EXHIBIT IA

MODEL LETTER TRANSMITTING MATERIALS TO PROVIDERS

(**Date**)

Provider Name
Address
City, State, ZIP Code

Dear (**Provider Name**):

This letter concerns the requirements and procedures through which your institution may be approved to participate in Medicare as a provider of services. This State agency certifies and periodically recertifies whether providers of services meet the Medicare Conditions of Participation, to assist the Centers for Medicare & Medicaid Services (CMS) in determining whether institutions and agencies can participate in Medicare. Such Medicare approval, when required, is a prerequisite to qualifying to participate in the State Medicaid program as well.

As a part of your request to participate in Medicare, you must enroll with the fiscal intermediary. Any questions concerning the Form CMS-855, Medicare General Enrollment Health Care Provider/Supplier Application, should be directed to your fiscal intermediary/carrier. You may obtain information regarding the From CMS-855 by contacting (**name**) at (**phone number**).

Enclosed are other forms which you must complete if you desire to participate. Complete and return them promptly in order to avoid unnecessarily delaying approval, since your institution cannot claim provider reimbursement for services furnished prior to approval. If the forms are not self-explanatory, you may phone (**phone number**) for assistance. Complete and return all copies of the enclosed forms.

On the second line of the Health Insurance Benefits Agreement, after the term, Social Security Act, enter the entrepreneurial name of the enterprise, followed by the trade name (if different from the entrepreneurial name). Ordinarily, this is the same as the business name used on all official IRS correspondence concerning payroll withholding taxes, such as the W-3 or 941 forms. For example, the ABC Corporation, owner of the community General Hospital, would enter on the agreement, “ABC Corporation d/b/a Community General Hospital.” A partnership of several persons might complete the agreement to read: “Robert Johnson, Louis Miller and Paul Allen, ptr., “Easy Care Home Health Services.” A sole proprietorship would complete the agreement to read: “John Smith d/b/a Mercy Hospital.” The person signing the Health Insurance Benefits Agreement must be someone who has the authorization of the owners of the enterprise to enter into this agreement.

Subject to availability, we are also enclosing the applicable Medicare Conditions of Participation for (**type of provider**). The Conditions are only a part of the regulations contained in Title 42, Chapter IV of the Code of Federal Regulations which Medicare providers must meet. You can purchase 42 CFR Chapter IV from the Superintendent of Documents, U.S. Government Printing Office, Washington D.C. 20402. However, the information you need is supplied in Medicare materials provided to you without charge, and explanations are furnished either by this office or by your Medicare fiscal intermediary.

Our surveyors will inspect the institution, interview you and members of your staff, review documents, and undertake other procedures necessary to evaluate the extent to which your institution meets the Conditions of Participation. If your institution has significant deficiencies in any of the Conditions, you will be informed. Following the survey, this agency will recommend to the Centers for Medicare & Medicaid Services whether your institution should be allowed to participate in the Medicare program.

After it is determined by the Centers for Medicare & Medicaid Services that **all** requirements are met, the Health Insurance Benefits Agreement will be countersigned by the CMS RO. One copy will be returned to you along with the notification that your institution has been approved. If operation of the entire institution is later transferred to another owner, ownership group, or to a lessee, the agreement will usually be automatically assigned to the successor. But you are required to notify the Centers for Medicare & Medicaid Services at the time you are planning such a transfer.

Those institutions and agencies that are denied approval to participate in the Medicare program are sent notification giving the reasons for the denial and information about their rights to appeal the decision.

Please do not hesitate to phone this office if you have any questions.

Sincerely Yours,

Enclosures

(See Exhibit 63 for list of pertinent forms to enclose.)

NOTE: When using this letter to transmit materials for Title XIX nursing facilities and intermediate care facilities for the mentally retarded omit sentences referring to the Form CMS-855, as this form is only used for providers who participate in Medicare. These Medicaid providers will complete the Form CMS-1513 instead of the Form CMS-855.