CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11637	**Date: October 7, 2022**
	Change Request 12731

SUBJECT: Provider Enrollment Appeals and Rebuttals - Revised Instructions and Model Letters

I. SUMMARY OF CHANGES: The purpose of this CR is to clarify Medicare Administrative Contractor (MAC) procedures for processing provider enrollment appeals and rebuttals. This CR clarifies MAC External Monthly Reporting Requirements for Rebuttals and Appeals. This CR also provides clarifying instruction regarding Model Letters. In addition, this CR creates additional appeals and rebuttal model letters.

EFFECTIVE DATE: December 9, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: December 9, 2022

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	10/10.4/10.4.8/10.4.8.1/Deactivation Rebuttals
R	10/10.6/10.6.19/Other Medicare Contractor Duties
R	10/10.7/10.7.1/Acknowledgement Letters
R	10/10.7/10.7.9/Revocation Letters
R	10/10.7/10.7.12/Deactivation Model Letter
R	10/10.7/10.7.13/Rebuttal Model Letters
R	10/10.7/10.7.14/Model Opt-out Letters
R	10/10.7/10.7.15/Revalidation Notification Letters

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: 11637	Date: October 7, 2022	Change Request: 12731

SUBJECT: Provider Enrollment Appeals and Rebuttals - Revised Instructions and Model Letters

EFFECTIVE DATE: December 9, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: December 9, 2022

I. GENERAL INFORMATION

A. Background: This CR will clarify MAC procedures for processing provider enrollment appeals and rebuttals. This CR clarifies MAC External Monthly Reporting Requirements for Rebuttals and Appeals. This CR also provides clarifying instruction regarding Model Letters. In addition, this CR creates additional appeals and rebuttal model letters.

B. Policy: 42 Code of Federal Regulations (C.F.R.) 424.546, 42 C.F.R. 424.540, 42 C.F.R. 424.535

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12731.1	No later than the 15th of each month the contractors shall send, via email at ProviderEnrollmentAppeals @cms.hhs.gov, a monthly report utilizing the attached reporting template containing all provider enrollment rebuttals received during the previous month, except those referred to CMS for processing, as well as any rebuttals for which a final outcome/decision was not previously reported to CMS.	X	X	X						NSC
12731.1.1	If the 15th day of the month falls on a weekend or a holiday, the contractors shall submit the report on the following business day.	X	X	X						NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12731.1.2	The contractors shall continue reporting submissions on each monthly report until a final outcome/decision has been reported to CMS.	X	X	X						NSC
12731.1.3	The contractors shall utilize the provider enrollment rebuttals reporting template in completing each monthly report.	X	X	X						NSC
12731.1.3.1	The contractors shall complete all columns listed for all rebuttal submissions received and processed by the contractor.	X	X	X						NSC
12731.1.3.2	The contractors shall not leave any column blank (except column K).	X	X	X						NSC
12731.1.3.3	The contractors shall format all dates in the provider enrollment rebuttals reporting template as mm/dd/yyyy (e.g. 10/12/2021).	X	X	X						NSC
12731.1.3.4	The contractors shall contact ProviderEnrollmentAppeals@cms.hhs.gov with any questions concerning how to complete the monthly provider enrollment rebuttals report.	X	X	X						NSC
12731.1.3.5	The contractors shall enter the provider's or supplier's legal business name for the response reported in Column A labeled, "Provider/Supplier Name (As it appears in Provider Enrollment Chain and Ownership System (PECOS))" on the provider enrollment rebuttals reporting template.	X	X	X						NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12731.1.3.5.1	The contractors shall format the provider's or supplier's legal business name exactly as it is formatted in the PECOS enrollment record, including capitalization, abbreviations, and punctuation.	X	X	X						NSC
12731.1.3.6	The contractors shall enter the provider's or supplier's National Provider Identifier (NPI) for the response reported in Column B labeled, "NPI" on the provider enrollment rebuttals reporting template.	X	X	X						NSC
12731.1.3.7	On the provider enrollment rebuttals reporting template the contractors shall enter the provider's or supplier's Enrollment Identification number (EID) from PECOS for the response reported in Column C labeled "EID (if applicable)."	X	X	X						NSC
12731.1.3.7.1	If there is no EID associated with the provider or supplier in PECOS the contractors shall enter the response "N/A" in Column C.	X	X	X						NSC
12731.1.3.8	On the provider enrollment rebuttals reporting template the contractors shall enter the provider's or supplier's Provider Transaction Access Number(s) (PTAN(s)) for the response reported in Column D, "PTAN(s) (if applicable)."	X	X	X						NSC
12731.1.3.8.1	If the provider or supplier has more than one PTAN (e.g. L2988; 190002033), the contractors shall separate multiple PTANs with a semicolon in Column D.	X	X	X						NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12731.1.3.8.2	If the provider or supplier does not have a PTAN, the contractors shall enter the response "N/A" in Column D.	X	X	X						NSC
12731.1.3.9	On the provider enrollment rebuttals reporting template, the contractors shall use one of the following for the response in Column E labeled, "Contractor (including jurisdiction)": • CGS J15 • FCSO JN • NGS J6 • NGS JK • Noridian JE • Noridian JF • Novitas JL • Novitas JH • NPE East • NPE West • NSC • Palmetto JJ • Palmetto JM • WPS J5 • WPS J8	X	X	X						NSC
12731.1.3.9.1	The contractors shall not use any other formats for the response in Column E.	X	X	X						NSC
12731.1.3.10	On the provider enrollment rebuttals reporting template, the contractors shall use one of the following references to Title 42 C.F.R. for the response in Column F labeled, "Regulatory Authority for Deactivation": • 424.540(a)(1) • 424.540(a)(2) • 424.540(a)(3)	X	X	X						NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• 424.540(a)(4) • 424.540(a)(5) • 424.540(a)(6) • 424.540(a)(7) • 424.540(a)(8) • Other (see Comments)									
12731.1.3.10.1	The contractors shall not use any other formats for the response in Column F.	X	X	X						NSC
12731.1.3.10.2	If the contractors enter "Other (see Comments)" in Column F, the contractors shall use Column K to provide explanatory notes (e.g., when a rebuttal is submitted in response to an enrollment action that does not afford rebuttal rights, describe the enrollment action in Column K).	X	X	X						NSC
12731.1.3.11	On the provider enrollment rebuttals reporting template in Column G labeled "Date Rebuttal Received," the contractors shall enter the date on which the rebuttal was received by the contractor.	X	X	X						NSC
12731.1.3.11.1	The contractors shall format the date as mm/dd/yyyy in Column G (e.g., 10/25/2020).	X	X	X						NSC
12731.1.3.12	On the provider enrollment rebuttals reporting template in Column H labeled "Date Receipt Acknowledgment Sent to Provider/Supplier/Legal Representative" the contractors shall enter the date on which the contractor sent a receipt acknowledgment.	X	X	X						NSC

Number	Requirement	Responsibility								
		A/B MAC			D ME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12731.1.3.12.1	If a receipt acknowledgment email/letter has not been sent to the provider/supplier/legal representative at the time the monthly report is sent to CMS the contractors shall enter the response "Not yet sent" in Column H.	X	X	X						NSC
12731.1.3.12.2	The contractors shall format the date as mm/dd/yyyy in Column H (e.g., 10/25/2020).	X	X	X						NSC
12731.1.3.12.3	If a receipt acknowledgement is not required for that case (e.g., rebuttal is dismissed), the contractor shall enter the response "N/A" in Column H.	X	X	X						NSC
12731.1.3.13	On the provider enrollment rebuttals reporting template in Column I labeled "Date Rebuttal Determination Issued" the contractors shall enter the date on which the contractor issued the rebuttal determination.	X	X	X						NSC
12731.1.3.13.1	The contractors shall format the date as mm/dd/yyyy in Column I (e.g., 10/25/2020).	X	X	X						NSC
12731.1.3.13.2	If a final rebuttal determination has not yet been issued, the contractors shall enter "In Process" as the response in Column I.	X	X	X						NSC
12731.1.3.14	On the provider enrollment rebuttals reporting template for the response in Column J labeled "Final Decision Result" the contractors shall enter one of the following: • Not Actionable • Favorable	X	X	X						NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Unfavorable • Dismissed • Withdrawn • In Process									
12731.1.3.14.1	The contractors shall not enter any other response in Column J.	X	X	X						NSC
12731.1.3.14.2	When the rebuttal is no longer actionable (i.e. moot) because the basis for the deactivation has been resolved (e.g. deactivation was rescinded) the contractors shall enter "Not Actionable" for the response in Column J.	X	X	X						NSC
12731.1.3.14.3	When the Contractors determine that an error was made in the implementation of the deactivation, overturned the deactivation, and returned the enrollment record to an approved status, the contractors shall enter "Favorable" for the response in Column J.	X	X	X						NSC
12731.1.3.14.4	When the contractors uphold the initial determination and the enrollment record remains deactivated the contractors shall enter "Unfavorable" for the response in Column J.	X	X	X						NSC
12731.1.3.14.5	When the rebuttal submission does not meet the rebuttal submission requirements (e.g., missing proper signature and provider/supplier/representative did not timely respond to development request) and the contractors have dismissed the rebuttal submission, the	X	X	X						NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	contractors shall enter "Dismissed" for the response in Column J.									
12731.1.3.14.6	When the provider/supplier/representative has properly submitted written notice of their intent to withdraw the rebuttal before the contractor issued a final determination, and the contractors have acknowledged the withdrawal the contractors shall enter "Withdrawn" for the response in Column J.	X	X	X						NSC
12731.1.3.14.7	If the contractors are still processing the submission and a final decision has not yet been issued when the provider enrollment rebuttals report is sent to CMS, the contractors shall enter "In Process" for the response in Column J.	X	X	X						NSC
12731.1.3.14.7.1	If a rebuttal submission is marked as "In Process" the contractors shall continue reporting that submission on the provider enrollment rebuttals report until a Final Determination is issued and reported on the provider enrollment rebuttals report.	X	X	X						NSC
12731.1.3.15	In the provider enrollment rebuttals reporting template for the response in Column K labeled "Comments (can be blank)" the contractors shall enter any applicable information related to the deactivation, rebuttal submission, and/or rebuttal determination that provides context in reporting the rebuttal and outcome to	X	X	X						NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	CMS.									
12731.1.3.15.1	The contractors should leave the response in Column K blank if no additional information is applicable.	X	X	X						NSC
12731.2	The contractors shall issue a withdrawal acknowledgment letter using the applicable rebuttal withdrawn model letter if a provider/supplier/representative submits a proper written request to withdraw its rebuttal submission prior to the issuance of a rebuttal determination.	X	X	X						NSC
12731.2.1	The contractors shall not issue a rebuttal determination for a rebuttal submission if the contractors issue a rebuttal withdrawal acknowledgment letter for that submission.	X	X	X						NSC
12731.3	The contractors shall send an acknowledgment letter within 10 calendar-days of receipt of the accepted rebuttal request using the Rebuttal Acknowledgment Model Letter, including a rebuttal tracking number and the provider's or supplier's NPI.	X	X	X						NSC
12731.3.1	The contractors shall send the rebuttal acknowledgment letter: 1. Via hard-copy mail to the address provided on the rebuttal submission; 2. Via hard-copy mail to the correspondence mailing address in the Medicare enrollment	X	X	X						NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	record (if different from the address on the rebuttal submission); 3. Via email if email address was provided with the rebuttal submission; and 4. Via email if email address is listed in the correspondence mailing address in the Medicare enrollment record (if different from the email address on the rebuttal submission).									
12731.3.2	If a valid fax number is available for the provider/supplier/representative, the contractors should also send the acknowledgment letter via fax.	X	X	X						NSC
12731.3.3	If a rebuttal determination is issued within 10 calendar days of the date of receipt of the rebuttal submission, the contractors should (but are not required to) issue a receipt acknowledgment letter.	X	X	X						NSC
12731.3.4	The contractors shall send (via mail, email and/or fax) all acknowledgment letters on the same day listed on the letter.	X	X	X						NSC
12731.4	If a rebuttal submission is not properly signed and no response is received to the development request within 15 days, the contractors shall dismiss the rebuttal submission using the	X	X	X						NSC

Number	Requirement	Responsibility								
		A/B MAC			D ME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	applicable rebuttal dismissal model letter.									
12731.5	If the submission is untimely and the contractor does not find good cause to waive the timeliness requirement, the contractors shall dismiss the rebuttal submission using the applicable rebuttal dismissal model letter.	X	X	X						NSC
12731.6	If a rebuttal submission either or both of the following: 1. does not specify the facts or issues with which the provider/supplier disagrees and the reasons for disagreement, or 2. does not contain a proper signature then the contractors shall send a development request to the provider/supplier/representative using the appropriate development model letter.	X	X	X						NSC
12731.6.1	If the contractors send a development letter to the provider/supplier/representative, then the contractors shall grant an additional 15 calendar days from the date of the development request letter for the provider/supplier/representative to submit an acceptable rebuttal submission.	X	X	X						NSC
12731.6.2	If a rebuttal submission is still deficient after sending a development request letter and the 15-calendar day time	X	X	X						NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	frame has expired, then the contractors shall dismiss the rebuttal submission.									
12731.6.2.1	The contractors shall dismiss the rebuttal submission using the applicable rebuttal dismissal model letter.	X	X	X						NSC
12731.6.3	The contractors shall send (via mail, email, and/or fax) all development letters on the same day listed on the letter.	X	X	X						NSC
12731.6.4	The contractors shall send the development request letter: 1. Via hard-copy mail to the address provided on the rebuttal submission; 2. Via hard-copy mail to the correspondence mailing address in the Medicare enrollment record (if different from the address on the rebuttal submission); 3. Via email if email address was provided with the rebuttal submission; and 4. Via email if email address is listed in the correspondence mailing address in the Medicare enrollment record (if different from the email address on the rebuttal submission).	X	X	X						NSC
12731.6.5	If fax number is available on the rebuttal submission or in the correspondence mailing address in the Medicare enrollment record, the	X	X	X						NSC

Number	Requirement	Responsibility								
		A/B MAC			D ME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	contractors should send the development request letter via fax.									
12731.6.6	If the Contractor identifies multiple deficiencies in the Rebuttal submission, the Contractor shall develop for all deficiencies in one letter, and grant one 15 calendar day period to respond to all deficiencies. The Contractor shall send the development letter to ProviderEnrollmentAppeals @cms.hhs.gov for approval before sending to the provider/supplier.	X	X	X						NSC
12731.6.7	If a missing signature, attorney statement, appointment of representative, and/or statement of facts/issues with which the provider/supplier disagrees is timely received in response to a development request, then the Contractors shall use the date of receipt of the missing signature, statement, and/or notice as the date of receipt of the rebuttal submission for processing timeliness standards.	X	X	X						NSC
12731.7	The contractors shall dismiss additional rebuttal requests that are submitted for the same deactivated enrollment for which a rebuttal has already been received.	X	X	X						NSC
12731.7.1	Contractors shall not formally “dismiss” duplicate submissions. If the submission is an exact duplicate of a previously accepted submission, the	X	X	X						NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Contractors shall not dismiss the duplicate submission as an "additional" submission.									
12731.8	The contractors shall only accept and process rebuttal submissions that comply with 42 C.F.R. 424.546(b).	X	X	X						NSC
12731.8.1	The contractors shall only accept and process rebuttal submissions that are submitted in writing.	X	X	X						NSC
12731.8.2	The contractors shall only accept and process rebuttal submissions that specify the facts or issues concerning the deactivation with which the provider/supplier disagrees and the reasons for disagreements.	X	X	X						NSC
12731.8.3	The contractors shall only accept and process rebuttal submissions that are submitted in the form of a letter that is properly signed and dated by one of the following: 1. Individual supplier; or 2. An authorized official; or 3. A delegated official; or 4. A legal representative.	X	X	X						NSC
12731.8.3.1	For rebuttals concerning an individual supplier's enrollment, the contractors shall only accept and process rebuttal submissions that are properly signed by the individual supplier or properly appointed legal representative.	X	X	X						NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12731.8.3.2	The contractors shall only accept and process rebuttal submissions that are signed by an individual purporting to be an authorized or delegated official if the individual meets the definition at 42 C.F.R. 424.502.	X	X	X						NSC
12731.8.3.2.1	For rebuttals concerning an individual supplier's enrollment, the contractors shall not accept and process rebuttal submissions that are submitted by the authorized or delegated official of the group to which the individual has reassigned their benefits unless the submission includes a signed statement from the individual supplier authorizing the authorized or delegated official from the group to act on the individual supplier's behalf.	X	X	X						NSC
12731.8.3.3	The contractors shall only accept and process rebuttal submissions that are signed by an individual purporting to be a legal representative, if the individual meets the requirements at 42 C.F.R. 498.10.	X	X	X						NSC
12731.8.3.3.1	The contractors shall accept and process rebuttal submissions that are signed by a legal representative who is an attorney that include a statement that the attorney has the authority to represent the provider/supplier.	X	X	X						NSC
12731.8.3.3.2	The contractors shall only accept and process rebuttal submissions that are signed	X	X	X						NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	by a legal representative who is not an attorney if the submission includes written notice of appointment of a representative.									
12731.8.3.3.2.1	The contractors shall only accept a notice of appointment of a representative that is signed and dated by the individual supplier, an authorized official, a delegated official, or a properly appointed legal representative.	X	X	X						NSC
12731.8.3.3.2.2	The contractors shall accept a fully executed Form CMS-1696 as a written notice of appointment of a representative for the purposes of a rebuttal submission.	X	X	X						NSC
12731.8.3.4	The contractors shall accept both original and electronic signatures for the purposes of rebuttal submissions.	X	X	X						NSC
12731.8.3.4.1	The contractors shall accept digital and electronic signatures such as those created by digital signature options, those created in software such as Adobe, and those in email messages.	X	X	X						NSC
12731.8.3.4.2	The contractors shall contact ProviderEnrollmentAppeals@cms.hhs.gov for questions regarding electronic and digital signatures on rebuttal submissions.	X	X	X						NSC
12731.8.3.5	If the contractor receives a signed rebuttal submission from someone purporting to be an authorized/delegated official but who is not listed	X	X	X						NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	on the Enrollment Record, the contractor shall forward the rebuttal to ProviderEnrollmentAppeals@cms.hhs.gov for instructions on how to proceed.									
12731.8.4	The contractors shall accept and process rebuttal submissions that are received via hard-copy mail, e-mail, and/or fax.	X	X	X						NSC
12731.8.5	The contractor shall only accept and process rebuttal submissions that are received by the contractor within 15 calendar days from the date on the deactivation notice.	X	X	X						NSC
12731.8.5.1	The contractors should make a good cause determination whether to accept any rebuttal that has been submitted beyond the 15 calendar day filing time frame with written CMS approval.	X	X	X						NSC
12731.8.5.1.1	The contractors should find good cause to accept an untimely rebuttal submission when there are circumstances beyond the provider's or supplier's control that prevented the timely submission of a rebuttal.	X	X	X						NSC
12731.8.5.1.1.1	The contractors shall not find good cause when the delay in submission is due to the provider's or supplier's failure to timely update the correspondence mailing address or other addresses included in the Medicare enrollment record or application, resulting in a	X	X	X						NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	delayed receipt of the deactivation notice.									
12731.8.5.1.2	The contractors shall send a request approval email to ProviderEnrollmentAppeals@cms.hhs.gov within five days of making the good cause determination if the contractor believes good cause exists to accept an untimely rebuttal submission.	X	X	X						NSC
12731.8.5.1.2.1	The contractors shall detail their reasoning for finding good cause in the request approval email.	X	X	X						NSC
12731.8.5.1.2.2	The contractors shall begin its processing timeliness calculation on the date the contractor receives a response from CMS to the request approval email.	X	X	X						NSC
12731.8.5.2	If the 15th calendar day from the date on the deactivation notice falls on a weekend or a federally-recognized holiday and the contractors receive a rebuttal submission on the next business day, the contractors shall accept the rebuttal submission as timely.	X	X	X						NSC
12731.9	When reviewing a rebuttal submission, the contractors shall only review whether the provider/supplier met the enrollment requirements and if billing privileges were deactivated appropriately.	X	X	X						NSC
12731.10	For deactivations under 42 C.F.R. 424.540(a)(2), the contractors shall review the submitted documentation and internal records to determine whether the change of	X	X	X						NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	information was properly submitted within the required time frame.									
12731.10.1	The contractors shall review whether the change of information was timely submitted pursuant to 42 C.F.R. 424.550, 410.33(g)(2), 424.57(c)(2), or 424.516(d), as applicable.	X	X	X						NSC
12731.10.2	If the contractors determine that the change of information was timely and properly submitted, the contractors shall approve the rebuttal submission, issue a favorable rebuttal determination, and reinstate the provider's or supplier's Medicare billing privileges.	X	X	X						NSC
12731.10.3	If the contractors determine that the change of information was not timely submitted or not properly submitted, the contractors shall deny the rebuttal request and issue an unfavorable determination.	X	X	X						NSC
12731.10.4	When determining whether the provider/supplier timely and properly submitted a change of information, the contractors shall review, at a minimum, the following: • Whether the deactivation was implemented after the required time frame to report a change of enrollment information had elapsed; • Whether the letter notifying the	X	X	X						NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	provider/supplier of the deactivation was sent to the correct address, as instructed in section 10.7 in Chapter 10 of Publication 100-08; and • Whether the enrollment changes were received in an enrollment application that was processed to completion within the required time frame.									
12731.11	For deactivations under 42 C.F.R. 424.540(a)(5), the contractor shall review all submitted documentation and internal records to determine whether the provider's or supplier's practice location was operational or otherwise valid at the time of deactivation.	X	X	X						NSC
12731.11.1	If the provider/supplier was indeed compliant or operational at the time of the deactivation, the contractors shall accept the rebuttal submission and reinstate the provider's or supplier's Medicare billing privileges to an approved status.	X	X	X						NSC
12731.12	The contractors shall send all determinations (including dismissals and withdrawals) related to rebuttal submissions: 1. Via hard-copy mail to the address provided on the rebuttal submission	X	X	X						NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	2. Via hard-copy mail to the correspondence mailing address in the Medicare enrollment record (if different from the address on the rebuttal submission); 3. Via email if email address was provided with the rebuttal submission; and 4. Via email if email address is listed in the correspondence mailing address in the Medicare enrollment record (if different from the email address on the rebuttal submission).									
12731.12.1	The contractors shall mail all determinations (including dismissals and withdrawals) on the same day listed on the letter.	X	X	X						NSC
12731.12.2	If fax number is available on the rebuttal submission or in the correspondence mailing address in the Medicare enrollment record, the contractors should send the rebuttal determination via fax.	X	X	X						NSC
12731.13	If the contractors issue a rebuttal determination that is favorable to the provider/supplier, the contractors shall make the necessary modification(s) to the provider's or supplier's Medicare billing privileges within 10 business days of the date on the favorable determination letter.	X	X	X						NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12731.13.1	If additional information/documentation is needed prior to reinstating the provider/supplier as part of a favorable rebuttal determination (e.g., deactivation due to non-response to revalidation and a complete application or missing information is needed to finalize the revalidation), the contractors shall document these next steps in its rebuttal determination letter.	X	X	X						NSC
12731.13.1.1	The contractors shall not reinstate the provider or supplier until the requested information is received and processed.	X	X	X						NSC
12731.14	The contractors shall not include any additional appeal rights on any rebuttal determination letter because pursuant to 42 C.F.R. 424.546(f), a determination made regarding a rebuttal request is not an initial determination and is not subject to further review.	X	X	X						NSC
12731.15	The Contractor shall send only one dismissal letter per rebuttal submission, if applicable.	X	X	X						NSC
12731.15.1	If the Contractor is dismissing the rebuttal for more than one reason, the Contractor shall combine the relevant Dismissal Model letters into a single dismissal letter, and send the draft to ProviderEnrollmentAppeals@cms.hhs.gov for approval before sending to the	X	X	X						NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	provider/supplier.									
12731.16	The contractors shall send an acknowledgment letter for all accepted Corrective Action Plan (CAP), and reconsideration request submissions.	X	X	X						NSC
12731.17	If the initial determination is not based on 42 C.F.R. 424.535(a)(1) or 424.530(a)(1), the contractors shall not include the section advising providers/suppliers of their right to submit a CAP in the revocation letter or denial letter.	X	X	X						NSC
12731.18	The contractors shall include the supplier's NPI number(s) on all letters denying or revoking enrollment as a supplier of durable medical equipment, prosthetics, orthotics, and supplies.									NSC
12731.19	The contractors shall send a rebuttal moot letter: 1. Via hard-copy mail to the address provided on the rebuttal submission 2. Via hard-copy mail to the correspondence mailing address in the Medicare enrollment record (if different from the address on the rebuttal submission); 3. Via email if email address was provided with the rebuttal submission; and 4. Via email if email address is listed in the correspondence	X	X	X						NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	mailing address in the Medicare enrollment record (if different from the email address on the rebuttal submission).									
12731.19.1	If fax number is available on the rebuttal submission or in the correspondence mailing address in the Medicare enrollment record, the contractors should send the rebuttal moot letter via fax.	X	X	X						NSC
12731.20	The contractors shall list in the OTHER APPLICABLE AUTHORITIES section any authorities that are cited or referenced in the REBUTTAL ANALYSIS section in rebuttal determination letters.	X	X	X						NSC
12731.21	The contractors shall include a section advising providers/suppliers of their right to submit a reconsideration request in all termination, approval, and cancellation letters related to opting-out of the Medicare program.	X	X	X						NSC
12731.22	The contractors shall observe and, as applicable, abide by the new and revised guidance and instructions concerning provider enrollment appeals in Sections 10.4.8.1, 10.6.19, 10.7.1, 10.7.9, 10.7.14, and 10.7.15 in Chapter 10 of Pub. 100-08.	X	X	X						NSC

III. PROVIDER EDUCATION TABLE

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

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Timothy Trego, 410-786-8976 or timothy.trego@cms.hhs.gov , Rebecca Grandfield, 410-786-4972 or rebecca.grandfield@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: 1

Medicare Program Integrity Manual
Chapter 10 – Medicare Enrollment
Table of Contents
(Rev. 11637; 10-07-22)

Transmittals for Chapter 10

10.4.8.1 – Deactivation Rebuttals

(Rev. 11637; Issued: 10-07-22; Effective: 12-09-22; Implementation: 12-09-22)

A. Background

Pursuant to 42 CFR § 424.546, a provider/supplier whose Medicare billing privileges have been deactivated under 42 CFR § 424.540(a) may file a rebuttal. A rebuttal is an opportunity for the provider/supplier to demonstrate that it meets all applicable enrollment requirements and that its Medicare billing privileges should not have been deactivated. Only one rebuttal request may be submitted per *enrollment* deactivation. Additional rebuttal requests *submitted for the same deactivated enrollment for which a rebuttal has already been received* shall be dismissed.

If an application is received for a deactivated provider/supplier while a rebuttal submission is pending or during the rebuttal submission timeframe, the contractor shall process the application consistent with current processing instructions. If the rebuttal determination is issued and overturns the deactivation prior to an application being approved, the contractor shall return the application received while the rebuttal determination was pending unless: (1) the submitted application is required to reactivate the provider/supplier's enrollment; or (2) if there are new changes being reported. If an application (1) is received while a rebuttal submission is pending, (2) is approved prior to the issuance of a rebuttal determination, and (3) results in the provider's *or* supplier's enrollment being reactivated without a gap in billing privileges, the contractor shall stop processing the rebuttal submission and issue an applicable moot letter.

B. Notification Letters for Deactivations

If a basis is found to deactivate a provider*'s or* supplier's Medicare billing privileges under one of the regulatory authorities in 42 *C.F.R.* § 424.540, the contractor shall deactivate the provider/supplier unless another CMS direct*ive* applies. If a revocation authority is applicable, the contractor shall follow the instructions in sections 10.4.7 and 10.4.8 et seq. of this chapter in lieu of deactivating the enrollment. If no revocation authority applies, the contractor shall send notification of the deactivation using the applicable model deactivation notice. *The contractor shall send a notification letter for every deactivated enrollment.* The contractor shall ensure the deactivation notice contains sufficient details so it is clear why the provider*'s or* supplier's Medicare billing privileges are being deactivated. The contractor shall send the deactivation notification letter via hard-copy mail and via e-mail (if a valid email address is available); the contractor should also send the notice via fax if a valid fax number is available. All notifications shall be saved in PDF format, and all notification letters shall be mailed on the same date listed on the letter.

C. Rebuttal Submissions

1. Requirements and Submission of Rebuttals

*Pursuant to 42 C.F.R. § 424.546(b), to be accepted and processed, t*he rebuttal submission *must*:

(1) Be in writing;

(2) Specify the facts or issues concerning the rebuttal with which the provider or supplier disagrees, and the reasons for disagreement;

(3) Include all documentation the provider or supplier wants CMS to consider in its review of the deactivation;

(4) Be submitted in the form of a letter that is signed and dated by the individual supplier (if enrolled as an individual physician or nonphysician practitioner), the authorized official or delegated official (as those terms are defined in 42 CFR 424.502), or a legal representative (as defined in 42 C.F.R. 498.10);

- *If the legal representative is an attorney, the attorney must include a statement that he/she/they have the authority to represent the provider or supplier; this statement is sufficient to constitute notice of such authority.*
- *If the legal representative is not an attorney, the provider or supplier must file with CMS written notice of the appointment of a representative; this notice of appointment must be signed and dated by, as applicable, the individual supplier, the authorized official or delegated official, or a legal representative.*
- *Authorized or delegated officials for groups cannot sign and submit a rebuttal on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their behalf.*
- *Signatures may be original or electronic. Valid signatures include handwriting (wet) signatures in ink and digital/electronic signatures. Digital or electronic signatures such as those created by digital signature options, created in software, such as Adobe) and email signatures shall be accepted. Contractors shall contact ProviderEnrollmentAppeals@cms.hhs.gov for questions regarding electronic and digital signatures.*

*(5) B*e received by the contractor within 15 calendar days from the date of the deactivation notice. The contractor shall accept a rebuttal submission via hard-copy mail, e-mail, and/or fax;

If the rebuttal submission is not appropriately signed or if a statement from the attorney or written notice of representation is not included in the submission, the contractor shall send a development request for a proper signature or the missing statement/written notice (using the applicable model letter) before dismissing the rebuttal submission. The contractor shall allow 15 calendar days from the date of the development request letter for the rebuttal submitter to respond to the development request.

If a rebuttal submission*:* (1) is not appropriately signed and no response is received to the development request (if applicable)*;* (2) is untimely (as described above)*;* (3) does not specify the facts or issues with which the provider/supplier disagrees and the reasons for disagreement *and no response is received to the development request;* or (4) is a duplicative submission, the contractor shall dismiss the rebuttal submission using the applicable *Rebuttal Dismissal Model Letter*. *For those rebuttal submissions that are improperly signed and/or do not specify the facts or issue with which the provider or supplier disagrees and the reasons for disagreement, the contractor shall send a development request via hard-copy mail, email, if available, to the provider/supplier requesting a proper signature and/or clarification on the facts or issues with which the provider or supplier disagrees and the reasons for disagreement using the applicable Rebuttal Development Model Letter. Sending the development letter via fax is optional. The contractor shall grant an additional 15-calendar days from the date of the development request letter for the provider or supplier to submit an acceptable rebuttal submission. If no response is received or the rebuttal submission is still deficient after the development request and the 15-calendar day timeframe has expired, the contractor shall dismiss the rebuttal submission using the applicable Rebuttal Dismissal Model Letter.*

The contractor may make a good cause determination to accept any rebuttal that has been submitted beyond the *15* calendar-day filing timeframe. Good cause may be found where there are circumstances beyond the provider*'s or* supplier's control that prevented the timely

submission of a rebuttal. These uncontrollable circumstances do not include the provider/supplier's failure to timely update its enrollment information, specifically its various addresses. If the contractor believes good cause exists to accept an untimely rebuttal submission, the contractor shall send a request approval email to ProviderEnrollmentAppeals@cms.hhs.gov within *five* calendar days of making the good cause determination. This email shall detail the contractor's reasoning for finding good cause. Processing timeliness standards shall begin on the date the contractor receives a response from CMS.

2. Time Calculations for Rebuttal Submissions

If the *15th* calendar day from the date on the deactivation notice falls on a weekend or federally-recognized holiday, the rebuttal shall be accepted as timely *if the contractor received it* by the next business day.

It is the provider*'s or* supplier's responsibility to timely update *his/her/their/*its enrollment record to reflect any changes to the provider*'s or* supplier's enrollment information including, but not limited to, its correspondence address. Failure to timely update a correspondence address or other addresses included in its Medicare enrollment record does not constitute an "in fact" showing that the deactivation notice was received after the presumed receipt date (as described above).

3. Processing Rebuttal Submissions

The contractor shall send an acknowledgement letter via hard-copy mail to the return address on the rebuttal submission within 10 calendar-days of receipt of the accepted rebuttal request using the Rebuttal *Acknowledgment* Model Letter, including a rebuttal tracking number *and the provider's or supplier's NPI*. The acknowledgement letter shall also be sent via email if a valid email address is available *(either in the enrollment record or rebuttal submission)*. It is optional for the contractor to send the acknowledgement letter via fax if a valid fax number is available. *If a rebuttal determination is issued within 10 calendar-days of the date of receipt of the rebuttal submission then the contractor is not required to issue a receipt acknowledgement letter.*

The contractor shall process all accepted rebuttal submissions within 30 calendar-days of the date of receipt. If, while reviewing the rebuttal submission, the provider *or* supplier wishes to withdraw its rebuttal, the request to withdraw must be submitted to the contractor in writing before the rebuttal determination is issued. *If a provider or supplier submits a written request to withdraw its rebuttal submission prior to the issuance of a rebuttal determination then the contractor shall issue a letter using the applicable Rebuttal Withdrawn Model Letter and no rebuttal determination shall be issued.*

The contractor's review *of the rebuttal submission* shall only consist of whether the provider *or* supplier met the enrollment requirements and if billing privileges were deactivated appropriately. All materials received by the provider/supplier shall be considered by the contractor in its review.

4. Reason-Specific Instructions

a. § 424.540(a)(1)

For deactivations under § 424.540(a)(1), the contractor shall review submitted documentation and internal systems to confirm whether billing occurred during the 12-month period preceding the date of deactivation, starting with the *first* day of the *first* month 12 months prior to the date of deactivation. If it is confirmed that billing occurred within 12 months, the contractor shall issue a favorable rebuttal determination. If no billing occurred during the 12-

month period prior to the date of deactivation, the contractor shall issue an unfavorable rebuttal determination. Consider the following illustration:

EXAMPLE: Dr. Awesome has been enrolled in Medicare since 2010. A review of billing data reveals that Dr. Awesome has not submitted any Medicare claims since January 2019. Dr. Awesome's enrollment is deactivated, *under 42 C.F.R. § 424.540(a)(1),* effective January 1, 2020. Dr. Awesome timely submits a rebuttal *in response to* the deactivation. Upon review *by the contractor*, it is confirmed that Dr. Awesome had not submitted claims since January 2019. *Therefore, a*n unfavorable *rebuttal* determination would therefore be appropriate in this scenario, for the deactivation was *appropriate*.

b. § 424.540(a)(2)

For deactivations under § 424.540(a)(2), the contractor shall review the submitted documentation and internal records to determine whether the change of information was properly submitted within *the required timeframe*. *The required timeframe to submit updated information is described at 42 C.F.R. §§ 424.550, 410.33(g)(2), 424.57(c)(2), and 424.516(d).* If information was submitted properly and timely, the contractor shall approve the rebuttal *submission, issue a favorable rebuttal determination,* and reinstate the provider *'s or* supplier's Medicare billing privileges to an approved status. If it was not submitted properly and timely, the contractor shall deny the rebuttal request *and issue an unfavorable rebuttal determination*, *as* the deactivation was *appropriate*. In making this determination, the contractor shall consider, at minimum, the following.

- Whether the deactivation was implemented after *the required timeframe to report a change of enrollment information elapsed;*
- Whether the letter notifying the provider/supplier of the deactivation was sent to the correct address as instructed in section 10.7 et seq. of this chapter*; and*
- Whether the enrollment changes were received in an enrollment application that was processed to completion within *the required timeframe*.

Consider the following illustration:

EXAMPLE: Dr. Happy has reassigned his benefits to *a* physician group, Smile, LLC. Smile, LLC is Dr. Happy's only reassignment and only practice location. Smile, LLC's *enrollment and corresponding* billing privileges are revoked effective January 1, 2018. Dr. Happy's enrollment is deactivated on *February 1*, 2018 for failing to update his enrollment record with respect to his practice location. Dr. Happy timely submits a rebuttal *in response to the* deactivation *of his individual enrollment*. Upon review *by the contractor* of the submitted documentation and internal records, it is discovered that Dr. Happy submitted a change of information application received *by the contractor* on February 28, 2018 that sought to update his practice location. However, this application was ultimately rejected due to his failure to timely respond to a development request.

In this scenario, the deactivation was correctly implemented after *30* days of the change of enrollment information – the change in practice location. However, an enrollment application updating Dr. Happy's practice location that was processed to completion was not received within *30* days of the change of enrollment information. Though *the contractor received* an application within *30* days of the change of enrollment information, that application was not processed to completion. Thus, an unfavorable rebuttal determination would be appropriate in this scenario, as the deactivation was *appropriately implemented*.

c. § 424.540(a)(3)

For deactivations under § 424.540(a)(3), the contractor shall review all submitted documentation and internal records to determine whether the provider *or* supplier furnished

complete and accurate information and all supporting documentation within 90 calendar days of receipt of notification from CMS to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information. In making this determination, the contractor shall consider, at minimum, the following:

- Whether the deactivation was implemented after 90 days of the revalidation request.
- Whether the letter notifying the provider or supplier of the requirement to revalidate was sent to the correct address as instructed in section 10.7 of this chapter.
- Whether a revalidation application was timely received *and* was processed to completion.

Consider the following scenario:

EXAMPLE: On January 1, 2022, the contractor appropriately and timely informs Dr. Great that the contractor must receive a revalidation application from Dr. Great by April 15, 2022. The contractor receives a revalidation application from Dr. Great on March 1, 2022. The contractor requests that Dr. Great furnish further information needed to process the revalidation application. Dr. Great does not respond to the development request within 30 days as requested. The contractor rejects the March 1, 2022 revalidation application and subsequently deactivates Dr. Great's enrollment on April 16, 2022 *under 42 C.F.R. § 424.540(a)(3)*. Dr. Great timely files a rebuttal in response to the deactivation. Upon review of the submitted documentation and internal records, the contractor confirms that Dr. Great was appropriately and timely notified of the requirement to revalidate and that it did not receive a revalidation application within 90 days of the revalidation request that could be processed to completion. Accordingly, an unfavorable rebuttal determination would be appropriate in this scenario, as the deactivation was *appropriately implemented*.

d. § 424.540(a)(4) and (5)

For deactivation*s* under § 424.540(a)(4), the contractor shall review all submitted documentation and internal records to determine whether the provider *or* supplier was, in fact, compliant with all enrollment requirements at the time of the deactivation

For deactivations under § 424.540(a)(5), the contractor shall review all submitted documentation and internal records to determine whether the provider's *or* supplier's practice location was operational or otherwise valid at the time of the deactivation.

If the provider *or* supplier was indeed compliant *or operational* at the time of the deactivation, the contractor shall approve the rebuttal request and reinstate the provider*'s or* supplier's Medicare billing privileges to an approved status; prior PEOG review of the rebuttal or approval of the rebuttal request is not required.

e. § 424.540(a)(6)-*(8)*

Although rebuttals under § 424.540(a)(6)-*(8)* these three deactivation grounds are uncommon, the provider *or* supplier may submit one. Upon receipt *of a rebuttal submission*, the contractor shall review all submitted documentation and internal records to determine whether the deactivation pursuant to the regulatory basis in question was *appropriate*. If it was not, the contractor shall approve the rebuttal request and reinstate the provider/supplier's Medicare billing privileges to an approved status; prior PEOG review of the rebuttal or approval of the rebuttal request is not required. If the rebuttal was not submitted properly and timely, the contractor shall dismiss the rebuttal request.

D. Determination

The contractor shall render a determination regarding a rebuttal submission using the appropriate *M*odel *R*ebuttal *D*ecision *L*etter. If the contractor is unable to render a determination, the contactor shall use the appropriate *M*odel *L*etter for the specific situation. All determinations (including dismissals and withdrawals) related to rebuttal submission*s* shall be sent *(1)* via hard-copy mail to the return address on the rebuttal submission; *(2) via hard-copy mail to the correspondence mailing address on the enrollment records (if different from return address on rebuttal submission);* and *(3)* by e-mail if a valid e-mail address is available *(submitted as part of the rebuttal submission and/or listed in the enrollment record correspondence mailing address)*. The contractor may also send via fax if a valid fax number is available. All documentation shall be saved in PDF format*. A*ll notification letters shall be mailed on the same date listed on the letter.

If the contractor issues a rebuttal determination favorable to the provider *or* supplier, it shall make the necessary modification(s) to the provider*'s or* supplier's Medicare billing privileges within 10 business days of the date *on* the favorable determination *letter*. This may include the elimination of the deactivation altogether so that there is no gap in billing privileges or a change in the deactivation effective date. If the contactor issues a rebuttal determination unfavorable to the provider *or* supplier, the provider*'s or* supplier's Medicare billing privileges shall remain deactivated until a reactivation application is received and processed to completion.

If a rebuttal determination overturns the deactivation, the contractor shall return any application(s) received while the rebuttal submission was being reviewed or during the rebuttal submission timeframe that ha*s* not been processed to completion, unless the application is needed to reactivate the enrollment or if there are new changes being reported. If the contractor confirms that the application is not needed and that no new changes are being reported, the contractor shall use the following return reason in the Returned Application Model Letter found at 10.7.7.A of this chapter in response to the scenario described above: "A rebuttal decision has been issued; therefore, the submitted Form CMS [855/588/20134] is not needed."

If additional information/documentation is needed prior to reinstating the provider *or* supplier *as part of a favorable rebuttal determination* (e.g., deactivation due to non-response to revalidation and a complete application or missing information is needed to finalize the revalidation), the contractor shall document these next steps in its rebuttal determination letter. The contractor shall not reinstate the provider *or* supplier until the requested information is received and processed. If the additional information/documentation is not received within 30 calendar days of the date of the rebuttal determination, the contractor shall contact the provider/supplier to again request the additional information/documentation within 10 calendar days of not receiving a response.

If no response is received within 30 calendar days of the second request for additional information/documentation, the contractor shall contact ProviderEnrollmentAppeals@cms.hhs.gov within 10 calendar days for further instruction.

E. No Further Review

Pursuant to 42 C.F.R*. § 424.546(f),* a determination made regarding a rebuttal request is not an initial determination and is not subject to further review. Thus, no additional appeal rights shall be included on any rebuttal determination letter.

F. External Monthly Reporting for Rebuttals

Using the provider enrollment rebuttals reporting template, the contractor shall complete all columns listed for all rebuttal submissions received and processed by the contractor. No

column shall be left blank (except Column K, as described below). If the contractor is unable to complete all columns for a given rebuttal submission, the contractor shall contact ProviderEnrollmentAppeals@cms.hhs.gov within five business days of discovery to seek further guidance.

The reports shall use only the formats identified below. All dates shall be formatted as mm/dd/yyyy (e.g. 01/13/2021). The reports shall be sent to CMS via email at ProviderEnrollmentAppeals@cms.hhs.gov no later than the 15th of each month. If this day falls on a weekend or a holiday, the report shall be submitted the following business day. The report shall include the prior month's rebuttal submissions, as well as outcomes for all submissions previously received that were not yet completed and reported to CMS (e.g., the February report shall cover all January rebuttals).

***IMPORTANT:** All submissions shall remain on the monthly report until a final outcome/decision has been reported to CMS.*

- ***Column A:** The response in Column A labelled, "Provider/Supplier Name (As it appears in PECOS)" shall be the provider's or supplier's Legal Business Name, exactly as it is spelled and formatted in the PECOS enrollment record (including capitalization, abbreviations, and punctuation).*

- ***Column B:** The response in Column B labelled, "NPI" shall be the provider's or supplier's NPI. If the provider/supplier has more than one NPI, the contract shall list each NPI, separated by a semi-colon.*

- ***Column C:** The response in Column C labelled, "EID (if applicable)" shall be the provider's or supplier's EID. If there is no EID associated with the provider/supplier, the response shall be "N/A".*

- ***Column D:** The response in Column D labelled, "PTAN(s) (if applicable)" shall include the provider's or supplier's PTAN. If the provider/supplier has more than one PTAN, each PTAN shall be separated by a semicolon (e.g. L5988; 190002033). If the provider/supplier does not have a PTAN, the response shall be "N/A".*

- ***Column E:** The response in Column E labelled, "Contractor (Including Jurisdiction)," shall be in one of the following formats. No other formats are acceptable.*

    - *CGS J15*
    - *FCSO*
    - *NGS J6*
    - *NGS JK*
    - *Noridian JE*
    - *Noridian JF*
    - *Novitas JH*
    - *Novitas JL*
    - *NPE East*
    - *NPE West*
    - *NSC*
    - *Palmetto JJ*
    - *Palmetto JM*
    - *WPS J5*
    - *WPS J8*

- ***Column F:** The response in Column F labelled, "Regulatory Authority for*

Deactivation," shall be in the following format. If the response is "Other (see Comments)" the Contractors shall use Column K to provide explanatory notes (e.g. when a rebuttal is submitted in response to an enrollment action that does not afford rebuttal rights, describe the enrollment action in Column K). No other formats are acceptable:

- *424.540(a)(1)*
- *424.540(a)(2)*
- *424.540(a)(3)*
- *424.540(a)(4)*
- *424.540(a)(5)*
- *424.540(a)(6)*
- *424.540(a)(7)*
- *424.540(a)(8)*
- *Other (see Comments)*

- ***Column G:*** *The response in Column G labelled, "Date Rebuttal Received" shall be the date on which the Contractor received the rebuttal. The date shall be formatted as mm/dd/yyyy (e.g. 10/25/2021).*

- ***Column H:*** *The response in Column H labelled, "Date Receipt Acknowledgement Sent to Provider/Supplier/Legal Representative," shall be "Not yet sent" if a receipt acknowledgement email/letter has not been sent to the provider/supplier/legal representative at the time the monthly report is sent to CMS. The response shall be "N/A" if a receipt acknowledgement email/letter is not required for that case (i.e., rebuttal determination is issued within 10-calendar days of the date of receipt of the rebuttal submission). Dates shall be formatted as mm/dd/yyyy (e.g. 06/15/2020).*

- ***Column I:*** *The response in Column I labelled, "Date Rebuttal Determination Issued" shall be the date on which the Contractor issues the rebuttal determination. The date shall be formatted as mm/dd/yyyy (e.g. 09/19/2019). If a final rebuttal determination has not yet been issued, the contractors shall enter "In Process" as the response.*

- ***Column J:*** *The response in Column J labelled, "Final Decision Result," shall be one of the following. No other formats are acceptable.*

  - ***Not Actionable:*** *Rebuttal is no longer actionable (moot) because the basis for the deactivation has been resolved (e.g. deactivation was rescinded).*
  - ***Favorable:*** *(to provider/supplier) Contractor has determined that an error was made in the implementation of the deactivation. Therefore, the initial determination was overturned and the enrollment record has been placed in approved status.*
  - ***Unfavorable:*** *(to provider/supplier) Contractor upholds the initial determination resulting in the enrollment remaining deactivated.*
  - ***Dismissed:*** *The rebuttal submission does not meet the rebuttal submission requirements (e.g. missing proper signature and did not timely respond to development request).*
  - ***Withdrawn:*** *Provider/supplier/representative has submitted written notice of its intent to withdraw its rebuttal before the contractor issued a determination and the contractor has acknowledge the withdrawal.*
  - ***In Process:*** *A final decision has not been issued. The Contractor is still processing the submission.*

- ***Column K:*** *The response in Column K labelled, "Comments," shall include any information related to the deactivation, rebuttal submission, or rebuttal determination*

that provides context for CMS in reporting the rebuttal and outcome. This column may be left blank if no additional information is necessary.

10.6.19 – Other Medicare Contractor Duties

(Rev. 11637; Issued: 10-07-22; Effective: 12-09-22; Implementation: 12-09-22)

The contractor shall adhere to all of the instructions in this chapter 10 (hereafter generally referred to as "this chapter") and all other CMS provider enrollment directives (e.g., Technical Direction letters). The contractor shall also assign the appropriate number of staff to the Medicare enrollment function to ensure that all such instructions and directives - including application processing timeframes and accuracy standards - are complied with and met.

A. Training

The contractor shall provide (1) training to new employees, and (2) refresher training (as necessary) to existing employees to ensure that each employee processes enrollment applications in a timely, consistent, and accurate manner. Training shall include, at a minimum:

- An overview of the Medicare program
- A review of all applicable regulations, manual instructions, and other CMS guidance
- A review of the contractor's enrollment processes and procedures
- Training regarding the Provider Enrollment, Chain and Ownership System (PECOS).

For new employees, the contractor shall also:

- Provide side-by-side training with an experienced provider enrollment analyst
- Test the new employee to ensure that he or she understands Medicare enrollment policy and contractor processing procedures, including the use of PECOS
- Conduct end-of-line quality reviews for 6 months after training or until the analyst demonstrates a clear understanding of Medicare enrollment policy, contractor procedures, and the proper use of PECOS.

For existing employees, periodic quality reviews and refresher trainings shall be performed by the contractor on a periodic basis.

B. PECOS

The contractor shall:

- Process all enrollment actions (e.g., initials, changes, revalidations, revocations, appeals, denials) through PECOS
- Deactivate or revoke the provider or supplier's Medicare billing privileges in the Multi-Carrier System or the Fiscal Intermediary Shared System only if the provider or supplier is not in PECOS, if the provider does not exist in MCS or FISS, prior to taking action contact CMS

- Close or delete any aged logging and tracking (L & T) records older than 120 days for which there is no associated enrollment application

- Participate in user acceptance testing for each PECOS release

- Attend scheduled PECOS training when requested

- Report PECOS validation and production processing problems through the designated tracking system for each system release

- Develop (and update as needed) a written training guide for new and current employees on the proper processing of Form CMS-855, CMS-20134 applications, opt out affidavits, and the appropriate entry of data into PECOS.

C. Customer Service

1. Responding to Provider Enrollment Inquiries

The contractor's customer service unit may handle provider enrollment inquiries that do not involve complex enrollment issues. Examples of inquiries that can be processed by customer service units include:

- Application status checks (e.g., "Has the contractor finished processing my application?") (The contractor may wish to establish electronic mechanisms by which providers can obtain updates on the status of their enrollment applications via the contractor's Web site or automated voice response (AVR).

- Furnishing information on where to access the Form CMS-855 or CMS-20134 applications (and other general enrollment information) on-line

- Explaining to providers/suppliers which Form CMS-855 or CMS-20134 applications should be completed.

2. Contractor's Responsiveness to Inquiries

Excluding matters pertaining to application processing (e.g., development for missing data) and appeals (e.g., appeal of revocation), the contractor is encouraged to respond to all enrollment-related provider/supplier correspondence (e.g., e-mails, letters, telephone calls) within 30 business days of receipt.

D. Contractor Outreach to Providers

The contractor is strongly encouraged to establish e-mail "list serves" with the provider community to disseminate important information thereto, such as contractor address changes, new CMS enrollment policies or internal contractor procedures, reminders about existing policies, etc. By being proactive in distributing information to its providers and suppliers on a regular basis (e.g., weekly, bi-weekly), the contractor can reduce the number of policy inquiries it receives and help facilitate the submission of complete and accurate Form CMS-855 or CMS-20134 applications.

E. Encouraging Use of Internet-based PECOS

When a prospective provider or supplier contacts the contractor to obtain a paper enrollment Form CMS-855 or CMS-20134, the contractor shall encourage the provider or supplier to

submit the application using Internet-based PECOS. The contractor shall also notify the provider or supplier of:

- The CMS Web site at which information on Internet-based PECOS can be found and at which the paper applications can be accessed (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index?redirect=/MedicareProviderSupEnroll/).
- The contractor's address so that the applicant knows where to return the completed application.
- Any supporting documentation required for the applicant's provider/supplier type.
- Other required forms as described in sections above. Notification can be given in any manner the contractor chooses.

F. Adherence to Responsibilities Based Upon Jurisdiction

1. Audit and Claims Contractors

a. Background

For purposes of enrollment via the Form CMS-855A, there are generally two categories of contractors: audit contractors and claims contractors. The audit contractor enrolls the provider, conducts audits, etc. The claims contractor pays the provider's claims. In most cases, the provider's audit contractor and claims contractor will be the same. On occasion, though, they will differ. This can happen, for instance, with provider-based entities, whereby the parent provider's contractor (audit contractor) will process the provider's enrollment application and a different contractor will pay the provider's claims (claims contractor).

Should the audit and claims contractors differ, the audit contractor shall process all changes of information, including all Form CMS-588 changes. The audit contractor shall notify the applicant during the initial enrollment process that all future changes of information must be sent to the audit contractor, not the claims contractor. If the provider inadvertently sends a change request to the claims contractor, the latter shall return the application per section 10.4(H)(1) of this chapter.

b. Process

If the audit contractor approves the Form CMS-855A transaction in question (e.g., initial enrollment), it shall:

(i) Send an e-mail to the claims contractor identifying the specific Form CMS-855A transaction involved and confirming that the information has been updated in the Provider Enrollment, Chain and Ownership System (PECOS). Pertinent identifying information, such as the provider name, CMS Certification Number and National Provider Identifier, shall be included in the e-mail notification. If the e-mail contains any supporting documentation that contains personal health information or personally identifiable information the audit contractor shall encrypt the e-mail prior to sending.

(ii) As applicable, fax, mail, or email an encrypted copy of the submitted Form CMS-588 to the appropriate claims contractor.

Upon receipt of the e-mail notification, the claims contractor shall access PECOS, review the enrollment record, and, as needed, update its records accordingly.

The audit contractor shall keep all original copies of Form CMS-855A paperwork and supporting documentation, including all Form CMS-588s.

c. Tie-In/Tie-Out Notices and Approval Notices

If the provider's audit contractor and claims contractor are different, the audit contractor shall e-mail or fax a copy of all tie-in/tie-out notices and approval letters it receives to the claims contractor. This is to ensure that the claims contractor is fully aware of the RO's action, as some ROs may only send copies of tie-in/tie-out notices and approval letters to the audit contractor. If the audit contractor chooses, it can simply contact the claims contractor by phone or e-mail and ask if the latter received the tie-in notice.

Again, it is imperative that audit and claims contractors effectively communicate and coordinate with each other in all payment-related and program integrity matters involving the provider.

G. Online Presence – Web Sites

The contractor must provide a link to CMS' provider/supplier enrollment Web site located at https://www.cms.gov/medicare/provider-enrollment-and-certification/medicareprovidersupenroll/index.html?redirect=/medicareprovidersupenroll/ . The link shall: (1) be available on the contractor's existing provider outreach Web site (which should be an established sub-domain of the contractor's current commercial Web site), and (2) comply with the guidelines stated in the Provider/Supplier Information and Education Web site section (Activity Code 14101) under the Provider Communications (PCOM) Budget and Performance Requirements (BPRs). Bulletins, newsletters, seminars/workshops and other information concerning provider enrollment issues shall also be made available on the existing provider outreach Web site. All contractor Web sites must comply with section 508 of the Rehabilitation Act of 1973 in accordance with, 36 CFR §1194, and must comply with CMS' Contractor Website Standards and Guidelines posted on CMS's Web site.

The CMS Provider/Supplier Enrollment Web site, furnishes the user with access to provider/supplier enrollment forms, specific requirements for provider/supplier types, manual instructions, frequently asked questions (FAQs), contact information, hot topics, and other pertinent provider/supplier information. The contractor shall not duplicate content already provided at the CMS provider/supplier enrollment Website, and shall not reproduce the forms or establish the contractor's own links to forms. It shall, however, have a link on its Website that goes directly to the forms section of the CMS provider/supplier enrollment site.

On a quarterly basis (specifically, no later than the 15th day of January, April, July, and October), each contractor shall review and provide updates regarding its contact information shown at URL:

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf
If the contractor services several States with a universal address and telephone number, the contractor shall report that information. In situations where no actions are required, a response from the contractor is still required (i.e., the contact information is accurate). In addition, only such information that pertains to provider enrollment activity for the contractor's jurisdiction is to be reported. All updates shall be sent directly via e-mail to the contractor's CMS PEOG Business Function Lead (BFL).

H. Document Retention

The contractor shall maintain and store all documents relating to the enrollment of a provider into the Medicare program. These documents include, but are not limited to, Medicare enrollment applications and all supporting documents, attachments, correspondence and correspondence tracking documentation, and appeals submitted in conjunction with an initial enrollment, reassignment, change of enrollment, revalidation, etc.

Supporting documentation includes, but is not limited to:

- Copies of Federal, State and/or local (city/county) professional licenses, certifications and/or registrations;
- Copies of Federal, State, and/or local (city/county) business licenses, certifications and/or registrations;
- Copies of professional school degrees or certificates or evidence of qualifying course work;
- Copies of CLIA certificates and FDA mammography certificates;
- Copies of any entry found on the Medicare Exclusion Database (MED) report that leads to a provider or supplier's revocation, and;
- Copies of Centers for Disease Control and Prevention (CDC) Diabetes Prevention Recognition Program (DPRP) recognition letters or certificates indicating Full or MDPP preliminary recognition.

The contractor shall dispose of the aforementioned records as described below:

1. Provider/Supplier and Durable Medical Equipment Supplier Application

a. Rejected applications as a result of provider failing to provide additional information

Disposition: Destroy when 7 years old.

b. Approved applications of provider/supplier

Disposition: Destroy 15 years after the provider/supplier's enrollment has ended.

c. Denied applications of provider/supplier.

Disposition: Destroy 15 years after the date of denial.

d. Approved application of provider/supplier, but the billing number was subsequently revoked.

Disposition: Destroy 15 years after the billing number is revoked.

e. Voluntary deactivation of billing number

Disposition: Destroy 15 years after deactivation.

f. Provider/Supplier dies

Disposition: Destroy 7 years after date of death.

2. Electronic Mail and Word Processing System Copies

a. Copies that have no further administrative value after the recordkeeping copy is made. These include copies maintained by individuals in personal files, personal electronic mail directories, or other personal directories on hard disk or network drives, and copies on shared network drives that are used only to produce the recordkeeping copy.

Disposition: Delete within 180 days after the recordkeeping copy has been produced.

b. Copies used for dissemination, revision or updating that are maintained in addition to the recordkeeping copy.

Disposition: Delete when dissemination, revision, or updating is complete.

I. Keeping Record of Activities

To ensure that proper internal controls are maintained and that important information is recorded in case of potential litigation, the contractor shall maintain documentation as outlined in this section 10.6.19(H). CMS cannot stress enough how crucial it is for contractors to document their actions as carefully and thoroughly as possible.

The requirements in this section 10.6.19(H) are in addition to, and not in lieu of, all other documentation or document maintenance requirements that CMS has mandated.

J. Keeping Record of Written and Telephonic Communications

(For purposes of this section 10.6.19(H), "written correspondence" includes mailed, faxed, and e-mailed correspondence.)

K. Keeping Record of Written Correspondence

The contractor shall:

- Retain copies of all written correspondence pertaining to the provider, regardless of whether the correspondence was initiated by the contractor, the provider, CMS, State officials, etc.

- Document when it sends written correspondence to providers. For instance, if the contractor crafts an approval letter to the supplier dated March 1 but sends it out on March 3, the contractor shall note this in the file.

- Document all referrals to CMS, the UPIC, or the OIG

L. Keeping Record of Telephonic or Face-to-Face Contact

Telephonic or Face-to-Face Contact is hereafter referred to as "oral communication."

The contractor shall document any and all actual or attempted oral communication with the provider, any representative thereof, or any other person or entity regarding a provider. This includes, but is not limited to, the following situations:

- Telephoning a provider about its application. (Even if the provider official was unavailable and a voice mail message was left, this must be documented.)

- Requesting information from the state or another contractor concerning the applicant or enrollee

- Contacting the UPIC for an update concerning a particular case

- Phone calls from the provider

- Conducting a meeting at the contractor's headquarters/offices with officials from a hospital concerning problems with its application

- Telephoning PEOG or the RO (e.g., the RO's survey and certification staff) and receiving instructions therefrom about a problem the contractor is having with an applicant or an existing provider

- Telephoning the provider's billing department with a question about the provider.

When documenting oral communications, the contractor shall indicate: (1) the time and date of the call or contact; (2) who initiated the contact; (3) who was spoken with; and (4) what the conversation pertained to. Concerning the last requirement, the contractor need not write down every word that was said during the conversation. Rather, the documentation should merely be adequate to reflect the contents of the conversation. The documentation can be crafted and stored electronically if the contractor can provide access within 24 hours upon request.

The documentation requirements in this subsection (A) only apply to enrolled providers and to providers that have already submitted an enrollment application. In other words, these documentation requirements go into effect only after the provider submits an initial application. To illustrate, if a hospital contacts the contractor requesting information concerning how it should enroll in the Medicare program, this need not be documented because the hospital has not yet submitted an enrollment application.

If an application is returned per section 10.4(H)(1) of this chapter, the contractor shall document this. The manner of documentation lies within the contractor's discretion.

M. Documenting Verification of Data Elements

Once the contractor has completed its review of the CMS-855, CMS-20134 applications,(e.g., approved/denied application, approved change request) and Opt Out Affidavits, it shall document that it has: (1) verified all data elements on the application, and (2) reviewed all applicable names on the above mentioned forms against the OIG/LEIE and the System for Access Management (SAM). It can be drafted in any manner the contractor chooses so long as it certifies that the above-mentioned activities were completed. The record can be stored electronically.

For each person or entity that appeared on the OIG/LEIE or SAM, the contractor shall document the finding via a screen printout. In all other situations, the contractor is not encouraged to document their reviews via screen printouts. Simply using the verification statement described above is sufficient. Although the contractor has the discretion to use screen prints if it so chooses, the verification statement is still required.

N. Release of Information

On October 13, 2006, CMS published System of Records Notice for the Provider Enrollment, Chain and Ownership System (PECOS) in the Federal Register. Consistent with this notice, once the provider has submitted an enrollment application (as well as after it has been

enrolled), the contractor shall not release – either orally or in writing - provider-specific data to any outside person or entity, unless specified otherwise in this chapter. (Provider-specific data includes, but are not limited to, owners/managers, adverse legal history, practice locations, group affiliations, effective dates, etc.) Examples of outside persons or entities include, but are not restricted to, national or state medical associations or societies, clearinghouses, billing agents, provider associations, or any person within the provider's organization other than the provider's authorized official(s) (section 15 of the CMS-855 and CMS-20134), delegated official(s) (section 16), or contact persons (section 13). The only exceptions to this policy are:

- A routine use found in the aforementioned System of Records applies.

- The provider (or, in the case of an organizational provider, an authorized or delegated official): (1) furnishes a signed written letter on the provider's letterhead stating that the release of the provider data is authorized, and (2) the contractor has no reason to question the authenticity of the person's signature. The letter can be mailed, faxed, or emailed to the contractor.

- The release of the data is specifically authorized in some other CMS instruction or directive.

(These provisions also apply in cases where the provider requests a copy of any Form CMS-855 or CMS-20134 paperwork the contractor has on file.)

It is recommended that the contractor notify the provider of the broad parameters of the aforementioned policy as early in the enrollment process as possible.

- The following information shall be made available over-the-phone to a caller who is able to provide a provider/suppliers name, PTAN, TIN/SSN and NPI number. The caller does not need to be listed on the provider/supplier's enrollment record as a contact person:

- Revalidation status (i.e., whether or not a provider/supplier has been revalidated),

- Revalidation due date,

- Revalidation approval date,

- The specific information related to a revalidation development request, and

- The date a provider/supplier was deactivated due to non-response to a revalidation or non-response to a development request.

In addition:

- When sending emails, the contractor shall not transmit sensitive data, such as social security numbers or employer identification numbers, without first encrypting the email.

- The contractor may not send PECOS screen printouts to the provider.

- With the exception of CMS-855S applications, if any contact person listed on a provider or supplier's enrollment record, requests a copy of a provider or supplier's Medicare approval letter or revalidation notice, the contractor shall send to the contact person via email, fax or mail. This excludes Certification Letters (Tie In notices), as the contractor is not responsible for generating these approvals.

O. Security

The contractor shall ensure that the highest level of security is maintained for all systems and its physical and operational processes, in accordance with the CMS/Business Partners Systems Security Manual (BPSSM) and the Program Integrity Manual.

Applications shall never be removed from the controlled area to be worked on at home or in a non-secure location. Additionally, provider enrollment staff must control and monitor all applications accessed by other contractor personnel.

All contractor staff shall be trained on security procedures as well as relevant aspects of the Privacy Act and the Freedom of Information Act. This applies to all management, users, system owners/managers, system maintainers, system developers, operators and administrators - including contractors and third parties - of CMS information systems, facilities, communication networks and information.

Note that these instructions are in addition to, and not in lieu of, all other instructions issued by CMS regarding security.

P. Contractor to Contractor Communications

Medicare contractors create Associate and Enrollment Records in the Provider Enrollment, Chain and Ownership System (PECOS). Ownership of an Associate or Enrollment Record belongs to the contractor within whose jurisdiction the provider/supplier is located. PECOS only permits the contractor that created the Associate or Enrollment Record (the "owning contractor") to make updates, changes, or corrections to those records. (That is, the owning contractor is the only contractor that can make changes to the associate record.)

Occasionally, updates, changes, or corrections do not come to the owning contractor's attention, but instead go to a different contractor. In those situations, the contractor that has been notified of the update/change/correction (the "requesting" contractor) must convey the changed information to the owning contractor so that the latter can update the record in PECOS.

The requesting contractor may notify the owning contractor via fax or email (encrypted if it contains personally identifiable information) of the need to update/change/correct information in a provider's PECOS record. The notification must contain:

1. The provider's legal business name, Provider Transaction Access Number, and National Provider Identifier; and

2. The updated/changed/corrected data (by including a copy of the appropriate section of the Form CMS-855 or CMS-20134).

Within 7 calendar days of receiving the requesting contractor's request for a change to a PECOS record, the owning contractor shall make the change and notify the requesting contractor thereof via fax, e-mail, or telephone.

If the owning contractor is reluctant to make the change, it shall contact its CMS Provider Enrollment & Oversight Group (PEOG) BFL for guidance. Note that the owning contractor may ask the requesting contractor for any additional information about the provider it deems necessary (e.g., IRS documentation, licenses).

The owning contractor need not ask the provider for a Form CMS-855 or CMS-20134 change of information in associate profile situations. It can simply use the Form CMS-855 or CMS-20134 copy that the requesting contractor sent/faxed to the owning contractor. For instance, suppose Provider X is enrolled in two different contractor jurisdictions – A and B. The provider enrolled with "A" first; its legal business name was listed as "John Brian Smith Hospital." It later enrolls with "B" as "John Bryan Smith Hospital." "B" has verified that "John Bryan Smith Hospital" is the correct name and sends a request to "A" to fix the name. "A" is not required to ask the provider to submit a Form CMS-855A change of information. It can use the CMS-855A copy that it received from "B."

Q. Establishment of Relationships

To the maximum extent possible, and to help ensure that it becomes aware of recent felony convictions of practitioners and owners of health care organizations, the contractor shall establish relationships with appropriate State government entities – such as, but not limited to, Medicaid fraud units, State licensing boards, and criminal divisions – designed to facilitate the flow of felony information from the State to the contractor. For instance, the contractor can request that the State inform it of any new felony convictions of health care practitioners.

R. Ongoing Monitoring Activities

1. Monitoring Information from State Licensing Boards

To help ensure that only qualified physicians and non-physician practitioners are enrolled in Medicare, the contractor shall undertake the activities described below.

For purposes of this section, the term "practitioner" includes both physicians and non-physician practitioners. In addition, the instructions in this section, apply only to these practitioners.

2. Monthly Reviews

No later than the 15th day of each month, the contractor shall review State licensing board information for each State within its jurisdiction to determine whether any of its currently enrolled practitioners have, within the previous 60 days:

- Had their medical license revoked, suspended or inactivated (due to retirement, death, or voluntary surrender of license);

- Otherwise lost their medical license or have had their licenses expire.

- For those practitioners who no longer have a valid medical license, the contractor shall take the necessary steps pursuant to guidance in this chapter.

- The mechanism by which the contractor shall perform these monthly licensure reviews lies within its discretion, though the most cost-effective method shall be used.

S. Regarding Potential Identity Theft or Other Fraudulent Activity

In conducting the verification activities described in section 10.6.19(H) of this chapter, if the contractor believes that a case of identity theft or other fraudulent activity likely exists (e.g., physician or practitioner indicates that he or she is not establishing a new practice location or changing his or her EFT information, and that the application submitted in his/her name is false), the contractor shall notify its CMS Provider Enrollment & Oversight Group Business

Function Lead (PEOG BFL) immediately; the BFL will instruct the contractor as to what, if any, action shall be taken

T. Medicare Contractor Duties – Reporting Requirements

See section 10.4.8.1(F) of this chapter.

10.7.1 – Acknowledgement Letters

(Rev. 11637; Issued: 10-07-22; Effective: 12-09-22; Implementation: 12-09-22)

A. Acknowledgement Letter Guidance

Sending an acknowledgement letter is optional *for enrollment applications*.
Acknowledgement letters are required for accepted CAP, Reconsideration Request. See sections 10.7.10, 10.7.11, and 10.7.13 of this chapter.

B. Model Acknowledgement Letter

1. Acknowledgement Example – Application Receipt

[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]

10.7.9 – Revocation Letters

(Rev. 11637; Issued: 10-07-22; Effective: 12-09-22; Implementation: 12-09-22)

A. Revocation Letter Guidance

The contractor:

- Must submit one or more of the Primary Revocation Reasons as found in section 10.4(M)(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 sufficient details to support the reason for the provider or supplier's revocation;

- Shall issue all revocation letters via certified letter, per regulations found in 42 CFR 405.800(b)(1), and;

- Shall issue two revocation letters to any solely owned organizations, one for the individual and the other for the organization.

B. Model Revocation Letters

1. Revocation Example - Letter for National Supplier Clearinghouse (NSC)

[month] [day], [year]

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

Reference # (PTAN #, Enrollment #, Case #, etc.)

Certified mail number: [number]
Returned receipt requested

Dear [Supplier Name]:

The purpose of this letter is to inform you that pursuant to 42 CFR §§ 405.800, 424.57(x), 424.535(g), and 424.535(a)[(x)], your Medicare supplier number [xxxxxxxxxx] for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) issued by the National Supplier Clearinghouse (NSC)

[will be revoked effective 30 days from the postmarked date of this letter]

[is revoked. The effective date of this revocation has been made retroactive to [month] [day], [year], which is the date [revocation reason]]

Pursuant to 42 CFR §424.535(c), the supplier is barred from re-enrolling for a period of [number of years] year(s) in the Medicare program from the effective date of the revocation. In order to re-enroll, you must meet all requirements for your supplier type.

[The Supplier Audit and Compliance Unit (SACU) reviewed and evaluated the documents you submitted in response to the developmental letter dated [date]. This letter allowed you to demonstrate your full compliance with the DMEPOS supplier standards and/or to correct the deficient compliance requirement(s).]

[The Supplier Audit and Compliance Unit (SACU) has not received a response to the developmental letter sent to you on [date]. This letter allowed you to demonstrate your full compliance with the DMEPOS supplier standards and/or to correct the deficient compliance requirement(s)]

[The National Supplier Clearinghouse has not received a response to the developmental letter sent to you on [date] informing you that the request for a hardship exception for the required application fee was denied. The notification afforded you the opportunity to pay the

mandatory application fee for processing your enrollment application and an appeal period which you did not select.]

[The National Supplier Clearinghouse has not received a response to the developmental letter sent to you on [date] informing you that the application fee was not paid at the time you filed the CMS 855S enrollment application. The 30day notification afforded you the opportunity to pay the mandatory application fee for processing your enrollment application]

We have determined that you are not in compliance with the supplier standards noted below:

42 CFR §424.57(c) [1-30] [Insert the specific performance standard not met]

Section 1834(j) of the Social Security Act states that, with the exception of medical equipment and supplies furnished incident to a physician's service, no payment may be made by Medicare for items furnished by a supplier unless the supplier has a valid Medicare billing number. Therefore, any expenses for items you supply to a Medicare beneficiary on or after the effective date of the revocation of your billing numbers are your responsibility and not the beneficiary's, unless you have proof that you have notified the beneficiary in accordance with section 1834 (a)(A)(ii) of the Social Security Act and the beneficiary has agreed to take financial responsibility if the items you supply are not covered by Medicare. You will be required to refund on a timely basis to the beneficiary (and will be liable to the beneficiary for) any amounts collected from the beneficiary for such items. If you fail to refund the beneficiary as required under 1834 (j) (4) and 1879(h) of the Social Security Act, you may be liable for Civil Monetary penalties.

You may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if *revoked* under 42 C.F.R. § 424.535(a)(1))

You may submit a corrective action plan (CAP) in response to *an enrollment revocation* under 42 C.F.R. § 424.535(a)(1). You may also request a reconsideration (described below). If your enrollment *was revoked* under authorities other than 42 C.F.R. § 424.535(a)(1), you may **only** submit a reconsideration request in response to those denial bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to enroll in the Medicare program. (Optional Coversheet sentence: [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]) The CAP must:

- Be received in writing within 35 calendar days of the date of this letter and mailed to the address below or emailed to the address below;
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration

request.
    - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

Please note that CAPs may not be appealed further to the Departmental Appeals Board. Further appeal rights do exist for reconsideration requests (described below). CAP requests should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for reviewing the CAP)

[Name of MAC]
[Address]
[City], *[*ST*]* [Zip]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of *Provider Enrollment* Appeals
7500 Security Boulevard
Mailstop AR-*19-51*
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address]or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

    - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If *revoked* under 42 C.F.R. § 424.535(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

[Name of MAC]
[Address]
[City], *[*ST*]* [Zip]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of *Provider Enrollment* Appeals
7500 Security Boulevard
Mailstop AR-*19-51*
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address]or [ProviderEnrollmentAppeals@cms.hhs.gov]

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]

2. Model Revocation Letter for Part B Suppliers and Certified Providers and Suppliers

[Month] [day], [year]

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

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your Medicare privileges are being revoked effective [Date of revocation] for the following reasons:

xx CFR §xxx.(x) [heading]
[Specific reason]

xx CFR §xxx.(x) [heading]
[Specific reason]

(For certified providers and certified suppliers only: Pursuant to 42 CFR §424.535(b), this action will also terminate your corresponding (provider or supplier) agreement.)

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if revoked under 42 C.F.R. § 424.535(a)(1))

You may submit a corrective action plan (CAP) in response to the revocation of Medicare billing privileges under 42 C.F.R. § 424.535(a)(1). You may also request a reconsideration (described below). If your Medicare billing privileges were revoked under authorities other than 42 C.F.R. § 424.535(a)(1), you may **only** submit a reconsideration request in response to those revocation bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to maintain enrollment in the Medicare program. (Optional Coversheet sentence [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]) The CAP must:

- Be received in writing within 35 calendar days of the date of this letter and mailed or emailed to the address below;

- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

    - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.

    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.

    - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

(Insert correct address based on whether the MAC or CMS is responsible for reviewing the CAP)

The CAP should be sent to:

[Name of MAC]
[Address]
[City], /ST/ [Zip]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of *Provider Enrollment* Appeals
7500 Security Boulevard
Mailstop AR-*19-51*
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address]or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If revoked under 42 C.F.R. § 424.535(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any

further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

[Name of MAC]
[Address]
[City], *[*ST*]* [Zip]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of *Provider Enrollment* Appeals
7500 Security Boulevard
Mailstop AR-*19-51*
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address]or [ProviderEnrollmentAppeals@cms.hhs.gov]

Pursuant to 42 CFR §424.535(c), CMS is establishing a re-enrollment bar for a period of [Insert amount of time] that shall begin 30 days after the postmark date of this letter. This re-enrollment bar only applies to your ability to submit a new enrollment application to the Medicare program. In order to re-enroll, you must meet all requirements for your provider or supplier type.

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]

C. Revocation Letter Examples

Note that each example contains *instructions to send appeals to both* CMS and the *contractor*, regardless of the example reason, so that the contractors may include the appropriate appeal address based on the provider or supplier type that has been revoked. *In addition, note that the section advising the provider/supplier of their right to submit a CAP are only included in the examples of revocations based on 42 C.F.R. § 424.535(a)(1).*

1. Abuse of Billing Revocation Letter Example

[month] [day], [year]

[Entity name]
[Address]
[City, State & ZIP Code]

Reference # (PTAN #, Enrollment #, Case #, etc.)

Dear [Provider/Supplier Name]:

Your Medicare privileges are being revoked effective June 16, 2012 for the following reasons:

Revocation reason: 42 CFR § *424.*535(a)(8)

Specifically, you submitted 186 claims to Medicare for services provided after the date of death of 15 beneficiaries.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.

    - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If revoked under 42 C.F.R. § 424.535(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must

be filed with the Federal agency that took the action.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

[Name of MAC]
[Address]
[City], *[*ST*]* [Zip]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of *Provider Enrollment* Appeals
7500 Security Boulevard
Mailstop AR-*19-51*
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Pursuant to 42 CFR §424.535(c), CMS is establishing a re-enrollment bar for a period of [Insert amount of time] that shall begin 30 days after the postmark date of this letter. This re-enrollment bar only applies to your ability to submit a new enrollment application to the Medicare program. In order to re-enroll, you must meet all requirements for your provider or supplier type.

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]

2. DMEPOS Supplier Revocation Letter Example

[month] [day], [year]

[Entity name]
[Address]
[City]*,* *[*ST*]* [Zip]

Reference #*: [*PTAN #, Enrollment #, Case #, etc. *]*
NPI: [xxxxxxxxxx]

Dear [Supplier Name]:

The purpose of this letter is to inform you that pursuant to 42 *C.F.R. §* 405.800, 42 *C.F.R. §424.*57(e), and 42 *C.F.R. §* 424.535(a)(5), your Medicare supplier number [xxxxxxxxxx] for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) issued by

the National Supplier Clearinghouse (NSC) is revoked. The effective date of this revocation has been made retroactive to April 26, 2012, which is the date the Centers for Medicare & Medicaid Services (CMS) determined that your practice location is not operational.

We have determined that you are not in compliance with the supplier standards noted below:

42 C.F.R. § 424.57(c)(7) Maintain a physical facility on an appropriate site, accessible to the public and staffed during posted hours of business with visible signage.

Recently a representative of the NSC attempted to conduct a visit of your facility on April 26, 2012. However, the visit was unsuccessful because your facility was closed, locked, and vacant. There was a "For Rent" sign on the window along with a sign directing customers to a nearby Rite Aid Pharmacy. Because we could not complete an inspection of your facility, we could not verify your compliance with the supplier standards. Based on a review of the facts, we have determined that your facility is not operational to furnish Medicare covered items and services. Thus, you are in violation of 42 CFR 424.535(a)(5).

42 C.F.R. § 424.57(c)(26) must meet the surety bond requirements specified in *42 C.F.R. §* 424.57(d).

We received a cancellation notice from Cook, Books & Hyde Surety indicating that the surety bond on file with the NSC number 99999999 has been cancelled effective January 19, 2012. You failed to maintain a valid surety bond as required by law.

Section 1834 (j) of the Social Security Act states that, with the exception of medical equipment and supplies furnished incident to a physician's service, no payment may be made by Medicare for items furnished by a supplier unless the supplier has a valid Medicare billing number. Therefore, any expenses for items you supply to a Medicare beneficiary on or after the effective date of the revocation of your billing numbers are your responsibility and not the beneficiary's, unless you have proof that you have notified the beneficiary in accordance with section 1834(a)(18)(ii) of the Social Security Act and the beneficiary has agreed to take financial responsibility if the items you supply are not covered by Medicare. You will be required to refund on a timely basis to the beneficiary (and will be liable to the beneficiary for) any amounts collected from the beneficiary for such items. If you fail to refund the beneficiary as required under *sections* 1834(j)(4) and 1879(h) of the Social Security Act, you may be liable for Civil Monetary penalties.

(Delete the following paragraph if no re-enrollment bar established.)[Pursuant to 42 C.F.R. § 424.535(c), CMS is establishing a re-enrollment bar for a period of [Insert amount of time] that shall begin 30 days after the postmark date of this letter. This re-enrollment bar only applies to your ability to submit a new enrollment application to the Medicare program. In order to re-enroll, you must meet all requirements for your provider or supplier type.]

In addition, if submitting a CMS 855S application after the re-enrollment bar has expired, 42 *C.F.R. §* 424.57(d)(3)(ii) states suppliers will be required to maintain an elevated surety bond amount of $50,000 for each final adverse action imposed. Therefore, if you do not request a reconsideration of this decision or receive an unfavorable decision through the administrative review process, you must submit an elevated surety bond. Please note this amount is in addition to, and not in lieu of, the base $50,000 amount that must be maintained.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the implementation of the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request,

please utilize and include the attached coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- *Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.*
- *State the issues or findings of fact with which you disagree and the reasons for disagreement.*
- *Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.*
    - *If the authorized representative is an attorney, the attorney's statement that he/she/they have the authority to represent the provider or supplier is sufficient to accept this individual as the representative.*
    - *If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.*
    - *Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their behalf.*

Providers and suppliers may:

- *Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.*
- *Include an email address if you want to receive correspondence regarding your appeal via email.*

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[*National Supplier Clearinghouse Contractor name*]
[*Address*]
[*City*], *[ST]* [*Zip*]

If you choose not to request a reconsideration of this decision, or you do not receive a favorable decision through the administrative review process, you must wait *[insert number]* years before resubmitting your CMS-855S application, per the re-enrollment bar cited above. Applications received in the NSC prior to this timeframe will be returned.

If you have any questions, please contact our office at *[NSC call center phone number]* between the hours of [x:00 AM/PM *ET/CT/PT/MT*] and [x:00 AM/PM *ET/CT/PT/MT*].

Sincerely,

[Name]
[Title]
[Company]

3. MDPP Supplier Use of an Ineligible Coach Revocation Letter Example

[month] [day], [year]

[Entity name]
[Address]
[City, State & ZIP Code]

Reference # (PTAN #, Enrollment #, Case #, etc.)

Dear [MDPP Supplier Name]:

Your Medicare privileges are being revoked effective June 16, 2018 for the following reasons:

Revocation reason: 42 CFR §424.535(a)(1) – Not in Compliance with Medicare Requirements

Per 42 CFR §424.205(d)(3), MDPP suppliers must only use eligible coaches.

Revocation reason: 42 CFR §424.205(h)(v) – Use of an Ineligible coach

Specifically, you were notified on April 1, 2018 that John Doe was ineligible to serve as an MDPP coach due to an assault conviction in June 2015. On April 15, 2018, you submitted a corrective action plan (CAP), which removed John Doe from Section 7 of your Form CMS-20134. On June 1, 2018, you submitted a claim with the NPI of John Doe for services rendered May 1st, after he was removed from your coach roster. This indicates knowingly use of an ineligible MDPP coach.

Revocations under 42 CFR §424.205(h)(v) are not eligible for CAP submission. The revocation becomes effective 30 days after the date of this notice.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if revoked under 42 C.F.R. § 424.535(a)(1))

You may submit a corrective action plan (CAP) in response to the revocation of Medicare billing privileges under 42 C.F.R. § 424.535(a)(1). You may also request a reconsideration (described below). If your Medicare billing privileges were revoked under authorities other than 42 C.F.R. § 424.535(a)(1), you may **only** submit a reconsideration request in response to those revocation bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to maintain enrollment in the Medicare program. (Optional Coversheet sentence [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]) The CAP must:

- Be received in writing within 35 calendar days of the date of this letter and mailed or emailed to the address below;

- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.
- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

(Insert correct address based on whether the MAC or CMS is responsible for reviewing the CAP)

[Name of MAC]
[Address]
[City], /ST/ [Zip]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of *Provider Enrollment* Appeals
7500 Security Boulevard
Mailstop AR-*19-51*
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address]or [ProviderEnrollmentAppeals@cms.hhs.gov]

<u>Reconsideration Request</u>:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider,

supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.

- Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If revoked under 42 C.F.R. § 424.535(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

[Name of MAC]
[Address]
[City], *[*ST*]* [Zip]

or

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of *Provider Enrollment* Appeals
7500 Security Boulevard
Mailstop AR-*19-51*
Baltimore, MD 21244-1850

Or emailed to:

[Insert MAC email address]or [ProviderEnrollmentAppeals@cms.hhs.gov]

Pursuant to 42 CFR §424.535(c), CMS is establishing a re-enrollment bar for a period of [Insert amount of time] that shall begin 30 days after the postmark date of this letter. This re-enrollment bar only applies to your ability to submit a new enrollment application to the Medicare program. In order to re-enroll, you must meet all requirements for your provider or supplier type.

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]

10.7.12 – Deactivation Model Letter

(Rev. 11637; Issued: 10-07-22; Effective: 12-09-22; Implementation: 12-09-22)

(To be sent by hard-copy mail, and via email if email address is listed in the provider/supplier correspondence mailing address on the enrollment record. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier Name] (as it appears in PECOS)
[Address]
[City], [State] [Zip Code]

Re: Deactivation of Medicare billing privileges
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Provider/Supplier Name]:

Your Medicare billing privileges are being deactivated effective [Month] [DD], [YYYY] pursuant to:

DEACTIVATION REASON:

- 42 C.F.R. § 424.540(a)[1-*8*]

[Specific reason for the deactivation of the provider/supplier's Medicare billing privileges.]

(If the deactivation is under 424.540(a)(1), an example narrative may include:

[*Contractor* Name] has reviewed your Medicare billing data and found that you have not submitted any claims since January 1, 2017, which is more than twelve calendar months from the date of this letter.)

(If the deactivation is under 424.540(a)(2), an example narrative may include:

[*Contractor* Name] has been informed that John Smith is deceased as of January 1, 2017. Your Medicare enrollment application, signed and certified on November 1, 2016, identifies John Smith as a 5% or greater owner. [*Contractor* Name] has not received a Medicare enrollment application reporting this change in ownership.)

REBUTTAL RIGHTS:

If you believe that this determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.545(b). The rebuttal must be received by this office in writing within 20 calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal.

This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.

The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative. *(Delete next sentence if letter is related to a DMEPOS supplier's enrollment.) [Please be advised that authorized or delegated officials for groups cannot sign and submit a rebuttal on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their behalf.]*

If the provider/supplier wishes to appoint a legal representative that is not an attorney to sign the rebuttal, the provider/supplier must include with the rebuttal a written notice authorizing the legal representative to act on the provider/supplier's behalf. The notice should be signed by the provider/supplier.

If the provider/supplier has an attorney sign the rebuttal, the rebuttal must include a statement from the attorney that he/she*/they have* the authority to represent the provider/supplier.

If you wish to receive communication regarding your rebuttal via email, please include a valid email address in your rebuttal submission.

The rebuttal should be sent to the following:
[*Contractor* Rebuttal Receipt Address]
[*Contractor* Rebuttal Receipt Email Address]
[*Contractor* Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM *ET/CT/MT/PT*] and [x:00 AM/PM *ET/CT/MT/PT*].

Sincerely,

[Name] [Title] [Company]

10.7.13 – Rebuttal Model Letters

(Rev. 11637; Issued: 10-07-22; Effective: 12-09-22; Implementation: 12-09-22)

Instruction

For the following model letters, all text within parentheses is intended as instruction/explanation and should be deleted before the letter is finalized and sent to the provider or supplier. All text within brackets requires the contractor to fill in the appropriate text. All letters shall be saved in PDF format.

A. Rebuttal Signature Development Model Letter

(To be sent by hard-copy mail, and via email if email address is provided *with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission.* Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal *Submission*
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (*optional*)

Dear [Name of the person(s) who submitted the rebuttal]:

We are in receipt of your rebuttal submission *on behalf of [Provider/Supplier]*, received on [Month] [DD], [YYYY].

(If the submission is not properly signed, use the following.) Your submission is not appropriately signed, as required in the Medicare Program Integrity Manual, Ch. 10, Section 10.4(M). [*Contractor* Name] request*s* that you submit a rebuttal properly signed by the individual provider, supplier, the authorized or delegated official, or a legal representative. *(Delete next sentence if letter is related to a DMEPOS supplier's enrollment.) [Please be advised that authorized or delegated officials for groups cannot sign and submit a rebuttal on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their behalf.]*

Your properly signed submission must be received within 15 calendar days of the date of this notice. If you do not timely respond to this request, *[Contractor Name] may dismiss* your rebuttal submission.

(If the submission is missing a statement by the attorney, use the following.) Your submission is missing an attorney statement that he or she has the authority to represent the provider or supplier. [*Contractor* Name] request*s* that you submit a rebuttal that includes an attorney statement that he*/she/they have* the authority to represent the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, *[Contractor Name] may dismiss* your rebuttal submission.

(If the submission is missing a signed written notice from the provider/supplier authorizing the legal representative to act on his/her/*their/*its behalf, use the following.) Your submission is missing a written notice of the appointment of a representative signed by the provider or supplier. *Please be advised that authorized or delegated officials for groups cannot sign and submit a rebuttal on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their behalf.* [*Contractor* Name] request*s* that you submit written notice of the appointment of a representative that is *properly* signed by the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, *[Contractor Name] may dismiss* your rebuttal submission.

Please send the required documentation to:

[Contractor Rebuttal Receipt Address]
[Contractor Rebuttal Receipt Email Address]
Fax: [Contractor Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 *a.m./p.m ET/CT/MT/PT*] and [x:00 *a.m./p.m ET/CT/MT/PT*].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[*Contractor* Name]

B. Rebuttal Further Information Required Development Model Letter

(To be sent by hard-copy mail, and via email if email address is provided *with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission.* Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal *Submission*
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (*Optional*)

Dear [Name of the person(s) who submitted the rebuttal]:

On [Month] [DD]. [YYYY], [*Contractor* Name] issued a favorable rebuttal determination, reversing the deactivation of [Provider/Supplier Name]'s Medicare billing privileges. As stated in the [Month] [DD], [YYYY] determination letter, the reactivation of [Provider/Supplier Name]'s Medicare enrollment is contingent upon the submission of [list required documentation]. Please send the required documentation to:

[*Contractor* Rebuttal Receipt Address]
[*Contractor* Rebuttal Receipt Email Address]
Fax: [*Contractor* Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 *a.m./p.m ET/CT/MT/PT*] and [x:00 *a.m./p.m ET/CT/MT/PT*].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[*Contractor* Name]

C. Rebuttal Moot Model Letter

(To be sent by hard-copy mail, and via email if email address is provided *with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing*

address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal *Submission*
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (*optional*)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal submission*, on behalf of [Provider/Supplier]*, received on [Month] [DD], [YYYY]. On [Month] [DD], [YYYY], [*Contractor* Name] approved an application to reactivate [Provider/Supplier]'s Medicare billing privileges without a gap. Therefore, the issue set forth in the rebuttal submission is no longer actionable. As a result, this issue is moot and a determination will not be made in regards to the rebuttal submission.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 *a.m./p.m ET/CT/MT/PT*] and [x:00 *a.m./p.m ET/CT/MT/PT*].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[*Contractor* Name]

D. Rebuttal Facts or Issues and Reasons for Disagreement Development Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address] (Address from which the Rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal Submission
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the Rebuttal]:

We are in receipt of your rebuttal submission on behalf of [Provider/Supplier Name], received on [Month] [DD], [YYYY].

As stated in the deactivation letter dated [Month] [DD], [YYYY], to be accepted and reviewed, your rebuttal must state the facts or issues identified in the deactivation letter with which you disagree and your reasons for disagreement. The rebuttal received on [Month] [DD], [YYYY] does not clearly identify the facts or issues with which you disagree and your reasons for disagreement. [Contractor Name] is granting you an additional 15 calendar days from the date of this notification letter to submit a proper rebuttal that clearly identifies the facts or issues with which you disagree and your reasons for disagreement. This revised rebuttal submission must be received within 15 calendar days of the date of this notice. If you do not timely respond to this request, [Contractor Name] may dismiss your rebuttal submission.

Please send the required documentation to:

[Contractor Rebuttal Receipt Address]
[Contractor Rebuttal Receipt Email Address]
Fax: [Contractor Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/CT/MT/PT] and [x:00 a.m./p.m ET/CT/MT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

E. Rebuttal Withdrawn Model Letter

(To be sent by hard-copy mail, and via email if email address is provided *with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission.* Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal *Submission*
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (*optional*)

Dear [Name of the person(s) who submitted the rebuttal]:

We are in receipt of your written withdrawal request in regards to your rebuttal received on [Month] [DD], [YYYY]*, submitted on behalf of [Provider/Supplier Name]*. [*Contractor* Name] has not yet issued a rebuttal determination. Therefore, [*Contractor* Name] considers *the* rebuttal to be withdrawn. As a result, a determination will not be issued in response to *the* rebuttal and *[Provider/Supplier Name] 's* Medicare billing privileges will remain deactivated.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 *a.m./p.m ET/CT/MT/PT*] and [x:00 *a.m./p.m ET/CT/MT/PT*].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[*Contractor* Name]

F. Rebuttal Receipt Acknowledgement Model Letter

(To be sent by hard-copy mail, and via email if email address is provided *with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission.* Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal *Submission*
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (*optional*)

Dear [Name of the person(s) who submitted the rebuttal]:

We are in receipt of your rebuttal on behalf of [Provider/Supplier Name]. Please be advised that [*Contractor* Name] has made an interim determination to maintain the deactivation of your Medicare billing privileges. However, [*Contractor* Name] will further review the information and documentation submitted in *the* rebuttal and will render a final determination regarding the deactivation of your Medicare billing privileges within 30 days of the date of receipt.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 *a.m./p.m ET/CT/MT/PT*] and [x:00 *a.m./p.m ET/CT/MT/PT*].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[*Contractor* Name]

G. Final Rebuttal Decision Email Template

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

To: [Email address provided by the person who submitted the rebuttal *and email address listed in the provider/supplier correspondence mailing address on the enrollment application if different from the email address on the rebuttal submission*.]

Subject: Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

Dear [Name of the person(s) who submitted the rebuttal]:

Please see the attached determination regarding your rebuttal*, submitted on behalf of [Provider/Supplier Name]*.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 *a.m./p.m ET/CT/MT/PT*] and [x:00 *a.m./p.m ET/CT/MT/PT*].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[*Contractor* Name]

H. Rebuttal Dismissal Model Letters

1. Untimely Rebuttal Dismissal Model Letter

(To be sent by hard-copy mail, and via email if email address is provided *with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission.* Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal *Submission*
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (*optional*)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [*Contractor* Name], based on the letter deactivating *[Provider/Supplier Name] 's* Medicare billing privileges dated [Month] [DD], [YYYY].

[*Contractor* Name] is unable to accept your rebuttal as it was not timely submitted. The deactivation letter was dated [Month] [DD], [YYYY]. A rebuttal must be received within *15* calendar days of the date of the [Month] [DD], [YYYY] deactivation letter. Your rebuttal was not received until [Month] [DD], [YYYY], which is beyond the applicable submission time frame. [Provider/Supplier/Legal Representative/Representative] failed to show good cause for *the* late request. Therefore, [*Contractor* Name] is unable to render a determination in this matter and *[Provider/Supplier] 's* Medicare billing privileges will remain deactivated.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 *a.m./p.m ET/CT/MT/PT*] and [x:00 *a.m./p.m ET/CT/MT/PT*].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[*Contractor* Name]

2. Improper Signature Rebuttal Dismissal Model Letter

(To be sent by hard-copy mail, and via email if email address is provided *with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission.* Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address](Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal *Submission*
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (*optional*)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [*Contractor* Name], based on the letter deactivating *[Provider/Supplier Name] 's* Medicare billing privileges dated [Month] [DD], [YYYY].

[*Contractor* Name] is unable to accept your rebuttal as it was not signed by an authorized or delegated official currently on file in your Medicare enrollment, the individual provider or supplier, a legal representative, or did not contain the required statement of representation

from an attorney or signed written notice appointing a non-attorney legal representative. *Please be advised that authorized or delegated officials for groups cannot sign and submit a rebuttal on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their behalf.* The signature requirement is stated in the [Month] [DD], [YYYY] deactivation letter. *Additionally, in a letter dated [Month] [DD], [YYYY], [Contractor Name] requested that you provide a properly signed submission and permitted an additional 15-calendar days to submit your response.*

(If no response received, use this language: [To date, [Contractor Name] has not received a response. As a result, [Contractor Name] is dismissing your rebuttal and no decision will be rendered.])

(If response received after 15 calendar days, use this language: [While [Contractor Name] received a response, it was not timely received within 15-calendar days. As a result, [Contractor Name] is dismissing your rebuttal and no decision will be rendered.])

If you have any questions, please contact our office at [phone number] between the hours of [x:00 *a.m./p.m ET/CT/MT/PT*] and [x:00 *a.m./p.m ET/CT/MT/PT*].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[*Contractor* Name]

3. No Rebuttal Rights Rebuttal Dismissal Model Letter

(To be sent by hard-copy mail, and via email if email address is provided *with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission.* Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address](Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal *Submission*
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (*optional*)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [*Contractor* Name]*, submitted on behalf of [Provider/Supplier Name]*.

[*Contractor* Name] is unable to accept your rebuttal submission because the action taken in regards to your Medicare billing privileges does not afford the opportunity for a rebuttal.

Under 42 C.F.R. § 424.546, only a provider or supplier whose Medicare billing privileges are deactivated may file a rebuttal in accordance with 42 C.F.R. § 405.374. *As a result, [Contractor Name] is dismissing your rebuttal and no decision will be rendered.*

If you have any questions, please contact our office at [phone number] between the hours of [x:00 *a.m./p.m ET/MT/CT/PT*] and [x:00 *a.m./p.m ET/MT/CT/PT*].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[*Contractor* Name]

4. More than One Submission Rebuttal Dismissal Model Letter

(To be sent by hard-copy mail, and via email if email address is provided *with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission.* Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address](Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal *Submission*
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (*optional*)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal *submitted on behalf of [Provider/Supplier Name]*, based on the deactivation letter dated [Month] [DD], [YYYY].

[*Contractor* Name] previously received a rebuttal for [Provider/Supplier Name] on [Month] [DD], [YYYY]. Per Chapter 10 of the Medicare Program Integrity Manual, only one rebuttal request may be submitted per deactivation. Therefore, [*Contractor* Name] is unable to accept your additional rebuttal[s] received on [Month] [DD], [YYYY]. *As a result, [Contractor Name] is dismissing your rebuttal and no decision will be rendered.*

If you have any questions, please contact our office at [phone number] between the hours of [x:00 *a.m./p.m ET/MT/CT/PT*] and [x:00 *a.m./p.m ET/MT/CT/PT*].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[*Contractor* Name]

5. No Specification of Why the Provider/Supplier Disagrees with Enrollment Deactivation and Reasons for Disagreement Rebuttal Dismissal Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address] (Address from which the Rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal Submission
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the Rebuttal]:

This letter is in response to the rebuttal submitted on behalf of [Provider/Supplier Name] based on the deactivation letter, dated [Month] [DD], [YYYY].

[Contractor Name] is unable to accept your rebuttal as it does not specify the facts or issues identified in the deactivation letter with which you disagree and your reasons for disagreement. The requirement to identify the facts or issues with which you disagree and your reasons for disagreement was stated in the deactivation letter, dated [Month] [DD], [YYYY], as well as in 42 C.F.R. § 424.546(b), and in Chapter 10 of the Medicare Program Integrity Manual. Additionally, in a letter dated [Month] [DD], [YYYY], [Contractor Name] requested that you identify the facts or issues identified in the deactivation letter with which you disagree and your reasons for disagreement and permitted an additional 15-calendar days to submit your response.

(If no response received, use this language: [To date, [Contractor Name] has not received a response. As a result, [Contractor Name] is dismissing your rebuttal and no decision will be rendered.])

(If response received after 15 calendar days, use this language: [While [Contractor Name] received a response, it was not timely received within 15-calendar days. As a result, [Contractor Name] is dismissing your rebuttal and no decision will be rendered.])

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/MT/CT/PT] and [x:00 a.m./p.m ET/MT/CT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]

[Position of Hearing Officer]
[Contractor Name]

I. Rebuttal Not Actionable Model Letter (Moot)

(To be sent by hard-copy mail, and via email if email address is provided *with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission.* Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal *Submission*
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (*optional*)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [*Contractor* Name], concerning the deactivation of [Provider/Supplier Name]'s Medicare billing privileges, effective [Month] [DD], [YYYY].

On [Month] [DD], [YYYY], [*Contractor* Name] reopened the deactivation for [Provider/Supplier Name] and issued a revised initial determination. This revised initial determination rendered the issue set forth in your rebuttal no longer actionable. *For your convenience a copy of the revised initial determination is attached.* Accordingly, the issue addressed in your rebuttal is now moot, and we are unable to render a determination on the matter.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 *a.m./p.m ET/MT/CT/PT*] and [x:00 *a.m./p.m ET/MT/CT/PT*].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[*Contractor* Name]

(The contractor shall include PDF copy of the letter that rendered the rebuttal moot (e.g. the revised initial determination).)

J. Favorable Rebuttal Model Letter

(To be sent by hard-copy mail, and via email if email address is provided *with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email*

address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address] (Address from which the Rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (*optional*)

Dear [Name of the Person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [*Contractor* Name] based on the deactivation of [Provider/Supplier Name]'s Medicare billing privileges. *(If the rebuttal was timely, use the following.) [*The deactivation letter was dated [Month] [DD], [YYYY] *and [Contractor Name] received the rebuttal on [Month] [DD], [YYYY]*; therefore, this rebuttal is considered timely.*] (If the rebuttal is untimely, but good cause has been found to accept the rebuttal, use the following.) [The deactivation letter was dated [Month] [DD], [YYYY] and [Contractor Name] received the rebuttal on [Month] [DD], [YYYY]. This rebuttal was not timely submitted, but a good cause waiver has been granted.]) [Contractor Name] based the* following determination on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DEACTIVATION REASON:

- 42 C.F.R. § 424.540(a)(*[*1-*8]*)

OTHER APPLICABLE AUTHORIT*[Y/IES]*: *(list any authorities cited in analysis)*

- *42 C.F.R. § 424.546*
- Medicare Program Integrity Manual (MPIM) chapter 10.XX (If applicable).
- *(Ex.: If deactivation based non-compliance, list supplier standards)*
- *(Ex.: If deactivation based on failure to report, list regulation that requires reporting)*

EXHIBITS:

- Exhibit 1: (Example: Rebuttal letter to CMS, signed by John Smith, Administrator for Home Healthcare Services, LLC, dated January 1, 2018);
- Exhibit 2: (Example: Letter from *[Contractor Name]* to Home Healthcare Services, LLC, dated December 1, 2017, deactivating Home Healthcare Services, LLC's Medicare billing privileges pursuant to 42 C.F.R. § 424.540(a)(3)).

(In this section list each document submitted by the provider or supplier. Each exhibit sh*all* include the date, as well as a brief description of the document. *The contractor* shall also include other documentation not submitted by the provider *or supplier* that the hearing officer reviewed in making the determination, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

[Contractor Name] has reviewed the documentation related to the matter for [Provider/Supplier Name] and *made* the determination in accordance with the applicable Medicare rules, policies and program instructions.

(Summarize the facts underlying the case which led up to the submission of the rebuttal.)

REBUTTAL ANALYSIS:

(A rebuttal reviews whether or not an error was made in the implementation of the deactivation of the provider's or supplier's Medicare billing privileges. This section *shall* summarize the statements made by the provider or supplier in its rebuttal*, t*hen *provide an* analysis of the arguments based on the applicable regulations and sub-regulations, *such as the* MPIM. *Any regulation or sub-regulatory guidance that is referenced in this section shall also be listed in "Other Applicable Authorities."* It is insufficient to state a rebuttal determination without explaining how and why the determination was made.)

DECISION:

(A short conclusory restatement.)

(Example: On [Month] [DD], [YYYY], [*Contractor* Name] received a revalidation application for Home Healthcare Services, LLC. On [Month] [DD], [YYYY], [*Contractor* Name] rejected Home Healthcare Services, LLC's revalidation application prior to 90 calendar days from the date of the revalidation request letter. As a result, [*Contractor* Name] finds that the deactivation of Home Healthcare Services, LLC's Medicare billing privileges *was not appropriately implemented* based on the information available.*)*

This is a **FAVORABLE DETERMINATION**. To effectuate this determination, [*Contractor* name] will reinstate [Provider/Supplier Name]'s Medicare billing privileges.

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the *Contractor* shall state what information is needed from the provider or supplier in this rebuttal determination. *Contractor*s shall state that the requested information/documentation must be received within 30 calendar days of the date of this determination letter)

If you have any questions, please contact our office at [phone number] between the hours of [x:00 *a.m./p.m ET/MT/CT/PT*] and [x:00 *a.m./p.m ET/MT/CT/PT*].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[*Contractor* Name]

K. Unfavorable Rebuttal Model Letter

(To be sent by hard-copy mail, and via email if email address is provided *with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission.* Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address] (Address from which the Rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (*optional*)

Dear [Person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [*Contractor* Name] based on the deactivation of [Provider/Supplier Name]'s Medicare billing privileges. *(If the rebuttal was timely, use the following.) [*The deactivation letter was dated [Month] [DD], [YYYY] *and [Contractor Name] received the rebuttal on [Month] [DD], [YYYY]*; therefore, this rebuttal is considered timely.*] (If the rebuttal is untimely, but good cause has been found to accept the rebuttal, use the following.) [The deactivation letter was dated [Month] [DD], [YYYY] and [Contractor Name] received the rebuttal on [Month] [DD], [YYYY]. This rebuttal was not timely submitted, but a good cause waiver has been granted.]) [Contractor Name] based the* following determination is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DEACTIVATION REASON:

- 42 C.F.R. § 424.540(a)(*[1-8]*)

OTHER APPLICABLE AUTHORIT*[Y/IES]*: *(list any authorities cited in analysis)*

- 42 C.F.R. § *424.546*
- Medicare Program Integrity Manual chapter 10.XX (If applicable)
- *(Ex.: If deactivation based non-compliance, list supplier standards)*
- *(Ex.: If deactivation based on failure to report, list regulation that requires reporting)*

EXHIBITS:

- Exhibit 1: (Example: Rebuttal letter to CMS, signed by John Smith, Administrator for Home Healthcare Services, LLC, dated January 1, 2018);
- Exhibit 2: (Example: Letter from *[Contractor Name]* to Home Healthcare Services, LLC, dated December 1, 2017, deactivating Home Healthcare Services, LLC's Medicare billing privileges pursuant to 42 C.F.R. § 424.540(a)(3)).

(In this section list each document submitted by the provider or supplier. Each exhibit *shall* include the date, as well as a brief description of the document. *The Contractor* shall also include other documentation not submitted by the provider *or supplier* that the hearing officer reviewed in making the determination, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

[Contractor Name] has reviewed the documentation related to the matter for [Provider/Supplier Name] and *made* the determination in accordance with the applicable Medicare rules, policies, and program instructions.

*(*Summarize the facts underlying the case which led up to the submission of the rebuttal.*)*

REBUTTAL ANALYSIS:

(A rebuttal reviews whether or not an error was made in the implementation of the deactivation of the provider's or supplier's Medicare billing privileges. This section sh*all* summarize the statements made by the provider or supplier in its rebuttal*, t*hen *provide an* analysis of the arguments based on the applicable regulations and sub-regulations, *such as the* MPIM. *Any regulation or sub-regulatory guidance that is referenced in this section shall also be listed in "Other Applicable Authorities."* It is insufficient to state a rebuttal determination without explaining how and why the determination was made.)

DECISION:

(A short conclusory restatement.)

(Example: On [Month] [DD], [YYYY], [*Contractor* Name] received a revalidation application for Home Healthcare Services, LLC. On [Month] [DD], [YYYY], [*Contractor* Name] sent a development request to continue processing Home Healthcare Services, LLC's revalidation application. Home Healthcare Services, LLC did not timely respond to [*Contractor* Name]'s development request. As a result, [*Contractor* Name] properly rejected Home Healthcare Services, LLC's revalidation application. Therefore, [*Contractor* Name] finds that the deactivation of Home Healthcare Services, LLC's Medicare enrollment under 42 C.F.R. § 424.540(a)(*[*1-*8]*) *was appropriately implemented*.)

This is an **UNFAVORABLE DETERMINATION**. [*Contractor* name] concludes that there was no error made in the deactivation of *[Provider/Supplier Name]'s* Medicare billing privileges. As a result, *[Provider/Supplier Name]'s* Medicare billing privileges will remain deactivated.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 *a.m./p.m ET/MT/CT/PT*] and [x:00 *a.m./p.m ET/MT/CT/PT*].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[*Contractor* Name]

10.7.14 – Model Opt-out Letters

(Rev. 11637; Issued:10-07-22; Effective:12-09-22; Implementation:12-09-22)

The *Contractor*s shall use the model letters in this section to respond to eligible practitioners' opt-out affidavits, request additional documentation, approve opt out affidavits and acknowledge the cancelation or early termination of an opt-out. The *Contractor*s shall not use these model letters to respond to Medicare enrollment applications or other correspondence. The *Contractor*s may issue the Model Opt-out Development Letter via fax, e-mail or mail to the eligible practitioner.

A. Opt-out Affidavit Development Letter

MACs shall use the following letter to request missing information from an eligible practitioner that wishes to opt-out of Medicare. This letter should be sent only one time and include a request for all missing information. The MAC may select the response type, either via mail, fax or email.

[month] [day], [year]

[Eligible Practitioner Name]

[Address]

[City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner]:

[Insert MAC] requires the following information to complete the processing of your Medicare opt-out affidavit:

[Specify information needed]

Submit the requested information within 30 calendar days of the postmark date of this letter [to the address listed below, via fax to (###-###-####), or via email to (enter PE analyst's email address here)]. We may reject your opt-out affidavit if you do not furnish the requested information within this timeframe.

[Name of MAC]
[Address]
[City], [ST] [Zip]

Attach a copy of this letter with your revised opt-out affidavit.

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM] .

Sincerely,

[Name]
[Title]
[Company]

B. Opt-out Rejection Letter

In the event that an eligible practitioner does not respond timely or does not respond with needed information to complete an opt-out affidavit, the MACs shall issue this rejection letter.

[month] [day], [year]

[Eligible Practitioner Name]

[Address]

[City] ST [Zip]

Reference: Case/Control Number

Dear Eligible Practitioner Name:

[Insert MAC] is rejecting your Medicare opt-out affidavit, received on [insert date], for the following reason(s):

[List all reasons for rejection:]

To resubmit your opt-out affidavit include all information needed to process your opt-out request. Additional information on submitting a complete opt-out affidavit can be found at: [enter MAC website address].

Return the completed opt-out affidavit to:

[Name of MAC]
[Address]
[City], [ST] [Zip]

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

C. Opt-out Return Letters

Opt-out affidavits should only be returned for the following reasons:

1. The eligible practitioner requesting to opt-out of Medicare is not appropriately licensed by the state,
2. The practitioner is a specialty that is ineligible to opt-out (e.g., Chiropractic Medicine, Physical Therapy, Occupational Therapy, etc.),
3. The opt-out affidavit is filed with an incorrect MAC,
4. The eligible practitioner decides not to opt out of Medicare while their opt-out affidavit is still in process, but not yet approved by the MAC,
5. The eligible practitioner submits a cancellation request too late (within 30 days of the auto-renewal date or after the auto-renewal date), this return letter provides appeal rights, or
6. The eligible practitioner submits a cancellation request more than 90 days prior to the auto-renewal date.

MACs shall issue the specific letter for the return reason.

1. Opt-out Return Letter – Unlicensed Eligible Practitioner

[month] [day], [year]
[Eligible Practitioner Name]

[Address]

[City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] is returning your Medicare opt-out affidavit, submitted on [insert date], as you are not licensed by the state for the specialty type you indicated on your opt-out affidavit.

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

2. Opt-out Return Letter – Ineligible Practitioner

[month] [day], [year]
[Eligible Practitioner Name]

[Address]

[City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] is returning your Medicare opt-out affidavit, submitted on [insert date], because you indicated a specialty that is ineligible to opt-out (e.g., Chiropractic Medicine, Physical Therapy, Occupational Therapy, etc.) of Medicare.

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

3. Opt-out Return Letter – Submitted to Incorrect MAC

[month] [day], [year]
[Eligible Practitioner Name]

[Address]

[City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] is returning your Medicare opt-out affidavit, submitted on [insert date], because your opt-out affidavit was filed with an incorrect Medicare Administrative Contractor for the state that you are located in. Your affidavit should be resubmitted to the appropriate contractor for processing.

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

4. Opt-out Return Letter – Withdraw of Affidavit During Processing

[month] [day], [year]

[Eligible Practitioner Name]

[Address]

[City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] is returning your Medicare opt-out affidavit, submitted on [insert date], because you have decided to withdraw your opt-out affidavit while it is still in process.

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

5. Opt-out Return Letter – Late Cancellation Request

[*M*onth] [*DD*], [*YYYY*]

[Eligible Practitioner Name]
[Address *from which opt-out was sent*]
[City]*, [ST]* [Zip]

Reference: *[*Case/Control Number*] (optional)*
NPI: [xxxxxxxxxx]

Dear [Eligible Practitioner Name]:

[*Contractor Name*] is returning your written request to cancel the automatic renewal *of* your Medicare opt-out status, submitted on *[Month] [DD], [YYYY]*, as it was *(choose appropriate language)* [not submitted at least 30 days prior to the end of your current opt-out period/received after the opt-out period automatically renews].

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the implementation of the initial determination. (Optional Coversheet sentence) [To facilitate the processing of your reconsideration request, please utilize and include the attached coversheet [also found at [[insert web address for coversheet]] with your submission.]

Reconsideration requests must:

- *Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.*
- *State the issues or findings of fact with which you disagree and the reasons for disagreement.*
- *Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.*
    - *If the authorized representative is an attorney, the attorney's statement that he/she/they have the authority to represent the provider or supplier is sufficient to accept this individual as the representative.*
    - *If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.*
    - *Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their behalf.*

Providers and suppliers may:

- *Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law*

Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.

- *Include an email address if you want to receive correspondence regarding your appeal via email.*

Failure to submit a reconsideration request is deemed a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to: (Insert correct address based on whether the contractor or CMS is responsible for handling the reconsideration.)

[Contractor Name]
[Address]
[City], [ST] [Zip]

OR

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop: AR-19-51
Baltimore, MD 21244-1850

Or emailed to: ([Contractor email] or ProviderEnrollmentAppeals@cms.hhs.gov).

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

6. Opt-out Return Letter – Cancellation Request Submitted Too Early

[*M*onth] [*DD*], [*YYYY*]

[Eligible Practitioner Name]
[Address *from which opt-out was sent*]
[City], *[ST]* [Zip]

Reference: *[*Case/Control Number*] (optional)*
NPI: [xxxxxxxxxx]

Dear [Eligible Practitioner Name]:

[Contractor Name] is returning your written request to cancel the automatic renewal your Medicare opt-out status, submitted on *[Month] [DD], [YYYY]*, as it was submitted at more than 90 days prior to the end of your current opt-out period.

Please submit your cancellation request no later than 30 days prior to the end of your current opt-out period to avoid auto-renewal of your opt-out status. Your autorenewal date is: *[Month] [DD], [YYYY]*.

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

D. Opt-out Affidavit Approval Letters

The *Contractor*s shall issue an Opt-out Affidavit Approval model letter when approving an opt-out affidavit and PECOS has been updated with the affidavit information. The approval letter shall be issued for the following reasons:

1. Approved Opt-Out, Eligible Practitioner May Order & Refer
2. Approved Opt-Out, Eligible Practitioner May Not Order & Refer (OIG Exclusion)
3. Approved Opt-Out, Eligible Practitioner May Not Order & Refer (Ineligible Specialty)
4. Approved Opt-Out, Eligible Practitioner May Not Order & Refer (Did Not Elect to Order & Refer)
5. Approved Opt-Out, Eligible Practitioner May Not Order & Refer (Eligible Practitioner Does Not Have an NPI)
6. Approved Opt-Out, Eligible Practitioner May Not Order & Refer (Eligible Practitioner has Revoked Billing Privileges)
7. Approved Opt-Out Change of Information

The Opt-out approval letter shall include:

- The eligible practitioner's personal information:
  - Name,
  - Address,
  - NPI,
  - Specialty, and
  - Eligibility to order and refer.

- The eligible practitioner's opt-out effective date.

- The date that the eligible practitioner can submit a request to cancel their opt-out affidavit (at least 30 days prior to the end-date of their current opt-out period).

- The date the eligible practitioner can terminate his/her*/their* opt-out early (if they are eligible to so, no later than 90 days after the effective date) of the eligible practitioner's initial 2-year opt-out period.

- Should the eligible practitioner opt-out a subsequent time after cancelling, contractors shall remove the paragraph noting "Since you are opting out for the very first time…" since this statement no longer applies.

1. Opt-out Affidavit Approval Letter – Eligible Practitioner Approved to Order & Refer

[Month] [DD], [YYYY]

[Eligible Practitioner Name]
[Address from which opt-out was sent]
[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)

Dear [Eligible Practitioner Name]:

[*Contractor Name*] approved your Medicare opt-out affidavit.

Opt-out Affidavit Information:

Eligible Practitioner Name:	[Name]
Address on File:	[Address, City, State, Zip]
National Provider Identifier (NPI):	[NPI]
Specialty:	[Specialty]
Ordering and Referring:	You are eligible to Order and Refer
Effective Date:	[Effective date]

Your opt-out will automatically renew every 2 years.

Since you are opting out for the very first time, you have a one-time, 90-day period to change your mind about opting out. If you decide to terminate during this 90-day period, you must submit your request, in writing, no later than [Month*] [*DD*]*, *[*YYYY]. After this 90-day period ends, you can only cancel the opt-out at the end of a 2 year opt-out period. If you were unable to submit a termination request, you may appeal after the 90-day period ends. Please follow the *Right to Submit a Reconsideration Request* sections below.

To cancel opt-out, you must submit a cancellation request at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out at the end of this opt-out period, you must submit your cancellation request before [Month*] [*DD*]*, *[*YYYY].

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the implementation of the initial determination. (Optional Coversheet sentence) [To facilitate the processing of your reconsideration request, please utilize and include the attached coversheet [also found at [[insert web address for coversheet]] with your submission.]

Reconsideration requests must:

- *Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.*
- *State the issues or findings of fact with which you disagree and the reasons for disagreement.*
- *Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.*
  - *If the authorized representative is an attorney, the attorney's statement that he/she/they have the authority to represent the provider or supplier is sufficient to accept this individual as the representative.*
  - *If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.*

- *Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their behalf.*

Providers and suppliers may:

- *Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.*
- *Include an email address if you want to receive correspondence regarding your appeal via email.*

Failure to submit a reconsideration request is deemed a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to: (Insert correct address and email address based on whether the contractor or CMS is responsible for handling the reconsideration.)

[Contractor Name]
[Address]
[City], [ST] [Zip]

OR

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop: AR-19-51
Baltimore, MD 21244-1850

Or emailed to: ([Contractor email] or ProviderEnrollmentAppeals@cms.hhs.gov).

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

2. Opt-out Affidavit Approval Letter – Eligible Practitioner May Not Order & Refer (Excluded by the OIG)

[Month] [DD], [YYYY]

[Eligible Practitioner Name]
[Address from which opt-out was sent]
[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)

Dear [Eligible Practitioner Name]:

[Insert *Contractor*] approved your Medicare opt-out affidavit.

Opt-out Affidavit Information:

Eligible Practitioner Name:	[Name]
Address on File:	[Address, City, State, Zip]
National Provider Identifier (NPI):	[NPI]
Specialty:	[Specialty]
Ordering and Referring:	You are not eligible to Order and Refer*
Effective Date:	[Effective date]

* You have been excluded by the OIG (and even if you have or have not obtained a waiver according to 42 *C.F.R. §* 1001.1901(c)), you may opt-out of Medicare, but you are not permitted to order and refer items and services to Medicare beneficiaries

Your opt-out will automatically renew every 2 years.

Since you are opting out for the very first time, you have a one-time, 90 day period to change your mind about opting out. If you decide to terminate during this 90 day period, you must submit your request, in writing, no later than [Month*] [*DD*]*, *[*YYYY]. After this 90 day period ends, you can only cancel the opt-out at the end of a 2 year opt-out period. If you were unable to submit a termination request, you may appeal after the 90 day period ends. Please follow the *Right to Submit a Reconsideration Request* sections below.

To cancel opt-out, you must submit a cancellation request at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out at the end of this opt-out period, you must submit your cancellation request before [Month*] [*DD*]*, *[*YYYY].

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the implementation of the initial determination. (Optional Coversheet sentence) [To facilitate the processing of your reconsideration request, please utilize and include the attached coversheet [also found at [[insert web address for coversheet]] with your submission.]

Reconsideration requests must:

- *Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.*
- *State the issues or findings of fact with which you disagree and the reasons for disagreement.*
- *Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.*
    - *If the authorized representative is an attorney, the attorney's statement that he/she/they have the authority to represent the provider or supplier is sufficient to accept this individual as the representative.*
    - *If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.*
    - *Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the*

provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their behalf.

Providers and suppliers may:

- *Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.*
- *Include an email address if you want to receive correspondence regarding your appeal via email.*

Failure to submit a reconsideration request is deemed a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to: (Insert correct address based on whether the contractor or CMS is responsible for handling the reconsideration.)

[Contractor Name]
[Address]
[City], [ST] [Zip]

OR

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop: AR-19-51
Baltimore, MD 21244-1850

Or emailed to: ([Contractor email] or ProviderEnrollmentAppeals@cms.hhs.gov).

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

3. Opt-out Affidavit Approval Letter – Eligible Practitioner May Not Order & Refer (Ineligible Specialty)

[Month] [DD], [YYYY]

[Eligible Practitioner Name]
[Address from which opt-out was sent]
[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)

Dear [Eligible Practitioner Name]:

[Insert *Contractor*] approved your Medicare opt-out affidavit.

Opt-out Affidavit Information:

Eligible Practitioner Name:	[Name]
Address on File:	[Address, City, State, Zip]
National Provider Identifier (NPI):	[NPI]
Specialty:	[Specialty]
Ordering and Referring:	You are not eligible to Order and Refer*
Effective Date:	[Effective date]

* You may opt-out of Medicare, but you are not permitted to order and refer items and services to Medicare beneficiaries, as your specialty is ineligible to order and refer.

Your opt-out will automatically renew every 2 years.

Since you are opting out for the very first time, you have a one-time, 90 day period to change your mind about opting out. If you decide to terminate during this 90 day period, you must submit your request, in writing, no later than [Month*] [*DD*]*, *[*YYYY]. After this 90 day period ends, you can only cancel the opt-out at the end of a 2 year opt-out period. If you were unable to submit a termination request, you may appeal after the 90 day period ends. Please follow the *Right to Submit a Reconsideration Request* section below.

To cancel opt-out, you must submit a cancellation request at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out at the end of this opt-out period, you must submit your cancellation request before [Month*] [*DD*]*, *[*YYYY].

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the implementation of the initial determination. (Optional Coversheet sentence) [To facilitate the processing of your reconsideration request, please utilize and include the attached coversheet [also found at [[insert web address for coversheet]] with your submission.]

Reconsideration requests must:

- *Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.*
- *State the issues or findings of fact with which you disagree and the reasons for disagreement.*
- *Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.*
    - *If the authorized representative is an attorney, the attorney's statement that he/she/they have the authority to represent the provider or supplier is sufficient to accept this individual as the representative.*
    - *If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.*
    - *Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their behalf.*

Providers and suppliers may:

- *Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.*
- *Include an email address if you want to receive correspondence regarding your appeal via email.*

Failure to submit a reconsideration request is deemed a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to: (Insert correct address based on whether the contractor or CMS is responsible for handling the reconsideration.)

[Contractor Name]
[Address]
[City], [ST] [Zip]

OR

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop: AR-19-51
Baltimore, MD 21244-1850

Or emailed to: ([Contractor email] or ProviderEnrollmentAppeals@cms.hhs.gov).

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

4. Opt-out Affidavit Approval Letter – Eligible Practitioner May Not Order & Refer (Did Not Elect to Order and Refer)

[Month] [DD], [YYYY]

[Eligible Practitioner Name]
[Address from which opt-out was sent]
[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)

Dear [Eligible Practitioner Name]:

[Insert *Contractor*] approved your Medicare opt-out affidavit.

Opt-out Affidavit Information:

Eligible Practitioner Name:	[Name]
Address on File:	[Address, City, State, Zip]

National Provider Identifier (NPI):	[NPI]
Specialty:	[Specialty]
Ordering and Referring:	You are not eligible to Order and Refer*
Effective Date:	[Effective date]

* You may opt-out of Medicare, but you are not permitted to order and refer items and services to Medicare beneficiaries as you did not elect to be and ordering and referring practitioner on your opt-out affidavit.

Your opt-out will automatically renew every 2 years.

Since you are opting out for the very first time, you have a one-time, 90 day period to change your mind about opting out. If you decide to terminate during this 90 day period, you must submit your request, in writing, no later than [Month*] [*DD*]*, *[*YYYY]. After this 90 day period ends, you can only cancel the opt-out at the end of a 2 year opt-out period. If you were unable to submit a termination request, you may appeal after the 90 day period ends. Please follow the *Right to Submit a Reconsideration Request* section below.

To cancel opt-out, you must submit a cancellation request at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out at the end of this opt-out period, you must submit your cancellation request before [Month*] [*DD*]*, *[*YYYY].

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the implementation of the initial determination. (Optional Coversheet sentence) [To facilitate the processing of your reconsideration request, please utilize and include the attached coversheet [also found at [[insert web address for coversheet]] with your submission.]

Reconsideration requests must:

- *Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.*
- *State the issues or findings of fact with which you disagree and the reasons for disagreement.*
- *Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.*
    - *If the authorized representative is an attorney, the attorney's statement that he/she/they have the authority to represent the provider or supplier is sufficient to accept this individual as the representative.*
    - *If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.*
    - *Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their behalf.*

Providers and suppliers may:

- *Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law*

Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.

- *Include an email address if you want to receive correspondence regarding your appeal via email.*

Failure to submit a reconsideration request is deemed a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to: (Insert correct address based on whether the contractor or CMS is responsible for handling the reconsideration.)

[Contractor Name]
[Address]
[City], [ST] [Zip]

OR

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop: AR-19-51
Baltimore, MD 21244-1850

Or emailed to: ([Contractor email] or ProviderEnrollmentAppeals@cms.hhs.gov).

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

5. Opt-out Affidavit Approval Letter – Eligible Practitioner May Not Order & Refer (Eligible Practitioner Does Not Have an NPI)

[Month] [DD], [YYYY]

[Eligible Practitioner Name]
[Address from which opt-out was sent]
[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)

Dear [Eligible Practitioner Name]:

[Insert *Contractor*] approved your Medicare opt-out affidavit.

Eligible Practitioner Name:	[Name]
Address on File:	[Address, City, State, Zip]
National Provider Identifier (NPI):	[Not Provided]
Specialty:	[Specialty]
Ordering and Referring:	You are not eligible to Order and Refer*
Effective Date:	[Effective date]

* You may opt-out of Medicare, but you are not permitted to order and refer items and services to Medicare beneficiaries, as you have not obtained an NPI.

Opt-out Affidavit Information:

Your opt-out will automatically renew every 2 years.

Since you are opting out for the very first time, you have a one-time, 90 day period to change your mind about opting out. If you decide to terminate during this 90 day period, you must submit your request, in writing, no later than [Month*] [*DD*]*, *[*YYYY]. After this 90 day period ends, you can only cancel the opt-out at the end of a 2 year opt-out period. If you were unable to submit a termination request, you may appeal after the 90 day period ends. Please follow the *Right to Submit a Reconsideration Request* section below.

To cancel opt-out, you must submit a cancellation request at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out at the end of this opt-out period, you must submit your cancellation request before [Month*] [*DD*]*, *[*YYYY].

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the implementation of the initial determination. (Optional Coversheet sentence) [To facilitate the processing of your reconsideration request, please utilize and include the attached coversheet [also found at [[insert web address for coversheet]] with your submission.]

Reconsideration requests must:

- *Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.*
- *State the issues or findings of fact with which you disagree and the reasons for disagreement.*
- *Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.*
    - *If the authorized representative is an attorney, the attorney's statement that he/she/they have the authority to represent the provider or supplier is sufficient to accept this individual as the representative.*
    - *If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.*
    - *Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their behalf.*

Providers and suppliers may:

- *Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during*

the administrative appeals process unless an ALJ allows additional information to be submitted.

- *Include an email address if you want to receive correspondence regarding your appeal via email.*

Failure to submit a reconsideration request is deemed a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to: (Insert correct address based on whether the contractor or CMS is responsible for handling the reconsideration.)

[Contractor Name]
[Address]
[City], [ST] [Zip]

OR

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop: AR-19-51
Baltimore, MD 21244-1850

Or emailed to: ([Contractor email] or ProviderEnrollmentAppeals@cms.hhs.gov).

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

6. Opt-out Affidavit Approval Letter – Eligible Practitioner May Not Order & Refer (Eligible Practitioner Has Revoked Billing Privileges)

[Month] [DD], [YYYY]

[Eligible Practitioner Name]
[Address from which opt-out was sent]
[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)

Dear [Eligible Practitioner Name]:

[Insert *Contractor*] approved your Medicare opt-out affidavit.

Opt-out Affidavit Information:

Eligible Practitioner Name:	[Name]
Address on File:	[Address, City, State, Zip]
National Provider Identifier (NPI):	[NPI]
Specialty:	[Specialty]
Ordering and Referring:	You are not eligible to Order and Refer*
Effective Date:	[Effective date]

* Your billing privileges have been revoked, you may opt-out of Medicare, but you are not permitted to order and refer items and services to Medicare beneficiaries

Your opt-out will automatically renew every 2 years.

Since you are opting out for the very first time, you have a one-time, 90 day period to change your mind about opting out. If you decide to terminate during this 90 day period, you must submit your request, in writing, no later than [Month*] [*DD*]*, *[*YYYY]. After this 90 day period ends, you can only cancel the opt-out at the end of a 2 year opt-out period. If you were unable to submit a termination request, you may appeal after the 90 day period ends. Please follow the *Right to Submit a Reconsideration Request* section below.

To cancel opt-out, you must submit a cancellation request at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out at the end of this opt-out period, you must submit your cancellation request before [Month*] [*DD*]*, *[*YYYY].

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the implementation of the initial determination. (Optional Coversheet sentence) [To facilitate the processing of your reconsideration request, please utilize and include the attached coversheet [also found at [[insert web address for coversheet]] with your submission.]

Reconsideration requests must:

- *Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.*
- *State the issues or findings of fact with which you disagree and the reasons for disagreement.*
- *Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.*
    - *If the authorized representative is an attorney, the attorney's statement that he/she/they have the authority to represent the provider or supplier is sufficient to accept this individual as the representative.*
    - *If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.*
    - *Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their behalf.*

Providers and suppliers may:

- *Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.*
- *Include an email address if you want to receive correspondence regarding your appeal via email.*

Failure to submit a reconsideration request is deemed a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to: (Insert correct address based on whether the contractor or CMS is responsible for handling the reconsideration.)

[Contractor Name]
[Address]
[City], [ST] [Zip]

OR

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop: AR-19-51
Baltimore, MD 21244-1850

Or emailed to: ([Contractor email] or ProviderEnrollmentAppeals@cms.hhs.gov).

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

7. Opt-out Affidavit Approval Letter – Approved Opt-Out Change of Information

[Month] [DD], [YYYY]

[Eligible Practitioner Name]
[Address from which opt-out was sent]
[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)

Dear [Eligible Practitioner Name]:

[Insert *Contractor*] has updated your Medicare opt-out affidavit.

Opt-out Affidavit Information:

Eligible Practitioner Name:	[Name]
Address on File:	[Address, City, State, Zip]
National Provider Identifier (NPI):	[NPI]
Specialty:	[Specialty]
Ordering and Referring:	You [are/are not] eligible to Order and Refer[*]
Effective Date:	[Effective date]
Changed Information:	

[* You may opt-out of Medicare, but you are not permitted to order and refer items and services to Medicare beneficiaries, as you have {enter reason for inability to order and refer}.]

As a reminder, to cancel opt-out, you must submit a cancellation request at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out

at the end of this opt-out period, you must submit your cancellation request before [Month*] [*DD*]*, *[*YYYY].

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 *a.m./p.m ET/MT/CT/PT*] and [x:00 *a.m./p.m ET/MT/CT/PT*].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

E. Opt-out Renewal Alert Letter

The *Contractor*s shall issue the following letter, informing the eligible practitioner that the opt-out is due to be automatically renewed.

[Month] [DD], [YYYY]

[Eligible Practitioner Name]
[Address from which opt-out was sent]
[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)
NPI: [xxxxxxxxxx]

Dear [Eligible Practitioner Name]:

We are writing to inform you that your opt-out will be automatically renewed for a new 2 year opt-out period, on [Month*] [*DD*]*, *[*YYYY].

To cancel your opt-out in the future, you will need to submit a cancellation request at least 30 days prior to the end of your opt-out period, which is [Month*] [*DD*]*, *[*YYYY].

If your intention is to cancel your opt-out, but fail to submit a cancellation notice to us, please see the *Right to Submit a Reconsideration Request* section of this letter below.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the implementation of the initial determination. (Optional Coversheet sentence) [To facilitate the processing of your reconsideration request, please utilize and include the attached coversheet [also found at [[insert web address for coversheet]] with your submission.]

Reconsideration requests must:

- *Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.*
- *State the issues or findings of fact with which you disagree and the reasons for disagreement.*
- *Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.*

- *If the authorized representative is an attorney, the attorney's statement that he/she/they have the authority to represent the provider or supplier is sufficient to accept this individual as the representative.*
- *If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.*
- *Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their behalf.*

Providers and suppliers may:

- *Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.*
- *Include an email address if you want to receive correspondence regarding your appeal via email.*

Failure to submit a reconsideration request is deemed a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to: (Insert correct address based on whether the contractor or CMS is responsible for handling the reconsideration.)

[Contractor Name]
[Address]
[City], [ST] [Zip]

OR

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop: AR-19-51
Baltimore, MD 21244-1850

Or emailed to: ([Contractor email] or ProviderEnrollmentAppeals@cms.hhs.gov).

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

F. Opt-out Affidavit Termination Letter

If an eligible practitioner timely terminates his/her*/their* initial opt-out, the *Contractor*s shall acknowledge this action by using this model letter. If the eligible practitioner requests a cancellation, the *Contractor*s shall indicate the date of the cancellation and remove the

following paragraph regarding termination. If the eligible practitioner terminates the opt-out, the *Contractor*s shall remove the cancellation language.

[Month] [DD], [YYYY]

[Eligible Practitioner Name]
[Address from which request was sent]
[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)
NPI: [xxxxxxxxxx]

Dear [Eligible Practitioner Name]:

[Insert *Contractor*] completed your request to terminate your Medicare opt-out affidavit.

Want to enroll as a Medicare billing provider or for the sole purpose of ordering and referring? Submit the appropriate Provider Enrollment Chain and Ownership System (PECOS) application or paper CMS-855 form.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the implementation of the initial determination. (Optional Coversheet sentence) [To facilitate the processing of your reconsideration request, please utilize and include the attached coversheet [also found at [[insert web address for coversheet]] with your submission.]

Reconsideration requests must:

- *Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.*
- *State the issues or findings of fact with which you disagree and the reasons for disagreement.*
- *Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.*
    - *If the authorized representative is an attorney, the attorney's statement that he/she/they have the authority to represent the provider or supplier is sufficient to accept this individual as the representative.*
    - *If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.*
    - *Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their behalf.*

Providers and suppliers may:

- *Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your*

request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.

- *Include an email address if you want to receive correspondence regarding your appeal via email.*

Failure to submit a reconsideration request is deemed a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to: (Insert correct address based on whether the contractor or CMS is responsible for handling the reconsideration.)

[Contractor Name] *[Address]* *[City], [ST] [Zip]*	*OR*	*Centers for Medicare & Medicaid Services* *Provider Enrollment & Oversight Group* *ATTN: Division of Provider Enrollment Appeals* *7500 Security Boulevard* *Mailstop: AR-19-51* *Baltimore, MD 21244-1850*

Or emailed to: ([Contractor email] or ProviderEnrollmentAppeals@cms.hhs.gov).

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

G. Opt-out Affidavit Cancellation Letter

If an eligible practitioner timely submits an opt-out cancellation request, the *Contractor*s shall acknowledge this action by using this model letter.

[Month] [DD], [YYYY]

[Eligible Practitioner Name]
[Address from which request was sent]
[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)
NPI: [xxxxxxxxxx]

Dear [Eligible Practitioner Name]:

[*Contractor Name*] completed your request to cancel your Medicare opt-out affidavit.

Your opt-out status will be canceled effective [Month*] [*DD*], [*YYYY].

Want to enroll as a Medicare billing provider or for the sole purpose of ordering of referring? Submit the appropriate Provider Enrollment Chain and Ownership System (PECOS) application or paper CMS-855 form.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the implementation of the initial determination. (Optional Coversheet sentence) [To facilitate the processing of your reconsideration request, please utilize and include the attached coversheet [also found at [[insert web address for coversheet]] with your submission.]

Reconsideration requests must:

- *Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.*
- *State the issues or findings of fact with which you disagree and the reasons for disagreement.*
- *Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.*
    - *If the authorized representative is an attorney, the attorney's statement that he/she/they have the authority to represent the provider or supplier is sufficient to accept this individual as the representative.*
    - *If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.*
    - *Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their behalf.*

Providers and suppliers may:

- *Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.*
- *Include an email address if you want to receive correspondence regarding your appeal via email.*

Failure to submit a reconsideration request is deemed a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to: (Insert correct address based on whether the contractor or CMS is responsible for handling the reconsideration.)

[Contractor Name]
[Address]
[City], [ST] [Zip]

OR

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop: AR-19-51
Baltimore, MD 21244-1850

Or emailed to: ([Contractor email] or ProviderEnrollmentAppeals@cms.hhs.gov).

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

10.7.15 –Revalidation Notification Letters

(Rev. 11637; Issued: 10-07-22; Effective: 12-09-22; Implementation: 12-09-22)

A. Revalidation Letter

REVALIDATION

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City], [State] [Zip Code]

Dear [Provider/Supplier Name],

Every five years, CMS requires you to revalidate your Medicare enrollment record. You need to update or confirm all the information in your record, including your practice locations and reassignments.

We need this from you by **[Due date, as Month dd yyyy]**. If we don't receive your response by then, we may stop your Medicare billing privileges.

If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

What record needs revalidating by [Due date, as Month dd yyyy]

[Name] | **NPI** [NPI] | **PTAN** [PTAN]
Reassignments: <Only include this title if the record has any reassignments>
[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]
<Repeat for other reassignments>

CMS lists the records that need revalidating at go.cms.gov/MedicareRevalidation.

What you need to do

Revalidate your Medicare enrollment record, through https://pecos.cms.hhs.gov/pecos/login.do or [form CMS-855 or Form CMS-20134].

- **Online:** PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.

- **Paper:** Download the right version of form [CMS-855 or Form CMS-20134] for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].

If you have a fee due, use PECOS to pay. If you feel you qualify for a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification. For more on fees and exceptions, search cms.gov for "CR 7350" or "Fee Matrix".

A new Electronic Funds Transfer (EFT) Authorization Form (CMS-588) is only required to be submitted as part of your revalidation package if: (1) you have no Form CMS-588 on file with Medicare at all; or (2) you are changing any of your existing Form CMS-588 data. The current version of the form can be found at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS588.pdf.

If you need help

Visit go.cms.gov/MedicareRevalidation
Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name]
[Title]
[Company]

B. Revalidation Letter – CHOW Scenario Only

[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 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 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 (1) you have no Form CMS-588 on file with Medicare at all; or (2) you are changing any of your existing Form CMS-588 data. 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]

C. Large Group Revalidation Notification Letter

[month] [day], [year]

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

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 the next seven months. They will need to respond by the revalidation due date provided for each provider. It is the responsibility of the physician and/or non-physician practitioner to revalidate all their Medicare enrollment information and not just 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]

D. Revalidation Pend Letter

PAYMENT HOLD

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City], [State] [Zip Code]

Dear [Provider/Supplier Name],

We are holding all payments on your Medicare claims, because you haven't revalidated your enrollment record with us. This does not affect your Medicare participation agreement, or any of its conditions.

Every [three or five years], CMS requires you to revalidate your Medicare enrollment record information. You need to update or confirm all the information in your record, including your practice locations and reassignments.

Failure to respond to this notice will result in a possible deactivation of your Medicare enrollment. If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

What record needs revalidating

[Name] | **NPI** [NPI] | **PTAN** [PTAN]
Reassignments:
[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]
<Repeat for other reassignments>

CMS lists the records that need revalidating at **go.cms.gov/MedicareRevalidation**.

How to resume your payments

Revalidate your Medicare enrollment record, through https://pecos.cms.hhs.gov/pecos/login.do or [form CMS-855 or Form CMS-20134].

- **Online:** PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.
- **Paper:** Download the right version of [form CMS-855 or Form CMS-20134] for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].

If you have a fee due, use PECOS to pay. If you feel you qualify for a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification.

If you need help

Visit **go.cms.gov/MedicareRevalidation**
Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name]
[Title]
[Company]

E. Revalidation Deactivation Letter

STOPPING BILLING PRIVILEGES

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City], [State] [Zip Code]

Dear [Provider/Supplier Name],

Your Medicare billing privileges are being deactivated effective [Month] [DD], [YYYY], pursuant to 42 C.F.R. § 424.540(a)(3) because you have not timely revalidated your enrollment record with us, or your revalidation application has been rejected because you did not timely respond to our requests for more information. We will not pay any claims after this date.

Every five years [three for the NSC], CMS requires you to revalidate your Medicare enrollment record.

What record needs revalidating

[Name] | **NPI** [NPI] | **PTAN** [PTAN]
Reassignments:
[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]
<Repeat for other reassignments>

CMS lists the records that need revalidating at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html.

Rebuttal Rights:

If you believe that this determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.546. The rebuttal must be received in writing within *15* calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.

The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative. *Authorized or delegated officials for groups cannot sign and submit a rebuttal on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their behalf.*

If the provider/supplier wishes to appoint a legal representative that is not an attorney to sign the rebuttal, the provider/supplier must include with the rebuttal a written notice authorizing the legal representative to act on the provider*'s or* supplier's behalf. The notice should be signed by the provider/supplier.

If the provider/supplier has an attorney sign the rebuttal, the rebuttal must include a statement from the attorney that he/she has the authority to represent the provider/supplier.

If you wish to receive communication regarding your rebuttal via email, please include a valid email address in your rebuttal request.

The rebuttal should be sent to the following:

[*Contractor* Rebuttal Receipt Address]
[*Contractor* Rebuttal Receipt Email Address]
[*Contractor* Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 *a.m./p.m ET/MT/CT/PT*] and [x:00 *a.m./p.m ET/MT/CT/PT*].

How to recover your billing privileges

Revalidate your Medicare enrollment record, through PECOS.cms.hhs.gov, or [Form CMS-855 or Form CMS-20134].

- Online: PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.

- Paper: Download the right version of [form CMS-855 or Form CMS-20134] for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].

If you have a fee due, use PECOS to pay. If you feel you deserve a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification.

If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

If you need help Visit https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html.

Call [contractor telephone number] or visit [contractorsite.com] for more options.

Sincerely,

[Name]
[Title]
[Company]

F. Revalidation Past-Due Group Member Letter

REVALIDATION | Past-Due Group Member

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City], [State] [Zip Code]

Dear [Provider/Supplier Name],

Every five years, CMS requires providers to revalidate their Medicare enrollment records. You have not revalidated by the requested due date of [revalidation due date].

You need to update or confirm all the information in your record, including your practice locations and reassignments. If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

If multiple records below need to be revalidated, please coordinate with the appropriate parties to provide only one response.

What record needs revalidating

[Name] | **NPI** [NPI] | **PTAN** [PTAN]
Reassignments: <Only include this title if the record has any reassignments>
[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]
<Repeat for other reassignments>

CMS lists the records that need revalidating at **go.cms.gov/MedicareRevalidation**.

What your group member needs to do

Revalidate their Medicare enrollment record, through https://pecos.cms.hhs.gov/pecos/login.do. or [form CMS-855 or Form CMS-20134].

- **Online:** PECOS is the fastest option. If they don't know their username or password, PECOS offers ways to retrieve them. Our customer service can also help by phone at 866-484-8049.
- **Paper:** Download the right version of [form CMS-855 or Form CMS-20134] for their situation at cms.gov. We recommend getting proof of receipt for this mailing. Mail to [contractor address].

If your group member needs help

Visit **go.cms.gov/MedicareRevalidation**
Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name]
[Title]
[Company]

G. Model Return Revalidation Letter

RETURN REVALIDATION

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City], [State] [Zip Code]

NPI: [xxxxxxxxxx]

Dear [Provider/Supplier Name],

Your Medicare enrollment application(s) was received on [date]. We are closing this request and returning your application(s) for the following reason(s):

- The [Form CMS-855 or Form CMS-20134] application received by [PROVIDER/SUPPLIER NAME] was unsolicited.

- An unsolicited revalidation is one that is received more than seven months prior to the provider/supplier's due date. Due dates are established around 5 years from the provider/suppliers last successful revalidation or their initial enrollment.
- To find the provider/suppliers revalidation due date, please go to http://go.cms.gov/MedicareRevalidation.
- If you are not due for revalidation in the current seven month period, you will find that your due date is listed as "TBD" (or To Be Determined). This means that you do not yet have a due date for revalidation within the current seven month period. This list with be updated monthly.

- If your intention is to change information on your Medicare enrollment file, you must complete a new Medicare enrollment application(s) and mark 'change' in section 1 of the [form CMS-855 or Form CMS-20134].

- Please address the above issues as well as sign and date the new certification statement page on your resubmitted application(s).

Providers and suppliers can apply to enroll in the Medicare program using one of the following two methods:

1. Internet-based Provider Enrollment, Chain and Organization System (PECOS). Go to: https://pecos.cms.hhs.gov/pecos/login.do.

2. Paper application process: Download and complete the Medicare enrollment application(s) at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html. DMEPOS suppliers should send the completed application to the National Supplier Clearinghouse (NSC).

If you need help

Visit http://go.cms.gov/MedicareRevalidation, or
Call2 [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name]
[Title]
[Company]

Provider/Supplier Name (As it appears in PECOS)	NPI	EID (if applicable)	PTAN(s) (if applicable)	Contractor (including jurisdiction)	Regulatory Authority for Deactivation	Date Rebuttal Received	Date Receipt Acknowledgment Sent to Provider/Supplier/ Legal Representative	Date Rebuttal Determination Issued	Final Decision Result	Comments (can be blank)

Column E Contractor (including Jurisdiction)	Column F Regulatory Authority for Deactivation	Column J Final Decision Result
CGS J15	424.540(a)(1)	Not Actionable
FCSO JN	424.540(a)(2)	Favorable
NGS J6	424.540(a)(3)	Unfavorable
NGS JK	424.540(a)(4)	Dismissed
Noridian JE	424.540(a)(5)	Withdrawn
Noridian JF	424.540(a)(6)	In Process
Novitas JL	424.540(a)(7)	
Novitas JH	424.540(a)(8)	
NPE East	Other (See Comments)	
NPE West		
NSC		
Palmetto JJ		
Palmetto JM		
WPS J5		
WPS J8		

NOTE: All dates shall be formatted as mm/dd/yyyy. No