CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 730	**Date: June 23, 2017**
	Change Request 10114

SUBJECT: Updates to the CMS-855R Processing Guide

I. SUMMARY OF CHANGES: This change request (CR) makes updates to the Centers for Medicare & Medicaid Services (CMS)-855R Processing Guide.

EFFECTIVE DATE: July 25, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 25, 2017

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
N/A	N/A

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:

One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 730	Date: June 23, 2017	Change Request: 10114

SUBJECT: Updates to the CMS-855R Processing Guide

EFFECTIVE DATE: July 25, 2017
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I. GENERAL INFORMATION

A. Background: Providers and suppliers must apply for enrollment in the Medicare program or make a change in their enrollment information using either the Internet-based Provider Enrollment Chain and Ownership System or the paper enrollment application process. The purpose of this change request (CR) is to communicate the updates to the CMS-855R processing guide, which is used to assist providers/suppliers in completing, and the Medicare Administrative Contractors in processing, the CMS-855R application. The CMS-855R processing guide is available as an addendum to the Program Integrity Manual, chapter 15 posted on cms.gov.

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 MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10114.1	Contractors shall be aware of the updates to the CMS-855R processing guide.		X							

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

Pre-Implementation Contact(s): Joseph Schultz, 410-786-2656 or Joseph.Schultz@cms.hhs.gov

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: 1

Processing the CMS-855R Medicare Enrollment Application - Reassignment of Benefits

Disclaimer: The information contained in this guide is to assist providers/suppliers in completing the CMS-855R application and MACs in processing the CMS-855R application.

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General Information

A. Purpose of the CMS-855R

The CMS-855R application is used by individual physicians and non-physician practitioners (hereafter collectively referred to as "individual practitioners") who want to reassign their right to receive Medicare payments to another eligible individual or entity (i.e., sole proprietorship/clinic/group practice/other health care organization); Medicare eligible professionals may also reassign their benefits to a critical access hospital (CAH) that bills Method II in order to participate in the Electronic Health Records (EHR) Incentive Program for Eligible Professionals (EPs). In addition, the CMS-855R is used to terminate a currently established reassignment of benefits.

Reassigning Medicare benefits allows an eligible individual or entity to submit claims on behalf of and receive payment for Medicare Part B services that the performing practitioner provides for the eligible billing individual or entity. Both the individual practitioner and the eligible individual or entity must be currently enrolled (or concurrently enrolling via submission of the (1) CMS-855I/CMS-855B for the eligible individual or entity and (2) the CMS-855I for the individual practitioner) in the Medicare program before the reassignment can take effect.

The Internet-based Provider Enrollment, Chain and Ownership System (PECOS) can be used to add or terminate a reassignment of benefits. To obtain additional information on Internet-based PECOS, refer to http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/InternetbasedPECOS.html.

In lieu of PECOS, the most current version of the CMS-855R application shall be completed. To obtain the current version of the form, refer to https://www.cms.gov/Medicare/cms-forms/cms-forms/cms-forms-list.html. If an outdated version of the application is submitted, the MAC shall develop for the correct version of the form.

B. Reassignment Packages

A separate CMS-855R must be submitted for each individual practitioner or eligible individual or entity for which a reassignment is being established or terminated. The individual practitioner may receive multiple Provider Transaction Access Numbers (PTANs) under a single Employer Identification Number (EIN), but may not reassign benefits to more than one EIN on a single CMS-855R application.

In situations where an entity wants to simultaneously enroll a group practice, the individual practitioners therein, and to reassign benefits accordingly, the MAC shall adhere to the instructions contained in the scenarios below. As early in the process as possible, the MAC shall examine the incoming forms to see if a reassignment may be involved; also, the MAC is encouraged (though not required) to have the same analyst handle all applications in the package.

1. **Only the CMS-855Rs are submitted** - If a brand new group with new practitioners is attempting to enroll but submits only the CMS-855Rs for its group members (i.e., neither

the initial CMS-855B nor the initial CMS-855Is were submitted), the MAC shall develop for the other forms.

2. **Only the CMS-855R is submitted and a CMS-855A/CMS-855B and CMS-855I is already on file** – Suppose an individual practitioner: (1) submits only the CMS-855R without including the CMS-855A/CMS-855B and CMS-855I, and (2) indicates on the CMS-855R that he/she will be reassigning all or part of his/her benefits to the sole proprietor/eligible organization or group. The MAC shall not develop for the other forms if they are already on file. The Part B MAC shall simply process the CMS-855R and reassign the individual practitioner's benefits to the sole proprietor /eligible organization or group.

3. **Only the CMS-855B is submitted** - If a brand new group wants to enroll but submits only the CMS-855B without including the CMS-855Is and CMS-855Rs for its group members (i.e., the CMS-855B arrives alone, without the other forms), the MAC shall develop for the other forms.

4. **Only the CMS-855I is submitted** – Suppose an individual practitioner: (1) submits only the CMS-855I without including the CMS-855B and CMS-855R, and (2) indicates on the CMS-855I that he/she will be reassigning all or part of his/her benefits to the group practice. The MAC shall develop for the other forms.

Suppose an individual practitioner: (1) submits only the CMS-855I, and (2) indicates on the CMS-855I that he/she will be reassigning all or part of his/her benefits to an existing Part A CAH II. The MAC shall develop for the CMS-855R. Upon receipt of the CMS-855R, the MAC shall process the application and reassign the individual practitioner's benefits to the Part A entity.

C. When Not to Use the CMS-855R

The CMS-855R shall not be used to report employment arrangements of physician assistants. Employment arrangements for physician assistants must be reported on the CMS-855I application. In addition, a CMS-855R application is not required to be submitted with a CMS-855B for an independent diagnostic testing facility (IDTF) that employs or contracts with interpreting physicians.

The CMS-855R shall not be used to revalidate reassignments. The individual practitioner should only use the CMS-855I and list his/her active reassignment information in section 4B thereof.

The CMS-855R application is required to terminate a reassignment. The termination cannot be done via the CMS-855I form (except for Internet-based PECOS applications when the termination is for the last PTAN on an enrollment).

Processing the CMS-855R Application

Note: If a data element on the individual practitioner's CMS-855R application is missing but the information is disclosed (1) elsewhere on the application or (2) in the supporting documentation

submitted with the application, the MAC need not obtain the missing data via an updated CMS-855R form page and a newly-signed certification statement; no further development – not even by telephone – is required. However, the following information must be furnished in the appropriate section(s) of the CMS-855R, even if the data is identified elsewhere on the form or in the supporting documentation:

a. Legal business names (LBN) or legal names
    - If an application is submitted with a valid National Provider Identifier (NPI) and Provider Transaction Number (PTAN) combination but the Legal Business Name (LBN) field is blank, an incomplete or inaccurate LBN is submitted, or the applicant includes a DBA name in section 4 of the Form CMS-855I or section 2 of the Form CMS-855R, and the contractor is able to confirm the correct LBN based on the NPI and PTAN combination provided, the contractor is not required to develop.
b. Tax identification numbers (TINs), EINs or Social Security Numbers (SSNs)
c. NPI-legacy number combinations in sections 2 and/or 3 of the CMS-855R

Section 1: Basic Information

The MAC shall ensure that the applicant completes this section of the CMS-855R with the submittal reason and effective date. (Note that a separate CMS-855R is required for each new reassignment or termination). The "Complete All Sections" column provides the sections of the CMS-855R that must be completed for each reason for submission.

Reason for Submitting This Application

This section identifies the reason for the application submission. If a submittal reason is not identified, the MAC shall contact the applicant/contact person via phone, or send a development letter to the individual practitioner/contact person to obtain the missing data.

- **You are enrolling or are currently enrolled in Medicare and will be reassigning your benefits**

    - The individual practitioner checks this box if he/she is establishing a new reassignment to an eligible individual or entity. The MAC shall ensure that an effective date is listed that identifies the effective date of the reassignment, and that all sections are completed as required.
    - If the individual practitioner is initially enrolling in Medicare and does not have a current CMS-855I application on file, he/she must submit a CMS-855I in addition to the CMS-855R. The MAC shall develop by mail, fax, or e-mail for the CMS-855I application if it is not currently on file.
    - If the CMS-855R is accompanied by an initial CMS-855I or submitted as a "stand-alone" form (that is, a CMS-855R is submitted as a new reassignment, such as when an enrolled physician who is operating as a sole proprietor joins a group practice and reassigns his benefits to the group), the effective date of the enrollment and the reassignment shall be consistent with the 30-day rule requirements specified in the Program Integrity Manual, chapter 15, section 15.17 (i.e., the later of the date of receipt by the MAC or the date the practitioner first began furnishing services at the new location). (**Note**: The effective date of the reassignment shall not be prior to the effective dates of the enrollments of the individual practitioner and the eligible individual or entity to which benefits are

reassigned.

- **You are an *individual* terminating a reassignment with a Sole Proprietor[1] or Clinic/Group/Organization**

    - The individual practitioner checks this box if he/she has a current reassignment of benefits arrangement with an eligible individual or entity that he/she wishes to terminate.
    - The MAC shall ensure that a termination date for the reassignment is listed in the Effective Date field and that sections 1, 2, 3, 5, and 6A of the CMS-855R application are completed as required. If the termination date is not included, the MAC shall send a development letter by mail, fax, or e-mail to the individual practitioner/contact person to obtain the missing data.

- **You are a *sole proprietor/clinic/group/organization* terminating a reassignment with an individual**

    - The eligible individual or entity checks this box if he/she/it has a current reassignment of benefits arrangement with an individual practitioner that he/she/it wishes to terminate.
    - The MAC shall ensure that a termination date for the reassignment is listed in the Effective Date field and that sections 1, 2, 3, 5, and 6B of the CMS-855R application are completed as required. If the termination date is not included, the MAC shall send a development letter by mail, fax or e-mail to the contact person to obtain the missing data.
    - Groups that are terminating physician assistant employments should use the CMS-855B. Sole proprietors and incorporated individuals who are terminating physician assistant employments should use the CMS-855I.

Section 2: Organization/Group Receiving the Reassigned Benefits

The MAC shall ensure that information is populated in each field to identify the eligible individual or entity to whom benefits are being reassigned, or with whom the reassignment is being terminated. The eligible individual or entity must be currently enrolled or enrolling concurrently in the Medicare program; otherwise, the reassignment cannot be processed.

A separate CMS-855R must be submitted for each sole proprietor/clinic/group/organization for which a reassignment is being established or terminated. The individual practitioner may receive multiple PTANs under a single EIN, but may not reassign benefits to more than one EIN on a single CMS-855R application.

If a **Sole Proprietor** is receiving the reassigned benefits, the MAC shall ensure that the:

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[1] A business is a sole proprietorship if it meets all of the following criteria:
- It files a Schedule C (1040) with the IRS (this form reports the business's profits/losses);
- One person owns all of the business's assets; and
- It is not incorporated.

- Legal name of the eligible individual is listed in the Organization/Group Legal Business Name field.
- Eligible individual's EIN (if he or she has one) is reflected in the TIN field.
- Eligible individual's PTAN (if he or she has one) is listed in the Medicare Identification Number field. If the eligible individual is submitting an initial enrollment with the CMS-855R to establish a new reassignment, a PTAN need not be listed, as one has not been assigned; the individual can enter the word "pending" in this field or leave the field blank.
- National Provider Identifier (NPI) of the eligible individual accepting the reassignment is listed in the NPI field.
- The individual practitioner and the eligible individual or entity are currently enrolled or enrolling concurrently in the Medicare program; otherwise, the reassignment cannot be processed. The MAC must check PECOS or its internal tracking systems for the CMS-855I and/or CMS-855B application(s).
- Data elements in sections 1, 2, and 3 of the CMS-855R are completed and the data furnished therein is consistent with that submitted on the CMS-855I (e.g., the practitioner's SSN matches that on his/her CMS-855I), and the data elements in section 6A/6B are completed and the appropriate signatures are present. If any of the information is missing or there is inconsistent data, the MAC shall develop for the information (e.g., sending a development letter by mail, fax or e-mail), unless exceptions have been provided through other CMS guidance.

In addition:

- The MAC shall verify the NPI against the National Plan and Provider Enumeration System (NPPES) or PECOS.
- When processing the CMS-855R application, the MAC need not perform any verification or validation activities involving the individual practitioner or the eligible individual or entity (e.g., reviewing licensure, checking the Medicare Exclusion Database (MED)). These validations are conducted during the CMS-855I and CMS-855B initial enrollment and revalidation processes, and via the monthly License Continuous Monitoring (LCM) checks and the systematic monthly MED checks in PECOS.
- If any required data elements in section 2 are not included, the MAC shall send a development letter by mail, fax or e-mail to the individual/entity/contact person to obtain the missing data. Previous processing exceptions apply.

If a C**linic/Group/Organization/Sole Owner/CAH** is receiving the reassigned benefits, the MAC shall ensure that the:

- Legal business name is reported in the Organization/Group Legal Business Name field. This name must exactly match the name on the entity's Internal Revenue Service (IRS) tax documents (CP-575), unless exceptions have been permitted through CMS guidance.
- Entity's TIN (as reported to the IRS) is listed in the TIN field.
- Entity's Medicare Identification Number (or PTAN) (if issued) is listed in the Medicare Identification Number field. The MAC may use its shared systems, PECOS, or its provider files as a resource to determine the PTAN before

contacting the entity to develop for this information. If the entity is submitting an initial enrollment concurrently with the CMS-855R to establish a new reassignment, a PTAN need not be listed, as one has not been assigned; the entity may enter the word "pending" in this field or leave the field blank.
- Entity's NPI is listed in the NPI field.

In addition:

- The MAC shall verify the legal business name against the IRS documentation, NPPES, or PECOS.
- If the entity is a CAH, the entity need not and should not complete a separate CMS-855B form to receive reassigned benefits. (**Note:** A reassignment to a CAH is only required if the Medicare eligible professional wants to participate in the EHR Incentive Program for EPs.)
- The MAC shall verify the NPI against NPPES or PECOS.
- When processing the CMS-855R application, the MAC need not perform any verification or validation activities involving the individual practitioner or the eligible individual or entity (e.g., reviewing licensure, checking the MED). These validations are conducted during the CMS-855I and CMS-855B initial enrollment and revalidation processes, and via the monthly LCM checks and the systematic monthly MED checks in PECOS.
- The MAC shall ensure that the data elements in sections 1, 2, and 3 of the CMS-855R are completed and the data furnished therein is consistent with that submitted on the CMS-855I (e.g., the practitioner's SSN matches that on his/her CMS-855I), and the data elements in section 6A/B are completed and the appropriate signatures are present. If any of the information is missing or there is inconsistent data, the MAC shall develop for the information (e.g., sending a development letter by mail, fax, or e-mail), unless exceptions have been provided through other CMS guidance.
- If any required data elements in section 2 are not included, the MAC shall send a development letter by mail, fax or e-mail to the eligible individual or entity/ contact person to obtain the missing data.

Section 3: Individual Practitioner Who Is Reassigning Benefits

The information supplied in this section is for the individual practitioner who will be reassigning his/her benefits or who will be terminating a reassignment. The MAC shall ensure that the:

- Individual practitioner's legal name (as reported to the Social Security Administration (SSA)) is listed in the First Name, Middle Initial, and Last Name fields. Any suffixes that may be reported to the IRS should also be included.
- SSN (as reported to the SSA) of the individual practitioner is reflected in the Social Security Number field.
- Medicare Identification Number (or PTAN) (if issued) of the individual practitioner is listed in the Medicare Identification Number field. If the individual practitioner is submitting an initial enrollment application concurrently with the

CMS-855R to establish a new reassignment, a PTAN need not be listed, as one has not been assigned; the individual practitioner can enter the word "pending" in this field or leave the field blank. If the reassignment is being terminated, the PTAN should be listed on the CMS-855R. The MAC may use the shared systems, PECOS, or its provider files as a resource for determining the PTAN before developing for this data.

- NPI of the individual practitioner reassigning his/her benefits is reflected in the National Provider Identifier field; it should match the information provided to NPPES.
- If the individual practitioner is enrolled currently as an ordering and certifying provider, the CMS-855O enrollment must be deactivated and the MAC shall develop for the CMS-855I if one is not submitted.
- When processing the CMS-855R application, the MAC need not perform any verification or validation activities involving the individual practitioner or the eligible individual or entity (e.g., reviewing licensure, checking the MED). These validations are conducted during the CMS-855I and CMS-855B initial enrollments and revalidation processes, and via the monthly LCM checks and the systematic monthly MED checks in PECOS.
- If any required data elements in section 3 are not included, the MAC shall send a development letter to the provider/contact person by mail, fax or e-mail to obtain the missing data, unless exceptions have been provided through other CMS guidance.

Section 4: Primary Practice Location

The individual practitioner may identify the primary physical practice location of the eligible individual or entity where the individual practitioner will render services most of the time; however, this section is optional and not required to be completed by the practitioner. If data is not populated in this section, the MAC shall take no further action. If data is populated in this section, the MAC shall choose the practice location entered on the CMS-855R from the selection of active practice locations provided in the drop-down selection in the reassignment grid in PECOS.

The practice location address must be the physical address where the practitioner sees patients. If the address listed is not a physical address linked to the group (i.e., section 4A of the CMS-855B), the MAC shall proceed with processing. Development is not required.

Section 5: Contact Person

This section captures information regarding the person who should be contacted regarding this application. Multiple contact persons may be listed, and the individual practitioner/contact person may copy this page and include it in the enrollment package sent to the MAC. The MAC shall ensure that the contact person provided the required data elements, such as his/her first name, middle initial, and last name with any suffixes, as well as the address, city/town, state, zip code and telephone. The contact person's fax number, e-mail address, and his/her relationship or affiliation with the eligible individual or entity is optional and not required to be submitted.

Communications regarding the processing of the CMS-855R shall be sent to the contact person listed. If multiple contact persons are listed, the MAC shall contact the first contact person listed

on the application. If he/she is not available, the MAC shall contact the other person(s) listed, unless the individual practitioner indicates otherwise via any means.

If no contact person is listed in this section, the MAC shall contact the individual practitioner listed in section 3 or the authorized or delegated official or another contact person on file. The MAC need not develop for the information in this section. If a contact person is listed, any other required data for the contact person (e.g., address) can be captured via telephone. This instruction applies only to section 5.

Section 6: Certification Statements and Signatures

The signatures in this section authorize the reassignment of benefits to an eligible individual or entity or the termination of a reassignment of benefits. Signature dates cannot be more than 120 days prior to the receipt date.

Providers and suppliers are able to submit their reassignment certifications either by signing section 6A and 6B of the paper CMS-855R application or, if completing the reassignment via Internet-based PECOS, by submitting signatures electronically or via downloaded paper certification statements (downloaded from www.cms.gov). If the provider or supplier downloads the paper certification statement from the CMS website, it shall write the web tracking ID on the top of the certification statement. Providers and suppliers should not submit signatures both electronically and by paper.

For Internet-based PECOS CMS-855R submissions, the MAC shall not begin processing new reassignment applications prior to its receipt of the certification statement. If the MAC does not receive the certification statement in its mailroom (or via email/fax or through e-signature) within 20 calendar days of the date in which the provider submitted its Internet-based PECOS application, the contractor shall reject the L&T. The MAC is not required to develop.

For paper CMS-855R submissions, if the provider submits an invalid certification statement or fails to submit a certification statement, the MAC shall still proceed with processing the application. An appropriate certification statement shall be solicited as part of the development process – preferably via email or fax. This includes certification statements that are: (a) unsigned; (b) undated; (c) contains a copied or stamped signature; (d) was signed (as reflected by the date of signature) more than 120 days prior to the date on which the MAC received the application; (e) for paper Form CMS-855I and Form CMS-855O submissions, someone other than the physician or non-physician practitioner signed the form, except as noted in section 15.5.14.1; or (f) missing certification statements. The MAC shall send one development request to include a list of all of the missing required data/documentation, including the certification statement. The MAC may reject the provider's application if the provider fails to furnish the missing information on the enrollment application - including all necessary documentation - within 30 calendar days from the date the contractor requested the missing information or documentation.

The MAC is not required to compare signatures of individual practitioners and authorized/delegated officials to that of a signature already on file. In addition, the MAC shall not request the individual's driver's license or current passport to verify signature.

Applications submitted to terminate a reassignment or to update the primary practice location

only require one signature from either the individual practitioner or the authorized/delegated official.

Section 6A – Individual Practitioner

The MAC shall ensure that the:

- Individual practitioner provided his/her first name, middle initial, and last name with any suffixes.
- Individual practitioner signed and dated the form in the Signature and Date Signed fields.

- If any required data elements in section 6A are missing, the MAC shall send a development letter by mail, fax, or e-mail to the individual practitioner/contact person to obtain the missing data. (**Note:** Middle initials and suffixes are not required fields and do not require development if missing.)
- When establishing a reassignment of benefits, the certification statement must be signed and dated by the individual practitioner **and** the authorized or delegated official. If the authorized or delegated official is not on file, the MAC shall send a development letter by mail, fax, or e-mail to the provider/contact person to (1) have an authorized or delegated official on file sign the application or (2) add the authorized or delegated official to the organization's enrollment via the CMS-855B application.
- When terminating a current reassignment, the certification statement must be signed and dated by **either** the individual practitioner or the authorized or delegated official. Both signatures are not required.

Section 6B – Delegated or Authorized Official of Group Practice/Clinic

The MAC shall ensure that the:

- Eligible individual accepting the assigned benefits or the authorized or delegated official of the clinic/group/organization must sign in this section. The signee must provide his/her first name, middle initial, and last name with any suffixes. The individual/authorized/delegated official must sign and date in the Signature and Date Signed fields. It is preferred that the signatures be provided in blue ink to identify a true original signature; however, it is not required.
- The certification statement is signed and dated by the individual practitioner **and** the authorized or delegated official when establishing a reassignment of benefits. If the authorized or delegated official is not on file, the MAC shall send a development letter by mail, fax, or e-mail to the provider/contact person to either have an authorized or delegated official on file sign the application or to add the authorized or delegated official to the organization's enrollment via the CMS-855B application.

When terminating a current reassignment, the certification statement must be signed and dated by **either** the individual practitioner or the authorized/delegated official. Both signatures are not required.

If any required data elements in section 6B are missing, the MAC shall send a development letter by mail, fax, or e-mail to the individual practitioner/contact person to obtain the missing data. (**Note:** Middle initials and suffixes are not required fields and do not require development if missing.)