letters, all text within parentheses is intended as instruction/explanation and should be deleted before the letter is finalized and sent to the provider/supplier. All text within brackets requires the contractor to fill in the appropriate text. All letters and emails shall be saved in PDF format. The date on the letter shall be the date it was sent to the provider/supplier.

A. Reconsideration Request Withdrawn Acknowledgement Template

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

1. Email Template

To: [Email address provided by the person who submitted the reconsideration request]

Subject: Medicare Provider Enrollment Reconsideration Request re: [Provider/Supplier Name]

Dear [Name of the person(s) who submitted the reconsideration request]:

We are in receipt of your written withdrawal request in regard to your reconsideration request received on [Month] [DD], [YYYY]. [MAC Name] has not yet issued a reconsidered decision, and therefore, [MAC Name] considers your reconsideration request to be withdrawn. As a result, a decision will not be issued in response to your reconsideration request.

Please be advised that failure to timely submit a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

2. Hard-Copy Letter Template

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Withdrawal
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the reconsideration request]:

We are in receipt of your written withdrawal request in regard to your reconsideration request received on [Month] [DD], [YYYY]. [MAC Name] has not yet issued a reconsidered decision, and therefore, [MAC Name] considers your reconsideration request to be withdrawn. As a result, a decision will not be issued in response to your reconsideration request.

Please be advised that failure to timely submit a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

B. Reconsideration Request Receipt Acknowledgement Template to Provider/Supplier/Representative

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

1. Email Template

To: [Email address provided by the person who submitted the reconsideration request]

Subject: Medicare Provider Enrollment Reconsideration Request re**:** [Provider/Supplier Name]

Dear [Name of the person(s) who submitted the reconsideration request]:

We are in receipt of your reconsideration request on behalf of [Provider/Supplier Name]. Please be advised that [MAC Name] has 90 calendar days to review your reconsideration request and render a decision.

If you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge (ALJ) to consider during a hearing, you must submit that information to the hearing office before a decision is rendered. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an ALJ specifically allows you to do so under 42 C.F.R. § 498.56(e).

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

2. Hard-Copy Letter Template

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the reconsideration request]:

We are in receipt of your reconsideration request on behalf of [Provider/Supplier Name]. Please be advised that [MAC Name] has 90 calendar days to review your reconsideration request and render a decision.

If you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge (ALJ) to consider during a hearing, you must submit that information to the hearing office before a decision is rendered. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an ALJ specifically allows you to do so under 42 C.F.R. § 498.56(e).

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]

[MAC Name]

C. Reconsideration Request Decision Email Template to Provider/Supplier/Representative

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the Reconsideration Request]

Subject: Medicare Provider Enrollment Reconsideration Request re**:** [Provider/Supplier Name]

(Be sure to attach a copy of the final decision[s] in PDF format.)

Dear [Name of the person(s) who submitted the Reconsideration Request]:

Please see the attached decision regarding your Medicare Provider Enrollment Reconsideration Request.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

D. Reconsideration Request Not Actionable (Moot) Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available. Be sure to attach a copy of the letter or correspondence that rendered the reconsideration request moot.)

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]

Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the reconsideration request]:

This letter is in response to the reconsideration request received by [MAC Name] based on the initial determination letter, dated [Month] [DD], [YYYY].

In correspondence dated [Month] [DD], [YYYY], the initial determination letter, dated [Month] [DD], [YYYY] informing you of the [initial determination (e.g. denial of your Medicare enrollment application, approval of your Medicare enrollment application, or revocation of your Medicare billing privileges)] was [insert description] (describe action taken in regards to the initial determination, i.e. rescission of the denial or revocation). For your convenience, a copy of the initial determination is included. Therefore, the issue set forth in the reconsideration request is no longer actionable. This issue is moot, and we are unable to render a decision on the matter.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

E. Untimely Reconsideration Request Dismissal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Dismissal
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the reconsideration request]:

This letter is in response to the reconsideration request received by [MAC Name], based on the

initial determination letter dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your reconsideration request as it was not timely submitted. The initial determination letter was dated [Month] [DD], [YYYY]. A reconsideration request must be received within 65 calendar days of the date of the initial determination letter. Your reconsideration request was not received by [MAC Name] until [Month] [DD], [YYYY], which is beyond the applicable submission time frame. You have failed to show good cause for your late request. Therefore, [MAC Name] is unable to render a decision in this matter.

Please be advised that failure to timely submit a proper reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

F. Reconsideration Request Dismissal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Dismissal
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the reconsideration request]:

This letter is in response to the reconsideration request received by [MAC Name], based on the [Month] [DD], [YYYY] initial determination letter.

(If the submission was missing the facts or issues, use the following.) [Your submission did not clearly identify the facts or issues with which you disagree and your reasons for disagreement. The requirement is stated in the [Month] [DD], [YYYY] initial determination letter, as well as in Chapter 10 of the Medicare Program Integrity Manual.]

(If the submission was not properly signed, use the following.) [[MAC Name] is unable to accept your reconsideration request as it was not signed by an authorized or delegated official currently on file in your Medicare enrollment record, the individual provider or supplier, or a properly appointed representative. The signature requirement is stated in the [Month] [DD], [YYYY] initial determination letter, as well as in Chapter 10 of the Medicare Program Integrity Manual.]

Please be advised that failure to timely submit a proper reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

G. Not Eligible to Submit Reconsideration Request Dismissal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Dismissal
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the Reconsideration Request]:

This letter is in response to the [reconsideration request] received by [MAC Name], based on the [Month] [DD], [YYYY] initial determination.

[MAC Name] is unable to accept your [reconsideration request] submission because the action taken in regards to your Medicare enrollment is not an initial determination subject to administrative review. More specifically, an initial determination has not been made as described in 42 C.F.R. § 498.3(b). Under 42 C.F.R. § 498.5(l), appeal rights related to provider enrollment extend only from initial determinations.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

H. Reconsideration Request Development Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Development Request
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the Reconsideration Request]:

We are in receipt of your reconsideration submission, received on [Month] [DD], [YYYY]. (If the submission is missing the facts or issues, use the following.) [Your submission does not clearly identify the facts or issues with which you disagree and your reasons for disagreement. [MAC Name] is granting you an additional 15 calendar days from the date of this notification letter to submit a proper reconsideration that clearly identifies the facts or issues with which you disagree and your reasons for disagreement. This revised reconsideration submission must be received within 15 calendar days of the date of this notice. If you do not timely respond to this request, your reconsideration submission may be dismissed.]

(If the submission is not properly signed, use the following.) [Your submission is not appropriately signed, as required in the Medicare Program Integrity Manual, Ch. 10, Section 10.6.18. [MAC Name] is requesting that you submit a reconsideration request that is properly signed by the individual provider, supplier, the authorized or delegated official, or a representative. Your properly signed submission must be received within 15 calendar days of the date of this notice. If you do not timely respond to this request, your reconsideration submission may be dismissed.]

(If the submission is missing a statement by the attorney, use the following.) [Your submission is missing an attorney statement that *the attorney* has the authority to represent the provider/supplier. [MAC Name] is requesting that you submit a rebuttal that includes an attorney statement that *the attorney* has the authority to represent the provider/supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, your reconsideration submission may be dismissed.]

(If the submission is missing a signed written notice from the provider/supplier authorizing the representative to act on *the provider's/supplier's* behalf, use the following.) [Your submission is missing a written notice of the appointment of a representative signed by the provider/supplier. [MAC Name] is requesting that you submit written notice of the appointment of a representative that is signed by the provider/supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, your reconsideration submission may be dismissed.]

Your submission should be sent to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[MAC Fax number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

I. Favorable Reconsideration Request Model Letter in Response to an Enrollment Denial

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on an enrollment denial. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this reconsideration request is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DENIAL REASON(S):

- 42 C.F.R. § 424.530(a)(denial reason 1-17)
- 42 C.F.R. § 424.530(a)(denial reason 1-17)

OTHER APPLICABLE AUTHORIT(Y/IES):

- 42 C.F.R. §
- (Ex: Medicare Program Integrity Manual (MPIM) chapter 10, section 10.XX)

EXHIBITS:

- Exhibit 1: (Ex.: Reconsideration request, signed by Doe, dated [Month] [DD] [YYYY].)
- Exhibit 2: (Ex: Copy of a medical license for Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider/supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider*/supplier* that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(The hearing officer needs to check to determine if a CAP was also submitted and approved for this provider or supplier. If so, the reconsideration decision should only address the remaining authorities and use the following sentence, "[MAC Name] has approved the CAP submitted on [Month] [DD], [YYYY] in a decision dated [Month] [DD], [YYYY]. Therefore, this decision will only address the remaining denial reason(s) 42 C.F.R. § 424.530(a)(denial reason *2*-1*8*).)

(If the CAP resolves the denial in its entirety, the applicable moot model letter should be issued in response to the reconsideration request instead of this decision template.)

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(Ex: On [Month] [DD], [YYYY], a disciplinary hearing was held regarding the medical license of Doe. However, on [Month] [DD], [YYYY], the Wisconsin Medical Board declined to take disciplinary action against Doe's medical license. As a result, [MAC Name] overturns the denial of Doe's Medicare enrollment application as it relates to 42 C.F.R. § 424.530(a)(1).

This decision is a **FAVORABLE DECISION**. To effectuate this decision, [MAC name] will continue processing the enrollment application.

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider/supplier in this reconsideration decision. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this decision letter.)

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 ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/.

To file a new appeal using DAB E-File, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the "Register New Account" form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which *the user* is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and
- Entering and uploading the requested information and documents on the "File New Appeal – Civil Remedies Division" form.

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
  - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
  - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations,

sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.

- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.

- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.

- More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

J. Favorable Reconsideration Request Model Letter in Response to a Reactivation Effective Date Determination

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] related to a reactivation effective date determination. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this reconsideration request is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

EFFECTIVE DATE REGULATION(S):

- 42 C.F.R. § 424.520(a-d) (Other effective date regulations may be included)

OTHER APPLICABLE AUTHORIT(Y/IES):

- 42 C.F.R. § 424.540 (Other applicable regulations for MPIM sections may be included)
- (Ex: Medicare Program Integrity Manual (MPIM) chapter 10, section 10.XX)

EXHIBITS:

- Exhibit 1: (Ex.: CMS-855I Medicare enrollment application, signed and certified by Smith on [Month] [DD], [YYYY].)
- Exhibit 2: (Ex: Copy of an email chain between Smith and Doe, dated [Month] [DD], [YYYY], requesting additional informed needed to process the revalidation application to completion for Smith to Doe.)

(In this section list each document submitted by the provider/supplier. Each exhibit shall include the date, if provided, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider/*supplier* that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider/supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(Ex.: On [Month] [DD], [YYYY], Smith's revalidation application was approved with a gap *in b*illing privileges from [Month] [DD], [YYYY] to [Month] [DD], [YYYY]. However, as indicated above, [MAC Name] has determined that the reactivation effective should be [Month] [DD], [YYYY]. As a result of the change in the reactivation effective date, the gap in Smith's Medicare billing privileges has been eliminated.)

This decision is a **FAVORABLE DECISION**. To effectuate this decision, [MAC name] [will modify/has modified] the reactivation effective date for [Provider/Supplier Name].

You must resubmit any claims that were denied or not previously submitted due to the former gap in your Medicare billing privileges.

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this reconsideration decision. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this decision letter.)

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 ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/.

To file a new appeal using DAB E-File, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the "Register New Account" form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which *the user* is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and
- Entering and uploading the requested information and documents on the "File New Appeal – Civil Remedies Division" form.

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
  - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
  - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)

- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.

- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.

- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.

- More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]

[Position of Hearing Officer]
[MAC Name]

K. Favorable Reconsideration Request Model Letter in Response to an Effective Date of Participation Determination (Non-Revalidation)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] in response to a determination of the effective date of participation in the Medicare program. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this reconsideration request is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

EFFECTIVE DATE REGULATION(S):

- 42 C.F.R. § 424.520(a-d)
- (Other effective date regulations may be included)

OTHER APPLICABLE AUTHORIT(Y/IES):

- (Ex: Medicare Program Integrity Manual (MPIM) chapter 10, section 10.XX)

EXHIBITS:

- Exhibit 1: (Ex.: CMS-855I Medicare enrollment application, signed and certified by Smith on [Month] [DD], [YYYY].)

- Exhibit 2: (Ex: Copy of an email chain between Smith and Doe, dated [Month] [DD], [YYYY], submitting the requested development documentation for Smith to Doe.

(In this section list each document submitted by the provider/supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider/*supplier* that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the determination of the effective date.)

RECONSIDERATION ANALYSIS:

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider/supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], Smith submitted an initial enrollment application, which was subsequently rejected for failure to timely respond to a development request for additional information/documentation. As part of *the* reconsideration request, Smith submitted an email receipt showing that *Smith* timely responded to the development request. As a result, [MAC Name] will modify Smith's Medicare effective date to [Month] [DD], [YYYY].)

This decision is a **FAVORABLE DECISION**. To effectuate this decision, [MAC name] [will modify/has modified] the enrollment effective date to [Month] [DD], [YYYY].

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider/supplier in this reconsideration decision. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this decision letter.)

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 ALJ review for the reconsideration portion of

this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/.

To file a new appeal using DAB E-File, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the "Register New Account" form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which *the user* is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and

- Entering and uploading the requested information and documents on the "File New Appeal – Civil Remedies Division" form.

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
  - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
  - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)

- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.

- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.

- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.

- More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]
Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

L. Favorable Reconsideration Request Model Letter for Revocation Determination

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on a revocation of Medicare billing privileges. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

REVOCATION REASON(S):

- 42 C.F.R. § 424.535(a)(revocation reason 1-23)
- 42 C.F.R. § 424.535(a)(revocation reason 1-23)

OTHER APPLICABLE AUTHORIT*(Y/IES)*:

- 42 C.F.R. §
- (Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)

EXHIBITS:

- Exhibit 1: (Ex.: Reconsideration request, signed by Doe, dated [Month] [DD] [YYYY].)
- Exhibit 2: (Ex: Copy of a medical license for Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider/supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider/*supplier* that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(The hearing officer needs to check to determine if a CAP was also submitted and approved for this provider or supplier. If so, the reconsideration decision should only address the remaining authorities and use the following sentence, "[MAC Name] has reviewed and/or approved the CAP submitted on [Month] [DD], [YYYY] in a decision dated [Month] [DD], [YYYY]. Therefore, this decision will only address the remaining revocation reason(s) 42 C.F.R. § 424.535(a)(revocation reason 1- 23).)

(If the CAP resolves the revocation in its entirety, the applicable moot model letter should be issued in response to the reconsideration request instead of this decision template.)

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider/supplier in its reconsideration request. Then conduct analysis of the provider/supplier arguments based on the applicable regulations and sub-regulations (MPIM). This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(Ex: On [Month] [DD], [YYYY], Doe's medical license was temporarily suspended by the Wisconsin medical board based on allegations of malpractice. However, on [Month] [DD] [YYYY], the Wisconsin medical board issued an order reversing the license suspension back to its implementation date based on the outcome of a hearing. As a result, [MAC Name] is overturning the revocation of Doe's Medicare billing privileges as it relates to 42 C.F.R. § 424.535(a)(1).*)*

This decision is a **FAVORABLE DECISION**. To effectuate this decision, [MAC name] [will reinstate/has reinstated] your Medicare billing privileges, effective [Month] [DD], [YYYY].

(The reinstatement date is based on Chapter 10 of the MPIM and the date of the provider's or supplier's revocation or the date the provider's or supplier's license was reinstated if the revocation involves a licensure issue.)

(If additional information is needed from the provider/supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider/supplier in this reconsideration decision. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this decision letter.)

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 ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/.

To file a new appeal using DAB E-File, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the "Register New Account" form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which *the user* is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and

- Entering and uploading the requested information and documents on the "File New Appeal – Civil Remedies Division" form.

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
    - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
    - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.

- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.

- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.

- More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

M. Unfavorable Reconsideration Request Model Letter in Response to an Enrollment Denial

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on an enrollment denial. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DENIAL REASON(S):

- 42 C.F.R. § 424.530(a)(denial reason 1-17)
- 42 C.F.R. § 424.530(a)(denial reason 1-17)

OTHER APPLICABLE AUTHORIT(Y/IES):

- 42 C.F.R. §
- (Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)

EXHIBITS:

- Exhibit 1: (Ex.: Reconsideration request, signed by Doe, dated [Month] [DD] [YYYY].)
- Exhibit 2: (Ex: Copy of a medical license for Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider/supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider/*supplier* that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

[Summarize the facts underlying the case which led up to the submission of the reconsideration request.]

RECONSIDERATION ANALYSIS:

(The hearing officer needs to check to determine if a CAP was also submitted and approved for this provider/supplier. If so, the reconsideration decision should only address the remaining authorities and use the following sentence, "[MAC Name] has approved the CAP submitted on [Month] [DD], [YYYY] in a decision dated [Month] [DD], [YYYY]. Therefore, this decision will only address the remaining denial reason(s) 42 C.F.R. § 424.530(a)(denial reason *2*-1*8*).)

(If the CAP resolves the denial in its entirety, the applicable moot model letter should be issued in response to the reconsideration request instead of this decision template.)

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider/supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations (MPIM). This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(Ex: On [Month] [DD], [YYYY], Doe's medical license was temporarily suspended by the Wisconsin medical board based on allegations of malpractice. Doe did not submit any documentation to demonstrate that *the* medical license was not suspended. In addition, [MAC Name] has confirmed that Doe's medical license remains suspended. As a result, [MAC Name] upholds the denial of Doe's Medicare enrollment application as it relates to 42 C.F.R. § 424.530(a)(1).)

This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that there was no error made in the denial of your Medicare enrollment. As a result, the denial of your Medicare enrollment is upheld.

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 ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/.

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2. Entering the information requested on the "Register New Account" form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which *the user* is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and

- Entering and uploading the requested information and documents on the "File New Appeal – Civil Remedies Division" form.

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
    - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
    - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.

- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.

- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.

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If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W.,

Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

N. Unfavorable Reconsideration Request Model Letter in Response to a Reactivation Effective Date Determination

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] in response to a reactivation effective date determination. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this

decision was rendered.

EFFECTIVE DATE REGULATION(S):

- 42 C.F.R. § 424.520(a-d) (Other effective date regulations may be included)

OTHER APPLICABLE AUTHORIT(Y/IES):

- 42 C.F.R. § 424.540(d)(2) (Other applicable regulations or MPIM sections may be included)
- (Ex: Medicare Program Integrity Manual (MPIM) chapter 10, section 10.XX)

EXHIBITS:

- Exhibit 1: (Ex.: CMS-855I Medicare enrollment application, signed and certified by Smith on [Month] [DD], [YYYY].)
- Exhibit 2: (Ex: Copy of an email chain between Smith and Doe, dated [Month] [DD], [YYYY], submitting the requested development documentation for Smith to Doe.)

(In this section list each document submitted by the provider/supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider/*supplier* that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider/supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], Smith's Medicare enrollment was deactivated for failing to timely respond to a revalidation request. On [Month] [DD], [YYYY], Smith submitted a revalidation

application, which was processed and approved. Per the MPIM, Ch. 10, Section 10.4.8, Smith's Medicare enrollment was reactivated, but with a gap in Medicare billing privileges from [Month] [DD], [YYYY] to [Month] [DD], [YYYY]. Smith's reconsideration request did not demonstrate an error in the determination of the reactivation effective date.)

This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that no error was made in the determination of a reactivation effective date resulting in a gap in your Medicare billing privileges. As a result, your reactivation effective date will remain [Month] [DD] [YYYY].

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 ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/.

To file a new appeal using DAB E-File, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the "Register New Account" form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which the user is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and

- Entering and uploading the requested information and documents on the "File New Appeal – Civil Remedies Division" form.

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
    - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
    - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.

- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.

- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.

- More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

O. Unfavorable Reconsideration Request Model Letter in Response to an Effective Date of Participation Determination (Non-Revalidation)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on an effective date of enrollment determination. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

EFFECTIVE DATE REGULATION(S):

- 42 C.F.R. § 424.520(a-d)
- (Other effective date regulations may be included)

OTHER APPLICABLE AUTHORIT(Y/IES):

- 42 C.F.R. §
- (Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)

EXHIBITS:

- Exhibit 1: (Ex.: CMS-855I Medicare enrollment application, signed and certified by Smith on [Month] [DD], [YYYY].)
- Exhibit 2: (Ex: Copy of an email chain between Smith and Doe, dated [Month] [DD], [YYYY], submitting the requested development documentation for Smith to Doe.)

(In this section list each document submitted by the provider/supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider/*supplier* that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider/supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations (MPIM). This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], Smith submitted an initial Medicare enrollment application. On [Month] [DD], [YYYY], [MAC Name] sent a development request to Smith for additional documentation/information to continue processing *the* enrollment application.

However, Smith did not submit the requested documentation within 30 days. As a result, [MAC Name] properly rejected Smith's Medicare enrollment application received on [Month] [DD]

[YYYY]. On [Month] [DD] [YYYY], Smith submitted another Medicare enrollment application, which was processed and subsequently approved with an effective date of [Month] [DD], [YYYY] in accordance with 42 C.F.R. § 424.520.)

This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that no error was made in the determination of your effective date of participation in the Medicare program. As a result, the effective date of participation will remain the same.

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 ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/.

To file a new appeal using DAB E-File, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the "Register New Account" form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which *the user* is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and

- Entering and uploading the requested information and documents on the "File New Appeal – Civil Remedies Division" form.

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:

    - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
    - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.

- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.

- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.

- More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email

Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

P. Unfavorable Reconsideration Request Model Letter for Revocation Determination

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on a revocation of Medicare billing privileges. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

REVOCATION REASON(S):

- 42 C.F.R. § 424.535(a)(revocation reason 1-23)
- 42 C.F.R. § 424.535(a)(revocation reason 1-23)

OTHER APPLICABLE AUTHORITIES:

- 42 C.F.R. § 424.535(c) (delete if no re-enrollment bar established)
- (Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)

EXHIBITS:

- Exhibit 1: (Ex.: Reconsideration request, signed by Doe, dated [Month] [DD] [YYYY].)
- Exhibit 2: (Ex: Copy of a medical license for Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider/supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider/*supplier* that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(The hearing officer needs to check to determine if a CAP was also submitted and approved for this provider or supplier. If so, the reconsideration decision should only address the remaining authorities and use the following sentence, "[MAC Name] has denied or approved the CAP submitted on [Month] [DD], [YYYY] in a decision dated [Month] [DD], [YYYY]. Therefore, this decision will only address the remaining revocation reason(s) 42 C.F.R. § 424.535(a)(revocation reason 1-23).)

(If the CAP resolves the revocation in its entirety, the applicable moot model letter should be issued in response to the reconsideration request instead of this decision template.)

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider/supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations (MPIM). This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], Doe's medical license was suspended by the Wisconsin Medical Board. Doe has not submitted evidence to demonstrate that the suspension of *the* medical license

was rescinded. In addition, [MAC Name] has confirmed that Doe's medical license remains suspended. As a result, [MAC Name] upholds the revocation of Doe's Medicare enrollment application under 42 C.F.R. § 424.535(a)(1).)

This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that there was no error made in the implementation of a revocation. As a result, the revocation of your Medicare billing privileges is upheld.

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 ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/.

To file a new appeal using DAB E-File, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the "Register New Account" form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which *the user* is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and

- Entering and uploading the requested information and documents on the "File New Appeal – Civil Remedies Division" form.

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
    - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
    - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.

- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.

- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.

- More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

Q. Reconsideration Further Information Required for Development Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the Reconsideration.]
Subject: Medicare Provider Enrollment Reconsideration re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration] (If submitted on behalf of an organization or group)
[Address] (Address from which the Reconsideration was sent)
[City], [State] [Zip Code]

Re: Reconsideration Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the Reconsideration]:

On [Month] [DD]. [YYYY], [MAC Name] issued a reconsideration decision. As stated in the [Month] [DD], [YYYY] reconsideration decision letter, the approval of [Provider/Supplier Name]'s Medicare enrollment is contingent upon the submission of [list required documentation]. Please send the required documentation within 30 calendar days to:

[MAC Reconsideration Receipt Address] [MAC Reconsideration Receipt Email Address] [MAC Reconsideration Receipt Fax Number]
If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,
[Signature of Hearing Officer] (May be electronic) [Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

R. Unfavorable Reconsideration Request Decision Model Letter for Opt-Out Termination/Cancellation

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on [Provider/Supplier Name]'s opt-out status. The initial opt-out approval was issued in a letter dated [Month] [DD], [YYYY], effective [Month] [DD], [YYYY]. (If the opt-out status has auto-renewed, include the following [Subsequently, on [Month] [DD], [YYYY], the opt-out period was automatically renewed for another two years.] The reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (If the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

OPT-OUT AUTHORITIES:

- 42 C.F.R. § 498.3(b)(19)
- 42 C.F.R. § 405.450
- 42 C.F.R. § 405.405
- 42 C.F.R. § 405.455
- 42 C.F.R. § 405.[xxx] (as applicable)

OTHER APPLICABLE AUTHORITIES:

- Medicare Benefit Policy Manual (MBPM) Ch. 15 §§ 40.1 – 40.39
- Medicare Program Integrity Manual (MPIM) Ch. 10 § 10.6.12
- (Ex: 42 C.F.R. §)
- (Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)

EXHIBITS:

- Exhibit 1: (Ex.: Reconsideration request, signed by Doe, dated [Month] [DD], [YYYY].)
- Exhibit 2: (Ex: Opt-out approval letter, dated [Month] [DD], [YYYY].)

(In this section list each document submitted by the *practitioner*, as well as the original opt-out affidavit and opt-out approval letter. If auto-renewal letter(s) were sent to the *practitioner*, those shall be included as exhibits. Each exhibit should include the date, as well as a brief description of the document. The MAC shall also include all other documentation not submitted by the *practitioner* that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, auto-renewal letters etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section shall summarize the statements/arguments made by the *practitioner* in its reconsideration request. The MAC shall then conduct analysis of the *practitioner* arguments based on the applicable regulations and sub-regulations (MPIM). It is insufficient to state a reconsideration decision without explaining how and why the decision was reached.)

DECISION:

(A short conclusory restatement.)

This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that there was no error made in the [insert reason for opt-out appeal (e.g. automatic renewal of your opt-out status/return of your cancellation request/return of your termination request/approval of your opt-out affidavit)]. As a result, [describe outcome of opt-out status (e.g. you will remain opted-out until at least January 1, 2025)]. 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 ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/.

To file a new appeal using DAB E-File, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the "Register New Account" form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which *the user* is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and
- Entering and uploading the requested information and documents on the "File New Appeal – Civil Remedies Division" form.

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
  - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
  - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.
- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.
- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.
- More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]

[MAC Name]

S. Favorable Reconsideration Request Decision Model Letter for Opt-Out Termination/Cancellation

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on [Provider/Supplier Name]'s opt-out status. The initial opt-out approval was issued in a letter dated [Month] [DD], [YYYY], effective [Month] [DD], [YYYY]. (If the opt-out status has auto-renewed, include the following [Subsequently, on [Month] [DD], [YYYY], the opt-out period was automatically renewed for another two years.] The reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (If the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

OPT-OUT AUTHORITIES:

- 42 C.F.R. § 498.3(b)(19)
- 42 C.F.R. § 405.450
- 42 C.F.R. § 405.405
- 42 C.F.R. § 405.455
- 42 C.F.R. § 405.[xxx] (as applicable)

OTHER APPLICABLE AUTHORITIES:

- Medicare Benefit Policy Manual (MBPM) Ch. 15 §§ 40.1 – 40.39
- Medicare Program Integrity Manual (MPIM) Ch. 10 § 10.6.12

- (Ex: 42 C.F.R. §)
- (Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)

EXHIBITS:

- Exhibit 1: (Ex.: Reconsideration request, signed by Doe, dated [Month] [DD], [YYYY].)
- Exhibit 2: (Ex: Opt-out approval letter, dated [Month] [DD], [YYYY].)

(In this section list each document submitted by the *practitioner*, as well as the original opt-out affidavit and opt-out approval letter. If auto-renewal letter(s) were sent to the *practitioner*, those shall be included as exhibits. Each exhibit should include the date, as well as a brief description of the document. The MAC shall also include all other documentation not submitted by the *practitioner* that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, auto-renewal letters etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section shall summarize the statements/arguments made by the *practitioner* in its reconsideration request. The MAC shall then conduct analysis of the *practitioner* arguments based on the applicable regulations and sub-regulations (MPIM). It is insufficient to state a reconsideration decision without explaining how and why the decision was reached.)

DECISION:

(A short conclusory restatement.)

[MAC name] finds that [describe error/facts that led to favorable decision]. As a result, [describe outcome of opt-out status (e.g. the automatic renewal of your opt-out status has been cancelled or your opt-out status has been terminated)].

This decision is a **FAVORABLE 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 ALJ review for the reconsideration portion of

this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/.

To file a new appeal using DAB E-File, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the "Register New Account" form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which *the user* is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and
- Entering and uploading the requested information and documents on the "File New Appeal – Civil Remedies Division" form.

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
  - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
  - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)

- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.
- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.
- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.
- More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

T. Unfavorable Reconsideration Request Decision Model Letter for Opt-Out Effective Date

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on [Provider/Supplier Name]'s opt-out status. The initial opt-out approval was issued in a letter dated [Month] [DD], [YYYY], effective [Month] [DD], [YYYY]. (If the opt-out status has auto-renewed, include the following [Subsequently, on [Month] [DD], [YYYY], the opt-out period was automatically renewed for another two years.] The reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (If the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

OPT-OUT AUTHORITIES:

- 42 C.F.R. § 498.3(b)(19)
- 42 C.F.R. § 405.405
- 42 C.F.R. § 405.410
- 42 C.F.R. § 405.425
- 42 C.F.R. § 405.445
- 42 C.F.R. § 405.455
- 42 C.F.R. § 405.450
- 42 C.F.R. § 405.[xxx] (as applicable)

OTHER APPLICABLE AUTHORITIES:

- Medicare Benefit Policy Manual (MBPM) Ch. 15 §§ 40.1 – 40.39
- Medicare Program Integrity Manual (MPIM) Ch. 10 § 10.6.12

- (Ex: 42 C.F.R. §)
- (Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)

EXHIBITS:

- Exhibit 1: (Ex.: Reconsideration request, signed by Doe, dated [Month] [DD], [YYYY].)
- Exhibit 2: (Ex: Opt-out approval letter, dated [Month] [DD], [YYYY].)

(In this section list each document submitted by the *practitioner*, as well as the original opt-out affidavit and opt-out approval letter. If auto-renewal letter(s) were sent to the *practitioner*, those shall be included as exhibits. Each exhibit should include the date, as well as a brief description of the document. The MAC shall also include all other documentation not submitted by the *practitioner* that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, auto-renewal letters etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section shall summarize the statements/arguments made by the *practitioner* in its reconsideration request. The MAC shall then conduct analysis of the *practitioner* arguments based on the applicable regulations and sub-regulations (MPIM). It is insufficient to state a reconsideration decision without explaining how and why the decision was reached.)

DECISION:

(A short conclusory restatement.)

This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that there was no error made in the opt-out effective date determination. As a result, the effective date of your opt-out status remains unchanged. 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 ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of

this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/.

To file a new appeal using DAB E-File, you first need to register a new account by:

4. Clicking Register on the DAB E-File home page;
5. Entering the information requested on the "Register New Account" form; and
6. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which *the user* is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and
- Entering and uploading the requested information and documents on the "File New Appeal – Civil Remedies Division" form.

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
  - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
  - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.
- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.
- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.
- More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

U. Favorable Reconsideration Request Decision Model Letter for Opt-Out Effective Date

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on [Provider/Supplier Name]'s opt-out status. The initial opt-out approval was issued in a letter dated [Month] [DD], [YYYY], effective [Month] [DD], [YYYY]. (If the opt-out status has auto-renewed, include the following [Subsequently, on [Month] [DD], [YYYY], the opt-out period was automatically renewed for another two years.] The reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (If the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

OPT-OUT AUTHORITIES:

- 42 C.F.R. § 498.3(b)(19)
- 42 C.F.R. § 405.405
- 42 C.F.R. § 405.410
- 42 C.F.R. § 405.425
- 42 C.F.R. § 405.445
- 42 C.F.R. § 405.455
- 42 C.F.R. § 405.450
- 42 C.F.R. § 405.[xxx] (as applicable)

OTHER APPLICABLE AUTHORITIES:

- Medicare Benefit Policy Manual (MBPM) Ch. 15 §§ 40.1 – 40.39
- Medicare Program Integrity Manual (MPIM) Ch. 10 § 10.6.12
- (Ex: 42 C.F.R. §)
- (Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)

EXHIBITS:

- Exhibit 1: (Ex.: Reconsideration request, signed by Doe, dated [Month] [DD], [YYYY].)
- Exhibit 2: (Ex: Opt-out approval letter, dated [Month] [DD], [YYYY].)

(In this section list each document submitted by the *practitioner*, as well as the original opt-out affidavit and opt-out approval letter. If auto-renewal letter(s) were sent to the *practitioner*, those shall be included as exhibits. Each exhibit should include the date, as well as a brief description of the document. The MAC shall also include all other documentation not submitted by the *practitioner* that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, auto-renewal letters etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section shall summarize the statements/arguments made by the *practitioner* in its reconsideration request. The MAC shall then conduct analysis of the *practitioner* arguments based on the applicable regulations and sub-regulations (MPIM). It is insufficient to state a reconsideration decision without explaining how and why the decision was reached.)

DECISION:

(A short conclusory restatement.)

This decision is a **FAVORABLE DECISION**. [MAC name] concludes that the correct effective date of our opt-out status is [Month] [DD], [YYYY]. 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 ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/.

To file a new appeal using DAB E-File, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the "Register New Account" form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which *the user* is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and
- Entering and uploading the requested information and documents on the "File New Appeal – Civil Remedies Division" form.

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
  - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
  - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.
- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.
- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.
- More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

10.7.12 – Deactivation Model Letters

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

(To be sent by hard-copy mail, and via email if email address is listed in the provider/supplier correspondence mailing address on the enrollment record. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier Name] (as it appears in PECOS)
[Address]
[City], [State] [Zip Code]

Re: Deactivation of Medicare billing privileges
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Provider/Supplier Name]:

Your Medicare billing privileges are being deactivated effective [Month] [DD], [YYYY] pursuant to:

DEACTIVATION REASON:

- 42 C.F.R. § 424.540(a)[1-8]

[Specific reason for the deactivation of the provider/supplier's Medicare billing privileges.]

(If the deactivation is under § 424.540(a)(1), an example narrative may include:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicare billing data and found that you have not submitted any Medicare claims in more than [six or twelve] consecutive calendar months prior to the date of this letter.)

(If the deactivation is under § 424.540(a)(2), an example narrative may include:

[Contractor Name] has been informed that Smith is deceased as of January 1, 2017. Your Medicare enrollment application, signed and certified on November 1, 2016, identifies Smith as a 5% or greater owner. [Contractor Name] has not received a Medicare enrollment application reporting this change in ownership.)

REBUTTAL RIGHTS:

If you believe that this determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.545(b). The rebuttal must be received by this office in writing within 15 calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all

information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.

The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative. (Delete next sentence if letter is related to a DMEPOS supplier's enrollment.) [Please be advised that authorized or delegated officials for groups cannot sign and submit a rebuttal on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.]

If the provider/supplier wishes to appoint a legal representative that is not an attorney to sign the rebuttal, the provider/supplier must include with the rebuttal a written notice authorizing the legal representative to act on the provider/supplier's behalf. The notice should be signed by the provider/supplier.

If the provider/supplier has an attorney sign the rebuttal, the rebuttal must include a statement from the attorney that *the attorney has* the authority to represent the provider/supplier.

If you wish to receive communication regarding your rebuttal via email, please include a valid email address in your rebuttal submission.

The rebuttal should be sent to the following:
[Contractor Rebuttal Receipt Address]
[Contractor Rebuttal Receipt Email Address]
[Contractor Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM ET/CT/MT/PT] and [x:00 AM/PM ET/CT/MT/PT].

Sincerely,

[Name] [Title] [Company]

10.7.13 – Deactivation Rebuttal Model Letters

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

Instruction

For the following model letters, all text within parentheses is intended as instruction/explanation and should be deleted before the letter is finalized and sent to the provider/supplier. All text within brackets requires the contractor to fill in the appropriate text. All letters and emails shall be saved in PDF format. The date on the letter shall be the date it was sent to the provider/supplier.

A. Deactivation Rebuttal Signature Development Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Deactivation Rebuttal Development Request
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the rebuttal]:

We are in receipt of your rebuttal submission, received on [Month] [DD], [YYYY], in response to the deactivation of [Provider/Supplier Name]'s billing privileges.

(If the submission is not properly signed, use the following.) [Your submission is not appropriately signed, as required in the Medicare Program Integrity Manual, Ch. 10, Section 10.4.8.1(C)(1). [Contractor Name] requests that you submit a rebuttal properly signed by the individual provider, supplier, the authorized or delegated official, or a legal representative. (Delete next sentence if letter is related to a DMEPOS supplier's enrollment.) [Please be advised that authorized or delegated officials for groups cannot sign and submit a rebuttal on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.] Your properly signed submission must be received within 15 calendar days of the date of this notice. If you do not timely respond to this request, [Contractor Name] may dismiss your rebuttal submission.

(If the submission is missing a statement by the attorney, use the following.) [Your submission is missing an attorney statement that *the attorney* has the authority to represent the provider or supplier. [Contractor Name] requests that you submit a rebuttal that includes an attorney statement that *the attorney has* the authority to represent the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, [Contractor Name] may dismiss your rebuttal submission.]

(If the submission is missing a signed written notice from the provider/supplier authorizing the legal representative to act on *the provider's/supplier's* behalf, use the following.) [Your submission is missing a written notice of the appointment of a representative signed by the provider or supplier. Please be advised that authorized or delegated officials for groups cannot sign and submit a rebuttal on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act

on *the reassigned provider's/supplier's* behalf. [Contractor Name] requests that you submit written notice of the appointment of a representative that is properly signed by the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, [Contractor Name] may dismiss your rebuttal submission.]

Please send the required documentation to:

[Contractor Rebuttal Receipt Address]
[Contractor Rebuttal Receipt Email Address]
Fax: [Contractor Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/CT/MT/PT] and [x:00 a.m./p.m ET/CT/MT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

B. Deactivation Rebuttal Further Information Required Development Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Deactivation Rebuttal Development Request
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Optional)

Dear [Name of the person(s) who submitted the rebuttal]:

On [Month] [DD]. [YYYY], [Contractor Name] issued a favorable rebuttal determination, reversing the deactivation of [Provider/Supplier Name]'s Medicare billing privileges. As stated in the [Month] [DD], [YYYY] determination letter, the reactivation of [Provider/Supplier

Name]'s Medicare enrollment is contingent upon the submission of [list required documentation]. Please send the required documentation to:

[Contractor Rebuttal Receipt Address]
[Contractor Rebuttal Receipt Email Address]
Fax: [Contractor Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/CT/MT/PT] and [x:00 a.m./p.m ET/CT/MT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

C. Deactivation Rebuttal Moot Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Deactivation Rebuttal Submission
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal submission, on behalf of [Provider/Supplier], received on [Month] [DD], [YYYY]. On [Month] [DD], [YYYY], [Contractor Name] approved an application to reactivate [Provider/Supplier]'s Medicare billing privileges without a gap. Therefore, the issue set forth in the rebuttal submission is no longer actionable. As a result, this issue is moot and a determination will not be made in regards to the rebuttal submission.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/CT/MT/PT] and [x:00 a.m./p.m ET/CT/MT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

D. Deactivation Rebuttal Facts or Issues and Reasons for Disagreement Development Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address] (Address from which the Rebuttal was sent)
[City], [State] [Zip Code]

Re: Deactivation Rebuttal Development Request
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the Rebuttal]:

We are in receipt of your rebuttal submission on behalf of [Provider/Supplier Name], received on [Month] [DD], [YYYY].

As stated in the deactivation letter dated [Month] [DD], [YYYY], to be accepted and reviewed, your rebuttal must state the facts or issues identified in the deactivation letter with which you disagree and your reasons for disagreement. The rebuttal received on [Month] [DD], [YYYY] does not clearly identify the facts or issues with which you disagree and your reasons for disagreement. [Contractor Name] is granting you an additional 15 calendar days from the date of this notification letter to submit a proper rebuttal that clearly identifies the facts or issues with which you disagree and your reasons for disagreement. This revised rebuttal submission must be received within 15 calendar days of the date of this notice. If you do not timely respond to this request, [Contractor Name] may dismiss your rebuttal submission.

Please send the required documentation to:

[Contractor Rebuttal Receipt Address]
[Contractor Rebuttal Receipt Email Address]

Fax: [Contractor Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/CT/MT/PT] and [x:00 a.m./p.m ET/CT/MT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

E. Deactivation Rebuttal Withdrawn Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Deactivation Rebuttal Withdrawal
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the rebuttal]:

We are in receipt of your written withdrawal request in regards to your rebuttal received on [Month] [DD], [YYYY], in response to the deactivation of [Provider/Supplier Name]'s billing privileges. [Contractor Name] has not yet issued a rebuttal determination. Therefore, [Contractor Name] considers the rebuttal to be withdrawn. As a result, a determination will not be issued in response to the rebuttal and [Provider/Supplier Name]'s Medicare billing privileges will remain deactivated.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/CT/MT/PT] and [x:00 a.m./p.m ET/CT/MT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

F. Deactivation Rebuttal Receipt Acknowledgement Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Deactivation Rebuttal Submission
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the rebuttal]:

We are in receipt of your rebuttal on behalf of [Provider/Supplier Name]. [Contractor Name] will further review the information and documentation submitted in the rebuttal and will render a final determination regarding the deactivation of [Provider/Supplier Name]'s Medicare billing privileges within 30 days of the date of receipt.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/CT/MT/PT] and [x:00 a.m./p.m ET/CT/MT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

G. Final Deactivation Rebuttal Decision Email Template

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

To: [Email address provided by the person who submitted the rebuttal and email address listed in the provider/supplier correspondence mailing address on the enrollment application if different from the email address on the rebuttal submission.]

Subject: Medicare Provider Enrollment Deactivation Rebuttal re: [Provider/Supplier Name]

Dear [Name of the person(s) who submitted the rebuttal]:

Please see the attached determination regarding your rebuttal, submitted on behalf of [Provider/Supplier Name].

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/CT/MT/PT] and [x:00 a.m./p.m ET/CT/MT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

H. Deactivation Rebuttal Dismissal Model Letters

1. Untimely Deactivation Rebuttal Dismissal Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Deactivation Rebuttal Dismissal
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [Contractor Name], based on the letter deactivating [Provider/Supplier Name]'s Medicare billing privileges dated [Month] [DD], [YYYY].

[Contractor Name] is unable to accept your rebuttal as it was not timely submitted. The deactivation letter was dated [Month] [DD], [YYYY]. A rebuttal must be received within 15 calendar days of the date of the [Month] [DD], [YYYY] deactivation letter. Your rebuttal was not received until [Month] [DD], [YYYY], which is beyond the applicable submission time frame. [Provider/Supplier/Legal Representative/Representative] failed to show good cause for the late request. Therefore, [Contractor Name] is unable to render a determination in this matter and [Provider/Supplier]'s Medicare billing privileges will remain deactivated.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/CT/MT/PT] and [x:00 a.m./p.m ET/CT/MT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

2. Improper Signature Deactivation Rebuttal Dismissal Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address](Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Deactivation Rebuttal Dismissal
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [Contractor Name], based on the letter deactivating [Provider/Supplier Name]'s Medicare billing privileges dated [Month] [DD], [YYYY].

[Contractor Name] is unable to accept your rebuttal as it was not signed by an authorized or delegated official currently on file in your Medicare enrollment, the individual practitioner, a legal representative, or did not contain the required statement of representation from an attorney

or signed written notice appointing a non-attorney legal representative. Please be advised that authorized or delegated officials for groups cannot sign and submit a rebuttal on behalf of a reassigned practitioner without the practitioner submitting a signed statement authorizing that individual to act on *the practitioner's* behalf. The signature requirement is stated in the [Month] [DD], [YYYY] deactivation letter. Additionally, in a letter dated [Month] [DD], [YYYY], [Contractor Name] requested that you provide a properly signed submission and permitted an additional 15-calendar days to submit your response.

(If no response received, use this language: [To date, [Contractor Name] has not received a response. As a result, [Contractor Name] is dismissing your rebuttal and no decision will be rendered.])

(If response received after 15 calendar days, use this language: [While [Contractor Name] received a response, it was not timely received within 15-calendar days. As a result, [Contractor Name] is dismissing your rebuttal and no decision will be rendered.])

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/CT/MT/PT] and [x:00 a.m./p.m ET/CT/MT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

3. No Rebuttal Rights Deactivation Rebuttal Dismissal Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address](Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal Submission Dismissal
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [Contractor Name], submitted on behalf of [Provider/Supplier Name].

[Contractor Name] is unable to accept your rebuttal submission because the action taken in regards to your Medicare billing privileges or enrollment does not afford the opportunity for a rebuttal. Only a provider/supplier whose enrollment is stayed under 42 C.F.R. § 424.541, or whose billing privileges are deactivated under § 424.540 may file a rebuttal. As a result, [Contractor Name] is dismissing your rebuttal and no decision will be rendered.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/MT/CT/PT] and [x:00 a.m./p.m ET/MT/CT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

4. More than One Submission Deactivation Rebuttal Dismissal Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address](Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Deactivation Rebuttal Dismissal
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal submitted on behalf of [Provider/Supplier Name], based on the deactivation letter dated [Month] [DD], [YYYY].

[Contractor Name] previously received a rebuttal for [Provider/Supplier Name] on [Month] [DD], [YYYY]. Per Chapter 10 of the Medicare Program Integrity Manual, only one rebuttal request may be submitted per deactivation. Therefore, [Contractor Name] is unable to accept your additional rebuttal[s] received on [Month] [DD], [YYYY] (list all dates). As a result,

[Contractor Name] is dismissing your rebuttal received on [Month] [DD], [YYYY] (list all dates) and no decision will be rendered.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/MT/CT/PT] and [x:00 a.m./p.m ET/MT/CT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

5. No Specification of Why the Provider/Supplier Disagrees with Enrollment Deactivation and Reasons for Disagreement Rebuttal Dismissal Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address] (Address from which the Rebuttal was sent)
[City], [State] [Zip Code]

Re*:* Deactivation Rebuttal Dismissal
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the Rebuttal]:

This letter is in response to the rebuttal submitted on behalf of [Provider/Supplier Name] based on the deactivation letter, dated [Month] [DD], [YYYY].

[Contractor Name] is unable to accept your rebuttal as it does not specify the facts or issues identified in the deactivation letter with which you disagree and your reasons for disagreement. The requirement to identify the facts or issues with which you disagree and your reasons for disagreement was stated in the deactivation letter, dated [Month] [DD], [YYYY], as well as in 42 C.F.R. § 424.546(b), and in Chapter 10 of the Medicare Program Integrity Manual. Additionally, in a letter dated [Month] [DD], [YYYY], [Contractor Name] requested that you identify the facts

or issues identified in the deactivation letter with which you disagree and your reasons for disagreement and permitted an additional 15 calendar days to submit your response.

(If no response received, use this language: [To date, [Contractor Name] has not received a response. As a result, [Contractor Name] is dismissing your rebuttal and no decision will be rendered.])

(If response received after 15 calendar days, use this language: [While [Contractor Name] received a response, it was not timely received within 15-calendar days. As a result, [Contractor Name] is dismissing your rebuttal and no decision will be rendered.])

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/MT/CT/PT] and [x:00 a.m./p.m ET/MT/CT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

I. Deactivation Rebuttal Not Actionable Model Letter (Moot)

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Deactivation Rebuttal Submission
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [Contractor Name], in response to the deactivation of [Provider/Supplier Name]'s Medicare billing privileges, effective [Month] [DD], [YYYY].

On [Month] [DD], [YYYY], [Contractor Name] reopened the deactivation for [Provider/Supplier Name] and issued a [letter reversing the deactivation or a revised deactivation letter]. This [letter reversing the deactivation or revised deactivation letter] rendered the issue set forth in your rebuttal no longer actionable. For your convenience a copy of the [letter reversing the deactivation or revised deactivation letter] is attached. Accordingly, the issue addressed in your rebuttal is now moot, and we are unable to render a determination on the matter.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/MT/CT/PT] and [x:00 a.m./p.m ET/MT/CT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

(The contractor shall include PDF copy of the letter that rendered the rebuttal moot (e.g. the letter reversing the deactivation or revised deactivation letter).)

J. Favorable Deactivation Rebuttal Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address] (Address from which the Rebuttal was sent)
[City], [State] [Zip Code]

Re: Deactivation Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the Person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [Contractor Name] based on the deactivation of [Provider/Supplier Name]'s Medicare billing privileges. (If the rebuttal was timely, use the following.) [The deactivation letter was dated [Month] [DD], [YYYY] and [Contractor Name] received the rebuttal on [Month] [DD], [YYYY]; therefore, this rebuttal is considered timely.] (If the rebuttal is untimely, but good cause has been found to accept the rebuttal, use the following.)

[The deactivation letter was dated [Month] [DD], [YYYY] and [Contractor Name] received the rebuttal on [Month] [DD], [YYYY]. This rebuttal was not timely submitted, but a good cause waiver has been granted.]) [Contractor Name] based the following determination on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DEACTIVATION REASON:

- 42 C.F.R. § 424.540(a)([1-8])

OTHER APPLICABLE AUTHORIT[Y/IES]: (list any authorities cited in analysis)

- 42 C.F.R. § 424.546
- Medicare Program Integrity Manual (MPIM) chapter 10.XX (If applicable).
- (Ex.: If deactivation based non-compliance, list supplier standards)
- (Ex.: If deactivation based on failure to report, list regulation that requires reporting)
- (Ex.: If deactivation under § 424.540(a)(8), list § 424.550(b)(1))

EXHIBITS:

- Exhibit 1: (Example: Rebuttal letter to CMS, signed by Smith, Administrator for Home Healthcare Services, LLC, dated January 1, 2018);
- Exhibit 2: (Example: Letter from [Contractor Name] to Home Healthcare Services, LLC, dated December 1, 2017, deactivating Home Healthcare Services, LLC's Medicare billing privileges pursuant to 42 C.F.R. § 424.540(a)(3)).

(In this section list each document submitted by the provider/supplier. Each exhibit shall include the date, as well as a brief description of the document. The contractor shall also include other documentation not submitted by the provider/supplier that the hearing officer reviewed in making the determination, e.g., enrollment applications, development letters, etc. The deactivation letter shall be included as an Exhibit.)

BACKGROUND:

[Contractor Name] has reviewed the documentation related to the matter for [Provider/Supplier Name] and made the determination in accordance with the applicable Medicare rules, policies and program instructions.

(Summarize the facts underlying the case which led up to the submission of the rebuttal.)

REBUTTAL ANALYSIS:

(A rebuttal reviews whether or not an error was made in the implementation of the deactivation of the provider's/supplier's Medicare billing privileges. This section shall summarize the statements made by the provider/supplier in its rebuttal, then provide an analysis of the arguments based on the applicable regulations and sub-regulations, such as the MPIM. Any regulation or sub-regulatory guidance that is referenced in this section shall also be listed in

"Other Applicable Authorities." It is insufficient to state a rebuttal determination without explaining how and why the determination was made.)

DECISION:

(A short conclusory restatement.)

(Example: On [Month] [DD], [YYYY], [Contractor Name] received a revalidation application for Home Healthcare Services, LLC. On [Month] [DD], [YYYY], [Contractor Name] rejected Home Healthcare Services, LLC's revalidation application prior to 90 calendar days from the date of the revalidation request letter. As a result, [Contractor Name] finds that the deactivation of Home Healthcare Services, LLC's Medicare billing privileges was not appropriately implemented based on the information available.)

This is a **FAVORABLE DETERMINATION**. To effectuate this determination, [Contractor name] will reinstate [Provider/Supplier Name]'s Medicare billing privileges.

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the Contractor shall state what information is needed from the provider or supplier in this rebuttal determination. Contractors shall state that the requested information/documentation must be received within 30 calendar days of the date of this determination letter)

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m. ET/MT/CT/PT] and [x:00 a.m./p.m. ET/MT/CT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

K. Unfavorable Deactivation Rebuttal Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address] (Address from which the Rebuttal was sent)
[City], [State] [Zip Code]

Re: Deactivation Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [Contractor Name] based on the deactivation of [Provider/Supplier Name]'s Medicare billing privileges. (If the rebuttal was timely, use the following.) [The deactivation letter was dated [Month] [DD], [YYYY] and [Contractor Name] received the rebuttal on [Month] [DD], [YYYY]; therefore, this rebuttal is considered timely.] (If the rebuttal is untimely, but good cause has been found to accept the rebuttal, use the following.) [The deactivation letter was dated [Month] [DD], [YYYY] and [Contractor Name] received the rebuttal on [Month] [DD], [YYYY]. This rebuttal was not timely submitted, but a good cause waiver has been granted.]) [Contractor Name] based the following determination on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DEACTIVATION REASON:

- 42 C.F.R. § 424.540(a)([1-8])

OTHER APPLICABLE AUTHORIT[Y/IES]: (list any authorities cited in analysis)

- 42 C.F.R. § 424.546
- Medicare Program Integrity Manual chapter 10.XX (If applicable)
- (Ex.: If deactivation based non-compliance, list supplier standards)
- (Ex.: If deactivation based on failure to report, list regulation that requires reporting)
- (Ex.: If deactivation under § 424.540(a)(8), list § 424.550(b)(1))

EXHIBITS:

- Exhibit 1: (Example: Rebuttal letter to CMS, signed by Smith, Administrator for Home Healthcare Services, LLC, dated January 1, 2018);
- Exhibit 2: (Example: Letter from [Contractor Name] to Home Healthcare Services, LLC, dated December 1, 2017, deactivating Home Healthcare Services, LLC's Medicare billing privileges pursuant to 42 C.F.R. § 424.540(a)(3)).

(In this section list each document submitted by the provider/supplier. Each exhibit shall include the date, as well as a brief description of the document. The Contractor shall also include other documentation not submitted by the provider/supplier that the hearing officer reviewed in making the determination, e.g., enrollment applications, development letters, etc. The deactivation letter shall be included as an Exhibit.)

BACKGROUND:

[Contractor Name] has reviewed the documentation related to the matter for [Provider/Supplier Name] and made the determination in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the rebuttal.)

REBUTTAL ANALYSIS:

(A rebuttal reviews whether or not an error was made in the implementation of the deactivation of the provider's/supplier's Medicare billing privileges. This section shall summarize the statements made by the provider/supplier in its rebuttal, then provide an analysis of the arguments based on the applicable regulations and sub-regulations, such as the MPIM. Any regulation or sub-regulatory guidance that is referenced in this section shall also be listed in "Other Applicable Authorities." It is insufficient to state a rebuttal determination without explaining how and why the determination was made.)

DECISION:

(A short conclusory restatement.)

(Example: On [Month] [DD], [YYYY], [Contractor Name] received a revalidation application for Home Healthcare Services, LLC. On [Month] [DD], [YYYY], [Contractor Name] sent a development request to continue processing Home Healthcare Services, LLC's revalidation application. Home Healthcare Services, LLC did not timely respond to [Contractor Name]'s development request. As a result, [Contractor Name] properly rejected Home Healthcare Services, LLC's revalidation application. Therefore, [Contractor Name] finds that the deactivation of Home Healthcare Services, LLC's Medicare enrollment under 42 C.F.R. § 424.540(a)([1-8]) was appropriately implemented.)

This is an **UNFAVORABLE DETERMINATION**. [Contractor name] concludes that there was no error made in the deactivation of [Provider/Supplier Name]'s Medicare billing privileges. As a result, [Provider/Supplier Name]'s Medicare billing privileges will remain deactivated.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/MT/CT/PT] and [x:00 a.m./p.m ET/MT/CT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

10.7.14 – Model Opt-out Letters

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

Instruction

The Contractors shall use the model letters in this section to respond to eligible practitioners' opt-out affidavits, request additional documentation, approve opt-out affidavits and acknowledge the cancelation, or early termination of an opt-out. The Contractors shall not use these model letters to respond to Medicare enrollment applications or other correspondence. The Contractors may issue the Model Opt-out Development Letter via fax, e-mail, or mail to the eligible practitioner.

For the following model letters, all text within parentheses is intended as instruction/explanation and should be deleted before the letter is finalized and sent to the provider/supplier. All text within brackets requires the contractor to fill in the appropriate text. All letters and emails shall be saved in PDF format. The date on the letter shall be the date it was sent to the provider/supplier.

A. Opt-out Affidavit Development Letter

(MACs shall use the following letter to request missing information from an eligible practitioner that wishes to opt-out of Medicare. This letter should be sent only one time and include a request for all missing information. The MAC may select the response type, either via mail, fax or email.)

[month] [day], [year]

[Eligible Practitioner Name]
[Address]
[City] [ST] [Zip]

Reference: [Case/Control Number]

Dear [Eligible Practitioner]:

[MAC] requires the following information to complete the processing of your Medicare opt-out affidavit:

- [Specify information needed]

Submit the requested information within 30 calendar days of the postmark date of this letter [to the address listed below, via fax to (###-###-####), or via email to /enter PE analyst's email address here]]. We may reject your opt-out affidavit if you do not furnish the requested information within this timeframe.

[Name of MAC]
[Address]
[City], [ST] [Zip]

Attach a copy of this letter with your revised opt-out affidavit.

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM] .

Sincerely,

[Name]
[Title]
[Company]

B. Opt-out Rejection Letter

(If an eligible practitioner does not respond timely or does not respond with needed information to complete an opt-out affidavit, the MACs shall issue this rejection letter.)

[month] [day], [year]

[Eligible Practitioner Name]
[Address]
[City] [ST] [Zip]

Reference: [Case/Control Number]

Dear [Eligible Practitioner Name]:

[MAC] is rejecting your Medicare opt-out affidavit, received on [insert date], for the following reason(s):

- [List all reasons for rejection]

To resubmit your opt-out affidavit include all information needed to process your opt-out request. Additional information on submitting a complete opt-out affidavit can be found at: [enter MAC website address].

Resubmit your completed opt-out affidavit to:
[Name of MAC]
[Address]
[City], [ST] [Zip]

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,
[Name]
[Title]
[Company]

C. Opt-out Return Letters

Opt-out affidavits should only be returned for the following reasons:

1. The eligible practitioner requesting to opt-out of Medicare is not appropriately licensed by the state;
2. The practitioner is a specialty that is ineligible to opt-out (e.g., Chiropractic Medicine, Physical Therapy, Occupational Therapy, etc.);
3. The opt-out affidavit is filed with an incorrect MAC;
4. The eligible practitioner decides not to opt out of Medicare while the opt-out affidavit is still in process, but not yet approved by the MAC;
5. The eligible practitioner submits a cancellation request too late (within 30 days of the auto-renewal date or after the auto-renewal date). This return letter provides appeal rights; or
6. The eligible practitioner submits a cancellation request more than 90 days prior to the auto-renewal date.

MACs shall issue the specific letter for the return reason.

1. Opt-out Return Letter – Unlicensed Eligible Practitioner

[month] [day], [year]

[Eligible Practitioner Name]
[Address]
[City] [ST] [Zip]

Reference: [Case/Control Number] (optional)
NPI: [xxxxxxxxxx]

Dear [Eligible Practitioner Name]:

[Insert MAC] is returning your Medicare opt-out affidavit, submitted on [insert date], as you are not licensed by the state for the specialty type you indicated on your opt-out affidavit.

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]

[Title]
[Company]

2. Opt-out Return Letter – Ineligible Practitioner

[month] [day], [year]

[Eligible Practitioner Name]
[Address]
[City] [ST] [Zip]

Reference: [Case/Control Number]
NPI: [xxxxxxxxxx]

Dear [Eligible Practitioner Name]:

[Insert MAC] is returning your Medicare opt-out affidavit, submitted on [insert date], because you indicated a specialty that is ineligible to opt-out (e.g., Chiropractic Medicine, Physical Therapy, Occupational Therapy, etc.) of Medicare.

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

3. Opt-out Return Letter – Submitted to Incorrect MAC

[month] [day], [year]

[Eligible Practitioner Name]
[Address]
[City] [ST] [Zip]

Reference: [Case/Control Number]
NPI: [xxxxxxxxxx]

Dear [Eligible Practitioner Name]:

[Insert MAC] is returning your Medicare opt-out affidavit, submitted on [insert date], because your opt-out affidavit was filed with an incorrect Medicare Administrative Contractor for the

state that you are located in. Your affidavit should be resubmitted to the appropriate contractor for processing.

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,
[Name]
[Title]
[Company]

4. Opt-out Return Letter – Withdraw of Affidavit During Processing

[month] [day], [year]
[Eligible Practitioner Name]
[Address]
[City] [ST] [Zip]

Reference: [Case/Control Number]
NPI: [xxxxxxxxxx]

Dear [Eligible Practitioner Name]:

[Insert MAC] is returning your Medicare opt-out affidavit, submitted on [insert date], because you have decided to withdraw your opt-out affidavit while it is still in process.

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,
[Name]
[Title]
[Company]

5. Opt-out Return Letter – Late Cancellation Request

[Month] [DD], [YYYY]

[Eligible Practitioner Name]
[Address from which opt-out was sent]
[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)
NPI: [xxxxxxxxxx]

We Can't Cancel Your Medicare Opt-Out Status

Dear [Eligible Practitioner Name]:

We can't cancel the automatic renewal of your Medicare opt-out status because we didn't get your cancellation request in time. Your opt-out status automatically renewed for 2 years on [Month] [DD], [YYYY].

To properly cancel your opt-out status, you needed to submit your request by [Month] [DD], [YYYY], which was at least 30 days before your automatic opt-out renewal. [Contractor Name] is returning your written request, which they got on [Month] [DD], [YYYY].

Next Steps

If you don't request reconsideration, your next chance to cancel the automatic renewal of your Medicare opt-out status is prior to [Month] [DD], [YYYY] for the renewal that will occur on [Month] [DD], [YYYY].

If you believe you submitted a proper cancellation request before [Month] [DD], [YYYY], you can submit a reconsideration request to appeal the determination that you didn't timely or properly cancel your opt-out status. CMS (or a contractor) will review your request to see if we made an error in determining that you didn't cancel your opt-out status in a proper or timely manner. We'll base this decision on the information you include in your reconsideration request, CMS and contractor documents, and applicable regulations in 42 C.F.R. §§ 405.400-405.455. Submitting a reconsideration request doesn't allow you to submit (or allow us to accept) an untimely request to cancel your opt-out status.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the implementation of the initial determination. (Optional Coversheet sentence) [To facilitate the processing of your reconsideration request, please utilize and include the attached coversheet [also found at [[insert web address for coversheet]] with your submission.]

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney has* the authority to represent the provider or supplier is sufficient to accept this individual as the representative.

- If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
- Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

Failure to submit a reconsideration request is deemed a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Contractor Name]
[Address]
[City], [ST] [Zip]

Or emailed to: [Contractor appeal email].

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

6. Opt-out Return Letter – Cancellation Request Submitted Too Early

[Month] [DD], [YYYY]

[Eligible Practitioner Name]
[Address from which opt-out was sent]

[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)
NPI: [xxxxxxxxxx]

Dear [Eligible Practitioner Name]:

[Contractor Name] is returning your written request to cancel the automatic renewal your Medicare opt-out status, submitted on [Month] [DD], [YYYY], as it was submitted at more than 90 days prior to the end of your current opt-out period.

Please submit your cancellation request no later than 30 days prior to the end of your current opt-out period to avoid auto-renewal of your opt-out status. The end of your current opt-out period is: [Month] [DD], [YYYY].

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

D. Opt-out Affidavit Approval Letters

The Contractors shall issue an Opt-out Affidavit Approval model letter when approving an opt-out affidavit and PECOS has been updated with the affidavit information. The approval letter shall be issued for the following reasons:

1. Approved Opt-Out, Eligible Practitioner May Order & Refer
2. Approved Opt-Out, Eligible Practitioner May Not Order & Refer (OIG Exclusion)
3. Approved Opt-Out, Eligible Practitioner May Not Order & Refer (Ineligible Specialty)
4. Approved Opt-Out, Eligible Practitioner May Not Order & Refer (Did Not Elect to Order & Refer)
5. Approved Opt-Out, Eligible Practitioner May Not Order & Refer (Eligible Practitioner Does Not Have an NPI)
6. Approved Opt-Out, Eligible Practitioner May Not Order & Refer (Eligible Practitioner has Revoked Billing Privileges)
7. Approved Opt-Out Change of Information

The Opt-out approval letter shall include:

- The eligible practitioner’s personal information:

  - Name,
  - Address,
  - NPI,
  - Specialty, and
  - Eligibility to order and refer.

- The eligible practitioner's opt-out effective date.

- The date that the eligible practitioner can submit a request to cancel the opt-out affidavit (at least 30 days prior to the end-date of the current opt-out period).

- The date the eligible practitioner can terminate opt-out early (if they are eligible to so, no later than 90 days after the effective date) of the eligible practitioner's initial 2-year opt-out period.

- Should the eligible practitioner opt-out a subsequent time after cancelling, contractors shall remove the paragraph noting "Since you are opting out for the very first time…" since this statement no longer applies.

1. Opt-out Affidavit Approval Letter – Eligible Practitioner Approved to Order & Refer

[Month] [DD], [YYYY]
[Eligible Practitioner Name]
[Address from which opt-out was sent]
[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)

Dear [Eligible Practitioner Name]:

You've Successfully Opted Out of Medicare

Opt-out Affidavit Information:

Practitioner Name:	[Name]
Address:	[Address, City, State, Zip]
NPI:	[NPI]
Specialty:	[Specialty]
Ordering and Referring:	You're eligible to Order and Refer
Effective Date:	[Effective date]

[Contractor Name] approved your Medicare opt-out affidavit. **You don't need to take additional action at this time.** However, since you're opting out of Medicare for the first time, you have a one-time, 90-day period to change your mind about opting out. If you decide to terminate your opt-out status during this 90-day period, submit your written request by [Month] [DD], [YYYY]. After this 90-day period ends, you can cancel your opt-out status at the end of the 2 year opt-out period only. Your opt-out status will automatically renew every 2 years.

To cancel your opt-out status, submit written cancellation request at least 30 days before the end of the opt-out period. For example, if you decide you want to cancel your opt-out status at the end of this opt-out period, submit your cancellation request by [Month] [DD], [YYYY].

If you believe you submitted a proper termination request within 90 days of the effective date above, you can submit a reconsideration request. A reconsideration request allows you to appeal the determination that you didn't timely and properly terminate your opt-out status. CMS (or a contractor) will review your request to see if we made an error in determining that you didn't terminate your opt-out status in a proper or timely manner. We'll base this decision on the information you include in your reconsideration request, CMS and contractor documents, and applicable regulations 42 C.F.R. §§ 405.400-405.455. Submitting a reconsideration request doesn't allow you to submit (or allow us to accept) an untimely request to terminate your opt-out status. **You may submit a reconsideration request by [Month] [DD], [YYYY] (65 days after the 90-day termination period ends).).**

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the implementation of the initial determination. (Optional Coversheet sentence) [To facilitate the processing of your reconsideration request, please utilize and include the attached coversheet [also found at [[insert web address for coversheet]] with your submission.]

Reconsideration requests must:

- Be received in writing by the date indicated above and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement *that the attorney has* the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

Failure to submit a reconsideration request is deemed a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Contractor Name]
[Address]
[City], [ST] [Zip]

Or emailed to: [Contractor email].

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,
[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

2. Opt-out Affidavit Approval Letter – Eligible Practitioner May Not Order & Refer (Excluded by the OIG)

[Month] [DD], [YYYY]

[Eligible Practitioner Name]
[Address from which opt-out was sent]
[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)

Dear [Eligible Practitioner Name]:

[Insert Contractor] approved your Medicare opt-out affidavit.

Opt-out Affidavit Information:

Eligible Practitioner Name:	[Name]
Address on File:	[Address, City, State, Zip]
National Provider Identifier (NPI):	[NPI]
Specialty:	[Specialty]
Ordering and Referring:	You are not eligible to Order and Refer*
Effective Date:	[Effective date]

* You have been excluded by the OIG (and even if you have or have not obtained a waiver according to 42 C.F.R. § 1001.1901(c)), you may opt-out of Medicare, but you are not permitted to order and refer items and services to Medicare beneficiaries.

Your opt-out will automatically renew every 2 years.

Since you are opting out for the very first time, you have a one-time, 90-day period to change your mind about opting out. If you decide to terminate during this 90-day period, you must submit your request, in writing, no later than [Month] [DD], [YYYY]. After this 90-day period ends, you can only cancel the opt-out at the end of a 2 year opt-out period. If you were unable to submit a termination request, you may appeal after the 90-day period ends. Please follow the Right to Submit a Reconsideration Request sections below.

To cancel opt-out, you must submit a cancellation request at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out at the end of this opt-out period, you must submit your cancellation request before [Month] [DD], [YYYY].

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the implementation of the initial determination. (Optional Coversheet sentence) [To facilitate the processing of your reconsideration request, please utilize and include the attached coversheet [also found at [[insert web address for coversheet]] with your submission.]

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney has* the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.

- Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

Failure to submit a reconsideration request is deemed a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Contractor Name]
[Address]
[City], [ST] [Zip]

Or emailed to: [Contractor appeal email].

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

3. Opt-out Affidavit Approval Letter – Eligible Practitioner May Not Order & Refer (Ineligible Specialty)

[Month] [DD], [YYYY]

[Eligible Practitioner Name]
[Address from which opt-out was sent]
[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)

Dear [Eligible Practitioner Name]:

[Insert Contractor] approved your Medicare opt-out affidavit.

Opt-out Affidavit Information:

Eligible Practitioner Name:	[Name]
Address on File:	[Address, City, State, Zip]
National Provider Identifier (NPI):	[NPI]
Specialty:	[Specialty]
Ordering and Referring:	You are not eligible to Order and Refer*
Effective Date:	[Effective date]

* You may opt-out of Medicare, but you are not permitted to order and refer items and services to Medicare beneficiaries, as your specialty is ineligible to order and refer.

Your opt-out will automatically renew every 2 years.

Since you are opting out for the very first time, you have a one-time, 90-day period to change your mind about opting out. If you decide to terminate during this 90-day period, you must submit your request, in writing, no later than [Month] [DD], [YYYY]. After this 90-day period ends, you can only cancel the opt-out at the end of a 2 year opt-out period. If you were unable to submit a termination request, you may appeal after the 90-day period ends. Please follow the Right to Submit a Reconsideration Request section below.

To cancel opt-out, you must submit a cancellation request at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out at the end of this opt-out period, you must submit your cancellation request before [Month] [DD], [YYYY].

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the implementation of the initial determination. (Optional Coversheet sentence) [To facilitate the processing of your reconsideration request, please utilize and include the attached coversheet [also found at [[insert web address for coversheet]] with your submission.]

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

- If the authorized representative is an attorney, the attorney's statement that *the attorney has* the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
- If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
- Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

Failure to submit a reconsideration request is deemed a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Contractor Name]
[Address]
[City], [ST] [Zip]

Or emailed to: [Contractor appeal email].

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

<u>4. Opt-out Affidavit Approval Letter – Eligible Practitioner May Not Order & Refer (Did Not Elect to Order and Refer)</u>

[Month] [DD], [YYYY]

[Eligible Practitioner Name]
[Address from which opt-out was sent]
[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)

Dear [Eligible Practitioner Name]:

[Insert Contractor] approved your Medicare opt-out affidavit.

Opt-out Affidavit Information:

Eligible Practitioner Name:	[Name]
Address on File:	[Address, City, State, Zip]
National Provider Identifier (NPI):	[NPI]
Specialty:	[Specialty]
Ordering and Referring:	You are not eligible to Order and Refer*
Effective Date:	[Effective date]

* You may opt-out of Medicare, but you are not permitted to order and refer items and services to Medicare beneficiaries as you did not elect to be and ordering and referring practitioner on your opt-out affidavit.

Your opt-out will automatically renew every 2 years.

Since you are opting out for the very first time, you have a one-time, 90-day period to change your mind about opting out. If you decide to terminate during this 90-day period, you must submit your request, in writing, no later than [Month] [DD], [YYYY]. After this 90-day period ends, you can only cancel the opt-out at the end of a 2 year opt-out period. If you were unable to submit a termination request, you may appeal after the 90-day period ends. Please follow the Right to Submit a Reconsideration Request section below.

To cancel opt-out, you must submit a cancellation request at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out at the end of this opt-out period, you must submit your cancellation request before [Month] [DD], [YYYY].

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the implementation of the initial determination. (Optional Coversheet sentence) [To facilitate the processing of your reconsideration request, please utilize and include the attached coversheet [also found at [[insert web address for coversheet]] with your submission.]

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney has* the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

Failure to submit a reconsideration request is deemed a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Contractor Name]
[Address]
[City], [ST] [Zip]

Or emailed to: [Contractor appeal email].

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]

[Position of Hearing Officer]
[Contractor Name]

5. Opt-out Affidavit Approval Letter – Eligible Practitioner May Not Order & Refer (Eligible Practitioner Does Not Have an NPI)

[Month] [DD], [YYYY]

[Eligible Practitioner Name]
[Address from which opt-out was sent]
[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)

Dear [Eligible Practitioner Name]:

[Insert Contractor] approved your Medicare opt-out affidavit.

Opt-out Affidavit Information:

Eligible Practitioner Name:	[Name]
Address on File:	[Address, City, State, Zip]
National Provider Identifier (NPI):	[Not Provided]
Specialty:	[Specialty]
Ordering and Referring:	You are not eligible to Order and Refer*
Effective Date:	[Effective date]

* You may opt-out of Medicare, but you are not permitted to order and refer items and services to Medicare beneficiaries, as you have not obtained an NPI.

Your opt-out will automatically renew every 2 years.

Since you are opting out for the very first time, you have a one-time, 90-day period to change your mind about opting out. If you decide to terminate during this 90-day period, you must submit your request, in writing, no later than [Month] [DD], [YYYY]. After this 90-day period ends, you can only cancel the opt-out at the end of a 2 year opt-out period. If you were unable to submit a termination request, you may appeal after the 90-day period ends. Please follow the Right to Submit a Reconsideration Request section below.

To cancel opt-out, you must submit a cancellation request at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out at the end of this opt-out period, you must submit your cancellation request before [Month] [DD], [YYYY].

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the implementation of the initial determination. (Optional Coversheet sentence) [To facilitate the processing of your reconsideration request, please utilize and include the attached coversheet [also found at [[insert web address for coversheet]] with your submission.]

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney has* the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

Failure to submit a reconsideration request is deemed a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Contractor Name]
[Address]
[City], [ST] [Zip]

Or emailed to: [Contractor appeal email].

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

6. Opt-out Affidavit Approval Letter – Eligible Practitioner May Not Order & Refer (Eligible Practitioner Has Revoked Billing Privileges)

[Month] [DD], [YYYY]

[Eligible Practitioner Name]
[Address from which opt-out was sent]
[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)

Dear [Eligible Practitioner Name]:

[Insert Contractor] approved your Medicare opt-out affidavit.

Opt-out Affidavit Information:

Eligible Practitioner Name:	[Name]
Address on File:	[Address, City, State, Zip]
National Provider Identifier (NPI):	[NPI]
Specialty:	[Specialty]
Ordering and Referring:	You are not eligible to Order and Refer*
Effective Date:	[Effective date]

* Your billing privileges have been revoked, you may opt-out of Medicare, but you are not permitted to order and refer items and services to Medicare beneficiaries

Your opt-out will automatically renew every 2 years.

Since you are opting out for the very first time, you have a one-time, 90-day period to change your mind about opting out. If you decide to terminate during this 90-day period, you must submit your request, in writing, no later than [Month] [DD], [YYYY]. After this 90-day period ends, you can only cancel the opt-out at the end of a 2 year opt-out period. If you were unable to submit a termination request, you may appeal after the 90-day period ends. Please follow the Right to Submit a Reconsideration Request section below.

To cancel opt-out, you must submit a cancellation request at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out at the end of this opt-out period, you must submit your cancellation request before [Month] [DD], [YYYY].

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the implementation of the initial determination. (Optional Coversheet sentence) [To facilitate the processing of your reconsideration request, please utilize and include the attached coversheet [also found at [[insert web address for coversheet]] with your submission.]

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that *the attorney has* the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

Failure to submit a reconsideration request is deemed a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Contractor Name]
[Address]
[City], [ST] [Zip]

Or emailed to: [Contractor appeal email].

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

7. Opt-out Affidavit Approval Letter – Approved Opt-Out Change of Information

[Month] [DD], [YYYY]

[Eligible Practitioner Name]
[Address from which opt-out was sent]
[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)

Dear [Eligible Practitioner Name]:

[Insert Contractor] has updated your Medicare opt-out affidavit.

Opt-out Affidavit Information:

Eligible Practitioner Name:	[Name]
Address on File:	[Address, City, State, Zip]
National Provider Identifier (NPI):	[NPI]
Specialty:	[Specialty]
Ordering and Referring:	You [are/are not] eligible to Order and Refer[*]
Effective Date:	[Effective date]
Changed Information:	

[* You may opt-out of Medicare, but you are not permitted to order and refer items and services to Medicare beneficiaries, as you have {enter reason for inability to order and refer}.]

As a reminder, to cancel opt-out, you must submit a cancellation request at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out at the

end of this opt-out period, you must submit your cancellation request before [Month] [DD], [YYYY].

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/MT/CT/PT] and [x:00 a.m./p.m ET/MT/CT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

E. Opt-out Renewal Alert Letter

(The contractor shall issue the following letter to inform the eligible practitioner that the opt-out is due to be automatically renewed.)

[Month] [DD], [YYYY]
[Eligible Practitioner Name]
[Address from which opt-out was sent]
[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)
NPI: [xxxxxxxxxx]

Action Needed to Cancel Your Medicare Opt-Out Status

Dear [Eligible Practitioner Name]:

Your Medicare opt-out status will be automatically renewed for a new 2-year opt-out period on [Month] [DD], [YYYY]. You don't need to take additional action at this time.

However, if you would like to cancel your opt-out status, submit a written cancellation request by [Month] [DD], [YYYY], which is at least 30 days before the end of your current opt-out period.

If you believe you submitted a proper cancellation request by [Month] [DD], [YYYY], you can submit a reconsideration request. A reconsideration request allows you to appeal the determination that you didn't timely and properly terminate your opt-out status. CMS (or a contractor) will review your request to see if we made an error in determining that you didn't cancel your opt-out status in a proper or timely manner. We'll base this decision on the information you include in your reconsideration request, CMS and contractor documents, and applicable regulations 42 C.F.R. §§ 405.400-405.455. Submitting a reconsideration request doesn't allow you to submit (or allow us to accept) an untimely request to cancel your opt-out

status. **You may submit a reconsideration request by [Month] [DD], [YYYY] (65 days after the last day to cancel the current opt-out period).**

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the implementation of the initial determination. (Optional Coversheet sentence) [To facilitate the processing of your reconsideration request, please utilize and include the attached coversheet [also found at [[insert web address for coversheet]] with your submission.]

Reconsideration requests must--

- Be received in writing by the date indicated above and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

    - If the authorized representative is an attorney, the attorney's statement that *the attorney has* the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request; and
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may--

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted; and
- Include an email address if you want to receive correspondence regarding your appeal via email.

Failure to submit a reconsideration request is deemed a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Contractor Name]
[Address]
[City], [ST] [Zip]

Or emailed to: ([Contractor email].

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

F. Opt-out Affidavit Termination Letter
(If an eligible practitioner timely terminates the initial opt-out, the Contractors shall acknowledge this action by using this model letter.)

[Month] [DD], [YYYY]

[Eligible Practitioner Name]
[Address from which request was sent]
[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)
NPI: [xxxxxxxxxx]

Dear [Eligible Practitioner Name]:

[Insert Contractor] completed your request to terminate your Medicare opt-out affidavit.

Want to enroll as a Medicare billing provider or for the sole purpose of ordering and referring? Submit the appropriate Provider Enrollment Chain and Ownership System (PECOS) application or paper CMS-855 form.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the implementation of the initial determination. (Optional Coversheet sentence) [To facilitate the processing of your reconsideration request, please utilize and include the attached coversheet [also found at [[insert web address for coversheet]] with your submission.]

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

    - If the authorized representative is an attorney, the attorney's statement that *the attorney has* the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

Failure to submit a reconsideration request is deemed a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Contractor Name]
[Address]
[City], [ST] [Zip]

Or emailed to: [Contractor appeal email].

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

G. Opt-out Affidavit Cancellation Letter
(If an eligible practitioner timely submits an opt-out cancellation request, the Contractors shall acknowledge this action by using this model letter.)

[Month] [DD], [YYYY]

[Eligible Practitioner Name]
[Address from which request was sent]
[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)
NPI: [xxxxxxxxxx]

Dear [Eligible Practitioner Name]:

[Contractor Name] completed your request to cancel your Medicare opt-out affidavit.

Your opt-out status will be canceled effective [Month] [DD], [YYYY].

Want to enroll as a Medicare billing provider or for the sole purpose of ordering of referring? Submit the appropriate Provider Enrollment Chain and Ownership System (PECOS) application or paper CMS-855 form.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the implementation of the initial determination. (Optional Coversheet sentence) [To facilitate the processing of your reconsideration request, please utilize and include the attached coversheet [also found at [[insert web address for coversheet]] with your submission.]

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

- If the authorized representative is an attorney, the attorney's statement that *the attorney has* the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
- If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
- Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

Failure to submit a reconsideration request is deemed a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Contractor Name]
[Address]
[City], [ST] [Zip]

Or emailed to: [Contractor appeal email].

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

10.7.15 –Revalidation Notification Letters

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

A. Revalidation Letter – Non-DMEPOS Supplier

REVALIDATION

[month] [day], [year]

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

Dear [Provider/Supplier Name],

Every five years, CMS requires you to revalidate your Medicare enrollment record. You need to update or confirm all the information in your record, including your practice locations and reassignments.

We need this from you by **[Due date, as Month dd yyyy]**. If we don't receive your response by then, we may stop your Medicare billing privileges.

If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

What record needs revalidating by [Due date, as Month dd yyyy]

[Name] | **NPI** [NPI] | **PTAN** [PTAN]
Reassignments: <Only include this title if the record has any reassignments>
[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]
<Repeat for other reassignments>

CMS lists the records that need revalidating at go.cms.gov/MedicareRevalidation.

What you need to do

Revalidate your Medicare enrollment record, through https://pecos.cms.hhs.gov/pecos/login.do or [form CMS-855 or Form CMS-20134].

- **Online:** PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.
- **Paper:** Download the right version of form [CMS-855 or Form CMS-20134] for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].

If you have a fee due, use PECOS to pay. If you feel you qualify for a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification. For more on fees and exceptions, search cms.gov for "CR 7350" or "Fee Matrix".

A new Electronic Funds Transfer (EFT) Authorization Form (CMS-588) is only required to be submitted as part of your revalidation package if: (1) you have no Form CMS-588 on file with Medicare at all; or (2) you are changing any of your existing Form CMS-588 data.
The current version of the form can be found at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS588.pdf.

If you need help

Visit go.cms.gov/MedicareRevalidation
Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name]
[Title]
[Company]

B. Revalidation Letter – DMEPOS Supplier

REVALIDATION

[month] [day], [year]
[Provider/Supplier Name]
[Address]
[City], [State] [Zip Code]

Dear [Provider/Supplier Name],

Every three years, CMS requires you to revalidate your Medicare enrollment record. You need to update or confirm all the information in your record, including your practice location.

We need this from you by [Due date, as Month dd yyyy]. If we do not receive your response by then, we may stop your Medicare billing privileges.

If you are a non-certified provider or supplier and your enrollment is deactivated, you will maintain your original PTAN. However, you will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

What record needs revalidating by [Due date, as Month dd yyyy]
[Name] | NPI [NPI] | PTAN [PTAN]
[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]

The CMS lists the records that need revalidating at go.cms.gov/MedicareRevalidation.

What you need to do

Revalidate your Medicare enrollment record, through https://pecos.cms.hhs.gov/pecos/login.do or [Form CMS-855S ~~or Form CMS-20134~~].

- **Online:** PECOS is the fastest option. If you do not know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.

- **Paper:** Download the right version of form [CMS-855S] for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].

If you have a fee due, use PECOS to pay. If you feel you qualify for a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification. For more on fees and exceptions, search cms.gov for "CR 7350" or "Fee Matrix".

A new Electronic Funds Transfer (EFT) Authorization Form (CMS-588) is only required to be submitted as part of your revalidation package if: (1) you have no Form CMS-588 on file with Medicare at all; or (2) you are changing any of your existing Form CMS-588 data.

The current version of the form can be found at http://www.cms.gov/Medicare/CMSForms/CMS-Forms/Downloads/CMS588.pdf.

If you need help

Visit go.cms.gov/MedicareRevalidation
Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name]
[Title]
[Company]

C. Revalidation Letter – CHOW Scenario Only

[month] [day], [year]

PROVIDER/SUPPLIER NAME
ADDRESS 1, ADDRESS 2
CITY STATE ZIP CODE

NPI:
PTAN:

Dear Provider/Supplier Name:

THIS IS A PROSPECTIVE PROVIDER ENROLLMENT REVALIDATION REQUEST

IMMEDIATELY SUBMIT AN UPDATED
PROVIDER ENROLLMENT PAPER APPLICATION 855 FORM TO VALIDATE YOUR ENROLLMENT INFORMATION

In accordance with Section 6401 (a) of the Patient Protection and Affordable Care Act, all new and existing providers must be reevaluated under the new screening guidelines. Medicare requires all enrolled providers and suppliers to revalidate their enrollment information every five years (reference 42 CFR §424.515). To ensure compliance with these requirements, existing regulations at 42 CFR §424.515(d) provide that the Centers for Medicare & Medicaid Services (CMS) is permitted to conduct off-cycle revalidations for certain program integrity purposes. Upon the CMS request to revalidate its enrollment, the provider/supplier has 60 days from the post mark date of this letter to submit complete enrollment information.

You previously submitted a change of ownership (CHOW) application that is currently being reviewed by the State Agency. Since your application has not been finalized, please validate that we have the most current information on file. Any updated information received since your initial submission will be forwarded to the State Agency for *a* final determination.

Providers and suppliers can validate their provider enrollment information using the paper application form. To validate by paper, download the appropriate and current CMS-855 Medicare Enrollment application from the CMS Web site at https://www.cms.gov/MedicareProviderSupEnroll/. Mail your completed application and all required supporting documentation to the [insert contractor name], at the address below.

[Insert application return address]

A new Electronic Funds Transfer (EFT) Authorization Form (CMS-588) is only required to be submitted as part of your revalidation package if (1) you have no Form CMS-588 on file with Medicare at all; or (2) you are changing any of your existing Form CMS-588 data. The current version of the form can be found at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS588.pdf.

If additional time is required to complete the validation applications, you may request one 60-day extension, which will be added onto the initial 60 days given to respond to the request. The request may be submitted in writing from the individual provider, the Authorized or Delegated Official of the organization or the contact person and addressed to the MAC(s). The request should include justification of why a 60-day extension is needed. The request may also be made by contacting your MAC(s), via phone.

Physicians, non-physician practitioners and physician and non-physician practitioner organizations must report a change of ownership, any adverse legal action, or a change of practice location to the MAC within 30 days. All other changes must be reported within 90 days. For most but not all other providers and suppliers, changes of ownership or control, including changes in authorized official(s), must be reported within 30 days; all other changes to enrollment information must be made within 90 days. For all provider and supplier types, any change of practice location (including practice location additions, deletions, and relocations) must be reported within 30 days.

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 deactivated and your CHOW not being processed. We strongly recommend you mail your documents using a method that allows for proof of receipt.

If you have any questions regarding this letter, please call [contractor telephone number will be inserted here] between the hours of [contractor telephone hours will be inserted here] 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]

D. Large Group Revalidation Notification Letter

[month] [day], [year]

PROVIDER/SUPPLIER GROUP NAME
ADDRESS 1, ADDRESS 2
CITY STATE ZIP CODE

NPI:
PTAN:

Dear Provider/Supplier Group Name:

THIS IS **NOT** A PROVIDER ENROLLMENT REVALIDATION REQUEST

This is to inform you that a number of physicians and/or non-physician practitioners reassigning all or some of their benefits to your group have been selected for revalidation. For your convenience, a list of those individuals is attached. A revalidation notice will be sent to the physician or non-physician practitioner within the next seven months. *The physician or non-physician practitioner* will need to respond by the revalidation due date provided for each provider. It is the responsibility of the physician /or non-physician practitioner to revalidate all *the physician's or practitioner's* Medicare enrollment information and not just that associated with the reassignment to your group practice.

In accordance with Section 6401 (a) of the Patient Protection and Affordable Care Act, all new and existing providers must be reevaluated under the new screening guidelines. Medicare requires all enrolled providers and suppliers to revalidate their enrollment information every five years (reference 42 CFR §424.515). To ensure compliance with these requirements, existing regulations at 42 CFR §424.515(d) provide that the Centers for Medicare & Medicaid Services (CMS) is permitted to conduct off-cycle revalidations for certain program integrity purposes.

Physicians and non-physician practitioners can revalidate by using either Internet-based PECOS or submitting a paper CMS-855 enrollment application. Failure to submit a complete revalidation application and all supporting documentation within 60 calendar days may result in the physician or non-physician practitioner's Medicare billing privileges being deactivated. As such, your group will no longer be reimbursed for services rendered by the physician or non-physician practitioner.

If you have any questions regarding this letter, please call [contractor telephone number will be inserted here] between the hours of [contractor telephone hours will be inserted here] or visit our Web site at [insert Web site] for additional information regarding the revalidation process.

Sincerely,

[Your Name]
[Title]

E. Revalidation Pend Letter

PAYMENT HOLD

[month] [day], [year]

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

Dear [Provider/Supplier Name],

We are holding all payments on your Medicare claims, because you haven't revalidated your enrollment record with us. This does not affect your Medicare participation agreement, or any of its conditions.

Every [three or five years], CMS requires you to revalidate your Medicare enrollment record information. You need to update or confirm all the information in your record, including your practice locations and reassignments.

Failure to respond to this notice will result in a possible deactivation of your Medicare enrollment. If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

What record needs revalidating

[Name] | **NPI** [NPI] | **PTAN** [PTAN]
Reassignments:

[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]
<Repeat for other reassignments>

CMS lists the records that need revalidating at **go.cms.gov/MedicareRevalidation**.

How to resume your payments

Revalidate your Medicare enrollment record, through https://pecos.cms.hhs.gov/pecos/login.do or [form CMS-855 or Form CMS-20134].

- **Online:** PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.
- **Paper:** Download the right version of [form CMS-855 or Form CMS-20134] for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].

If you have a fee due, use PECOS to pay. If you feel you qualify for a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification.

If you need help

Visit **go.cms.gov/MedicareRevalidation**
Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name]
[Title]
[Company]

F. Revalidation Deactivation Letter

STOPPING BILLING PRIVILEGES

[month] [day], [year]

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

Dear [Provider/Supplier Name],

Your Medicare billing privileges are being deactivated effective [Month] [DD], [YYYY], pursuant to 42 C.F.R. § 424.540(a)(3) because you have not timely revalidated your enrollment

record with us, or your revalidation application has been rejected because you did not timely respond to our requests for more information. We will not pay any claims after this date.

Every five years [three for DMEPOS suppliers], CMS requires you to revalidate your Medicare enrollment record.

What record needs revalidating

[Name] | **NPI** [NPI] | **PTAN** [PTAN]
Reassignments:
[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]
<Repeat for other reassignments>

CMS lists the records that need revalidating at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html.

Rebuttal Rights:

If you believe that this determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.546. The rebuttal must be received in writing within 15 calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.

The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative. (Delete next sentence if letter is related to a DMEPOS supplier's enrollment.) Authorized or delegated officials for groups cannot sign and submit a rebuttal on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

If the provider/supplier wishes to appoint a legal representative that is not an attorney to sign the rebuttal, the provider/supplier must include with the rebuttal a written notice authorizing the legal representative to act on the provider's or supplier's behalf. The notice should be signed by the provider/supplier.

If the provider/supplier has an attorney sign the rebuttal, the rebuttal must include a statement from the attorney *that the attorney* has the authority to represent the provider/supplier.

If you wish to receive communication regarding your rebuttal via email, please include a valid email address in your rebuttal request.

The rebuttal should be sent to the following:

[Contractor Rebuttal Receipt Address]

[Contractor Rebuttal Receipt Email Address]
[Contractor Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/MT/CT/PT] and [x:00 a.m./p.m ET/MT/CT/PT].

How to recover your billing privileges

Revalidate your Medicare enrollment record, through PECOS.cms.hhs.gov, or [Form CMS-855 or Form CMS-20134].

- Online: PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.

- Paper: Download the right version of [form CMS-855 or Form CMS-20134] for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].

If you have a fee due, use PECOS to pay. If you feel you deserve a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification.

If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

If you need help Visit https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html.

Call [contractor telephone number] or visit [contractorsite.com] for more options.

Sincerely,

[Name]
[Title]
[Company]

G. Revalidation Past-Due Group Member Letter

REVALIDATION | Past-Due Group Member

[month] [day], [year]

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

Dear [Provider/Supplier Name],

Every five years, CMS requires providers to revalidate their Medicare enrollment records. You have not revalidated by the requested due date of [revalidation due date].

You need to update or confirm all the information in your record, including your practice locations and reassignments. If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

If multiple records below need to be revalidated, please coordinate with the appropriate parties to provide only one response.

What record needs revalidating

[Name] | **NPI** [NPI] | **PTAN** [PTAN]
Reassignments: <Only include this title if the record has any reassignments>
[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]
<Repeat for other reassignments>

The CMS lists the records that need revalidating at **go.cms.gov/MedicareRevalidation**.

What your group member needs to do

Revalidate *the member's* Medicare enrollment record, through https://pecos.cms.hhs.gov/pecos/login.do. or [form CMS-855 or Form CMS-20134].

- **Online:** PECOS is the fastest option. If *the member doesn't* know *the member's* username or password, PECOS offers ways to retrieve them. Our customer service can also help by phone at 866-484-8049.
- **Paper:** Download the right version of [form CMS-855 or Form CMS-20134] for *the enrollment* situation at cms.gov. We recommend getting proof of receipt for this mailing. Mail to [contractor address].

If your group member needs help

Visit **go.cms.gov/MedicareRevalidation**
Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name]
[Title]
[Company]

H. Model Return Revalidation Letter

RETURN REVALIDATION

[month] [day], [year]

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

NPI: [xxxxxxxxxx]

Dear [Provider/Supplier Name],

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

- The [Form CMS-855 or Form CMS-20134] application received by [PROVIDER/SUPPLIER NAME] was unsolicited.
    - An unsolicited revalidation is one that is received more than seven months prior to the provider/supplier's due date. Due dates are established around 5 years from the provider/supplier's last successful revalidation or initial enrollment.
    - To find the provider/suppliers revalidation due date, please go to http://go.cms.gov/MedicareRevalidation.
    - If you are not due for revalidation in the current seven-month period, you will find that your due date is listed as "TBD" (or To Be Determined). This means that you do not yet have a due date for revalidation within the current seven-month period. This list with be updated monthly.

- If your intention is to change information on your Medicare enrollment file, you must complete a new Medicare enrollment application(s) and mark 'change' in section 1 of the [form CMS-855 or Form CMS-20134].

- Please address the above issues as well as sign and date the new certification statement page on your resubmitted application(s).

Providers and suppliers can apply to enroll in the Medicare program using one of the following two methods:

1. Internet-based Provider Enrollment, Chain and Organization System (PECOS). Go to: https://pecos.cms.hhs.gov/pecos/login.do.

2. Paper application process: Download and complete the Medicare enrollment application(s) at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html.

If you need help

Visit http://go.cms.gov/MedicareRevalidation, or

Call2 [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name]
[Title]
[Company]

10.7.19 – ESRD Approval Letters

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

In the ESRD situations described in this section 10.7.19, the letters below shall be used as directed in section 10.2.1.3 notwithstanding any other instruction to the contrary in this chapter.

A. ESRD Service Station/Modality Changes

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

Your State Agency has notified [insert contractor name] [insert contractor number] that your end-stage renal disease (ESRD) facility changed [your approved service modalities and/or number of stations.] Therefore, your facility is now approved for a total of [number of in-center hemodialysis stations] maintenance stations and the services outlined below:

Medicare Enrollment Information

Legal Business Name (LBN)
Doing Business As (DBA)
Provider/Supplier Type
National Provider Identifier (NPI)
Provider Transaction Access Number (PTAN)
Effective Date

CMS Certification Information

CCN
Effective Date
Changed Information
Effective Date of Change(s) (Include detailed changes or section. Select from list below.)

__In-Center Hemodialysis (HD)
__In-Center Peritoneal Dialysis (PD)
__In-Center Nocturnal HD
__Home HD Training and Support

__HD in LTC
__Home PD Training and Support
__PD in LTC
__Dialyzer Reuse

You should report to the [State Agency ([SA])] any changes in location, services, or organization which might affect your certification status or the status of your ESRD facility. In addition, providers must notify CMS when there is a change of ownership. Therefore, you must notify your Medicare Administrative Contractor (MAC) and the [SA] promptly if there is a change in the legal status of the ownership of this facility.

We look forward to continuing to work with you in the administration of the Medicare program. If you have any questions regarding this, please contact [STATE AGENCY NAME], [STATE AGENCY EMAIL ADDRESS].

[Include appropriate MAC signature]

Cc: State Agency
Accrediting Organization (if appropriate)

B. State Agency Approved Initial

[Month, Day, Year]
[Provider/Supplier Name]
[Address]
[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and Contractor number]] received a response from the Medicare State Agency [and Accrediting Organization}]. Your initial enrollment application is approved.

Your unit has been approved as a renal dialysis [facility/center]. This approval is for a total of [number] maintenance stations. Your [facility/center] is approved to provide the following services:

[List all that apply--]

__In-Center Hemodialysis (HD)
__In-Center Peritoneal Dialysis (PD)
__In-Center Nocturnal HD
__Home HD Training and Support
__HD in LTC
__Home PD Training and Support
__PD in LTC

__Dialyzer Reuse

Medicare Enrollment and Provider/Supplier Information

Medicare Enrollment Information
Legal Business Name (LBN)
Doing Business As Name
Primary Practice Location Address
Provider/Supplier Type
National Provider Identifier (NPI)
Provider Transaction Access Number (PTAN)
Enrollment Effective Date

Please inform the [State Survey Agency/AO] if you wish to relocate your [facility/center], change the services that you are currently providing, change the number of approved stations, or undergo a change in ownership.

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.
Contact our electronic data interchange (EDI) department for enrollment and further instructions on electronic claims filing at [phone number].

Enroll, make changes, or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR § 424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations, at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

• Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
• State the issues or findings of fact with which you disagree and the reasons for disagreement.
• Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

- If the authorized representative is an attorney, the attorney's statement that *the attorney* has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
- If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
- Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 CFR Part 498.

The reconsideration request should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Blvd.
Mailstop: AR-19-51
Baltimore, MD 21244-1850

Or emailed to: ProviderEnrollmentAppeals@cms.hhs.gov

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]
CC: State Agency [and AO, if applicable]

C. Change of Ownership

[Month, Day, Year]

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

Subject: ESRD Medicare Change of Ownership

Dear Administrator:

[Insert Contractor name [and Contractor number]] has received a response from the State Agency. Your change of ownership application is now approved.

[INSERT or CHECK THE APPLICABLE PARAGRAPH]:

__ [Facility status is not changing]
When an ESRD facility undergoes a change of ownership, the new owner is subject to all of the Medicare program terms and conditions that applied to the prior owner.

___ [Changing from free-standing to hospital-based]
When an ESRD facility undergoes a change of ownership and changes its status from a free-standing ESRD facility to a hospital-based ESRD center, the existing CCN, formerly known as the Medicare Provider/Supplier Number, is automatically terminated and the ESRD center is issued a new CCN number that links it to the provider with which it is associated. The new owner is subject to all of the Medicare program terms and conditions that applied to the prior owner.

___ [Changing from hospital-based to free-standing]
When an ESRD center undergoes a change of ownership and changes its status from a hospital-based ESRD center to a free-standing ESRD facility, the existing CCN, formerly known as the Medicare Provider/Supplier Number, is automatically terminated and the ESRD facility is issued a new CCN to indicate the free-standing designation. The new owner is subject to all of the Medicare program terms and conditions that applied to the prior owner. Therefore, the CCN of [old CCN] is hereby terminated effective [Date of CHOW]. Your facility's approved CCN is provided below.

Your facility has been approved for a total of [number of in-center hemodialysis stations] maintenance stations. Also, your facility is approved to provide the following services:

[CHECK OR INSERT ALL APPLICABLE]

__In-Center Hemodialysis (HD)
__In-Center Peritoneal Dialysis (PD)
__In-Center Nocturnal HD
__Home HD Training and Support
__HD in LTC
__Home PD Training and Support

__PD in LTC
__Dialyzer Reuse

Medicare Enrollment Information

Legal Business Name (LBN)
Doing Business As Name
Primary Practice Location Address
Provider/Supplier Type
National Provider Identifier (NPI)
Provider Transaction Access Number (PTAN)
Effective Date of Change of Ownership

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system. Contact our electronic data interchange (EDI) department for enrollment and further instructions on electronic claims filing at [phone number].

Enroll, make changes, or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR § 424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations, at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

    - If the authorized representative is an attorney, the attorney's statement that *the attorney has* the authority to represent the provider or supplier is sufficient to accept this individual as the representative.

- If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of *a* representative with the submission of the reconsideration request.
- Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 CFR Part 498.

The reconsideration request should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Blvd.
Mailstop: AR-19-51
Baltimore, MD 21244-1850
Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]

[Company]
CC: State Agency [and AO, if applicable]

10.7.20 – Stay of Enrollment Letters

(Rev. 13355; Issued: 08-13-25; Effective: 05-05-25; Implementation: 05-05-25)

This section 10.7.20 contains letters that contractors shall use in stay of enrollment situations. Note that the contractor may remove language from the letter that obviously does not apply to the provider/supplier type in question (e.g., reassignment language in a letter pertaining to an HHA under a stay).

A. Imposition of Stay of Enrollment Notification Letter – Revalidation Non-Response Stay of Enrollment

[month] [day], [year]

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

Dear [Provider/Supplier Name],

Pursuant to 42 CFR § 424.541, we are placing a stay on your Medicare enrollment record effective [insert day of letter's issuance] because you have not responded to our revalidation request of [date revalidation request letter sent]. Your revalidation was due on [insert date].

During this stay, claims for services and items you furnish during this period will be rejected. However, this does not affect your Medicare participation agreement or any of its conditions, and you remain enrolled in the Medicare program.

Every [three or five years], CMS requires you to revalidate your Medicare enrollment record information. Failure to submit a revalidation application within 30 days of this notice may result in a deactivation of your Medicare enrollment. If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN; however, you will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

What record needs revalidating

[Name] | **NPI** [NPI] | **PTAN** [PTAN]

Reassignments:

[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]

<Repeat for other reassignments>

The CMS lists the records that need revalidating at:

go.cms.gov/MedicareRevalidation

How to resume your payments:

- **Revalidate your Medicare enrollment record**, through https://pecos.cms.hhs.gov/pecos/login.do or [Form CMS-855 or Form CMS-20134].

- **Online:** PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484- 8049.

- **Paper:** Download the right version of [form CMS-855 or Form CMS-20134] for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].

If you have a fee due, use PECOS to pay. If you feel you qualify for a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification.

Rebuttal Rights:

If you believe that this determination is not correct, you may rebut the stay of enrollment as indicated in 42 C.F.R. § 424.541(b). The rebuttal must be received in writing within 15 calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this stay of your Medicare enrollment.

The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative. (Delete next sentence if letter is related to a DMEPOS supplier's enrollment.) Authorized or delegated officials for groups cannot sign and submit a rebuttal on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

If the provider/supplier wishes to appoint a legal representative who is not an attorney to sign the rebuttal, the provider/supplier must include with the rebuttal a written notice authorizing the legal representative to act on the provider's or supplier's behalf. The notice should be signed by the provider/supplier.

If the provider/supplier has an attorney sign the rebuttal, the rebuttal must include a statement from the attorney *that the attorney has* the authority to represent the provider/supplier.

If you wish to receive communication regarding your rebuttal via email, please include a valid email address in your rebuttal request.

The provider's or supplier's failure to submit a rebuttal that is both timely and fully compliant with all of the requirements above constitutes a waiver of all rebuttal rights.
The rebuttal should be sent to the following:

[Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop: AR-19-51
Baltimore, MD 21244-1850

OR, as applicable

Name and address of MAC]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/MT/CT/PT] and [x:00 a.m./p.m ET/MT/CT/PT].

If you need help

Visit **go.cms.gov/MedicareRevalidation**

Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,

[Name]
[Title]
[Company]

B. Imposition of Stay Notification Letter – All Situations Other than Section 10.7.20(A) Stay of Enrollment

[month] [day], [year]

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

Dear [Provider/Supplier Name],

Pursuant to 42 CFR § 424.541, we are placing a stay on your Medicare enrollment record effective [day of letter's issuance] because [provide explanation, such as "you did not report a new managing employee within 30 days of the change as required under 42 CFR § 424.516 (or 42 CFR § 424.57(c)(2) for DMEPOS suppliers)" or "your current ownership information on file with Medicare is incorrect"].

[Example of supporting facts and rationale: [ABC, Inc.'s Medicare 855 enrollment record reflects that Doe is the owner, authorized official, director and managing employee of Argo Medical Supplies & Services, Inc. However, CMS has found

information on the New York Secretary of State which reveals that Doe is listed as manager effective October 11, 2023. A manager (which meets the definition of managing employee, per 42 C.F.R. § 424.502) is required to be reported on the 855S enrollment record.]]

During this stay, claims for services and items you furnish during this period will be rejected. However, this does not affect your Medicare participation agreement or any of its conditions, and you remain enrolled in the Medicare program.

[In order to maintain enrollment in the Medicare program, you must submit a CMS 855 Change of Information Application. Failure to do so by [today's date + 30] may result in a deactivation or revocation of your Medicare enrollment. If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN; however, you will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

What record needs to be updated.

[Name] | **NPI** [NPI] | **PTAN** [PTAN]

[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]

How to resume your payments:

- **Online:** PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484- 8049.
- **Paper:** Download the right version of [form CMS-855 or Form CMS-20134] for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].

If you have a fee due, use PECOS to pay. If you feel you qualify for a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification.

Rebuttal Rights:

If you believe that this determination is not correct, you may rebut the stay of enrollment as indicated in 42 C.F.R. § 424.541(b). The rebuttal must be received in writing within 15 calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this stay of your Medicare enrollment.

The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative. (Delete next sentence if letter is related to a

DMEPOS supplier's enrollment.) Authorized or delegated officials for groups cannot sign and submit a rebuttal on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on *the reassigned provider's/supplier's* behalf.

If the provider/supplier wishes to appoint a legal representative that is not an attorney to sign the rebuttal, the provider/supplier must include with the rebuttal a written notice authorizing the legal representative to act on the provider's or supplier's behalf. The notice should be signed by the provider/supplier.

If the provider/supplier has an attorney sign the rebuttal, the rebuttal must include a statement from the attorney that *the attorney has* the authority to represent the provider/supplier.

If you wish to receive communication regarding your rebuttal via email, please include a valid email address in your rebuttal request.

The provider's or supplier's failure to submit a rebuttal that is both timely and fully compliant with all of the requirements above constitutes a waiver of all rebuttal rights.

The rebuttal should be sent to the following:

[Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop: AR-19-51
Baltimore, MD 21244-1850

OR, as applicable

Name and address of MAC]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/MT/CT/PT] and [x:00 a.m./p.m ET/MT/CT/PT].

Sincerely,

[Name]
[Title]
[Company]

C. Stay of Enrollment Rebuttal Model Letters

Instruction

For the following model letters, all text within parentheses is intended as instruction/explanation and should be deleted before the letter is finalized and sent to the provider/supplier. All text within brackets requires the contractor to fill in the appropriate text. All letters and emails shall be saved in PDF format. The date on the letter shall be the date it was sent to the provider/supplier.

1. Rebuttal Further Information Required Development Model Letter - Stay of Enrollment

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Stay of Enrollment Rebuttal Development Request
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Optional)

Dear [Name of the person(s) who submitted the rebuttal]:

On [Month] [DD]. [YYYY], [Contractor Name] issued a favorable rebuttal determination, reversing the stay of [Provider/Supplier Name]'s Medicare enrollment and billing privileges. As stated in the [Month] [DD], [YYYY] determination letter, the reinstatement of [Provider/Supplier Name]'s Medicare enrollment is contingent upon the submission of [list required documentation] (lists of 3 or more items should be in a bulleted list). Please send the required documentation to:

[Contractor Rebuttal Receipt Address]
[Contractor Rebuttal Receipt Email Address]
Fax: [Contractor Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/CT/MT/PT] and [x:00 a.m./p.m ET/CT/MT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

2. Rebuttal Facts or Issues and Reasons for Disagreement Development Model Letter - Stay of Enrollment

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address] (Address from which the Rebuttal was sent)
[City], [State] [Zip Code]

Re: Stay of Enrollment Rebuttal Development Request
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the Rebuttal]:

This letter is in response to the rebuttal received by [Contractor Name], based on the letter dated [Month] [DD], [YYYY] imposing a stay of [Provider/Supplier Name]'s Medicare billing enrollment pursuant to 42 C.F.R. § 424.541. We received your rebuttal submission on [Month] [DD], [YYYY].

As stated in the stay of enrollment letter dated [Month] [DD], [YYYY], and 42 C.F.R. § 424.541(b), to be accepted and reviewed, your rebuttal must state the facts or issues identified in the stay of enrollment letter with which you disagree and your reasons for disagreement. The rebuttal received on [Month] [DD], [YYYY] does not clearly identify the facts or issues with which you disagree and your reasons for disagreement. [Contractor Name] is granting you an additional 15 calendar days from the date of this notification letter to submit a proper rebuttal that clearly identifies the facts or issues with which you disagree and your reasons for disagreement. This revised rebuttal submission must be received within 15 calendar days of the date of this notice. If you do not timely respond to this request, [Contractor Name] may dismiss your rebuttal submission.

Please send the required documentation to:

[Contractor Rebuttal Receipt Address]
[Contractor Rebuttal Receipt Email Address]
Fax: [Contractor Rebuttal Receipt Fax Number]

Please note that failure to submit a timely and proper rebuttal submission constitutes a waiver of all rebuttal rights under 42 C.F.R. § 424.541(b)(4).

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/CT/MT/PT] and [x:00 a.m./p.m ET/CT/MT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

3. Rebuttal Withdrawn Model Letter - Stay of Enrollment

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Stay of Enrollment Rebuttal Withdrawal
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the rebuttal]:

We are in receipt of your written request to withdraw your rebuttal received on [Month] [DD], [YYYY], submitted in response the stay of [Provider/Supplier]'s enrollment. [Contractor Name] has not yet issued a rebuttal determination. Therefore, [Contractor Name] considers the rebuttal to be withdrawn. As a result, a determination will not be issued in response to the rebuttal and [Provider/Supplier Name]'s Medicare enrollment will remain subject to a stay of enrollment imposed under 42 C.F.R. § 424.541.

Please note that failure to submit a timely and proper rebuttal submission constitutes a waiver of all rebuttal rights under § 424.541(b)(4).

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/CT/MT/PT] and [x:00 a.m./p.m ET/CT/MT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

4. Rebuttal Receipt Acknowledgement Model Letter - Stay of Enrollment

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Stay of Enrollment Rebuttal Submission
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the rebuttal]:

On [Month] [DD], [YYYY] we received your rebuttal regarding the stay of [Provider/Supplier Name]'s enrollment. The stay of enrollment was imposed by letter dated [Month] [DD], [YYYY]. [Contractor Name] will further review the information and documentation submitted in the rebuttal and will render a final determination regarding the stay of enrollment within 30 days of the date of receipt.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/CT/MT/PT] and [x:00 a.m./p.m ET/CT/MT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

5. Final Rebuttal Decision Email Template - Stay of Enrollment

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal

submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

To: [Email address provided by the person who submitted the rebuttal and email address listed in the provider/supplier correspondence mailing address on the enrollment application if different from the email address on the rebuttal submission.]

Subject: Medicare Stay of Enrollment Rebuttal re: [Provider/Supplier Name]

Dear [Name of the person(s) who submitted the rebuttal]:

Please see the attached determination regarding your rebuttal, in response to the stay of [Provider/Supplier Name]'s enrollment.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/CT/MT/PT] and [x:00 a.m./p.m ET/CT/MT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

6. Rebuttal Dismissal Model Letters - Stay of Enrollment

a. Untimely Rebuttal Dismissal Model Letter - Stay of Enrollment

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Stay of Enrollment Rebuttal Dismissal
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [Contractor Name], based on the letter dated [Month] [DD], [YYYY] imposing a stay of [Provider/Supplier Name]'s Medicare enrollment pursuant to 42 C.F.R. § 424.541.

[Contractor Name] is unable to accept your rebuttal as it was not timely submitted. The stay of enrollment letter was dated [Month] [DD], [YYYY]. Pursuant to 42 C.F.R. § 424.541(b)(1), a rebuttal must be received within 15 calendar days of the date of the stay of enrollment letter. Your rebuttal was not received until [Month] [DD], [YYYY], which is beyond the applicable submission time frame. You failed to show good cause for the late request. Therefore, [Contractor Name] is unable to render a determination in this matter and the stay of enrollment will not be modified.

Please note that failure to submit a timely and proper rebuttal submission constitutes a waiver of all rebuttal rights under 42 C.F.R. § 424.541(b)(4).

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/CT/MT/PT] and [x:00 a.m./p.m ET/CT/MT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

b. Improper Signature Rebuttal Dismissal Model Letter - Stay of Enrollment

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address](Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Stay of Enrollment Rebuttal Dismissal
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [Contractor Name], based on the letter dated [Month] [DD], [YYYY] imposing a stay of [Provider/Supplier Name]'s Medicare enrollment pursuant to 42 C.F.R. § 424.541.

[Contractor Name] is unable to accept your rebuttal because it did not contain any of the following:

1. Signature by an authorized or delegated official currently on file in [Provider/Supplier]'s Medicare enrollment, the individual practitioner or a legal representative;
2. The required statement of representation from an attorney;
3. Signed written notice appointing a non-attorney legal representative.

Please be advised that authorized or delegated officials for groups cannot sign and submit a rebuttal on behalf of a reassigned practitioner without a signed statement authorizing that individual from the group to act on the practitioner's behalf.

The signature requirement is stated in the [Month] [DD], [YYYY] stay of enrollment letter, and in 42 C.F.R. § 424.541(b)(3)(iv). Additionally, in a letter dated [Month] [DD], [YYYY], [Contractor Name] requested that you provide a properly signed rebuttal and permitted an additional 15 calendar days to submit your response.

(If no response received, use this language: [To date, [Contractor Name] has not received a response. As a result, [Contractor Name] is dismissing your rebuttal, and no decision will be rendered.])

(If response received after 15 calendar days, use this language: [While [Contractor Name] received a response, it was not timely received within 15 calendar days. As a result, [Contractor Name] is dismissing your rebuttal, and no decision will be rendered.])

Please note that failure to submit a timely and proper rebuttal submission constitutes a waiver of all rebuttal rights under 42 C.F.R. § 424.541(b).

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/CT/MT/PT] and [x:00 a.m./p.m ET/CT/MT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

c. No Rebuttal Rights Rebuttal Dismissal Model Letter - Stay of Enrollment

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address](Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal Submission Dismissal
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [Contractor Name] on [Month] [DD], [YYYY], submitted on behalf of [Provider/Supplier Name].

[Contractor Name] is unable to accept your rebuttal submission because the action taken in regard to [Provider/Supplier]'s Medicare enrollment or billing privileges does not afford the opportunity for a rebuttal. Only a provider/supplier whose enrollment is stayed under 42 C.F.R. § 424.541, or whose billing privileges are deactivated under § 424.540 may file a rebuttal. As a result, [Contractor Name] is dismissing your rebuttal, and no decision will be rendered.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/MT/CT/PT] and [x:00 a.m./p.m ET/MT/CT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

d. More than One Submission Rebuttal Dismissal Model Letter - Stay of Enrollment

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address](Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Stay of Enrollment Rebuttal Submissions
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [Contractor Name], based on the letter dated [Month] [DD], [YYYY] imposing a stay of [Provider/Supplier Name]'s Medicare billing enrollment pursuant to 42 C.F.R. § 424.541.

[Contractor Name] previously received a rebuttal for [Provider/Supplier Name] on [Month] [DD], [YYYY]. Per Chapter 10.4.9.1(A) of the Medicare Program Integrity Manual, only one rebuttal request may be submitted per stay of enrollment letter. Therefore, [Contractor Name] is unable to accept your additional rebuttal[s] received on [Month] [DD], [YYYY] (list all additional dates if applicable). As a result, [Contractor Name] is dismissing your rebuttal and no decision will be rendered.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/MT/CT/PT] and [x:00 a.m./p.m ET/MT/CT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

e. No Specification of Why the Provider/Supplier Disagrees with Enrollment Stay and Reasons for Disagreement Rebuttal Dismissal Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address] (Address from which the Rebuttal was sent)
[City], [State] [Zip Code]

Re: Stay of Enrollment Rebuttal Dismissal

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the Rebuttal]:

This letter is in response to the rebuttal received by [Contractor Name], in response to the letter dated [Month] [DD], [YYYY] imposing a stay of [Provider/Supplier Name]'s Medicare billing enrollment pursuant to 42 C.F.R. § 424.541.

[Contractor Name] is unable to accept your rebuttal as it does not specify the facts or issues identified in the stay of enrollment letter with which you disagree and your reasons for disagreement. The requirement to identify the facts or issues with which you disagree and your reasons for disagreement was stated in the stay of enrollment letter, dated [Month] [DD], [YYYY], in 42 C.F.R. § 424.541(b)(3), and in Chapter 10 of the Medicare Program Integrity Manual. Additionally, in a letter dated [Month] [DD], [YYYY], [Contractor Name] requested that you identify the facts or issues identified in the stay of enrollment letter with which you disagree and your reasons for disagreement. This letter permitted an additional 15 calendar days to submit your response.

(If no response received, use this language: [To date, [Contractor Name] has not received a response. As a result, [Contractor Name] is dismissing your rebuttal, and no decision will be rendered.])

(If response received after 15 calendar days, use this language: [While [Contractor Name] received a response, it was not timely received within 15-calendar days. As a result, [Contractor Name] is dismissing your rebuttal, and no decision will be rendered.])

Please note that failure to submit a timely and proper rebuttal submission constitutes a waiver of all rebuttal rights under 42 C.F.R. § 424.541(b)(3).

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/MT/CT/PT] and [x:00 a.m./p.m ET/MT/CT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

7. Stay of Enrollment Rebuttal Not Actionable (Moot) Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on

the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Stay of Enrollment Rebuttal Submission
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [Contractor Name], based on the letter dated [Month] [DD], [YYYY] imposing a stay of [Provider/Supplier Name]'s Medicare billing enrollment pursuant to 42 C.F.R. § 424.541.

On [Month] [DD], [YYYY], [Contractor Name] reviewed the stay of enrollment for [Provider/Supplier Name] and [revised imposition letter (OR) lifted the stay]. The [revised imposition letter (OR) rescission letter (OR) letter lifting the stay], dated [Month] [DD], [YYYY], rendered the issue set forth in your rebuttal no longer actionable. For your convenience a copy of the [revised imposition letter (OR) rescission letter (OR) letter lifting the stay] is attached. Accordingly, the issue addressed in your rebuttal is now moot, and we are unable to render a determination on the matter.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/MT/CT/PT] and [x:00 a.m./p.m ET/MT/CT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

(The contractor shall include PDF copy of the letter that rendered the rebuttal moot (e.g. the revised imposition letter or rescission letter.)

8. Favorable Stay of Enrollment Rebuttal Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on

the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address] (Address from which the Rebuttal was sent)
[City], [State] [Zip Code]

Re: Stay of Enrollment Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the Person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [Contractor Name] based on the stay of [Provider/Supplier Name]'s Medicare enrollment pursuant to 42 C.F.R. § 424.541. (If the rebuttal was timely, use the following.) [The stay of enrollment letter was dated [Month] [DD], [YYYY] and [Contractor Name] received the rebuttal on [Month] [DD], [YYYY]; therefore, this rebuttal is considered timely.] (If the rebuttal is untimely, but good cause has been found to accept the rebuttal, use the following.) [The stay of enrollment letter was dated [Month] [DD], [YYYY] and [Contractor Name] received the rebuttal on [Month] [DD], [YYYY]. This rebuttal was not timely submitted, but a good cause waiver has been granted.]) [Contractor Name] based the following determination on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

APPLICABLE AUTHORITIES: (list any authorities cited in analysis)

- 42 C.F.R. § 424.541
- [enrollment requirement that led to stay]
- Medicare Program Integrity Manual (MPIM) chapter 10.XX (If applicable)

EXHIBITS:

- Exhibit 1: (Example: Rebuttal letter to CMS, signed by Smith, Administrator for Home Healthcare Services, LLC, dated January 1, 2018);
- Exhibit 2: (Example: Letter from [Contractor Name] to Home Healthcare Services, LLC, dated December 1, 2017, imposing a stay of Home Healthcare Services, LLC's Medicare enrollment pursuant to § 424.541).

(In this section list each document submitted by the provider/supplier. Each exhibit shall include the date, as well as a brief description of the document. The contractor shall also include other documentation not submitted by the provider/supplier that the hearing officer reviewed in

making the determination, e.g., enrollment applications, development letters, etc. The stay of enrollment letter shall be included as an Exhibit.)

BACKGROUND:

[Contractor Name] has reviewed the documentation related to the matter for [Provider/Supplier Name] and made the determination in accordance with the applicable Medicare rules, policies and program instructions.

(Summarize the facts underlying the case which led up to the submission of the rebuttal.)

REBUTTAL ANALYSIS:

(A rebuttal reviews whether the imposition of the stay and/or the effective date of the stay are correct. This section shall summarize the statements made by the provider/supplier in its rebuttal, then provide an analysis of the arguments based on the applicable regulations and sub-regulations, such as the MPIM. Any regulation or sub-regulatory guidance that is referenced in this section shall also be listed in the "Applicable Authorities" section above. At a minimum, the review shall consist of whether the *provider/*supplier was non-complaint and whether the non-compliance can be remedy by submitted the applicable CMS form, as well as the effective date of the stay. It is insufficient to state a rebuttal determination without explaining how and why the determination was made.)

DECISION:

(A short conclusory restatement.)

(Example: On [Month] [DD], [YYYY], [Contractor Name] notified Home Healthcare Services, LLC of the [Month] [DD], [YYYY] deadline to revalidate its Medicare enrollment. On [Month] [DD], [YYYY], [Contractor Name] imposed a stay of Home Healthcare Services, LLC's enrollment. However, [Contractor Name] received a revalidation on [Month] [DD], [YYYY]. Therefore, Home Healthcare Services, LLC was in compliance with the revalidation requirement. As a result, [Contractor Name] finds that the stay of Home Healthcare Services, LLC's Medicare enrollment was not correct.)

This is a **FAVORABLE DETERMINATION**. To effectuate this determination, [Contractor name] will remove the stay and reinstate [Provider/Supplier Name]'s Medicare enrollment.

(If additional information is needed from the provider/supplier in order to reinstate the enrollment, the Contractor shall state what information is needed from the provider or supplier in this rebuttal determination. Contractors shall state that the requested information/documentation must be received within 30 calendar days of the date of this determination letter)

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/MT/CT/PT] and [x:00 a.m./p.m ET/MT/CT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

9. Unfavorable Stay of Enrollment Rebuttal Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address] (Address from which the Rebuttal was sent)
[City], [State] [Zip Code]

Re: Stay of Enrollment Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [Contractor Name] based on the stay of [Provider/Supplier Name]'s Medicare enrollment pursuant to 42 C.F.R. § 424.541. (If the rebuttal was timely, use the following.) [The stay of enrollment letter was dated [Month] [DD], [YYYY] and [Contractor Name] received the rebuttal on [Month] [DD], [YYYY]; therefore, this rebuttal is considered timely.] (If the rebuttal is untimely, but good cause has been found to accept the rebuttal, use the following.) [The stay of enrollment letter was dated [Month] [DD], [YYYY] and [Contractor Name] received the rebuttal on [Month] [DD], [YYYY]. This rebuttal was not timely submitted, but a good cause waiver has been granted.]) [Contractor Name] based the following determination on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

APPLICABLE AUTHORITIES: (list any authorities cited in analysis)

- 42 C.F.R. § 424.541
- [enrollment requirement that led to stay]
- Medicare Program Integrity Manual (MPIM) chapter 10.XX (If applicable)

EXHIBITS:

- Exhibit 1: (Example: Rebuttal letter to CMS, signed by Smith, Administrator for Home Healthcare Services, LLC, dated January 1, 2018);
- Exhibit 2: (Example: Letter from [Contractor Name] to Home Healthcare Services, LLC, dated December 1, 2017, imposing a stay of Home Healthcare Services, LLC's Medicare enrollment pursuant to § 424.541).

(In this section list each document submitted by the provider/supplier. Each exhibit shall include the date, as well as a brief description of the document. The Contractor shall also include other documentation not submitted by the provider/supplier that the hearing officer reviewed in making the determination, e.g., enrollment applications, development letters, etc. The stay of enrollment letter shall be included as an Exhibit.)

BACKGROUND:

[Contractor Name] has reviewed the documentation related to the matter for [Provider/Supplier Name] and made the determination in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the rebuttal.)

REBUTTAL ANALYSIS:

(A rebuttal reviews whether the imposition of the stay and/or the effective date of the stay are correct. This section shall summarize the statements made by the provider/supplier in its rebuttal, then provide an analysis of the arguments based on the applicable regulations and sub-regulations, such as the MPIM. Any regulation or sub-regulatory guidance that is referenced in this section shall also be listed in the "Applicable Authorities" section above. At a minimum, the review shall consist of whether the *provider/*supplier was non-complaint and whether the non-compliance can be remedy by submitted the applicable CMS form, and the effective date of the stay. It is insufficient to state a rebuttal determination without explaining how and why the determination was made.)

DECISION:

(A short conclusory restatement.)

(Example: On [Month] [DD], [YYYY], [Contractor Name] received a revalidation application for Home Healthcare Services, LLC. On [Month] [DD], [YYYY], [Contractor Name] sent a development request to continue processing Home Healthcare Services, LLC's revalidation application. Home Healthcare Services, LLC did not timely respond to [Contractor Name]'s development request. [Contractor Name] properly rejected Home Healthcare Services, LLC's revalidation application. As a result, Home Healthcare Services, LLC was non-compliant with the revalidation requirement. Therefore, [Contractor Name] finds that the stay of Home Healthcare Services, LLC's Medicare enrollment under 42 C.F.R. § 424.541 was appropriately implemented.)

This is an **UNFAVORABLE DETERMINATION**. [Contractor name] concludes that there was no error made in the stay of [Provider/Supplier Name]'s Medicare enrollment. As a result, **the stay of [Provider/Supplier Name]'s enrollment remains intact**. During this stay, claims for services and items [Provider/Supplier Name] furnishes during this period will be rejected. However, this does not affect [Provider/Supplier Name]'s Medicare participation agreement or any of its conditions, and [Provider/Supplier Name] remains enrolled in the Medicare program.

NEXT STEPS:

Failure to (choose applicable requirement that led to stay of enrollment) [timely revalidate your Medicare enrollment (OR) timely submit a Change of Information application] may result in a deactivation or revocation of your Medicare enrollment. If you are a non-certified provider/supplier, and your enrollment is deactivated, you will maintain your original PTAN; however, you will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/MT/CT/PT] and [x:00 a.m./p.m ET/MT/CT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]