CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 12209	**Date: August 17, 2023**
	Change Request 13308

SUBJECT: Tenth General Update to Provider Enrollment Instructions in Chapter 10 of CMS Publication (Pub.) 100-08

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to address several provider enrollment topics, including certified provider/supplier enrollment and revised model letters.

EFFECTIVE DATE: September 17, 2023

**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: September 17, 2023

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	10/10.2/10.2.1.3/End-Stage Renal Disease Facilities (ESRDs)
R	10/10.2/10.2.1.4/Federally Qualified Health Centers (FQHCs)
R	10/10.2/10.2.1.8.1/Rural Emergency Hospitals (REHs)
R	10/10.2/10.2.2.1/Ambulatory Surgical Centers (ASCs)
R	10/10.2/10.2.2.8/Portable X-Ray Suppliers (PXRSs)
R	10/10.3/10.3.3.1/Form CMS-588 – Electronic Funds Transfer (EFT) Authorization Agreement
R	10/10.4/10.4.7.4/Reenrollment Bar
R	10/10.6/10.6.14/Application Fees
R	10/10.6/10.6.18/Appeals Process
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

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: 12209	Date: August 17, 2023	Change Request: 13308

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I. GENERAL INFORMATION

A. Background: Chapter 10 of Pub. 100-08 outlines policies related to Medicare provider enrollment and instructs contractors on the processing of Form CMS-855 provider enrollment applications. This CR clarifies several provider enrollment topics, including certified provider/supplier enrollment and revised model letters.

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

II. 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	
13308.1	The contractor shall observe the policies and guidance in Section 10.3.3.1(B) in Chapter 10 of Pub. 100-08.									NPEAST, NPWEST
13308.2	The contractor shall observe the reenrollment bar policies and guidance in Section 10.4.7.4(C) in Chapter 10 of 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.									
13308.3	The contractor shall observe the edits to the addresses and other verbiage in the various model letters included in this CR and in other sections of Chapter 10.	X	X	X						NPEAST, NPWEST

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. 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

V. CONTACTS

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

VI. 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

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(Rev. 12209; Issued: 08-17-23)

Transmittals for Chapter 10

10.2.1.3 - End-Stage Renal Disease Facilities (ESRDs)

(Rev. 12209; Issued: 08-17-23; Effective: 09-18-23; Implementation: 09-18-23)

(In this section 10.2.1.3, the terms "ESRD" and "ESRD facility" have the same meaning and will be used interchangeably).

A. General Background Information

ESRD facilities are entities that provide renal services and related care for patients with irreversible and permanent kidney failure.

The provider-based rules for ESRD facilities are outlined in 42 CFR § 413.174 and are slightly different than those in the main provider-based regulation (42 CFR § 413.65). (For instance, § 413.174 uses the term "hospital-based" as opposed to "provider-based.")

The ESRD Network is a group of organizations under contract with CMS that serve as liaisons between the agency and ESRD providers. The organizations oversee the care that ESRD patients receive, collect data, and furnish technical assistance to ESRD providers and patients.

B. Types of ESRD Facilities

Pub. 100-07, State Operations Manual, lists several classifications of ESRD facilities. They are summarized as follows:

1. Hospital-Based ESRD Facility

A hospital-based ESRD facility is a separately certified ESRD facility that (1) is an outpatient department of a hospital and (2) meets the ESRD conditions of coverage at 42 CFR Part 494. A hospital-based ESRD facility is owned and administered by a hospital or critical access hospital and is physically located on the hospital campus. If a hospital operates multiple separately certified hospital-based ESRD facilities, each separate ESRD facility must have its own CCN and be separately enrolled.

A hospital-based ESRD facility is discussed at 42 CFR § 413.174(c) and must meet the criteria listed therein (e.g., ESRD facility and hospital have a common governing body and are financially integrated). Hospital-based ESRD facilities are assigned CCNs from the 2300-2499 series.

2. Satellite Renal Dialysis Facility (Hospital-Based)

A satellite renal dialysis facility is a hospital-owned and hospital-administered ESRD facility but is not located on the campus of the hospital. A single hospital may have several satellite renal dialysis facilities. Each satellite facility: (1) is separately certified and surveyed; (2) must independently meet the ESRD conditions of coverage; (3) is assigned its own CCN; and (4) be separately enrolled. Satellite renal dialysis facilities (hospital-based) are assigned CCNs in the 3500-3699 series.

3. Independent Renal Dialysis Facility

An independent renal dialysis facility is any outpatient ESRD facility that does not meet the definition of a hospital-based renal dialysis facility or satellite renal dialysis facility as described in the paragraphs above. An independent renal dialysis facility may be physically located on a hospital campus, but it is not owned and/or administered by the hospital.

Independent renal dialysis facilities are assigned CCNs in the 2500-2899 series and are individually enrolled.

4. Special Purpose Renal Dialysis Facility (SPRDF) (§ 494.120)

This type of renal disease facility is temporarily certified to furnish dialysis at special locations on a short-term basis (i.e., up to 8 months in any 12-month period) to a group of dialysis patients who would otherwise be unable to obtain treatment in the geographical area. The SOG Location must clearly specify the limited nature of the SPRDF certification, the time period covered by the certification, and the automatic termination of payment on the last day of the certification period in its notifications. The special locations for SPRDF fall into two categories:

(A) Vacation Camps - Vacation camps serve dialysis patients temporarily residing there. A vacation camp SPRDF would allow campers to receive hemodialysis at the camp site, avoiding interruption of the camping experience. Vacation camps may be approved for the duration of the camp but up to a maximum of 8 months in any 12-month period.

(B) Emergency Circumstance SPRDFs - These locations are set up to provide dialysis services to those ESRD patients who would otherwise be unable to obtain such services in their geographical area as a result of a natural or man-made disaster or a need for a greater capacity to dialyze patients who may have been evacuated from another location. The CMS SOG Location may extend the time period in emergency SPRDF approvals, where necessary, beyond the standard eight-month period based upon the termination of the emergency condition.

SPRDFs are assigned CCNs in the 3700-3799 series when owned and administered by a hospital and in the 2900-2999 series for independent facilities. Although they are individually enrolled, they cannot convert to a permanent ESRD facility (i.e., to a non-SPRDF). They must instead reapply as a brand new ESRD facility and receive an initial certification survey.

C. Processing Instructions for ESRD Initial Form CMS-855A Applications

An ESRD facility is separately and individually certified and does not have any branch, multiple, or parent locations. As such, each type of ESRD facility/location must independently and separately enroll as such via the Form CMS-855A; multiple sites cannot be listed on a single application.

Note that the instructions in this section 10.2.1.3(C) apply to all ESRD facility types except for SPRDFs. This ESRD type is not "transitioning" as that term is described in this chapter. Accordingly, the contractor shall continue to process initial applications from SPRDFs consistent with longstanding instructions rather than those described in this section 10.2.1.3(C) (e.g., receiving the final approval from the SOG location rather than the state; no need to send the application to PEOG after final SOG location approval).

1. Receipt of Application

Upon receipt of an initial ESRD 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 section 10.2.1.3 and this chapter.

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

- Part I of the Form CMS-3427A (End Stage Renal Disease Application and Survey and Certification Report) (See Pub. 100-07, chapter 2, section 2247B for more information on this form.)

- A certificate of need (CON) if required by state law (though SPRDFs need not submit a CON)

(The ESRD must complete and submit Part I of the Form CMS-3427A, though the ESRD need not complete those sections of the form reserved for CMS. For organizational ESRDs, an authorized official (as defined in § 424.502) must sign the form; for sole proprietorships, the sole proprietor must sign. Note that there is no provider agreement for ESRD facilities; the Form CMS-3427A is a survey and certification document, not a provider/supplier agreement.)

Notwithstanding the foregoing, if Part I of the Form-CMS-3427A and/or CON evidence is missing, unsigned, undated, or otherwise incomplete, the contractor need not develop for the form(s) or the information thereon. (Nor need the contractor: (1) research individual state laws to ascertain whether the state requires a CON; or (2) review the data on the CON.) 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 10.2.1.3(C) prohibits the contractor from returning or rejecting the ESRD 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 10.2.1.3(C) 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 ESRD, 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----typically via the Form CMS-1539, although the contractor may accept any notification that is in writing (e-mail is fine). No later than 5 business days after receiving this notification, the contractor shall commence the actions described in section 10.2.1.3(C)(2)(B) above.

(B) Approval Recommended

If the state recommends approval, it will typically do so via a Form CMS-1539; however, 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 AO
- 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.)

(As required per section 10.6.21 of this chapter, the e-mail subject line shall include the following: SUBJECT LINE: S&C: Facility Type; Application Type; Facility Name; National Provider Identifier; CCN; Application Receipt Date (MMDDYY*) (*Date the Contractor Received the Application from the Provider/Supplier). (Note, however, that this data need not be duplicated in the e-mail's body.))

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

D. Additional/Changed Stations

If an enrolled ESRD seeks to add/change services or stations (e.g., add ESRD services in SNFs, additional modalities), the ESRD need not submit a Form CMS-855A application to do so, for these services and stations do not constitute practice locations and cannot otherwise

be reported on the application. Instead, the ESRD contacts the state or accreditation organization (AO) to request these changes. The ESRD must complete a Form CMS-3427 and submit it to the state or AO (as applicable). A survey may be performed, and the state will update the applicable national database with any administrative changes.

The state will also send a CMS-1539 or approval letter to the contractor as notification of the additional/change service(s) or station(s). When the contractor receives such a notice, it shall abide by the following:

- As applicable, and consistent with longstanding practice, the contractor shall enter all relevant data into PECOS. No referral to or prior approval from PEOG is necessary. However, the contractor may contact its PEOG BFL if it has questions regarding the Form CMS-1539 or the supplier's PECOS record.
- For situations involving new/expanded/changed ESRD stations, the contractor shall send to the supplier the "ESRD Service Station/Modality Changes" letter identified in section 10.7.19 of this chapter. (The state and, as applicable, the AO shall be copied on said letter.)

E. ESRD Location Changes

An ESRD facility that is changing its location must submit either a Form CMS-855A change of information application or an initial enrollment application. The specific transaction type involved (change request or initial) will depend on the particular situation. These situations include the following, and they will generally trigger the termination of the ESRD's existing CCN and the issuance of a new one.

(i) A hospital-based ESRD facility is relocating to an off-campus location in the same state.

In this situation, the ESRD's current CCN will be retired.

If the off-campus location will still function under a common governing body, operate under the hospital's policies and practices, continue to serve the same community, and utilize the same staff at this new location, the new CCN will be that of a renal satellite facility. The application can be processed as a change of information pursuant to the instructions in section 10.6.1.2(A).

If the off-campus location will no longer be operationally, administratively, or financially integrated with the hospital, the new CCN will be that of an independent dialysis facility. The hospital must voluntarily terminate this location from its enrollment, and the site must enroll as a new ESRD facility.

If the contractor has any questions as to whether the relocated location will still be sufficiently integrated with the hospital to permit a change of information application rather than an initial enrollment, the contractor may contact the state for guidance. The processing time clock stops while the contractor awaits the state's guidance.

(ii) An independent ESRD facility is relocating to become a hospital-based facility or a renal satellite facility of a hospital

Since the ESRD facility will be serving a different community under different policies, etc., the facility must terminate its existing enrollment and enroll as a new ESRD facility.

(iii) An independent ESRD facility is relocating to another location and will remain independent

If the ESRD facility will be serving a different community, the facility must terminate its existing enrollment and enroll as a new/initial ESRD facility. If it will serve the same community, the relocation can be processed as a change of information.

(iv) ESRD facility relocating out-of-state

If an ESRD facility of any type (e.g., independent, satellite) is relocating out-of-state --- and notwithstanding any other instruction to the contrary in this chapter ---- it must terminate its existing enrollment and enroll as an initial/new applicant.

F. CHOWs and Changes of Information

For ESRD CHOWs, the contractor shall follow the instructions in section 10.6.1.1 of this chapter. For ESRD changes of information, the contractor shall follow the instructions in section 10.6.1.2 of this chapter.

G. New ESRD Model Letters

Notwithstanding any other instruction to the contrary in this chapter, the contractor shall use the applicable ESRD letters in section 10.7.19 of this chapter for initial enrollments and state-approved changes of ownership.

H. Beds and Services

A *Form* CMS-3427 *from the state must be* included with an initial or CHOW Form CMS-1539 that identifies, as applicable, the services or number of beds at issue. If, nonetheless, this data is not furnished by the state to the contractor for an initial or CHOW application, the contractor may secure it from the state (or, for CHOWs, and as applicable, the AO).

I. ESRD Survey and Certification

The standard CMS survey and certification form used for ESRDs is the Form CMS-3427. For more information on this form, see Pub. 100-07, chapter 2, section 2247B.

For further information on ESRD facilities, refer to:

- Section § 1881 of the Social Security Act
- 42 CFR Part 405, Subpart U
- Pub. 100-07, chapter 2, section 2270 – 2287B
- Pub. 100-02, chapter 11
- Pub. 100-04, Claims Processing Manual, chapter 8

10.2.1.4 - Federally Qualified Health Centers (FQHCs)

(Rev. 12209; Issued: 08-17-23; Effective: 09-18-23; Implementation: 09-18-23)

A. Statutory Background

Section 4161(a)(2) of OBRA '90 (P.L. 101-508) amended §1861(aa) of the Act and established FQHC services as a benefit under the Medicare program effective October 1, 1991. The statutory requirements that entities must meet to be considered an FQHC for

Medicare purposes are at §1861(aa)(4) of the Act. Regulations establishing the FQHC benefit and outlining the Conditions for Coverage for FQHCs were published on June 12, 1992, in the Federal Register (57 FR 24961) and became effective on the date of publication. These regulations were amended on April 3, 1996 (61 FR 14640). Section 13556 of OBRA 1993 (P.L. 103-66) amended §1861(aa) of the Act by adding outpatient health programs or facilities operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act, as entities eligible to participate in Medicare as FQHCs.

B. Requirements

FQHCs furnish services such as those performed by physicians, nurse practitioners, physician assistants, clinical psychologists, certified nurse-midwives, and clinical social workers. This also includes certain preventive services like prenatal services, immunizations, blood pressure checks, hearing screenings and cholesterol screenings. (See Pub. 100-02, chapter 13 for more information). To participate in the Medicare program, applicants seeking initial enrollment as an FQHC must submit a Form CMS-855A application to the appropriate Medicare Administrative Contractor (MAC). Even though they complete the Form CMS-855A application, FQHCs are considered Part B certified suppliers and are paid Part B benefits for FQHC services.

FQHCs are not required to obtain a state survey. However, FQHCs still must meet all applicable state and local requirements and submit all applicable licenses. Typically, the Health Resources and Services Administration (HRSA) will verify such state/local compliance by asking the FQHC to attest that it meets all state/local laws.

FQHCs can be located in a rural or urban area that is designated as either a health professional shortage area or an area that has a medically underserved population.

For purposes of Medicare enrollment, an FQHC is defined as an entity that has entered into an agreement with CMS to meet Medicare program requirements under 42 CFR § 405.2434(a), and (as outlined in Pub. 100-07, chapter 9, exhibit 179):

- Is receiving a grant under § 330 of the Public Health Service (PHS) Act;
- Is receiving funding under a contract with the recipient of a § 330 grant, and meets the requirements to receive a grant under § 330 of the PHS Act;
- Is an FQHC "Look-Alike" (i.e., HRSA), has notified it that it meets the requirements for receiving a § 330 grant, even though it is not actually receiving such a grant);
- Was treated by CMS as a comprehensive federally funded health center as of January 1, 1990; or
- Is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an Urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act.

C. Initial FQHC Applications

1. Contractor Review and Required Documents

In contrast to both past practice and the process that is normally followed with other certified provider/certified supplier types, the contractor does not make a recommendation for approval to the state/SOG Location for FQHC applications. Instead, the contractor will either approve or deny the application at the contractor level pursuant to the instructions in this section.

The following documents must be included with the FQHC's completed Form CMS-855A application:

- One signed and dated copy of the attestation statement (Exhibit 177). In order to attest to being in compliance, the facility must be open and operating when the attestation is signed. Since FQHCs must sign an agreement stipulating that they will comply with § 1861(aa)(4) of the Act and specific FQHC regulations, this statement serves as the Medicare FQHC benefit (or provider/supplier) agreement when it is also signed and dated by PEOG. (See Pub. 100-07, chapter 2, section 2826B.)
- HRSA Notice of Grant Award (NOA) or FQHC Look-Alike Designation that includes an address for the site of the applicant which matches the practice location reported on the Form CMS-855A. A Notice of Grant Award by HRSA verifies that the applicant qualifies as a FQHC grant recipient; the FQHC Look-Alike Designation Memo from HRSA verifies look-alike status.
- Form CMS-588; Electronic Funds Transfer (EFT) Authorization Agreement.
- Clinical Laboratory Improvement Act (CLIA) Certificate (if applicable). Facilities that examine human specimens for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings is considered a laboratory and must meet CLIA requirements. These facilities must apply and obtain a certificate from the CLIA program that corresponds to the complexity of tests performed. Certain types of laboratories and laboratory tests are NOT subject to meeting CLIA requirements. One example would be facilities which serve only as collection stations. A collection station receives specimens to be forwarded to a laboratory performing diagnostics test. Pub. 100-07, chapter 6, section 6002 provides additional details regarding laboratories and laboratory tests NOT subject to CLIA requirements. It is the FQHC's responsibility to review the CLIA requirements and obtain a CLIA certificate if needed. Neither the contractor nor CMS determines whether the FQHC needs to obtain and submit a CLIA certificate.
- Copy of state license (if applicable).

2. General Processing Concepts

(A) Practice Locations - An FQHC cannot have multiple sites or practice locations. Each location must be separately enrolled and will receive its own CCN.

(B) Date on the NOA - The project period (Item 6 of the NOA) must be valid through the date on which the FQHC's application was complete (as determined by the contractor). The contractor shall develop for a correct NOA date(s) if the project period and/or budget period do not meet the aforementioned requirement. (In developing for this data, the contractor may (but is not required to) send the "Reminder and Assistance for Health Centers for CMS FQHC Site Enrollment" guidance to the FQHC.)

(C) Name on Exhibit 177 - The contractor shall ensure that Exhibit 177 contains the same legal business name and address as that which the FQHC provided in Section 2 and Section 4, respectively, of the Form CMS-855A. If the attestation contains a different name, the contractor shall develop for the correct name.

(D) Date on Exhibit 177 - The contractor shall ensure that the date on which the Exhibit 177 was signed is on or after the date the FQHC listed as its effective date on the Form CMS-855A application. If the Exhibit 177 was signed prior to the listed effective date, the contractor shall (using the development procedures outlined in this chapter) develop for an Exhibit 177 signed on or after the FQHC's listed effective date; the FQHC should be providing services in order to meet the regulations noted in Exhibit 177.

(E) Date Application Complete - When reviewing an initial FQHC application, the contractor shall determine the date on which the FQHC's application was complete. To illustrate, assume that the FQHC submitted an initial application on March 1. Two data elements were missing, so the contractor requested additional information. The two elements were submitted on March 30. The contractor shall therefore indicate the March 30 date in its approval letter as the effective date of the FQHC.

(F) Contractor Jurisdiction - Except for tribal and Urban Indian FQHCs, a freestanding FQHC that is initially enrolling is assigned to the Medicare Administrative Contractor (MAC) that covers the state in which the FQHC is located. An initially enrolling tribal or Urban Indian FQHC is assigned to the Jurisdiction H MAC.

(G) Tribal/Urban Indian Organizations – Certain outpatient health programs or facilities may be operated by a tribe or tribal organization or by an Urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act. The contractor shall confirm the applicant's attestation and tribal/urban Indian status if the FQHC indicates on the application that it has such status; several means are available:

- The applicable Indian Health Service (IHS) web link at https://www.ihs.gov/locations/. The contractor can search for the facility by clicking on the "Find Health Care" sub-link https://www.ihs.gov/findhealthcare/?CFID=15011511&CFTOKEN=36378825 or downloading the Excel complete listing of HIS facilities. (These are the highly recommended means of verification.)

- Contacting (1) the IHS directly, (2) contacting the applicable SOG Location, or (3) the contractor's PEOG BFL.

(H) Potential RHC Relationship – On occasion, a rural health clinic (RHC) may seek to convert to an FQHC. (A facility cannot be both an RHC and an FQHC.) Accordingly, in its review of an initial FQHC application, the contractor shall check PECOS to determine whether an RHC is enrolled at the same location. If one is, the contractor shall refer the matter to MedicareProviderEnrollment@cms.hhs.gov. In doing so, the contractor shall furnish to PEOG (1) the names, NPIs, and shared address of the RHC and FQHC, and (2) a copy of all information submitted with the FQHC application; the e-mail's subject line shall state: "RHC & FQHC shared address".

3. Determination

a. Approval

The contractor shall contact PEOG via email at MedicareProviderEnrollment@cms.hhs.gov if it believes that the FQHC's initial application should be approved. The contractor shall provide to PEOG: (1) a copy of the draft approval letter (see section 10.7.5.1(N) of this chapter for a model FQHC approval letter); (2) the Form CMS-855A application or PECOS Application Data Report (ADR) and all supporting documentation; (3) a copy of the FQHC's HRSA documentation; and (4) Exhibit 177.

While awaiting PEOG's final determination---and beginning on the date following the sending of the aforementioned e-mail---the application processing time clock is stopped. It resumes on the date on which the contractor receives PEOG's decision. 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.

b. Denial

If the contractor believes that the FQHC's application should be denied, the contractor shall notify the applicant of the denial using the appropriate model letter guidance in section 10.7.8 of this chapter. If the contractor is uncertain as to whether a denial is warranted or what the appropriate denial ground under 42 CFR 424.530(a) should be, it may contact its PEOG BFL for guidance.

4. Post-PEOG Review and Response to Contractor

If PEOG determines (based on the information the contractor furnished) that the FQHC's application should be approved, PEOG will:

- Assign the CCN, which will be part of the 1800-1989 series
- Assign the effective date, which will be the date the FQHC application was considered complete by the contractor
- Make any necessary revisions to the draft approval letter
- Sign and date the attestation using the completion date, which is also the effective date (Exhibit 177)
- E-mail all of the foregoing documents and data to the contractor, at which point the aforementioned processing time clock resumes.

5. Post-Approval Contractor Action

If PEOG notifies the contractor that the FQHC's application should be approved, the contractor shall send the approval letter to the FQHC with a copy of the signed Exhibit 177.

D. Changes of Information

1. Location Changes

a. Verification

If an FQHC is changing the physical location of an existing site, the FQHC must submit the following documentation (as applicable to that FQHC) to the contractor:

- For §330 grantees, a Notice of Grant Award approving the physical location change and the new address; or
- For look-alikes, an updated letter from HRSA approving the physical location change and listing the new address.

(Consistent with the instructions in this chapter, the contractor shall develop for this documentation with the FQHC if the latter fails to submit it.)

For tribal/Urban Indian organizations, the contractor may confirm the new location via the IHS website or by contacting IHS. (See section 10.2.1.4(C)(2)(G) above for the web link.)

In all cases, the new address listed on the notice of grant award (NOA), IHS website, etc., must match that listed on the Form CMS-855A change request. If it does not, the contractor shall develop with the FQHC for clarification consistent with the instructions in this chapter. In addition, both the budget date and the project date on the NOA must be valid through the date on which the FQHC's change request application was complete (as determined by the

contractor). The contractor shall develop for a correct NOA date(s) if the project period and/or budget period do not meet the aforementioned requirement.

b. Approval

If approving the location change or updating the contact information (as described in section 10.6.1.2 of this chapter), the contractor does not issue a recommendation of approval to the SOG Location, notwithstanding any instruction to the contrary in this chapter; rather, the contractor shall approve the location change in PECOS and issue an approval letter to the FQHC (with an e-mailed copy to PEOG at MedicareProviderEnrollment@cms.hhs.gov (Subject line: FQHC COI—Address Change/Contact Change/Other). PEOG will update ASPEN accordingly.). Beginning on March 15, 2021, tie-in notices will not be issued for address changes.

c. Denial

If the contractor does not approve the location change (i.e., the FQHC is no longer located in a shortage area, the FQHC fails to submit the applicable HRSA supporting documentation after contractor development (discussed above), or another reason is implicated), the contractor shall refer the matter to PEOG at ProviderEnrollmentRevocations@cms.hhs.gov consistent with all applicable instructions in this chapter and other CMS directives. (The referral shall include, at a minimum, the FQHC's LBN and NPI as well as a brief explanation of the situation and the reason for referral.) PEOG will review the matter and instruct the contractor on how to proceed.

2. LBN, TIN, or DBA Name Changes Not Involving a CHOW

The contractor shall process LBN, TIN, or DBA name changes not involving a CHOW consistent with the instructions in sections 10.6.1.2(B)(1) and (3) of this chapter. No notification to the state or SOG Location regarding the change is needed.

3. All Other Change Requests

For all change requests not described in subsections (D)(1) and (2) above, the contractor shall follow the instructions in sections 10.6.1.2(C)(1) and (2) of this chapter.

E. Changes of Ownership (CHOWs)

This section 10.2.1.4(E) addresses procedures for processing FQHC CHOWs. Except as noted otherwise, these instructions take precedence over those in section 10.6.1.1.3 et seq. of this chapter.

For background information on CHOWs (which, for purposes of section 10.2.1.4(E), includes acquisitions/mergers and consolidations) and potential CHOW situations, see sections 10.6.1.1.1 and 10.6.1.1.2 of this chapter. The contractor shall, as needed, refer to these instructions in examining whether a CHOW has occurred. In reviewing said sections, the contractor shall note the following:

- The "provider agreement" for FQHCs is the Exhibit 177.
- No recommendations to the state or SOG Location are involved. The contractor and PEOG alone will handle the transaction. In particular, the contractor---in lieu of making a recommendation to the state/SOG Location---will send its "final analysis" to PEOG. PEOG will then: (i) review the transaction; (ii) determine whether the CHOW should be approved; (iii) as needed, update ASPEN and perform any other related tasks; and (iv) notify the contractor of the results of its review and provide any required direction. The

aforementioned process, in effect, combines a recommendation to the state/SOG Location and the contractor's post-recommendation e-mail to PEOG (described in section 10.6.1.1.3.3(B)) into a single step. For purposes of this section 10.2.1.4(E), the term "final analysis" (in the context of FQHC CHOWs) is roughly the equivalent of a recommendation to the state. Accordingly, when sending its "final analysis" to PEOG as described above, the contractor may—but is not required to—change the application's status in PECOS to "approval recommended."

In addition---and except as otherwise stated---the contractor shall adhere to the following subsections and instructions in sections 10.6.1.1.3 et seq. and 10.6.1.1.4:

(i) Section 10.6.1.1.3.1(A) (This does not include the list of documents in section 10.6.1.1.3.1(A)(iii), although all other instructions in section 10.6.1.1.3.1(A)(iii) shall be followed (e.g., development for missing/deficient documents). The required FQHC CHOW documents are identified in this section 10.2.1.4(E).)

(ii) Section 10.6.1.1.3.1(B) (Regarding section 10.6.1.1.3.1(B)(4), the contractor shall make this referral to PEOG before (and separate from) sending its final analysis to PEOG.)

(iii) Sections 10.6.1.1.3.1.1(A)(1), (A)(2), (A)(3), (B)(1), (B)(2), (B)(3)(a) and (c), (F), and (G). (The contractor can disregard references to state recommendations in these sections.) The remaining topics/instructions in section 10.6.1.1.3.1.1 are either inapplicable to FQHC CHOWs or addressed in this section 10.2.1.4(E).

(iv) Sections 10.6.1.1.4(A), (B), (C), (D), (E), (F), (G), and (H) (With respect to the application of 10.6.1.1.4(C) to FQHC CHOWs, receipt of an approval recommendation from the state (as described in 10.6.1.1.4(C)) is the equivalent of the contractor sending its final analysis to PEOG.)

The following instructions address FQHC-specific CHOW processing activities that the contractor shall follow in addition to the procedures contained in the section 10.6.1.1 et seq. subsections outlined in (i) through (iv) above. If any inconsistency exists between these two sets of instructions (i.e., recommending approval to the state as described in 10.6.1.1 et seq. versus making a final analysis to PEOG as described below), the latter takes precedence.

1. Special Processing Steps

a. Required Documents – The contractor shall ensure that the FQHC submits all documentation otherwise required per this chapter. For FQHC CHOW purposes, this also includes:

- 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(B) for more information on such documents.)

- Evidence of state licensure of the new entity, if applicable. (This can be furnished consistent with existing instructions in this chapter concerning submission of evidence of state licensure.)

- Exhibit 177 containing the new owner's information.

- HRSA NOA or FQHC Look-Alike Designation containing the new owner's information. (NOTE: Both the budget date and the project date on the NOA must be valid through the date on which the FQHC's CHOW application was complete (as determined by the

contractor). The contractor shall develop for a correct NOA date(s) if the project period and/or budget period do not meet the aforementioned requirement.)

b. Old and New Owner Applications

i. Order of Receipt - To the maximum extent practicable, FQHC CHOW applications from the previous and new owners should be processed as they arrive.

ii. Non-Receipt of Previous Owner's Application – Although the contractor shall attempt to collect the old owner's application, it may make its final analysis without it.

c. Relocation of Entity - A new owner may seek to relocate the FQHC concurrent with a CHOW. In such cases, the contractor shall ensure that the FQHC submits (along with the documents in (E)(1)(a) above):

- For § 330 grantees, a Notice of Grant Award approving the physical location change and the new address; or
- For look-alikes, an updated letter from HRSA approving the physical location change and listing the new address.

For tribal/Urban Indian organizations, the contractor may confirm the new location via the IHS website or by contacting IHS. (See section 10.2.1.4(C)(2)(H) above for the web link.)

The new address listed on the notice of grant award, IHS website, etc., must match that on the Form CMS-855A CHOW application. If it does not, the contractor shall develop with the FQHC for clarification consistent with the instructions in this chapter.

Notwithstanding the foregoing, the entire transaction shall be processed as a CHOW rather than a COI.

d. Intervening Change of Ownership

In situations where the FQHC (1) submits a Form CMS-855 initial application or CHOW application and (2) subsequently submits a Form CMS-855 CHOW application, the contractor shall adhere to the following:

Situation 1 – The FQHC submitted an initial application followed by a CHOW application, and the contractor has not yet sent its final analysis to PEOG: The contractor shall return both applications and require the FQHC to re-submit an initial application with the new owner's information.

Situation 2 - The FQHC submitted a CHOW application followed by another CHOW application, and the contractor has not yet sent its final analysis to PEOG regarding the first application: The contractor shall process both applications, preferably in the order they were received. When sending its final analysis to PEOG, the contractor shall explain the dual CHOW application submission.

Situation 3 - The FQHC submitted an initial application followed by a CHOW application, and the contactor has sent its final analysis of the initial application to PEOG but before it has notified the FQHC of the approval of the initial application: The contractor shall:

- Return the CHOW application.

- Notify PEOG via e-mail that a change of ownership has occurred (the new owner should be identified) and that the contractor will require the FQHC to resubmit a new initial

application containing the new owner's information.

- Request via letter that the FQHC 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 FQHC fails to do so, the contractor shall return the originally submitted initial application and notify the FQHC accordingly. If the FQHC submits the requested application, the contractor shall process it consistent with the instructions in this chapter; 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 FQHC accordingly.

Situation 4 - The FQHC submitted a CHOW application followed by another CHOW application, and the contactor has sent its final analysis of the first CHOW application to PEOG but before it has notified the FQHC of the approval thereof - The contractor shall:

- Notify PEOG 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 FQHC to resubmit a new CHOW application containing the subsequent/second new owner's information.

- Process the new/second CHOW application as normal. If a final analysis to PEOG is made for this application, the contractor shall explain this situation in its e-mail; the first CHOW application becomes moot. If the newly submitted/second CHOW application is returned or rejected per the instructions in this chapter, the first application should, too, be returned or rejected (as applicable). The contractor shall notify the provider and PEOG accordingly.

2. Post-Initial Review Actions and Scenarios

After the contractor completes the tasks described in the above-referenced sections, several results are possible. These are discussed below. Should the contractor encounter a scenario not addressed herein, it may contact its PEOG BFL for guidance prior to its final analysis. As a reminder, nothing in this section 10.2.1.4(E)(2) prohibits the contractor from returning or rejecting the application if otherwise permitted to do so per this chapter.

a. The contractor ascertains that the transaction falls within the scope of § 489.18 and that the new owner has accepted assignment – If there are no apparent grounds for denying the CHOW application, the contractor shall send its final analysis to PEOG via e-mail at MedicareProviderEnrollment@cms.hhs.gov with the following information and documents: (1) the Form CMS-855 application or PECOS Application Data Report; (2) a copy of the final sales/transfer agreement; (3) a copy of the provider-signed Exhibit 177; and (4) NOA. PEOG will countersign the Exhibit 177 and assign an effective date of the CHOW based on the date the application was complete (as determined by the contractor). Within 5 business days of receiving from PEOG the signed Exhibit 177 and effective date, the contractor shall: (1) send the CHOW approval letter and a copy of the CMS-countersigned Exhibit 177 to the FQHC; and (2) switch the PECOS record to "approved" consistent with existing instructions.

If a denial ground exists, however, the contractor shall refer the matter to its PEOG BFL for guidance notwithstanding any other instruction in this chapter to the contrary. The contractor should include an explanation of the ground(s) it believes exists for the denial (including the regulatory citation); the e-mail referral shall state in the subject line "FQHC Guidance Required."

b. The contractor ascertains that the transaction falls within the scope of § 489.18 but the new owner has not accepted assignment – The contractor shall: (a) return the application; and (b) notify the new owner in the return letter that it must submit the following within 30 days

from the date of the return letter: (1) an initial Form CMS-855 application to enroll as a new FQHC; and (2) a voluntary termination application for the existing FQHC. If the new owner fails to do so within 30 days of the request, the contractor shall contact its PEOG BFL via e-mail with this information notwithstanding any other instruction to the contrary in this chapter. PEOG will review the matter and respond to the contractor.

c. The contractor ascertains that the transaction does not fall within the scope of § 489.18 (e.g., stock transfer), regardless of whether the new owner accepted assignment - This qualifies as an ownership change under 42 CFR § 424.516 rather than a CHOW under § 489.18. The contractor shall: (A) return the application; and (B) notify the FQHC in the return letter that it must submit a Form CMS-855 application to report the ownership change within 30 days of the return letter and provide all supporting documentation (including a revised NOA and agreement). If the provider fails to do so, the contractor shall contact its PEOG BFL via e-mail with this information notwithstanding any other instruction to the contrary in this chapter.

F. Timeframes and Alternatives

While awaiting PEOG's final determination (and beginning on the date following the sending of the aforementioned e-mail) for the applications described in subsections (C), (D), and (E), the application processing time clock is stopped. It resumes on the date on which the contractor receives PEOG's decision. 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 10.2.1.4 negates other processing alternatives outlined in this chapter that can apply to the processing of FQHC applications.

G. Supporting Documentation

1. Revalidations

Upon revalidation of an FQHC site, the FQHC must submit --- along with any other supporting documentation required per this chapter --- either an NOA (for awardees) or notice of look-alike designation (NLD, for look-alikes) approving the site. If an NOA or NLD is unavailable for the site, a copy of the FQHC's "Form 5B: Service Sites" list downloaded from HRSA's Electronic Handbooks documenting all of the provider's approved FQHC program sites is acceptable. However, any NOA, NLD, or Form 5B must include the physical address of the site in question that matches the physical address on file with CMS and the address submitted on the Form CMS-855A application. If the addresses do not match, the contractor shall develop for additional information.

2. Initial Applications, CHOWs, and Location Changes

The contractor cannot accept a copy of the Form 5B as supporting documentation for initial applications, CHOWs, and new/changed FQHC locations. As explained previously, only a valid, "in effect" NOA or NLD, as applicable, is acceptable.

***H*. Revocations and Other Transactions**

Except as otherwise stated or required by CMS, the contractor shall continue to adhere to the applicable instructions in this chapter and all other CMS directives regarding:

- Potential FQHC revocations and referrals (including sending the referral/information to the appropriate PEOG mailbox)
- Changes of ownership

- Changes of information
- Revalidations
- Reactivations

I. Complaint Investigations

CMS SOG Locations investigate complaints that raise credible allegations of an FQHC's noncompliance with health and safety standards found at 42 CFR 405 Subpart X, and 42 CFR 491 Subpart A (except for 42 CFR § 491.3). The contractor shall refer such complaints to the SOG Location that has jurisdiction over the FQHC.

J. FQHC DPV Errors

(This only applies to initial applications (subsection (C)(1) above) and location changes (subsection (D)(1).)

A site visit for FQHCs is generally not required. However, the contractor shall order a site visit if there is a DPV error. The site visit shall be ordered before the contractor sends the applicable e-mail described in subsections (C)(3)(a) and (D)(1)(b) above. If the site visit finds that the facility is not open and operational, the contractor shall deny the application. If the facility is open and operational, the contractor can proceed as normal.

K. Additional Data

For additional general information on FQHCs, refer to:

- Section 1861(aa)(3-4) of the Social Security Act
- 42 CFR Part 491 and 42 CFR Part 405, subpart X
- Pub. 100-07, chapter 2, sections 2825 – 2826H
- Pub. 100-07, chapter 9, exhibits 177 and 179
- Admin Info 21 06-ALL – Transitioning FQHC Certification Enrollment Performed by the CMS SOG (Standard Operating Procedures attached)
- Pub. 100-04, chapter 9
- Pub. 100-02, chapter 13

For additional information on the appropriate contractor jurisdictions for incoming FQHC enrollment applications, see Pub. 100-04, chapter 1, section 20 as well as Pub. 100-07, chapter 9, exhibit 179.

10.2.1.8.1 – Rural Emergency Hospitals (REHs)

(Rev. 12209; Issued: 08-17-23; Effective: 09-18-23; Implementation: 09-18-23)

Section 125 of Division CC of the Consolidated Appropriations Act, 2021 added a new section 1861(kkk) to the Social Security Act (the Act) to establish REHs as a new Medicare provider type to address the growing concern over closures of rural hospitals. In accordance with section 1861(kkk), a facility is eligible to convert to an REH if it was a CAH or rural hospital with not more than 50 beds as of December 27, 2020. REHs must provide emergency services and observation care and are prohibited by the statute from providing inpatient services.

The CY 2023 OPPS/ASC final rule (CMS-1772-F) established, among other things, requirements that REHs must meet in order to bill Medicare. These included enrollment requirements, addressed in part in new 42 CFR § 424.575. In short, the rule specified the following:

- A CAH or rural hospital wishing to convert to an REH must submit a Form CMS-855A change of information application, rather than an initial application
- No application fee need be paid
- REHs will be in the "limited" screening category under 42 CFR § 424.518
- REHs fall within 42 CFR § 424.520(a) in terms of establishing an effective date of billing privileges.

This section 10.2.1.8.1 instructs contractors on the processing of REH enrollment applications. Note that REHs (like CAHs) are not "transitioning" as that term is used in this chapter with respect to the survey and certification process.

A. Initial Process

(CMS will notify the contractors and the public as to when prospective REHs may begin to submit applications.)

1. Submission

In submitting a Form CMS-855A change of information (COI) application to convert to an REH, the facility must:

(a) Check the "You are changing your Medicare information" box in Section 1(A)

(b) Check the "Other" box in Section 2(A)(2) and write "Rural emergency hospital" or "REH" in the line next thereto

(c) Complete Sections 2(B) (with REH information), 3, and 15 and/or 16 (as applicable)

(d) Report any additions/deletions/changes to its current enrollment information (that is, its current CAH or rural hospital enrollment) that will stem from its conversion to an REH (e.g., new billing agency, adding/deleting two managing employees, deleting a 10 percent owner)

(e) Submit all required state licenses/certifications for operation as an REH (if available to the provider at the time)

(CMS will conduct outreach to the prospective REH community regarding the above requirements.)

However, the facility need not submit with its application:

- An application fee

- Any documentation related to its existing enrollment as a CAH or rural hospital (e.g., CAH licensure) except if a new adverse legal action is also being reported, in which case the contractor shall follow the instructions in section 10.6.6 of this chapter concerning documentation acquisition.

- Any other documentation that: (1) is specific to the survey and certification process; and (2) a non-transitioned, certified provider/supplier typically submits directly to the state or SOG Location pursuant to this process (e.g., a signed provider agreement). The state or SOG Location will, as applicable, collect this information. If the provider nonetheless submits these materials with its application, the contractor shall include them in any recommendation package it sends to the state; however, the contractor need not review them for compliance, signatures, etc.

2. Initial Contractor Review

In reviewing the application, the contractor shall adhere to the following:

(i) Eligibility - The contractor *need not* check PECOS to see whether the REH was enrolled as a CAH or a rural hospital as of December 27, 2020. *CMS and the state agency will determine whether the facility meets the REH statutory and regulatory requirements. So long as the hospital indicates in Section 2 that it is an REH, the contractor can process the application normally (and consistent with the instructions in this section 10.2.1.8.1).*

(ii) Submission of New/Initial Enrollment – In the highly unlikely event that the facility submits a full, initial REH enrollment application rather than a COI, the contractor shall nonetheless process the application. No fee is required. (See subsection (A)(3) below for more information.)

(iii) Application Fee – If the facility submits an application fee and/or hardship waiver, the contractor shall refund/return it consistent with the instructions in this chapter. However, if the facility seeks to add a new location pursuant to its application, the contractor in all cases shall contact its PEOG BFL for guidance.

(iv) Returns – If the contractor determines that a basis exists for returning the application under 42 CFR § 424.526 and section 10.4.1.4.2 of this chapter, the contractor shall contact its PEOG BFL for guidance.

(v) Authorized/Delegated Officials – The facility is not required to assign and utilize new authorized and delegated officials pursuant to the conversion. It may continue to use the officials who are part of its existing CAH or rural hospital enrollment. However, as with any other change of information stemming from the conversion, the facility must report any changes to its current authorized/delegated officials; this could occur, for example, if the facility will be under new leadership or management.

(vi) Voluntary Termination – The facility is not required to submit a voluntary termination application to terminate its existing CAH or rural hospital enrollment. Any termination will be effectuated upon the approval of the REH's enrollment. (See subsection (B) below.)

3. Processing and PECOS

Subject to the provisions in subsections 10.2.1.8.1(A)(1) and (2) above, the contractor shall process the COI consistent with the COI processing instructions in this chapter. This includes, but is not limited to, performing all required verifications (e.g., a new managing employee and/or delegated official is reported), developing for any missing or incomplete data, etc. It does not include, however, making determinations normally reserved to the state or SOG Location. For REHs, this includes, but is not limited to: (1) the number of beds; (2) whether emergency services, observation care, and inpatient services will be performed; (3) whether the facility is indeed in a rural area; and (4) whether CoPs are met.

Absent clear evidence to the contrary, the contractor can assume that any Form CMS-855A data that is not reported as changing per subsection (A)(1)(d) above is remaining intact. For instance, suppose the provider does not report any changes in Section 4 of the COI. The contractor can assume that the provider's practice location data will remain as is.

During the aforementioned process, the contractor shall create a new enrollment record in PECOS for the REH. The record shall include: (1) the data submitted on the COI; and (2) data that is currently part of the CAH's or rural hospital's enrollment record but is not changing on the COI. To illustrate, assume a CAH submits a COI to convert to an REH.

Sections 6, 7, and 8 are blank, but Section 2(B) contains new REH licensure data. The new REH enrollment record shall include the Section 2(B) REH licensure information as well as the Section 6, 7, and 8 data that is in the CAH's current enrollment record. The CAH's enrollment record shall remain active and intact at this point.

For submitted initial applications:

- The contractor shall process the application consistent with this chapter's instructions for processing initial applications involving non-transitioning certified providers/suppliers.

- While the contractor shall create a new PECOS enrollment record for the REH, it need not (unlike with a COI) populate it with data from the facility's existing CAH or rural hospital record. It can simply use the data on the initial application; the application shall be designated as an initial application in PECOS.)

4. Recommendation/Disposition

i. Approval Recommended – If the contractor believes that a recommendation for approval is warranted, it shall forward its recommendation to the state consistent with the instructions for processing non-transitioned certified provider/supplier applications. The state will review the matter and thereafter refer it to the SOG Location for final review.

ii. Rejection or Denial – If the contractor believes the application should be rejected or denied, it shall send an e-mail to its PEOG BFL that: (1) identifies the provider (e.g., LBN); (2) explains the basis for the contractor's position; and (3) if a potential denial is involved, includes a copy of the draft denial letter for non-transitioned certified providers/suppliers. PEOG will review the matter. If PEOG approves the rejection or denial, the contractor shall --- within 3 business days of receiving said approval --- follow existing procedures for rejecting or denying an application; the state and SOG shall be copied on any denial letter.

B. Post-SOG Location Procedures

1. Denial

If the SOG Location denies the REH's request for participation, it will notify the contractor thereof. The contractor shall accordingly follow the procedures in this chapter for denying non-transitioned certified provider/supplier applications. (No prior PEOG approval of the denial is needed.) The facility's CAH or rural hospital enrollment, however, remains as is.

2. Approval

If the SOG Location notifies the contractor of its approval of the REH's request for participation, the contractor shall follow the procedures in this chapter for approving non-transitioned certified provider/supplier applications. As part of this, the contractor shall: (a) switch the REH's PECOS record to "Approved" (using the participation effective date on the SOG Location approval notice); and (b) deactivate the facility's CAH or rural hospital enrollment (with a status of "voluntary withdrawal"), as well as any CAH reassignments, effective the day before the REH's approval effective date.

C. Additional Considerations

1. Letters

- Denial – Any denial letter sent pursuant to this section 10.2.1.8.1 shall include the following language: "Your existing enrollment as a [insert critical access hospital or other hospital type, as applicable] is not affected by this determination."

The contractor shall use the denial letter applicable to the type of application submitted (e.g., a COI denial letter for a COI application).

- Approval – The approval letter shall include the following language: "With your enrollment as a rural emergency hospital, your existing enrollment as a [insert critical access hospital or other hospital type, as applicable] has been deactivated effective [insert date]. You will no longer be able to bill for [insert critical access hospital or other hospital type, as applicable] services under this enrollment." (No separate voluntary termination letter is required.)

The contractor shall use the approval letter applicable to the type of application submitted (e.g., an initial approval letter for an initial application).

The exact placement of the aforementioned language in the letters lies within the contractor's discretion.

2. Processing Alternatives and Clock Stoppages – Except as otherwise indicated in this section 10.2.1.8.1, all processing alternatives and clock stoppages described in this chapter apply to REH enrollment applications.

D. Enrolled REHs

Once enrolled, the REH, like all providers and suppliers, must maintain compliance with the enrollment requirements in 42 CFR Part 424, subpart P. This includes, but is not limited to, reporting changes to its enrollment information, undergoing revalidation (and submitting the required fee with this application), etc. The contractor need not undertake any special actions unique to enrolled REHs that are different from those applicable to all other provider/supplier types.

It is possible that an enrolled REH may seek to return to its former status as a CAH or rural hospital. To do so---and consistent with 42 CFR Part 424, subpart P and this chapter---it must submit an initial enrollment application and, for the REH enrollment, a voluntary termination application. It cannot do so via a change of information.

10.2.2.1 – Ambulatory Surgical Centers (ASCs)

(Rev. 12209; Issued: 08-17-23; Effective: 09-18-23; Implementation: 09-18-23)

ASCs are a certified supplier type that enroll via the Form CMS-855B.

A. Background

An ASC is defined in 42 CFR § 416.2 as any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission; the entity must have an agreement with CMS to participate in Medicare as an ASC and must meet the conditions set forth in 42 CFR Part 416, subparts B and C (The ASC supplier agreement (Form CMS-370) is similar to the provider agreement signed by Part A providers.)

An ASC satisfies the criterion of being a "distinct" entity when it is separate and clearly distinguishable from any other healthcare facility or office-based physician practice. Thus, distinct entity means that surgical services may only be provided at the single location listed

in the Medicare supplier agreement. Medicare-certified ASCs are not permitted to have multiple locations under the same supplier agreement. If an entity owns multiple surgical locations and wishes them to participate in Medicare as an ASC, each location must seek separate participation and enrollment and must demonstrate independent compliance with the ASC conditions of coverage, for the regulations do not permit configurations of multiple ASC locations under one Medicare agreement. (Each location would be considered a new, initial enrollment; thus, if an enrolled ASC wishes to add a second practice location, the transaction would constitute a new, initial enrollment rather than the addition of a practice location to an existing enrollment.) ASCs may only have one surgical location per CMS Certification Number (CCN). See also CMS Publication (Pub. 100-07), State Operations Manual, chapter 2, section 2210 for more information.

As stated in § 416.26(a), CMS may deem an ASC to be in compliance with any or all of the ASC conditions of coverage set forth in 42 CFR Part 416, subpart C if:

- The ASC is accredited by a national accrediting body, or licensed by a state agency, that CMS determines provides reasonable assurance that the conditions are met;

- In the case of deemed status through accreditation by a national accrediting body, where state law requires licensure, the ASC complies with state licensure requirements; and

- The ASC authorizes the release to CMS of the findings of the accreditation survey.

Unless CMS deems the ASC to be in compliance with the ASC conditions of coverage in 42 CFR Part 416, subpart C, the state survey agency must survey the facility to ascertain compliance with those conditions. (See 42 CFR § 416.26(b).)

B. Processing Instructions for ASC Initial Form CMS-855B Applications

1. Receipt of Application

Upon receipt of an ASC initial Form CMS-855B 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 ASC has submitted all documentation otherwise required per this chapter. For ASC initial enrollment*, this* also includes the Form CMS-370 (ASC supplier agreement).

(The ASC must complete, sign, date, and include the Form CMS-370, though the ASC need not complete those sections of the form reserved for CMS. For organizational ASCs, an authorized official (as defined in § 424.502) must sign the form; for sole proprietorships, the sole proprietor must sign.)

Notwithstanding the foregoing, if the Form CMS-370 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 10.2.2.1(B) prohibits the contractor from returning or rejecting the ASC 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 10.2.2.1(B) 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 ASC, 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 10.7.8 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).) No later than 5 business days after receiving this notification, the contractor shall commence the actions described in section 10.2.2.1(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 or similar documentation received from the state
- A copy of the supplier Form CMS-370
- 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 supplier 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 ASPEN, and (4) approve (with possible edits) the approval letter. Within 5 business days of receiving from PEOG the signed supplier agreement, effective date, and CCN, the contractor shall: (1) send the approval letter and a copy of the CMS-countersigned supplier agreement to the ASC; (2) send a copy of both the approval letter and the supplier agreement to the state and/or AO; and (3) switch the PECOS record from "approval recommended" to "approved" consistent with existing instructions.

C. Additional Enrollment Information

The contractor shall ensure that, as applicable, all licenses, certifications, and accreditations submitted by ASCs are included in the enrollment package that is forwarded to the state.

If the ASC applicant's address or telephone number cannot be verified, the contractor shall contact the applicant for further information. If the supplier states that the facility or its phone number is not yet operational, the contractor shall continue processing the application. However, it shall indicate in its recommendation letter to the state agency ("state")/SOG Location that the address and telephone number of the facility could not be verified.

When enrolling the ASC, and except as otherwise stated in this chapter or as otherwise instructed by PEOG, the contractor shall use the effective date indicated on the state approval notice/letter (e.g. CMS-1539). This is the date from which the supplier can bill for services.

D. ASCs and Reassignment

Physicians and non-physician practitioners who meet the reassignment exceptions in 42 CFR § 424.80, and CMS Pub. 100-04, Claims Processing Manual, chapter 1, sections 30.2.6 and 30.2.7 may reassign their benefits to an ASC. In such a reassignment, the individual and the ASC must sign the Form CMS-855R. However, the ASC need not separately and additionally enroll as a group practice in order to receive benefits. It can accept reassignment as an ASC.

E. ASCs Changes of Ownership (CHOWs) and Changes of Information

Though ASCs are not mentioned in 42 CFR § 489.18, CMS generally applies the CHOW provisions of § 489.18 to them. CHOWs involving ASCs are thus handled in accordance with the principles in § 489.18 and Pub. 100-07, chapter 3, sections 3210 through 3210.5(C). For ASC CHOW processing instructions, see section 10.6.1.1 of this chapter.

The contractor shall process ASC changes of information in accordance with section 10.6.1.2 of this chapter.

F. Additional General ASC Information

For more information on ASCs, refer to:

- 42 CFR Part 416

- Pub. 100-07, chapter 2, section 2210 and Appendix L. (See Pub. 100-07, chapter 2, section 2210 for information regarding the sharing of space between ASCs and other providers and suppliers.)

- Pub. 100-02, Benefit Policy Manual, chapter 15, sections 260 – 260.5.3

- Pub. 100-04, chapter 14

G. ASCs and Hospitals

See the following instructions for guidance regarding hospital-operated/affiliated ASCs:

- Pub. 100-04, chapter 14, section 10.1

- Pub. 100-02, chapter 15, section 260.1

10.2.2.8 – Portable X-Ray Suppliers (PXRSs)

(Rev. 12209; Issued: 08-17-23; Effective: 09-18-23; Implementation: 09-18-23)

PXRSs are a certified supplier type that enroll via the Form CMS-855B.

A. Background

To qualify as a PXRS, an entity must meet the conditions for coverage discussed in 42 CFR § 486.100-110.

A PXRS can be simultaneously enrolled as a mobile independent diagnostic testing facility (IDTF), though they cannot bill for the same service. A PXRS requires a state survey, while a mobile IDTF does not (although an IDTF requires a site visit).

A PXRS does not have a supplier agreement.

B. Processing Instructions for PXRS Initial Form CMS-855B Applications

1. Receipt of Application

Upon receipt of a PXRS initial Form CMS-855B 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 PXRS has submitted all documentation otherwise required per this chapter. For PXRS initial enrollment, *this includes the* Form CMS-1880 (Request for Certification as Supplier of Portable X-Ray Suppliers)

If the Form CMS-1880 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 10.2.2.8(B) prohibits the contractor from returning or rejecting the PXRS 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 10.2.2.8(B) 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 PXRS, 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 10.7.8 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).) A site visit need not be performed. No later than 5 business days after receiving this notification, the contractor shall commence the actions described in section 10.2.2.8(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 order a site visit as described in this chapter.

If the PXRS fails the site visit, the contractor shall follow the denial procedures addressed in subsection (B)(2)(B) above. If the PXRS passes the site visit, the contractor shall (within 3

business days of completing its review of the results) 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 or similar documentation received from the state
- A copy of the supplier-signed Form CMS-1880
- 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 ASPEN, 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 (CMS-1561) to the PXRS; (2) send a copy of both the approval letter and the provider agreement to the state and/or AO (as applicable); and (3) switch the PECOS record from "approval recommended" to "approved" consistent with existing instructions.

C. Site Visits

1. Initial application –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 provider prior to the completion of the NSVC's site visit and the contractor's review of the results.

2. New/changed location - If a PXRS 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 no later than 5 business days after the contractor receives the approval recommendation from the state but before the contractor sends to PEOG the applicable e-mail described in section 10.6.1.2(A)(3) of this chapter. (See the latter section for more information. This is to ensure that the new/changed location 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 make a final decision regarding the change of information application prior to the completion of the NSVC's site visit and the contractor's review of the results.

D. Reassignment

PXRSs may receive reassigned benefits. A PXRS need not separately enroll as a group practice in order to receive them.

E. Practice Location Information

In Section 4 of the Form CMS-855B, the PXRS must furnish certain information, including:

- Whether it furnishes services from a "mobile facility" or "portable unit." (A PXRS can be either, though it usually is a portable unit.) A "mobile facility" typically describes a vehicle that travels from place to place to perform services inside the vehicle. Examples of such vehicles include mobile homes and trailers. A portable unit involves a supplier

transporting medical equipment to a particular location. Unlike with mobile facilities, the equipment on a portable unit is separate from and unattached to the vehicle.

- Its base of operations. This is from where personnel are dispatched and where equipment is stored. It may or may not be the same address as the practice location.

- All geographic locations at which services will be rendered.

- Vehicle information if the services will be performed inside or from the vehicle. Unless stated otherwise in this chapter or in another CMS directive, copies of all licenses and registrations must be submitted as well.

F. Additional Enrollment Information

The contractor shall include any licenses, certifications, and accreditations submitted by PXRSs in the enrollment package that is forwarded to the state.

If the PXRS's address or telephone number cannot be verified, the contractor shall contact the applicant for further information. If the supplier states that the facility or its phone number is not yet operational, the contractor shall continue processing the application. However, it shall indicate in its recommendation letter to the state that the address and telephone number of the facility could not be verified.

When enrolling the PXRS, and except as otherwise stated in this chapter or as otherwise instructed by PEOG, the contractor shall use the effective date that is indicated on the state approval letter/notice. This is the date from which the supplier can bill for services.

G. PXRS Changes of Ownership (CHOWs) and Changes of Information

Though PXRSs are not mentioned in 42 CFR § 489.18, CMS generally applies the CHOW provisions of § 489.18 to them. CHOWs involving PXRSs are thus handled in accordance with the principles in § 489.18 and Pub. 100-07, chapter 3, sections 3210 through 3210.5(C). For PXRS CHOW processing instructions, see section 10.6.1.1 of this chapter.

The contractor shall process PXRS changes of information in accordance with section 10.6.1.2 of this chapter.

H. Additional Information

For more information on PXRSs, refer to:

- 42 CFR §§ 486.100 – 486.110

- Pub. 100-07, chapter 2, sections 2420 – 2424B

- Pub. 100-02, chapter 15, sections 80.4 - 80.4.4

- Pub. 100-04, chapter 13, sections 90 - 90.5

10.3.3.1 – Form CMS-588 – Electronic Funds Transfer (EFT) Authorization Agreement

(Rev. 12209; Issued: 08-17-23; Effective: 09-18-23; Implementation: 09-18-23)

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 *(DMEPOS)*

1. The NPEs now process all Form CMS-588 forms submitted by DMEPOS suppliers. The DME MACs no longer perform this function. The NPEs will input all EFT data into PECOS.

2. CMS previously only required the submission of a DMEPOS supplier's Form CMS-588 upon initial enrollment. DMEPOS suppliers are now required to submit a Form CMS-588 upon any Form CMS-855S initial enrollment, revalidation, reactivation, or any change of information if the supplier is currently paid via paper checks.

3. A DMEPOS supplier's EFT information will be applied across all four DME MAC jurisdictions. It will not be limited to the DME MAC jurisdiction listed on the supplier's Form CMS-855S enrollment application.

4. EFT payments will not be made until the bank account is fully verified.

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.

Once it has been processed, the Form CMS-588 will be printed and delivered (along with the voided check and bank letter verifying the account information) to the contractor's financial area for proper processing of the EFT data. If this information cannot be verified and the provider/supplier fails to timely respond to a developmental request, the contractor shall reject the Form CMS-588 and, if applicable, the accompanying Form CMS-855 or Form CMS-20134.

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 all of his/her benefits 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.

10.4.7.4 – Reenrollment Bar

(Rev. 12209; Issued: 08-17-23; Effective: 09-18-23; Implementation: 09-18-23)

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 their billing privileges revoked, they are 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) -- For licensure issues, 1 year if no billing after loss of license
- §424.535(a)(6) (Grounds Related to Screening) – 1 year
- §424.535(a)(11) (Initial Reserve Operating Funds) – 1 year

The following revocation reasons will receive reenrollment bar lengths per CMS discretion:

- §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) will receive reenrollment bar lengths per CMS' discretion.

C. Applicability of Bar

1. Revocation Reasons Other Than § 424.535(a)(1), (a)(5), (a)(6), (a)(9), (a)(10), and (a)(11)

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 - John 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 John Smith is the sole owner/member.

SCENARIO 2 - Jack Jones and Stan 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 Jack Jones and his wife, Jane Jones.

SCENARIO 3 - John 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. John Smith is listed as a 75 percent owner.

2. Revocation Reasons § 424.535(a)(1), (a)(5), (a)(6), (a)(9), (a)(10), and (a)(11)

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)(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
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

* 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 Careers (FQHCs)
- Histocompatibility Laboratories
- Home Health Agencies
- 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.)

10.6.14 – Application Fees

(Rev. 12209; Issued: 08-17-23; Effective: 09-18-23; Implementation: 09-18-23)

*(*The contractor shall review section 10.3 of this chapter for special instructions regarding application fee and waiver submissions with PECOS applications.*)*

A. Background

Pursuant to 42 CFR § 424.514 - and with the exception of physicians, non-physician practitioners, physician group practices, non-physician group practices, and Medicare Diabetes Prevention Program (MDPP) suppliers – institutional providers that are (1) initially enrolling in Medicare, (2) adding a practice location, or (3) revalidating their enrollment information per 42 CFR § 424.515 (regardless of whether the revalidation application was requested by CMS or voluntarily submitted by the provider or supplier), must submit with their application:

- An application fee in an amount prescribed by CMS, and/or

- A request for a hardship exception to the application fee.

For purposes of this requirement, the term “institutional provider,” as defined in 42 CFR § 424.502, means any provider or supplier that submits a paper Medicare enrollment application using the Form CMS-855A, Form CMS-855B (not including physician and non-physician practitioner organizations), Form CMS-855S, or associated Internet-based Provider Enrollment, Chain and Ownership System (PECOS) enrollment application. A physician, non-physician practitioner, physician group, or non-physician practitioner group that is enrolling as a supplier of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) via the Form CMS-855S application must submit the required application fee with its Form CMS-855S form.

For a list of fee requirements broken out by provider/supplier and application type, refer to the Application Fee Matrix.

Except as otherwise noted, nothing in this section 10.6.14 supersedes any other CMS directive to the contractor pertaining to application fees.

(For purposes of this section 10.6.14, the term "provider" will be used in lieu of "institutional provider.")

B. Contractor Activities Upon Receipt

Upon receipt of a paper or PECOS application from a provider that is otherwise required to submit an application fee, the contractor shall first determine whether the application is an initial enrollment, a revalidation, or involves the addition of a practice location. If the application does not fall within any of these categories, the contractor shall process the application as normal. If it does fall within one of these categories, the contractor shall undertake the following:

1. Determine whether the provider has: (1) paid the application fee via Pay.gov (all payments must be made via Pay.gov); and/or (2) included a hardship exception request with the application or certification statement.

2. Outcomes

i. The provider has neither paid the fee nor submitted the hardship exception request-- The contractor shall send a development letter to the provider notifying it that: (A) it has 30 days from the date of the letter to pay the application fee via Pay.gov and any other items that may be missing or needed; and (B) failure to do so will result in the rejection of the provider's application (for initial enrollments and new practice locations) or revocation of the provider's Medicare billing privileges (for revalidations).

ii. The provider has submitted a hardship exception request but has not paid a fee - The contractor shall send the request and all documentation accompanying the request via e-mail to its PEOG BFL. If CMS:

- Denies the hardship exception request – CMS will notify the provider in the decision letter (on which the contractor will be copied) that the application fee must be paid within 30 calendar days from the date of the letter. During this 30-day period, the contractor shall determine whether the fee has been submitted via Pay.gov. If the fee is not paid within 30 calendar days, the contractor shall deny the application (initial enrollments and new locations) pursuant to 42 CFR § 424.530(a)(9) or revoke the provider's Medicare billing privileges under 42 CFR § 424.535(a)(6) (revalidations).

  (The contractor shall begin processing the application as normal if, at any time during this 30-day period: (1) for paper applications, the provider submits a Pay.gov receipt as proof of payment; or (2) for PECOS applications, the provider pays the fee via PECOS.)

- Approves the hardship exception request - CMS will notify the provider of such in the decision letter (on which the contractor will be copied). The contractor shall continue processing the application as normal.

iii. Has submitted a hardship exception request and has paid a fee - The contractor shall send the request and all documentation accompanying the request via regular mail, fax, or e-

mail to its PEOG BFL. As the fee has been paid, the contractor shall begin processing the application as normal.

3. PECOS Applications

(For PECOS applications, the provider must submit any required application fee (i.e., initials, revalidations, new practice locations) or hardship waiver via PECOS at the time it submits its application; otherwise, PECOS will not accept the application. Some of the instructions in subsection (B)(2) may therefore be inapplicable to PECOS applications.)

As stated in section 10.3 of this chapter, 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 $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.

C. Fee Amount

1. General Background

Except as stated in subsection (C)(2), the application fee must be in the amount prescribed by CMS for the calendar year (1) in which the application is submitted (for PECOS applications) or (2) of the postmark date (for paper applications). The current fee amount can be found via PECOS at the following link: https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do

Fee amounts for future years will be adjusted by the percentage change in the consumer price index (for all urban consumers) for the 12-month period ending on June 30 of the prior year. CMS will give the contractor and the public advance notice of any change in the fee amount for the coming calendar year.

2. Transition to Subsequent Year

There can be situations where the provider submits an application in the previous calendar year without a required fee, the contractor develops for the fee, and the provider submits the fee in the subsequent year. The submitted fee must be that for the subsequent year and not the preceding year.

D. Non-Refundable

Per 42 CFR § 424.514(d)(2)(v), the application fee is non-refundable unless it was submitted with one of the following:

1. A hardship exception request that is subsequently approved;

2. An application that was rejected prior to the contractor's initiation of the screening process; or

3. An application that is subsequently denied as a result of the imposition of a temporary moratorium under 42 CFR § 424.570.

(For purposes of section 10.6.14(D) only, the term "rejected" includes applications that are returned.)

In addition, the fee should be refunded if: (i) it was not required for the transaction in question (e.g., the provider submitted a fee with its application to report a change in phone number); or (ii) it was not part of an application submission.

E. Format

The provider must submit the application fee electronically through https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do, either via credit card, debit card, or electronic check.

Should the provider submit an application with a paper check or any other hard copy form of payment (e.g., money order), the contractor shall not deposit the instrument. It shall instead treat the situation as a non-submission of the fee and follow the instructions in section 10.4(C) of this chapter (depending on whether a hardship exception request was submitted). When sending the applicable letter requesting payment within 30 days, the contractor shall explain that all payments must be made via.Pay.gov, stamp the submitted paper check "VOID," and include the voided paper check with the letter.

F. Practice Locations

DMEPOS suppliers, federally qualified health centers (FQHCs), independent diagnostic testing facilities (IDTFs), and certain other provider and supplier types described in this chapter must individually enroll each site. The enrollment of each site thus requires a separate fee. For **all other providers** (except physicians, non-physician practitioners, and physician and non-physician practitioner groups, none of which are required to submit the fee), a fee must accompany any application that adds a practice location. (This includes the addition of a hospital unit – such as a psychiatric unit – in the Practice Location section of the Form CMS-855A.) If multiple locations are being added on a single application, however, only one fee is required; indeed, the fee for providers that are <u>not</u> required to separately enroll each location is based on the application submission, not the number of locations listed on a single application.

G. Other Application Fee Policies

1. PECOS Enrollment Records

a. Paper Applications - The fee is based on the Form CMS-855 application submission, not on how enrollment records are created in PECOS. For instance, suppose a hospital submits an initial Form CMS-855A. In the Identifying Information/hospital type section of the application, the hospital indicates that it has a psychiatric unit and a rehabilitation unit. Separate PECOS enrollment records must be created for each unit. However, only one application fee is required because only one Form CMS-855A application was submitted.

b. PECOS Applications – In a similar vein, the fee is based on the number of applications involved. Even if the provider submits one set of data into PECOS, it may involve several different applications, thus requiring separate fees. To illustrate, assume a provider exists in Tennessee, Arkansas, and Missouri, each of which is in a separate contractor jurisdiction. As discussed in section 10.3 of this chapter, the group may submit a consolidated application (e.g., one set of data encompassing all three enrollments), which PECOS would then split into three separate applications. Three fees must be paid, however, because three separate enrollment applications are involved.

2. Group Practices/Clinics

A physician/non-physician practitioner clinic or group practice enrolling via the Form CMS-855B is exempt from the fee even if it is tribally-owned/operated or hospital-owned. Yet if a hospital is adding a physician/non-physician practitioner clinic or group practice to its Form CMS-855A enrollment, a fee is required because the hospital is adding a practice location.

3. Change of Ownership via Form CMS-855B or Form CMS-855S

A provider or supplier need not pay an application fee if the application is reporting a change of ownership via the Form CMS-855B or Form CMS-855S. (For providers and suppliers reporting a change of ownership via the Form CMS-855A, the ownership change does not necessitate an application fee if the change does not require the provider or supplier to enroll as a new provider or supplier.)

4. Reporting a Change in Tax Identification Number

A provider need not pay an application fee if the application is reporting a change in TIN for a Part A, Part B, or DMEPOS provider or supplier.

5. Requesting a Reactivation

A provider need not pay an application fee to reactivate Medicare billing privileges unless the provider/supplier was deactivated for failing to respond to a revalidation request, in which case the resubmitted application constitutes a revalidation (not a reactivation) application, hence requiring a fee.

6. Changing the Physical Location of an Existing Practice Location

A provider need not pay an application fee when changing the physical location of an existing practice location (as opposed to reporting an additional/new practice location).

The application fee requirement is separate and distinct from the site visit requirement and risk categories discussed in this chapter. Physicians, non-physician practitioners, physician groups, and non-physician practitioner groups are exempt from the application fee even if they fall within the "high" level of categorical screening per 42 CFR § 424.518. Likewise, physical therapists enrolling as individuals or group practices need not pay an application fee even though they fall within the "moderate" level of categorical screening and are subject to a site visit.

H. Refund Requests

Unless otherwise approved by CMS, the provider must request a refund no later than 150 days from the date it submitted its application. In its request, the provider shall include documentation acceptable to process the refund request. For credit card refunds, the provider shall include its Pay.gov receipt or the Pay.gov tracking ID number.

If a refund is requested and the fee was paid via ACH Debit, the contractor shall collect from the provider a completed "Authorization and Payment Information Form for Electronic Funds Transfer" form (previously furnished to contractors) and submit it to the PEMACReports@cms.hhs.gov mailbox. In the subject line of this e-mail, the contractor shall: (1) identify the provider's legal business name, National Provider Identifier (NPI), and the Pay.gov Tracking ID; and (2) include the completed, previously-mentioned form.

I. Institutional Provider and Fee: Year-to-Year Transition

There may be isolated instances where, at the end of a calendar year, a provider pays the fee amount for that year (Year 1) but the submission date (for Internet-based PECOS applications) or the application postmark date (for paper applications) falls in the beginning of the following year (Year 2). Assuming that Year 2's fee is higher than Year 1's, the provider must pay the Year 2 fee. The contractor shall thus: (1) send an e-mail to its PEOG BFL requesting a full refund of the fee and including any pertinent documentation in support of the request; and (2) send a letter to the provider notifying it that (i) it has 30 days from the date of the letter to pay the correct fee amount (i.e., the Year 2 amount) via Pay.gov and (ii) failure to do so will result in the rejection of the provider's application (for initial enrollments and new practice locations) or revocation of the provider's Medicare billing privileges (for revalidations). The letter shall also state that because a hardship exception request was not submitted with the original application, CMS will not consider granting a hardship exception in lieu of the fee.

J. Hardship Exception

1. Background

A provider requesting a hardship exception from the application fee must include with its enrollment application a letter (and any supporting documentation) that describes the hardship and why the hardship justifies an exception. If a paper Form CMS-855 application is submitted, the hardship exception letter must accompany the application; if the application is submitted via PECOS, the hardship exception letter must accompany the application (i.e., the provider must upload the letter and supporting documentation into PECOS). Hardship exception letters shall not be considered if they were submitted separately from the application. If the contractor receives a hardship exception request separately from the application or certification statement, it shall: (1) return it to the provider; and (2) notify the provider via letter, e-mail or telephone that it will not be considered.

2. Criteria for Determination

The application fee generally should not represent a significant burden for an adequately capitalized provider. Hardship exceptions should not be granted when the provider simply asserts that the imposition of the application fee represents a financial hardship. The provider must instead make a strong argument to support its request, including furnishing comprehensive documentation (which may include, without limitation, historical cost reports, recent financial reports such as balance sheets and income statements, cash flow statements, tax returns, etc.).

Other factors that may suggest that a hardship exception is appropriate include the following:

a. Considerable bad debt expenses,

b. Significant amount of charity care/financial assistance furnished to patients,

c. Presence of substantive partnerships (whereby clinical and/or financial integration are present) with those who furnish medical care to a disproportionately low-income population,

d. Whether an institutional provider receives considerable amounts of funding through disproportionate share hospital payments, or

e. Whether the provider is enrolling in a geographic area that is a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121-5206 (Stafford Act).

Upon receipt of a hardship exception request with the application, the contractor shall send the request and all documentation accompanying the request via regular mail, fax, or e-mail to its PEOG BFL. CMS has 60 calendar days from the date of the contractor's receipt of the hardship exception request to determine whether it should be approved; during this period, the contractor shall not commence processing the provider's application. CMS will communicate its decision to the provider and the contractor via letter, after which the contractor shall carry out the applicable instructions in section 10.6.14(K) below.

If the provider fails to submit appropriate documentation to support its request, the contractor need not contact the provider to request it. The contractor can simply forward the request "as is" to its PEOG BFL. It is ultimately the provider's responsibility to furnish the necessary supporting evidence at the time it submits its hardship exception request.

K. Appeals of Hardship Determinations

A provider may appeal CMS' denial of its hardship exception request via the procedures outlined below:

1. If the provider is dissatisfied with CMS' decision to deny a hardship exception request, it may file a written reconsideration request with CMS within 60 calendar days from receipt of the notice of initial determination (e.g., CMS' denial letter). The request must be signed by the individual provider or supplier, a legal representative, or any authorized official within the entity. Failure to file a reconsideration request within this timeframe is deemed a waiver of all rights to further administrative review.

The reconsideration request should be mailed 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

Notwithstanding the filing of a reconsideration request, the contractor shall still implement the post-hardship exception request instructions in this section 10.6.14(K). A reconsideration request, in other words, does not stay the implementation of section 10.6.14(K)'s instructions.

The CMS has 60 calendar days from the date of the reconsideration request to render a decision. The reconsideration shall be: (a) conducted by a CMS staff person who was independent from the initial decision to deny the hardship exception request; and (b) based on CMS' review of the original letter and documentation submitted by the provider.

Upon receipt of the reconsideration, CMS will send a letter to the provider to acknowledge receipt of its request. In its acknowledgment letter, CMS will advise the requesting party that the reconsideration will be conducted and a determination issued within 60 days from the date of the request.

If CMS denies the reconsideration, it will notify the provider of this via letter, with a copy to the contractor. If CMS approves the reconsideration request, it will notify the provider of this

via letter, with a copy to the contractor, after which the contractor shall process the application as normal, or, to the extent applicable:

i. If the application has already been rejected, request that the provider resubmit the application without the fee, or

ii. If Medicare billing privileges have already been revoked, reinstate said billing privileges in accordance with existing instructions and request that the provider resubmit the application without the fee.

Corrective Action Plans (CAPs) may not be submitted in lieu of or in addition to a request for reconsideration of a hardship exception request denial.

2. If the provider is dissatisfied with the reconsideration determination regarding the application fee, it may request a hearing before an Administrative Law Judge (ALJ). Such an appeal must be filed, in writing, within 60 days from receipt of the reconsideration decision. ALJ requests should be sent to:

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

Failure to timely request an ALJ hearing is deemed a waiver of all rights to further administrative review.

If the ALJ reverses PEOG's reconsideration decision and approves the hardship exception request but the application has already been rejected, the contractor – once PEOG informs it of the ALJ's decision - shall notify the provider via letter, e-mail, or telephone that it may resubmit the application without the fee. If the provider's Medicare billing privileges have already been revoked, the contractor shall reinstate said billing privileges in accordance with existing instructions and request that the provider resubmit the application without the fee.

3. If the provider is dissatisfied with the ALJ's decision, it may request Board review by the Departmental Appeals Board (DAB). Such request must be filed within 60 days after the date of receipt of the ALJ's decision. Failure to timely request a review by the DAB is deemed a waiver of all rights to further administrative review.

If the DAB reverses the ALJ's decision and approves the hardship exception request but the application has already been rejected, the contractor - once PEOG informs it of the DAB's decision - shall notify the provider via letter, e-mail, or telephone that it may resubmit the application without the fee. If the provider's Medicare billing privileges have already been revoked, the contractor shall reinstate said billing privileges in accordance with existing instructions and request that the provider resubmit the application without the fee.

To the extent permitted by law, a provider dissatisfied with a DAB decision may seek judicial review by timely filing a civil action in a United States District Court. Such requests shall be filed within 60 days from receipt of the notice of the DAB's decision.

10.6.18 – Appeals Process

(Rev. 12209; Issued: 08-17-23; Effective: 09-18-23; Implementation: 09-18-23)

A. Review Procedures for Determinations that Affect Participation in the Medicare Program

1. Background

This review process of initial determinations applies to all providers and suppliers and ensures that all current and prospective providers and 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 and 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 and 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; and (3) the effective date of participation in the Medicare program.

Any corrective action plan (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 and Opt-Out Status) shall be forwarded to CMS at ProviderEnrollmentAppeals@cms.hhs.gov for review within 10 business days of the date of receipt. The Medicare Administrative Contractor (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 or 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 and suppliers may be entitled to submit a CAP and/or a reconsideration request. A CAP is a plan that allows a provider or 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 42 C.F.R. § 424.535(a)(1). While CAPs may only be submitted in response to a denial under 42 C.F.R. § 424.530(a)(1) or a revocation under 42 C.F.R. § 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 or 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 which have been revoked (as defined in Section 10.4(M)(2)(e) of this chapter);

- CAPs and reconsideration requests for Independent Diagnostic Testing Facilities;

- CAPs and reconsideration requests for Medicare Diabetes Prevention Programs (MDPP);

- CAPs and reconsideration requests for Opioid Therapy 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), and (14);

- 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), (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 42 C.F.R. § 424.535(e);

- Reconsideration requests for revocations pursuant, in whole or in part, to 42 C.F.R. § 424.535(j);

- Reconsideration requests challenging the addition of years to an existing re-enrollment bar;

- 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;

- Reconsideration requests challenging an individual or entity being included on the CMS Preclusion List as defined in § 422.2 or § 423.100; and

- Reconsideration requests regarding opt-out status.

If the provider or supplier is denied enrollment or has its Medicare billing privileges revoked, under 42 C.F.R. § 424.530(a)(1) or 42 C.F.R. § 424.535(a)(1), (5) or (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 or 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 or 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 or 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 42 C.F.R. § 424.535(a)(1). However, in the event a CAP is submitted 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), (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 or supplier that has not been previously forwarded to PEOG by the MAC. The MAC shall not take any action on a provider 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.

All documentation related to CAPs and reconsideration requests (including, but not limited to, the decisions) shall be saved in PDF format. The date on the CAP and reconsideration request decisions should 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 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 they 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 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 or supplier's application;

- All background information and investigative data the hearing officer used to make their decision. Including any on-site visit reports; the MAC's recommendation for administrative action based on the on-site visit;

- 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 or 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 or 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 or 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 or 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 or supplier who wishes to submit a reconsideration request must file its 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 considered to be the date of filing. See section D 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. The time limit may be extended if good cause for late filing 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.

If a reconsideration request is not timely filed, as required in 42 C.F.R. § 498.22, CMS will make a 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 with an explanation as to why good cause is believed to exist before making a finding of good cause or taking any other action regarding the CAP and/or reconsideration request. 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.

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. The provider is presumed to have received the initial determination on April 6. The provider submits a CAP and/or reconsideration request by mail that is received on June 10, 65 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 or supplier's responsibility to timely update its enrollment record to reflect any changes to the provider or supplier's enrollment information, including its correspondence 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 provider, supplier, the authorized or 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 he or she has the authority to represent

the provider or supplier. This statement is sufficient to constitute notice. If the representative is not an attorney, the provider or supplier must file written notice of the appointment of a representative with the contractor. This notice of appointment must be signed by the individual provider or supplier, or the authorized or delegated official. The signature need not be original and can be electronic.

Authorized or delegated officials for groups cannot sign and submit a CAP and/or 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 his/her behalf.

(**NOTE:** The provider or supplier's contact person (as listed in section 13 of the Form CMS-855) does not qualify as a "representative" for purposes of signing a reconsideration request without the requisite appointment statement and signature by the individual provider or supplier.)

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) 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 CAP and/or reconsideration request 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 (if applicable), the MAC shall dismiss the CAP and/or reconsideration request using the applicable model dismissal letter.

7. Representative for CAP and/or Reconsideration Request

Per 42 C.F.R. § 498.10, a provider or supplier may appoint as its 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 attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative. If the representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its 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 or supplier.

8. Submission of Enrollment Application while a CAP and/or Reconsideration Request is Pending/Submission Timeframe has not Expired

If a provider or supplier's enrollment application is denied, the provider or 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 provides any additional information to update their enrollment 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 the provider's or supplier's CAP and/or reconsideration request submission. The MAC shall not modify the enrollment record of a provider or supplier that currently has a pending CAP and/or reconsideration request for revocations or is

still within the submission time period for denials unless instructed by CMS to do so. Any applications received while the provider or supplier is in a revoked status should be returned to the provider or supplier and not processed pursuant to Section 10.4(H)(1).

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

CAP submission:

(a) Must contain, at a minimum, verifiable evidence that the provider or 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)(4) 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 provider or supplier, the authorized or delegated official that has been reported within your Medicare enrollment record, or a properly appointed representative;

(d) Should include all documentation and information the provider or 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 of which one is § 424.530(a)(1), the CAP may only be accepted with respect to § 424.530(a)(1), but not with respect to the other grounds. If the provider or supplier submits a CAP that does not comply with this paragraph, the MAC shall address this in the acknowledgement email or letter sent to the provider or supplier using the model acknowledgement letter (If multiple grounds are involved of which one is § 424.530(a)(1), the MAC shall:

A. Only consider the portion of the CAP pertaining to § 424.530(a)(1). The other denial bases may only be reviewed as a reconsideration.

(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.

A. 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. If the provider or 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 or supplier using the model acknowledgment letter. (If multiple grounds are involved of which one is § 424.535(a)(1), the MAC shall:

1. Only consider the portion of the CAP pertaining to § 424.535(a)(1). The other revocation bases may only be reviewed as a reconsideration.

3. Receipt Acknowledgment of CAP

If the MAC receives an acceptable CAP for a provider or supplier, the MAC shall use the model acknowledgment letter 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 its representative 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 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 or supplier an acknowledgment email or letter. Instead, the MAC shall dismiss the CAP using the applicable model dismissal letter.

4. Dismissing a CAP

A CAP shall be dismissed when the provider or supplier does not have the right to submit a CAP for the initial determination, or when the provider or supplier submitted the CAP improperly or untimely (see Section 10.6.18(B)(2)). 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 or 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 and review the reconsideration request in accordance with the instruction in Section 10.6.18(C).

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 or 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 42 C.F.R. § 424.530(a)(1) or revocation under 42 C.F.R. § 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. 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 or supplier came into compliance. Consider the following example:

Example 1: A provider or supplier is denied enrollment under 42 C.F.R. § 424.530(a)(1) or revoked under 42 C.F.R. § 424.535(a)(1) because its required license has been suspended. The provider timely submits a CAP in which it provides evidence that its licensure has been reinstated and is currently active. After confirming the status of current licensure, the MAC should render a favorable CAP decision because the provider or supplier has corrected the licensure issue that led to enrollment denial or revocation.

If the provider or supplier submitted a CAP for reasons in addition to 42 C.F.R. § 424.535(a)(1), the MAC shall include in the decision letter that the CAP was reviewed only in regards to the 42 C.F.R. § 424.535(a)(1) basis.

If the provider or 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 or 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 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 or 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 or supplier or the individual that submitted the CAP, 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 reconsideration request/envelope or the mailing address on the provider's/supplier's enrollment record if no return address is included on the reconsideration request. 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 or supplier by issuing a favorable decision letter following the applicable model CAP letter. 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

A physician's initial enrollment application is denied on March 1, 2018. The physician submits a CAP showing that, as of March 20th, the physician was in compliance with all Medicare requirements. If the MAC or CMS approves the CAP, the effective date of for the physician's Medicare billing privileges should be March 20th, as that is the day on which the physician came into compliance with all Medicare requirements. The 30-day retrospective billing provision should not be applied in this situation because the rule assumes that the provider was in compliance with Medicare requirements during the 30-day period. This was

not the case here. The physician was not in compliance with all Medicare requirements until March 20.

b. Revocations

A physician's medical license is suspended on June 1st. The physician's Medicare enrollment is revoked under 42 C.F.R. § 424.535(a)(1) on June 15th. The physician then submits a CAP showing that, as of July 1st, the physician is currently licensed. If the MAC or CMS approves the CAP, the effective date for reactivation of the physician's Medicare billing privileges should be July 1st as that is the day on which physician came into compliance with all Medicare requirements. The 30-day retrospective billing provision does not be 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 their 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, or the individual who submitted the CAP may withdraw the CAP at any time prior to the mailing of the CAP determination. The withdrawal of 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, it shall send a letter or e-mail to the provider or supplier acknowledging receipt of the request to withdraw the CAP and advising that the request has been dismissed, utilizing the applicable model letter.

8. Concurrent Submission of CAP and Reconsideration Request

If a provider or 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 any revocation of billing privileges under 42 C.F.R. § 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 42 C.F.R. § 424.530(a)(1) or 42 C.F.R. § 424.535(a)(1). If the MAC renders a favorable decision as it relates to 42 C.F.R. § 424.530(a)(1) or 42 C.F.R. § 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(B)(8)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 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 or supplier 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, do not include further appeal rights for a CAP only decision.

- The MAC shall notify the provider or supplier of the denial of the CAP via the applicable CAP model letter.

- The provider or supplier may continue with the appeals process if it has filed a reconsideration request or is preparing to submit such a request and has not exceeded the timeframe in which to do so.

- The reconsideration request, if properly submitted, shall be processed.

C. Reconsideration Requests

1. Background

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 or supplier the opportunity to correct the deficiencies that led to the initial determination.

2. Requirements for Reconsideration Request Submission

a. Must contain, at a minimum, state the issues, 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 10.6.19(A)(4) 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 that is signed by the individual provider or supplier, the authorized or delegated official that has been reported within your Medicare enrollment record, or a properly appointed representative;

d. Should include all documentation and information the provider or 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 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 address on the provider's or supplier's enrollment record. In the acknowledgment letter/email (if applicable), 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 and email (if applicable) in the reconsideration file. If the reconsideration should have been submitted to CMS, the MAC shall not send the provider or supplier an acknowledgment email or letter. 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)).

If the provider's or supplier's 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 or supplier an acknowledgment email or letter. Instead, the MAC shall dismiss the reconsideration request using the applicable model dismissal letter.

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) for receipt date determinations. However, consistent with 42 C.F.R. § 498.24(a), the provider or supplier, may submit corrected, new, or previously omitted documentation or other facts in support of its reconsideration request at any time prior to the reconsideration decision being 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. This includes:

- 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 or supplier subsequent to the initial determination.

If the appealing party 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 or supplier or the individual 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 mailing address on the provider's/supplier's enrollment record if no return address is included on the reconsideration request. The MAC should also fax the CAP decision letter if a valid fax number is available. The reconsideration letter shall follow the applicable model letter and include:

- The regulatory basis to support each reason for the initial determination;
- A summary of the documentation that the provider or supplier 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 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 or supplier 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-regulations supporting the decision, as well as any documentation reviewed;
- If applicable, an explanation of how the provider or supplier does not meet the Medicare enrollment criteria or requirements;
- 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 or supplier must include with its appeal (name/legal business name; supplier number (if applicable); tax identification number/employer identification number (TIN/EIN); NPI; and a copy of the reconsideration decision).

Example 1: If a provider or supplier submits a reconsideration request in response to a revocation pursuant to 42 C.F.R. § 424.535(a)(5), the MAC shall review the initial determination, the enrollment application preceding the site visit, the site investigation report(s), the reconsideration request and supporting documentation, as well as any other relevant information, to 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.) If the MAC finds that an error was made during the site visit, which found the provider or supplier to be non-operational, 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 or 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 42 C.F.R. § 424.535(a)(5) using the applicable model letter.

If the MAC overturns the initial determination, the MAC shall reinstate the provider's or supplier's billing privileges to an approved status as of the effective date determined in the

reconsidered determination 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 or supplier, authorized or delegated official, or its representative at the return address included on the reconsideration request. The reconsideration decision is sufficient for providing notice to the provider or 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 or 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 NSC.

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 or supplier.

If additional information/documentation is needed prior to reinstating the provider or supplier, the MAC shall document these next steps in their 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 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.

6. Withdrawal of Reconsideration Request

The provider, supplier, or the individual who submitted the reconsideration request may withdraw the reconsideration request at any time prior to the mailing of the reconsideration decision. The withdrawal of a 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, it shall send a letter or e-mail to the provider or supplier acknowledging receipt of the request to withdraw the reconsideration request and advising that the request has been dismissed, utilizing the applicable model letter.

7. Requests for Reversal under 42 C.F.R. § 424.530(c)/424.535(e)

Under 42 C.F.R. § 424.530(c)/424.535(e), a provider or supplier 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, or an authorized or delegated official; or a medical director, supervising physician, or other personnel of the provider or supplier furnishing Medicare reimbursable services. The revocation may be reversed, at the discretion of CMS, if the provider or supplier terminates and submits proof that it has terminated its business relationship with the individual against whom the adverse action is imposed within 30 days of the initial determination. 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 or supplier to reverse or rescind a denial or enrollment or revocation due to the termination of the business relationship between the provider or supplier and the individual against whom the adverse action is imposed, 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 as CMS would contact the MAC to rescind the revocation or reinstate the provider 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. 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 or supplier 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.

D. Further Appeal Rights for Reconsidered Determinations

1. Administrative Law Judge (ALJ) Hearing

The CMS or a provider or 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 Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision. A provider or supplier may file an 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, 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 his/her/its 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 he or she 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; he/she 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.

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.

E. External Monthly Reporting Requirements for CAPs and Reconsideration Requests

Using the provider enrollment appeals reporting template, the MAC shall complete all columns listed for all appeal submissions except those submissions that are referred to CMS for processing (CAPs and reconsideration requests). No column shall be left blank. 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 response in column A labelled, "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)-(15).

- **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)-(22).

- **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.

- **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 L labelled, "Final Decision Result," shall be one of the following (If a final decision has not been issued, the column shall read as "In Process." If the appeal submission is referred to CMS for processing then the appeal should not be included on the MAC Monthly Appeals Report

1. Not Actionable: Appeal is no longer actionable (moot) because the basis for the initial determination has been resolved. (Ex: Fingerprints have received a passed designation, initial determination has been reopened and revised).

2. Favorable (to provider/supplier): MAC 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.

3. Unfavorable (to provider/supplier): MAC upholds the initial determination resulting in the enrollment remaining in a revoked or denied status, or the effective date remaining the same.

4. Dismissed: The appeal does not meet the appeal submission requirements. (Ex: incorrect signature, untimely, not appealable, etc.)

5. Rescinded: MAC has received instruction from CMS to rescind the initial determination and return the enrollment record to an approved status.

6. Withdrawn: Provider/supplier has submitted written notice of its intent to withdraw its appeal (CAP or reconsideration request).

The response in Column M labelled, "Date Final Decision Issued," shall be "In Process" if a final decision has not been issued at the time the monthly report is sent to CMS.

The response in Column K labelled, "Date Receipt Acknowledgement Sent to Provider/Supplier/Legal Representative," shall be "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. The response shall be "N/A" if a receipt acknowledgement email/letter is not required for that case.
The response in Column F labelled, "MAC (Including Jurisdiction)," shall be in one of the following formats:

1. **CGS**
2. **FCSO**
3. **NGS JK**
4. **NGS J6**
5. **Palmetto JM**

6. **Palmetto JJ**

7. **NSC**

8. **WPS J8**

9. **WPS J5**

10. **Noridian JE**

11. **Noridian JF**

12. **Novitas JL**

13. **Novitas JH**

The response in Column G, "Regulatory Authority (As identified on initial determination)," shall be in the following format (the authorities will need to be modified based on the type of initial determination):

- For Effective Date appeal: 424.520;
- For Denial appeal with only one authority cited in the initial determination: 424.530(a)(1-15);
- For Denial appeal with multiple authorities cited in the initial determination: 424.530(a)(1-15)(1-15)
- For Revocation appeal with only one authority cited in the initial determination: 424.535(a)(1-22)
- For Revocation appeal with multiple authorities cited in the initial determination: 424.535(a)(1-22)(1-22).
- For Other appeal: N/A with an explanation in the Comments column N.

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.

10.7.4 – DME Approval Letter Templates

(Rev. 12209; Issued: 08-17-23; Effective: 09-18-23; Implementation: 09-18-23)

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 he or she 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 its 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 his/her 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]

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 he or she 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 its 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 his/her 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 he or she 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 its 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 his/her 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]

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 his/her/their 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 he/she/they have 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. 12209; Issued: 08-17-23; Effective: 09-18-23; Implementation: 09-18-23)

A. Approval – Change of Information (Part A/B Certified Org, No Recommendation 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.

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.

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.
- 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 he or she 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 its 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 his/her 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 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.
- 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 he or she 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 its 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 his/her 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 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. Approval Recommended - Initial (Part A/B Certified)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] assessed your initial Medicare enrollment application and forwarded it to the Centers for Medicare & Medicaid Services (CMS) [City] Regional Office for a final review.

A survey may be conducted by a State Survey Agency or deemed accrediting organization approved by CMS to ensure compliance.

We will contact you when we have a decision.

Medicare Enrollment Information

Legal Business Name (LBN)	
Doing Business As (DBA)	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Medicare Year-End Cost Report Date (Part A only)	

For questions concerning the application, contact [Insert State] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

[CC: SOG Location and State]

F. Approval Recommended – 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],

[Insert Contractor] assessed your [Change of Information or Change of Ownership] Medicare enrollment application and forwarded it to the Centers for Medicare & Medicaid Services (CMS) [City] Regional Office for a final review.

A survey may be conducted by a State Survey Agency or deemed accrediting organization approved by CMS to ensure compliance.

We will contact you when we have a decision.

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)	

Recommended Changes (applicable to COI and CHOW, remove if doesn't apply)	Existing	
	New	
	Effective Date	

For questions concerning the recommended application, contact [Insert State] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

[CC: SOG Location and State]

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] Regional Office 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.
- 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 he or she 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 its 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 his/her 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 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 his/her/their 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 he/she/they have 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.
- 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 he or she 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 its 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 his/her 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 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. 12209; Issued: 08-17-23; Effective: 09-18-23; Implementation: 09-18-23)

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 aforementioned 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).

A. Approval – Change of Information (Part A/B Certified Org; No Recommendation 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 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.

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [& Accrediting Organization (AO), if applicable]

B. Approval - State Agency Approved Change of Information (Part A/B Certified; Recommendation 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 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.

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [& AO, if applicable]

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. The corresponding executed [insert provider/supplier agreement type] is enclosed/attached. Your enrollment and [provider/supplier agreement-specific] 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 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.

- 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 he or she 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 its 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 his/her 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
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

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 and [provider/supplier agreement] is approved. Your executed [insert provider/supplier agreement name] is enclosed/attached. The effective date is the date you met all federal requirements.

Medicare Enrollment and Provider/Supplier Specific Participation Agreement 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 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.
- 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 he or she 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 its 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 his/her 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
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

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. Approval Recommended - 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]] assessed your initial Medicare enrollment application and your request for participation in the Medicare program as a [insert provider/supplier type] provider/supplier. A recommendation for approval has been forwarded to the [enter name of State Agency], which will review this application for further compliance. A survey may be conducted by a State Survey Agency or deemed accrediting organization approved by CMS.

We will contact you when we have a decision.

Medicare Enrollment Information	
Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type	

National Provider Identifier (NPI)	
Medicare Year-End Cost Report Date	Date that the provider/supplier requested (delete if not applicable)

For questions concerning the application, contact [Insert State] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

F. Approval Recommended – 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],

[Insert Contractor name [and Contractor number]] assessed your [change of information, change of ownership, revalidation, or reactivation] Medicare enrollment application. A recommendation of approval has been sent to [name of State Agency], which will conduct a review for further compliance.

A survey may be conducted by a State Survey Agency or deemed accrediting organization approved by CMS to ensure compliance.

We will contact you when we have a decision.

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 Information		
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 recommended application, contact [Insert State Agency name] 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 Information		
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.
- 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 he or she 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 its 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 his/her 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
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

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 particular revalidation 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 provider/supplier agreement and your Medicare enrollment 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	
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.
- 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 he or she 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 its 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 his/her 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.

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
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

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, your provider agreement has been terminated and your enrollment in the Medicare program has been voluntarily terminated effective on the dates shown below.

Medicare Enrollment and Provider 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	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Effective Date of Enrollment Termination and Deactivation	

Provider/Supplier 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. 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 his/her/their 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 he/she/they have 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 Information	
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.
- 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 he or she 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 its 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 his/her 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
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

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. Your [provider/supplier agreement] has also been terminated.

Medicare Enrollment and Provider 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 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 his/her/their 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 he/she/they have 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 and corresponding Provider 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 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 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.
- 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 he or she 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 its 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 his/her 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 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.
- 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 he or she 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 its 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 his/her 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.
- 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
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]

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 Seller],

[Insert Contractor name] has [Insert appropriate situation (e.g., reviewed [insert HHA's current name] change of ownership application; learned that [insert HHA'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 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 current name] provider agreement and Medicare billing privileges do not convey to the new owner. The prospective provider/owner of [insert HHA's current name] must instead:

- Enroll in the Medicare program as a new (initial) home health agency 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 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	
Primary Practice Location Address	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Effective Date of Enrollment Deactivation	

Provider/Supplier 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 his/her/their 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 he/she/they have 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 Iowa, Kansas, Missouri, Nebraska	ACC & LTC	ROkcmSCB@cms.hhs.gov
CMS Denver Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming	ACC & LTC	DenverMAC@cms.hhs.gov
CMS Dallas Arkansas, Louisiana, New Mexico, Oklahoma, Texas	ACC & LTC	RODALDSC@cms.hhs.gov
CMS San Francisco Arizona, California, Hawaii, Nevada, Pacific Territories	ACC & LTC	ROSFOSO@cms.hhs.gov
CMS Seattle Alaska, Idaho, Oregon, Washington	ACCB LTC	CMS_RO10_CEB@cms.hhs.gov Seattle_LTC@cms.hhs.gov

10.7.6 – Part B Non-Certified Provider and Supplier Approval Letter Templates

(Rev. 12209; Issued: 08-17-23; Effective: 09-18-23; Implementation: 09-18-23)

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 he or she 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 its 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 his/her 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 he or she 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 its 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 his/her 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 he or she 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 its 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 his/her 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]

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 he or she 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 its 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 his/her 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 he or she 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 its 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 his/her 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 he or she 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 its 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 his/her 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 he or she 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 its 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 his/her 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 he or she 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 its 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 his/her 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 he or she 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 its 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 his/her 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 he or she 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 its 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 his/her 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 he or she 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 its 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 his/her 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. 12209; Issued: 08-17-23; Effective: 09-18-23; Implementation: 09-18-23)

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 [Jane 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 [he/she] 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 he or she 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 its 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 his/her 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 he or she 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 its 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 his/her 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 he or she 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 its 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 his/her 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 he or she 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 its 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 his/her 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 he or she 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 its 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 his/her 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 he or she 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 its 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 his/her 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 he or she 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 its 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 his/her 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 he or she 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 its 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 his/her 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 he or she 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 its 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 his/her 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 he or she 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 its 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 his/her 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 he or she 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 its 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 his/her 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*
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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 he or she 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 its 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 his/her 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 he or she 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 its 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 his/her 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
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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:

John 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 he or she 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 its 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 his/her 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 he or she 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 its 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 his/her 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.12209; Issued: 08-17-23; Effective: 09-18-23; Implementation: 09-18-23)

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]]

Pursuant to 42 CFR §424.535(c), the supplier is barred from re-enrolling for a period of [number of years] year(s) in the Medicare program from the effective date of the revocation. In order to re-enroll, you must meet all requirements for your supplier type.

[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 Monetary penalties.

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 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 he or she 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 its 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 his/her 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 he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
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    - 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 his/her 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
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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. 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 he or she 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 its 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 his/her 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
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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 he or she 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 its 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 his/her 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]

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.

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 their 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, 2012 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 he or she 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 its 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 his/her 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]

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.

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 re-enrollment bar established.)[Pursuant to 42 C.F.R. § 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.]

In addition, if submitting a Form CMS-855S application after the re-enrollment bar has expired, 42 C.F.R. § 424.57(d)(3)(ii) states suppliers will be required to maintain an elevated surety bond amount of $50,000 for each final adverse action imposed. Therefore, if you do not request a reconsideration of this decision or receive an unfavorable decision through the administrative review process, you must submit an elevated surety bond. Please note 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 he/she/they have 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 its 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 his/her/their 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:

[Contractor name]
[Address]
[City], [ST] [Zip]

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 John 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 John Doe from Section 7 of your Form CMS-20134. On June 1, 2018, you submitted a claim with the NPI of John Doe for services rendered May 1st, after he 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 he or she 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 its 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 his/her 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--

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- 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 he or she 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 its 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 his/her 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.
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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]

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.

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]