CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2984	**Date: July 11, 2014**
	Change Request 8760

SUBJECT: Beneficiary Signature Requirements for Ambulance Services

I. SUMMARY OF CHANGES: This change request removes the requirement that a representative provide his/her address when signing for ambulance services on behalf of a beneficiary. This applies to Pub. 100-04, Chapter 1, Section 50.1.3, and Chapter 26, Section 10.3, Item 12. It also applies to Pub. 100-02.

EFFECTIVE DATE: August 12, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: August 12, 2014

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	1/50.1.3/Signature on the Request for Payment by Someone Other Than the Patient
R	26/10.3/Items 11a – 13 – Patient and Insured Information

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 obliged 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. 100-04	Transmittal: 2984	Date: July 11, 2014	Change Request: 8760

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I. GENERAL INFORMATION

A. Background: Prior to July 1, 2014, the address of the representative signing the Form-1500 for a physically or mentally disabled patient was required by Medicare.

B. Policy: Effective for services on or after July 1, 2014, the address of the representative for the beneficiary is no longer required by Medicare.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8760 - 04.1	Medicare contractors shall be aware that a representative is no longer required to provide his or her address when signing on behalf of a beneficiary for ambulance services.	X	X							

III. PROVIDER EDUCATION TABLE

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

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Marianne Myers, 410-786-5962 or marianne.myers@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

Medicare Claims Processing Manual
Chapter 1 - General Billing Requirements

50.1.3 - Signature on the Request for Payment by Someone Other Than the Patient

(Rev. 2984, Issued: 07-11-14, Effective: 08-12-14, Implementation: 08-12-14)

General

If at all practical the patient should sign the request on the provider's records at the start of care, or upon admission for hospital or SNF admissions. However, where a beneficiary is unable to execute a request for payment because of a mental or physical condition, the request may be executed on his/her behalf by a legal guardian, representative payee (a person designated by the Social Security Administration or other governmental agency to receive an incompetent beneficiary's monthly cash benefits), relative, friend, representative of an institution providing him/her care or support, or of a governmental agency providing assistance. A physician or supplier (or his/her employee) cannot request payment for services furnished except under circumstances fully documented to show that the enrollee is unable to sign and that there is no other person who could.

For this purpose, "an institution providing him/her care" includes a long-term care facility, a hospital (whether psychiatric or general), a SNF, and a nursing home. Only an employee of the institution or agency may be authorized to act as its representative to sign claims on behalf of incompetent patients.

The name of the incompetent person should be shown on the signature line of the Request for Medicare Payment (or equivalent authorization retained in the file, followed by "by" and the signature of the requestor. The requestor, other than a representative payee, should attach a statement to the Request for Medicare Payment explaining his/her relationship to the beneficiary and the reason the beneficiary cannot sign. If such a statement is not submitted, *A/B MACs* must obtain an explanation if other development is needed or if the physician or supplier (or employee) has signed. Except in such cases, *A/B MACs* should not delay processing the claim to obtain an explanation.

A/B MACs are permitted to honor an otherwise properly completed and submitted claim signed by the administrator (or other authorized employee) of a nonprofit long-term care facility on behalf of a resident who has given the facility the necessary power of attorney (P/A). (A long-term care facility, as distinguished from a nursing or other SNF, is an institution that contractually provides room, board, medical, and other necessary services to people who commonly enter and remain there for life, even when in good health. It may include a skilled nursing unit.) *A/B MACs* may assume that the facility has the necessary authority when the administrator enters in the signature space the resident's name, followed by "P/A," the administrator's signature, his title, and the name of the home. A signature on behalf of a competent enrollee based on a P/A granted to anyone other than an authorized official of a nonprofit long-term care facility is not acceptable.

NOTE: The fact that such a request may be honored does not mean that payment can be made to the requestor.

In certain circumstances, it would be impracticable for an individual to sign the request for payment himself because when he is admitted to a hospital or skilled nursing facility or first receives outpatient or home health services, he is unconscious, incompetent, in great pain, or otherwise in such a condition that he should not be asked to transact any business. In such a situation, his representative payee (i.e., a person designated by the Social Security Administration to receive monthly benefits on the patient's behalf), a relative, legal guardian, or a representative of an institution (other than the provider) usually responsible for his care, or a representative of a governmental entity providing welfare assistance, if present at time of admission, should be asked and permitted to sign on his behalf.

A. Provider Signs Request

If, at the time of admission, the patient cannot be asked to sign the request for payment and there is no person present exercising responsibility for him, an authorized official of the provider may sign the request. Except in the outpatient case described below, where the patient is not physically present, a provider should not routinely sign the request on behalf of any patient. If experience reveals an unusual frequency of such provider-signed request from a particular provider, the matter will be subject to review by the *A/B MAC (A)*.

The hospital or SNF need not attempt to obtain the patient's signature where the physician sends a specimen (e.g., blood or urine sample) to a laboratory of a participating hospital or SNF for analysis, the patient does not go to the hospital or SNF, but the tests are billed through that provider. The hospital or SNF may sign on behalf of the patient and should note in its records "Patient not physically present for tests." This does not apply in cases in which the patient actually goes to the hospital or SNF laboratory for tests and the provider fails to obtain the patient's signature while he is there.

If it is impractical to obtain the patient's signature because a home health agency does not make a visit to his home (e.g., the physician certifies that the patient needs a certain item of durable medical equipment but no visits are certified), the agency may furnish the equipment and need not obtain the patient's signature. An agency representative should sign on behalf of the patient and indicate in the provider record "Patient not visited."

B. Patient Dies

If the patient dies before the request for payment is signed, it may be signed by the legal representative of the estate, or by any of the persons or institutions (including an authorized official of the provider) who could have signed it had the patient been alive and incompetent.

A request for payment for inpatient hospital services filed with the hospital may serve as an application for HI entitlement when filed by or on behalf of a live patient, but **not** when filed on behalf of a deceased patient. See §50.1.4.

C. Need for Explanation of Signer's Relationship to Patient

When someone other than the patient signs the request for payment, the signer will submit a brief statement explaining the relationship to the patient and the circumstances which made it impracticable for the patient to sign. The provider will retain the statement in its *files*. The *A/B MAC (A)* will generally accept such a statement as representing the true facts of the case in the absence of evidence to the contrary. If development is needed for some other reason, the *A/B MAC (A)* will ask the provider to furnish the explanation of relationship and circumstances. However, processing the claim should not ordinarily be delayed to obtain the explanation if nothing else prevents payment.

Medicare Claims Processing Manual

Chapter 26 - Completing and Processing Form CMS-1500 Data Set

10.3 - Items 11a - 13 - Patient and Insured Information

(Rev. 2984, Issued: 07-11-14, Effective: 08-12-14, Implementation: 08-12-14)

Item 11a Enter the insured's 8-digit birth date (MM | DD | CCYY) and sex if different from item 3.

Item 11b – Form version 08/05: Enter employer's name, if applicable. If there is a change in the insured's insurance status, e.g., retired, enter either a 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) retirement date preceded by the word, "RETIRED."
Form version 02/12: provide this information to the right of the vertical dotted line.

Item 11c - Enter the 9-digit PAYERID number of the primary insurer. If no PAYERID number exists, then enter the **complete** primary payer's program or plan name. If the primary payer's EOB does not contain the claims processing address, record the primary payer's claims processing address directly on the EOB. This is required if there is insurance primary to Medicare that is indicated in item 11.

Item 11d - Leave blank. Not required by Medicare.

Item 12 - The patient or authorized representative must sign and enter either a 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or an alpha-numeric date (e.g., January 1, 1998) unless the signature is on file. In lieu of signing the claim, the patient may sign a statement to be retained in the provider, physician, or supplier file in accordance with Chapter 1, "General Billing Requirements." If the patient is physically or mentally unable to sign, a representative specified in chapter 1, may sign on the patient's behalf. In this event, the statement's signature line must indicate the patient's name followed by "by" the representative's name, relationship to the patient, and the reason the patient cannot sign. The authorization is effective indefinitely unless the patient or the patient's representative revokes this arrangement.

NOTE: This can be "Signature on File" and/or a computer generated signature.

The patient's signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service or supplier when the provider of service or supplier accepts assignment on the claim.

Signature by Mark (X) - When an illiterate or physically handicapped enrollee signs by mark, a witness must enter his/her name and address next to the mark.

Item 13 - The patient's signature or the statement "signature on file" in this item authorizes payment of medical benefits to the physician or supplier. The patient or his/her authorized representative signs this item or the signature must be on file separately with the provider as an authorization. However, note that when payment under the Act can only be made on an assignment-related basis or when payment is for services furnished by a participating physician or supplier, a patient's signature or a "signature on file" is not required in order for Medicare payment to be made directly to the physician or supplier.

The presence of or lack of a signature or "signature on file" in this field will be indicated as such to any downstream coordination of benefits trading partners (supplemental insurers) with whom CMS has a payer-to-payer coordination of benefits relationship. Medicare has no control over how supplemental claims are processed, so it is important that providers accurately address this field as it may affect supplemental payments to providers and/or their patients.

In addition, the signature in this item authorizes payment of mandated Medigap benefits to the participating physician or supplier if required Medigap information is included in item 9 and its subdivisions. The patient or his/her authorized representative signs this item or the signature must be on file as a separate Medigap

authorization. The Medigap assignment on file in the participating provider of service/supplier's office must be insurer specific. It may state that the authorization applies to all occasions of service until it is revoked.

NOTE: This can be "Signature on File" signature and/or a computer generated signature.