



2013

Disclosure Desk Reference Guide

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1 - Disclosure of Information

The main purpose of this document is to provide information to protect the privacy of Medicare beneficiaries by ensuring that contractors disclose Medicare beneficiaries' personally-identifiable information (PII) and protected health information (PHI) to providers only when appropriate. Contractors shall protect an individual's privacy to the extent possible by using authenticating elements that must be given by the inquirer prior to the release of any beneficiary-specific information. Contractors shall authenticate providers in addition to authenticating four beneficiary data elements before disclosure of beneficiary information.

Contractors should always remember that access and disclosure involve looking at Medicare data, such as claims or eligibility data, and releasing information. Access and disclosure rules do not apply in situations where contractors do not have to look at beneficiary specific information (for example, explaining a Remittance Advice). Contractors shall discuss general (non-beneficiary-specific) information without obtaining authentication of the caller/writer. Contractors shall continue to respond to policy/non-PII and non-PHI related questions without having to authenticate the inquirer.

Contractors are reminded that the authentication and disclosure guidelines contained in this section do not supersede any requirements for the operation of the contractor's Provider Customer Service Program, including requirements for handling telephone and written inquiries.

Contractors are not required to respond to inquiries if the contractor does not have access to the information necessary to answer the inquiry. If possible, the contractor should refer the inquirer to the entity (e.g., another Medicare contractor) that may be able to address the inquiry. If the contractor needs to refer the inquiry to another entity for response, the contractor shall inform the caller or writer of the referral and close out the inquiry.

Where the Disclosure Desk Reference is silent, contractors should use discretion to determine release of the information. Contractors shall keep in mind the following key question: Does this provider need this information in order to properly bill Medicare? If, after internal discussion by supervisors and/or the contractor's privacy official, questions remain, contractors shall send an email requesting clarification to ProviderServices@cms.hhs.gov.

Note about Medicare Advantage Plans, Medicare Advantage Prescription Drug Plans and Medicare Prescription Drug Plans: These Plans have access to eligibility information to enroll Medicare beneficiaries in Part C or Part D. Once enrolled, Plans have access to Medicare information about their enrollees. Provider contact centers should not be receiving inquiries from these Plans. Contractors receiving inquiries from these Plans shall tell the Plans that they do not handle these inquiries and to instruct the Plans to check their guidance from CMS about how to access beneficiary information.

1.1 - Provider Authentication Elements

The requirements to authenticate providers who use the IVR system or call a CSR are the National Provider Identifier (NPI), Provider Transaction Access Number (PTAN), and the last 5-digits of the taxpayer identification number (TIN).

1.2 - National Provider Identifier (NPI)

The NPI is the first authentication data element the contractor will use to identify the provider. The contractor shall validate there is an association between the NPI and the caller/writer. The NPI may be included in the provider enrollment letters. In scenarios where the crosswalk cannot validate this information, refer to subsection 2.1.C.

1.3 - Provider Transaction Access Number (PTAN)

The PTAN is the second authentication data element the contractor will use to identify the provider. The contractor shall validate there is an association between the PTAN and the caller/writer. In scenarios where the crosswalk can not validate this information, refer to subsection 2.1.C for clarification. The CSR shall accept any valid PTAN provided by the inquirer where there is a one-to-many relationship. The PTAN is included in the provider enrollment letters.

1.4 - Taxpayer Identification Number (TIN)

The last 5-digits of the TIN are the third authentication data element the contractor will use to identify the provider. The contractor shall ensure there is an association between the NPI, PTAN, and the last 5-digits of the TIN to the provider prior to releasing any beneficiary or claim specific information, as well as financial data.

2 - Inquiry Types

Telephone and written inquiries are addressed in the following subsections.

2.1 - Telephone Inquiries

The Disclosure Desk Reference chart contains the information contractors shall use to authenticate the identity of a caller. Once the identity has been authenticated, the information

can then be released by CSRs or inquiries answered via Interactive Voice Response (IVR). Contractors are reminded that the guidance contained in this section does not supersede requirements in IOM Pub. 100-9 Chapter 6 section 30.2 and Section 50.1 concerning operation of the Provider Contact Center and handling of telephone inquiries.

- A. CSR Telephone Inquiries** - CSRs shall authenticate providers with three data elements - NPI, PTAN, and last 5-digits of the TIN. Contractors shall have the discretion to use the provider name as an additional authentication element in order to ascertain the specific claim and/or beneficiary information being requested.

- B. IVR Telephone Inquiries** – Contractors’ IVRs shall authenticate providers with three data elements - NPI, PTAN, and last 5-digits of the TIN.

- C. Authentication of Providers with No NPI** – All enrolled Medicare FFS providers are required to have NPIs, as are those applying for enrollment. There are situations in which a Medicare provider’s NPI may have been deactivated by the NPI Enumerator. (The NPI Enumerator is the entity that processes NPI applications and processes requests from providers for NPI deactivations.) Reasons for requesting NPI deactivation include retirement, dissolution of a health care provider (merged with another, went out of business), and death (deactivations because of death are done only after the NPI Enumerator verifies the death as reported by the Social Security Administration. NPIs that have been deactivated by the NPI Enumerator are then deactivated by Medicare in the Medicare systems. There may be situations where an inquiry is made regarding a claim submitted by a provider who has since deceased. If a provider enters an NPI or NPI/PTAN pair that has been deactivated in the Medicare system, the IVR may be unable to authenticate the provider at the front end. Additionally, the provider may be able to be authenticated by the IVR, but if the claim was processed using a different NPI/PTAN pair that has since been deactivated in the Medicare system, the IVR may not be able to find the claim and return claims status information. In such instances, since CSRs also authenticate using the NPI, CSRs shall authenticate on at least two additional data elements available in the provider’s Medicare record, such as provider name, remittance address, and provider master address before releasing information to the provider.

- D. Beneficiary Authentication** - Contractors shall authenticate four beneficiary data elements before disclosure of beneficiary information no matter the type of telephone inquiry (CSR or IVR). The data elements are (1) last name, (2) first name or initial, (3) Health Insurance Claim Number (HICN) and (4) either date of birth (eligibility, next eligible date, Certificate of Medical Necessity (CMN)/Durable Medical Equipment Medicare Administrative Contractor Information Form (DIF) (pre-claim) or date of service (claim status, CMN/DIF (post-claim.)) Specific guidance related to these data

elements, along with any exceptions, is contained in the disclosure chart in section 4 of this Guide.

If the CSR or IVR determines that the authentication elements provided are insufficient or inaccurate, the inquirer will be required to provide accurate information before the information being sought is released. The CSR and, if feasible, the IVR, should relay to the inquirer which element does not match (i.e., date of birth rather than day or month or year) and instruct the caller to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.

As mentioned above, for situations not specifically addressed here, the CSR shall use his/her discretion, taking care to protect the beneficiary's privacy and confidentiality. CSRs shall refer situations in which he/she is unsure of whether or not to release information to his/her supervisor or to the contractor's privacy official. Contractors shall forward further questions to CMS at the provider services mailbox noted in section 1 of this Guide.

In situations where a caller is transferred from the IVR to a CSR, if the provider data elements were authenticated in the IVR and that information is passed to the CSR, the CSR should not re-authenticate the provider before information is released. If a contractor's desktop system displays caller authentication elements when the CSR picks up the call, then only the beneficiary elements need to be authenticated. The main point is that the CSR shall have all information relating to authentication and need only request from the caller those data elements not being populated on the CSR's screen by the desktop system.

2.3 - Contractor Discretion Concerning IVR Information

Contractors shall have discretion about whether to offer some types of information through their IVR. If contractors decide to offer this information, the Disclosure Desk Reference in this Guide offers guidelines on how to authenticate providers prior to releasing information. Contractors shall review the charts in section 4 for more information.

Contractors shall use, among other data, analysis and provider feedback to determine what to offer via the IVR. Additionally, contractors shall determine the information relevant to their providers that can be automated and that which, if automated, would direct the most calls to the IVR and away from the CSRs. However, contractors shall note that the information contained in the disclosure chart does not supersede any requirements for IVR operation elsewhere in this chapter (IOM Pub. 100-9 Chapter 6 section 50.1)

2.4 - Written Inquiries

Authentication elements for providers are determined by how the inquiry is received, as CMS allows exceptions for inquiries received on provider letterhead. Contractors shall use the guidelines in the chart to authenticate providers for written inquiries as well as the information below. Contractors are reminded that the guidance contained in this section does not supersede requirements in IOM Pub.100-9 Chapter 6 section 30.3.

- A. Written Inquiry - Provider Authentication** - Contractors shall authenticate providers on written inquiries with three data elements: NPI, PTAN, and last 5-digits of the TIN.

Contractors shall authenticate providers for all written inquiries using the elements mentioned above, with the exceptions noted in subsection B below.

- B. Exception: Method of Receipt – Hardcopy on Letterhead or Email with Attachment on Letterhead** - For written inquiries received on the provider’s official letterhead, including emails with an attachment on letterhead, authentication of the provider will be met if the provider’s name and address are included in the letterhead and clearly establish the identity of the provider. Therefore, the provider’s practice location and name on the letterhead must match the information in the contractor’s file for this provider.

In addition, the letter or email shall match one of the following elements mentioned above: NPI, PTAN, or last 5-digits of the TIN. Providers shall also be educated to send in written inquiries on letterhead that includes at least one of the following: NPI, PTAN, or last 5-digits of the TIN. If all authentication elements are met, contractors shall respond with the information requested in writing via regular mail. (Contractors shall see the information about responding to inquiries received via email and fax in subsection E, below.)

If there are multiple addresses on the letterhead and at least one of those addresses matches the information in the contractor’s file, authentication is considered met.

Providers shall be educated to use letterhead for written inquiries that contains all practice location addresses or to use letterhead that has the address that Medicare has on record for that provider.

Contractors shall treat requests submitted via fax on provider letterhead as written inquiries and subject to the same authentication requirements as those received in regular mail. Contractors shall not fax responses containing PII or PHI, but shall instead send the information via regular mail.

- C. Method of Receipt – Hardcopy/No Letterhead, Email/No Attachment on Letterhead or Pre-formatted Inquiry Forms** – For inquiries received without letterhead, including hardcopy, fax, email, pre-formatted inquiry forms or inquiries written on Remittance

Advices (RAs) or Medicare Summary Notices (MSNs), contractors shall authenticate providers as detailed in subsection A. above.

- D. Special Note about Inquiries Received Via Email and Fax** - For requests received via email and fax, assuming all authentication elements are present as detailed in subsections A. or B. above, whichever is applicable, contractors shall respond as directed in section 30.3.4 of IOM Pub. 100-09 in writing via regular mail with the requested information if there is PII or PHI in the response. In the written response on contractor letterhead, contractors shall inform the provider that beneficiary-specific information cannot be disclosed electronically via email or fax and that, in the future, the provider must send a written inquiry through regular mail or use the IVR for requesting beneficiary-specific information. Additionally, contractors shall have discretion to respond to these requests by telephone as specified in IOM Pub. 100-9 Chapter 6 section 30.3.3.

For email requests only, contractors shall not notify the provider by email that they will be responding via paper or telephone. However, contractors have discretion to send an automated email reply to an email request as long as no PII or PHI is in the automated reply. Contractors shall ensure that the automated reply conveys the message that no beneficiary-specific information may be disclosed via email and that, in the future, the provider must send a written inquiry through regular mail or use the IVR for beneficiary-specific information.

Contractors are reminded that they may respond via email to email requests not involving PII or PHI (e.g., policy questions.)

- E. Beneficiary Authentication** - Assuming provider authentication requirements are met as detailed in subsections A. or B. above, whichever is applicable; contractors shall always authenticate beneficiary data elements before disclosure of information without regard to the date of the written inquiry or method of receipt. See the chart in Section 4.4 of this Guide for more information about authentication of beneficiary elements.
- F. Requests Received Without Authentication Elements** - For any written requests received without one or more authentication elements, without regard to date of inquiry or method of receipt, contractors shall return the request in its entirety to the provider stating that the requested information will be supplied upon submission of all authentication elements. Contractors shall indicate which overall elements are missing or do not match for authentication (e.g., date of birth rather than day of birth or month of birth or year of birth.) Contractors shall return the inquiry to the provider via regular mail, although if sent via email without any protected health information, the inquiry may be returned via email.

Contractors have discretion to follow up with a telephone call to obtain the rest of the authentication elements instead of returning the inquiry or to close out the written

inquiry with a telephone call (see IOM Pub. 100-9 Chapter 6 section 30.3.3.) Contractors shall not leave a message containing PII or PHI on an answering machine. Contractors shall remind the provider to check its copy of the beneficiary's Medicare card and/or follow up with the beneficiary for the correct information.

For situations not specifically addressed here, the contractor shall use discretion, taking care to protect the beneficiary's privacy and confidentiality. Contractors shall refer situations in which they are unsure of whether or not to release information to a supervisor or to the contractor's privacy official. Contractors shall forward further questions to CMS at CMS ProviderServices@cms.hhs.gov.

3 - Overlapping Claims

Contractors sometimes receive multiple claims with the same or similar dates of service or billing periods. Overlap occurs when a date of service or billing period conflicts with another, indicating that one or the other may be incorrect.

In cases where a contractor receives an inquiry from a provider or another Medicare contractor requesting provider information to resolve an overlapping claim, contractors shall work with each other. Resolution can occur through various ways. One way is for one contractor to call the other contractor with or without the provider on the line. This will allow the contractor calling to assure the other contractor that the provider has given all necessary authentication elements. The contractor shall then release the needed information.

Only the contractor who is initially contacted by the provider shall authenticate the provider. Contractors shall authenticate the provider by verifying the provider's NPI, PTAN and last 5 digits of the TIN, as well as the beneficiary name, HICN, and the date of service for post-claim information or date of birth for pre-claim information. Authentication does not need to be repeated when contacting the second contractor.

Contractors shall authenticate other contractors by one of three ways.

- A. Both parties on the call look at the MBR record (or other beneficiary record to which they both have access.) The CSR can name a field on the MBR and ask that the other contractor identify what is in that particular field.
- B. The CSR may ask for the employee's phone number and call him/her back, making sure that the area code and exchange matches a listed phone number for that contractor. Caller ID or a similar service may be used to verify the area code and exchange in lieu of a callback.
- C. The CSR may take the name and telephone number of the contractor CSR, the name and telephone number of his/her supervisor, the date, and reason for the inquiry and post this information in the "Notes" screen or similar screen.

Contractors shall have discretion to develop other avenues to resolve overlapping claims with one another. Contractors are encouraged to share ideas with one another. However, if a contractor resolves an overlapping claim in a way other than directly calling the other contractor, the CSR shall make it clear to the inquiring provider that the information is not disseminated by CMS and CMS is not responsible for the accuracy of the information. All contractors shall work together to facilitate correct payment of all parties. In general, the servicing contractor of the inquirer shall take the lead in resolving an overlapping situation.

Contractors shall release overlapping claim information whenever a provider is inquiring about a claim that was rejected for overlapping information, or if the provider found overlapping information when checking eligibility for a new admittance. In situations where the provider is seeking to avoid a claim being rejected, the contractor should, at its discretion, release information prior to claim submission. An example of this is a situation where some end stage renal disease (ESRD) facilities prefer to obtain the inpatient hospital benefit days for the month, prior to the ESRD monthly bill being generated. This allows the ESRD facility to code the claim appropriately and bill around the inpatient hospital stay/stays. This situation falls into the category of disclosing information needed to bill Medicare properly and the release of such information is appropriate as long as all authentication elements are met. Other situations may arise that fall into this category as well, for example, skilled nursing facility and inpatient hospital stays. Contractors shall, in these situations, ensure that the request is legitimate and necessary for proper billing.

For specific information regarding the resolution of a claim rejected by CWF, refer to IOM Pub. 100-4, Chapter 27, section 50.

3.1 - Pending Claims

Contractors shall disclose information about pending claims to providers, preferably via the IVR, if feasible. A pending claim is one that is being processed or has been processed and is on the payment floor. As long as all authentication requirements are met, the IVR or the CSR shall provide information about pending claims, including receipt (yes/no) and the fact that the claim is still pending. Contractors shall have discretion to provide more information about pending claims, including Internal Control Number (ICN), pay date/amount or denial. If contractors choose to provide this additional information, the IVR or the CSR shall state that until payment is made or the RA issued, any information given on the call or in the written response may change. If a contractor chooses to provide this information via the IVR, providers should be educated to request this information via the IVR rather than calling the CSR.

3.2 - Requests for Information Available on the IVR

If a request for claim status or eligibility is received by a CSR or written inquiry correspondent and the requested information can be found on the IVR, the inquirer shall be directed to the IVR. If at any time during a telephone inquiry the inquirer requests information that can be

found on the IVR, the CSR shall refer the inquirer back to the IVR. CSRs should not transfer callers back into the CSR queue.

3.3 - Requests for Information Available on the Remittance Advice

If a CSR or written inquiry correspondent receives an inquiry about information that can be found on a remittance advice (RA), the CSR/correspondent should take the opportunity to educate the inquirer on how to read the RA, in an effort to encourage the use of self-service. The CSR/correspondent should advise the inquirer that the RA is needed in order to answer any questions for which answers are available on the RA. Providers should also be advised that any billing staff or representatives who make inquiries on their behalf will need a copy of the RA.

The contractor should take this opportunity to suggest the use of the Medicare Remit Easy Print (MREP) software. Information about MREP is available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/AccessToDataApplication/MedicareRemitEasyPrint.html>

Also available is a web site that serves as a resource allowing providers to check the definitions of the Claim Adjustment Reason Codes and Remittance Advice Remark Codes. Contractors should refer providers to <http://www.wpc-edi.com/products/codelists/alertservice>.

3.4 - Deceased Beneficiaries

Although the Privacy Act of 1974 does not apply to deceased individuals, the HIPAA Privacy Rule concerning protected health information applies to individuals, both living and deceased. Therefore, contractors shall comply with authentication requirements when responding to requests for information related to deceased beneficiaries.

4 - Disclosure Desk Reference for Provider Contact Centers

NOTE – Contractors shall apply the guidance in sections 4.1, 4.2, 4.3 and 4.4 of this Guide to providers/suppliers, billing services and clearinghouses unless otherwise specified. The use of provider/supplier in these charts refers to all institutional and non-institutional entities and individuals who bill the Medicare program.

4.1 - Authentication of Provider Elements for CSR Inquiries

INQUIRY TYPE:	THE FOLLOWING PROVIDER ELEMENTS SHALL BE AUTHENTICATED (all elements must match unless otherwise specified):	THEN THE FOLLOWING ELEMENTS SHOULD BE RELEASED AFTER BENEFICIARY ELEMENTS HAVE BEEN AUTHENTICATED:
CSR	<ul style="list-style-type: none"> • Provider NPI • Provider PTAN • -AND- • Provider’s last 5-digits of TIN 	Contractors shall refer to chart below.

4.2 - Authentication of Provider Elements for IVR Inquiries

INQUIRY TYPE:	THE FOLLOWING PROVIDER ELEMENTS SHALL BE AUTHENTICATED (all elements must match unless otherwise specified):	THEN THE FOLLOWING ELEMENTS SHOULD BE RELEASED AFTER BENEFICIARY ELEMENTS HAVE BEEN AUTHENTICATED:
IVR	<ul style="list-style-type: none"> • Provider NPI • Provider PTAN • -AND- • Provider’s last 5-digits of TIN 	Contractors shall refer to chart below.

4.3 - Authentication of Provider Elements for Written Inquiries

INQUIRY TYPE:	THE FOLLOWING PROVIDER ELEMENTS SHALL BE AUTHENTICATED (all elements must match unless otherwise specified):	THEN THE FOLLOWING ELEMENTS SHOULD BE RELEASED AFTER BENEFICIARY ELEMENTS HAVE BEEN AUTHENTICATED:
Written inquiries, including fax and email	<ul style="list-style-type: none"> • Provider NPI • Provider PTAN • AND- • Provider’s last 5-digits <p>of TIN NOTE: If the inquiry is sent on provider letterhead with the provider’s name, address and at least one of the following elements – NPI, PTAN, or last five digits of the provider’s TIN, authentication is considered met.</p> <p>See subsection 2.4.C of the Guide for information about requests on preformatted inquiry forms.</p>	Contractors shall refer to chart below.

4.4 - Authentication of Beneficiary Elements

IF THE PROVIDER CONTACT INQUIRES ABOUT:	AND INQUIRES VIA:	AFTER THE PROVIDER ELEMENTS HAVE BEEN AUTHENTICATED, THE FOLLOWING BENEFICIARY ELEMENTS SHALL BE AUTHENTICATED (all elements must match unless otherwise specified):	THEN THE FOLLOWING ELEMENTS SHOULD BE RELEASED:
1. Routine Eligibility Elements ²	Call to CSR or written inquiry	<ul style="list-style-type: none"> • Beneficiary full last name (including hyphenated names, suffixes (e.g., Jr., Sr.) and abbreviation of titles (e.g., Fr. for Father, Sr. for Sister) <p>NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the CSR shall be certain that the beneficiary surname given by the provider is a match to the name on the beneficiary record being displayed.</p> <ul style="list-style-type: none"> • Beneficiary first name or first initial • Current or previously assigned HICN, including both alpha and numerical 	<p>Contractors have the discretion to routinely release all elements or only release when requested. Contractors shall use inquiry and rejected/denied claims analysis results to decide what elements to routinely release.</p> <ul style="list-style-type: none"> • Part A current and previous entitlement and termination dates • Part B current and previous entitlement and termination dates • Deductible Met – Yes / No • Managed Care – Yes / No • MSP – Yes / No • Crossover established – Yes / No • Home Health – Yes / No

Note about Medicare Advantage Plans, Medicare Advantage Prescription Drug Plans and Medicare Prescription Drug Plans: These Plans have access to eligibility information to enroll Medicare beneficiaries in Part C and Part D. Once enrolled, Plans have access to Medicare information about their enrollees. Provider contact centers should not be receiving inquiries from these Plans. Contractors receiving inquiries from these Plans shall tell the Plans that they do not handle these inquiries and to check their guidance from CMS about how access beneficiary information.

		<p>characters (if a new HICN displays when the provider supplies the HICN, then the CSR may disclose the new number)</p> <ul style="list-style-type: none"> • Date of birth <p>NOTE: If there is an error, the CSR should tell the inquirer which overall element (for example, date of birth instead of day of birth, month of birth, or year of birth) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.</p> <p>NOTE: Contractors shall release this information with a caveat that this information may not be correct and that the beneficiary is the best source for insurance information. For inquiries about the accuracy of the MSP information on the beneficiary's auxiliary record, CSRs shall refer the caller to the Coordination of Benefits Contractor at 1-800-999-1118. The COBC is responsible for the accuracy of the MSP information in Medicare's file.</p> <p>NOTE: For inquiries concerning why the supplemental payer insurer did or did not include the beneficiary on its eligibility files so that claims can be crossed over, the CSRs shall direct the provider to the beneficiary's supplemental insurer.</p>	<ul style="list-style-type: none"> • Hospice – Yes / No • SNF – Yes / No • Pneumococcal Vaccine – Yes / No <p>-----</p> <p>When prompted by the inquirer:</p> <ul style="list-style-type: none"> • Deductible amount remaining (Part A) or applied (Part B) • Managed Care – plan #, name, address, type, enrollment and termination dates • MSP – insurer name, policy #, effective and termination dates, type of primary insurance, and insurer address • Claims Crossover Status – insurer or supplemental payer names(s), Coordination of Benefits Agreement (COBA) ID(s), effective and termination dates, deletion dates.
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			<ul style="list-style-type: none"> • Home Health – applicable earliest and latest dates • Hospice - applicable earliest and latest dates • SNF – applicable earliest and latest dates • Pneumococcal Vaccine – administration date • Influenza Vaccine – administration date • Hepatitis B Vaccine – administration date • Blood Deductible • Date of Death
2. Routine Eligibility Elements ³	IVR (involves touchtone or speech recognition technology)	<ul style="list-style-type: none"> • Beneficiary last name – first 6 letters (no special characters); if using speech recognition technology, may use first 6 letters or entire last name, including hyphenated last names, suffixes (e.g., Jr., Sr.) and abbreviation of titles (e.g., Fr. for Father, Sr. for Sister) <p>NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the contractor shall program the IVR to ensure that the beneficiary surname given by the provider is a good match to the name on the beneficiary record being accessed. For</p>	<p>Contractors shall frequently analyze IVR usage and inquiry and rejected/denied claims analysis results to determine which elements should be routinely offered. Elements in other categories below may be offered routinely, if providers are frequently requesting this information and to include it here would improve provider service and satisfaction and decrease CSR-handled calls.</p> <ul style="list-style-type: none"> • Part A current and previous entitlement and termination dates • Part B current and previous entitlement and termination dates • Deductible Met – Yes / No • Managed Care – Yes / No • MSP – Yes / No

³ **Note about Medicare Advantage Plans, Medicare Advantage Prescription Drug Plans and Medicare Prescription Drug Plans:**

These Plans have access to eligibility information to enroll Medicare beneficiaries in Part C or Part D. Once enrolled, Plans have access to Medicare information about their enrollees. Provider contact centers should not be receiving inquiries from these Plans. Contractors receiving inquiries from these Plans shall tell the Plans that they do not handle these inquiries and to check their guidance from CMS about how to access beneficiary information.

		<p>surnames of less than 6 letters, contractors should program their IVRs to match names of less than 6 letters or should include instructions for callers in the IVR operating guide on how to input spaces or blanks so that 6 digits are input.</p> <ul style="list-style-type: none"> • Beneficiary first name or first initial • Currently or previously assigned HICN, including both alpha and numerical characters (the IVR may disclose the current HICN when a previously assigned HICN is input) • Date of birth <p>NOTE: The IVR response, if feasible, should relay which overall element (for example, date of birth instead of day of birth, month of birth, or year of birth) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.</p>	<ul style="list-style-type: none"> • Crossover established – Yes / No • Home Health – Yes / No • Hospice – Yes / No • SNF – Yes / No • Pneumococcal Vaccine – Yes / No <p>-----</p> <p>NOTE: For the elements below, contractors have discretion on whether to offer these elements and if so, how to program the IVR to offer these additional elements.</p> <p>When prompted by the inquirer:</p> <ul style="list-style-type: none"> • Deductible amount remaining (Part A) or applied (Part B) • Managed Care – plan #, name, address, type, enrollment and termination dates • MSP – insurer name, policy #, effective and termination dates, type of primary insurance, and insurer address. * Contractors shall release this information with a caveat that this information may not be correct and that the beneficiary is the best source for insurance information. For inquiries about the accuracy of the MSP information on the beneficiary's auxiliary record, the IVR shall refer the caller to the Coordination of Benefits Contractor at 1-800-999-1118. The COBC is responsible for the accuracy of the MSP information in Medicare's file. • Claims Crossover Status – insurer or supplemental payer names(s), Coordination of Benefits Agreement (COBA) ID(s), effective and
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			<p>termination dates, deletion dates. * For inquiries concerning why the supplemental payer insurer did or did not include the beneficiary on its eligibility files so that claims can be crossed over, the IVR shall direct the provider to the beneficiary's supplemental insurer.</p> <ul style="list-style-type: none"> • Home Health – applicable earliest and latest dates • Hospice - applicable earliest and latest dates • SNF – applicable earliest and latest dates • Pneumococcal Vaccine – administration date • Influenza Vaccine –administration date • Hepatitis B Vaccine –administration date • Blood Deductible • Date of Death
<p>3. Optional Eligibility Elements Based on Type of Provider and Type of Service Provided (Contractors shall use discretion in determining the type of information to be released to an inquirer; the contractor shall only release this information to assist the provider in</p>	<p>Call to CSR or written inquiry</p>	<ul style="list-style-type: none"> • Beneficiary full last name (including hyphenated names, suffixes (e.g., Jr., Sr.) and abbreviation of titles (e.g., Fr. for Father, Sr. for Sister) <p>NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the CSR shall be certain that the beneficiary surname given by the provider is a match to the name on the beneficiary record being displayed.</p> <ul style="list-style-type: none"> • Beneficiary first name or first initial • Current or previously assigned HICN, including both alpha and numerical 	<p>NOTE – Contractors should not routinely make this information available to all providers/suppliers. Contractors should make this information available on a need to know basis and should disclose it only to enable a provider to bill Medicare properly. For example, a SNF may need information about hospital stays in order to bill properly.</p> <ul style="list-style-type: none"> • ESRD: <ul style="list-style-type: none"> • Renal Supplies: <ul style="list-style-type: none"> • ESRD effective dates • Transplant discharge date • Alternate Method Dialysis: <ul style="list-style-type: none"> • Method 1 • Method 2

<p>billing Medicare properly. Contractors are not required to respond to inquiries if the contractor does not have access to the information necessary to answer the inquiry. If possible, the contractor should refer the inquirer to the entity (i.e., another Medicare contractor) that may be able to address the inquiry. In instances where the provider is part of a multiple physician practice, but the specialty is not identified, contractors have discretion as to whether data should be released.)</p>		<p>characters (if a new HICN displays when the provider supplies the HICN, then the CSR may disclose the new number)</p> <ul style="list-style-type: none"> • Date of birth <p>NOTE: If there is an error, the CSR should tell the inquirer which overall element (for example, date of birth instead of day, month and year) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.</p>	<ul style="list-style-type: none"> • ESRD effective date <ul style="list-style-type: none"> • Transplant discharge date • Home Health: <ul style="list-style-type: none"> • Provider name • Servicing contractor • Applicable dates • Hospice: <ul style="list-style-type: none"> • Provider name • Servicing contractor • Applicable dates • Hospital: <ul style="list-style-type: none"> • Days remaining • Deductible amount • Co-insurance days remaining • Lifetime reserve days • Benefits Exhaust Date • Date of earliest billing action/date of last billing action • Long Term Care: <ul style="list-style-type: none"> • Hospital days remaining • Deductible amount • Co-insurance days remaining • Lifetime reserve days • Rehabilitation Room & Board: <ul style="list-style-type: none"> • Hospital days remaining • Co-insurance hospital days remaining • Lifetime reserve days • Psychiatric Limitation:
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			<ul style="list-style-type: none"> • Days remaining (full benefit, lifetime) • Co-insurance days remaining (regular coinsurance, lifetime reserve coinsurance) • Benefits Exhaust Date • SNF: <ul style="list-style-type: none"> • Days remaining • Co-insurance days remaining • Date of earliest billing action/date of last billing action • Therapy Cap information, including remaining limitation dollar amount and/or amount applied: <ul style="list-style-type: none"> • Speech therapy • Occupational therapy
<p>4. Optional Eligibility Elements Based on Type of Provider and Type of Service Provided (Contractors shall use discretion in determining whether to release this information and, if so, the type of information to be released to an inquirer; the contractor shall only</p>	<p>IVR (involves touchtone or speech recognition technology)</p>	<ul style="list-style-type: none"> • Beneficiary last name – first 6 letters (no special characters); if using speech recognition technology, may use first 6 letters or entire last name, including hyphenated last names, suffixes (e.g., Jr., Sr.) and abbreviation of titles (e.g., Fr. for Father, Sr. for Sister) <p>NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the contractor shall program the IVR to ensure that the beneficiary surname given by the provider is a good match to the name on the</p>	<p>NOTE – Contractors should not routinely make this information available to all providers/suppliers. Contractors should make this information available on a need to know basis and should disclose it only to enable a provider to bill Medicare properly. For example, a SNF may need information about hospital stays in order to bill properly.</p> <ul style="list-style-type: none"> • ESRD: <ul style="list-style-type: none"> • Renal Supplies: <ul style="list-style-type: none"> • ESRD effective dates • Transplant discharge date • Alternate Method Dialysis: <ul style="list-style-type: none"> • Method 1

<p>release this information to assist the provider in billing Medicare properly. Contractors are not required to respond to inquiries if the contractor does not have access to the information necessary to answer the inquiry. In instances where the provider is part of a multiple physician practice, but the specialty is not identified, contractors have discretion as to whether data should be released.)</p>		<p>beneficiary record being accessed. For surnames of less than 6 letters, contractors should program their IVRs to match names of less than 6 letters or should include instructions for callers in the IVR operating guide on how to input spaces or blanks so that 6 digits are input.</p> <ul style="list-style-type: none"> • Beneficiary first name or first initial • HICN, including both alpha and numerical characters (the IVR may disclose the current HICN when a previously assigned HICN is input) • Date of birth <p>NOTE: The IVR response, if feasible, should relay which overall element (for example, date of birth instead of day of birth, month of birth, or year of birth) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.</p>	<ul style="list-style-type: none"> • Method 2 • ESRD effective date <ul style="list-style-type: none"> • Transplant discharge date • Home Health: <ul style="list-style-type: none"> • Provider name • Servicing contractor • Applicable dates • Hospice: <ul style="list-style-type: none"> • Provider name • Servicing contractor • Applicable dates • Hospital: <ul style="list-style-type: none"> • Days remaining • Deductible amount • Co-insurance days remaining • Lifetime reserve days • Benefits Exhaust Date • Date of earliest billing action/date of last billing action • Long Term Care: <ul style="list-style-type: none"> • Hospital days remaining • Deductible amount • Co-insurance days remaining • Lifetime reserve days • Rehabilitation Room & Board: <ul style="list-style-type: none"> • Hospital days remaining • Co-insurance hospital days remaining • Lifetime reserve days
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			<ul style="list-style-type: none">• Psychiatric Limitation:<ul style="list-style-type: none">• Days remaining (full benefit, lifetime)• Co-insurance days remaining (regular coinsurance, lifetime reserve coinsurance)• Benefits Exhaust Date• SNF:<ul style="list-style-type: none">• Days remaining• Co-insurance days remaining• Date of earliest billing action/date of last billing action• Therapy Cap information, including remaining limitation dollar amount and/or amount applied:<ul style="list-style-type: none">• Speech therapy• Occupational therapy• Physical therapy
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<p>5. Preventive Services -Next Eligible Date - Contractors shall use discretion in determining the type of provider to whom to release this information; the contractor shall only release this information to assist the provider in</p>	<p>Call to CSR or written inquiry</p>	<ul style="list-style-type: none"> • Beneficiary full last name (including hyphenated names, suffixes (e.g., Jr., Sr.) and abbreviation of titles (e.g., Fr. for Father, Sr. for Sister) <p>NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the CSR shall be certain that the beneficiary surname given by the provider is a match to the name on the beneficiary record being displayed.</p> <ul style="list-style-type: none"> • Beneficiary first name or first initial 	<p>Next eligible dates for professional / technical components for the following services:</p> <ul style="list-style-type: none"> • Abdominal Aortic Aneurysm Screening • Adult Immunizations • Bone Mass Measurements • Cancer Screenings • Cardiovascular Screening • Diabetes Screening • Diabetes Supplies • Diabetes Self-Management Training • Medical Nutrition Therapy (for Medicare beneficiaries with diabetes or renal disease)
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<p>determining a beneficiary's eligibility for these services or billing Medicare properly.</p>		<ul style="list-style-type: none"> • Currently or previously assigned HICN, including both alpha and numerical characters (if a new HICN displays when the provider supplies the HICN, then the CSR may disclose the new number) • Date of birth <p>NOTE: If there is an error, the CSR should tell the inquirer which overall element (for example, date of birth instead of day of birth, month of birth, or year of birth) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.</p>	<ul style="list-style-type: none"> • Glaucoma Screening • Initial Preventive Physical Exam ("Welcome to Medicare" Physical Exam) • Smoking and Tobacco-Use Cessation Counseling <p>The inquirer should provide the HCPCS code or a description of the service. If a description is provided, instead of a HCPCS code, confirm the exact service being referenced to ensure that the information being disclosed is what is being requested.</p> <p>NOTE: The list of preventive services is accurate as of the publication date of this document and is provided for informational and educational purposes only. If preventive services change before the Disclosure Desk Reference is updated, contractors shall use the most current list of preventive services. Be sure to pay close attention to relevant Change Requests for updates. In addition, more information can be found at the following Web sites:</p> <p>http://www.cms.hhs.gov/PreventionGenInfo/</p> <p>http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp</p> <p>http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf</p>
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<p>6. Preventive Services -Next Eligible Date - Contractors shall use discretion in determining whether to release this information in the IVR and, if so, the type of provider to whom to release this information; the contractor shall only release this information to assist the provider in determining a beneficiary's eligibility for these services or billing Medicare properly.</p>	<p>IVR (involves touchtone or speech recognition technology)</p>	<ul style="list-style-type: none"> • Beneficiary last name – first 6 letters (no special characters); if using speech recognition technology, may use entire last name, including hyphenated last names, suffixes (e.g., Jr., Sr.) and abbreviation of titles (e.g., Fr. for Father, Sr. for Sister) <p>NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the contractor shall program the IVR to ensure that the beneficiary surname given by the provider is a good match to the name on the beneficiary record being accessed. For surnames of less than 6 letters, contractors should program their IVRs to match names of less than 6 letters or should include instructions for callers in the IVR operating guide on how to input spaces or blanks so that 6 digits are input.</p> <ul style="list-style-type: none"> • Beneficiary first name or first initial • Currently or previously assigned HICN, including both alpha and numerical characters (the IVR may disclose the current 	<p>Next eligible dates for professional / technical components for the following services:</p> <ul style="list-style-type: none"> • Abdominal Aortic Aneurysm Screening • Adult Immunizations • Bone Mass Measurements • Cancer Screenings • Cardiovascular Screening • Diabetes Screening • Diabetes Supplies • Diabetes Self-Management Training • Medical Nutrition Therapy (for Medicare beneficiaries with diabetes or renal disease) • Glaucoma Screening • Initial Preventive Physical Exam ("Welcome to Medicare" Physical Exam) • Smoking and Tobacco-Use Cessation Counseling <p>he inquirer should provide the HCPCS code or a description of the service. If a description is provided, instead of a HCPCS code, confirm the exact service being referenced to ensure that the information being disclosed is what is being requested.</p>
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		<p>HICN when a previously assigned HICN is input)</p> <ul style="list-style-type: none"> • Date of birth <p>NOTE: The IVR response, if feasible, should relay which overall element (for example, date of birth instead of day of birth, month of birth, or year of birth) does not match and to check the beneficiary’s record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.</p>	<p>NOTE: The list of preventive services is accurate as of the publication date of this document and is provided for informational and educational purposes only. If preventive services change before the Disclosure Desk Reference is updated, contractors shall use the most current list of preventive services. Be sure to pay close attention to relevant Change Requests for updates. In addition, more information can be found at the following Web sites:</p> <p>http://www.cms.hhs.gov/PrevntionGenInfo/</p> <p>http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp</p> <p>http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf</p>
<p>7. Processed claims information</p> <p>NOTE – Contractors should release information prior to claim submission only with the beneficiary’s authorization or if, in the contractor’s discretion, the</p>	<p>CSR (also applies to written inquiries)</p>	<ul style="list-style-type: none"> • Beneficiary full last name (including hyphenated names, suffixes (e.g., Jr., Sr.) and abbreviation of titles (e.g., Fr. for Father, Sr. for Sister) <p>NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the CSR shall be certain that the beneficiary surname given by the provider is a match to the name on the beneficiary record being displayed.</p>	<p>Contractors shall use discretion in determining what information to release.</p> <p>Assigned Claims Participating and non-participating - any information on that provider/supplier’s claim or any other related claim from that provider/supplier for that beneficiary, including whether the claim was crossed to whom it was crossed with, and the reason why it crossed, if applicable.</p>

<p>provider needs information in order to bill Medicare properly and avoid an overlapping rejected claim.</p>		<ul style="list-style-type: none"> • Beneficiary first name or first initial • Currently or previously assigned HICN, including both alpha and numerical characters (if a new HICH displays when the provider supplies the HICN, then the CSR may disclose the new number) • Date of service <p>NOTE: If there is an error, the CSR should tell the inquirer which overall element(for example, date of birth instead of day of birth, month of birth, or year of birth) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.</p>	<p>Non-assigned Claims Information regarding only the claim in question; information is restricted to claim received (yes / no), date processed and why it was denied or reduced, including whether the claim was crossed over, to whom it was crossed with, and the reason why it crossed, if applicable.</p> <p>The following paragraphs apply to both assigned and unassigned claims.</p> <p>General Note – Contractors should speak with the provider/supplier about his/her own claims. Contractors should also disclose information about another provider/supplier as long as both providers/ suppliers have a relationship with the beneficiary and the purpose of the disclosure is to facilitate the payment of the provider/supplier that receives the information.</p> <p>** If a provider inquires about a claim that was denied due to the beneficiary being beneficiaries in penal custody, the contractor shall tell the provider that Social Security records indicate that this patient was a prisoner when the service was rendered and that Medicare does not cover items and services furnished to an individuals while they are under State or local custody in penal authority.</p>
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			Contractor shall tell the provider that Social Security records indicate that the individual has been deported and that Medicare does not cover items and services furnished for individuals who have been deported.
<p>8. Processed claims information</p> <p>Contractors shall not release any processed claims information about beneficiaries in penal custody or deported beneficiaries (including unlawfully present beneficiaries) via the IVR.</p>	IVR (involves touchtone or speech recognition technology)	<ul style="list-style-type: none"> Beneficiary last name – first 6 letters (no special characters); if using speech recognition technology, may use first 6 letters or entire last name, including hyphenated last names, suffixes (e.g., Jr., Sr.) and abbreviation of titles (e.g., Fr. for Father, Sr. for Sister) <p>NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the contractor shall program the IVR to ensure that the beneficiary surname given by the provider is a good match to the name on the beneficiary record being accessed. For surnames of less than 6 letters, contractors should program their IVRs to match names of less than 6 letters or should include instructions for callers in the IVR operating guide on how to input spaces or blanks so that 6 digits are input.</p> <ul style="list-style-type: none"> Beneficiary first name or first initial Currently or previously assigned HICN, including both alpha and numerical 	<p>Contractors shall use discretion in determining what information to release.</p> <p>Assigned Claims Participating and non-participating - any information on that provider / supplier's claim or any other related claim from that provider / supplier for that beneficiary, including whether the claim was crossed over to whom it was crossed with, and the reason why it crossed, if applicable.</p> <p>Non-assigned Claims Information regarding only the claim in question; information is restricted to claim received (yes / no), date processed and why it was denied or reduced, including whether the claim was crossed over to whom it was crossed with, and the reason why it crossed, if applicable.</p>

		<p>characters (the IVR may disclose the current HICN when a previously assigned HICN is input)</p> <ul style="list-style-type: none"> • Date of service <p>NOTE: The IVR response, if feasible, should relay which overall element (for example, date of birth instead of day of birth, month of birth, or year of birth) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.</p>	
9. Certificate of Medical Necessity (CMN) and DME MAC Information Form (DIF)	Call to CSR or written inquiry	<p>Before a claim is submitted:</p> <ul style="list-style-type: none"> • Beneficiary full last name (including hyphenated names, suffixes (e.g., Jr., Sr.) and abbreviation of titles (e.g., Fr. for Father, Sr. for Sister) <p>NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the CSR shall be certain that the beneficiary surname given by the provider is a match to the name on the beneficiary record being displayed.</p> <ul style="list-style-type: none"> • Beneficiary first name or first initial • Current or previously assigned HICN, including both alpha and numerical 	<p>Contractors shall use discretion in determining what information to release. Contractors should only release information from CMNs and/or DIFs that will facilitate providers / suppliers billing Medicare properly. Although not an authentication element, the caller will need to provide the HCPCS Code or item description in order for the CSR to provide the correct information about the CMN and/or DIF.</p> <ul style="list-style-type: none"> • Initial date • Recertification date • Length of need • Other elements necessary to properly bill Medicare <p>Contractors shall confirm whether the answers to</p>

		<p>characters (if a new HICN displays when the supplier gives the HICN, then the CSR may disclose the new number)</p> <ul style="list-style-type: none"> • Date of birth <p>After a claim is processed:</p> <ul style="list-style-type: none"> • Beneficiary full last name (including hyphenated names, suffixes (e.g., Jr., Sr.) and abbreviation of titles (e.g., Fr. for Father, Sr. for Sister)) <p>NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the CSR shall be certain that the beneficiary surname given by the provider is a match to the name on the beneficiary record being displayed.</p> <ul style="list-style-type: none"> • Beneficiary first name or first initial • Currently or previously assigned HICN, including both alpha and numerical characters (if a new HICN displays when the supplier gives the HICN, then the CSR may disclose the new number) • Date of service <p>NOTE: If there is an error, the CSR should tell the inquirer which overall element (for example, date of birth instead of day of birth, month of birth, or year of birth) does not match and to check the beneficiary's record, which should include a</p>	<p>the question sets on the CMN and/or DIF on file match what the supplier has in his/her records.</p>
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		copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.	
10. Certificate of Medical Necessity (CMN) and DME MAC Information Form (DIF)	IVR (involves touchtone or speech recognition technology)	<p>Before a claim is submitted:</p> <ul style="list-style-type: none"> • Beneficiary last name – first 6 letters (no special characters); if using speech recognition technology, may use first 6 letters or entire last name, including hyphenated last names, suffixes (e.g., Jr., Sr.) and abbreviation of titles (e.g., Fr. for Father, Sr. for Sister); <p>NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the contractor shall program the IVR to ensure that the beneficiary surname given by the provider is a good match to the name on the beneficiary record being accessed. For surnames of less than 6 letters, contractors should program their IVRs to match names of less than 6 letters or should include instructions for callers in the IVR operating guide on how to input spaces or blanks so that 6 digits are input.</p> <ul style="list-style-type: none"> • Beneficiary first name or first initial • Currently or previously assigned HICN, including both alpha and numerical characters (the IVR may disclose the current 	<p>Contractors shall use discretion in determining what information to release. Contractors should only release information from CMNs and/or DIFs that will facilitate providers / suppliers billing Medicare properly. Although not an authentication element, the caller will need to provide the HCPCS Code in order for the IVR to return the correct information about the CMN and/or DIF.</p> <ul style="list-style-type: none"> • Initial date • Recertification date • Length of need • Other elements necessary to properly bill Medicare

		<p>HICN when a previously assigned HICN is input)</p> <ul style="list-style-type: none"> • Date of birth <p>After a claim is processed:</p> <ul style="list-style-type: none"> • Beneficiary last name – first 6 letters (no special characters); if using speech recognition technology, may use entire last name, including hyphenated last names, suffixes (e.g., Jr., Sr.) and abbreviation of titles (e.g., Fr. for Father, Sr. for Sister) <p>NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the contractor shall program the IVR to ensure that the beneficiary surname given by the provider is a good match to the name on the beneficiary record being accessed. For surnames of less than 6 letters, contractors should program their IVRs to match names of less than 6 letters or should include instructions for callers in the IVR operating guide on how to input spaces or blanks so that 6 digits are input.</p> <ul style="list-style-type: none"> • Beneficiary first name or first initial • Currently or previously assigned HICN, including both alpha and numerical characters (the IVR may disclose the current HICN when a previously assigned HICN is 	
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		<p>input)</p> <ul style="list-style-type: none"> • Date of service <p>NOTE: The IVR response, if feasible, should relay which overall element (for example, date of birth instead of day of birth, month of birth, or year of birth) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.</p>	
11. Call back to a Provider	Referencing a specific claim.	Authenticate the provider using the most current authentication protocol.	<p>If you call back a provider or provider representative about a specific claim you may release the name of the beneficiary and/or date of birth in order for the provider or provider representative to pull up or retrieve the necessary information and authenticate you.</p> <p>Authenticate the beneficiary using the following elements except for the elements that you released (name and/or date of birth).</p> <ul style="list-style-type: none"> • HICN • Date of service or procedure
12. Call back to a provider	For reasons other than a specific claim.	Authenticate the provider using the most current authentication protocol.	<p>If you call back a provider or provider representative for reasons other than a specific claim you may release the name of the beneficiary and/or date of birth in order for the provider or provider representative to pull up or retrieve the necessary information and</p>

			<p>authenticate you.</p> <p>Authenticate the beneficiary using the following elements except for the elements that you released (name and/or date of birth).</p> <ul style="list-style-type: none">• HICN• One of the following pieces of information: address, phone number, whether the beneficiary has Part A or Part B, entitlement date(s).
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