CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 578	**Date: February 25, 2015**
	Change Request 9011

Transmittal 575, dated February 13, 2015, is being rescinded and replaced by Transmittal 578 to correct the Effective/Implementation dates in the manual instruction. The correct dates are May 15, 2015. All other information remains the same.

SUBJECT: Incorporation of Revalidation Policies into Pub. 100-08, Program Integrity Manual (PIM), Chapter 15

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to incorporate various existing revalidation policies into Pub. 100-08, Program Integrity Manual (PIM), chapter 15.

EFFECTIVE DATE: May 15, 2015.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 15, 2015
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/Table of Contents
N	15/15.3.2/NPI Punctuation
R	15/15.5.2.1/Licenses and Certifications
R	15/15.5.2.6/Section 2 of the Form CMS-855I
R	15/15.5.4/Practice Location Information
D	15/15.6.1.1.3/Form CMS-855B Applications Submitted by Suppliers Other Than Independent Diagnostic Testing Facilities (IDTFs)
D	15/15.6.1.1.4/Form CMS-855B Applications Submitted by Independent Diagnostic Testing Facilities (IDTFs)
R	15/15.10.3/Voluntary Terminations
R	15/15.24.1/Model Acknowledgement Letter
R	15/15.24.1.1/Acknowledgement Letter Example
R	15/15.24.5/Model Revalidation Letter

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N	15/15.24.5.1/Model Revalidation Letter – CHOW Scenario Only
N	15/15.24.5.2/Model Large Group Revalidation Notification Letter
N	15/15.24.5.3/Model Revalidation Pend Letter
N	15/15.24.5.4/Model Revalidation Deactivation Letter
R	15/15.24.7/Approval Letter Guidance
R	15/15.24.8.6/Denial Example #6 – Existing or Delinquent Overpayments
R	15/15.24.9/Revocation Letter Guidance
R	15/15.29/Provider and Supplier Revalidations
N	15/15.29.1/Revalidation Lists
N	15/15.29.2/Mailing Revalidation Letters
N	15/15.29.3/Non-Response to Revalidation Actions
N	15/15.29.3.1/Phone Calls
N	15/15.29.3.2/Pend Status
N	15/15.29.3.3/Deactivation Actions
N	15/15.29.4/Receipt of Revalidation Application
N	15/15.29.4.1/Revalidation Received and Development Required
N	15/15.29.4.2/Revalidation Received After a Pend is Applied
N	15/15.29.4.3/Revalidation Received After a Deactivation Occurs
N	15/15.29.4.4/Change of Information Received After Revalidation Letter Mailed
N	15/15.29.5/Revalidating Providers Involved in a Change of Ownership (CHOW)
N	15/15.29.6/Extension Requests
N	15/15.29.7/Large Group Revalidation Coordination
N	15/15.29.8/Finalizing the Revalidation Application
N	15/15.29.9/Revalidation Reporting
N	15/15.29.10/Revalidation Files on CMS.gov

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: 578	Date: February 25, 2015	Change Request: 9011

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SUBJECT: Incorporation of Revalidation Policies into Pub. 100-08, Program Integrity Manual (PIM), Chapter 15

EFFECTIVE DATE: May 15, 2015**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: May 15, 2015

I. GENERAL INFORMATION

A. Background: This CR is intended to formally incorporate into Pub. 100-08, PIM, chapter 15 various revalidation policies currently in effect. As these policies were previously established via business requirements, said business requirements are not being repeated in this CR.

Any new business requirements are outlined in the business requirements section of this CR.

B. Policy: This CR incorporates various existing revalidation policies into Pub. 100-08, PIM, chapter 15.

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	
9011.1	The contractor shall abide by the examples in section 3.2 of this chapter with respect to punctuation and special characters.	X	X	X						
9011.2	When processing a voluntary termination of a reassignment, the contractor shall contact the group to confirm that: (1) the group member Provider Transaction Access Number (PTAN) is being terminated from all locations; and (2) if multiple group member PTANs exist for multiple group locations, each PTAN is terminated.		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9011.3	MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	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): Frank Whelan, 410-786-1302 or frank.whelan@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 Program Integrity Manual
Chapter 15 - Medicare Enrollment

Table of Contents
(Rev.578, Issued: 02-25-15)

15.3.2 – NPI Punctuation

(Rev.578, Issued: 02-25-15, Effective: 05-15- 15, Implementation: 05-15-15)

PECOS and NPPES allow for the entry of punctuation and certain special characters in the provider's Legal Business Name (LBN). Examples of acceptable punctuation and special characters are ampersands, apostrophes, commas, hyphens, left and right parentheses, periods, pound signs, and quotation marks.

When punctuation or special characters are part of a provider's LBN as shown on the IRS CP-575, the punctuation or special characters should also appear in the LBN in NPPES and the LBN in PECOS. However, the contractor may use its discretion with respect to accepting a match between NPPES and PECOS if a comma or a period is the only discrepancy between the LBN in NPPES and the LBN in PECOS. The contractor should not delay processing a provider's Medicare enrollment application by requiring the provider to change its LBN in NPPES in order to conform to a discrepancy related to punctuation and/or special character.

Examples of LBN Matches and Non-Matches and Actions to Be Taken

NPPES LBN	***PECOS LBN***	***Exact Match***
Health Systems, Inc.	*HEALTH SYSTEMS, INC.*	*Yes, this is an exact match.*
Quality Care, Incorporated	*Quality Care, Inc.*	*No, this is not an exact match (because of the abbreviation 'Inc.' in the PECOS LBN).* *In this case, the contractor may accept the match since both versions are an accurate match (e.g., Incorporated or Inc; Limited Liability Company or LLC; etc.)*
Health & Rehabilitation, Inc.	*Health and Rehabilitation Inc.*	*No, this is not an exact match (because the ampersand and 'and' do not match).* *In this case, the contractor shall refer to the IRS CP-575. If the ampersand is displayed on the IRS CP-575, the Medicare contractor may accept the match. If the ampersand is not present and the word 'and' is present, the Medicare contractor shall ask the provider to correct its NPPES information. The provider must change its LBN in NPPES to read in accordance with the IRS CP-575.*
Allergy & Asthma, Inc.	*Allergy & Asthma, INC.*	*Yes, this is an exact match. Upper and lower cases do not affect a match.*
Foot-Ankle, LLC	*Foot Ankle LLC*	*No, this is not an exact match (because the hyphen is in one LBN but not in the other).*

		In this case, the contractor shall refer to the IRS CP-575. If the hyphen is displayed on the IRS CP-575, the contractor may accept the match. If the hyphen is not present, the contractor shall ask the provider to correct its NPPES information. The provider must change its LBN in NPPES to read in accordance with the IRS CP-575.
Rehab and Health, Inc.	*Rehabilitation and Health, Inc.*	*No, this is not an exact match (because 'Rehab' and 'Rehabilitation are different words).* *In this case, the contractor should refer to the IRS CP-575. If the LBN 'Rehab and Health, Inc.' is displayed on the IRS CP-575, the contractor may accept the match. If 'Rehabilitation and Health, Inc.' is present, the contractor should ask the provider to correct its NPPES information. The provider must change its LBN in NPPES to read in accordance with the IRS CP-575.*

Many enrolled providers may actually be subparts of other enrolled providers, and some of those subparts entered their "doing business as name" as their LBN when applying for their NPIs. Once a contractor determines for certain that this situation exists, the contractor shall ask the provider to correct its NPPES information. The provider can (1) change its LBN in NPPES to read in accordance with the IRS CP-575, and (2) report its "doing business as" name in NPPES as an "Other Name" and indicate the type of other name as a "doing business as" name.

15.5.2.1 – Licenses and Certifications

(Rev.578, Issued: 02-25-15, Effective: 05-15-15, Implementation; 05-15-15)

The extent to which the applicant must complete the licensure or certification information in section 2 of the Form CMS-855 depends upon the provider type involved. For instance, some states may require a particular provider to be "certified" but not "licensed," or vice versa.

The provisions in this section 15.5.2.1 are subject to the "processing alternatives" described in sections 15.7.1.3.1 through 15.7.1.3.2 of this chapter.

A. Form CMS-855B and Form CMS-855I

The contractor shall verify that the supplier is licensed and/or certified to furnish services in:

- The state where the supplier is enrolling

- Any other state within the contractor's jurisdiction in which the supplier (per section 4 of the Form CMS-855) will maintain a practice location.

The only licenses that must be submitted with the application are those required by Medicare or the state to function as the supplier type in question. Licenses and permits that are not of a medical nature are not required, though business licenses needed for the applicant to operate as a health care facility or practice must be submitted. In addition, there may be instances where the supplier is not required to be licensed at all in a particular state; the contractor shall still ensure, however, that the supplier meets all applicable state and Medicare requirements.

The contractor shall also adhere to the following:

- **State Surveys:** Documents that can only be obtained after state surveys or accreditation need not be included as part of the application. (This typically occurs with ambulatory surgical centers (ASCs) and portable x-ray suppliers.) The supplier must, however, furnish those documents that can be submitted prior to the survey/accreditation.

The contractor shall include any licenses, certifications, and accreditations submitted by ASCs and portable x-ray suppliers in the enrollment package that is forwarded to the state and/or RO.

Once the contractor receives the approval letter or tie-in notice from the RO for the ASC or portable x-ray supplier, the contractor is encouraged, but not required, to contact the RO, state agency, or supplier for the applicable licensing and/or certification data and to enter it into PECOS.

- ***T*emporary Licenses:** If the supplier submits a temporary license, the contractor shall note the expiration date in PECOS. Should the supplier fail to submit the permanent license after the temporary license expiration date, the contractor shall initiate revocation procedures. (A temporary permit – one in which the applicant is not yet fully licensed and must complete a specified number of hours of practice in order to obtain the license – is not acceptable.)

- **Revoked/Suspended Licenses:** If the applicant had a previously revoked or suspended license reinstated, the applicant must submit a copy of the reinstatement notice with the application.

- **Date of Enrollment –** For suppliers other than ASCs and portable x-rays, the date of enrollment is the date the contractor approved the application. The enrollment date cannot be made retroactive. To illustrate, suppose the supplier met all the requirements needed to enroll in Medicare (other than the submission of a Form CMS-855I) on January 1. He sends his Form CMS-855I to the contractor on May 1, and the contractor approves the application on June 1. The date of enrollment is June 1, not January 1.

(**NOTE:** The matter of the date of enrollment is separate from the question of the date from which the supplier may bill.)

See section 15.7.5.1, of this chapter for special instructions related to periodic license reviews and certain program integrity matters.

B. Form CMS-855A

Documents that can only be obtained after state surveys or accreditation need not be included as part of the application, nor must the data be provided in section 2 of the Form CMS-855A. The provider shall, however, furnish those documents that can be submitted prior to the survey/accreditation. The contractor shall include all submitted licenses, certifications, and accreditations in the enrollment package that is forwarded to the state and/or RO.

Once the contractor receives the approval letter or tie-in notice from the RO, the contractor is encouraged, but not required, to contact the RO, state agency, or provider for the applicable licensing and/certification data and to enter it into PECOS.

15.5.2.6 – Section 2 of the Form CMS-855I

(Rev.578, Issued: 02-25-15, Effective: 05-15-15, Implementation; 05-15-15)

A. Specialties

On the CMS-855I, the physician must indicate his/her supplier specialties, showing "P" for primary and "S" for secondary. Non-physician practitioners must indicate their supplier type.

The contractor shall deny the application if the individual fails to meet the requirements of his/her physician specialty or supplier type.

B. Education for Non-Physician Practitioners

The contractor shall verify all required educational information for non-physician practitioners. While the non-physician practitioner must meet all Federal and State requirements, he/she need not provide documentation of courses or degrees taken to satisfy these requirements unless specifically requested to do so by the contractor. To the maximum extent possible, the contractor shall use means other than the practitioner's submission of documentation- such as a State or school Web site - to validate the person's educational qualifications.

A physician need not submit a copy of his/her degree unless specifically requested to do so by the contractor. To the maximum extent possible, the contractor shall use means other than the physician's submission of documentation- such as a State or school Web site - to validate the person's educational status.

C. Resident/Intern Status

If the applicant is a "resident" in an "approved medical residency program" (as these two terms are defined at 42 CFR §413.75(b)), the contractor shall refer to Pub. 100-02, chapter 15, section 30.3 for further instructions. (The contractor may also want to refer to 42 CFR §415.200, which states that services furnished by residents in approved programs are not "physician services.")

The physician should indicate the exact date that its residency program, internship, or fellowship was completed, so that the appropriate effective date can be issued.

*A*n intern cannot enroll in the Medicare program. (For purposes of this requirement, the term "intern" means an individual who is not licensed by the State because he/she is still in post-graduate year (PGY) 1.) Also, an individual in a residency or fellowship program cannot be reimbursed for services performed as part of that program.

D. Physician Assistants

As stated in the instructions on page 3 of the CMS-855I, physician assistants (PAs) who are enrolling in Medicare need only complete sections 1, 2, 3, 13, 15, and 17 of the CMS- 855I. The physician assistant must furnish his/her NPI in section 1 of the application, and must list his/her employers in section 2E.

The contractor must verify that the employers listed are: (1) enrolled in Medicare, and (2) not excluded or debarred from the Medicare program. (An employer can only receive payment for a PA's services if both are enrolled in Medicare.) All employers must also have an established record in PECOS. If an employer is excluded or debarred, the contractor shall deny the application.

Since PAs cannot reassign their benefits – even though they are reimbursed through their employer – they should not complete a CMS-855R.

E. Psychologists Billing Independently

The contractor shall ensure that all persons who check "Psychologist Billing Independently" in section 2D2 of the CMS-855I answer all questions in section 2I. If the supplier answers "no" to question 1, 2, 3, 4a, or 4b, the contractor shall deny the application.

F. Occupational/Physical Therapist in Private Practice (OT/PT)

All OT/PTs in private practice must respond to the questions in section 2J of the CMS-855I. If the OT/PT plans to provide his/her services as: (1) a member of an established OT/PT group, (2) an employee of a physician-directed group, or (3) an employee of a non-professional corporation, and that person wishes to reassign his/her benefits to that group, this section does not apply. Such information will be captured on the group's CMS-855B application.

If the OT/PT checks that he/she renders all of his/her services in patients' homes, the contractor shall verify that he/she has an established private practice where he/she can be contacted directly and where he/she maintains patient records. (This can be the person's home address, though all Medicare rules and instructions regarding the maintenance of patient records apply.) In addition, section 4D of the CMS-855I should indicate where services are rendered (e.g., county, State, city of the patients' homes). Post office boxes are not acceptable.

If the individual answers "yes" to question 2, 3, 4, or 5, the contractor shall request a copy of the lease agreement giving him/her exclusive use of the facilities for PT/OT services only if it has reason to question the accuracy of his/her response. If the contractor makes this request and the provider cannot furnish a copy of the lease, the contractor shall deny the application.

15.5.4 – Practice Location Information

(Rev.578, Issued: 02-25-15, Effective: 05-15-15, Implementation; 05-15-15)

Unless specifically indicated otherwise, the instructions in this section 15.5.4 apply to the Form CMS-855A, the Form CMS-855B, and the Form CMS-855I.

The instructions in section 15.5.4.1 apply only to the Form CMS-855A; the instructions in section 15.5.4.2 apply only to the Form CMS-855B; and the instructions in section 15.5.4.3 only apply to the Form CMS-855I.

A. Practice Location Verification

The contractor shall verify that the practice locations listed on the application actually exist. If a particular location cannot at first be verified, the contractor shall request clarifying information; for instance, the contractor can request that the applicant furnish letterhead showing the appropriate address.)

The contractor shall also verify that the reported telephone number is operational and connects to the practice location/business listed on the application. *However, the contractor need not contact every location for applicants that are enrolling multiple locations; the contractor can verify each location's telephone number with the contact person listed on the application and note the verification accordingly in the contractor's verification documentation per section 15.7.3 of this chapter.* (The telephone number must be one where patients and/or customers can reach the applicant to ask questions or register complaints.) The contractor *may also* match the applicant's telephone number with known, in-service telephone numbers - via, for instance, the Yellow Pages or the Internet - to correlate telephone numbers with addresses. If the applicant uses his/her/its cell phone for their business, the contractor shall verify that this is a telephone connected directly to the business. If the contractor cannot verify the telephone number, it shall request clarifying information from the applicant; the inability to confirm a telephone number may indicate that an

onsite visit is necessary. In some instances, a 1-800 number or out-of-state number may be acceptable if the applicant's business location is in another State but his/her/its practice locations are within the contractor's jurisdiction.

Additionally, once the verification of practice locations is complete, the contractor need not verify the address via the Internet (for example, 411.com, USPS.com, etc.). Finalist (which is integrated into PECOS) verifies the validity of an address with the United States Postal Service (USPS). Additional verification is only needed if Finalist cannot validate an actual address.

Also:

- If an individual practitioner or group practice: (1) is adding a practice location and (2) is normally required to complete a questionnaire in section 2 of the Form CMS-855I or Form CMS-855B specific to its supplier type (e.g., psychologists, physical therapists), the person or entity must submit an updated questionnaire to incorporate services rendered at the new location.

- Any provider submitting a Form CMS-855A, Form CMS-855B or Form CMS-855I application must submit the 9-digit ZIP Code for each practice location listed.

- For *providers/suppliers paid via the Fiscal Intermediary Shared System (FISS),* the practice location name entered into the Provider Enrollment, Chain and Ownership System *(PECOS)* shall be *the "doing business as" name (if it is different from the legal business name). For suppliers paid via the Multi-Carrier System (MCS), the practice location name entered into PECOS shall be the legal business name.*

B. Do Not Forward (DNF)

Unless instructed otherwise in another CMS directive, the contractor shall follow the DNF initiative instructions in Pub. 100-04, chapter 1, section 80.5. Returned paper checks, remittance notices, or EFT payments shall be flagged if returned from the post office or banking institution, respectively, as this may indicate that the provider's "special payment" address (section 4 of the Form CMS-855) or EFT information has changed. The provider should submit a Form CMS-855 or Form CMS-588 request to change this address; if the provider does not have an established enrollment record in the Provider Enrollment, Chain and Ownership System, it must complete an entire Form CMS-855 and Form CMS-588. The Durable Medical Equipment Medicare Administrative Contractors are responsible for obtaining, updating and processing Form CMS-588 changes.

In situations where a provider is closing his/her/its business and has a termination date (e.g., he/she is retiring), the contractor will likely need to make payments for prior services rendered. Since the practice location has been terminated, the contractor may encounter a DNF message. If so, the contractor should request the provider to complete the "special payment" address section of the Form CMS-855 and to sign the certification statement. The contractor, however, shall not collect any other information unless there is a need to do so.

C. Remittance Notices/Special Payments

For new enrollees, all payments must be made via EFT. The contractor shall thus ensure that the provider has completed and signed the Form CMS-588 and shall verify that the bank account is in compliance with Pub. 100-04, chapter 1, section 30.2.

If an enrolled provider that currently receives paper checks submits a Form CMS-855 change request – no matter what the change involves – the provider must also submit:

- A Form CMS-588 that switches its payment mechanism to EFT. (The change request cannot be processed until the Form CMS-588 is submitted.) All future payments (excluding special payments) must be made via EFT.

- An updated section 4 that identifies the provider's desired "special payments" address.

The contractor shall also verify that the bank account is in compliance with Pub. 100-04, chapter 1, section 30.2.

(Once a provider changes its method of payment from paper checks to EFT, it must continue using EFT. A provider cannot switch from EFT to paper checks.)

The "special payment" address may only be one of the following:

- One of the provider's practice locations

- A P.O. Box

- The provider's billing agent. The contractor shall request additional information if it has any reason to suspect that the arrangement – at least with respect to any special payments that might be made – may violate the Payment to Agent rules in Pub. 100-04, chapter 1, section 30.2.

- The chain home office address. Per Pub.100-04, chapter 1, section 30.2, a chain organization may have payments to its providers sent to the chain home office. The legal business name of the chain home office must be listed on the Form CMS-588. The TIN on the Form CMS-588 should be that of the provider.

- Correspondence address

15.10.3 – Voluntary Terminations

(Rev.578, Issued: 02-25-15, Effective: 05-15-15, Implementation; 05-15-15)

Voluntary terminations shall be processed in accordance with the timeframes in section 15.6.2, et al. of this chapter.

If the termination involves a certified provider or certified supplier, the contractor may terminate the entity without making a recommendation to the State and Regional Office (RO). Within 3 business days after the contractor finishes processing the termination, however, it shall notify the State and RO of this via letter, e-mail, or fax.

Upon receipt of a voluntary termination, the contractor may ask the provider to complete the "Special Payments" portion of section 4 of the Form CMS-855 so that future payments can be sent thereto. If the provider has no special payments address already on file, the addition should be included in the same transaction as the termination (i.e., one transaction incorporating both items). If the provider wants to change its existing special payments address, the transaction should be treated as a separate change request (i.e., one termination and one change request). The provider is not required to submit a Form CMS-588 in conjunction with a termination.

When processing a voluntary termination of a reassignment, the contractor shall contact the group to confirm that: (1) the group member PTAN is being terminated from all locations; and (2) if multiple group member PTANs exist for multiple group locations, each PTAN is terminated. However, if a group has one PTAN with multiple addresses, the contractor need not contact the group to confirm the termination.

15.24.1 – Model Acknowledgement Letter

(Rev.578, Issued: 02-25-15, Effective: 05-15-15, Implementation; 05-15-15)

(This letter is optional)

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference *ID: (Case #, Control Number,* etc.)

Dear [Provider/Supplier Name]:

Your Medicare enrollment application(s) was received on [date] and [is/are] currently being reviewed. You will receive a letter within 30 calendar days if we need any additional information.

Additional *provider/supplier identification* information: *NPI, DBA Name, etc.*

Please retain this letter in case you must submit additional information to support your application. If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM]

Sincerely,

[Name]
[Title]
[Company]

15.24.1.1 – Acknowledgement Letter Example

(Rev.578, Issued: 02-25-15, Effective: 05-15-15, Implementation; 05-15-15)

June 27, 2012

Timothy Payne, M.D.
1234 Anywhere Street
Elkhart MT 87321

Reference *ID: (Case #, Control Number,* etc.)

Dear Timothy Payne, M.D.:

Your Medicare enrollment application(s) was received on June 1, 2012 and is currently being reviewed. You will receive a letter within 30 calendar days if we need any additional information.

Additional *provider/supplier identification* information: *NPI, DBA Name, etc.*

Please retain this letter in case you must submit additional information to support your application. If you have any questions, please contact our office at 555-555-1212 between the hours of 8:00 AM and 5:00 PM.
Sincerely,

William Boatwright
Applications Analyst
Medicare Administrative Contractor, Inc.

15.24.5 – Model Revalidation Letter

(Rev.578, Issued: 02-25-15, Effective: 05-15-15, Implementation; 05-15-15)

[Month Day & Year]

PROVIDER/SUPPLIER NAME *NPI:*
ADDRESS 1, ADDRESS 2 *PTAN:*
CITY STATE ZIP CODE

Dear Provider/Supplier Name:

THIS IS A PROVIDER ENROLLMENT REVALIDATION REQUEST

***IMMEDIATELY** SUBMIT AN UPDATED*

PROVIDER ENROLLMENT PAPER APPLICATION 855 FORM OR

REVIEW, UPDATE AND CERTIFY YOUR INFORMATION

VIA THE INTERNET-BASED PECOS SYSTEM

In accordance with Section 6401(a) of the Patient Protection and Affordable Care Act, all new and existing providers must be reevaluated under the new screening guidelines. Medicare requires all enrolled providers and suppliers to revalidate their enrollment information every five years (reference 42 CFR § 424.515). To ensure compliance with these requirements, existing regulations at 42 CFR § 424.515(d) provide that the Centers for Medicare & Medicaid Services (CMS) is permitted to conduct off-cycle revalidations for certain program integrity purposes. Upon the CMS request to revalidate its enrollment, the provider/supplier has 60 days from the post mark date of this letter to submit complete enrollment information using one of the following methods:

Providers and suppliers can revalidate their provider enrollment in the Medicare program using either the:

(1) Internet-based Provider Enrollment, Chain, and Ownership System (PECOS)

To revalidate via the Internet-based PECOS, go to https://pecos.cms.hhs.gov. The system allows you to review information currently on file, upload any supporting documentation, and electronically sign and submit your revalidation application. If you choose not to electronically sign your application, remember to print, sign, date, and mail the certification statement along with all required supporting documentation to your Medicare contractor. To process the revalidation, the original signature and documentation must be received within 15 days of the application internet submission date.

You must have an active National Provider Identifier (NPI) and a web user account (User ID/Password) established in the Identity and Access Management System (I&A)

(https://nppes.cms.hhs.gov/IAWeb/login.do). Physicians and non-physician practitioners will access Internet-based PECOS with the same User ID and password that they use for NPPES.

For provider/supplier organizations that would like an individual(s) (Authorized Official, surrogate) to use Internet-based PECOS on their behalf, an account must be established in the I&A system. If you have not registered, do so now by going to https://pecos.cms.hhs.gov and clicking on "Register for a user account" under the "Become a Registered User" section.

To avoid any registration issues, review the I&A related documents available on the I&A homepage at https://nppes.cms.hhs.gov/IAWeb/login.do.

(2) Paper Application Form

To revalidate by paper, download the appropriate and current CMS-855 Medicare Enrollment application from the CMS Web site at https://www.cms.gov/MedicareProviderSupEnroll/. Mail your completed application and all required supporting documentation to the [insert contractor name], at the address below.

[Insert application return address]

A new Electronic Funds Transfer (EFT) Authorization Form (CMS-588) is only required to be submitted as part of your revalidation package if the current version or later, approved by the Office of Management and Budget (OMB) on 09/2013, is not on file with Medicare. The current version of the form can be found at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS588.pdf.

If additional time is required to complete the revalidation application, you may request one 60-day extension, which will be added onto the initial 60 days given to respond to the request. The request may be submitted in writing from the individual provider, the Authorized or Delegated Official of the organization, or the contact person and should be addressed to the MAC(s). The request should include justification of why a 60-day extension is needed. The request may also be made by contacting your MAC(s) via phone.

With the exception of physicians, non-physicians practitioners, physician group practices and non-physician practitioner group practices, all revalidating providers and suppliers that submit enrollment applications using the CMS-855A, CMS-855B (not including physician and non-physician practitioner organizations) or the CMS-855S or associated Internet-based PECOS enrollment application must submit with their application a confirmation that the application fee was paid or a request for a hardship exception. (Note: physicians who are DMEPOS suppliers are subject to the fee for the DMEPOS enrollment). Application fees must be submitted via PECOS at https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do, which will allow payment of the fee by electronic check, debit, or credit card prior to submitting the application (reference 42 CFR § 424.514)). If you feel you qualify for a hardship exception waiver, submit a letter on practice letterhead and financial statements requesting a waiver in lieu of the enrollment fee, along with your application or certification statement. Revalidations are processed only when application fees have cleared or the hardship exception waiver has been granted. You will be notified by mail if your hardship exception waiver request has been granted or if a fee is required. More information on who is subject to an enrollment fee can be found at https://www.cms.gov/MedicareProviderSupEnroll/Downloads/ApplicationFeeRequirementMatrix.pdf.

For more information on application fees and other screening requirements under the Patient Protection and Affordable Care Act (PPACA), view the MLN Matters Article at http://www.cms.gov/MLNMattersArticles/downloads/MM7350.pdf.

Physicians, non-physician practitioners, and physician and non-physician practitioner organizations must report a change of ownership, any adverse legal action, or a change of practice location to the MAC within 30 days. All other changes must be reported within 90 days. For most but not all other providers and suppliers, changes of ownership or control (including changes in authorized official(s)) must be reported within 30 days; all other changes to enrollment information must be made within 90 days.

Failure to submit complete enrollment application(s) and all supporting documentation within 60 calendar days of the postmark date of this letter may result in your Medicare billing privileges being deactivated. We strongly recommend you mail your documents using a method that allows for proof of receipt.

If you have any questions regarding this letter, please call [insert contractor telephone number] between the hours of [insert contractor telephone hours] or visit our website at [insert website] for additional information regarding the enrollment process or the [insert application type].

Sincerely,

[Your Name]
[Title]

15.24.5.1 – Model Revalidation Letter – CHOW Scenario Only

(Rev.578, Issued: 02-25-15, Effective: 05-15-15, Implementation; 05-15-15)

[Month Day & Year]

PROVIDER/SUPPLIER NAME
ADDRESS 1, ADDRESS 2
CITY STATE ZIP CODE

NPI:
PTAN:

Dear Provider/Supplier Name:

THIS IS A PROSPECTIVE PROVIDER ENROLLMENT REVALIDATION REQUEST

***IMMEDIATELY** SUBMIT AN UPDATED*
PROVIDER ENROLLMENT PAPER APPLICATION 855 FORM TO VALIDATE YOUR ENROLLMENT INFORMATION

In accordance with Section 6401 (a) of the Patient Protection and Affordable Care Act, all new and existing providers must be reevaluated under the new screening guidelines. Medicare requires all enrolled providers and suppliers to revalidate their enrollment information every five years (reference 42 CFR § 424.515). To ensure compliance with these requirements, existing regulations at 42 CFR § 424.515(d) provide that the Centers for Medicare & Medicaid Services (CMS) is permitted to conduct off-cycle revalidations for certain program integrity purposes. Upon the CMS request to revalidate its enrollment, the provider/supplier has 60 days from the post mark date of this letter to submit complete enrollment information.

You previously submitted a change of ownership (CHOW) application that is currently being reviewed by the CMS Regional Office (RO) and the State Agency. Since your application has not been finalized, please validate that we have the most current information on file. Any updated information received since your initial submission will be forwarded to the CMS RO and the State Agency for their final determination.

Providers and suppliers can validate their provider enrollment information using the paper application form. To validate by paper, download the appropriate and current CMS-855 Medicare Enrollment application from the CMS Web site at https://www.cms.gov/MedicareProviderSupEnroll/ . Mail your completed application and all required supporting documentation to the [insert contractor name], at the address below.

[Insert application return address]

A new Electronic Funds Transfer (EFT) Authorization Form (CMS-588) is only required to be submitted as part of your revalidation package if the current version or later, approved by the Office of Management and Budget (OMB) on 09/2013, is not on file with Medicare. The current version of the form can be found at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS588.pdf.

If additional time is required to complete the validation applications, you may request one 60-day extension, which will be added onto the initial 60 days given to respond to the request. The request may be submitted in writing from the individual provider, the Authorized or Delegated Official of the organization or the contact person and addressed to the MAC(s). The request should include justification of why a 60-day extension is needed. The request may also be made by contacting your MAC(s), via phone.

Physicians, non-physician practitioners and physician and non-physician practitioner organizations must report a change of ownership, any adverse legal action, or a change of practice location to the MAC within 30 days. All other changes must be reported within 90 days. For most but not all other providers and suppliers, changes of ownership or control, including changes in authorized official(s) must be reported within 30 days; all other changes to enrollment information must be made within 90 days.

Failure to submit complete enrollment application(s) and all supporting documentation within 60 calendar days of the postmark date of this letter may result in your Medicare billing privileges being deactivated and your CHOW not being processed. We strongly recommend you mail your documents using a method that allows for proof of receipt.

If you have any questions regarding this letter, please call [contractor telephone number will be inserted here] between the hours of [contractor telephone hours will be inserted here] or visit our Web site at [insert Web site] for additional information regarding the enrollment process or the [insert application type].

Sincerely,
[Your Name]
[Title]

15.24.5.2 – Model Large Group Revalidation Notification Letter

(Rev.578, Issued: 02-25-15, Effective: 05-15-15, Implementation; 05-15-15)

[Month Day & Year]

PROVIDER/SUPPLIER GROUP NAME
ADDRESS 1, ADDRESS 2
CITY STATE ZIP CODE

NPI:
PTAN:

Dear Provider/Supplier Group Name:

*THIS IS **NOT** A PROVIDER ENROLLMENT REVALIDATION REQUEST*

This is to inform you that a number of physicians and/or non-physician practitioners reassigning all or some of their benefits to your group have been selected for revalidation. For your convenience, a list of those individuals is attached. A revalidation notice will be sent to the physician or non-physician practitioner within 60 days. He or she will have 60 days from the post mark date of the letter to revalidate his or her enrollment information. It is the responsibility of the physician or non-physician practitioner to revalidate

all of his or her Medicare enrollment information and not simply that associated with the reassignment to your group practice.

In accordance with Section 6401 (a) of the Patient Protection and Affordable Care Act, all new and existing providers must be reevaluated under the new screening guidelines. Medicare requires all enrolled providers and suppliers to revalidate their enrollment information every five years (reference 42 CFR § 424.515). To ensure compliance with these requirements, existing regulations at 42 CFR § 424.515(d) provide that the Centers for Medicare & Medicaid Services (CMS) is permitted to conduct off-cycle revalidations for certain program integrity purposes.

Physicians and non-physician practitioners can revalidate by using either Internet-based PECOS or submitting a paper CMS-855 enrollment application. Failure to submit a complete revalidation application and all supporting documentation within 60 calendar days may result in the physician or non-physician practitioner's Medicare billing privileges being deactivated. As such, your group will no longer be reimbursed for services rendered by the physician or non-physician practitioner.

If you have any questions regarding this letter, please call [contractor telephone number will be inserted here] between the hours of [contractor telephone hours will be inserted here] or visit our Web site at [insert Web site] for additional information regarding the revalidation process.

Sincerely,

[Your Name]
[Title]

15.24.5.3 – Model Revalidation Pend Letter

(Rev.578, Issued: 02-25-15, Effective: 05-15-15, Implementation; 05-15-15)

[Month Day & Year]

PROVIDER/SUPPLIER NAME
ADDRESS 1, ADDRESS 2
CITY STATE ZIP CODE

NPI:
PTAN:

Dear Provider/Supplier Name:

TERMINATION OF PAYMENTS NOTICE.
*IN ORDER TO RESUME PAYMENTS, **IMMEDIATELY** SUBMIT AN UPDATED PROVIDER ENROLLMENT PAPER APPLICATION CMS-855 FORM OR REVIEW, UPDATE AND CERTIFY YOUR INFORMATION VIA THE INTERNET-BASED PECOS SYSTEM*

This is to inform you that all claims associated with your Medicare Provider Transaction Access Number (PTAN) [insert PTAN] have been placed in a Pend status effective [insert effective date of Pend], due to the failure to respond to a revalidation request mailed on [insert revalidation request date]. As a result, you will not receive any paper checks, Standard Remittance Advices (SPRs), or Electronic Funds Transfers (EFT). The Centers for Medicare & Medicaid Services (CMS) has the authority to perform off-cycle revalidations consistent with Medicare regulations found at 42 CFR § 424.515.

To resolve this issue and to continue to bill the Medicare program for services furnished to Medicare beneficiaries, you must complete and submit a Medicare enrollment application. Failure to submit this information could result in the deactivation of your Medicare billing privileges. Providers and suppliers can revalidate their provider enrollment in the Medicare program using either the:

(1) Internet-based Provider Enrollment, Chain, and Ownership System (PECOS)

To revalidate via the Internet-based PECOS, go to https://pecos.cms.hhs.gov. The system allows you to review information currently on file, upload any supporting documentation, and electronically sign and submit your revalidation application. If you choose not to electronically sign your application, remember to print, sign, date, and mail the certification statement along with all required supporting documentation to your Medicare contractor. To process the revalidation, the original signature and documentation must be received within 15 days of the application internet submission date.

You must have an active National Provider Identifier (NPI) and a web user account (User ID/Password) established in the Identity and Access Management System (I&A) (https://nppes.cms.hhs.gov/IAWeb/login.do). Physicians and non-physician practitioners will access Internet-based PECOS with the same User ID and password that they use for NPPES.

For provider/supplier organizations that would like an individual(s) (Authorized Official, surrogate) to use Internet-based PECOS on their behalf, an account must be established in the I&A system. If you have not registered, do so now by going to https://pecos.cms.hhs.gov and clicking on "Register for a user account" under the "Become A Registered User" section.

To avoid any registration issues, review the I&A related documents available on the I&A homepage at https://nppes.cms.hhs.gov/IAWeb/login.do.

(2) Paper Application Form

To revalidate by paper, download the appropriate and current CMS-855 Medicare Enrollment application from the CMS Web site at https://www.cms.gov/MedicareProviderSupEnroll/. Mail your completed application and all required supporting documentation to the [insert contractor name], at the address below.

[Insert application return address]

A new Electronic Funds Transfer (EFT) Authorization Form (CMS-588) is only required to be submitted as part of your revalidation package if the current version or later, approved by the Office of Management and Budget (OMB) on 09/2013, is not on file with Medicare. The current version of the form can be found at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS588.pdf.

If additional time is required to complete the revalidation application, you may request one 60-day extension, which will be added onto the initial 60 days given to respond to the request. The request may be submitted in writing from the individual provider, the Authorized or Delegated Official of the organization or the contact person, and should be addressed to the MAC(s). The request should include justification of why a 60-day extension is needed. The request may also be made by contacting your MAC(s), via phone.

With the exception of physicians, non-physicians practitioners, physician group practices, and non-physician practitioner group practices, all other revalidating providers and suppliers that submit enrollment applications using the CMS-855A, CMS-855B (not including physician and non-physician practitioner organizations) or the CMS-855S or associated Internet-based PECOS enrollment application must submit with their application a confirmation that the application fee was paid or a request for a hardship exception. (Note: Physicians that are DMEPOS suppliers are subject to the fee for the DMEPOS enrollment). Application fees must be submitted via PECOS at https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do,

which will allow payment of the fee by electronic check, debit, or credit card prior to submitting the application (reference 42 CFR 424.514). If you believe you qualify for a hardship exception waiver, submit a letter on practice letterhead and financial statements requesting a waiver in lieu of the enrollment fee, along with your application or certification statement. Revalidations are processed only when application fees have cleared or the hardship exception waiver has been granted. You will be notified by mail if your hardship exception waiver request has been granted or if a fee is required. More information on who is subject to an enrollment fee can be found at https://www.cms.gov/MedicareProviderSupEnroll/Downloads/ApplicationFeeRequirementMatrix.pdf. For more information on the application fees and other screening requirements under the Patient Protection and Affordable Care Act (PPACA) view the MLN Matters Article at http://www.cms.gov/MLNMattersArticles/downloads/MM7350.pdf.

Physicians, non-physician practitioners, and physician and non-physician practitioner organizations must report a change of ownership, any adverse legal action, or a change of practice location to the MAC within 30 days. All other changes must be reported within 90 days. For most but not all other providers and suppliers, changes of ownership or control (including changes in authorized official(s)) must be reported within 30 days; all other changes to enrollment information must be made within 90 days.

The Pend status is considered an administrative function to protect against the misuse of your billing number and to protect the Medicare Trust Funds from unnecessary overpayments. This action does not have any effect on your participation agreement and/or any conditions of participation. Failure to submit complete enrollment application(s) and all supporting documentation may result in your Medicare billing privileges being deactivated. We strongly recommend you mail your documents using a method that allows for proof of receipt.

If you have any questions regarding this letter, please call [contractor telephone number will be inserted here] between the hours of [contractor telephone hours will be inserted here] or visit our Web site at [insert Web site] for additional information regarding the enrollment process or the [insert application type].

Sincerely,

[Your Name]
[Title]

15.24.5.4 – Model Revalidation Deactivation Letter

(Rev.578, Issued: 02-25-15, Effective: 05-15-15, Implementation; 05-15-15)

[Month Day & Year]

PROVIDER/SUPPLIER NAME *NPI:*
ADDRESS 1, ADDRESS 2 *PTAN:*
CITY STATE ZIP CODE

Dear Provider/Supplier Name:

NOTICE OF DEACTIVATION OF MEDICARE BILLING PRIVILEGES.

*IN ORDER TO RESUME BILLING, **IMMEDIATELY** SUBMIT AN UPDATED PROVIDER ENROLLMENT PAPER APPLICATION CMS-855 FORM OR REVIEW, UPDATE AND CERTIFY YOUR INFORMATION VIA THE INTERNET-BASED PECOS SYSTEM*

This is to inform you that your Medicare Provider Transaction Access Number (PTAN) [insert PTAN] that is associated to the National Provider Identifier (NPI) [insert NPI] has been deactivated effective [insert effective date of deactivation] due to the failure to respond to a revalidation request mailed on [insert revalidation request date]. The Centers for Medicare & Medicaid Services (CMS) has the authority to perform off-cycle revalidations consistent with Medicare regulations found at 42 CFR § 424.515 and 42 CFR § 424.57.

To reactivate your Medicare billing privileges and to bill the Medicare program for services furnished to Medicare beneficiaries, you must complete and submit a Medicare enrollment application. Providers and suppliers must meet all current Medicare requirements in place at the time of reactivation. Providers and suppliers can reactivate using the following options:

(1) Internet-based Provider Enrollment, Chain and Ownership System (PECOS).

To revalidate via the Internet-based PECOS, go to https://pecos.cms.hhs.gov. The system allows you to review information currently on file, upload any supporting documentation, and electronically sign and submit your revalidation application. If you choose not to electronically sign your application, remember to print, sign, date, and mail the certification statement along with all required supporting documentation to your Medicare contractor. To process the revalidation, the original signature and documentation must be received within 15 days of the application internet submission date.

You must have an active National Provider Identifier (NPI) and a web user account (User ID/Password) established in the Identity and Access Management System (I&A) (https://nppes.cms.hhs.gov/IAWeb/login.do). Physicians and non-physician practitioners will access Internet-based PECOS with the same User ID and password that they use for NPPES.

For provider/supplier organizations that would like an individual(s) (Authorized Official, surrogate) to use Internet-based PECOS on their behalf, an account must be established in the I&A system. If you have not registered, do so now by going to https://pecos.cms.hhs.gov and clicking on "Register for a user account" under the "Become a Registered User" section.

To avoid any registration issues, review the I&A related documents available on the I&A homepage at https://nppes.cms.hhs.gov/IAWeb/login.do.

(2) Paper Application Form

To revalidate by paper, download the appropriate and current CMS-855 Medicare Enrollment application from the CMS Web site at https://www.cms.gov/MedicareProviderSupEnroll/. Mail your completed application and all required supporting documentation to the [insert contractor name], at the address below.

[Insert application return address]

A new Electronic Funds Transfer (EFT) Authorization Form (CMS-588) is only required to be submitted as part of your revalidation package if the current version or later, approved by the Office of Management and Budget (OMB) on 09/2013, is not on file with Medicare. The current version of the form can be found at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS588.pdf.

With the exception of physicians, non-physicians practitioners, physician group practices, and non-physician practitioner group practices, all revalidating providers and suppliers that submit enrollment applications using the CMS-855A, CMS-855B (not including physician and non-physician practitioner organizations) or the CMS-855S or associated Internet-based PECOS enrollment application must submit with their application a confirmation that the application fee was paid or a request for a hardship exception. (Note: Physicians who are DMEPOS suppliers are subject to the fee for the DMEPOS enrollment). Application fees must be submitted via PECOS https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do,

which will allow payment of the fee by electronic check, debit, or credit card prior to submitting the application (reference 42 CFR § 424.514)). If you believe that you qualify for a hardship exception waiver, submit a letter on practice letterhead and financial statements requesting a waiver in lieu of the enrollment fee, along with your application or certification statement. Revalidations are processed only when application fees have cleared or the hardship exception waiver has been granted. You will be notified by mail if your hardship exception waiver request has been granted or if a fee is required. More information on who is subject to an enrollment fee can be found at https://www.cms.gov/MedicareProviderSupEnroll/Downloads/ApplicationFeeRequirementMatrix.pdf.

For more information on the application fees and other screening requirements under the Patient Protection and Affordable Care Act (PPACA), view the MLN Matters Article at http://www.cms.gov/MLNMattersArticles/downloads/MM7350.pdf.

Physicians, non-physician practitioners, and physician and non-physician practitioner organizations must report a change of ownership, any adverse legal action, or a change of practice location to the MAC within 30 days. All other changes must be reported within 90 days. For most, but not all other providers and suppliers, changes of ownership or control (including changes in authorized official(s)) must be reported within 30 days; all other changes to enrollment information must be made within 90 days.

The deactivation of Medicare billing privileges is considered an action to protect from the misuse of your billing number and to protect the Medicare Trust Funds from unnecessary overpayments. This deactivation does not have any effect on your participation agreement and/or any conditions of participation.

If you have any questions regarding this letter, please call [contractor telephone number will be inserted here] between the hours of [contractor telephone hours will be inserted here] or visit our Web site at [insert Web site] for additional information regarding the enrollment process or the [insert application type].

Sincerely,

[Your Name]
[Title]

15.24.7 – Approval Letter Guidance

(Rev.578, Issued: 02-25-15, Effective: 05-15-15, Implementation; 05-15-15)

The contractor may mail, e-mail, or fax the approval letter to the provider or supplier. If the fax or e-mail is not received by the provider or supplier, a letter shall be mailed.

- Depending on the type of approval, one of the following shall be selected for insertion in the first sentence:

[Initial Medicare enrollment application]
[Revalidated Medicare enrollment application]
[Change of information request]
[Add/Terminate a Reassignment of Benefits request]

- If provider/supplier is NOT exclusively ordering or certifying, REMOVE the following sentence:

  This application is for the sole purpose of ordering or certifying items or services for Medicare beneficiaries to other providers and suppliers.

- Ordering or Certifying Providers

  The last two sentences of the 1st paragraph shall be the following:

  Listed below is your National Provider Identifier (NPI). To start billing, you must use your NPI on all Medicare claim submissions.

  REMOVE paragraph 2 and paragraph 3, which refer to PTAN usage.

  If provider/supplier IS exclusively ordering or certifying, REMOVE the following three fields:

  Practice location: [Address]
  Provider Transaction Access Number (PTAN): [PTAN]
  You are a: [participating]/[non-participating]

  The effective date field shall remain in the letter and reflect the date on which the contractor received the signed paper CMS-855O form or the Web-based certification statement/e-signature.

  Effective date: [Effective date or Termination date of Ordering or Certifying Status]

- Revalidated and Change of Ownership (CHOW) Approvals

  For revalidated and Change of Ownership (CHOW) approvals, paragraphs #2 and #3 of the letter are optional.

  - If letter is NOT approving a Change of Ownership (CHOW), REMOVE the following field:

  Medicare Year End Cost Report Date: [Date]

  - On the effective date field, if voluntarily terminating Medicare participation, insert "of termination" after "Effective date"

- Physicians, certain non-physician practitioners, and physician and non-physician practitioner organizations may appeal their effective date made by the contractor (JSM/TDL-11023)

- Supply additional "Medicare Enrollment Information" for each additional location and NPI/PTAN combination) only when approving an Initial or Revalidation application. If multiple locations and NPI/PTAN combinations exist, a separate document identifying this information shall be attached to the approval letter.

- Changes of information submitted to report a change to a data element other than those listed as one

of the predefined elements, shall be added to the predefined list under the Medicare Enrollment Information section to acknowledge the change has been incorporated.

- The 2nd,3rd and 4th paragraphs may be edited or deleted in appropriate circumstances:

  To start billing, you must use your NPI on all Medicare claim submissions. Because the PTAN is not considered a Medicare legacy identifier, do not report it as an "other" provider identification number to the National Plan and Provider Enumeration System (NPPES).

  Your PTAN has been activated and will be the required authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system. The IVR allows you to inquire about claims status, beneficiary eligibility and transaction information.

  If you plan to file claims electronically, please contact our EDI department at [phone number].

- Under "Medicare Enrollment Information, for group member enrollment, the following fields may be added:

  Group National Provider Identifier (NPI): [NPI]
  Group Provider Transaction Access Number (PTAN): [PTAN]

15.24.8.6 – Denial Example #6 – Existing or Delinquent Overpayments

(Rev.578, Issued: 02-25-15, Effective: 05-15-15, Implementation; 05-15-15)

June 5, 2012

Xantippe Jones, LMFT
7824 Freudian Way
Yakima, WA 94054

Dear Mr. Jones:

Your application to enroll in Medicare is denied for the following reason(s):

Denial Reason 6 (42 CFR § 424.530(a)(6))

The current owner (as defined in § 424.502), physician or non-physician practitioner has an existing overpayment at the time of filing an enrollment application.

Dates (entered date of existing or delinquent overpayment period)

Pertinent details of action(s) (Whether the person or entity is on a Medicare-approved plan of repayment or payments are currently being offset; whether the overpayment is currently being appealed; the reason for the overpayment.)

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. The reconsideration request must be signed by the authorized or delegated official within the entity. CAP requests should be sent to:

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

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

The reconsideration request should be sent to:

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

If you have any questions, please contact our office at 601-555-1234 between the hours of 9:00 AM and 5:00 PM.

Sincerely,

Crispin Bacon
Provider Enrollment Analyst
Medicare Administrative Contractor, Inc.

15.24.9 – Revocation Letter Guidance

(Rev.578, Issued: 02-25-15, Effective: 05-15-15, Implementation; 05-15-15)

The contractor:

- *M*ust submit one or more of the 12 Primary Revocation Reasons as found in *section 15.27.2* into the appropriate section on the specific Revocation Letter. Only the CFR citation and a short heading shall be cited for the primary revocation reason.

- *Shall include* a Specific Revocation Reason, as appropriate. The Specific Revocation Reason should state sufficient details so it is clear as to why the provider or supplier is being denied.

15.29 - Provider and Supplier Revalidations

(Rev.578, Issued: 02-25-15, Effective: 05-15-15, Implementation; 05-15-15)

The contractor shall follow *the guidance provided in sections 15.29.1 through 15.29.10 when* processing revalidation applications, *unless indicated otherwise in another CMS directive. Also, this guidance takes precedence over all others instructions in this chapter 15 with respect to revalidation processing unless, again, another CMS directive specifies otherwise.*

Consistent with section 6401(a) of the Patient Protection and the Affordable Care Act (ACA), all existing providers and suppliers are required to revalidate their enrollment information under new enrollment screening criteria. Providers and suppliers are normally required to revalidate their Medicare enrollment every 5 years (every 3 years for suppliers of Durable Medical Equipment, Prosthetics Orthotics and Supplies (DMEPOS)). However, CMS reserves the right to perform off-cycle revalidations as deemed necessary.

15.29.1 – Revalidation Lists

(Rev.578, Issued: 02-25-15, Effective: 05-15-15, Implementation; 05-15-15)

CMS will identify the providers and suppliers required to revalidate during each cycle (List 1). CMS will communicate when new lists become available through the appropriate channels, at which time the contractor shall obtain the list from the CGI Share Point Ensemble website. This list will also be made available on CMS.gov so that providers and suppliers are aware of who has been selected to revalidate and should be expecting a revalidation notice from their contractor, as well as who has been sent a revalidation notice. The list is informational only, and providers and suppliers shall not take any action to revalidate until asked by their contractor to do so.
CMS will also provide contractors with an additional list (List 2) consisting of large groups (200+ members) accepting reassigned benefits from individual providers identified on the CMS List 1. Large groups will receive a letter from their contractor informing them that providers linked to their group have been selected to revalidate. A spreadsheet detailing the applicable provider's Name, National Provider Identifier (NPI) and Specialty will also be provided. The letter and spreadsheet will be mailed to the group's correspondence address within 15 days of the contractor receiving the CMS list. This is informational only; groups should not take any action to revalidate their providers until asked by their contractor to do so.

Groups with less than 200 reassignments will not receive a letter or spreadsheet from their MAC, but can utilize Internet-based PECOS or the CMS list available on CMS.gov to determine if their providers have been mailed a revalidation notice.

15.29.2 –Mailing Revalidation Letters

(Rev.578, Issued: 02-25-15, Effective: 05-15-15, Implementation; 05-15-15)

The contractor shall mail and complete revalidations per enrollment record. Revalidations shall not be completed by National Provider Identifiers (NPIs) or Provider Transaction Access Numbers (PTANs).

When applicable, within 15 days of receiving the CMS list (List 2), the contractor shall mail or email a notification letter to the authorized/delegated official or the enrollment contact to notify them that providers within their group will be receiving a request to revalidate in the next 60 days. The contractor shall include with the notification letter the spreadsheet identifying the individual providers that will be revalidated. The contractor shall designate an enrollment analyst for each of the large groups to coordinate revalidation activities. The designated enrollment analyst shall be identified on the group notification letter and shall work directly with the group's enrollment contact person or the authorized/delegated official on file.

Within 60 days of receiving the list from CMS, the contractor shall mail a revalidation letter to the providers and suppliers identified on the list in a colored envelope (preferably yellow) to distinguish the notice from other correspondence. The contractor may stagger the mailings however it sees fit to meet the 60-day timeframe.

The contractor shall issue one letter and reference all associated Provider Transaction Access Numbers (PTANs). A sample revalidation letter can be found in section 15.24.5 of this chapter. The contractor shall send the letter to the provider or supplier's special payment address and correspondence address. If the special payment and correspondence address are the same, the second letter shall be sent to the primary practice location. If only one address is available, the contractor shall only send one letter. Two letters shall not be sent to the same address.

For "individual group member only" providers with one or more reassignments, the contractor shall send the revalidation letter to the provider's correspondence address and to a special payment address of one of the groups to which they reassign. Contractor discretion shall be used in determining which group address shall be utilized. If a provider has completed a new reassignment and that PTAN is not on the CMS revalidation mailing list but is attached to the enrollment record being revalidated, the contractor shall not include that PTAN on the revalidation request or develop for the new reassignment/new PTAN as part of the revalidation.

If one of the locations is found to be incorrect or the letter gets returned as undeliverable, the contractor shall re-send the returned letter to an address not used for the initial mailing. If it is determined that all locations are the same and the contractor has exhausted all reasonable means of contacting the provider/supplier, the contractor shall deactivate the provider/supplier's enrollment in either MCS/FISS or PECOS, whenever possible.

15.29.3 – Non-Response to Revalidation Actions

(Rev.578, Issued: 02-25-15, Effective: 05-15-15, Implementation; 05-15-15)

15.29.3.1 – Phone Calls

(Rev.578, Issued: 02-25-15, Effective: 05-15-15, Implementation; 05-15-15)

Providers and suppliers shall be given 60 days from the date of the revalidation letter to submit their revalidation application. If a revalidation application is not received, the contractor shall contact the provider or supplier via telephone regarding the revalidation request between days 60-70 or days 71-80 (DMEPOS suppliers only) of mailing the revalidation notice. The contractor may place calls prior to the timeframes outlined if the current timeframes fall on a weekend or holiday. The contractor may begin telephone or email contacts to providers/suppliers to communicate non-receipt of the revalidation application earlier if it chooses, so long as the provider/supplier has been contacted by days 60-70.

The contractor shall use the telephone number linked to the correspondence or practice location address listed in PECOS or another telephone number on file, if available. A minimum of two attempts to contact the provider or supplier telephonically shall be made, unless the first attempt reveals that the telephone number is no longer in service. If no valid telephone numbers can be found during the first attempt, only one telephone attempt is required.

Telephone attempts should generally be made between the hours of 8:00 am and 6:00 pm of the provider's or supplier's time zone. Busy signals shall not be considered a successful attempt. Leaving voicemails is acceptable so long as a name and phone number is left for the provider or supplier to contact someone directly at the contractor site. Consistent with section 15.7.3 of this chapter, all telephone contacts shall be documented with the date and time of each call and noted in the provider's or supplier's file.

15.29.3.2 – Pend Status

(Rev.578, Issued: 02-25-15, Effective: 05-15-15, Implementation; 05-15-15)

If a revalidation application has not been received by days 71–75 of mailing the revalidation notice, the contractor shall place the provider or supplier in a pend status; this will hold all paper checks, Standard Remittance Advices (SPRs), and Electronic Funds Transfers (EFT) from being issued. This administrative action shall be applied in PECOS using instructions outlined in other CMS directives. The contractor shall not directly apply this action in the shared systems. The contractor shall communicate the purpose of the pend status to the individual provider, contact person, or authorized or delegated official of the organization via telephone or letter; the contractor shall use its own discretion in determining the best method.

If the method used to communicate the pend status is via telephone, the contractor should forgo sending the pend letter. The contractor shall use the telephone number linked to the correspondence or practice location address listed in PECOS or another phone number on file, if available. Leaving a voicemail to communicate the pend status is not acceptable. A minimum of two attempts shall be made to contact the provider or supplier telephonically before a letter is issued.

If the letter option is used, the contractor shall use the sample letter found in section 15.24.5.3 of this chapter. The letter shall be mailed to the provider's or supplier's special payment and correspondence addresses. If the correspondence address is not available, the physical practice address shall be used.

"Individual group member only" providers who reassign any of their benefits to one or more groups shall not be placed in a pend status. Instead, they shall be deactivated during this period if no response is received. This action shall not affect the group's PTANs but only the reassignment arrangement between the group and the deactivated group member.

15.29.3.3 – Deactivation Actions

(Rev.578, Issued: 02-25-15, Effective: 05-15-15, Implementation; 05-15-15)

If a revalidation application has not been received by days 120 – 125 of sending the revalidation notice, the contractor shall end-date the pend status and deactivate the provider's or supplier's enrollment record (including all associated PTANs) in PECOS. The contractor shall not revoke a provider/supplier for failing to respond to a revalidation requested unless directed otherwise by CMS.

The contractor shall establish the effective date of deactivation as the same date the action is being taken. When deactivating a group with group members, the contractor shall end-date all group member PTANs linked to that group. The deactivation of the entire enrollment record shall only occur if a response has not been received for any of the provider's or supplier's PTANs.

The contractor shall utilize the sample letter found in section 15.24.5.4 of this chapter to communicate the deactivation action. The letter shall be mailed to the provider's or supplier's special payment or correspondence address within 5 business days of the deactivation action.

If an individual provider is deactivated for failure to respond to a revalidation request, the contractor shall search the provider's associate record to determine if the provider is identified as a supervising physician on any independent diagnostic testing facility (IDTF) enrollments. If so, the provider shall be disassociated as the supervising physician for that entity. If the deactivated provider is the only supervising physician on file for the IDTF, the contractor shall develop for an active supervising physician to bring the IDTF into compliance. The contractor shall give the IDTF 30 days to respond. Failure to provide an active supervising physician in the designated timeframe shall result in revocation of the IDTF's billing privileges for non-compliance with the IDTF standards.

15.29.4 - Receipt of Revalidation Application

(Rev.578, Issued: 02-25-15, Effective: 05-15-15, Implementation; 05-15-15)

The contractor shall not return a revalidation application received by a provider or supplier on the CMS revalidation list unless it falls within one of the categories identified in section 15.8.1 of this chapter. The contractor shall also accept and process unsolicited revalidation submissions with an accompanying application fee or hardship request, if applicable.

The contractor may only accept revalidation applications signed by the individual provider or the authorized official (AO) or delegated official (DO) of the provider/supplier organization.

If a provider/supplier wishes to voluntary withdrawal from Medicare (including deactivating all active PTANs), the contractor shall accept this request via phone, U.S. mail or fax from the individual provider or the AO/DO (on letterhead); the contractor shall not require the provider/supplier to complete a CMS-855 application. If the request is made via telephone, the contractor shall document the telephone conversation (in accordance with section 15.7.3 of this chapter) and take the appropriate action in PECOS.

15.29.4.1 – Revalidation Received and Development Required

(Rev.578, Issued: 02-25-15, Effective: 05-15-15, Implementation; 05-15-15)

If the revalidation application is received but requires development (i.e., missing information such as application fee, hardship request, PTANs, documentation, signature), the contractor shall notify the provider or supplier via mail, phone, fax or email. Providers and suppliers shall be given 30 days to respond to the contractor's request and may submit the missing information via mail, fax, or e-mail containing scanned documentation (this includes missing signatures and dates).

If licensure and/or educational requirements (i.e., non-physician practitioner's degree or diploma) can be verified online, the contractor shall not require the provider/supplier to submit this documentation. Residency information shall also not be required as part of revalidation. The contractor shall not require further development for data that is missing on the provider/supplier's revalidation application if the information is disclosed (1) elsewhere on the application, or (2) in the supporting documentation submitted with the application with the exception of the following items:

- *Adverse legal action data*
- *Legal business name (LBN)*
- *Tax identification number (TIN)*
- *NPI-legacy number combinations*
- *Supplier/Practitioner type*
- *"Doing business as" name*
- *Effective dates of sale/transfer/consolidation or indication of acceptance of assets/liabilities*

In scenarios where a revalidation response is received for a single PTAN within an enrollment record that has multiple PTANs, the contractor shall develop for the remaining PTANs not accounted for. If no response is received, the contractor shall revalidate the single PTAN and end-date the PTAN(s) within the enrollment record that were not revalidated. (The same would apply if the provider or supplier has five PTANs. To illustrate, a response was received for all five. However, two of the five required development, and a response was not received for those two PTANs. The two PTANs would be end-dated and the remaining three revalidated. In both scenarios, the entire enrollment should not be deactivated; only the non-response PTANs should be end dated and the other PTANs revalidated.)

If the provider/supplier fails to disclose (1) all locations on the application that currently exist on file with Medicare or (2) all PTANs in the claims systems, the contractor shall confirm the missing data with the individual provider, the AO/DO, or the enrollment contact person via telephone or U.S. mail without requesting a newly-signed certification statement and end-date the locations or PTANs, if appropriate. If the

provider/supplier requests to collapse its PTANs as a result of revalidation, the contractor shall process those requests, if appropriate (based on payment localities, etc.).

If the provider or supplier fails to timely respond to the developmental request by days 50-55, the contractor shall place the provider or supplier in a pend status using the instructions outlined in section 15.29.3.2 of this chapter. "Individual group member only" providers who reassign any of their benefits to one or more groups shall not be placed in a pend status. Instead, they shall be deactivated during this period if no response to the develop request is received. This action shall not affect the group's PTANs but only the reassignment arrangement between the group and the deactivated group member.

If, after 60 days from applying the pend flag, the provider or supplier still has not responded to the development request, the contractor shall deactivate the provider's or supplier's enrollment record (including all associated PTANs). The contractor shall establish the effective date of deactivation as the same date the action is being taken. When deactivating a group with group members, the contractor shall end-date all group member PTANs linked to that group. The deactivation of the entire enrollment record shall only occur if a response has not been received for any of the provider's or supplier's PTANs.

15.29.4.2 – Revalidation Received after a Pend is Applied

(Rev.578, Issued: 02-25-15, Effective: 05-15-15, Implementation; 05-15-15)

The contractor shall remove the pend within 15-20 business days of receiving the revalidation application, even though the submitted application has not been processed to completion. This will release all held paper checks, SPRs, and EFT payments.

The contractor shall process the revalidation application using current processing instructions and mail a decision letter to the provider or supplier to notify it that the revalidation application has been processed.

15.29.4.3 – Revalidation Received After a Deactivation Occurs

(Rev.578, Issued: 02-25-15, Effective: 05-15-15, Implementation; 05-15-15)

If the deactivation resulted from the provider's or supplier's failure to respond to a development request, the contractor shall allow the provider or supplier to only submit the missing information/documentation to revalidate without requiring submission of a new application -- but only if the information is received prior to 120 days after the date of deactivation. The contractor shall re-open and work from the previously submitted application. If the deactivation was a result of the provider or supplier failing to respond at all, it must submit a full application to revalidate.

The contractor shall reactivate the deactivated PTAN(s) within 15-20 days of receiving the revalidation application or missing information, even though the revalidation has not been processed to completion. The PTAN and effective date shall remain the same if the revalidation application was received prior to 120 days after the date of deactivation. If the revalidation is received more than 120 days after deactivation, a new PTAN and effective date shall be issued to the provider or supplier, consistent with the effective date requirements in section 15.17 of this chapter. This requirement also applies to group members.

When revalidating a group that had group members, the contractor shall reactivate only those group members that had active PTANs linked to that group at the time of the deactivation. A new CMS-855 is not required from the group members.

When processing the revalidation application after a deactivation occurs, the contractor shall not:

- *Require any provider/supplier whose PTAN(s) have been deactivated to obtain a new State survey or accreditation as a condition of revalidation*

- *Collect a 2nd application fee if a fee was previously submitted with the initial revalidation application (this only applies to applications submitted within 120 days after the date of deactivation). The contractor shall use instructions outlined in other CMS directives to properly document this information in PECOS.*

After the revalidation application is complete, the contractor shall mail an approval letter to the provider/supplier to notify it that the revalidation was successful and that any previously denied claims due to the deactivation shall be resubmitted.

15.29.4.4 – Change of Information Received After Revalidation Letter Mailed

(Rev.578, Issued: 02-25-15, Effective: 05-15-15, Implementation; 05-15-15)

If a change of information (COI) application is received from the provider/supplier prior to the contractor having mailed the revalidation letter, the contractor shall process the COI as normal and proceed with mailing the revalidation notice.

If the provider/supplier submits an application marked as a revalidation but only includes enough information to be considered a COI, the contractor shall (1) develop for a complete application containing the missing data elements, and (2) treat it as a revalidation.

15.29.5 – Revalidating Providers Involved in a Change of Ownership (CHOW)

(Rev.578, Issued: 02-25-15, Effective: 05-15-15, Implementation; 05-15-15)

The contractor shall require revalidations for providers involved in a CHOW where the RO/State has not made a final determination and the PECOS enrollment record is in an "Approval Pending Regional Office Review" status. If the CHOW was received within 180 days of the contractor having received the CMS list that required the contractor to revalidate the provider, the contractor shall forgo mailing the revalidation request. If the CHOW was received more than 180 days after receiving the CMS list, the contractor shall send the revalidation request to the new owner using the sample revalidation letter in section 15.24.5.1 of this chapter. Upon receipt of the revalidation application, the contractor shall (1) compare the information submitted on the revalidation application against the information in PECOS in "Approval Pending Regional Office Review" status, and (2) send any supplemental/changed information to the RO/State to be considered as part of their final determination. The contractor shall not require an application fee to be submitted with the buyer's revalidation request.

15.29.6 – Extension Requests

(Rev.578, Issued: 02-25-15, Effective: 05-15-15, Implementation; 05-15-15)

If additional time is required to complete the revalidation application, providers and suppliers may request one 60-day extension, which will be added onto the initial 60 days given to respond to the request (e.g., revalidation letter sent on March 1 with a due date of April 30; an extension is granted giving the provider or supplier until June 30 to respond). Extension requests may also be granted to providers and suppliers currently in a pend status. Upon receipt and acceptance of the extension request, the contractor shall remove the pend status in PECOS.

The request may be submitted in writing (fax/email permissible) from the individual provider, the authorized or delegated Official, or the contact person and addressed to the contractor. The request should include justification of why a 60-day extension is needed. The request may also be made by contacting the contractor via telephone.

The contractor shall accept large group (200+ members) extension requests on behalf of individuals reassigned to their group as long as they meet the following requirements:

- *The provider reassigns all benefits to the group requesting the extension, and*
- *The extension is requested by the authorized or delegated Official of the group or the enrollment contact person.*

The group must provide to the contractor the provider's name, National Provider Identifier (NPI) and justification as to why an extension is needed. The extension can be requested in writing (fax/email permissible) or via telephone.

15.29.7 – Large Group Revalidation Coordination

(Rev.578, Issued: 02-25-15, Effective: 05-15-15, Implementation; 05-15-15)

The contractor shall designate an enrollment analyst for each of the large groups to coordinate revalidation activities. The designated enrollment analyst shall be identified on the group notification letter and shall work directly with the group's enrollment contact person or the authorized/delegated official on file. The contractor may also establish a designated enrollment analyst to manage revalidating providers that have multiple PTANs.

The contractor should perform verification of large groups with the contact person listed on the enrollment application.

The contractor shall allow the large groups to deactivate reassignments that are no longer valid through the submission of a spreadsheet. The spreadsheet shall be submitted with a letter on company letterhead and signed by the authorized/delegated official of the organization. This process is only applicable to large groups revalidating their providers.

15.29.8 – Finalizing the Revalidation Application

(Rev.578, Issued: 02-25-15, Effective: 05-15-15, Implementation; 05-15-15)

Prior to processing the revalidation application to completion, the contractor shall ensure that:

- *A site visit (if applicable to the provider/supplier in question) is requested to be conducted by the National Site Visit Contractor (NSVC)*
- *The provider/supplier meets all applicable federal regulatory requirements regarding licensure, certification and/or educational requirements, as listed in the Code of Federal Regulations (CFR) and as described in CMS Publication 100-02 for his or her supplier type.*
- *The most current version or later of the CMS-588 Electronic Funds Transfer (EFT) agreement (approved by the Office of Management and Budget (OMB) on 09/2013) is on file with Medicare. If not on file, the contractor shall develop for it.*
- *The provider/supplier's information is revalidated based on the information in PECOS.*
- *Practice locations continue to be verified; however, there is no need to contact each and every location separately. Verification shall be done with the contact person listed on the application and noted accordingly in the contractor's verification documentation per section 15.7.3 of this chapter.*
- *The appropriate logging & tracking (L&T) record type and finalization status are identified in PECOS.*
- *An enrollment record is not marked as revalidated in PECOS if responses have been received for some PTANs yet not all PTANs have been addressed (meaning that no action has been taken on the non-response PTANs, i.e., end-dated). If all PTANs have been addressed (i.e., revalidated, end-dated), the enrollment can be marked as revalidated.*

- *PECOS and the claims systems remain in sync. The contractor shall not directly update the shared systems without first updating PECOS when processing a revalidation unless instructed otherwise in another CMS directive.*

15.29.9 – Revalidation Reporting

(Rev.578, Issued: 02-25-15, Effective: 05-15-15, Implementation; 05-15-15)

No later than the 5th and the 20th of each month, the contractor shall submit its revalidation report to revalidation@cms.hhs.gov and its Business Function Lead (BFL) identifying the following information for providers/suppliers in its contractor jurisdiction only:

- *Date Revalidation Notice Sent*
- *Revalidation Package Received Date*
- *Revalidation Completed Date*
- *Reactivation Completed Date (if applicable)*

The contractor shall submit this data in the format specified through CMS directives.

15.29.10 - Revalidation Files on CMS.gov

(Rev.578, Issued: 02-25-15, Effective: 05-15-15, Implementation; 05-15-15)

*By visiting **http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html** on the CMS website, providers/suppliers can identify if they should expect to receive a revalidation notice or if a revalidation notice has been mailed. Available in the "Downloads" section is a list of providers and suppliers that have been selected to revalidate and that should be receiving a revalidation notice from their contractor within the next 60 days. This list is updated periodically after new revalidation lists are provided to the contractors. This is informational only' providers and suppliers should not take any action to revalidate until asked by their contractor to do so.*

Also available in the "Downloads" section is a listing of all providers and suppliers that have been mailed a revalidation notice. The files are broken down by the month in which the revalidation request was mailed. CMS will add lists on a bimonthly basis. If a provider/supplier is listed and has not received the revalidation request from its contractor, it should contact its contractor. Contact information for each contractor can be found on that webpage.