CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 824	**Date: September 5, 2018**
	Change Request 10845

Transmittal 822, dated August 24, 2018, is being rescinded and replaced by Transmittal 824, dated September 5, 2018, to remove information related to processing an application only after a fee has been paid from Chapter 15, Section 15.19.1 - Application Fees, of Pub. 100-08, because it contradicted business requirement 10845.3. All other information remains the same.

SUBJECT: Update to Chapter 15 of Publication (Pub.) 100-08, Certification Statement Policies

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to make modifications to certain provider enrollment certification statement policies. Specifically, provider enrollment certification statements may be uploaded into the Provider Enrollment Chain and Ownership System (PECOS).

EFFECTIVE DATE: October 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 1, 2018

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/15.5/15.5.14/Certification Statement Signature Requirements
R	15/15.5/15.5.14/15.5.14.4/Submission of Paper and Internet-based PECOS Certification Statements
R	15/15.5/15.5.14/15.5.14.5/Certification Statement Development
R	15/15.5/15.5.15/15.5.15.2/Form CMS-855A and Form CMS-855B, and Form CMS-20134 Signatories
R	15/15.7/15.7.1/15.7.1.1/Receipt/Review of Paper Applications
R	15/15.7/15.7.1/15.7.1.2/Receipt/Review of Internet-Based PECOS Applications
R	15/15.7/15.7.1/15.7.1.5/Receiving Missing/Clarifying Data/Documentation
R	15/15.11/Electronic Fund Transfers (EFT)
R	15/15.5/15.14/Certification Statement Signature Requirements
R	15/15.7/15.7.1/15.7.1.2/Receipt/Review of Internet-Based PECOS Applications
R	15/15.17/Establishing an Effective Date of Medicare Billing Privileges
R	15/15.19/15.19.1/Application Fees

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-08	Transmittal: 824	Date: September 5, 2018	Change Request: 10845

Transmittal 822, dated August 24, 2018, is being rescinded and replaced by Transmittal 824, dated September 5, 2018, to remove information related to processing an application only after a fee has been paid from Chapter 15, Section 15.19.1 - Application Fees, of Pub. 100-08, because it contradicted business requirement 10845.3. All other information remains the same.

SUBJECT: Update to Chapter 15 of Publication (Pub.) 100-08, Certification Statement Policies

EFFECTIVE DATE: October 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 1, 2018

I. GENERAL INFORMATION

A. Background: This CR will align provider enrollment certification statement policy with PECOS functionality. PECOS allows an option to upload paper certification statements.

B. Policy: There is no legislative or regulatory impact associated with this CR.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
10845.1	Contractors shall accept all handwritten signatures for forms CMS-855, CMS-20134, CMS-460 and CMS-588 via paper application submission and web-based application submission upload.	X	X	X						NSC
10845.1.1	MACs shall not accept stamped signatures	X	X	X						NSC
10845.1.2	In response to development	X	X	X						NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	request, for Internet-based PECOS applications, the MAC shall accept uploaded, faxed and emailed paper certification statements.									
10845.2	Contractors shall no longer accept paper certification statements for web-based application submissions (CMS-855 and CMS-20134 only) via mail because if the provider chooses to submit its certification statement via paper rather than through e-signature, it shall do so via PECOS upload functionality.	X	X	X						NSC
10845.2.1	MACs shall archive certification statements mailed in for web-based applications.	X	X	X						NSC
10845.3	MACs shall begin processing ALL applications upon receipt and shall	X	X	X						NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	develop for missing certification statements and all other missing information, including application fee, upon review.									
10845.3.1	In order to develop for missing certification statements, MACs shall enter the current date in the Logging and Tracking number certification statement field in the PECOS if the certification statement date is missing.	X	X	X						NSC
10845.3.2	Contractors shall consider the web-based application date of receipt as the date of the web-based application submission.	X	X	X						NSC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10845.4	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X	X	X		

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: 0

15.5.14 – Certification Statement Signature Requirements

(Rev. 824; Issued: 09-05-18; Effective: 10-01-18; Implementation: 10-01-18)

Unless otherwise specified, the instructions in sections 15.5.14 through 15.5.14.5 apply to: (1) signatures on the paper Form CMS-855 or paper Form CMS-20134, (2) signatures on the certification statement for Internet-based Provider Enrollment, Chain and Ownership System (PECOS) applications, and (3) electronic signatures.

All handwritten signatures are valid and appropriate in regards to (1) signatures on the paper Form CMS-855 or paper Form CMS-20134, (2) uploaded signatures on the certification statement for Internet-based Provider Enrollment, Chain and Ownership System (PECOS) applications.

15.5.14.4 – Submission of Paper and Internet-based PECOS Certification Statements

(Rev. 824; Issued: 09-05-18; Effective: 10-01-18; Implementation: 10-01-18)

A. Paper Submissions

A signed certification statement shall accompany the paper CMS-855 application and CMS-20134. If the provider submits an invalid certification statement or fails to submit a certification statement, the contractor 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)* was signed (as reflected by the date of signature) more than 120 days prior to the date on which the contractor received the application); (*d*) 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; (*e*) missing certification statements, *or (f) stamped*. The contractor shall send one development request to include a list of all of the missing required data/documentation, including the certification statement. The contractor may reject the 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. Unless stated otherwise in this chapter or in another CMS directive:

- The contractor shall begin processing the *application upon receipt and shall develop for missing certification statements and all other missing information, including application fee, upon review.*

- The certification statement may be returned via scanned email or fax.

- Signature dates cannot be prior to 120 days of the receipt date of the application.

- For paper applications that require development, it is only necessary that the dated signature of at least one of the provider's authorized or delegated officials be on the certification statement that must be sent in within 30 days; obtaining the signatures of the other authorized and delegated officials is not required.

- For paper changes of information applications (as the term "changes of information" is defined in section 15.6.2 of this chapter), if the certification statement is signed by an individual who is not on file with the contractor as being an authorized or delegated official of the provider, the contractor may accept the certification statement but shall develop for information on the person in question in accordance with sections 15.5.14.3.1 and 15.5.14.3.2 of this chapter.

- The contractor is not required to compare the signature thereon with the same provider, authorized or delegated official's signature on file to ensure that it is the same person. The contractor shall not request the submission of a driver's license or passport to verify a signature.

B. Internet-based PECOS Submissions

If the provider submits its application online and chooses to submit its certification statement via paper rather than through e-signature, it *shall* do so *via PECOS upload functionality. The provider shall not mail in its paper certification statement as it will not be accepted.* Unless stated otherwise in this chapter or in another CMS directive:

- The contractor shall begin processing the *application upon receipt and shall develop for missing certification statements and all other missing information, including application fee, upon review.*

- Signature dates cannot be prior to 120 days of the receipt date of the application.

- If the provider submits an invalid certification statement, the contractor shall treat this as missing information and develop for a correct certification statement – preferably via email or fax. This includes certification statements that are: (a) unsigned; (b) undated; (*c*) was signed (as reflected by the date of signature) more than 120 days prior to the date on which the contractor received the application); (*d*) 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; (e) missing certification statements, or (f) stamped. The contractor shall send one development request to include a list of all of the missing required data/documentation, including the certification statement. The contractor may reject the 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.*

- For Internet-based PECOS applications that require development, it is only necessary that the dated signature of at least one of the provider's authorized or delegated officials be on the certification statement that must be sent in within 30 days; obtaining the signatures of the other authorized and delegated officials is not required.

- For Internet-based PECOS changes of information applications (as the term "changes of information" is defined in section 15.6.2 of this chapter), if the certification statement is signed by an individual who is not on file with the contractor as being an authorized or delegated official of the provider, the contractor may accept the certification statement but shall develop for information on the person in question in accordance with sections 15.5.14.3.1 and 15.5.14.3.2 of this chapter.

- The contractor is not required to compare the signature thereon with the same provider, authorized or delegated official's signature on file to ensure that it is the same person. The contractor shall not request the submission of a driver's license or passport to verify a signature.

15.5.14.5 – Certification Statement Development

(Rev. 824; Issued: 09-05-18; Effective: 10-01-18; Implementation: 10-01-18)

If the provider submits an invalid certification statement (e.g., unsigned; undated; or stamped signature; signed more than 120 days of the receipt date, incorrect individual signed it; not all authorized officials signed it) or neglects to send a certification statement, the contractor shall treat this as missing information and develop for a correct certification statement using the procedures outlined in this chapter. The contractor shall send a development letter to the provider – preferably via email or fax.

Any development requests that require the submission of a newly-signed certification statement, may be submitted by the provider via scanned email, fax or mail *(paper applications only)*. Only the actual signature page is required; the additional page containing the certification terms need not be submitted. This also applies to the provider's initial submission of a certification statement; such instances require the submission of only the signature page and not the certification terms.

15.5.15.2 – Form CMS-855A and Form CMS-855B, and Form CMS-20134 Signatories

(Rev. 824; Issued: 09-05-18; Effective: 10-01-18; Implementation: 10-01-18)

For Form CMS-855A, CMS-855B, and CMS-20134 initial applications, the certification statement must be signed and dated by an authorized official of the provider. (See section 15.1.1 of this chapter for a definition of "authorized official.") The provider can have an unlimited number of authorized officials, so long as each meets the definition of an authorized official. Section 6 of the Form CMS-855 or Form CMS-20134 must be completed for each authorized official.

If an authorized official is listed as a "Contracted Managing Employee" in section 6 of the Form CMS-855 or CMS-20134 and does not qualify as an authorized official under some other category in section 6, he/she cannot be an authorized official.
The contractor shall notify the provider accordingly. If the person is not listed as a "Contracted Managing Employee" in section 6 and the contractor has no reason to suspect that the person does not qualify as an authorized official, no further investigation is required. Should the contractor have doubts that the individual qualifies as an authorized official, it shall contact the official or the applicant's contact person to obtain more information about the official's job title and/or authority to bind. If the contractor remains unconvinced that the individual qualifies as an authorized official, it shall notify the provider that the person cannot be an authorized official. If that person is the only authorized official listed and the provider refuses to use a different authorized official, the contractor shall deny the application.

An authorized official must be a 5 percent direct owner, chairman of the board, etc., of the enrolling provider. One cannot use his/her status as the chief executive officer, chief financial officer, etc., of the provider's parent company, management company, or chain home office as a basis for his/her role as the provider's authorized official.

In addition:

1. *Deletion of Authorized Official - If an authorized official is being deleted, the contractor need not obtain (1) that official's signature, or (2) documentation verifying that the person is no longer an authorized official.*

2. *Change in Authorized Officials - A change in authorized officials does not impact*

the authority of existing delegated officials to report changes and/or updates to the provider's enrollment data or to sign revalidation applications.

3. *Authorized Official Not on File - If the provider submits a change of information (e.g., change of address) and the authorized official signing the form is not on file, the contractor shall ensure that: (1) the person meets the definition of an authorized official, and (2) section 6 of the Form CMS-855 or Form CMS-20134 is completed for that person. The signature of an existing authorized official is not needed in order to add a new authorized official. Note that the original change request and the addition of the new official shall be treated as a single change request (i.e., one change request encompassing two different actions) for purpose of enrollment processing and reporting.*

4. *Effective Date - The effective date in the Provider Enrollment, Chain and Ownership System for section 15 of the Form CMS-855 or Form CMS-20134 should be the date of signature.*

5. *Social Security Number - To be an authorized official, the person must have and must submit his/her social security number (SSN). An Individual Taxpayer Identification Number (ITIN) cannot be used in lieu of an SSN in this regard.*

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

7. *Certification Statement Development – When the contractor develops for missing or additional information and the provider must submit a newly-signed certification statement, only the actual signature page is required; the additional page containing the certification terms need not be submitted unless the contractor requests it. This applies to the provider's initial submission of a certification statement for a particular application as well; such instances do not require the submission of both the signature page and the page containing the certification terms.*

15.7.1.1 – Receipt/Review of Paper Applications

(Rev. 824; Issued: 09-05-18; Effective: 10-01-18; Implementation: 10-01-18)

A. Background

The contractor shall begin processing the application *upon application receipt.* This

includes, but is not limited to (and subject to the processing alternatives in sections 15.7.1.3.1 through 15.7.1.3.4):

- Ensuring that all required data elements on the application have been completed and that all required supporting documentation has been submitted

- Submitted a valid and dated certification statement signed by an appropriate individual (e.g., the enrolling physician for Form CMS-855I applications)

- Validating all data on and submitted with the application, provided that a data source is available,

- Entering all information contained on the application into the Provider Enrollment, Chain and Ownership System (PECOS).

The contractor may begin the verification process at any time. Also, the contractor is not required to create a PECOS logging and tracking (L & T) record within a certain specified timeframe (e.g., within 20 days after receipt of the application).

B. Other Guidelines

1. Acknowledgment of Receipt of Application – The contractor may, but is not required to, send out acknowledgment letters or emails.

2. "Not Applicable" – Unless a "processing alternative" applies, the provider cannot write "N/A" in response to a question that requires a "yes" or "no" answer. This is considered an incomplete reply, thus warranting the issuance of a request for missing information.

3. Unsolicited Submission of Information - If the provider submits missing/clarifying data or documentation on its own volition (i.e., without being contacted by the contractor), the contractor shall include this additional data/documentation in its overall application review.

4. Reenrollment Bar – If the contractor suspects that a provider or supplier is attempting to circumvent an existing reenrollment bar by enrolling under a different business identity or as a different business type, the contractor shall contact CMS' Provider Enrollment Business Function Lead (PEBFL) for guidance.

5. State and Country of Birth – The state of birth and country of birth are optional data elements on the Form CMS-855. As such, the contractor shall not develop for this information if it was not disclosed on the application and shall not request other contractors to update the PECOS Associate Control (PAC) ID to include this data.

6. Photocopying Pages - The contractor may accept photocopied pages in any Form CMS-855 or Form CMS-20134. For example, suppose a corporation wants to enroll five medical clinics it owns. The section 5 data on the Form CMS-855B is exactly the same for all five clinics. The contractor may accept photocopied section 5 pages for these providers.

7. White-Out & Highlighting - The contractor shall not write on or highlight any part of the original Form CMS-855 or Form CMS-20134 application or any supplementary pages the applicant submits (e.g., copy of license). Provider usage of white-out is acceptable, although the contractor should contact the applicant to resolve any ambiguities. In addition, the contractor must determine whether the amount of white-

out used on a particular application is within reason. For instance, if an entire application page is whited-out, the contractor should request that the page be resubmitted.

15.7.1.2 – Receipt/Review of Internet-Based PECOS Applications

(Rev. 824; Issued: 09-05-18; Effective: 10-01-18; Implementation: 10-01-18)

A. Background

1. The provider may submit their certification statement via e-signature or *PECOS upload* to their contractor. See section 15.5.14.4 for further instructions on certification statement submissions.

2. Switch to "In Review" and Application Returns

If the provider *fails to submit or* has submitted an invalid certification statement, the contractor shall still proceed with processing the application. An appropriate certification statement shall be solicited as part of the development process. If the certification statement was a) unsigned; (b) undated; *(c)* was signed (as reflected by the date of signature) more than 120 days prior to the date on which the contractor received the application); (*d*) 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; *(e) missing certification statements, or (f) stamped. The contractor shall send one development request to include a list of all of the missing required data/documentation, including the certification statement. The contractor may reject the 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. In order to develop for missing certification statements, MACs shall enter the current date in the Logging and Tracking number certification statement field in the PECOS if the certification statement date is missing.*

Once the above step is complete, the contractor shall: (1) enter the date of signature in the "Certification Date" box in the logging & tracking (L & T) record, and (2) change the L & T status to "In Review."

If the contractor can determine (without having yet begun processing the application) that an application can be returned under section 15.8.1 of this chapter (e.g., Form CMS-855I was submitted more than 60 days prior to the effective date), the contractor may return the application without waiting for the arrival of the certification statement.

B. Processing of Application

After tasks (1) and (2) above have been completed, the contractor shall begin processing the application. Subject to the processing alternatives in sections through 15.7.1.3.4, processing includes (but is not limited to):

- Ensuring that all required data elements on the application have been completed and that all required supporting documentation has been submitted (either via paper or the Digital Data Repository (DDR))

- Validating all data on and submitted with the application, provided that a data source is available

15.7.1.5 – Receiving Missing/Clarifying Data/Documentation

(Rev. 824; Issued: 09-05-18; Effective: 10-01-18; Implementation: 10-01-18)

The procedures in this section 15.7.1.5 are subject to the processing alternatives identified in sections 15.7.1.3.1 through 15.7.1.3.4 of this chapter.

A. Requirement to Furnish All Missing/Clarifying Material

The provider must furnish all missing/clarifying data/documentation requested by the contractor within the 30-day timeframe. Whether the provider furnished all the information is a decision resting solely with the contractor. Should the provider furnish some (but not all) of the requested data/clarification within the specified time period, the contractor need not contact the provider again to request the remaining information. For instance, suppose the contractor requested missing data in sections 3, 4, and 5 of the Form CMS-855A. The provider only furnished the section 3 data. The contractor may reject the application without attempting another contact.

For Internet-based PECOS applications, the provider *shall upload* its paper certification statement.

B. Format of Furnishing Missing Data

1. Paper Applications

Unless stated otherwise in this chapter or in another CMS directive, the provider shall: (1) provide the missing/clarification information (excluding documentation) on the applicable Form CMS-855 or Form CMS-20134 page(s) and (2) submit the missing material via mail, fax, or scanned email. A newly signed and dated certification statement must accompany the Form CMS-855 or Form CMS-20134 page(s) containing the missing data – unless the only missing information is supporting documentation, in which case no new certification statement is needed. The certification statement may be submitted by the provider via scanned email, fax or mail along with the missing information.

2. Internet-Based PECOS Applications

Unless stated otherwise in this chapter or in another CMS directive, the provider may (1) submit the missing information by entering it into PECOS, (2) submit the missing documentation via fax, email, mail, or the Digital Data Repository (DDR), and/or (3) submit the certification statement via PECOS upload or e-signature. (The provider may submit the missing data via the applicable paper Form CMS-855 or Form CMS-20134 pages if it submitted its application via Internet-based PECOS). The certification statement may be submitted by the provider via scanned email orfax along with the missing information.

C. Format of Clarifying Data

In cases where clarifying (as opposed to missing) information is requested, the contractor may accept the clarification by email, fax, or letter. If the provider furnishes the clarification via telephone, the contractor shall – unless another CMS directive states otherwise - request that the provider furnish said clarification in writing (preferably via email).

If the provided clarification ultimately requires the provider to change or alter data that must be reported on the paper or Web Form CMS-855 or Form CMS-20134, the

contractor shall instruct the provider via a follow-up email or fax to submit the revised data on the applicable Form CMS-855 or Form CMS-20134 page or via Internet-based PECOS and to furnish a new certification statement. The provider must submit the revised data and new certification statement within 30 days of the original request for clarification (rather than 30 days from the date of the follow-up request to provide the data via the Form CMS-855 or Form CMS-20134). The certification statement may be submitted by the provider via scanned email orfax along with the missing information.

Consider the following illustrations:

EXAMPLE 1: The contractor notifies the provider via an emailed letter on March 1 of a discrepancy regarding its ownership information on the Form CMS-855A. The provider emails the contractor on March 3 and explains the discrepancy. Based on this email, the contractor determines that the provider must correct its ownership data in section 5 of its Form CMS-855A. The contractor sends a follow-up email to the provider on March 7 instructing the provider to do so. The provider must submit the revised data on the Form CMS-855 (with a new certification statement) by March 31 (not April 6, or 30 days from the date of the follow-up email).

EXAMPLE 2: The contractor notifies the provider via emailed letter on March 1 of a discrepancy regarding its ownership information on the Form CMS-855A. The provider telephones the contractor on March 6 and explains the discrepancy to the contractor's satisfaction. Although the discrepancy does not require the provider to make any revisions to its Form CMS-855A, the contractor shall request that the provider furnish its explanation in writing no later than 30 days from its March 1 email (or March 31), not 30 days from the date of its March 6 request for the written explanation.

EXAMPLE 3: The contractor notifies the provider via emailed letter on March 1 of a discrepancy regarding its ownership information on its paper Form CMS-855A. Determining (based on the contractor's email) that the ownership information it provided was incorrect, it submits a revised section 5 of its Form CMS-855A to the contractor with a new certification statement but without any accompanying explanation of the change (e.g., no accompanying letter or email). The contractor receives the revised section 5 on March 12. If the contractor determines that the discrepancy has been resolved via the revised submission, it is not required to contact the provider for an accompanying written explanation. (This is because the clarification was furnished in writing via the CMS-855 itself.) If, however, the contractor would like a written explanation or otherwise needs clarification about the submission, it may request that a written explanation be submitted no later than March 31.

D. Maintenance of Received Material

The contractor shall maintain all missing/clarifying information or documentation received (including new certification statements) in the provider file. Storage can be electronic or via hard copy, but it must be in an otherwise easily accessible format.

15.11 – Electronic Fund Transfers (EFT)

(Rev. 824; Issued: 09-05-18; Effective: 10-01-18; Implementation: 10-01-18)

A. General Information

If a provider does not have an established enrollment record in the Provider

Enrollment, Chain and Ownership System (PECOS) and wants to change any of its EFT information (e.g., bank routing number), it must submit a complete Form CMS-855 or Form CMS-20134 before the contractor can effectuate the change.

With the exception of the situation described in section (B) below, it is immaterial whether the provider or the bank was responsible for triggering the changed data. Under 42 CFR §424.510(d)(2)(iv) and §424.510(e):

- All providers (including Federal, State and local governments) enrolling in Medicare must use EFT in order to receive payments. Moreover, any provider not currently on EFT that (1) submits any change to its existing enrollment data or (2) submits a revalidation application must also submit a Form CMS-588 and thereafter receive payments via EFT.

- If a provider is already receiving payments via EFT and is located in a jurisdiction that is undergoing a change of Medicare contractors, the provider must continue to receive payments via EFT. However, the change in contractors does not require the provider to submit a new Form CMS-588 unless CMS states otherwise.

- *For web-based application submissions, the Form CMS-588 shall be submitted via PECOS upload functionality.*

B. Verification

Providers and suppliers may submit a Form CMS-588 via paper or through PECOS. In either case, the contractor shall ensure that:

- The information submitted on the Form CMS-588 is complete and accurate.

- The provider/supplier submitted (1) a voided check or (2) a letter from the bank verifying the account information.

- The routing number and account number matches what was provided on the Form CMS-588.

- The signature is valid. (**NOTE:** For electronic Form CMS-588 submissions, the provider can either e-sign the form or submit a written signature via the paper Form CMS-588. *For web-based application submissions, the Form CMS-588 shall be submitted via PECOS upload functionality).*

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

C. Miscellaneous Policies

1. Banking Institutions - All payments must be made to a banking institution. EFT payments to non-banking institutions (e.g., brokerage houses, mutual fund families) are not permitted.

If the provider's bank of choice does not or will not participate in the provider's proposed EFT arrangement, the provider must select another financial institution.

2. Verification - The contractor shall ensure that all EFT arrangements comply with CMS Publication 100-04, chapter 1, section 30.2.5.

3. Sent to the Wrong Unit - If a provider submits an EFT change request to the contractor but not to the latter's enrollment unit, the recipient unit shall forward it to the enrollment staff, which shall then process the change. The enrollment unit is responsible for processing EFT changes. As such, while it may send the original EFT form back to the recipient unit, the enrollment unit shall keep a copy of the EFT form and append it to the provider's Form CMS-855 or Form CMS-20134 in the file.

4. Bankruptcies and Garnishments – If the contractor receives a copy of a court order to send payments to a party other than the provider, it shall contact the applicable RO's Office of General Counsel.

5. Closure of Bank Account – If a provider has closed its bank/EFT account but will remain enrolled in Medicare, the contractor shall place the provider on payment withhold until an EFT agreement (and Form CMS-855 or Form CMS-20134, if applicable) is submitted and approved by the contractor. If such an agreement is not submitted within 90 days after the contractor learned that the account was closed, the contractor shall commence revocation procedures in accordance with the instructions in this chapter. The basis for revocation would be §424.535(a) due to the provider's failure to comply with the EFT requirements outlined in §424.510(e)(1) and (e)(2).

6. Reassignments – If a physician or non-physician practitioner is reassigning all of his/her benefits to another supplier and the latter is not currently on EFT, neither the practitioner nor the reassignee needs to submit a Form CMS-588. This is because (1) the practitioner is not receiving payment directly, and (2) accepting a reassignment does not qualify as a change of information request. If, however, the group later submits a change of information request and is not on EFT, it must submit a Form CMS-588.

7. Final Payments – If a non-certified supplier (e.g., physician, ambulance company) voluntarily withdraws from Medicare and needs to obtain its final payments, the contractor shall send such payments to the provider's EFT account of record. If the account is defunct, the contractor can send payments to the provider's "special payments" address or, if none is on file, to any of the provider's practice locations on record. If neither the EFT account nor the aforementioned addresses are available, the provider shall submit a Form CMS-855, or Form CMS-20134, Form CMS-588 request identifying where it wants payments to be sent.

8. Chain Organizations - Per CMS Publication 100-04, chapter 1, section 30.2, a chain organization may have payments to its providers be sent to the chain home office. However, any mass EFT changes (involving large numbers of chain providers) must be submitted and processed in the same fashion as any other change in EFT data. For instance, if a chain has 100 providers and each wants to change its EFT account to that of the chain home office, 100 separate Form CMS-588s must be submitted. If any of the chain providers have never completed a Form CMS-855 or Form CMS-20134 before, they must do so at that time.

15.17 – Establishing an Effective Date of Medicare Billing Privileges

(Rev. 824; Issued: 09-05-18; Effective: 10-01-18; Implementation: 10-01-18)

(This section only applies to the following individuals and organizations: physicians;

physician assistants; nurse practitioners; clinical nurse specialists; certified registered nurse anesthetists; anesthesiology assistants; certified nurse- midwives; clinical social workers; clinical psychologists; registered dietitians or nutrition professionals; physician and non-physician practitioner organizations (e.g., group practices) consisting of any of the categories of individuals identified above; and ambulance suppliers.)

A. Background

In accordance with 42 CFR §424.520(d), the effective date for the individuals and organizations identified above is the later of:

- The date the supplier filed an enrollment application that was subsequently approved, or

- The date the supplier first began furnishing services at a new practice location.

***NOTE**: The date of filing for paper Form CMS-855 applications is the date on which the contractor received the application, regardless of whether the application was submitted via paper or Internet-based PECOS.*

B. Retrospective Billing

Consistent with 42 CFR §424.521(a), the individuals and organizations identified above may retrospectively bill for services when:

- The supplier has met all program requirements, including state licensure requirements, and

- The services were provided at the enrolled practice location for up to—

1. 30 days prior to their effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries, or

2. 90 days prior to their effective date if a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§5121-5206 (Stafford Act) precluded enrollment in advance of providing services to Medicare beneficiaries.

The contractor shall interpret the phase "circumstances precluded enrollment" to mean that the supplier meets all program requirements (including state licensure) during the 30-day period before an application was submitted and no final adverse action, as identified in § 424.502, precluded enrollment. If a final adverse action precluded enrollment during this 30-day period, the contractor shall only establish an effective billing date the day after the date that the final adverse action was resolved, as long as it is not more than 30 days prior to the date on which the application was submitted.

If the contractor believes that the aforementioned Presidentially-declared disaster exception may apply in a particular case, it shall contact its CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL) for a determination on this issue.

C. Legal Distinction between Effective Date of Enrollment and Retrospective Billing Date

The effective date of enrollment is "the later of the date of filing or the date (the supplier) first began furnishing services at a new practice location." The retrospective billing date, however, is "up to…30 days prior to (the supplier's) effective date (of enrollment)." To illustrate, suppose that a non-Medicare enrolled physician begins furnishing services at an office on March 1. She submits a paper Form CMS-855I initial enrollment application on May 1; the contractor receives the application on May 4. The application is approved on June 1. The physician's effective date of enrollment is May 4, which is the later of (1) the date of filing, and (2) the date she began furnishing services. The retrospective billing date is April 4 (or 30 days prior to the effective date of enrollment), assuming that the requirements of 42 CFR § 424.521(a) are met.

Hence, the effective date entered into PECOS and the Multi-Carrier System will be April 4; claims submitted for services provided before April 4 will not be paid.

15.19.1 – Application Fees

(Rev. 824; Issued: 09-05-18; Effective: 10-01-18; Implementation: 10-01-18)

A. Background

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

- An application fee in an amount prescribed by CMS, and/or
- A request for a hardship exception to the application fee.

This requirement applies to applications that the contractor receives on or after March 25, 2011.

For purposes of this requirement, the term "institutional provider," as defined in 42 CFR §424.502, means any provider or supplier that submits a paper Medicare enrollment application using the Form CMS-855A, Form CMS-855B (not including physician and non-physician practitioner organizations), Form CMS-20134, Form CMS-855S or associated Internet-based Provider Enrollment, Chain and Ownership System (PECOS) enrollment application. A physician, non-physician practitioner, physician group, or non-physician practitioner group that is enrolling as a supplier of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) via the Form CMS-855S application must submit the required application fee with its Form CMS-855S form.

B. Fee

1. Amount

The application fee must be in the amount prescribed by CMS for the calendar year in which the application is submitted. The fee for March 25, 2011 through December 31, 2011 was $505.00. The fee for January 1, 2016 through December 31, 2016 is $554.00. Fee amounts for future years will be adjusted by the percentage change in the consumer price index (for all urban consumers) for the 12-month period ending on June 30 of the

prior year. CMS will give the contractor and the public advance notice of any change in the fee amount for the coming calendar year.

2. Non-Refundable

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

a. A hardship exception request that is subsequently approved;

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

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

(For purposes of (B)(2)(b) above, the term "rejected" includes applications that are returned pursuant to section 15.8.1 of this chapter.)

In addition, the fee should be refunded if:

- It was not required for the transaction in question (e.g., the provider submitted a fee with its application to report a change in phone number).

- It was not part of an application submission.

3. Format

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

Also, with respect to the application fee requirement:

- The fee is based on the Form CMS-855 or Form CMS-20134 application submission, not on how enrollment records are created in PECOS. For instance, suppose a hospital submits an initial Form CMS-855A. In section 2A2 of the application, the hospital indicates that it has a psychiatric unit and a rehabilitation unit. Separate PECOS enrollment records must be created for each unit. However, only one application fee is required because only one Form CMS-855A application was submitted.

- A physician/non-physician practitioner clinic or group practice enrolling via the Form CMS- 855B is exempt from the fee even if it is: (1) tribally-owned/operated or (2) hospital-owned. However, if a hospital is adding a physician/non-physician practitioner clinic or group practice to its Form CMS-855A enrollment, a fee is required because the hospital is adding a practice location.

C. Hardship Exception

1. Background

A provider or supplier requesting a hardship exception from the application fee must include with its enrollment application a letter (and any supporting documentation) that

describes the hardship and why the hardship justifies an exception. If a paper Form CMS-855 or Form CMS-20134 application is submitted, the hardship exception letter must accompany the application; if the application is submitted via Internet-based PECOS, the hardship exception letter must accompany the certification statement. Hardship exception letters shall not be considered if they were submitted separately from the application or certification statement, as applicable. If the contractor receives a hardship exception request separately from the application or certification statement, it shall: (1) return it to the provider, and (2) notify the provider via letter, e-mail or telephone that it will not be considered.

2. Criteria for Determination

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

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

(a) Considerable bad debt expenses,

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

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

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

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

Upon receipt of a hardship exception request with the application or certification statement, the contractor shall send the request and all documentation accompanying the request via regular mail, fax, or e-mail to its CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL). CMS will communicate its decision to the provider and the contractor via letter, after which the contractor shall carry out the applicable instructions in section 19.1(D) below. If the provider fails to submit appropriate documentation to support its request, the contractor is not required to contact the provider to request it. The contractor can simply forward the request "as is" to its PEOG BFL. Ultimately, it is the provider's responsibility to furnish the necessary supporting evidence at the time it submits its hardship exception request.

D. Receipt

If an application fee is required the contractor shall undertake the following:

a. Determine whether the provider has-- (1) *P*aid the application fee via Pay.gov*;* and/or (2) *I*ncluded a hardship exception request with the application or certification statement.

b. If the provider--

i. Has neither paid the fee nor submitted the hardship exception request, the contractor shall send a letter to the provider notifying it that it has 30 days from the date of the letter to pay the application fee via Pay.gov, and that failure to do so will result in the rejection of the provider's application (for initial enrollments and new practice locations) or revocation of the provider's Medicare billing privileges (for revalidations). The letter shall also state that because a hardship exception request was not submitted with the original application, CMS will not consider granting a hardship exception in lieu of the fee.

ii. Has paid the fee but has not submitted a hardship exception request, the contractor shall begin processing the application as normal.

iii. Has submitted a hardship exception request but has not paid a fee, the contractor shall send the request and all documentation accompanying the request via regular mail, fax, or e- mail to its PEOG BFL. If CMS:

a. Denies the hardship exception request, it will notify the provider in the decision letter (on which the contractor will be copied) that the application fee must be paid within 30 calendar days from the date of the letter. During this 30-day period, the contractor shall determine whether the fee has been submitted via Pay.gov.
b. Approves the hardship exception request, it will notify the provider of such in the decision letter (on which the contractor will be copied)*; or*

iv. Has submitted a hardship exception request and has paid a fee, the contractor shall send the request and all documentation accompanying the request via regular mail, fax, or e- mail to its PEOG BFL. As the fee has been paid, the contractor shall begin processing the application as normal.

E. Year-to-Year Transition

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

F. Appeals of Hardship Determinations

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

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

The reconsideration request should be mailed to:

Centers for Medicare & Medicaid Services Center
for Program Integrity
Provider Enrollment & Oversight Group 7500
Security Boulevard
Mailstop: AR-18-50 Baltimore,
MD 21244- 1850

Notwithstanding the filing of a reconsideration request, the contractor shall still carry out the post- hardship exception request instructions in subsections (D)(b)(iii)(a) and (iv) above, as applicable. A reconsideration request, in other words, does not stay the execution of the instructions in section 19.1(D) above.

CMS has 60 calendar days from the date of the reconsideration request to render a decision. The reconsideration shall be:

(a) Conducted by a CMS staff person who was independent from the initial decision to deny the hardship exception request.

(b) Based on CMS' review of the original letter and documentation submitted by the provider.

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

If CMS denies the reconsideration, it will notify the provider of this via letter, with a copy to the contractor. If CMS approves the reconsideration request, it will notify the provider of this via letter, with a copy to the contractor, after which the contractor shall process the application as normal, or, to the extent applicable. If the application has already been rejected, request that the provider resubmit the application without the fee.

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

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

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

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

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

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

If the DAB reverses the ALJ's decision and approves the hardship exception request, and the application has already been rejected, the contractor - once PEOG informs it of the DAB's decision - shall notify the provider via letter, e-mail or telephone that it may resubmit the application without the fee.

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

G. Miscellaneous

The contractor shall abide by the following:

1. Paper Checks Submitted Outside of Pay.gov – As stated earlier, all payments must be made via Pay.gov. Should the provider submit an application with a paper check or any other hard copy form of payment (e.g., money order), the contractor shall not deposit the instrument It shall instead treat the situation as a non-submission of the fee and follow the instructions in (D)(b)(i) or (iii) above (depending on whether a hardship exception request was submitted). When sending the applicable letter requesting payment within 30 days, the contractor shall explain that all payments must be made via.Pay.gov, stamp the submitted paper check "VOID," and include the voided paper check with the letter.

2. Practice Locations – DMEPOS suppliers, federally qualified health centers (FQHCs), and independent diagnostic testing facilities (IDTFs) must individually enroll each site. Consequently, the enrollment of each site requires a separate fee. For **all other providers and suppliers** (except physicians, non- physician practitioners, and physician and non-physician practitioner groups, none of which are required to submit

the fee), a fee must accompany any application that adds a practice location. (This includes the addition of a hospital unit – such as a psychiatric unit – in section 4 of the Form CMS-855A.) If multiple locations are being added on a single application, however, only one fee is required. The fee for providers and suppliers other than DMEPOS suppliers, FQHCs, and IDTFs is based on the application submission, not the number of locations being added on a single application. For MDPP suppliers, which have administrative locations and not practice locations, the application fee must only be paid upon initial enrollment and revalidation, and not when an additional administrative location is being added to an initial application.

3. Other Application Submissions – A provider or supplier need not pay an application fee if the application is:

- Reporting a change of ownership via the Form CMS-855B, Form CMS- 855S, or Form CMS-20134. (For providers and suppliers reporting a change of ownership via the Form CMS-855A, the ownership change does not necessitate an application fee if the change does not require the provider or supplier to enroll as a new provider or supplier.)

- Reporting a change in tax identification number (whether Part A, Part B, or DMEPOS).

- Requesting a reactivation of the provider's Medicare billing privileges unless the provider had been deactivated for failing to respond to a revalidation request, in which case the resubmitted application constitutes a revalidation (not a reactivation) application, hence requiring a fee.

- Changing the physical location of an existing practice location (as opposed to reporting an additional/new practice location).

The application fee requirement is separate and distinct from the site visit requirement and risk categories discussed below. Physicians, non-physician practitioners, physician groups and non- physician practitioner groups are exempt from the application fee even if they fall within the "high" level of categorical screening per section 15.19.2.5 of this chapter. Similarly, physical therapists enrolling as individuals or group practices need not pay an application fee even though they fall within the "moderate" level of categorical screening and are subject to a site visit.

4. Non-Payment of the Fee - If the application is rejected or denied due to non-payment of the fee, the contractor shall:

- Enter the application into PECOS, with the receipt date being the date on which the contractor received the application in its mailroom.

- Indicate in PECOS that a developmental request was made.

- Switch the enrollment record to a "denied" or "rejected" status (as applicable) per section 15.19.1(D).

- Notify the applicant of the rejection or denial in accordance with section 15.19.1(D).

5. Refund Requests – Unless otherwise approved by CMS, the provider must request a refund no later than 150 days from the date it submitted its application. In its request, the provider shall include documentation acceptable to process the refund request. For

credit card refunds, the provider shall include its Pay.gov receipt or the Pay.gov tracking ID number; if the fee was paid via ACH Debit, a W-9 is required.