CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 12550	**Date: March 21, 2024**
	Change Request 13509

SUBJECT: Eleventh General Update to Provider Enrollment Instructions in Chapter 10 of CMS Publication (Pub.) 100-08

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to address several provider enrollment topics, including revised model letters.

EFFECTIVE DATE: April 21, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 21, 2024

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	10/10.3/10.3.1.2.4/Section 4 (Practice Location Information) – Form CMS-855B
R	10/10.3/10.3.1.3.4/Section 4 (Business Information) - Form CMS-855I
R	10/10.4/10.4.2.1/Denials – General Principles
R	10/10.4/10.4.2.2/Denial Reasons
R	10/10.4/10.4.7.1/Revocations – Background and General Requirements
R	10/10.4/10.4.7.2/Revocation Effective Dates
R	10/10.4/10.4.7.3/Revocation Reasons
R	10/10.4/10.4.7.4/Reenrollment Bar
R	10/10.6/10.6.6/Final Adverse Actions
R	10/10.6/10.6.12/Opting-Out of Medicare
R	10/10.6/10.6.21.1/Additional Miscellaneous Enrollment Topics
R	10/10.7/Model Letters
R	10/10.7/10.7.5/Part A/B Certified Provider and Supplier Approval Letter Templates
R	10/10.7/10.7.5.1/Part A/B Certified Provider and Supplier Letter Templates – Post-Transition
R	10/10.7/10.7.9/Revocation Letters
R	10/10.7/10.7.14/Model Opt-out 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: 12550	Date: March 21, 2024	Change Request: 13509

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I. GENERAL INFORMATION

A. Background: Chapter 10 of Pub. 100-08 outlines policies related to Medicare provider enrollment and instructs contractors on the processing of Form CMS-855 provider enrollment applications. This CR clarifies several provider enrollment topics, including revised model letters.

B. Policy: This CR does not involve any legislative or regulatory policies.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13509.1	The contractor shall follow the instructions in this CR pertaining to referrals of adverse legal action cases to CMS.	X	X	X						NPEAST, NPWEST
13509.2	The contractor shall observe the removal of the Social Security Number data element from Sections 10.6.12(B)(1) and (2) in Chapter 10 of		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Pub. 100-08.									
13509.3	The contractor shall observe the changes to and additions of model letters in Sections 10.7.5, 10.7.5.1, 10.7.9, and 10.7.14 in Chapter 10 of Pub. 100-08.	X	X	X						NPEAST, NPWEST
13509.4	The contractor shall observe the changes to Section 10.6.21.1(C) in Chapter 10 of Pub. 100-08 regarding site visits.	X	X	X						NPEAST, NPWEST

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

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

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

ATTACHMENTS: 0

Medicare Program Integrity Manual

Chapter 10 – Medicare Enrollment

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(Rev. 12550; Issued: 03-21-24)

[Transmittals for Chapter 10]

10.3.1.2.4 – Section 4 (Practice Location Information) – Form CMS-855B

(Rev. 12550; Issued: 03-21-24; Effective: 04-21-24; Implementation: 04-21-24)

A. Reporting and Verification Policies

1. ZIP Code – The supplier must submit the 9-digit ZIP Code for each practice location listed.

2. Practice Location Name - For suppliers paid via the Multi-Carrier System (MCS), the practice location name entered into PECOS shall be the legal business name. *(Beginning with PECOS 2.0, however, the DBA name can be entered as the practice location name.)*

3. Practice Location Verification – Except as stated otherwise in this chapter or in another CMS directive, the contractor shall verify that the practice locations listed on the application actually exist and are valid addresses with the United States Postal Service (USPS). PECOS includes a USPS Address Matching System Application Program Interface (API), which validates address information entered and flags the address if it is determined to be invalid, unknown, undeliverable, vacant, unlikely to deliver mail (No-Stat), a CMRA (i.e., UPS Store, mailboxes, etc.), or a known invalid address false positive. These address types are not permitted in PECOS and are flagged upon entry.

4. Phone Number Verification - The contractor shall verify that the reported telephone number is operational and connects to the practice location/business listed on the application. However, the contractor need not contact every location for applicants that are enrolling multiple locations; the contractor can verify each location's telephone number with the contact person listed on the application and note the verification in PECOS. (The telephone number must be one at which patients and/or customers can reach the applicant to ask questions or register complaints.) The contractor may also match the applicant's telephone number with known, in-service telephone numbers - via, for instance, the Yellow Pages or the Internet - to correlate telephone numbers with addresses. If the applicant uses his/her/its cell phone for their business, the contractor shall verify that this is a telephone connected directly to the business. If the contractor cannot verify the telephone number, it shall request clarifying information from the applicant; the inability to confirm a telephone number may indicate that an onsite visit is necessary. In some instances, a 1-800 number or out-of-state number may be acceptable if the applicant's business location is in another state but his/her/its practice locations are within the contractor's jurisdiction.

5. Special Certified Supplier Instructions (ASCs and Portable X-Ray Suppliers (PXRS)) - If the supplier's address and/or telephone number cannot be verified, the contractor shall request clarifying information from the supplier. If the supplier states that the facility and its phone number are not yet operational, the contractor may continue processing the application. However, it shall indicate in its recommendation letter that the address and telephone number of the facility could not be verified. For purposes of PECOS, the contractor can temporarily use the date the certification statement was signed as the effective date.

6. Specific Section 4 Subsection Policies

a. Practice Location Type - In Section 4A, if the "type of practice location" checkbox is blank, the contractor can confirm the information via the PCV, e-mail, or fax.

b. Section 4B - If neither box is checked and no address is provided, the contractor can contact the supplier by telephone, the PCV, e-mail, or fax to confirm the supplier's intentions. If the "special payments" address is indeed the same as the practice location, no further development is needed. If, however, the supplier wants payments to be sent to a different address, the address in Section 4B must be completed via the Form CMS-855B.

c. Updated Questionnaire - If the supplier (1) is adding a practice location and (2) is normally required to complete a questionnaire in the Form CMS-855B specific to its supplier type (i.e.: physical or occupational therapist groups), the entity must submit an updated questionnaire to incorporate services rendered at the new location.

d. Section 4E – If the "Check here" box in Section 4E is not checked and no address is provided, the contractor can contact the supplier by telephone, the PCV, e-mail, or fax to confirm the supplier's intentions. If the base of operations address is the same as the practice location, no further development is needed. If the supplier indicates that the base of operations is at a different location, the address in Section 4E must be furnished via the Form CMS-855B.

e. Section 4F - If the vehicle certificates are furnished but the applicable Form CMS-855B sections are blank, the contractor can verify via telephone, the PCV, e-mail, or fax that said vehicles are the only ones the supplier has.

B. Do Not Forward (DNF)

Unless instructed otherwise in another CMS directive, the contractor shall follow the DNF initiative instructions in Pub. 100-04, chapter 1, section 80.5. Returned paper checks, remittance notices, or EFT payments shall be flagged if returned from the post office or banking institution, respectively, as this may indicate that the supplier's "special payment" address (the Practice Location Information section of the Form CMS-855B) or EFT information has changed. The supplier should submit a Form CMS-855B to change this address; if the supplier does not have an established enrollment record in PECOS, it must complete an entire Form CMS-855B. (For DMEPOS suppliers, the DME MAC is responsible for obtaining, updating, and processing Form CMS-588 changes.)

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

C. Remittance Notices/Special Payments

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

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

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

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

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

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

- One of the supplier's practice locations
- A P.O. Box
- The supplier's billing agent. The contractor shall request additional information if it has any reason to suspect that the arrangement – at least with respect to any special payments that might be made – may violate the Payment to Agent rules in Pub. 100-04, chapter 1, section 30.2.
- Correspondence address
- A lockbox. The contractor shall request additional information if it has any reason to suspect that the arrangement - at least with respect to any special payments that might be made - may violate the Payment to Agent rules in Pub. 100-04, chapter 1, section 30.2.

D. Out-of-State Practice Locations

(The policies in this section 10.3.1.2.4(D) apply unless CMS instructs otherwise in this chapter or in another directive.)

If a supplier is adding a practice location in another state that is within the contractor's jurisdiction, a separate, initial Form CMS-855B enrollment application is not required if the following 5 conditions are met:

(i) The location is not part of a separate organization (e.g., a separate corporation, partnership);

(ii) The location does not have a separate TIN and LBN;

(iii) The state in which the new location is being added does not require the location to be surveyed;

(iv) Neither the new location nor its owner is required to sign a separate certified supplier agreement; and

(v) The location is not an IDTF, ASC, or other supplier type that must individually and separately enroll each of its locations.

Consider the following scenarios:

EXAMPLE 1 - The contractor's jurisdiction consists of States X, Y and Z. Jones Group Practice (JGP), Inc., is enrolled in State X with 3 locations. It wants to add a fourth location in State Y. The new location will be under JGP, Inc. JGP will not be establishing a separate corporation, LBN, or TIN for the fourth location. Since there is no state agency or SOG Location involvement with group practices, all five conditions are met. JGP can add the fourth location via a change of information request, rather than an initial application. The change request must include all information relevant to the new location (e.g., licensure, new managing employees). (For paper applications only---and to the extent required---the contractor shall create a separate PECOS enrollment record for the State Y location.)

EXAMPLE 2 - The contractor's jurisdiction consists of States X, Y and Z. Jones Group Practice (JGP), Inc., is enrolled in State X with 3 locations. It wants to add a fourth location

in State Y but under a newly created, separate entity - Jones Group Practice, LP. The fourth location must be enrolled via a separate, initial Form CMS-855B.

EXAMPLE 3 - The contractor's jurisdiction consists of States X, Y and Z. Jones Group Practice (JGP), Inc., is enrolled in State X with 3 locations. It wants to add a fourth location in State Q. Since State Q is not within the contractor's jurisdiction, a separate initial enrollment for the fourth location is necessary.

E. Unavoidable Phone Number or Address Changes - Unless CMS specifies otherwise, any change in the supplier's phone number or address that the supplier did not cause (e.g., area code change, municipality renames the supplier's street) must still be updated via the Form CMS-855B.

10.3.1.3.4 – Section 4 (Business Information) - Form CMS-855I

Rev. 12550; Issued: 03-21-24; Effective: 04-21-24; Implementation: 04-21-24)

A. Practice Location Verification

The contractor shall verify that the practice locations listed on the application actually exist and are valid addresses with the United States Postal Service (USPS). PECOS includes a USPS Address Matching System Application Program Interface (API), which validates address information entered and flags the address if it is determined to be invalid, unknown, undeliverable, vacant, unlikely to deliver mail (No-Stat), a CMRA (i.e., UPS Store, mailboxes, etc.), or a known invalid address false positive. These address types are not permitted in PECOS and are flagged upon entry. To reiterate: the practice location address in the Practice Location Information section must be a valid address with USPS; addresses entered into PECOS are verified via computer software to determine if they are valid and deliverable.

Any supplier submitting a Form CMS-855I application must submit the 9-digit ZIP Code for each practice location listed.

If the "Type of practice location" checkbox in Section 4A is blank, the contractor can confirm the information via the PCV, e-mail, or fax.

A practitioner who only renders services in patients' homes (i.e., house calls) must supply his/her home address in the Practice Location Information/Rendering Services in Patients' Homes section. In addition, if a practitioner renders services in a retirement or assisted living community, the Practice Location Information section must include the name and address of that community. In either case, the contractor shall verify that the address is a physical address. Post office boxes and drop boxes are not acceptable.

If the physician or non-physician practitioner uses his/her home address as his/her practice location and exclusively performs services in patients' homes, nursing homes, etc., no site visit is necessary.

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

For suppliers paid via the Multi-Carrier System (MCS)--and except as otherwise stated in section 10.3--the practice location name entered into PECOS shall be the legal business name. *(Beginning with PECOS 2.0, however, the DBA name can be entered as the practice location name.)*

Each practice location is to be verified. However, there is no need to separately contact each location on the application. Such verification can be done via the contact person listed on the application; the contact person's verification shall be documented in PECOS.

B. Telephone Number Verification

The contractor shall verify that the reported telephone number is operational and connects to the practice location/business listed on the application. However, the contractor need not contact every location for applicants that are enrolling multiple locations; the contractor can verify each location's telephone number with the contact person listed on the application and note the verification accordingly in PECOS. (The telephone number must be one where patients and/or customers can reach the applicant to ask questions or register complaints.) The contractor may also match the applicant's telephone number with known, in-service telephone numbers - via, for instance, the Yellow Pages or the Internet - to correlate telephone numbers with addresses. If the applicant uses his/her/its cell phone for their business, the contractor shall verify that this is a telephone connected directly to the business. If the contractor cannot verify the telephone number, it shall request clarifying information from the applicant; the inability to confirm a telephone number may indicate that an onsite visit is necessary. In some instances, a 1-800 number or out-of-state number may be acceptable if the applicant's business location is in another state but his/her/its practice locations are within the contractor's jurisdiction.

C. Unintended Changes

Unless CMS specifies otherwise, any change in the supplier's phone number or address that the supplier did not cause (i.e., area code change, municipality renames the supplier's street) must still be updated via the Form CMS-855I.

D. Remittance Notices/Special Payments Mailing Address section

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

- One of the supplier's practice locations

- A P.O. Box

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

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

- Correspondence address

If neither box in this section is checked and no address is provided, the contractor can contact the supplier by telephone, the PCV, e-mail, or fax to confirm the supplier's intentions. If the "special payments" address is the same as the practice location, no further development is needed. If, however, the supplier wants payments to be sent to a different address, the address in the Remittance Notices/Special Payments Mailing Address section must be completed via the Form CMS-855I.

E. Do Not Forward (DNF)

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

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

F. EFT

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

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

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

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

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

G. Solely-Owned Organizations

1. Paper Applications

All pertinent data for solely-owned organizations can be furnished via the Form CMS-855I alone. The contractor, however, shall require the supplier to submit a Form CMS-855B *and a* Form CMS-855I *(including to reassign benefits)* if, during the verification process, it discovers that the supplier is not a solely-owned organization. (**NOTE**: A solely-owned supplier type that normally completes the Form CMS-855B to enroll in Medicare must still do so. For example, a solely-owned LLC that is an ambulance company must complete the Form CMS-855B even though the Practice Location Information/Sole Proprietor/Sole Proprietorship section makes mention of solely-owned LLCs. Use of the Practice Location Information section of the Form CMS-855I is limited to suppliers that perform physician or practitioner services.)

(Sole proprietorships need not complete the Business Information portions of Section 4 of the Form CMS-855I. Per definition, a sole proprietorship is not a corporation, professional association, etc. Do not confuse a sole proprietor with a physician whose business is that of a corporation, LLC, etc., of which he/she is the sole owner.)

In the Business Information section, the supplier may list a type of business organization other than a professional corporation, a professional association, or a limited liability company (e.g., closely-held corporation). This is acceptable so long as that business type is recognized by the state in which the supplier is located.

The contractor shall verify all data furnished in the Business Information section (e.g., legal business name, TIN, adverse legal actions). If the Business Information section is left blank, the contractor may assume it does not pertain to the applicant.

A solely-owned physician or practitioner organization that utilizes the Business Information section to enroll in Medicare can generally submit change of information requests to Medicare via the Form CMS-855I. However, if the change involves data not captured on the Form CMS-855I, the change must be made on the applicable CMS form (e.g., Form CMS-855B).

H. Individual Reassignment/Affiliation Information

If the applicant indicates that he/she intends to render all or part of his/her services in a private practice, clinic/group, or any organization to which he/she would reassign benefits, the contractor shall ensure that the applicant (or the group or organization) has submitted a Form CMS-855*I reassignment* for each individual, clinic/group practice, or organization to which the individual plans to reassign benefits. The contractor shall also verify that the individual, clinic/group practice, or organization is enrolled in Medicare. If it is not, the contractor shall enroll the individual, clinic/group practice, or organization prior to approving the reassignment.

I. Sole Proprietor Use of EIN

The practitioner may obtain a separate EIN if he/she wants to receive reassigned benefits as a sole proprietor.

J. NPI Information for Groups

If an individual, clinic/group practice, or organization is already established in PECOS (i.e., status of "approved" unless the Form CMS-855I is submitted for the purpose of revalidation), the physician or non-physician practitioner need not submit the NPI in the Business Information/Individual Reassignment/Affiliation Information section of the Form CMS-855I. The only NPI that the physician or non-physician practitioner must supply is the NPI found in the Personal Identifying Information (Individual Information) section.

NOTE: Physicians and non-physician practitioners must furnish the NPI in the Business Information/Individual Reassignment/Affiliation Information section of the Form CMS-855I for individuals/groups/organizations not established in PECOS with a status of "approved."

K. Out-of-State Practice Locations

Except as stated otherwise in section 10.3 or in another CMS directive, if a supplier is adding a practice location in another state, a separate, initial Form CMS-855I enrollment application is required for that location even if:

- The location is part of the same organization (e.g., a solely-owned corporation),

- The location has the same tax identification number (TIN) and legal business name (LBN), and

- The location is in the same contractor jurisdiction.

To illustrate, suppose the contractor's jurisdiction consists of States X, Y, and Z. Dr. Jones, a sole proprietor, is enrolled in State X with 2 locations. He wants to add a third location in State Y under his social security number and his sole proprietorship's employer identification number. A separate, initial Form CMS-855I application is required for the State Y location.

10.4.2.1 - Denials – General Principles

(Rev. 12550; Issued: 03-21-24; Effective: 04-21-24; Implementation: 04-21-24)

A. Notification Letters for Denials

If the contractor finds a legal basis for denying an application - and, if applicable under section 10.4.2 et seq., section 10.6.6, or another CMS directive, receives approval from PEOG for said denial - the contractor shall deny the application and notify the provider by letter. Except as stated otherwise in this chapter, the denial letter shall contain:

(i) A legal (i.e., regulatory) basis for each reason for the denial;

(ii) A clear explanation of why the application is being denied, including the facts or evidence that the contractor used in making its determination;

(iii) An explanation of why the provider does not meet the applicable enrollment criteria;

(iv) The appropriate regulatory basis (e.g., 42 CFR § 424.530(a)(1)) for the denial. (The contractor shall not use provisions from this chapter 10 as the basis for denial.)

(v) Procedures for submitting a corrective action plan (CAP, for denials based on 42 CFR § 424.530(a)(1)); and

(vi) Complete and accurate information about the provider's further appeal rights.

In addition, the letter shall follow the format of the applicable model denial letter in section 10.7 et seq. of this chapter.

There is no reenrollment bar for denied applications. Reenrollment bars apply only to revocations.

B. When Prior PEOG Approval of the Denial Necessary

For cases involving *42 CFR § 424.530(a)(1) (Noncompliance – Not Professionally Licensed Individual Practitioners), § 424.530(a)(2) (Provider or Supplier Conduct),* 42 CFR § 424.530(a)(3) (Felony Convictions), § 424.530(a)(4) (False or Misleading Information or Application), § 424.530(a)(6) *(Medicare Debt)*, *§ 424.530(a)(7) (Payment Suspension), § 424.530(a)(11) (Prescribing Authority),* § 424.530(a)(12) (Revoked Under Different Name, Numerical Identifier, or Business Identity), § 424.530(a)(13) (Affiliation that Poses an Undue Risk), § 424.530(a)(14) (Other Program Termination or Suspension),), § 424.530(a)(15) (Patient Harm), and § 424.530(a)(17) (False Claims Act Civil Judgments), the contractor shall obtain approval of both the denial and the denial letter from PEOG via the ProviderEnrollmentRevocations@cms.hhs.gov mailbox prior to sending the denial letter.

The contractor shall also obtain prior PEOG approval of the denial and denial letter if otherwise required to do so in this chapter or another CMS directive (i.e., certain denial situations other than those described in this subsection 10.4.2.1(B) require prior PEOG approval, *such as those outlined in section 10.6.6*). (Note that MDPP denials no longer require prior PEOG approval except in cases where such approval is otherwise mandated per this section 10.4.2.1(B) (e.g., MDPP denials under (a)(3), (a)(4), etc.)

PEOG will notify the contractor of its determination (including, as applicable, whether a reapplication bar under § 424.530(f) is to be imposed) and instruct the contractor as to how to proceed. Absent a CMS instruction or directive to the contrary, the denial letter shall be sent to the provider via certified mail no later than 5 business days after PEOG concludes that the provider's application should be denied. The contractor shall not proceed with finalizing the denial until it receives the aforementioned guidance from PEOG. If this guidance is delayed, the contractor shall carve the impacted application(s) out of its timeliness reporting; the contractor shall document and report the impacted application(s) in its Monthly Status Reports.

C. When Prior PEOG Approval of the Denial Unnecessary – Timeframe for Sending Letter

Absent a CMS instruction or directive to the contrary, the denial letter shall be sent to the provider/supplier via certified mail no later than 5 business days after the contractor determines that the provider's application should be denied.

D. No Denial Recommendation to State

If the applicant is a certified provider or certified supplier and a denial reason is implicated, the contractor need not submit a recommendation for denial to the state/SOG Location. Except as stated otherwise in this chapter, the contractor can simply: (1) deny the application (though, as explained in this chapter, some denials might require prior PEOG approval); (2) close out the PECOS record; (3) send a denial letter to the provider; and (4) copy the state and the SOG Location on said letter.

E. PECOS Entry

All denied applications and all applicable denial reasons shall be entered into PECOS, including fingerprint and non-covered provider or supplier type denials. For non-covered provider or supplier type denials, the contractor shall select the "Other" specialty/provider/supplier type option and input the type listed on the application.

10.4.2.2 - Denial Reasons

(Rev. 12550; Issued: 03-21-24; Effective: 04-21-24; Implementation: 04-21-24)

A. Denial Reason 1– Not in Compliance with Medicare Requirements (42 CFR §424.530(a)(1))

"The provider or supplier is determined not to be in compliance with the enrollment requirements *in this Title 42* or on the enrollment application applicable to its provider or supplier type and has not submitted a plan of corrective action as outlined in 42 CFR part 488." Such non-compliance includes, but is not limited to, the following situations:

i. The provider or supplier does not have a physical business address or mobile unit where services can be rendered.

ii. The provider or supplier does not have a place where patient records are stored to determine the amounts due such provider or other person.

iii. The provider or supplier is not appropriately licensed.

iv. The provider or supplier is not authorized by the federal/state/local government to perform the services that it intends to render.

v. The provider or supplier does not meet CMS regulatory requirements for the specialty that it seeks to enroll as. (See section 10.2.8 of this chapter for examples of suppliers that are not eligible to participate.)

vi. The provider or supplier does not have a valid social security number (SSN) or employer identification number (EIN) for itself, an owner, partner, managing organization/employee, officer, director, medical director, and/or authorized or delegated official.

vii. The applicant does not qualify as a provider of services or a supplier of medical and health services. (For instance, the applicant is not recognized by any federal statute as a Medicare provider or supplier (see section 10.2.8 of this chapter.)) An entity seeking Medicare payment must be able to receive reassigned benefits from physicians in accordance with the Medicare reassignment provisions in § 1842(b)(6) of the Act (42 U.S.C. 1395u(b)).

viii. The provider or supplier does not otherwise meet general enrollment requirements.

(With respect to (v) above – and, as applicable, (iii) and (iv) - the contractor's denial letter shall cite the appropriate statutory and/or regulatory citation(s) containing the specific licensure/certification/authorization requirement(s) for that provider or supplier type. For a listing of some of these statutes and regulations, refer to section 10.2 et seq. of this chapter.)

NOTE: The contractor must identify in its denial letter the exact provision within said statute(s)/regulation(s) with which the provider/supplier is non-compliant.

(NOTE: For (a)(1) denials involving an individual practitioner who is not appropriately licensed due to a disciplinary action, PEOG -- rather than the contractor -- will make all denial determinations for this noncompliance requirement).

B. Denial Reason 2– Excluded/Debarred from Federal Program (42 CFR § 424.530(a)(2))

(i) "The provider or supplier, or any owner, managing employee, managing organization, officer, director, authorized or delegated official, medical director, supervising physician, or other health care or administrative or management services personnel (such as a billing specialist, accountant, or human resources specialist) furnishing services payable by a federal health care program, of the provider or supplier is—

(A) Excluded from Medicare, Medicaid, or any other federal health care program, as defined in 42 CFR § 1001.2, in accordance with section 1128, 1128A, 1156, 1842, 1862, 1867 or 1892 of the Social Security Act, or

(B) Debarred, suspended, or otherwise excluded from participating in any other Federal procurement or non-procurement program or activity in accordance with section 2455 of the Federal Acquisition Streamlining Act."

(ii) The individuals and organizations identified in paragraph (a)(2)(i) of this section include, but are not limited to, W–2 employees and contracted individuals and organizations of the

provider or supplier.

(Unless stated otherwise in section 10.6.6 of this chapter or in another CMS directive, the contractor need not review the OIG exclusion list for any "health care or administrative or management services personnel" who are not otherwise required to be reported on the enrollment application.)

C. Denial Reason 3 – Felony Conviction (42 CFR § 424.530(a)(3))

"The provider, supplier, or any owner, managing employee, managing organization, officer, director, of the provider or supplier was, within the preceding 10 years, convicted (as that term is defined in 42 CFR § 1001.2) of a federal or state felony offense that CMS determines to be detrimental to the best interests of the Medicare program and its beneficiaries.

(i) Offenses include, but are not limited in scope and severity to:

(A) Felony crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

(B) Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

(C) Any felony that placed the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.

(D) Any felonies outlined in section 1128 of the Social Security Act.

(ii) Denials based on felony convictions are for a period to be determined by the Secretary, but not less than 10 years from the date of conviction if the individual has been convicted on one previous occasion for one or more offenses.

(iii) The individuals and organizations identified in paragraph (a)(3) of this section include, but are not limited to, W–2 employees and contracted individuals and organizations of the provider or supplier."

While a reenrollment bar is established for revoked providers/suppliers, this does not preclude the contractor from denying reenrollment to a provider/supplier that was convicted of a felony within the preceding 10-year period or that otherwise does not meet all of the criteria necessary to enroll in Medicare.

Note that if an MDPP coach meets the above felony requirements, this would not itself warrant a denial of the MDPP supplier under § 424.535(a)(3). This is because the coach, not the MDPP supplier, has the felony conviction. The MDPP supplier could, however, be denied enrollment under § 424.530(a)(1) (non-compliance with enrollment requirements) for having an ineligible coach.

As explained in section 10.6.6 of this chapter, the contractor shall submit all felonies found on Form CMS-855 and CMS-20134 applications to PEOG for review via ProviderEnrollmentRevocations@cms.hhs.gov. (See section 10.6.6 for more information.)

D. Denial Reason 4– False or Misleading Information on Application (42 CFR § 424.530(a)(4))

"The provider or supplier submitted false or misleading information on the enrollment application to gain enrollment in the Medicare program."

E. Denial Reason 5– On-Site Review/Other Reliable Evidence that Requirements Not Met (42 CFR §424.530(a)(5))

"Upon on-site review or other reliable evidence, CMS determines that the provider or supplier:

(i) Is not operational to furnish Medicare-covered items or services; or
(ii) Otherwise fails to satisfy any Medicare enrollment requirement."

F. Denial Reason 6– *Medicare Debt* (42 CFR § 424.530(a)(6))

1. Background

Consistent with 42 CFR § 424.530(a)(6), an enrollment application may be denied if:

*(i) T*he provider, supplier, or owner thereof *(as defined in § 424.502)* has an existing Medicare *debt*:

(*ii*) The enrolling provider, supplier, or owner (as defined in § 424.502) thereof was previously the owner of a provider or supplier that had a Medicare debt that existed when the latter's enrollment was voluntarily terminated, involuntarily terminated, or revoked, and all the following criteria are met:

(*A*) The owner left the provider or supplier with the Medicare debt within 1 year before or after that provider or supplier's voluntary termination, involuntary termination, or revocation.

(*B*) The Medicare debt has not been fully repaid.

(*C*) CMS determines that the uncollected debt poses an undue risk of fraud, waste, or abuse. In making this determination [under § 424.530(a)(6)(ii)], CMS considers the following factors:

(*1*) The amount of the Medicare debt.

(*2*) The length and timeframe that the enrolling provider, supplier, or owner thereof was an owner of the prior entity.

(*3*) The percentage of the enrolling provider, supplier, or owner's ownership of the prior entity.

(*4*) Whether the Medicare debt is currently being appealed.

(*5*) Whether the enrolling provider, supplier, or owner thereof was an owner of the prior entity at the time the Medicare debt was incurred."

In addition, a denial of Medicare enrollment under paragraph (a)(6)(*ii*) can be avoided if the enrolling provider, supplier, or owner thereof does either of the following: (1) satisfies the criteria set forth in § 401.607 and agrees to a CMS-approved extended repayment schedule for the entire outstanding Medicare debt; or (2) repays the debt in full.

1. Contractor's Determination of Overpayment

When processing a Form CMS-855A, CMS-855B, CMS-855I, CMS-855S, or CMS-20134 initial or change of ownership application (if applicable), the contractor shall determine – using a system generated monthly listing – whether the provider, supplier, or any owner listed in Section 5 or 6 of the application has an existing or delinquent Medicare overpayment, as described in section 10.4.2.2(F)(1) above and § 424.530(a)(6). If such an overpayment exists, the contractor shall deny the application, using 42 CFR §424.530(a)(6) as the basis. However, prior PEOG approval is required before proceeding with the denial. The contractor shall under no circumstances deny an application under § 424.530(a)(6) without receiving PEOG approval to do so.

2. Examples

Example #1: Dr. X, a sole proprietor, has a $70,000 overpayment. Three months later, he joins Group Y and becomes a 50 percent owner thereof. Group Y submits an initial enrollment application two months thereafter. Group Y's enrollment could be denied because Dr. X is an owner.

Example #2: Dr. John Smith's practice ("Smith Medicine") is set up as a sole proprietorship. He incurs a $50,000 overpayment. He terminates his Medicare enrollment. Six months later, he tries to enroll as a sole proprietorship; his practice is named "JS Medicine." A denial is warranted because § 424.530(a)(6) applies to physicians and the $50,000 overpayment was attached to him as the sole proprietor.

Example #3 - Same scenario as example #2, but assume that his new practice is an LLC of which he is only a 30 percent owner. A denial is still warranted because he is an owner of the enrolling supplier and the $50,000 overpayment was attached to him.

Example #4 - Jane Smith is a nurse practitioner in a solo practice. Her practice ("Smith Medicine") is set up as a closely-held corporation, of which she is the 100 percent owner. Smith Medicine is assessed a $20,000 overpayment. She terminates her Medicare enrollment. Nine months later, she submits a Form CMS-855I application to enroll herself, Jane Smith as a new individual provider. The business will be established as a sole proprietorship. A denial is not warranted because the $20,000 overpayment was attached to Smith Medicine, not to Jane Smith.

In each of these examples, however, denial could be avoided if (1) the party with the overpayment is on a Medicare-approved plan of repayment or (2) the overpayments in question are currently being offset or being appealed.

3. Additional Considerations Involving § 424.530(a)(6)

The contractor shall also observe the following with respect to § 424.530(a)(6):

a. In determining whether an overpayment exists, the contractor need only review its own records; it need not contact other contractors to determine whether the person or entity has an overpayment in those contractor jurisdictions.

b. The instructions in this section 10.4.2.2(F) apply only to (i) initial enrollments and (ii) new owners in a change of ownership.

c. The term "owner" under § 424.502 means any individual or entity that has any partnership interest in, or that has 5 percent or more direct or indirect ownership of, the provider or supplier as defined in sections 1124 and 1124A(A) of the Act.

d. If the person or entity had an overpayment at the time the application was filed but repaid it in full by the time the contractor performed the review described in this section 10.4.2.2(F), the contractor shall not deny the application based on § 424.530(a)(6).

G. Denial Reason 7– Medicare or Medicaid Payment Suspension (42 CFR § 424.530(a)(7))

(i) The provider or supplier, or any owning or managing employee or organization of the provider or supplier, is currently under a Medicare or Medicaid payment suspension as defined in §§ 405.370 through 405.372 or in § 455.23 of this chapter.

(ii) CMS may apply the provision in this paragraph (a)(7) to the provider or supplier under any of the provider's, supplier's, or owning or managing employee's or organization's current or former names, numerical identifiers, or business identities or to any of its existing enrollments.

(iii) In determining whether a denial is appropriate, CMS considers the following factors:

(A) The specific behavior in question.

(B) Whether the provider or supplier is the subject of other similar investigations.

(C) Any other information that CMS deems relevant to its determination.

H. Denial Reason 8– Home Health Agency (HHA) Capitalization (42 CFR § 424.530(a)(8))

An HHA submitting an initial application for enrollment:

a. Cannot, within 30 days of a CMS or Medicare contractor request, furnish supporting documentation verifying that the HHA meets the initial reserve operating funds requirement in 42 CFR § 489.28(a); or

b. Fails to satisfy the initial reserve operating funds requirement in 42 CFR § 489.28(a).

I. Denial Reason 9– Hardship Exception Denial and Fee Not Paid (42 CFR § 424.530(a)(9))

"The institutional provider's (as that term is defined in 42 CFR § 424.502) hardship exception request is not granted, and the institutional provider does not submit the required application fee within 30 days of notification that the hardship exception request was not approved."

(This denial reason should only be used when the institutional provider fails to submit the application fee after its hardship request was denied. The contractor shall use § 424.530(a)(1) as a basis for denial when the institutional provider: (a) does not submit a hardship exception request and fails to submit the application fee within the prescribed timeframes; or (b) submits the fee, but it cannot be deposited into a government-owned account.)

J. Denial Reason 10– Temporary Moratorium (42 CFR § 424.530(a)(10))

"The provider or supplier submits an enrollment application for a practice location in a geographic area where CMS has imposed a temporary moratorium." (This denial reason applies to initial enrollment applications and practice location additions.)

K. Denial Reason 11 – Prescribing Authority (42 CFR § 424.530(a)(11))

"1. A physician or eligible professional's Drug Enforcement Administration (DEA) Certificate of Registration to dispense a controlled substance is currently suspended or revoked or is surrendered in response to an order to show cause; or

2. The applicable licensing or administrative body for any state in which a physician or eligible professional practices has suspended or revoked the physician or eligible professional's ability to prescribe drugs, and such suspension or revocation is in effect on the date the physician or eligible professional submits his or her enrollment application to the Medicare contractor."

(Except as otherwise stated in this chapter or in another CMS directive, the contractor need not verify whether an individual's DEA certificate was surrendered in response to a show cause order.)

NOTE: With respect to (a)(11), PEOG -- rather than the contractor – will make all determinations regarding whether this provision applies.

L. Denial Reason 12 (42 CFR § 424.530(a)(12) - Revoked Under Different Name, Numerical Identifier, or Business Identity)

"The provider or supplier is currently revoked under a different name, numerical identifier, or business identity, and the applicable reenrollment bar period has not expired. In making its determination, CMS considers the following factors:

(i) Owning and managing employees and organizations (regardless of whether they have been disclosed on the Form CMS-855 [or CMS-20134] application);
(ii) Geographic location;
(iii) Provider or supplier type;
(iv) Business structure; or
(v) Any evidence indicating that the two parties [the revoked provider/supplier and the newly-enrolling provider/supplier] are similar or that the provider or supplier was created to circumvent the revocation or reenrollment bar."

NOTE: With respect to (a)(12), PEOG – rather than the contractor – will make all determinations regarding whether a provider or supplier was revoked under a different name, numerical identifier or business identity.

M. Denial Reason 13 (42 CFR § 424.530(a)(13) - Affiliation that Poses an Undue Risk)

"The provider or supplier has or has had an affiliation under 42 CFR § 424.519 (specifically, the factors listed in 42 CFR § 424.519(f)) that poses an undue risk of fraud, waste, and abuse to the Medicare program."

An affiliation is defined as any of the following:

(i) A 5 percent or greater direct or indirect ownership interest that an individual or entity has in another organization.
(ii) A general or limited partnership interest (regardless of the percentage) that an individual or entity has in another organization.
(iii) An interest in which an individual or entity exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operations of another organization (including, for purposes of § 424.519 only, sole proprietorships), either under contract or

through some other arrangement, regardless of whether or not the managing individual or entity is a W–2 employee of the organization.
(iv) An interest in which an individual is acting as an officer or director of a corporation.
(v) Any reassignment relationship under § 424.80.

NOTE: With respect to (a)(13), PEOG -- rather than the contractor – will make all determinations regarding whether a provider or supplier has an affiliation per 42 CFR § 424.519 that poses an undue risk of fraud, waste and abuse.

N. Denial Reason 14 (42 CFR § 424.530(a)(14) – Other Program Termination or Suspension)

"(1) The provider or supplier is currently terminated or suspended (or otherwise barred) from participation in a state Medicaid program or any other federal health care program; or (2) the provider or supplier's license is currently revoked or suspended in a state other than that in which the provider or supplier is enrolling."

In determining whether a denial under § 424.530(a)(14) is appropriate, CMS considers the following factors:

a. The reason(s) for the termination, suspension, or revocation;

b. Whether, as applicable, the provider or supplier is currently terminated or suspended (or otherwise barred) from more than one program (for example, more than one state's Medicaid program), has been subject to any other sanctions during its participation in other programs or by any other state licensing boards, or has had any other final adverse actions (as that term is defined in § 424.502) imposed against it; and

c. Any other information that CMS deems relevant to its determination."

NOTE: With respect to (a)(14), PEOG -- rather than the contractor – will make all determinations regarding whether a provider or supplier has a termination or suspension from another program *or has a license that is currently revoked or suspended in a state other than that in which the provider or supplier is enrolling.*

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O. Denial Reason 15 (42 CFR § 424.530(a)(15) – Patient Harm)

"The physician or other eligible professional has been subject to prior action from a state oversight board, federal or state health care program, Independent Review Organization (IRO) determination(s), or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health care with underlying facts reflecting improper physician or other eligible professional conduct that led to patient harm. In determining whether a denial is appropriate, CMS considers the following factors:

(A) The nature of the patient harm

(B) The nature of the physician's or other eligible professional's conduct

(C) The number and type(s) of sanctions or disciplinary actions that have been imposed against the physician or other eligible professional by a state oversight board, IRO, federal or state health care program, or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health care. Such actions include, but are not limited to in scope or degree: (i) license restriction(s) pertaining to certain procedures or practices; (ii) required compliance appearances before state oversight board members; (iii) license restriction(s) regarding the ability to treat certain types of patients (for example,

cannot be alone with members of a different gender after a sexual offense charge); (iv) administrative/monetary penalties; and (v) formal reprimand(s).

(D) If applicable, the nature of the IRO determination(s).

(E) The number of patients impacted by the physician's or other eligible professional's conduct and the degree of harm thereto or impact upon."

Section 424.530(a)(15) does not apply to actions or orders pertaining exclusively to either of the following: (i) required participation in rehabilitation or mental/behavioral health programs; or (ii) required abstinence from drugs or alcohol and random drug testing.

NOTE: With respect to (a)(15), PEOG -- rather than the contractor – will make all determinations regarding whether this provision applies.

P. Denial Reason 17 – False Claims Act Judgment (42 CFR § 424.530(a)(17))

"(i) The provider or supplier, or any owner, managing employee or organization, officer, or director of the provider or supplier, has had a civil judgment under the False Claims Act (31 U.S.C. 3729 through 3733) imposed against them within the previous 10 years.

(ii) In determining whether a denial under this paragraph is appropriate, CMS considers the following factors:

(A) The number of provider or supplier actions that the judgment incorporates (for example, the number of false claims submitted)

(B) The types of provider or supplier actions involved

(C) The monetary amount of the judgment

(D) When the judgment occurred

(E) Whether the provider or supplier has any history of final adverse actions (as that term is defined in § 424.502)

(F) Any other information that CMS deems relevant to its determination."

NOTE: With respect to (a)(17), PEOG -- rather than the contractor – will make all determinations regarding whether this provision applies.

Q. Denial Reason 18 – Standard or Condition Violation (42 CFR § 424.530(a)(18))

"(i) The independent diagnostic testing facility is non-compliant with any provision in 42 CFR 410.33(g).

(ii) The DMEPOS supplier is non-compliant with any provision in § 424.57(c).

(iii) The opioid treatment program is non-compliant with any provision in § 424.67(b) or (e).

(iv) The home infusion therapy supplier is non-compliant with any provision in § 424.68(c) or (e).

(v) The Medicare diabetes prevention program is non-compliant with any provision in § 424.205(b) or (d)."

(Similar to current practice with respect to § 424.530(a)(1), the contractor can make denial determinations under § 424.530(a)(18) without prior PEOG approval. The contractor's denial letter shall cite the exact statutory and/or regulatory citation(s) containing the specific standard/condition with which the provider/supplier is non-compliant. For a listing of some of these statutes and regulations, refer to section 10.2 et seq. of this chapter.)

(See section 10.4.2.3 for more information regarding § 424.530(a)(18).)

10.4.7.1 – Revocations – Background and General Requirements

(Rev. 12550; Issued: 03-21-24; Effective: 04-21-24; Implementation: 04-21-24)

A. Introduction

Medicare revokes currently enrolled providers/suppliers' Medicare billing privileges and corresponding provider/supplier agreements pursuant to federal regulations at 42 CFR § 424.535. (A Medicare revocation is a "termination" as defined at 42 CFR § 455.101.) A revocation of Medicare billing privileges does not affect a provider's ability to submit claims to non-Medicare payers using their NPI.

If the contractor determines that a provider's billing privileges should be revoked or receives information from PEOG that a provider's billing privileges should be revoked, it shall undertake activities to process the revocation, apply the revocation in PECOS, notify the provider, and afford appeal rights. This section 10.4.7.1 includes, but is not limited to, information concerning the contractor's responsibilities to:

(i) Prepare a draft revocation letter

(ii) E-mail the letter to the appropriate PEOG mailbox with additional pertinent information regarding the basis for revocation

(iii) Receive PEOG's determination and follow PEOG's instructions regarding the case

(iv) If PEOG authorizes the revocation: (a) revoke the provider's billing privileges effective on the appropriate date; (b) establish the applicable reenrollment bar; (c) update PECOS with the appropriate reenrollment bar length; (d) assess an overpayment, as applicable; and (e) send the revocation letter (including affording appeal rights) to the provider via certified mail.

B. Administrative Requirements

This section 10.4.7.1(B) addresses (in greater specificity than section 10.4.7.1(A)) certain contractor administrative activities pertaining to revocations. As stated in section 10.4.7.1(A), however, the contractor shall take into account the instructions in sections 10.6.6 and 10.7 et seq.

1. Processing Timeframes

If the contractor receives approval from PEOG (or receives an unrelated request from PEOG) to revoke a provider's billing privileges, the contractor shall complete all steps associated with the revocation no later than five (5) business days from the date it received PEOG's approval/request. The contractor shall notify PEOG that it has completed all revocation steps no later than three (3) business days after completion.

2. Revocation Letters - Contents

i. General Information

When the contractor discovers a basis for revoking a provider's enrollment under 42 CFR § 424.535 - and, if applicable under section 10.6.6 of this chapter or another CMS directive, receives PEOG's approval for the revocation - the contractor shall revoke billing privileges and notify the provider by letter. The revocation letter shall contain:

(a) A legal (i.e., regulatory, such as § 424.535(a)(3) or §424.535(a)(9)) basis for each reason for revocation (the contractor shall not use provisions from this chapter as the basis for revocation);

(b) A clear explanation of why Medicare billing privileges are being revoked, including the facts or evidence that the contractor used in making its determination;

(c) An explanation of why the provider does not meet the applicable enrollment criteria;

(d) The effective date of the revocation;

(e) Procedures for submitting a CAP (if revoked under § 424.535(a)(1));

(f) Complete and accurate information about the provider's appeal rights;

(g) Any other information contained in or required by the applicable model letter in section 10.7 et seq.

ii. One Letter Per Enrollment

The contractor shall issue a unique revocation letter per enrollment. For example, regarding revocation letters for solely owned organizations, when revoking a physician/non-physician practitioner's billing privileges and those of his/her solely owned organization, the contractor shall issue **two** revocation letter: one for the individual and the other for the solely owned organization. The contractor shall not issue one letter to convey revoked Medicare billing privileges for both the individual and the solely owned organization.

3. Revocation Letters – PEOG Approval

Using the guidance in this section 10.4.7.1(B) et seq., section 10.6.6, and section 10.7 et seq., the contractor shall determine whether it must submit its draft revocation letter to PEOG for approval prior to sending it to the provider.

i. Prior PEOG Approval Required

If prior PEOG approval of the letter is required, the contractor shall submit the letter to the appropriate PEOG mailbox for PEOG review. PEOG will examine the letter for technical correctness and determine matters such as: (1) whether the revocation affects the revoked provider's other locations; (2) the length and application of the reenrollment bar; and (3) the revocation effective date. PEOG will notify the contractor of the outcome of its review and instruct the contractor how to proceed.

The contractor shall not begin finalizing the revocation until it receives guidance from PEOG.

The contractor may not alter an approved revocation letter; if it needs to revise said letter, the contractor shall submit the letter to PEOG for a new review via the process described above.

Unless CMS has directed otherwise, the contractor shall document and report the impacted application/enrollment in its Monthly Status Reports.

ii. When PEOG Approval of Revocation Letter is Unnecessary

The contractor need not obtain prior PEOG approval of the revocation and the revocation letter if the revocation involves any of the following situations:

- § 424.535(a)(1) (*for (a)(1) noncompliance issues other than Noncompliance – Not Professionally Licensed Individual Practitioners OR* except as otherwise required in this chapter or another CMS directive)
- § 424.535(a)(6)
- § 424.535(a)(11)

4. Issuing the Revocation Letter to the Provider

The contractor shall send revocation letters by USPS certified mail. (The contractor may e-mail a follow-up copy of the letter after issuing it via USPS certified mail.) The contractor shall date and mail the letter on the same business day.

10.4.7.2 – Revocation Effective Dates

(Rev. 12550; Issued: 03-21-24; Effective: 04-21-24; Implementation: 04-21-24)

A. Effective Dates

The contractor shall apply a revocation effective date based upon federal regulations at § 424.535(g). In general, and as discussed below, these dates are either prospective or retroactive.

1. Revocations with Retroactive Effective Dates (§ 424.535(g)(2))

The following revocation reasons require a retroactive effective date per § 424.535(g):

(i) Federal exclusion or debarment

(ii) Felony conviction

(iii) License suspension, revocation, *or voluntary surrender in lieu of further disciplinary action*

(iv) *Determination that the provider or supplier is no longer operational*

(v) Termination from a federal health care program other than Medicare (for example, Medicaid)

(vi) *Termination of a provider agreement under 42 CFR part 489; or*

(vii) Violation of provider or supplier standard as described in 42 CFR §§ 424.535(a)(23) and § 424.535(g)(2)

A revocation based upon any of these reasons is effective with (as applicable to the specific revocation reason):

- *The date of the exclusion, debarment, felony conviction, license suspension/revocation/voluntary surrender in lieu of further disciplinary action, or*

federal health care program (other than Medicare) termination;

- *The date that CMS or the contractor determined that the provider is no longer operational;*
- *The date the provider agreement is terminated (under 42 CFR part 489) or, as applicable the date CMS establishes under 42 CFR § 489.55; or*
- *The date of the specific provider or supplier standard or condition violation as described in § 424.535(g)(2)*

To illustrate, for a revocation involving a licensure revocation/suspension, the revocation effective date (and the date listed on the revocation letter) shall be the date of the actual license revocation/suspension.

Additionally, and as described in 424.535(g)(3), if the action that triggered the revocation occurred before the provider's or supplier's enrollment, the revocation effective date is the enrollment effective date that CMS assigned to the provider or supplier. To illustrate, for a revocation involving an adverse legal action that occurred on February 1 (of which CMS was not aware) and the provider was enrolled effective April 1, the revocation effective date would be April 1 rather than February 1. Strictly for purposes of applying § 424.535(g)(3) -- and notwithstanding any guidance to the contrary in section 10.6.2 of this chapter – the effective date of enrollment is the date that was established under §§ 424.520 or 424.521, whichever is earlier.

2. Revocations with Prospective Effective Dates (§ 424.535(g)(1))

The contractor shall use a prospective effective date (i.e., the date that is 30 days after CMS or the CMS contractor mails notice of its determination to the provider) for revocations not based upon one of the reasons listed in §§ 424.535(g)(2) and section 10.4.7.2(A) above (e.g., § 424.535(a)(8) -- abuse of billing).

B. Revocations Based Upon More than One Reason

When a revocation involves more than one reason, the contractor shall determine whether any of the grounds require a retroactive effective date (listed in §§ 424.535(g) and section 10.4.7.2(B) above; if a retroactive date is indeed implicated, the contractor shall apply the appropriate retroactive date.

10.4.7.3 – Revocation Reasons

(Rev.12550; Issued:03-21-24; Effective: 04-21-24; Implementation: 04-21-24)

Sections 10.4.7.3(A) through (*V*) list the revocation reasons in 42 CFR § 424.535. Section 10.4.7.3(*W*) discusses extensions of revocations per 42 CFR § 424.535(i).

A. Revocation Reason 1 – Noncompliance (42 CFR § 424.535(a)(1))

"The provider or supplier is determined not to be in compliance with the enrollment requirements in this Title 42 or in the enrollment application applicable to its provider or supplier typeand has not submitted a plan of corrective action as outlined in 42 CFR Part 488. The provider or supplier may also be determined not to be in compliance if it has failed to pay any user fees as assessed under part 488 of this chapter."

(Title 42 includes the principal provider enrollment regulations in 42 CFR Part 424, subpart P; the IDTF enrollment standards in 42 CFR § 410.33; the OTP enrollment standards in 42 CFR § 424.67; etc.)

Noncompliance includes but is not limited to: (1) the provider/supplier no longer has a physical business address or mobile unit where services can be rendered; (2) the provider/supplier does not have a place where patient records are stored to determine the amounts due such provider or other person; and/or (3) the provider/supplier no longer meets or maintains general enrollment requirements. Noncompliance also includes situations when the provider/supplier has failed to pay any user fees as assessed under 42 CFR Part 488.

Other situations (some of which were mentioned in the previous paragraph) in which § 424.535(a)(1) may be used as a revocation reason include, but are not limited to, the following:

- The provider or supplier does not have a physical business address or mobile unit where services can be rendered.

- The provider or supplier does not have a place where patient records are stored to determine the amounts due such provider or other person.

- The provider or supplier is not appropriately licensed. *(NOTE: For (a)(1) revocations involving an individual practitioner who is not appropriately licensed due to a disciplinary action, PEOG -- rather than the contractor -- will make all determinations to revoke for this noncompliance requirement).*

- The provider or supplier is not authorized by the federal/state/local government to perform the services that it intends to render.

- The provider or supplier does not meet CMS regulatory requirements for the specialty that it is enrolled as.

- The provider or supplier does not have a valid social security number (SSN) or employer identification number (EIN) for itself, an owner, partner, managing organization/employee, officer, director, medical director, and/or authorized or delegated official.

- The provider or supplier fails to furnish complete and accurate information and all supporting documentation within 60 calendar days of the provider/supplier's notification from CMS or its contractor to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information. (This revocation reason will not apply if CMS has instructed the contractor to use deactivation reason § 424.540(a)(3) in lieu thereof.)

- The provider or supplier does not otherwise meet general enrollment requirements.

(Concerning the last bullet above – and, as applicable, bullets 3, 4 and 5 – the contractor's revocation letter shall cite the appropriate statutory and/or regulatory citation(s) containing the specific licensure/certification/authorization requirement(s) for that provider/supplier type.)

Special Instructions Regarding Certified Providers/Suppliers – The SOG Location may involuntarily terminate a certified provider/supplier if the latter no longer meets CMS requirements, conditions of participation, or conditions of coverage. When this occurs, CMS terminates the provider'/supplier's provider agreement and notifies the contractor thereof. Upon receipt of the CMS notice (and except as otherwise stated in this chapter), the contractor shall follow the revocation procedures in this chapter (including, as applicable, those in section 10.6.6)), using § 424.535(a)(1) as the revocation basis; the contractor shall

not process the involuntary termination as a deactivation based upon a voluntary withdrawal from Medicare.

Note that the contractor need not (but certainly may) contact the SOG Location to obtain further details of the termination.

B. Revocation Reason 2 – Provider or Supplier Conduct (42 CFR § 424.535(a)(2))

"*(i)* The provider or supplier, or any owner, managing employee, managing organization, officer, director, authorized or delegated official, medical director, supervising physician, or other health care or administrative or management personnel furnishing services payable by a federal health care program, of the provider or supplier is:

(*A*) Excluded from the Medicare, Medicaid, and any other federal health care program, as defined in 42 CFR § 1001.2, in accordance with section 1128, 1128A, 1156, 1842, 1862, 1867 or 1892 of the Act.

(*B*) Is debarred, suspended, or otherwise excluded from participating in any other federal procurement or non-procurement program or activity in accordance with the FASA implementing regulations and the Department of Health and Human Services non-procurement common rule at 45 CFR part 76.

(ii) The individuals and organizations identified in paragraph (a)(2)(i) of this section include, but are not limited to, W–2 employees and contracted individuals and organizations of the provider or supplier."

If the contractor finds an excluded party (and unless section 10.6.6 states otherwise, in which case the latter section takes precedence), the contractor shall notify its PEOG BFL immediately. PEOG will notify the Contracting Officer's Representative (COR) for the appropriate Unified Program Integrity Contractor (UPIC). The COR will, in turn, contact the OIG for further investigation.

C. Revocation Reason 3 – Felony Conviction (42 CFR § 424.535(a)(3))

"The provider, supplier, or any owner, managing employee, managing organization, officer, or director of the provider or supplier was, within the preceding 10 years, convicted (as that term is defined in 42 CFR §1001.2) of a federal or state felony offense that CMS determines to be detrimental to the best interests of the Medicare program and its beneficiaries. [Under § 424.535(a)(3)(ii),] [o]ffenses include, but are not limited in scope and severity to:

- Felony crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.
- Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.
- Any felony that placed the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.
- Any felonies that would result in mandatory exclusion under section 1128(a) of the Act.

[Under § 424.535(a)(3)(iii),] revocations based on felony convictions are for a period to be determined by the Secretary, but not less than 10 years from the date of conviction if the individual has been convicted on one previous occasion for one or more offenses."]

[Under § 424.535(a)(3)(iv),] the individuals and organizations identified in paragraph (a)(3)

of this section include, but are not limited to, W–2 employees and contracted individuals and organizations of the provider or supplier.]

The expiration of a reenrollment bar issued pursuant to 42 CFR § 424.535(c) does not preclude CMS or its contractors from denying reenrollment to a provider that (i) was convicted of a felony within the preceding 10-year period or (ii) otherwise does not meet all criteria necessary to enroll in Medicare.

D. Revocation Reason 4 – False or Misleading Information on Application (42 CFR § 424.535(a)(4))

"The provider or supplier certified as ''true'' misleading or false information on the enrollment application to be enrolled or maintain enrollment in the Medicare program. (Offenders may be subject to either fines or imprisonment, or both, in accordance with current laws and regulations.)"

E. Revocation Reason 5 - On-Site Review/Other Reliable Evidence that Requirements Not Met (42 CFR § 424.535(a)(5))

"Upon on-site review or other reliable evidence, CMS determines that the provider or supplier:

(i) Is not operational to furnish Medicare-covered items or services; or
(ii) Otherwise fails to satisfy any Medicare enrollment requirement."

F. Revocation Reason 6 - Hardship Exception Denial and Fee Not Paid (42 CFR §424.535(a)(6))

(i) An institutional provider does not submit an application fee or hardship exception request that meets the requirements set forth in § 424.514 with the Medicare revalidation application; or

(ii) The hardship exception is not granted and the institutional provider does not submit the applicable application form or application fee within 30 days of being notified that the hardship exception request was denied.

(iii) Either of the following occurs:

- CMS is not able to deposit the full application amount into a government-owned account; or

- The funds are not able to be credited to the United States Treasury;

(iv) The provider or supplier lacks sufficient funds in the account at the banking institution whose name is imprinted on the check or other banking instrument to pay the application fee; or

(v) There is any other reason why CMS or its Medicare contractor is unable to deposit the application fee into a government-owned account.

G. Revocation Reason 7 – Misuse of Billing Number (42 CFR § 424.535(a)(7))

"The provider or supplier knowingly sells to or allows another individual or entity to use its billing number. This does not include those providers or suppliers that enter into a valid

reassignment of benefits as specified in 42 CFR § 424.80 or a change of ownership as outlined in 42 CFR § 489.18."

H. Revocation Reason 8 – Abuse of Billing Privileges (42 CFR § 424.535(a)(8))

"Abuse of billing privileges includes either of the following:

(i) The provider or supplier submits a claim or claims for services that could not have been furnished to a specific individual on the date of service. These instances include but are not limited to the following situations:

(A) Where the beneficiary is deceased.

(B) The directing physician or beneficiary is not in the state or country when services were furnished.

(C) When the equipment necessary for testing is not present where the testing is said to have occurred.

(ii) CMS determines that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements. In making this determination, CMS considers, as appropriate or applicable, the following factors:

(A) The percentage of submitted claims that were denied during the period under consideration.

(B) Whether the provider or supplier has any history of final adverse actions (as that term is defined in § 424.502) and the nature of any such actions.

(C) The type of billing non-compliance and the specific facts surrounding said non-compliance (to the extent this can be determined).

(D) Any other information regarding the provider or supplier's specific circumstances that CMS deems relevant to its determination."

(**NOTE**: Concerning (a)(8), PEOG -- rather than the contractor -- will (1) make all determinations regarding whether a provider has a pattern or practice of submitting non-compliant claims; (2) consider the relevant factors; and (3) accumulate all information needed to make such determinations.)

I. Revocation Reason 9 – Failure to Report (42 CFR § 424.535(a)(9))

"The provider or supplier failed to comply with the reporting requirements specified in 42 CFR § 424.516(d) or (e), § 410.33(g)(2), or § 424.57(c)(2) [which pertain to the reporting of changes in adverse actions and practice locations]."

With respect to § 424.535(a)(9) (and except as otherwise stated in section 10.6.6):

- If the provider reports a change in practice location more than 30 days after the effective date of the change, the contractor shall not pursue a revocation on this basis. However, if the contractor independently determines – through an on-site inspection under 42 CFR § 424.535(a)(5)(ii) or via another verification process - that the provider's address has changed but the provider has not notified the contractor thereof within the aforementioned 30-day timeframe, the contractor may pursue a revocation (e.g., seeking PEOG's approval to revoke).

- If an IDTF reports a change in ownership, change of location, change in general supervision or change in adverse legal action more than 30 days after the effective date of the change, the contractor may pursue a revocation on this basis (e.g., seeking PEOG's approval to revoke).

- If a DMEPOS supplier reports a change of information more than 30 days after the effective date of the change, the contractor may pursue a revocation on this basis (e.g., seeking PEOG's approval to revoke).

J. Revocation Reason 10 – Failure to Document or Provide CMS Access to Documentation (42 CFR § 424.535(a)(10))

"The provider or supplier did not comply with the documentation requirements specified in 42 CFR § 424.516(f). A provider that furnishes any covered ordered, certified, referred, or prescribed Part A or B services, items or drugs is required to maintain documentation for 7 years."

K. Revocation Reason 11 - Home Health Agency (HHA) Capitalization (42 CFR § 424.535(a)(11))

"An HHA fails to furnish - within 30 days of a CMS or contractor request - supporting documentation verifying that the HHA meets the initial reserve operating funds requirement found in 42 CFR § 489.28(a)."

L. Revocation Reason 12 – Other Program Termination (42 CFR § 424.535(a)(12))

"The provider or supplier is terminated, revoked, or otherwise barred from participation in a particular State Medicaid Agency or any other federal health care program."

In making its determination, CMS considers the following factors listed in 42 CFR § 424.535(a)(12):

"(A) The reason(s) for the termination or revocation;

(B) Whether the provider or supplier is currently terminated, revoked, or otherwise barred from more than one program (for example, more than one state's Medicaid program) or has been subject to any other sanctions during its participation in other programs; and;

(C) Any other information that CMS deems relevant to its determination."

Under § 424.535(a)(12)(ii), "Medicare may not revoke [a provider/supplier's Medicare billing privileges] unless and until the provider or supplier has exhausted all applicable appeal rights or the timeframe for filing an appeal has expired without the provider or supplier filing an appeal."

M. Revocation Reason 13 - Prescribing Authority (42 CFR § 424.535(a)(13))

"(i) The physician or eligible professional's Drug Enforcement Administration (DEA) Certificate of Registration is suspended or revoked or is surrendered in response to an order to show cause; or

(ii) The applicable licensing or administrative body for any state in which the physician or eligible professional practices suspends or revokes the physician's or other eligible professional's ability to prescribe drugs."

N. Revocation Reason 14 – Improper Prescribing Practices (42 CFR § 424.535(a)(14))

"CMS determines that the physician or other eligible professional has a pattern or practice of prescribing Part B or D drugs that falls into one of the following categories:

(i) The pattern or practice is abusive or represents a threat to the health and safety of Medicare beneficiaries or both. In making this determination, CMS considers the following factors:

(A) Whether there are diagnoses to support the indications for which the drugs were prescribed;

(B) Whether there are instances when the necessary evaluation of the patient for whom the drug was prescribed could not have occurred (for example, the patient was deceased or out of state at the time of the alleged office visit);

(C) Whether the physician or eligible professional has prescribed controlled substances in excessive dosages that are linked to patient overdoses;

(D) The number and type(s) of disciplinary actions taken against the physician or eligible professional by the licensing body or medical board for the State or States in which he or she practices, and the reason(s) for the action(s);

(E) Whether the physician or eligible professional has any history of final adverse actions (as that term is defined in § 424.502);

(F) The number and type(s) of malpractice suits that have been filed against the physician or eligible professional related to prescribing that have resulted in a final judgment against the physician or eligible professional or in which the physician or eligible professional has paid a settlement to the plaintiff(s) (to the extent this can be determined);

(G) Whether any State Medicaid program or any other public or private health insurance program has restricted, suspended, revoked, or terminated the physician or eligible professional's ability to prescribe medications, and the reason(s) for any such restriction, suspension, revocation, or termination; and

(H) Any other relevant information provided to CMS.

(ii) The pattern or practice of prescribing fails to meet Medicare requirements. In making this determination, CMS considers the following factors:

(A) Whether the physician or eligible professional has a pattern or practice of prescribing without valid prescribing authority.

(B) Whether the physician or eligible professional has a pattern or practice of prescribing for controlled substances outside the scope of the prescriber's DEA registration.

(C) Whether the physician or eligible professional has a pattern or practice of prescribing drugs for indications that were not medically accepted - that is, for indications neither approved by the FDA nor medically accepted under section 1860D-2(e)(4) of the Act - and whether there is evidence that the physician or eligible professional acted in reckless disregard for the health and safety of the patient."

(**NOTE**: Concerning (a)(14), PEOG -- rather than the contractor -- will (1) make all determinations regarding whether a provider/supplier has a pattern or practice of prescribing Part B or D drugs; (2) consider the relevant factors; and (3) accumulate all information needed to make such determinations.)

O. Revocation Reason 15 – False Claims Act Judgment (42 CFR § 424.535(a)(15))

"(i) The provider or supplier, or any owner, managing employee or organization, officer, or director of the provider or supplier, has had a civil judgment under the False Claims Act (31 U.S.C. 3729 through 3733) imposed against them within the previous 10 years.

(ii) In determining whether a revocation under this paragraph is appropriate, CMS considers the following factors:

(A) The number of provider or supplier actions that the judgment incorporates (for example, the number of false claims submitted)

(B) The types of provider or supplier actions involved

(C) The monetary amount of the judgment

(D) When the judgment occurred

(E) Whether the provider or supplier has any history of final adverse actions (as that term is defined in § 424.502)

(F) Any other information that CMS deems relevant to its determination."

NOTE: With respect to (a)(15), PEOG -- rather than the contractor – will make all determinations regarding whether this provision applies.

P. **Revocation Reason 1*7* – Debt Referred to the United States Department of Treasury (42 CFR § 424.535(a)(17))**

"The provider or supplier has *failed to repay a debt* that CMS appropriately refers to the United States Department of Treasury." In determining whether a revocation is appropriate, CMS considers the following factors:

"(i)*(A)* The reason(s) for the failure to fully repay the debt (to the extent this can be determined);

(B) Whether the provider or supplier has attempted to repay the debt (to the extent this can be determined);

(C) Whether the provider or supplier has responded to CMS' requests for payment (to the extent this can be determined);

(D) Whether the provider or supplier has any history of final adverse actions or Medicare or Medicaid payment suspensions;

(E) The amount of the debt; and

(F) Any other evidence that CMS deems relevant to its determination."

(NOTE: *With respect to (a)(17):*

- *Section 424.535(a)(17)(ii) excludes from paragraph (a)(17)(i)'s purview those cases where: (1) the provider's or supplier's Medicare debt has been discharged by a bankruptcy court; or (2) the administrative appeals process concerning the debt has not been exhausted or the timeline for filing such an appeal, at the appropriate appeal level, has not expired.*
- PEOG – rather than the contractor – will make all (a)(17) determinations.

Q. **Revocation Reason 1*8* – Revoked Under a Different Name, Numerical Identifier or Business Identity (42 CFR § 424.535(a)(18))**

"The provider or supplier is currently revoked [from Medicare] under a different name, numerical identifier, or business identity, and the applicable reenrollment bar period has not expired." In making its determination, CMS considers the following factors:

"(i) Owning and managing employees and organizations (regardless of whether they have been disclosed on the Form CMS-855 [or CMS-20134] application);

(ii) Geographic location;

(iii) Provider or supplier type;

(iv) Business structure; or

(v) Any evidence indicating that the two parties [the revoked provider or supplier and newly enrolling provider or supplier] are similar or that the provider or supplier was created to circumvent the revocation or reenrollment bar."

(NOTE: Concerning (a)(18), PEOG – rather than the contractor – will make all determinations regarding whether a provider/supplier was revoked under a different name, numerical identifier, or business identity.)

R. **Revocation Reason 1*9* – Affiliation that Poses an Undue Risk (42 CFR § 424.535(a)(19))**

1. Specific Reason

"The provider or supplier has or has had an affiliation under 42 CFR § 424.519 that poses an undue risk of fraud, waste and abuse to the Medicare program." In making this determination, CMS considers the following factors listed in 42 CFR § 424.519(f)(1) through (6):

"(1) The duration of the affiliation

(2) Whether the affiliation still exists and, if not, how long ago it ended

(3) The degree and extent of the affiliation

(4) If applicable, the reason for the termination of the affiliation

(5) Regarding the affiliated provider/supplier's disclosable event [under § 424.519(b)]:

(i) The type of disclosable event.

(ii) When the disclosable event occurred or was imposed.

(iii) Whether the affiliation existed when the disclosable event occurred or was imposed.

(iv) If the disclosable event is an uncollected debt: (A) the amount of the debt; (B) whether the affiliated provider or supplier is repaying the debt; and (C) to whom the debt is owed.

(v) If a denial, revocation, termination, exclusion, or payment suspension is involved, the reason for the disclosable event.

(6) Any other evidence that CMS deems relevant to its determination."

2. Definition of Affiliation

For purposes of § 424.519 only, 42 CFR § 424.502 defines "affiliation" as:

- A 5 percent or greater direct or indirect ownership interest that an individual or entity has in another organization.

- A general or limited partnership interest (regardless of the percentage) that an individual or entity has in another organization.

- An interest in which an individual or entity exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operations of another organization (including, for purposes of [§ 424.519 only], sole proprietorships), either under contract or through some other arrangement, regardless of whether or not the managing individual or entity is a W–2 employee of the organization.

- An interest in which an individual is acting as an officer or director of a corporation.

- Any reassignment relationship under § 424.80."

(NOTE: Concerning (a)(19), PEOG -- rather than the contractor -- will make all determinations regarding whether a provider/supplier has an affiliation per § 424.519 that poses an undue risk of fraud, waste, and abuse.)

***S*. Revocation Reason *20* – Billing from a Non-Compliant Location (42 CFR § 424.535(a)(20))**

"CMS may revoke a provider's or supplier's Medicare enrollment or enrollments, even if all of the practice locations associated with a particular enrollment comply with Medicare enrollment requirements, if the provider or supplier billed for services performed at or items furnished from a location that it knew or should have known did not comply with Medicare enrollment requirements. In determining whether and how many of the provider/supplier's enrollments (involving the non-compliant location or other locations) should be revoked, CMS considers the following factors [enumerated in § 424.535(a)(20)(i) through (vii)]:

(i) The reason(s) for and the specific facts behind the location's non-compliance;

(ii) The number of additional locations involved;

(iii) The provider or suppliers possibly history of final adverse actions or Medicare or Medicaid payment suspensions;

(iv) The degree of risk the location's continuance poses to the Medicare Trust Funds;

(v) The length of time that the location was considered non-compliant;

(vi) The amount that was billed for services performed at or items furnished from the non-compliant location; and,

(vii) Any other evidence that CMS deems relevant to its determination."

(NOTE: Concerning (a)(20), PEOG – rather than the contractor – will make all determinations regarding whether a provider/supplier has performed services or furnished items from a location that did not comply with Medicare enrollment requirements.)

T. **Revocation Reason *21* – Abusive Ordering, Certifying, Referring, or Prescribing of Part A or B Services, Items or Drugs (42 CFR § 424.535(a)(21))**

"The physician or eligible professional has a pattern or practice of ordering, certifying, referring or prescribing Medicare Part A or B services, items or drugs that is abusive, represents a threat to the health and safety of Medicare beneficiaries, or otherwise fails to meet Medicare requirements." In making its determination, CMS considers the following factors [enumerated in § 424.535(i) through (ix)]:

(i) Whether the physician or eligible professional's diagnosis supports the order, certification, referral or prescription in question;

(ii) Whether there are instances where the necessary evaluation of the patient for whom the order, certification, referral or prescription could have not occurred (for example: the patient was deceased or out of state at the time of the alleged office visit);

(iii) The number and types of disciplinary actions taken against the physician or eligible professional by the licensing body or medical board for the state(s) in which he or she practices and the reason(s) for the action(s);

(iv) Whether the physician or eligible professional has any history of final adverse actions (as defined by 42 CFR § 424.502);

(v) The length of time over which the pattern or practice has continued;

(vi) How long the physician or eligible professional has been enrolled in Medicare;

(vii) The number of type(s) of malpractice suits that have been filed against the physician or eligible professional related to ordering, certifying, referring or prescribing that resulted in a final judgement against the physician or eligible professional or the physician or eligible professional paid a settlement to the plaintiff(s) (to the extent this can be determined);

(viii) Whether any State Medicaid Agency (SMA) or other public health insurance program has restricted, suspended, revoked or terminated the physician's or eligible professional's ability to practice medicine and reason for any such restriction, suspension, revocation or termination; and

(ix) Any other information that CMS deems relevant to its determination.

(NOTE: Concerning (a)(21), PEOG – rather than the contractor – will make all determinations regarding whether a physician or eligible professional has a pattern or practice of ordering, certifying, referring or prescribing Medicare Part A or B services, items, or drugs

that is abusive, threatening to the safety of Medicare beneficiaries, or fails to meet Medicare requirements).

U. **Revocation Reason *22* – Patient Harm (42 CFR § 424.535(a)(22))**

The physician or other eligible professional has been subject to prior action from a state oversight board, federal or state health care program, Independent Review Organization (IRO) determination(s), or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health care with underlying facts reflecting improper physician or other eligible professional conduct that led to patient harm. In determining whether a revocation is appropriate, CMS considers the following factors [enumerated in § 424.535(a)(22)(i)(A) through (E)):

(A) The nature of the patient harm.
(B) The nature of the physician's or other eligible professional's conduct.
(C) The number and type(s) of sanctions or disciplinary actions that have been imposed against the physician or other eligible professional by the state oversight board, IRO, federal or state health care program, or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health care. Such actions include, but are not limited to in scope or degree:

(i) License restriction(s) pertaining to certain procedures or practices.

(ii) Required compliance appearances before State medical board members.

(iii) License restriction(s) regarding the ability to treat certain types of patients (for example, cannot be alone with members of a different gender after a sexual offense charge).

(iv) Administrative or monetary penalties.

(v) Formal reprimand(s).

(D) If applicable, the nature of the IRO determination(s).

(E) The number of patients impacted by the physician/other eligible professional's conduct and the degree of harm thereto or impact upon."

(Per 42 CFR § 424.535(a)(22)(ii), paragraph (a)(22) does not apply to actions or orders pertaining exclusively to either of the following:

- Required participation in rehabilitation or mental/behavioral health programs; or
- Required abstinence from drugs or alcohol and random drug testing.)

V. Revocation Reason 23 – Standard or Condition Violation (42 CFR § 424.535(a)(23))

"(i) The independent diagnostic testing facility is non-compliant with any provision in 42 CFR 410.33(g).

(ii) The DMEPOS supplier is non-compliant with any provision in § 424.57(c).

(iii) The opioid treatment program is non-compliant with any provision in § 424.67(b) or (e).

(iv) The home infusion therapy supplier is non-compliant with any provision in § 424.68(c) or (e).

(v) The Medicare diabetes prevention program is non-compliant with any provision in § 424.205(b) or (d).”

(The contractor can make revocation determinations under § 424.535(a)(23) without prior PEOG approval. The contractor’s revocation letter shall cite the exact statutory and/or regulatory citation(s) containing the specific standard/condition with which the provider/supplier is non-compliant. For a listing of some of these statutes and regulations, refer to section 10.2 et seq. of this chapter.)

(See section 10.4.7.5(A) for more information regarding § 424.535(a)(23).)

***W*. Extension of Revocation**

If a provider’s Medicare enrollment is revoked under § 424.535(a), CMS may revoke any and all of the provider’s Medicare enrollments, including those under different names, numerical identifiers or business identities and those under different types. In determining whether to revoke a provider’s other enrollments, CMS considers the following factors:

(i) The reason for the revocation and the facts of the case;

(ii) Whether any final adverse actions have been imposed against the provider or supplier regarding its other enrollments;

(iii) The number and type(s) of other enrollments; and

(iv) Any other information that CMS deems relevant to its determination.

10.4.7.4 – Reenrollment Bar

(Rev. 12550; Issued: 03-21-24; Effective: 04-21-24; Implementation: 04-21-24)

If any inconsistency exists between an instruction in this section 10.4.7.4 and a directive in section 10.6.6, the latter instruction takes precedence. In addition, the contractor shall adhere to any instruction in section 10.6.6 that addresses a reenrollment bar matter not discussed in section 10.4.7.4.

A. Background

As stated in 42 CFR § 424.535(c), if a provider/supplier has their billing privileges revoked, they are barred from participating in the Medicare program from the effective date of the revocation until the end of the reenrollment bar. The reenrollment bar begins 30 days after CMS or its contractor mails notice of the revocation and lasts a minimum of 1 year, but not greater than 10 years, depending on the severity of the basis for revocation. In addition, CMS may impose a reenrollment bar of up to 20 years if the provider/supplier is being revoked from Medicare for the second time.

Per § 424.535(c), the reenrollment bar does not apply if the revocation: (i) is based on § 424.535(a)(1); and (ii) stems from a provider/supplier’s failure to respond timely to a revalidation request or other request for information. If both of these conditions are met, no reenrollment bar will be applied.

The contractor shall update PECOS to reflect that the individual cannot participate in Medicare for the applicable length of the reenrollment bar. Except as otherwise stated in this chapter, PEOG (rather than the contractor) determines reenrollment bars that exceed 3 years.

In addition, CMS may add up to 3 more years to the provider/supplier's reenrollment bar if it determines that the provider/supplier is attempting to circumvent its existing reenrollment bar.

B. Establishment of Length

The following serves merely as general, non-binding guidance regarding the establishment of the length of reenrollment bars. It is crucial to note that every situation must and will be judged on its own merits, facts, and circumstances. It should not be assumed that a particular timeframe will always be applied to a specific revocation reason in all cases. CMS retains the discretion to apply a reenrollment bar period that is different from that indicated below (though which in no case will be greater than 10 to 20 years).

- § 424.535(a)(1) (Noncompliance) – *1 year*
- §424.535(a)(6) (Grounds Related to Screening) – 1 year
- §424.535(a)(11) (Initial Reserve Operating Funds) – 1 year
- *§424.535(a)(23) (Provider/Supplier Standards) – 1 year*

The following revocation reasons will receive reenrollment bar lengths per CMS discretion:

- *§424.535(a)(1) (Noncompliance- Not Professionally Licensed Individual Practitioners)*
- *§424.535(a)(2) (Provider or supplier conduct)*
- *§424.535(a)(3) (Felonies)*
- *§424.535(a)(4) (False or misleading information)*
- *§424.535(a)(5) (On-site review)*
- *§424.535(a)(7) (Misuse of billing number)*
- *§424.535(a)(8) (Abuse of billing privileges)*
- *§424.535(a)(9) (Failure to Report)*
- *§424.535(a)(10) (Failure to document or provide CMS access to documentation)*
- *§424.535(a)(12) (Other program termination)*
- *§424.535(a)(13) (Prescribing authority)*
- *§424.535(a)(14) (Improper Prescribing Practices)*
- §424.535(a)(15) (False Claims Act Civil Judgment)
- §424.535(a)(17) (Debt Referred to the United States Department of Treasury)
- §424.535(a)(18) (Revoked Under a Different Name, Numerical Identifier or Business Identity)
- §424.535(a)(19) (Affiliation that Poses an Undue Risk)
- §424.535(a)(20) (Billing from a Non-Compliant Location)
- §424.535(a)(21) (Abusive ordering, certifying, referring, or prescribing of Part A or B services, items, or drugs)
- §424.535(a)(22) (Patient Harm)

C. Applicability of Bar

1. Revocation Reasons Other Than § 424.535(a)(1), (a)(5), (a)(6), (a)(9), (a)(10), (a)(11), and (a)(23)

In general, and unless stated otherwise above, any reenrollment bar at a minimum applies to: (1) all practice locations under the provider's PECOS or legacy enrollment record; and (2) any effort to reestablish any of these locations (i) at a different address and/or (ii) under a different business or legal identity, structure, or TIN. If the contractor receives an application and is unsure whether a revoked provider is attempting to reestablish a revoked location, it

shall contact its PEOG BFL for guidance. Instances where the provider might be attempting to do so include - but are not limited to – the following:

SCENARIO 1 - John Smith was the sole owner of Group Practice X, a sole proprietorship. Six months after X was revoked under § 424.535(a)(9), the contractor receives an initial application from Group Practice Medicine, LLC, of which John Smith is the sole owner/member.

SCENARIO 2 - Jack Jones and Stan Smith were 50 percent owners of World Home Health Agency, a partnership. One year after World Home Health was revoked under § 424.535(a)(7), the contractor receives an initial application from XYZ Home Health, a corporation owned by Jack Jones and his wife, Jane Jones.

SCENARIO 3 - John Smith was the sole owner of XYZ Medical Supplies, Inc. XYZ's lone location was at 1 Jones Street. XYZ's billing privileges were revoked after it was determined that the site was non-operational. Nine months later, the contractor receives an initial application from Johnson Supplies, LLC. The entity has two locations in the same city in which 1 Jones Street is located. John Smith is listed as a 75 percent owner.

2. Revocation Reasons § 424.535(a)(1), (a)(5), (a)(6), (a)(9), (a)(10), (a)(11), and (a)(23)

For these revocation reasons, any reenrollment bar applies only to the specific enrollment that was the subject of the reenrollment bar.

D. Discussing Provider Enrollment Appeals Process in Revocation Letter

(If a conflict exists between the instructions in this section 10.4.7.4(D) and those in either (i) those in section 10.6.18 or (ii) the language in the applicable model letter in section 10.7 et seq., the guidance in section 10.6.18 or the model letter takes precedence.)

In the revocation letter, the contractor shall include information concerning the provider's appeal rights. The following table summarizes where the provider must send a corrective action plan (CAP) and/or reconsideration request.

	CAP requests should be sent to:		**Reconsideration request should be sent to:**	
Revocation Regulation	**Institutional***	**Non-institutional**	**Institutional***	**Non-Institutional**
424.535(a)(1) related to an enrollment requirement (i.e., 425.516)	Alone or in combination: CMS	MAC	CMS	MAC
424.535(a)(1) Licensure	CAP rights (to CMS)	CAP rights (to the MAC)	CMS	MAC
424.535(a)(1) DME or IDTF	CAP rights (to CMS)	CAP rights (to the MAC)	CMS	MAC
424.535(a)(2) Exclusion	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(2) Debarment	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(3)	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(4)	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(5)	No CAP rights	No CAP rights	CMS	MAC
424.535(a)(6)	No CAP rights	No CAP rights	CMS	MAC
424.535(a)(7)	No CAP rights	No CAP rights	CMS	CMS

424.535(a)(8)	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(9)	No CAP rights	No CAP rights	CMS	MAC
424.535(a)(10)	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(11)	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(12)	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(13)	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(14)	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(15)	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(17)	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(18)	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(19)	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(20)	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(21)	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(22)	No CAP rights	No CAP rights	CMS	CMS
424.535(a)(23)	No CAP rights	No CAP rights	CMS	CMS

* Institutional providers:

- Ambulance Service Supplier
- Ambulatory Surgery Centers
- CLIA Labs
- Community Mental Health Center
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Critical Access Hospitals
- End Stage Renal Disease (ESRDs)
- Federally Qualified Health Centers (FQHCs)
- Histocompatibility Laboratories
- Home Health Agencies
- *Home Infusion Therapy Suppliers*
- Hospices
- Hospitals and Hospital Units
- Independent Diagnostic Testing Facilities (IDTFs)
- Intensive Cardiac Rehabilitation
- Indian Health Service Facility
- Mammography Screening Centers
- Mass Immunization/Flu Roster Billers
- Medicare Diabetes Prevention Programs (MDPPs)
- Opioid Treatment Centers (OTPs)
- Organ Procurement Organizations (OPOs)
- Outpatient Physical Therapy/Outpatient Speech Pathology Services (OPT/OSP)
- Pharmacies
- Portable X-Ray Suppliers (PXRSs)
- Radiation Therapy Centers
- Rehabilitation Services
- Religious Non-Medical Health Care Institutions (RNCHIs)
- Rural Health Clinics (RHCs)
- Skilled Nursing Facilities (SNFs)

The CMS defines "institutional provider" in 42 CFR § 424.502 to mean any provider/supplier that submits a paper Medicare enrollment application using the Form CMS-855A, Form CMS-855B (except physician and non-physician practitioner organizations), or Form CMS-

855S, or the associated Internet-based PECOS enrollment application. (Note that MDPP suppliers no longer fall within this regulatory definition of institutional provider. Per 42 CFR § 424.205(b)(5), the provider enrollment application fee is inapplicable to all MDPP suppliers that submit a Form CMS-20134 enrollment application. Solely for purposes of appeal submissions, however, MDPP suppliers are included in the bulleted list above.)

10.6.6 – Final Adverse Actions

(Rev. 12550; Issued: 03-21-24; Effective: 04-21-24; Implementation: 04-21-24)

Unless stated otherwise, the instructions in this section 10.6.6 apply to the following sections of the Form CMS-855 and Form CMS-20134:

- Final Adverse Actions/Convictions (Section 3 of the Form CMS-855A, Form CMS-855B, Form CMS-855I, Form CMS-855O, and Form CMS-20134, and Section 7 of the Form CMS-855S)

- Business Information section/Private Practice Business Information section of the Form CMS-855I

- Organizational Ownership and/or Managing Control Final Adverse Legal Action History Section (Section 5 of the Form CMS-855A, Form CMS-855B, and Form CMS-20134, and Section 8 of the Form CMS-855S)

- Individual Ownership and/or Managing Control Final Adverse Legal Action History Section (Section 6 of the Form CMS-855A, Form CMS-855B, Form CMS-855I, and Form CMS-20134, and Section 9 of the Form CMS-855S)

For purposes of this section 10.6.6, the terms "final adverse action" and "adverse legal action" (as those terms are explained in section 10.6.6(F) of this chapter) will be collectively referred to as "ALA(s)", unless otherwise noted.

A. Prior Approval

The contractor shall send the application (if applicable) and ALA information to CMS (in accordance with section 10.6.6(I) below) for review for potential administrative action if:

- If the provider/supplier discloses its ALA on the Form CMS-855 or Form CMS-20134;

- If the provider/supplier discloses the ALA of an associated individual/entity on the Form CMS-855 or Form CMS-20134; or

- The contractor discovers---on its own volition and regardless of whether the provider/supplier is submitting a Form CMS-855 or Form CMS-20134---a provider's/supplier's ALA or that of an associated individual or entity of the provider/supplier.

In this chapter, and unless otherwise noted, "associated" individuals/entities refer to parties listed under the "Ownership Interest and/or Managing Control Information" sections of the Form CMS-855 or Form CMS-20134.

B. Review of the Provider Enrollment, Chain and Ownership System (PECOS)

If the contractor is reviewing a provider's/supplier's Form CMS-855 or Form CMS-20134 application for potential denial or revocation based on an ALA, the contractor shall search PECOS to determine whether the individual/entity with the ALA has any other associations

(e.g., is listed in PECOS as an owner or managing employee of three Medicare-enrolled providers). This review requires searching the tax identification number (TIN) of the individual/entity and clicking "Associates w/ Connections" in PECOS. The TIN is the social security number or employer identification number (EIN).

If the contractor finds such an association and there are grounds to revoke the associated enrollment(s) of other provider(s)/supplier(s), the contractor shall submit the revocation referral(s) to CMS at ProviderEnrollmentRevocations@cms.hhs.gov.

C. Chain Home Offices, Billing Agencies, and Home Health Agency Nursing Registries

If the contractor discovers that an entity listed in Section 7 of the Form CMS-855A, Section 8 of the Forms CMS-855A/B/I/20134, or Section 12 of the Form CMS-855A has had an ALA imposed against it, the contractor shall contact its Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL) for guidance if needed. For any ALA against individuals listed in Section 7 of the Form CMS-20134, the contractor shall refer to section 10.3.2.7 of this chapter, where this process is outlined in detail.

D. Review of the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) Online Searchable Database and the System for Award Management (SAM)

(NOTE: The required reviews described in this subsection (D) do not apply to (a) voluntary termination submissions and (*b*) associated individuals/entities being deleted/removed on the Form CMS-855 or Form CMS-20134. Moreover, the review requirement only applies to data that is reported via an **actual submission**. Data that has previously been reported (and thus is not part of the submission in question) need not be reviewed. To illustrate, suppose a provider has 20 managing employees on file in PECOS. It submits a change request to add two more managing officials. The contractor need only review the two officials. It need not check the other 20.)

Except as otherwise stated in this section 10.6.6, the contractor shall review each submission of a Form CMS-855 or Form CMS-20134 for (1) any exclusion(s) by HHS OIG of the provider/supplier and (2) exclusion(s) of any associated individuals/entities listed in the "Ownership Interest and/or Managing Control Information" Sections (e.g., an owner, managing employee, or authorized official), regardless of whether the provider/supplier reported the exclusion on the application (as applicable).

The OIG Online Searchable Database is located at exclusions.oig.hhs.gov; it includes all active exclusions for an individual or entity. The contractor shall verify the exclusion by entering the TIN of the excluded individual/entity and shall save that screenshot of the exclusion. (No screenshot is needed if no exclusion is involved.) The contractor shall also search for (1) any waivers to the HHS OIG exclusion and (2) any conviction(s) that may be tied to an exclusion (see section 10.6.6(G) and the applicable Decision Tree tables in section 10.6.6(I) for more details. In addition, if PECOS shows any associated enrollments (by TIN) of the excluded individual/entity that are not voluntarily withdrawn from Medicare, the contractor shall include this information in the ALA referral to CMS (as well as indicate whether CMS can take administrative action on the associated enrollment(s)).

In addition---and except as otherwise stated in this section 10.6.6---the contractor shall review each submission of a Form CMS-855 or Form CMS-20134 and search the SAM (i.e., at SAM.gov; formerly, the General Services Administration Excluded Parties List System) for exclusions/debarments if there is no HHS OIG exclusion—as identified on the OIG Online Searchable Database—for the provider/supplier and for any associated individuals/entities listed under the "Ownership Interest and/or Managing Control

Information" Sections (e.g., an owner, managing employee, or authorized official). Only if SAM populates an exclusion/debarment—that the OIG Online Searchable Database does not populate—shall the contractor save that SAM screenshot when sending the ALA referral to CMS (even if the contractor learns from OIG that the exclusion is not active).

When an entity or individual is listed as debarred in the SAM (i.e., at SAM.gov), the SAM record may identify associated entities and persons that are also debarred. To illustrate, suppose John Smith is identified as debarred. The SAM record may also list individuals and entities associated with John Smith that are debarred as well, such as "John Smith Company," "Smith Consulting," "Jane Smith," and "Joe Smith."

If the contractor learns via the Form CMS-855 or Form CMS-20134 verification process, a Unified Program Integrity Contractor (UPIC) referral, or other similar means that a particular individual/entity is debarred or excluded, the contractor shall search the individual/entity in the SAM to see if the SAM record discloses any associated parties that are debarred or excluded. If associated parties are listed, the contractor – after verifying, via the instructions in this chapter, that the associated party is indeed debarred – shall check PECOS to determine whether the party is listed in any capacity. If the party is listed, the contractor shall take all applicable steps outlined in this chapter with respect to revocation proceedings against the party and against any persons/entities with whom the party is associated. For instance, using our example above, if the contractor confirms that Jane Smith is debarred and PECOS shows Jane Smith as an owner of Entity X, the contractor shall, as applicable, send an ALA referral to CMS for review for potential administrative action against X as outlined in this section 10.6.6.

In instances where an HHS OIG exclusion populates SAM but not the OIG Online Searchable Database, this could mean that the provider/supplier (or associated individual/entity) has been reinstated but the SAM has not been accordingly updated. In such cases, the contractor shall contact the appropriate OIG official to (1) verify whether the exclusion is still active, (2) determine the date of reinstatement (if applicable), and (3) request the reinstatement letter from HHS OIG (if applicable). The contractor can find the appropriate OIG official on the Exclusion Record of an individual/entity on SAM by clicking on the respective Excluding Agency (as the respective contact information would populate there). The contractor shall, as applicable, include this information and the reinstatement letter (if available) when sending the ALA referral to CMS.

E. Disclosure of ALA

This section 10.6.6(E) discusses the disclosure and non-disclosure of ALAs on the Form CMS-855 and Form CMS-20134 as well as required documentation.

1. ALA Disclosed

a. Non-Felonies

If the provider/supplier discloses a non-felony ALA on the Form CMS-855/20134, the provider/supplier must furnish documentation concerning (i) the type of reported non-felony ALA, (ii) the date the non-felony ALA occurred, and (iii) what court or governing/administrative body imposed the action. (This documentation is referenced in Section 3 of the Form CMS-855/20134.) The provider/supplier must furnish the documentation regardless of whether the non-felony ALA occurred in a state different from that in which the provider/supplier seeks enrollment or is enrolled. The contractor shall develop for any such documentation that the provider/supplier fails to submit using the general developmental procedures outlined in this chapter.

b. Felony Convictions

(As a reminder, this subsection (E)(1)(b) applies only if the felony was disclosed.)

(i) Acquisition

For felony conviction documentation (and except as stated in subsection (E)(1)(b)(ii) below), the contractor shall:

- Develop for any required documentation (as described in subsection (E)(1)(a)(i) through (iii) above and on Section 3 of the Form CMS-855) that the provider/supplier fails to submit using the general developmental procedures outlined in this chapter; and

- Follow the instructions in subsection (E)(3) regarding the acquisition of the felony-specific documentation discussed therein.

(ii) Potential Overlap

In all instances discussed in this subsection (E)(1)(b), the contractor shall secure the mandatory documentation subsection (E)(3)(b) below. If the mandatory documentation captures the same information described in subsection (E)(1)(a)(i) through (iii) above, however, the contractor need not obtain the separate/additional (E)(1)(a)(i) through (iii) documentation. For instance, suppose the mandatory documentation identifies the court that imposed the action. The contractor need not obtain additional documentation verifying this data (as stated in subsection (E)(1)(a)(i) through (iii) above and Section 3 of the Form CMS-855). If, however, the mandatory documentation does not contain the data in subsection (E)(1)(a)(i) through (iii), the contractor shall develop for this information if the felony was reported.

2. ALA Is Not Disclosed

This section (E)(2) applies to situations where the contractor discovers an ALA that was not reported on the Form CMS-855/20134.

a. Non-Felonies

For ALAs other than felony convictions, the contractor need not develop for ALA documentation unless CMS instructs otherwise.

b. Felony Conviction

For felony conviction documentation, the contractor shall follow the instructions in section 10.6.6(E)(3).

3. Special Requirements Concerning Felony Documentation

a. Introduction

(This subsection (E)(3) applies (i) only to felony convictions and (ii) regardless of whether the felony conviction was reported on the Form CMS-855/20134.)

If, in felony conviction situations, the provider/supplier does not submit the mandatory documentation described in section 10.6.6(E)(3)(b) below (and, as applicable, the documentation in subsection (E)(1)(a)(i) through (iii) above), the contractor shall directly develop for the documentation with the provider/supplier using the existing development

procedures outlined in this chapter; prior approval or instruction from CMS to develop in this scenario is not needed. After obtaining the documents (or after an unsuccessful attempt), the contractor shall submit the felony referral, application, and any supporting document(s) to CMS for review. The provider/supplier must fully submit all of the requested documentation within 30 calendar days of the date of the development request. If the provider/supplier fails to do so, the contractor shall reject the application, upon PEOG approval; PEOG will then determine, if applicable, whether a revocation is warranted.

b. Documentation to Be Submitted

Mandatory – When sending the felony referral for review (and except as otherwise stated in this chapter), the contractor shall obtain from the provider/supplier and submit to CMS the following documentation:

- Judgment and/or sentencing order (as applicable);
- Any amended judgment and/or amended sentencing order (if applicable); and
- Jury verdict form or guilty plea acceptance document (as applicable; availability may vary from court to court). Note that some courts may incorporate the jury verdict or guilty plea entry/acceptance directly into the judgment and/or sentencing order. Also, some courts may not have a separate jury verdict form or guilty plea entry/acceptance, in which case the judgment and/or sentencing order suffices.

Not Required but Encouraged – The following documentation is optional, though the contractor is encouraged to, if possible, secure and submit this material to CMS; the data below could help furnish valuable background and context to CMS regarding the case.

- Any document showing the court's dismissal of charges (if applicable)
- Plea agreement (if applicable)
- Docket report/case summary
- Information or indictment
- Any amended information document(s) or superseding indictment(s)
- Police criminal complaint and/or affidavit of probable cause

4. Additional Policies

a. Reinstatements - If the individual or entity in question was excluded or debarred but has since been reinstated, the contractor shall confirm the reinstatement through HHS OIG or, in the case of debarment, through the federal agency that took the action. The appropriate OIG contact for such reinstatement verification requests is sanction@oig.hhs.gov. SAM.gov provides the appropriate contact for the federal agency that took debarment action on the screenshot page of that action (when searching the individual/entity).

b. Scope of Disclosure – All ALAs that occurred under the legal business name (LBN) and TIN of the disclosing entity (e.g., applicant, Section 5 owner) must be reported.

Example (A) - Smith Pharmacy, Inc. had 22 separately enrolled locations in 2017. Each location was under Smith's LBN and TIN. In 2018, two locations were excluded by the OIG and then subsequently revoked by CMS. Smith submits a Form CMS-855S application for a new location on Jones Street. Suppose, however, that each of Smith's locations had its own LBN and TIN. The Jones Street application need not disclose the two revocations from 2018.

Example (B) – A home health agency (HHA), hospice, and hospital are enrolling under Corporation X's LBN and TIN. X is listed as the provider in Section 2 of each applicant's Form CMS-855A. All three successfully enroll. Six months later, Company X's enrollment for the HHA is revoked due to an OIG exclusion. Both the hospice and the hospital must

report that X was excluded on a Form CMS-855A change request because X is under the provider's LBN and TIN. Assume now that X seeks to enroll an ambulatory surgical center (ASC) under X's LBN and TIN. The exclusion would have to be reported in Section 3 of the ASC's initial Form CMS-855B.

Example (C) – Company Y is listed as the provider/supplier for two HHAs and two suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). These four providers/suppliers are under Y's LBN and TIN. Each provider/supplier is located in a different state. All are enrolled. Y's enrollment for one of the DMEPOS suppliers is revoked due to a felony conviction. Y now seeks to enroll an ASC in a fifth state. Y must disclose its felony conviction even though the felony conviction occurred in a state different from that in which the ASC is located.

c. Timeframe – With the exception of felony and misdemeanor convictions (and unless stated otherwise in this chapter), all ALAs must be reported in the final adverse legal action section of the Form CMS-855 or Form CMS-20134 regardless of when the final adverse legal action occurred.

d. Evidence to Indicate ALA – There may be instances where the provider or supplier states on the Form CMS-855 or Form CMS-20134 that the person or entity has never had an ALA imposed against him/her/it, but the contractor finds evidence to indicate otherwise. In such cases, the contractor shall follow the decision tree in section 10.6.6(I) below.

e. MDPP Coaches - MDPP suppliers enrolling via the Form CMS-20134 are not required to report any ALA as it relates to MDPP coaches submitted on Section 7 of that form.

F. Scope of a Reportable ALA

Providers and suppliers shall disclose all reportable ALAs on their enrollment applications. To satisfy the reporting requirement, the provider/supplier shall complete the Final Adverse Legal Action section(s) (Form CMS-855 or Form CMS-20134) in its entirety and attach all applicable documentation concerning the ALA to the application. All ALAs must be reported, regardless of whether any records have been expunged or sealed or any appeals are pending.

ALAs that must be disclosed on the Form CMS-855 or Form CMS-20134 include:

1. Felony conviction(s) within 10 years

a. Reporting – Providers/suppliers are required to report a felony (federal or state) when: (1) a conviction has occurred; and (2) the felony conviction date (e.g., the date of a court's acceptance of a guilty plea or the date of a jury verdict) is within 10 years from the submission date of a Form CMS-855 or Form CMS-20134 application.

b. When a Conviction Occurs - A conviction (as the term 'convicted' is defined in 42 CFR 1001.2) has occurred when:

(A) A judgment of conviction has been entered against an individual or entity by a federal, state, or local court, regardless of whether:

(1) There is a post-trial motion or an appeal pending, or

(2) The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;

(B) A federal, state, or local court has made a finding of guilt against an individual or entity;

(C) A federal, state, or local court has accepted a plea of guilty or nolo contendere by an individual or entity; or

(D) An individual or entity has entered into participation in a first offender, deferred adjudication, or other program or arrangement where judgment of conviction has been withheld.

A felony conviction shall be reported by the provider/supplier even if the conviction has been sealed or expunged or there is an appeal or post-trial motion pending. Furthermore, in instances where the defendant pleads guilty to a felony and a court orders deferred adjudication/adjudication withheld/treatment in lieu of conviction/probation with a suspended imposition of sentence/pre-trial diversion, these dispositions generally fall under 42 CFR 1001.2's definition of 'convicted.' Consequently, the provider/supplier shall report these types of convictions on the Form CMS-855 or Form CMS-20134.

c. Additional Information

For any submission of a Form CMS-855 or Form CMS-20134 for initial enrollment, reactivation, change of information, or revalidation---and except as stated in the following paragraph---the contractor shall review and use APS as a resource to determine if there are any felony convictions on which CMS can take administrative action. The contractor shall include any felony conviction(s) and/or ongoing criminal case(s) listed on APS in its referral email to CMS.

(NOTE: The aforementioned APS review is not required for (a) voluntary termination submissions, (*b*) associated individuals/entities being deleted/removed on the Form CMS-855, and (*c*) any individuals and entities listed on the application who have previously been reviewed against APS as part of any prior application submission. Moreover, the APS review requirement only applies to data that is reported via an actual submission. Data that has previously been reported (and thus is not part of the submission in question) need not be reviewed.)

The aforementioned APS review would be to determine whether (a) the provider/supplier submitting the Form CMS-855 or Form CMS-20134 or (b) any associated individual/entity (e.g., owner or managing employee) listed in the "Ownership Interest and/or Managing Control Information" sections of the provider/supplier's Form CMS-855 or Form CMS-20134 has a felony conviction.

2. Misdemeanor conviction within 10 years

- Report a misdemeanor conviction (federal or state) when—
    - A conviction has occurred;
    - The misdemeanor conviction date (e.g., the date of a court's acceptance of a guilty plea, or the date of a jury verdict) is within 10 years from the submission date of a Form CMS-855 or Form CMS-20134 application; and
    - The misdemeanor is related to any of the following:
        - The delivery of an item/service under Medicare or a state health care program;
        - The abuse or neglect of a patient in connection with the delivery of a health care item or service;

- Theft, fraud, embezzlement, breach of fiduciary duty or other financial misconduct in connection with the delivery of a health care item/service;

- The interference with or obstruction of any investigation into any criminal offense described under 42 CFR 1001.101 or 1001.201; or

- The unlawful manufacture, distribution, prescription or dispensing of a controlled substance.

- A conviction has occurred when any of the criteria in 42 CFR 1001.2 (and as described in the second in bullet in (F)(1)(b) above) are met.

- A misdemeanor conviction shall be reported even if the conviction has been sealed, expunged, or there is an appeal or post-trial motion pending.

3. Current or past suspension(s)/revocations(s)/voluntary surrender(s) in lieu of further disciplinary action of a medical license(s)

- A medical license board suspends or revokes a medical license for any period of time; or the provider voluntarily surrenders her/his medical license in lieu of further disciplinary action.

4. Current or past suspensions(s)/revocation(s) of an accreditation -- An accrediting body suspends or revokes an accreditation for any period of time.

5. Current or past exclusion(s) imposed by HHS OIG -- Items/services furnished, ordered, or prescribed by a specified individual/entity are not reimbursed under Medicare, Medicaid, and/or all other federal health care programs until the individual or entity is reinstated by the HHS OIG.

6. Current or past debarment(s) from participation in any federal executive branch procurement or non-procurement program -- An individual or entity is suspended throughout the executive branch of the federal government, as it applies to procurement and non-procurement programs. An individual or entity will not be solicited from, contracts will not be awarded to, or existing contracts will not be renewed or otherwise extended to those individuals or entities with a debarment (e.g., GSA debarment).

7. Medicaid exclusion(s), revocation(s) or termination(s) of any billing number -- A state terminates an active provider agreement or prohibits a provider from enrolling in the Medicaid program. Any Medicaid terminations shall be forwarded to ProviderEnrollmentRevocations@cms.hhs.gov for review by PEOG.

G. Reviewing for ALAs

The contractor shall address the reporting of ALA in its review of initial enrollment, revalidation, reactivation, or change of information applications submitted by a provider or supplier. The contractor may receive information of ALAs not yet reported by the provider or supplier from CMS or other contractors via the application screening process. The contractor shall consider this information and take action as described in (but not limited to) this section 10.6.6 and other applicable sections of this chapter.

Providers and suppliers shall include all reportable ALAs on their enrollment applications. This information must be reported by the provider/supplier on the initial/revalidation application and pursuant to the reporting requirements specified in 42 CFR § 424.516 and

section 10.4(J) of this chapter. Reportable ALAs are listed in section 10.6.6(F) above. All applicable ALAs shall be reported, regardless of whether any (1) records were expunged or sealed, (2) appeals are pending, or (3) waivers were granted.

Notwithstanding any other instruction to the contrary in this chapter, the contractor need not send an ALA referral to CMS/PEOG for review if:

- *The provider/supplier previously disclosed that same reportable ALA on a Form CMS-855 or Form CMS-20134 application and CMS/PEOG had already reviewed it; or*
- *The provider/supplier discloses a non-reportable ALA along with a reportable one. In this case, the non-reportable ALA need not be referred to CMS/PEOG in conjunction with the reportable ALA.*

H. Non-Reportable ALAs

Non-reportable ALAs include but are not limited to: license probations in which the state board does not prohibit the practice of medicine; malpractice suits; *false claims act civil judgments*; and felony or misdemeanor convictions that are not within the previous 10 years from the submission date of a Form CMS-855 or Form CMS-20134 application.

The contractor need not send an ALA referral to CMS for review if the provider/supplier previously reported that same *non-reportable* ALA on a Form CMS-855 or Form CMS-20134 application that CMS had already reviewed.

I. ALA Decision Tree

To assist the contractor in determining what actions to take when an ALA is involved, CMS has produced an ALA Decision Tree (see below) for the contractor to use as a guide. Except as otherwise stated in this section 10.6.6, chapter 10 itself, or another CMS directive, the contractor: (1) shall follow the ALA Decision Tree when it receives ALA information regarding a provider or supplier (or discovers an ALA through independent research or other means); and (2) shall not develop with the provider or supplier for reported or unreported ALA(s). Note that the term "provider" in the Decision Tree includes "supplier" unless noted otherwise.

The instructions in the Decision Tree take precedence over all others in this chapter.

TABLE 1 -- INITIAL/REACTIVATION APPLICATIONS – LICENSE OR ACCREDITATION CURRENTLY SUSPENDED / REVOKED / VOLUNTARILY SURRENDERED IN SAME STATE – REPORTED			
Licensure Scenario	**Did the provider report the ALA taken on their license / accreditation?**	**MAC Action**	**Notes**
Provider's accreditation/medical license is currently suspended / revoked / voluntarily surrendered in lieu of further disciplinary action by a state licensing authority, where the licensure action is in the same state in which the provider is enrolling.	Yes	The contractor shall send the application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision *under 42 CFR § 424.530(a)(1) and any other applicable denial reasons.* Refer to Tables 3 – 13.	The contractor shall read board orders thoroughly to determine if there is any other ALA associated with the license suspension, revocation, or voluntary surrender *in lieu of further disciplinary action* (e.g., a felony conviction). *If the board order mentions another license suspension / revocation / voluntary surrender from another state, the contractor shall include this information in its referral to CMS and note*

TABLE 1 -- INITIAL/REACTIVATION APPLICATIONS – LICENSE OR ACCREDITATION CURRENTLY SUSPENDED / REVOKED / VOLUNTARILY SURRENDERED IN SAME STATE – REPORTED			
Licensure Scenario	**Did the provider report the ALA taken on their license / accreditation?**	**MAC Action**	**Notes**
			whether revocation action is appropriat e for any other enrollment . The contractor shall not *refer* to *CMS/PEOG* under 42 CFR § 424.530(a)(1) if the licensure action is any of the following: (i) a suspension is "stayed" in its entirety; (ii) the license is placed on probation *but is otherwise still active for the practice of medicine*; (iii) advertising/ administrative penalties; or (iv) fines, violations, stipulations, reprimands.

TABLE 2 -- INITIAL/REACTIVATION APPLICATIONS – LICENSE OR ACCREDITATION CURRENTLY OR PREVIOUSLY SUSPENDED/REVOKED/VOLUNTARILY SURRENDERED IN SAME STATE – NOT REPORTED			
Licensure Scenario	**Did the provider report the ALA taken on their license or accreditation?**	**MAC Action**	**Notes**
Provider's accreditation /medical license is currently or was previously suspended / revoked / voluntarily surrendered in lieu of further disciplinary action by a state licensing authority, where the licensure action is in the same state in which the provider is enrolling.	No	The contractor shall send the application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision under *42 CFR § 424.530(a)(1),* § 424.530(a)(4) and*/or* any other applicable denial *reasons. Refer to Tables 1 and 3 – 14.*	424.530 (a)(4) shall ONLY be included as a denial reason if the provider has never reported this ALA. The contractor shall read board orders thoroughly to determine if there is any other ALA associated with the license suspension / revocation / voluntarily *surrendered in lieu of further disciplinary action*. If the board order mentions another license suspension / revocation / voluntary *surrendered in lieu of further disciplinary action*. from another state, the contractor shall include this information in its referral to CMS under § 424.530(a)(4) and any other applicable denial *reasons;* the contractor shall note whether revocation action is appropriate for any other enrollment. There is no reporting requirement for/if: (i) a suspension is "stayed" in its entirety; (ii) the license *is on probation but otherwise is still active for the practice of medicine*; (iii) advertising / administrative penalties; or (iv) fines, violations, stipulations, reprimands.

TABLE 3 -- INITIAL/REACTIVATION APPLICATIONS – LICENSE CURRENTLY SUSPENDED OR REVOKED IN DIFFERENT STATE – REPORTED			
Licensure Scenario	**Did the provider report the ALA taken on their license?**	**MAC Action**	**Notes**
Provider's medical license currently suspended / revoked / in a state different from that in which the provider is enrolling.	Yes *or No*	The contractor shall send the application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision under 42 CFR § 424.530(a)(14) and any other applicable denial *reasons. Refer to Tables 1-2 and 4-14*.	Denial under 42 CFR § 424.530(a)(14) is appropriate only if the license suspension/revocation action in the different state (i.e., the state other than that in which the provider is enrolling) occurred on or after March 17, 2020. The contractor shall read board orders thoroughly to determine if there is any other ALA associated with the license suspension or revocation (e.g., a felony conviction). The contractor shall note whether revocation action is appropriate for any other enrollment. Note that voluntary surrenders in lieu of further disciplinary action do not give rise to denial under 42 CFR § 424.530(a)(14).

TABLE 4 -- INITIAL/REACTIVATION APPLICATIONS – FELONIES			
Felony	**Did the provider report the felony conviction?**	**MAC Action**	**Notes**
Provider or an individual/entity listed on the application as a 5 percent or greater owner, partner, managing employee, corporate director, corporate officer, *or managing organization* has been adjudged guilty of a felony.	Yes or No	The contractor shall send the application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision *under 42 CFR § 424.530(a)(3) and any other applicable denial reasons. Refer to Tables 1-3 and 5-14.*	A felony is defined as a crime that has a maximum penalty—as specified in the criminal statute—by imprisonment for a period of more than one year. All felony convictions within the preceding 10 years of the submission date of a Form CMS-855 or Form CMS-20134 application shall be forwarded to CMS for review and decision unless CMS instructs otherwise.

TABLE 5 -- INITIAL/REACTIVATION APPLICATIONS – MISDEMEANORS			
Misdemeanor	**Did the provider report the misdemeanor conviction?**	**MAC Action**	**Notes**
Provider or an individual/entity listed on the application as a 5 percent or greater owner, partner, managing employee, corporate director, corporate officer, *or managing organization* has been adjudged guilty of a misdemeanor related to health care abuse or neglect of a patient; financial misconduct; interference with a criminal investigation; or unlawful manufacture, distribution, or dispensing of a controlled substance.	Yes or No	Process application unless another reported or unreported ALA precludes processing. Refer to Tables 1 – 4 and 6 – 1*4*.	A misdemeanor is defined as a crime that has a maximum penalty—as specified in the criminal statute—by imprisonment for a period of not more than a year (i.e., one year or less).

TABLE 6 -- INITIAL/REACTIVATION APPLICATIONS – ACTIVE EXCLUSION*/DEBARMENT* - REPORTED			
Current Exclusion *or Debarment*	**Did the provider report the exclusion *or debarment*?**	**MAC Action**	**Notes**
Provider or an individual/entity listed on the application as a 5 percent or greater owner, partner, managing employee, *corporate director, corporate officer, managing organization,* authorized official, delegated official, medical director, supervising physician, or other health care *or administrative or management services* personnel has an active OIG exclusion *or SAM debarment*.	Yes	Send application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision *under 42 CFR § 424.530(a)(2) and any other applicable denial reasons.* Refer to *Tables 1 – 5 and 7-14.*	A waiver does not guarantee automatic enrollment into the Medicare program. All waivers shall be sent to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision, along with the corresponding ALA information and application.

TABLE 7 -- INITIAL/REACTIVATION APPLICATIONS – ACTIVE EXCLUSION/DEBARMENT – NOT REPORTED			
Current Exclusion or Debarment	**Did the provider report the exclusion or debarment?**	**MAC Action**	**Notes**
Provider or an individual/entity listed on the application as a 5 percent or greater owner, partner, managing employee, corporate director, corporate officer, managing organization, authorized official, delegated official, medical director, supervising physician, or other health care or administrative or management services personnel has an active OIG exclusion *or SAM debarment.*	No	Send application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision *under 42 CFR § 424.530(a)(2), § 424.530(a)(4), and/or any other applicable denial reasons. Refer to Tables 1 – 6 and 8 – 14.*	*Note that (a)(4) shall ONLY be included as a denial reason if the provider has never reported this ALA.* *A waiver does not guarantee automatic enrollment into the Medicare program. All waivers shall be sent to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision, along with the corresponding ALA information and application.*

TABLE 8 -- INITIAL/REACTIVATION APPLICATIONS – EXPIRED EXCLUSION/DEBARMENT - REPORTED			
Exclusion Period/Debarment Period Has Expired	**Did the provider report the past exclusion or debarment?**	**MAC Action**	**Notes**
Provider or an individual/entity listed on the application as a 5 percent or greater owner, partner, managing employee, corporate director, corporate officer, managing organization, authorized official, delegated official, medical director, supervising physician, or other health care or administrative or management services personnel had an OIG exclusion or a federal/SAM debarment (or an exclusion by a federal agency other than OIG) and has been reinstated by HHS and/or OIG and/or the federal agency in question.	Yes	Process application unless there is another reported or unreported ALA that precludes processing the application. Refer to Tables 1 – 7 and 1*0* – 1*4*.	

TABLE 9 -- INITIAL/REACTIVATION APPLICATIONS – EXPIRED EXCLUSION/DEBARMENT – NOT REPORTED			
Exclusion Period/Debarment Period Has Expired	**Did the provider report the past exclusion or debarment?**	**MAC Action**	**Notes**
Provider or an individual/entity listed on the application as a 5 percent or greater owner, partner, managing employee, corporate director, corporate officer, managing organization, authorized official, delegated official, medical director, supervising physician, or other health care or administrative or management services personnel had an OIG exclusion or a federal/SAM debarment (or an exclusion by a federal agency other than OIG) and has been reinstated by HHS and/or OIG and/or the federal agency in question.	No	Send application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision *under 42 CFR § 424.530(a)(4) and any other applicable denial reasons. Refer to Tables 1 – 7 and 10-14.*	*Note that (a)(4) shall ONLY be included as a denial reason if the provider has never reported this ALA.* *A waiver does not guarantee automatic enrollment into the Medicare program. All waivers shall be sent to ProviderEnrollmentRevocations @cms.hhs.gov for review and decision, along with the corresponding ALA information and application.* If CMS previously revoked this provider due to that prior OIG exclusion, debarment, or other federal action--and the provider or associated individual/entity has been reinstated by OIG/HHS/federal agency--the contractor shall process the application unless there is another reported or unreported ALA that precludes processing the application.

TABLE 10 -- INITIAL/REACTIVATION APPLICATIONS – MEDICARE PAYMENT SUSPENSION – CURRENT OR PAST			
Medicare Payment Suspension Status	**Did the provider report the Medicare payment suspension?**	**MAC Action**	**Notes**
Current Medicare payment suspension	Yes or No	Process application unless there is another reported or unreported ALA that precludes processing the application. Refer to Tables 1 – 9 and 11 – 14.	Providers are NOT required to report current Medicare payment suspensions to CMS. The contractor shall consider whether other denial reasons exist. Refer to Tables 1 – 9 and 11 – 14.
Past Medicare payment suspension	Yes or No	Process application unless there is another reported or unreported ALA that precludes processing the application. Refer to Tables 1 – 9 and 11 – 14.	Providers are NOT required to report past Medicare payment suspensions to CMS. The contractor shall consider whether other denial reasons exist. Refer to Tables 1 – 9 and 11 – 14.

TABLE 11 -- INITIAL/REACTIVATION APPLICATIONS – MEDICARE REVOCATION – ALL PRIOR ENROLLMENT BAR(S) EXPIRED			
Medicare Revocation	**Did the provider report the Medicare revocation?**	**MAC Action**	**Notes**
All prior enrollment bar(s) have expired.	Yes or No	Process application unless there is another reported or unreported ALA that precludes processing the application. Refer to Tables 1 – 10 and *12-14*.	Providers are NOT required to report current or past Medicare revocations to CMS. The contractor shall consider whether other denial reasons exist. Refer to Tables 1 – 10 and *12-14*. Under 42 CFR § 424.530(a)(3), CMS can still deny an application if there is a felony conviction within the preceding 10 years by a provider/supplier or by an individual/entity listed on the application as a 5 percent or greater owner, managing employee, *partner, corporate director, corporate officer, or managing organization*. This denial authority is still applicable and should be considered by the contractor even if the previous Medicare revocation had a 3-year re-enrollment bar and the bar has expired. In such instances, the contractor shall send the ALA information and application to CMS for review and decision at ProviderEnrollmentRevocaions@cms.hhs.gov.

TABLE 12 -- INITIAL/REACTIVATION APPLICATIONS – MEDICARE REVOCATION – ACTIVE REENROLLMENT BAR			
Medicare Revocation	**Did the provider report the Medicare revocation?**	**MAC Action**	**Notes**
Enrollment bar is active (in the state in which the provider is enrolling or in another state)	Yes or No	*If the application is for an enrollment that has an active reenrollment bar on the enrollment itself, the application should be returned.*	

TABLE 13 -- INITIAL/REACTIVATION APPLICATIONS - OTHER PROGRAM TERMINATION – CURRENT			
Other Program Termination	**Did the provider report the other program termination?**	**MAC Action**	**Notes**
The provider is currently terminated or suspended (or otherwise barred) from participation in a state Medicaid program or any other federal health care program.	Yes	Send application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision *under 42 CFR § 424.530(a)(14) and any other applicable denial reasons.* Refer to *Tables 1 – 12 and 14.*	Denial may be appropriate under 42 CFR § 424.530(a)(14) if the provider is currently terminated/suspended/barred from participation in a state Medicaid program or any other federal health care program (e.g., TRICARE). The termination or suspension must occur by letter dated on or after March 17, 2020.

TABLE 14- INITIAL/REACTIVATION APPLICATIONS – FALSE CLAIMS ACT (FCA) CIVIL JUDGMENTS			
False Claims Act (FCA) Civil Judgments	***Did the provider report the False Claims Act (FCA) Civil Judgment?***	***MAC Action***	***Notes***
Provider or any individual/entity listed as a 5 percent or greater owner, partner managing employee or organization, corporate officer, or corporate director thereof has had a civil judgment under the FCA imposed against them within the previous 10 years.	Yes or No	*Send application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision under 42 CFR § 424.530(a)(17) and any other applicable denial reasons. Refer to Tables 1 – 13.*	*The FCA (31 U.S.C. 3729–3733) is the federal government's principal civil remedy for addressing false or fraudulent claims for federal funds. Section 3729(a)(1) of the FCA lists specific actions that can result in an FCA judgment against a defendant.* *Denial may be appropriate under 42 CFR § 424.530(a)(17) if the FCA civil judgment is within the preceding 10 years of the submission date of a Form CMS-855 or Form CMS-20134. FCA civil judgments must occur on or after January 1, 2024.* *Note that the term ''civil judgment'' is not inclusive of FCA settlement agreements and should not be referred to CMS for review.* *Providers are NOT required to report FCA civil judgments to CMS.*

TABLE 15 – REVALIDATIONS/CHANGE OF INFORMATION APPLICATIONS – PREVIOUS LICENSURE OR ACCREDITATION – SAME STATE – REPORTED

If the contractor discovers an ALA that has not been reported by a provider, the contractor shall, upon CMS' approval, record the ALA in the PECOS Final Adverse Legal Actions Section ~~and/~~or PECOS profile for the associated individual/entity (as appropriate).

- If the contractor is inputting the ALA which has not been reported by the provider—and if CMS does not take administrative action due to that ALA—the contractor shall select "No" for the "Display in PI" field, thereby making this ALA not visible in the provider interface (as applicable).

- If the contractor is inputting the ALA which has not been reported by the provider—and if CMS does take administrative action due to that ALA—the contractor shall select "Yes" for the "Display in PI" field, thereby making the ALA visible in the provider interface.

Unless otherwise stated, the foregoing statements apply to Tables 15 through 26.

Provider holds a valid accreditation / medical license in the state in which it is revalidating or changing information	**Did the provider report the ALA taken on their license/ accreditation?**	**MAC Action**	**Notes**
Provider's accreditation/ medical license was previously suspended/revoked / voluntarily surrendered in lieu of further disciplinary action by a state licensing authority *but is currently active for the practice of medicine AND* where the licensure action is in the same state in which the provider is currently enrolled.	Yes	The contractor shall check whether the provider billed for dates of service during the period of license susp/rev/vol surrender in lieu of further disciplinary action. If the provider billed for dates of service during this period, the contractor shall send the application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov *for review and decision for potential revocation action under 42 CFR § 424.535(a)(8). The contractor shall note this information when sending a referral to CMS for review.* If the provider did not bill during the period of license susp/rev/vol surrender in lieu of further disciplinary action, the application shall be processed unless there is another reported or unreported ALA that precludes processing. Refer to Tables *17 – 27*.	The contractor shall read board orders thoroughly to determine if there is any other ALA (e.g., a felony conviction) associated with the license susp/rev/*vol surrender in lieu of further disciplinary action*. If the board order mentions another license susp/rev/*vol surrender in lieu of further disciplinary action* from another state, the contractor shall include this information in its referral to CMS and note whether revocation action is appropriate for any other enrollment. *The contractor shall not refer to CMS/PEOG for revocation under 42 CFR § 424.535(a)(1) if the licensure action is any of the following: (i) a suspension is "stayed" in its entirety; (ii) the license is placed on*

			probation but otherwise is active for the practice of medicine; (iii) advertising / administrative penalties; or (iv) fines, violations, stipulations, reprimands.

TABLE 1*6* – REVALIDATION/CHANGE OF INFORMATION APPLICATIONS – LICENSE PREVIOUSLY SUSPENDED/REVOKED/VOLUNTARY SURRENDERED - SAME STATE – NOT REPORTED			
Provider holds a valid accreditation/ medical license in the state in which it is revalidating or changing information	**Did the provider report the ALA taken on its license or accreditation?**	**MAC Action**	**Notes**
Provider's accreditation/ medical license was previously suspended / revoked / voluntarily surrendered in lieu of further disciplinary action by a state licensing authority *but is now active AND* the licensure action is in the same state in which the provider is enrolling.	No	*The contractor shall send the application and ALA information to* ProviderEnrollment Revocations@cms.hhs.gov *for review and decision under § 424.535(a)(4) and any other applicable revocation reasons.* Refer to *Tables 17 – 27.* *Note that §* 424.535 (a)(4) shall ONLY be included as a *revocation* reason if the provider has never reported this ALA and CMS did not previously revoke the provider for that ALA.	The contractor shall check whether the provider billed for dates of service during the period of license susp/rev/*vol surrender* in lieu of further disciplinary action. If the provider billed for dates of service during this period, there may be potential revocation action under 42 CFR § 424.535(a)(8). The contractor shall note this information when sending a referral to CMS for review. The contractor shall read board orders thoroughly to determine if there is any other ALA associated with the license susp/rev/*vol surrender in lieu of further disciplinary action.* If the board order mentions another license susp/rev/*vol surrender in lieu of further disciplinary action* from another state, the contractor shall include this information in its referral to CMS and note whether revocation action is appropriate for any other enrollment. There is no reporting requirement for/if: (i) a suspension is "stayed" in its entirety; (ii) *if license is on probation but otherwise is active for the practice of medicine*; (iii) advertising / administrative penalties; or (iv) fines, violations, stipulations, reprimands.

TABLE 17 – REVALIDATIONS/CHANGE OF INFORMATION APPLICATIONS – CURRENT LICENSURE OR ACCREDITATION – SAME STATE – REPORTED			
Provider holds a valid accreditation / medical license in the state in which it is revalidating or changing information	***Did the provider report the ALA taken on their license/ accreditation?***	***MAC Action***	***Notes***
Provider's accreditation/ medical license is currently suspended/revoke d/ voluntarily surrendered in lieu of further disciplinary action by a state licensing authority where the licensure action is in the same state in which the provider is currently enrolled.	*Yes*	*The contractor shall send the application and ALA information to ProviderEnrollment Revocations@cms.hhs.gov for review and decision under 42 CFR § 424.535(a)(1) and any other applicable revocation reasons. Refer to Tables 15-16 and 18- 27.*	*The contractor shall check whether the provider billed for dates of service during the period of license susp/rev/vol surrender in lieu of further disciplinary action. If the provider billed for dates of service during this period, there may be potential revocation action under 42 CFR § 424.535(a)(8).* *The contractor shall note this information when sending a referral to CMS for review.* *The contractor shall read board orders thoroughly to determine if there is any other ALA associated with the license susp/rev/vol surrender in lieu of further disciplinary action. If the board order mentions another license susp/rev/vol surrender in lieu of further disciplinary action from another state, the contractor shall include this information in its referral to CMS and note whether revocation action is appropriate for any other enrollment.* *There is no reporting requirement for/if: (i) a suspension is "stayed" in its entirety; (ii) if license is on probation but is otherwise active for the practice of medicine; (iii) advertising / administrative penalties; or (iv) fines, violations, stipulations, reprimands.*

TABLE 1*8* -- REVALIDATION/CHANGE OF INFORMATION APPLICATIONS – FELONIES			
Felony	**Did the provider report the felony conviction?**	**MAC Action**	**Notes**
Provider or an individual/entity listed on the application as a 5 percent or greater owner, partner, managing employee, corporate director, corporate officer, *or managing organization* has been adjudged guilty of a felony.	Yes or No	Send application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision *under § 424.535(a)(3) and any other applicable revocation reasons.* Refer to *Tables 15-17 and 19 – 27.*	A felony is defined as a crime that has a maximum penalty—as specified in the criminal statute—by imprisonment for a period of more than one year. All felony convictions within the preceding 10 years of the submission date of a Form CMS-855 or Form CMS-20134 application shall be forwarded to CMS for review and decision unless CMS instructs otherwise.

TABLE 1*9* – REVALIDATION/CHANGE OF INFORMATION APPLICATIONS – MISDEMEANORS			
Misdemeanor	**Did the provider report the misdemeanor conviction?**	**MAC Action**	**Notes**
Provider or an individual/entity listed on the application as a 5 percent or greater owner, partner, managing employee, corporate director, *corporate officer, or managing organization* has been adjudged guilty of a misdemeanor that is related to health care abuse or neglect of a patient; financial misconduct; interference with a criminal investigation; or unlawful manufacture, distribution, or dispensing of a controlled substance.	Yes or No	Process application unless there is another reported or unreported ALA that precludes processing the application. Refer to Tables *15 – 18* and *20 – 27.*	A misdemeanor is defined as a crime that has a maximum penalty—as specified in the criminal statute—by imprisonment for a period of not more than a year (i.e., one year or less).

TABLE *20* – REVALIDATION/CHANGE OF INFORMATION APPLICATIONS – ACTIVE OIG EXCLUSION OR SAM DEBARMENT - REPORTED			
Current Exclusion or Debarment	**Did the provider report the exclusion?**	**MAC Action**	**Notes**
Provider or an individual/entity listed on the application as a 5 percent or greater owner, partner, managing employee, corporate director, corporate officer, managing organization, authorized official, delegated official, medical director, supervising physician, or other health care or administrative or management services personnel has an active OIG exclusion or SAM debarment.	Yes	Send application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision *under § 424.535(a)(2) and any other applicable revocation reasons. Refer to Tables 15-19 and 21 – 27.*	A waiver does not guarantee automatic enrollment into the Medicare program. All waivers shall be sent to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision, along with the corresponding ALA information and application.

TABLE *21* -- REVALIDATION/CHANGE OF INFORMATION APPLICATIONS – ACTIVE OIG EXCLUSION OR SAM DEBARMENT – NOT REPORTED			
Current Exclusion *or Debarment*	**Did the provider report the exclusion?**	**MAC Action**	**Notes**
Provider or an individual/entity listed on the application as a 5 percent or greater owner, partner, managing employee, corporate director, corporate officer, managing organization, authorized official, delegated official, medical director, supervising physician, or other health care or administrative or management services personnel has an active OIG exclusion or SAM debarment.	No	Send application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision *under 42 CFR § 424.535(a)(2), 42 CFR § 424.535(a)(4) and/or any other applicable revocation reasons. Refer to Tables 15 – 20 and 22 – 27.*	*Note (a)(4) shall ONLY be included as a revocation reason if the provider has never reported this ALA.* *A waiver does not guarantee automatic enrollment into the Medicare program.* All waivers shall be sent to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision, along with the corresponding ALA information and application.

TABLE 2*2* – REVALIDATION/CHANGE OF INFORMATION APPLICATIONS – EXCLUSION/DEBARMENT – EXPIRED - REPORTED			
Exclusion or Debarment Status	**Did the provider report the exclusion or debarment?**	**MAC Action**	**Notes**
Provider or an individual/entity listed on the application as a 5 percent or greater owner, partner, managing employee, corporate director, corporate officer, managing organization, authorized official, delegated official, medical director, supervising physician, or other health care or administrative or management services personnel had an OIG exclusion or a federal/SAM debarment (or an exclusion by a federal agency other than OIG) and has been reinstated by OIG and/or HHS and/or the other federal agency.	Yes	Process application unless there is another reported or unreported ALA that precludes processing the application. Refer to Tables 1*5* – *20* and 2*3* – 2*7*.	

TABLE 2*3* – REVALIDATION/CHANGE OF INFORMATION APPLICATIONS – EXCLUSION/DEBARMENT – EXPIRED – NOT REPORTED			
Exclusion or Debarment Status	**Did the provider report the exclusion or debarment?**	**MAC Action**	**Notes**
Provider or an individual/entity listed on the application as a 5 percent or greater owner, partner, managing employee, corporate director, corporate officer, managing organization, authorized official, delegated official, medical director, supervising physician, or other health care or administrative or management services personnel had an OIG exclusion or a federal/SAM debarment (or an exclusion by a federal agency other than OIG) and has been reinstated by OIG and/or HHS and/or other federal agency.	No	Send application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision *under 42 CFR § 424.535(a)(4) and any other applicable revocation reasons. Refer to Tables 15 – 21 and 24 – 27.*	*Note that (a)(4) shall ONLY be included as a revocation reason if the provider has never reported this ALA.* If CMS previously revoked this provider due to the prior OIG exclusion and the provider or associated individual/entity has been reinstated by OIG, the contractor shall process the application unless there is another reported or unreported ALA that precludes processing.

TABLE 24 - REVALIDATION/CHANGE OF INFORMATION APPLICATIONS – MEDICARE PAYMENT SUSPENSION – CURRENT OR PAST			
Medicare Payment Suspension Status	**Did the provider report the Medicare payment suspension?**	**MAC Action**	**Notes**
Current Medicare payment suspension	Yes or No	Process application unless there is another reported or unreported ALA that precludes processing the application. Refer to Tables *15 – 22* and *25 – 27*.	Providers are NOT required to report current or past Medicare payment suspensions to CMS.
Past Medicare payment suspension	Yes or No	Process application unless there is another reported or unreported ALA that precludes processing the application. Refer to Tables *15 – 22* and *25 – 27*.	Providers are NOT required to report current or past Medicare payment suspensions to CMS.

TABLE 2*5* -- REVALIDATION/CHANGE OF INFORMATION APPLICATIONS – MEDICARE REVOCATION – ACTIVE ENROLLMENT BAR			
Status	**Did the provider report the Medicare revocation?**	**MAC Action**	**Notes**
Enrollment bar is active in the state in which the provider is submitting this application, or the enrollment bar is active in another state.	Yes or No	*If the application is for an enrollment that has an active reenrollment bar on the enrollment itself, the application should be returned.*	.

TABLE 2*6* -- REVALIDATION/CHANGE OF INFORMATION APPLICATIONS – OTHER PROGRAM TERMINATION (CURRENT)			
Other Program Termination	**Did the provider report the other program termination?**	**MAC Action**	**Notes**
The provider/supplier is currently terminated or suspended (or otherwise barred) from participation in a state Medicaid program or any other federal health care program.	Yes	Send application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision *under 42 CFR § 424.535(a)(12) and any other applicable revocation reasons. Refer to Tables 15-25 and 27.*	Revocation may be appropriate under 42 CFR § 424.535(a)(12) if the provider/supplier is currently terminated/suspended/barred from participation in a state Medicaid program or any other federal health care program (e.g., TRICARE). The state Medicaid program termination or suspension must occur by letter dated on or after January 1, 2011. Any other federal health care program (e.g., TRICARE) termination or suspension must occur by letter dated on or after March 17, 2020.

TABLE 27- REVALIDATION/CHANGE OF INFORMATION APPLICATIONS – FALSE CLAIMS ACT (FCA) CIVIL JUDGMENTS			
FCA Civil Judgments	**Did the provider report the FCA Civil Judgment?**	**MAC Action**	**Notes**
Provider, or any individual/entity listed as a 5 percent or greater owner, partner managing employee or organization, corporate officer, or corporate director thereof, has had a civil judgment under the FCA imposed against them within the previous 10 years.	Yes or No	*Send application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov for review and decision under 42 CFR § 424.535(a)(15) and any other applicable revocation reasons. Refer to Tables 15 – 26.*	*The FCA (31 U.S.C. 3729–3733) is the federal government's principal civil remedy for addressing false or fraudulent claims for federal funds. Section 3729(a)(1) of the FCA lists specific actions that can result in an FCA judgment against a defendant.* *Revocation may be appropriate under 42 CFR § 424.535(a)(15) if the FCA civil judgment is within the preceding 10 years of the submission date of a Form CMS-855 or Form CMS-20134. FCA civil judgments must occur on or after January 1, 2024.* *Note the term ''civil judgment'' is not inclusive of FCA settlement agreements and should not be referred to CMS for review.* *Providers are NOT required to report FCA civil judgments to CMS.*

10.6.12 – Opting-Out of Medicare

(Rev. 12550; Issued: 03-21-24; Effective: 04-21-24; Implementation: 04-21-24)

Physicians and practitioners are typically required to submit claims on behalf of beneficiaries for all items and services they provide for which Medicare payment may be made under Part B. They are also not permitted to charge beneficiaries in excess of the limits on charges that apply to the item or service being furnished. However, certain types of physicians and practitioners may "opt-out" of Medicare. A physician or practitioner who opts-out is not required to submit claims on behalf of beneficiaries and also is excluded from limits on charges for Medicare-covered services. Medicare does not pay anyone for services (except for certain emergency and urgent care services) furnished by an opt-out physician or practitioner. Instead, opt-out physicians and practitioners sign private contracts with beneficiaries. Please refer to CMS Pub. 100-02, Chapter 15, sections 40 - 40.39 for more information regarding the maintenance of opt-out affidavits and the effects of improper billing of claims during an opt-out period.

The instructions in this section 10.6.12 address the contractor's processing of opt-out affidavits. (See Pub. 100-02, chapter 15, section 40.8 for private contract definitions and requirements.)

A. Who May Opt-Out of Medicare

Only the following physicians and practitioners (sometimes collectively referenced as "eligible practitioners" in this section) can "opt-out" of Medicare:

Physicians who are:

- Doctors of medicine or osteopathy,
- Doctors of dental surgery or dental medicine,
- Doctors of podiatry, or
- Doctors of optometry who are legally authorized to practice dentistry, podiatry, optometry, medicine, or surgery by the state in which such function or action is performed.

Non-physician practitioners who are:

- Physician assistants,
- Nurse practitioners,
- Clinical nurse specialists,
- Certified registered nurse anesthetists,
- Certified nurse midwives,
- Clinical psychologists,
- Clinical social workers,
- Registered dietitians or nutrition professionals who are legally authorized to practice by the state and otherwise meet Medicare requirements,
- Mental health counselors, or
- Marriage and family therapists

(Organizations are not permitted to opt-out of Medicare.)

This means that neither the eligible practitioner nor the beneficiary submits the bill to Medicare for services performed. Instead, the beneficiary pays the eligible practitioner out-of-pocket and neither party is reimbursed by Medicare. In fact, a private contract is signed between the eligible practitioner and the beneficiary that states, in essence, that neither can receive payment from Medicare for the services performed. (The contract, though, must be

signed before the services are provided so the beneficiary is fully aware of the eligible practitioner's opt-out status.) Moreover, the eligible practitioner must submit an affidavit to Medicare expressing his/her decision to opt-out of the program. The contractor's provider enrollment unit must process these affidavits.

Eligible practitioners who opt-out of Medicare are not the same as non-participating physicians/suppliers. The latter are enrolled in Medicare and choose on a claim-by-claim basis whether they want to accept assignment unless the service can only be paid on an assignment-related basis as required by law (e.g., for drugs, ambulance services, etc.). Non-participating physicians/suppliers must therefore comply with Medicare's mandatory claim submission, assignment, and limiting charge rules. Opt-out eligible practitioners, on the other hand, are excused from the mandatory claim submission, assignment, and limiting charge rules, though **only** when they maintain compliance with all of the requirements for opting out.

In an emergency care or urgent care situation, an eligible practitioner who has opted-out may treat a Medicare beneficiary with whom he or she does not have a private contract. In those circumstances, the eligible practitioner must complete a Form CMS-855 application.

B. Requirements for an Opt-out Affidavit

1. Affidavit Contents

As stated in Pub. 100-02, chapter 15, section 40.9, the affidavit shall state that, upon signing the affidavit, the eligible practitioner agrees to the following requirements:

- Except for emergency or urgent care services, during the opt-out period the eligible practitioner will provide services to Medicare beneficiaries only through private contracts, but for their provision under a private contract, would have been Medicare-covered services;

- The eligible practitioner will not submit a claim to Medicare for any service furnished to a Medicare beneficiary during the opt-out period, nor will the eligible practitioner permit any entity acting on the eligible practitioner's behalf to submit a claim to Medicare for services furnished to a Medicare beneficiary;

- During the opt-out period, the eligible practitioner understands that he/she may receive no direct or indirect Medicare payment for services that the eligible practitioner furnishes to Medicare beneficiaries with whom the eligible practitioner has privately contracted, whether as an individual, an employee of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare beneficiary under a Medicare Advantage plan;

- An eligible practitioner who opts out of Medicare acknowledges that, during the opt-out period, the eligible practitioner's services are not covered under Medicare and that no Medicare payment may be made to any entity for the eligible practitioner's services, directly or on a capitated basis;

- On acknowledgment by the eligible practitioner to the effect that, during the opt- out period, the eligible practitioner agrees to be bound by the terms of both the affidavit and the private contracts that the eligible practitioner has entered into;

- Acknowledge that the eligible practitioner recognizes that the terms of the affidavit apply to all Medicare-covered items and services furnished to Medicare beneficiaries by the eligible practitioner during the opt-out period (except for emergency or urgent care services furnished to the beneficiaries with whom the eligible practitioner has not

previously privately contracted) without regard to any payment arrangements the eligible practitioner may make;

- With respect to an eligible practitioner who has signed a Part B participation agreement, acknowledge that such agreement terminates on the effective date of the affidavit;

- Acknowledge that the eligible practitioner understands that a beneficiary who has not entered into a private contract and who requires emergency or urgent care services may not be asked to enter into a private contract with respect to receiving such services;

- Identify the eligible practitioner sufficiently so that the Medicare contractor can ensure that no payment is made to the eligible practitioner during the opt-out period; and

- Be filed with all MACs that have jurisdiction over claims the eligible practitioner would otherwise file with Medicare; the initial two-year opt-out period will begin the date on which the affidavit meeting the requirements of 42 C.F.R. § 405.420 is signed, provided the affidavit is filed within 10 days after the eligible practitioner signs his or her first private contract with a Medicare beneficiary.

(See Pub. 100-02, chapter 15, section 40.9 for more information on the requirements of opt-out affidavits. See also section 10.6.12(B)(5) below for acceptable opt-out formats.)

The contractor shall review initial opt-out affidavits to ensure that they contain the following information about the eligible practitioner to create an affidavit record in PECOS:

- Full name (first, middle and last),
- Birthdate,
- Address and telephone number,
- License information*, and*
- NPI (if one has been obtained)

If, in order to create a PECOS affidavit record, the contractor needs to obtain data that is missing from an affidavit, it may (1) obtain this information from other sources (such as the state license board) or (2) contact the eligible practitioner only **one time** directly. The contractor shall **not** use Internet-based PECOS or the Form CMS-855 to secure the data from the eligible practitioner, for the eligible practitioner **is not** enrolling in Medicare. If the eligible practitioner is requested to submit missing information to permit the processing of the affidavit and fails to do so within 30 days, the contractor shall reject the opt-out affidavit.

2. Opting-Out and Ordering/Certifying/Referring

If an eligible practitioner who wishes to opt-out elects to order/certify/refer Medicare items or services, the contractor shall develop for the following information (if not provided on the affidavit):

- NPI (if one is not contained on the affidavit voluntarily)*; and*

- Date of birth.

If this information is requested but not received, the eligible practitioner's affidavit can still be processed; however, he/she cannot be listed as an ordering/certifying/referring provider.

3. Adverse Actions

The contractor shall review the List of Excluded Individuals and Entities (LEIE) and the System for Award Management (SAM) for all eligible practitioners who submit opt-out affidavits. Excluded eligible practitioners may opt-out of Medicare but cannot order certify/refer.

As noted in 42 CFR § 405.425(i) and (j), individuals who are revoked from Medicare cannot order, certify, or refer Part A or B services or items to Medicare beneficiaries if they opt-out of Medicare after revocation.

4. No Dual Status

a. Form CMS-855O - Eligible practitioners cannot be enrolled via the Form CMS-855O and actively opted-out simultaneously. Prior to processing an initial Form CMS-855O or opt-out affidavit submission, the contractor shall *ascertain whether* an approved Form CMS-855O enrollment or valid opt-out affidavit does not exist in PECOS. If:

- *The individual submits an initial CMS-855O and has a valid opt-out affidavit on file* - - The contractor shall return the application.
- *The individual submits an opt-out affidavit and has an active Form CMS-855O enrollment – The contractor may process the opt-out affidavit and, as applicable, follow existing procedures for deactivating the existing enrollment.*

b. Form CMS-855I – A Form CMS-855I enrollment can simultaneously exist with a valid opt-out affidavit **only** if the Form CMS-855I is to bill for emergency services. If a Form CMS-855I is received **and** an opt-out affidavit is active, the contractor shall contact the eligible practitioner (via any means) to clarify if he/she submitted the application to solely bill for emergency services provided to a beneficiary. If so, the application shall be processed via normal procedures. If not, the application may be returned. (See Pub. 100-02, chapter 15, section 40.28 for more information on emergency and urgent care services.)

An eligible practitioner who has opted out of Medicare need not also enroll via the Form CMS-855O if he/she wishes to order/refer/certify (e.g., providing the necessary information on his/her affidavit per this section 10.6.12).

5. Acceptable Opt-Out Affidavit Formats

The contractor may provide a sample opt-out affidavit form for eligible practitioners to complete. The opt-out affidavit form must provide spaces for the eligible practitioners to furnish their personal information.

Eligible practitioners may also create their own affidavit. If he/she elects to do so, he/she should include information found in section 10.6.12(B)(1) to ensure timely processing of the opt-out affidavit.

The contractor and eligible practitioners may use the information below as an opt-out affidavit form.

I, {Enter Physician/Non-Physician Practitioner Name}, being duly sworn, depose and say:

- Opt-out is for a period of two years. At the end of the two year period, my opt-out status will automatically renew. If I wish to cancel the automatic extension, I understand that I must notify my Medicare Administrative Contractor (MAC) in writing at least 30 days prior to the start of the next two-year opt-out period.

- Except for emergency or urgent care services (as specified in the Medicare Benefit Policy Manual Publication 100-02, Chapter 15 §40.28), during the opt-out period I will provide services to Medicare beneficiaries only through private contracts that meet the criteria of §40.8 for services that, but for their provision under a private contract, would have been Medicare-covered services.

- I will not submit a claim to Medicare for any service furnished to a Medicare beneficiary during the opt-out period, nor will I permit any entity acting on my behalf to submit a claim to Medicare for services furnished to a Medicare beneficiary, except as specified in § 40.28.

- During the opt-out period, I understand that I may receive no direct or indirect Medicare payment for services that I furnish to Medicare beneficiaries with whom I have privately contracted, whether as an individual, an employee of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare beneficiary under Medicare Advantage.

- I acknowledge that during the opt-out period, my services are not covered under Medicare and that no Medicare payment may be made to any entity for my services, directly or on a capitated basis.

- I acknowledge and agree to be bound by the terms of both the affidavit and the private contracts that I have entered into during the opt-out period.

- I acknowledge and understand that the terms of the affidavit apply to all Medicare-covered items and services furnished to Medicare beneficiaries by myself during the opt-out period (except for emergency or urgent care services furnished to the beneficiaries with whom I have not previously privately contracted) without regard to any payment arrangements I may make.

- I acknowledge that if I have signed a Part B participation agreement, that such agreement terminates on the effective date of this affidavit.

- I acknowledge and understand that a beneficiary who has not entered into a private contract and who requires emergency or urgent care services may not be asked to enter into a private contract with respect to receiving such services and that the rules of §40.28 apply if I furnish such services.

- I have identified myself sufficiently so that the MAC can ensure that no payment is made to me during the opt-out period. If I have already enrolled in Medicare, I have included my Medicare PTAN, if one has been assigned. If I have not enrolled in Medicare, I have included the information necessary to opt-out.

- I will file this affidavit with all MACs who have jurisdiction over claims that I would otherwise file with Medicare and the initial two- year opt-out period will begin the date the affidavit meeting the requirements of 42 C.F.R. §405.420 is signed, provided the affidavit is filed within 10 days after the physician/practitioner signs his or her first private contract with a Medicare beneficiary.

Eligible practitioners should also be encouraged to include the following information (to complete an affidavit record in PECOS): NPI; Medicare Identification Number (if issued); SSN (not an ITIN); date of birth; specialty; e-mail address; any request to order/certify/refer.

C. Effective Date of an Opt-Out Period

As noted in Pub. 100-02, chapter 15, section 40.17, eligible practitioners receive effective dates based on their participation status.

1. Eligible Practitioners Who Have Never Enrolled In Medicare

Eligible practitioners need not enroll prior to opting-out of Medicare. If a non-enrolled eligible practitioner submits an opt-out affidavit, the effective date of the opt-out period begins the date the affidavit is signed by the eligible practitioner.

2. Non-Participating Practitioners

If an eligible practitioner who is a non-participating provider decides to terminate his/her active Medicare billing enrollment and instead opt-out of Medicare, the effective date of the opt-out period begins the date the affidavit is signed by the eligible practitioner.

3. Participating Practitioners

If an eligible practitioner who is a participating provider (one who accepts assignment for all their Medicare claims) decides to terminate his/her active Medicare billing enrollment and opt-out of Medicare, the effective date of the opt-out period begins the first day of the next calendar quarter. Per 42 CFR § 405.410(d), an eligible practitioner may opt-out of Medicare at the beginning of any calendar quarter, provided that the affidavit described in 42 CFR § 405.420 is submitted to the applicable contractor(s) at least 30 days before the beginning of the selected calendar quarter. (The contractor shall, however, add 5 calendar days to the 30-day period to allow for mailing.) An opt-out affidavit must therefore be submitted at least 30 days before the first day of the calendar quarter in order to receive January 1, April 1, July 1 or October 1 as the effective date. If the opt-out affidavit is submitted within 30 days prior to January 1, April 1, July 1 or October 1, the effective date would be the first day of the next calendar quarter. (For example, an enrolled participating eligible practitioner's opt-out affidavit was submitted on December 10. The eligible practitioner's effective date could not be January 1, for the affidavit was not submitted at least 30 days prior to January 1. The effective date would be April 1.) The eligible practitioner would need to remain enrolled as a participating supplier until the end of the next calendar quarter so that claims can be properly submitted until the opt-out period begins.

4. Opt-Out After Enrollment

(This section 10.6.12(C)(4) applies notwithstanding any instruction to the contrary in this chapter.)

If an enrolled physician or eligible practitioner is now opting-out, the existing PECOS enrollment record shall be end-dated the same day as the affidavit effective date.

D. Emergency and Urgent Care Services

If an eligible practitioner who has opted-out provides emergency or urgent care services, he/she must apply for enrollment via the Form CMS-855I. Once he/she receives his/her PTAN, he/she must submit the claim(s) for any emergency or urgent care service furnished. The contractor shall contact its PEOG BFL for additional guidance when this type of situation arises. (See Pub. 100-02, chapter 15, section 40.28 for more information on emergency and urgent care services.)

E. Termination of an Opt-Out Affidavit

As noted in Pub. 100-02, chapter 15, section 40.35, an eligible practitioner who has not previously opted-out may terminate his/her opt-out period early. However, he/she must submit written notification thereof (with his/her signature) no later than 90 days after the effective date of the initial 2-year opt-out period. To properly terminate an affidavit, moreover, the eligible practitioner must:

1. Not have previously opted-out of Medicare (the eligible practitioner cannot terminate a renewal of his/her opt-out);
2. Notify all the MACs that the eligible practitioner has filed an affidavit no later than 90 days after the effective date of the affidavit;
3. Notify all beneficiaries (or their legal representation) with whom the eligible practitioner entered into private contracts of the eligible practitioner's decision to terminate his/her opt-out and of the beneficiaries' right to have claims filed on their behalf with Medicare for the services furnished during the period between the effective date of the opt-out and the effective date of the termination of the opt-out period and;
4. Refund to each beneficiary with whom the physician or practitioner has privately contracted all payments collected in excess of the Medicare limiting charge or deductibles and coinsurance.

For eligible practitioners who were previously enrolled to bill Medicare for services, the contractor shall reactivate the eligible practitioner's enrollment record in PECOS and reinstate his/her PTAN as if no opt-out affidavit existed. The eligible practitioner may bill for services provided during the opt-out period.

For eligible practitioners who were not previously enrolled to bill Medicare for services, the contractor shall remove the affidavit record from PECOS; this will help ensure that the eligible practitioner can submit the appropriate application(s) (via PECOS or paper Form CMS-855 for individual and/or reassignment enrollment) in order to establish an enrollment record in PECOS and thus bill for services rendered during the opt-out period.

F. Opt-Out Period Auto-Renewal and Cancellation of the Opt-Out Affidavit

1. General Policies

Eligible practitioners who initially opted-out or renewed an affidavit on or after June 16, 2015 need not submit a renewal of their affidavit. The opt-out will be automatically renewed for another 2-year period. Yet if the eligible practitioner decides to cancel his/her opt-out, he/she must submit a written notice to each contractor to which he or she would file claims (absent the opt-out) not later than 30 days before the end of the current 2 year opt-out period.

If the eligible practitioner decides to enroll in Medicare after his/her opt-out is canceled, he/she must submit a Form CMS-855I application. The effective date of enrollment, however, cannot be before the cancellation date of the opt-out period. (For example, suppose an eligible practitioner submits a cancellation of her opt-out to end the period on March 31, which is two years from the eligible practitioner's opt-out affidavit effective date. Her requested effective date of enrollment cannot be before April 1.)

If the eligible practitioner submits a cancellation request within 30 days of the end of the current opt-out period or after the opt-out period automatically renews, the contractor shall return the cancellation request to the eligible practitioner and provide appeal rights.

2. Auto-Renewal Report and Opt-Out Renewal Alert

The contractor shall issue an Opt-Out Renewal Alert Letter (found in section 10.7.14(E) of this chapter) to any eligible practitioner whose opt-out period is set to auto-renew. For this

purpose, CMS will provide a monthly opt-out report to all contractors via the Share Point Ensemble site. The contractor shall access the report monthly through the Share Point Ensemble site. The contractor shall also review the opt-out report for opted-out eligible practitioners that will auto-renew in the next three-and-a-half months. In addition, the contractor shall issue an Auto-Renewal Alert Letter to eligible practitioners at least 90 days prior to the auto-renewal date; the eligible practitioner will thus have at least 60 days prior to the date a cancellation notice must be submitted to cancel the current opt-out.

The Opt-out Auto-Renewal Alert Letter will provide (1) the date on which the current opt-out period will be auto renewed and (2) the date by which the eligible practitioner will need to submit a cancellation request. The letter will also furnish the eligible practitioner appeal rights if he/she fails to submit a cancellation request and the opt-out renews.

The contractor shall (1) complete the Opt-Out Renewal Alert Letter Report to include the date the Alert Letter was issued, (2) post its reports no later than the 15th of the following month to the Share Point Ensemble site, and (3) email its PEOG BFL when the report has been posted.

If an opted-out eligible practitioner submits a Form CMS-855I without submitting a cancellation request of his or her opt-out, the contractor shall develop for the cancellation notice. Once the cancellation notice is received, the contractor shall then process the application(s).

If the eligible practitioner submits a cancellation request within 30 days of the end of the current opt-out period or after the opt-out period automatically renews, the contractor shall return the cancellation request to the eligible practitioner and provide appeal rights using the Late Cancellation Request return letter. In addition, if the eligible practitioner submits a cancellation request more than 90 days prior to the auto-renewal date, the contractor shall return the cancellation request to the eligible practitioner using the Cancellation Request Received Too Early return letter.

G. Failure to Properly Cancel or Terminate Opt-Out

Eligible practitioners who fail to properly cancel or terminate their opt-out may appeal the decision to continue (1) the auto-renewal of the opt-out or (2) the eligible practitioner's initial opt-out period.

Opt-out approval letters include appeal rights for eligible practitioners who initially opt-out and fail to properly terminate the opt-out within 90 days of the approval.

10.6.21.1 – Additional Miscellaneous Enrollment Topics

(Rev. 12550; Issued: 03-21-24; Effective: 04-21-24; Implementation: 04-21-24)

(The instructions in this section 10.6.21.1 take precedence over all other contrary instructions in this chapter, including, but not limited to, the existing guidance in sections 10.3.1 et al. The policies in this section will eventually be incorporated into the sections of this chapter that are applicable to the subject matter.)

A. Type of Practice Location

For Form CMS-855A, CMS-855B, and CMS-855I applications, the contractor may collect the practice location type in Section 4 of the application via telephone or---if the practice location type is otherwise apparent---may forgo development altogether.

B. Voluntary Terminations for Non-Certified Suppliers

If a non-certified supplier wishes to voluntarily withdraw from Medicare (including deactivating all active PTANs), the supplier must submit the applicable Form CMS-855/20134 to do so. It cannot make this request via letter, phone, etc.

C. Initial Enrollments with Multiple Locations

(This section 10.6.21.1(C) takes precedence over all other instructions in this chapter excluding section 10.3.)

If a high or moderate-risk provider or supplier (hereafter "provider") is initially enrolling in Medicare and has multiple practice locations, the SVC will conduct a site visit of each location rather than simply one selected location. In such instances, the contractor shall note the following:

1. Certified Providers/Suppliers – If, per this chapter, the site visits are to be performed after the contractor receives a recommendation of approval from the state, the contractor shall wait until all site visits are completed before taking the next required step (e.g., referring the application to PEOG to final review).

2. Site Visit Failure – If one of the locations fails its site visit, the contractor shall follow existing guidance for handling such situations (e.g., approving the application but without the failed location).

10.7 – Model Letters

(Rev. 12550; Issued: 03-21-24; Effective: 04-21-24; Implementation: 04-21-24)

The contractor shall use the following letters when rejecting, returning, approving or denying an application, or when revoking an entity's Medicare billing privileges. Any exceptions to this guidance shall be approved by the contractor's CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL), unless specified otherwise. The contractor shall document approval received by its PEOG BFL for QASP purposes.

As stated in section 10.3, PECOS will automatically generate and send some of the letters described in this section 10.7 et seq. If any modifications or additions to a certain PECOS-generated letter are required pursuant to the instructions in this section 10.7 et seq. or elsewhere in this chapter, the contractor shall, of course, ensure that such edits are made before the letter is sent. This includes situations where a particular party is typically copied on a letter but the circumstances of the transaction do not require the party to be copied.

In the event of a conflict between the instructions in section 10.3 and section 10.7, et al, the instructions in section 10.3 take precedence.

A. Issuing Letters - Model Letter Guidance

All letters sent by contractors to providers and suppliers shall contain and/or adhere to the formats/requirements addressed in sections 10.7(A) and (B). Note, however, the following:

(i) For certified provider/supplier types and transactions that have formally "transitioned" as described in section 10.7.5.1, the requirements (e.g., data elements) of the model letters in section 10.7.5.1 take precedence over any contrary instruction in section 10.7. For example, if section 10.7 requires a data element that a specific letter in section 10.7.5.1 pertaining to the same enrollment transaction/situation does not, the section 10.7.5.1 letter requirements

supersede the former. Likewise, if section 10.7 requires the removal/addition of language that is/is not in the applicable section 10.7.5.1 letter, the latter controls.

(ii) For certified provider/supplier types and transactions that have not transitioned (and except as otherwise stated in section 10.7 (e.g., subsection (A)(2)(n)), the contractor shall continue to follow the existing instructions in section 10.7 and utilize the letters in section 10.7.5.

1. General Guidance

(a) The CMS logo (2012 version) displayed per previous CMS instructions.

(b) The contractor's logo shall be displayed however the contractor deems appropriate. There are no restrictions on font, size, or location. The only restriction is that the contractor's logo must not conflict with the CMS logo.

(*c*) All dates in letters, except otherwise specified, shall be in the following format: month/dd/YYYY (e.g., January 26, 2012).

(*d*) Letters shall contain fill-in sections as well as static, or "boilerplate" sections. The fill-in sections are delineated by words in brackets in italic font in the model letters.

(*e*) The static sections shall be left as-is unless there is specific guidance for removing a section (e.g., removing a CAP section for certain denial and revocation reasons; removing state survey language for certain provider/supplier types that do not require a survey). If there is no guidance for removing a static section, the contractor must obtain approval from its PEOG BFL to modify or remove such a section.

2. Approval Letters

(a) Part A/B certified provider and supplier paper/web COI and revalidation "referral to state" shall detail the requested changes (e.g., practice location changed to 123 Main Street, Baltimore MD 21244).

(b) For COI and revalidation applications that do not require a tie-in or recommendation but require notification to the SOG Location as a cc, the contractor shall add the additional fields applicable to the letter (e.g., cc the state/SOG Location). The contractor should itemize the changes if it is beneficial to the SOG Location.

(c) Part A/B and DME provider and supplier paper/web COI and revalidation letters shall only list the section title (at the sub-section level) from the paper/web Form CMS-855 and Form CMS-20134 application (e.g., Correspondence Mailing Address, Final Adverse Legal Actions, Remittance Notices/Special Payments Mailing Address, etc.).

(d) If, as part of a revalidation, the provider/supplier only partially revalidates (i.e., a provider has multiple PTANs, and one PTAN is revalidated with the others end-dated), the contractor shall notate the reassignments that were terminated due to non-response and the effective date of termination (i.e., the revalidation due date or the development due date).

(e) If the provider is submitting a change as part of a voluntary termination application (e.g. special payment address, EFT, authorized official), the contractor shall enter the applicable fields into the Medicare Enrollment information table.

(f) Approval letters may include a generic provider enrollment signature and contact information (e.g. customer service line). However, all development letters shall include a provider enrollment analyst's name and phone number for provider/supplier contacts.

(g) Participation status shall only be included in initial and reactivation letters for Part B sole proprietors, Part B sole owners, any Part B organizations and DME suppliers. Change of information approval letters shall only include the participation status if it was changed as part of the application submission.

(h) The contractor shall add lines to the enrollment information tables on any reactivation letter if the provider/supplier has reactivated following non-response to a revalidation and enrollment information was changed on the application.

(i) The contractor shall enter an effective date on all change of information approval letters if a new PTAN is issued based on the changes (e.g., a new location is added to a new payment locality).

(j) The contractor shall add appeal rights to all change of information and revalidation approval letters if a new PTAN is issued based on the changes (e.g., a new location is added to a new payment locality; a new reassignment is created).

(k) If the provider/supplier is revalidating multiple reassignments to different groups, the contractor shall add additional lines to the grid to identify the separate groups and PTANs.

(l) If the provider/supplier revalidates both reassignments and one or more sole proprietorship locations, the contractor shall indicate on the appropriate letter that the approval covers the reassignments and sole proprietorship locations.

(m) In the Part B non-certified supplier letters, the contractor shall populate 42 CFR§ 424.205 for MDPP suppliers or § 424.516 for all other providers/suppliers with the following paragraph: "Submit updates and changes to your enrollment information within the timeframes specified at [42 CFR § 424.516 or 42 CFR§ 424.205]. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617."

(n) For all pre-transition and post-transition seller CHOWs (both HHA and non-HHA), the contractor shall use the "M. Approval – Seller CHOW (Part A/B Certified Org") letter in section 10.7.5.1 when voluntarily terminating the seller's enrollment in a 42 CFR § 489.18 CHOW (which includes mergers, acquisitions, and consolidations). The contractor shall use the effective date of the CHOW as the "Effective Date of Enrollment Termination" in the letter.

(o) The contractor shall remove the following language when issuing the Approval – Voluntary Termination (Part B Non-Certified Org or Part B Sole Owner) letter in section 10.7.6(V) for a Part B non-certified supplier: "Reassignments and any physician assistant employment arrangements are also deactivated", unless other active reassignments/employment arrangements exist on the enrollment.

3. Denial/Revocation Letters

(a) The contractor shall populate the fill-in sections with the appropriate information, such as primary regulatory citation, specific denial and revocation reasons, names/addresses, etc.

(b) The fill-in sections shall be indented ½ inch from the normal text of the letter.

(c) All specific or explanatory reasons shall appear in bold type and shall match the federal registry heading. This applies to headings. For example, if the revocation letter contains the following specific explanatory language, the heading should be in bold type and the explanation should be in normal type as shown in the excerpt below:

42 CFR § 424.535(a)(8)(i) – Abuse of Billing Privileges

Data analysis conducted on claims billed by [Dr. Ambassador], for dates of service [Month XX, XXXX], to [Month XX, XXXX], revealed that [Dr. Ambassador] billed for services provided to [XX] Medicare beneficiaries who were deceased on the purported date of service.

(d) There may be more than one primary reason listed.

(e) This subsection (A)(3)(e) applies to certified provider and certified supplier denial or revocation letters that meet both of the following requirements:

- The provider enrollment denial or revocation also requires the denial or termination of the corresponding provider or supplier agreement (e.g., Form CMS-1561, Form CMS-370, etc.)
- The SOG Location is responsible for handling the reconsideration/appeal of the provider/supplier agreement denial or termination.

If these requirements are met -- and notwithstanding any instruction to the contrary in this chapter -- the contractor shall insert the following language into the provider enrollment denial or revocation letter (preferably at the conclusion of the letter's discussion/outline of appeal rights):

"Note that the provider enrollment appeal rights addressed in this letter are unrelated to any appeal rights concerning the [denial or termination, as applicable] of your [provider or supplier, as applicable] agreement. The two processes are separate and distinct, and a successful appeal of your enrollment [denial or revocation, as applicable] does not automatically restore your [provider or supplier] agreement. Any such restoration of the latter is handled by the Survey Operations Group Location and not by CMS' Provider Enrollment & Oversight Group."

4. Voluntary Terminations

If a provider/supplier (certified or non-certified) is voluntarily terminating their enrollment, the contractor shall use the applicable voluntary termination letter.

5. No PEOG Approval

The following letter revisions do not require prior PEOG BFL approval. (Notwithstanding the language in subsection 10.7(A)(i), this includes the letters in section 10.7.5.1 et seq.)

(a) If the contractor cannot format the enrollment information table as provided in these model letters, the contractor may provide the information in a similar non-table format.

(b) Placing a reference n umber or numbers between the provider/supplier address and the salutation. (For Internet-based PECOS applications, the contractor can include its document control number and the Web Tracking ID in this field.)

(c) The contractor shall enter "N/A" or leave blank a data element in an enrollment information table if said field is inapplicable (e.g., doing business as (DBA), effective date for changes).

(d) The contractor shall include the applicable PTAN and NPI for the application submission on the letter. If multiple PTANs or NPIs apply, the contractor should: (1) enter "multiple" in the PTAN and NPI fields; (2) copy and add additional PTAN/NPI rows to the enrollment information tables; or (3) attach a list of any and all PTAN and NPI combinations that apply in the letter.

(e) For individual revalidations in which multiple PTANs may be revalidating from multiple reassignments or individual associations, the contractor may also list the group's LBN and PTAN effective date in connection with the appropriate individual NPI-PTAN combinations. The contractor has flexibility in relaying these fields when multiplicities exist, ensuring they meet the template's reporting requirements.

(f) Appropriate documents attached to specific letters as needed.

(g) Placing language in any letter regarding self-service functions, such as the Provider Contact Center Interactive Voice Response (IVR) system and Electronic Data Interchange (EDI) enrollment process.

B. Sending Letters

The contractor shall note the following:

1. Except as stated otherwise in this chapter (e.g., certain applications from already-transitioned certified provider/supplier types), the contractor shall issue approval letters within 5 business days of approving the application in PECOS.

2. For all applications other than the Form CMS-855S, the contractor shall send development/approval letters, etc., to the contact person if one is listed. Otherwise, the contractor may send the letter to the provider/supplier at the e-mail, mailing address, or fax provided in the correspondence address or special payments address sections.

3. The contractor may insert an attention field with the contact's name as part of the mailing address, but the letter should still be addressed to the provider/supplier. As applicable, the contractor shall continue to send letters to the DMEPOS supplier's correspondence address until their automated process can be updated to include the contact person as a recipient of the letters.

4. For initial, change of information, revalidation, and voluntary termination applications submitted by sole owners, the contractor should issue one approval letter. However, the Medicare enrollment information table shall distinctly list the individual and sole owner information.

5. If, as part of revalidation, a physician assistant is adding and terminating an employment relationship, one letter shall be issued (approving the revalidation). However, the termination and additional employment relationship shall be noted in the approval letter.

6. The contractor shall issue all denial and revocation letters via certified mail.

7. Notwithstanding any other instruction to the contrary in this chapter, the contractor shall copy via email the applicable accrediting organization (AO) (along with, as currently required, the state agency) on a recommendation for approval letter or final provider/supplier notification letter (e.g., final approval, denial, etc.) letter if: (1) the provider/supplier lists the AO on the Form CMS-855 or ADR application; (2) PEOG notifies the contractor of the AO's involvement; or (3) the contractor otherwise becomes aware of the provider/supplier's AO affiliation.

8. Notwithstanding any other instruction to the contrary in this chapter, DMEPOS suppliers shall send all applicable rebuttals, CAPs, and reconsideration requests to Chags Health Information Technology LLC (C-HIT). The contact information is:

Chags Health Information Technology LLC
P.O. Box 45266
Jacksonville, FL 32232
Phone: (800) 245-9206
E-mail: PEARC@c-hit.com
Fax: (866) 410-7404

The NPEs shall ensure that all previous section 10.7 et seq. references to the National Supplier Clearinghouse as the destination for rebuttals, CAPs, and reconsideration requests be replaced with C-HIT consistent with prior CMS guidance.

10.7.5 – Part A/B Certified Provider and Supplier Approval Letter Templates

(Rev. 12550; Issued: 03-21-24; Effective: 04-21-24; Implementation: 04-21-24)

A. Approval – Change of Information (Part A/B Certified Org, No *Referral to State* Required)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] has approved your Change of Information (COI) application.

Medicare Enrollment Information

Legal Business Name (LBN)	
Doing Business As (DBA)	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Changed Information	Include detailed changes or section titles, as applicable.

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR §424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

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*; and*
- 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 CFR Part 498.

The reconsideration request should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Blvd.
Mailstop: AR-19-51

Baltimore, MD 21244-1850

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

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

Sincerely,

[Name]
[Title]
[Company]

[CC: SOG Location and State]

B. Approval - Post Tie-In Change of Information (Part A/B Certified)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] has processed the Medicare Tie in Notice approving your change of information application.

Medicare Enrollment Information

Legal Business Name (LBN)	
Doing Business As (DBA)	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Changed Information	Include detailed changes or section titles, as applicable.

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR §424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

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*; and*
- 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*; and*
- 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 CFR Part 498.

The reconsideration request should be sent to:

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

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

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

Sincerely,

[Name]
[Title]
[Company]

C. Approval - Post Tie-In Change of Ownership (Part A/B Certified)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] has processed the Medicare Tie in Notice approving your change of ownership application.

Medicare Enrollment Information

Legal Business Name (LBN)	
Doing Business As (DBA)	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
PTAN Effective Date	
CHOW Effective Date	
Medicare Year-End Cost Report Date (Part A CHOWs only)	

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Contact our electronic data interchange (EDI) department for enrollment and further instructions on electronic claims filing at [phone number].

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR §424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

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*; and*
- 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*; and*
- 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:

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

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

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

Sincerely,

[Name]
[Title]
[Company]

D. Approval - Post Tie-In/Initial (Part A/B Certified)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] has processed the Medicare Tie in Notice approving your initial enrollment application.

Medicare Enrollment Information

Legal Business Name (LBN)	
Doing Business As (DBA)	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
PTAN Effective Date	
Medicare Year-End Cost Report Date (Part A only)	

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Contact our electronic data interchange (EDI) department for enrollment and further instructions on electronic claims filing at [phone number].

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR §424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

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*; and*
- 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*; and*
- 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:

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

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

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

Sincerely,

[Name]
[Title]
[Company]

E. *Forwarded to State -* Initial (Part A/B Certified)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

This letter updates you on the status of your initial enrollment application. Your application is required to go through a multi-step review process.

[Contractor Name] is a CMS Medicare Administrative Contractor (MAC) charged with enrolling providers and suppliers in the Medicare program. We have assessed your enrollment application and forwarded it to the [Enter State Agency] for the next step in the process. The State Agency will conduct a review for further compliance with the applicable Federal, State, and local requirements. Once the State Agency's review is complete, CMS will conduct a final review and issue a decision.

We will contact you when your application has completed all stages of review and a decision has been made.

Medicare Enrollment Information	
Legal Business Name (LBN)	
Doing Business As (DBA)	
National Provider Identifier (NPI)	
Provider/Supplier Type	
Medicare Year-End Cost Report Date (Part A only)	

For questions concerning the application's review at this stage, contact [Insert State] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

F. *Forwarded to State –* Change of Information or Change of Ownership (Part A/B

Certified)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

This letter updates you on the status of your [change of information or change of ownership enrollment] application. Your application is required to go through a multi-step review process.

[Contractor Name] is a CMS Medicare Administrative Contractor (MAC) charged with enrolling providers and suppliers in the Medicare program. We have assessed your enrollment application and forwarded it to the [Enter State Agency] for the next step in the process. The State Agency will conduct a review for further compliance with the applicable Federal, State, and local requirements. Once the State Agency's review is complete, CMS will conduct a final review and issue a decision.

We will contact you when your application has completed all stages of review and a decision has been made.

Medicare Enrollment Information

Legal Business Name (LBN)		
Doing Business As (DBA)		
Provider/Supplier Type		
National Provider Identifier (NPI)		
Provider Transaction Access Number (PTAN)		
Medicare Year-End Cost Report Date (Part A only)		
Requested Changes (applicable to COI and CHOW, remove if doesn't apply)	Existing	
	New	
	Effective Date	

For questions concerning the application's review at this stage, contact [Insert State] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

G. Approval – Revalidation (Part A/B Certified Org)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] has [approved your revalidation application/assessed your revalidation application and forwarded it to the Centers for Medicare & Medicaid Services (CMS) [City] SOG for a final review].

Medicare Enrollment Information

Legal Business Name (LBN)	
Doing Business As (DBA)	
Provider/Supplier Type	
Provider/Supplier National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
PTAN Effective Date	
Changed Information	Include detailed changes or section titles, as applicable.

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR §424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

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*; and*
- 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*; and*
- 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:

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

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

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

Sincerely,

[Name]
[Title]
[Company]

H. Approval – Voluntary Termination (Part A/B Certified Org)

[Month, Day, Year]

[Provider/Supplier Name]

[Address]
[City] ST [Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] completed your application to voluntarily disenroll from the Medicare program.

Medicare Enrollment Information

Legal Business Name (LBN)	
Doing Business As (DBA)	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Effective Date of Termination and Deactivation	

Medicare will not reimburse you for any claims with dates of service on or after your effective date of termination. With this voluntary termination, your billing privileges are also being deactivated effective on the aforementioned date of the termination pursuant to 42 C.F.R. § 424.540(a)(7).

REBUTTAL RIGHTS:

If you believe that this deactivation 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 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. 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]

[CC: SOG Location and State for Certified Providers/Suppliers]

I. Approval – Reactivation (Part A/B Certified Org)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor] approved your reactivation enrollment application.

Medicare Enrollment Information

Legal Business Name (LBN)	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
PTAN Effective Date	
Participation Status	

Include if applicable: [While your PTAN(s) and effective date(s) remain the same, you will have a gap in billing privileges from [deactivation date] through [reactivation date] for failing to fully revalidate during a previous revalidation cycle. You will not be reimbursed for services provided to Medicare beneficiaries during this time period since you were not in compliance with Medicare requirements.]

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Contact our electronic data interchange (EDI) department for enrollment and further instructions on electronic claims filing at [phone number].

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR §424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

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*; and*
- 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*; and*
- 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:

Centers for Medicare & Medicaid Services

Center for Program Integrity
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Blvd.
Mailstop: AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

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

Sincerely,

[Name]
[Title]
[Company]

10.7.5.1 – Part A/B Certified Provider and Supplier Letter Templates – Post-Transition

(Rev. 12550; Issued: 03-21-24; Effective: 04-21-24; Implementation: 04-21-24)

The model letters in this section 10.7.5.1 pertain to certain enrollment transactions involving certified providers and certified suppliers. Except as otherwise stated, the contractor shall begin utilizing these letters (instead of those in section 10.7.5) upon completion of the transition of the applicable CMS Survey & Operations Group (SOG) function to the contractor and the CMS Provider Enrollment & Oversight Group (PEOG). In other words, once a provider specialty, provider agreement, or provider enrollment transaction type (for example, voluntary terminations) has been transitioned, the contractor shall commence using the section 10.7.5.1 letter(s) pertaining to said transaction. CMS will notify contractors once a particular transition has occurred.

For certified provider/supplier transactions (and transaction outcomes) not specifically addressed in this section 10.7.5.1, the contractor shall continue to use the existing model letters in section 10.7 et seq. (even after the aforementioned transition).

In addition:

(i) Most of the documents in this section 10.7.5.1 identify parties that must receive a copy of the letter in question. If an inconsistency exists between said copied parties and those listed elsewhere in this chapter concerning a particular letter, the parties identified in this section 10.7.5.1 take precedence. To illustrate, suppose another section of this chapter requires X, Y, and Z to be copied on a certain letter while section 10.7.5.1 only requires X to be copied. The contractor in this situation need only copy X.

(ii) The contractor need only copy an accrediting organization (AO) on a particular letter if the provider/supplier has an AO for the identified provider/supplier specialty. The contractor can typically ascertain this by checking PECOS (for currently enrolled providers/suppliers) or reviewing the application (for initial enrollments) to see if an AO is disclosed. Also, PEOG will often identify an AO (if one exists) in cases where it must review the transaction before notifying the contractor of its final approval (e.g., CHOWs, certain changes of information, voluntary termination).

(iii) See section 10.7.5.1(P) below for the applicable e-mail addresses of the SOG Locations. The contractor shall insert the relevant e-mail address into any letter in section 10.7.5.1 that addresses the provider/supplier's right to a reconsideration of a provider agreement determination.

(iv) Any data element boxes that the contractor cannot complete because the information is unavailable or inapplicable (e.g., CMS Certification Number (CCN) in certain instances) can be: (1) left blank; (2) denoted with "N/A," "Not applicable," or any similar term; or (3) removed altogether.

(v) The Provider Transaction Access Number (PTAN) box should contain the CCN for all provider/supplier types other than ASCs and PXRSs; the PTAN for the latter two supplier types will be that which the contractor assigns or has assigned.

(vi) The Primary Practice Location Address box shall include the suite number if one was/is listed on the application.

(vii) For the Denial letter in section 15.7.5.1(H), the contractor shall indicate (in any manner it chooses) whether the denial pertains to the buyer's or the seller's application if a prospective CHOW was involved.

(viii) In cases where provider/supplier data has changed and the contractor must list "detailed information or application section titles (as applicable)", the contractor has the discretion to list either (i.e., the info or the section titles).

A. Approval – Change of Information (Part A/B Certified Org; No *Referral* to State Was Required)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and Contractor number]] has approved your Change of Information (COI) application.

Medicare Enrollment Information	
Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Changed Information	Include detailed changes or application section titles, as applicable.

Provider/Supplier Agreement-Specific Information	
CMS Certification Number (CCN)	
CCN Effective Date	

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Enroll, make changes, or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR § 424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations, at [insert contractor's web address] or https://www.cms.gov.

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*; and*
- 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*; and*
- 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 CFR Part 498.

The reconsideration request should be sent to:

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

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

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

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [& Accrediting Organization (AO), if applicable]

Attachments: [Include any attachments that the contractor must send to the provider/supplier, the state agency, and/or the AO per the instructions in this chapter 10.]

B. Approval - State Agency Approved Change of Information (Part A/B Certified; *Referral to* State Was Required)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and Contractor number]] has received a response from the Medicare State Agency. Your change of information application is now approved.

Medicare Enrollment Information	
Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	

Medicare Enrollment Information	
Changed Information	Include detailed changes or application section titles, as applicable

Provider/Supplier Agreement Specific Information	
CMS Certification Number (CCN)	
CCN Effective Date	

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Enroll, make changes, or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR § 424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

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*; and*
- 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*; and*

- 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 CFR Part 498.

The reconsideration request should be sent to:

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

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

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

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

Attachments: [Include any attachments that the contractor must send to the provider/supplier, the state agency, and/or the AO per the instructions in this chapter 10.]

C. Approval - State Agency Approved Change of Ownership (Part A/B Certified Excluding FQHCs)

[Month, Day, Year]

[Provider/Supplier Name]
[Address]
[City, State, Zip]
Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and Contractor number]] has received a response from the State Agency. Your change of ownership application is now approved. The corresponding executed [insert provider/supplier agreement type] is enclosed/attached. Your enrollment and [provider/supplier agreement-specific] information is outlined below:

Medicare Enrollment Information

Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	

Provider/Supplier Agreement Specific Information	
CMS Certification Number (CCN)	
CCN Effective Date (use effective date of seller's CCN)	
CHOW Effective Date	

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Contact our electronic data interchange (EDI) department for enrollment and further instructions on electronic claims filing at [phone number].

Enroll, make changes, or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR § 424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations, at [insert contractor's web address] or https://www.cms.gov.

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*; and*
- 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*; and*
- 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 CFR Part 498.

The reconsideration request should be sent to:

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

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

And

If you are also requesting a reconsideration of the provider/supplier agreement determination, you must submit a separate Reconsideration Request. Your requests must be e-mailed to: [Insert: Name and e-mail address of CMS Location Office]

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

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

Attachments: [Include any attachments that the contractor must send to the provider/supplier, the state agency, and/or the AO per the instructions in this chapter 10.]

D. Approval - State Agency Approved Initial (Part A/B Certified)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and Contractor number]] received a response from the Medicare State Agency. Your initial enrollment application and [provider/supplier agreement] is approved. Your executed [insert provider/supplier agreement name] is enclosed/attached. The effective date is the date you met all federal requirements.

Medicare Enrollment and Provider/Supplier Specific Participation Agreement Information

Medicare Enrollment Information	
Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Enrollment Effective Date	

Provider/Supplier Agreement Specific Information	
CMS Certification Number (CCN)	
CCN Effective Date	
Medicare Year-End Cost Report Date	

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Contact our electronic data interchange (EDI) department for enrollment and further instructions on electronic claims filing at [phone number].

Enroll, make changes, or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR § 424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations, at [insert contractor's web address] or https://www.cms.gov.

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*; and*
- 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*; and*
- 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 CFR Part 498.

The reconsideration request should be sent to:

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

Or emailed to: ProviderEnrollmentAppeals@cms.hhs.gov

And

If you are also requesting a provider/supplier agreement reconsideration, you must submit a separate Reconsideration Request. Your requests must be e-mailed to:

[Insert: Name and e-mail address of CMS Location Office]

Your e-mail must include the following in the subject line: "Subject: Medicare Provider/Supplier Agreement Reconsideration Request"

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

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

Attachments: [Include any attachments that the contractor must send to the provider/supplier, the state agency, and/or the AO per the instructions in this chapter 10.]

E. *Forwarded to State -* Initial (Part A/B Certified)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

This letter updates you on the status of your initial enrollment application. Your application is required to go through a multi-step review process.

[Contractor Name] is a CMS Medicare Administrative Contractor (MAC) charged with enrolling providers and suppliers in the Medicare program. We have assessed your enrollment application and forwarded it to the [Enter State Agency] for the next step in the process. The State Agency will conduct a review for further compliance with the applicable Federal, State, and local requirements. Once the State Agency's review is complete, CMS will conduct a final review and issue a decision.

We will contact you when your application has completed all stages of review and a decision has been made.

Medicare Enrollment Information	
Legal Business Name (LBN)	
Doing Business As (DBA)	
National Provider Identifier (NPI)	
Provider/Supplier Type	
Medicare Year-End Cost Report Date (Part A only)	

For questions concerning the application's review at this stage, contact [Insert State] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

F. *Forwarded to State* – Change of Information, Change of Ownership, Revalidation, or Reactivation Containing Changed New/Changed Data that the State Must Review (if applicable) (Part A/B Certified)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

This letter updates you on the status of your [list type of transaction] enrollment application. Your application is required to go through a multi-step review process.

[Contractor Name] is a CMS Medicare Administrative Contractor (MAC) charged with enrolling providers and suppliers in the Medicare program. We have assessed your enrollment application and forwarded it to the [Enter State Agency] for the next step in the process. The State Agency will conduct a review for further compliance with the applicable Federal, State, and local requirements. Once the State Agency's review is complete, CMS will conduct a final review and issue a decision.

We will contact you when your application has completed all stages of review and a decision has been made.

Medicare Enrollment Information	
Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	

Provider/Supplier Agreement Information		
CMS Certification Number (CCN)		
Requested Changes (applicable to COI, CHOW, or Revalidation; remove if inapplicable)	Existing	Seller
	New	Buyer
	Effective Date	

For questions concerning the application's review at this stage, contact [Insert State] at [contact information].

Sincerely,

[Name]
[Title]

[Company]

CC: State Agency [and AO, if applicable]

G. Approval Revalidation (Part A/B Certified Org)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and add Contractor number]] has approved your revalidation application [include if the application was sent to the state: "and forwarded it to the State Agency. The State Agency review has also been completed"]. Your Medicare enrollment information is provided below.

Medicare Enrollment Information

Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
PTAN Effective Date	
Changed Information	Include detailed changes or application section titles, as applicable.

Provider/Supplier Agreement Information		
CMS Certification Number (CCN)		
Requested Changes (applicable to COI, CHOW, or Revalidation; remove if inapplicable)	Existing	Seller
	New	Buyer
	Effective Date	

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR § 424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations, at [insert contractor's web address] or https://www.cms.gov.

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*; and*
- 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*; and*
- 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 CFR Part 498.

The reconsideration request should be sent to:

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

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

And

If you are also requesting a provider/supplier agreement reconsideration, you must submit a separate Reconsideration Request. Your requests must be e-mailed to:

[Insert: Name and e-mail address of CMS Location Office]

Your e-mail must include the following in the subject line: "Subject: Medicare Provider/Supplier Agreement Reconsideration Request"

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

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

H. Denial Letter – Post-1539 (Or Other Similar Notice) Received from State Agency for the following application types—Initials, COIs, CHOWs, Revalidations, and Reactivations

(This letter only applies in cases where:

(1) A recommendation to the state was required per the instructions in this chapter (e.g., the particular revalidation application contained information/changes requiring state review), and (2) The state sends notification to the contractor (e.g., via the 1539 or other notice) that the application should be denied and/or, if applicable, the provider/supplier agreement should be terminated.

As explained in this chapter, certain changes of information and revalidation applications can result in an enrollment revocation and provider agreement termination, though most do not. Accordingly, the contractor shall insert the applicable review result language (e.g., see bracketed options below) in the first paragraph of the letter.)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[The [insert name of State Agency] completed its evaluation of your [initial application] or [change of information] or [change of ownership] or [revalidation] or [reactivation]. [Insert the following language based on the situation involved and the specific result of the state's review:

[INITIAL ENROLLMENT: Your participation in the Medicare Program and your enrollment in the Medicare Program is [denied] for the following reasons]:

[NO REVOCATION AND/OR PROVIDER AGREEMENT TERMINATION INVOLVED: Your application for [insert] is denied for the following reasons]:

[REVOCATION AND/OR PROVIDER AGREEMENT TERMINATION RESULTING FROM THE APPLICATION SUBMISSION. As a result of the state's review, your provider/supplier agreement for participation in the Medicare program is terminated and your enrollment in the Medicare program is revoked for the following reason(s]:

[**INSERT DENIAL OR TERMINATION REASON GIVEN BY THE STATE AGENCY**]

Information about your provider/supplier agreement and your Medicare enrollment are outlined in the text box below.

Medicare Administrative Contractor Name & Contractor Number	
Medicare Enrollment Determination	
Status	**DENIED [OR REVOKED]**
Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Provider/Supplier Agreement Determination	
Provider/Supplier Agreement	**DENIED [OR TERMINATED]**
CMS Certification Number (CCN)	

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*; and*
- 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*; and*
- 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.

RECONSIDERATIONS REQUEST—MAILING ADDRESSES:

Requests for Reconsideration: Medicare Provider Enrollment: The reconsideration request regarding your Medicare enrollment may be submitted electronically via e-mail to: ProviderEnrollmentAppeals@cms.hhs.gov or addressed as follows:

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

And

Requests for Reconsideration: Medicare Provider/Supplier Agreement: For reconsideration of the Provider/Supplier Agreement determination, you must submit a separate Reconsideration Request. Your requests must be e-mailed to:

[Insert: Name and e-mail address of CMS Location Office]

Your e-mail must include the following in the subject line: "Subject: Medicare Provider/Supplier Agreement Reconsideration Request"

[If a failed survey was involved, the contractor shall include the following language here: "Note that any survey deficiencies may only be addressed as part of the provider/supplier agreement reconsideration process."]

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

Sincerely,

[Name]

[Title]
[Company]

CC: State Agency [and AO, if applicable]

I. Approval – Voluntary Termination (Part A/B Certified Org)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and Contractor number]] has received notification from the State Agency that you are voluntarily terminating your provider/supplier agreement **or** [Insert Contractor name [and Contractor number]] has completed processing your application [or letter] to voluntarily disenroll from the Medicare program. Therefore, your provider agreement has been terminated and your enrollment in the Medicare program has been voluntarily terminated effective on the dates shown below.

Medicare Enrollment and Provider Agreement Information

Medicare Enrollment Termination and Deactivation of Billing Privileges	
Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Effective Date of Enrollment Termination and Deactivation	

Provider/Supplier Agreement Termination	
CMS Certification Number (CCN)	
Effective Date of CCN Termination	
Reason for Termination	

In accordance with 42 CFR § 489.52, Medicare will not reimburse you for any claims with dates of service on or after your effective date of termination. With this termination, your billing privileges are also being deactivated effective on the aforementioned date of the termination pursuant to 42 C.F.R. § 424.540(a)(7).

REBUTTAL RIGHTS:

If you believe that this deactivation 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 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. 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]

CC: State Agency [and AO, if applicable]

J. Approval – Reactivation (Part A/B Certified Org)

(This letter should be used for reactivation approvals regardless of whether the application was referred to the state agency for review.)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and add Contractor number]] has approved your reactivation enrollment application.

Medicare Enrollment Information

Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
PTAN Effective Date	

Provider/Supplier Agreement Specific Information	
CMS Certification Number (CCN)	
CCN Effective Date	

Include if applicable: [While your PTAN(s) and effective date(s) remain the same, you will have a gap in billing privileges from [deactivation date] through [reactivation date] for failing to fully revalidate during a previous revalidation cycle. You will not be reimbursed for services provided to Medicare beneficiaries during this time period since you were not in compliance with Medicare requirements.]

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Contact our electronic data interchange (EDI) department for enrollment and further instructions on electronic claims filing at [phone number].

Enroll, make changes, or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR § 424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations, at [insert contractor's web address] or https://www.cms.gov.

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*; and*

- 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*; and*
- 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 CFR Part 498.

The reconsideration request should be sent to:

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

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

And

Requests for Reconsideration: Medicare Provider/Supplier Agreement: For reconsideration of the Provider/Supplier Agreement determination, you must submit a separate Reconsideration Request. Your requests must be e-mailed to:

[Insert: Name and e-mail address of CMS Location Office]

Your e-mail must include the following in the subject line: "Subject: Medicare Provider/Supplier Agreement Reconsideration Request"

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

Sincerely,

[Name]
[Title]
[Company]

(Note: No CC: to State Agency/AO required. Deactivations do not impact certified provider CCN participation status.)

K. Voluntary Termination: Failure to Respond to Request for Information

Month, Day, Year

PROVIDER/SUPPLIER NAME
ADDRESS
CITY, STATE, ZIP

Reference # Application ID

Dear Provider Name (LBN),

[Insert Contractor name [and Contractor number]] has received notification from the State Agency that you are no longer operational. We have not received a response to the request sent on Month DD, YYYY to update your enrollment information. Therefore, we have disenrolled you from the Medicare program. Your [provider/supplier agreement] has also been terminated.

Medicare Enrollment and Provider Agreement Information

Medicare Enrollment Termination and Deactivation of Billing Privileges Information	
Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type/Specialty	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Effective Date of Enrollment Deactivation	

Provider/Supplier Agreement Termination Information	
CMS Certification Number (CCN)	
Effective Date of CCN Termination	

In accordance with 42 CFR § 489.52, Medicare will not reimburse you for any claims with dates of service on or after your effective date of termination. With this termination, your billing privileges are also being deactivated effective on the aforementioned date of the termination pursuant to 42 C.F.R. § 424.540(a)(7).

REBUTTAL RIGHTS:

If you believe that this deactivation 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 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. 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]

CC: State Agency [and AO, if applicable]

L. Voluntary Termination Cessation of Business

[Month, Day, Year]

PROVIDER/SUPPLIER NAME
ADDRESS
CITY, STATE, ZIP

Reference Number:

Dear Provider/Supplier Name:

[Insert Contractor name [and Contractor number]] was notified by State Agency Name that on MONTH DD, YYYY, the State Agency attempted to verify if your Type of Provider is operational. The State Agency has reported that your facility was closed, not operational, and/or ceased business at your address of record.

Pursuant to 42 CFR § 489.52(b)(3), CMS considers a cessation of business and providing services to the community to constitute a voluntary withdrawal from the Medicare program.

If you believe that our determination is incorrect and your Type of Provider facility remains operational, you must notify the State Agency and copy this office within 10 days from your receipt of this notice that your facility is still operational and participating in the Medicare program. You must provide the State Agency and this office with information to clarify why your facility was not functional at the address of record at the time the State Agency performed the site survey.

STATE AGENCY NAME
ADDRESS
CITY, STATE, ZIP

We request that you complete and submit a CMS-855 or an application via the Internet-Based Provider Enrollment Chain and Ownership System (PECOS) for a change of information to indicate that your facility/practice location remains open and operational or to request a voluntary termination of your enrollment.

If we do not hear from you, your Medicare enrollment and corresponding Provider Agreement will be terminated pursuant to 42 CFR § 489.52(b)(3). With this termination, your billing privileges will also be deactivated effective on the aforementioned date of the termination pursuant to 42 C.F.R. § 424.540(a)(7).

If you have any questions, please contact our office at:

Sincerely,

[Name]
[Title]
[Company]

M. Approval – Seller CHOW (Part A/B Certified Org)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and Contractor number]] has received notification from the [use "State Agency" or "CMS Survey & Operations Group Location", as appropriate] that the change of ownership involving [insert seller name] is now approved. Therefore, you have been disenrolled from the Medicare program effective on the date shown below.

Medicare Enrollment Termination Information

Medicare Enrollment Termination	
Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Effective Date of Enrollment Termination	

Provider/Supplier Agreement Information	
CMS Certification Number (CCN)	
Effective Date of CCN Termination	

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

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

N. Federally Qualified Health Centers (FQHCs) – Initial Enrollment Approval Letter

Notwithstanding any other instruction to the contrary in this chapter, the contractor shall use this letter (which was formerly in section 10.7.19 of this chapter) for all FQHC initial enrollment approvals. For all other FQHC transactions (e.g., revalidations), the contractor may use the applicable letters in either 10.7.5 or 10.7.5.1.

[Month, Day, Year]

[FQHC Name]
[Address]
[City, State, Zip]

Reference # (Application Tracking Number)

Dear [FQHC],

[Insert Contractor] has approved your enrollment as a federally qualified health center (FQHC).

Medicare Enrollment Information

Legal Business Name (LBN)	
Doing Business As (DBA)	
Physical Location Address	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)/CMS Certification Number (CCN)	
PTAN/CCN Effective Date	
Medicare Year-End Cost Report Date	

Provider/Supplier Agreement Information	
CMS Certification Number (CCN)	
Effective Date of CCN	

Included with this letter is a copy of your "Attestation Statement for Federal Qualified Health Center" (Exhibit 177), which CMS has signed.

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Contact our electronic data interchange (EDI) department for enrollment and further instructions on electronic claims filing at [phone number].

Enroll, make changes to, or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR § 424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

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*; and*
- 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*; and*
- 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:

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

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

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

Sincerely,

[Name]
[Title]
[Company]

O. Approval – FQHC Change of Ownership

[Month, Day, Year]

[Provider/Supplier Name]
[Address]
[City, State, Zip]
Reference # (Application Tracking Number)

Dear [Provider/Supplier],

Your change of ownership application is now approved. The corresponding executed "Attestation Statement for Federal Qualified Health Center" (Exhibit 177), which CMS has signed, is enclosed/attached. Your enrollment and Exhibit 177 information is outlined below:

Medicare Enrollment Information	
Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	

Provider Agreement Specific Information	
CMS Certification Number (CCN)	
CCN Effective Date (use effective date of seller's CCN)	
CHOW Effective Date	

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Contact our electronic data interchange (EDI) department for enrollment and further instructions on electronic claims filing at [phone number].

Enroll, make changes, or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR § 424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations, at [insert contractor's web address] or https://www.cms.gov.

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*; and*
- 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.

You 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*; and*
- 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 CFR Part 498.

The reconsideration request should be sent to:

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

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

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

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

Attachments: [Include any attachments that the contractor must send to the provider/supplier, the state agency, and/or the AO per the instructions in this chapter 10.]

P. 36-Month Rule Voluntary Termination Letter

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [HHA *or Hospice* Seller],

[Insert Contractor name] has [Insert appropriate situation (e.g., reviewed [insert HHA's current name] change of ownership application; learned that [insert HHA's current name] may have undergone a change in majority ownership pursuant to 42 C.F.R. § 424.550(b)(1); etc.]. After our review, [Insert Contractor name] has determined that [insert HHA's *or hospice's* current name] has undergone a change in majority ownership under 42 C.F.R. § 424.550(b)(1) and that none of the exceptions described in 42 C.F.R. § 424.550(b)(2) apply to this situation. Pursuant to 42 C.F.R. § 424.550(b)(1), therefore, [insert HHA's *or hospice's* current name] provider agreement and Medicare billing privileges do not convey to the new owner. The prospective provider/owner of [insert HHA's *or hospice's* current name] must instead:

- Enroll in the Medicare program as a new (initial) home health agency under the provisions of 42 C.F.R § 424.510; and
- Obtain a state survey or an accreditation from an approved accreditation organization.

Consistent with the foregoing, [insert HHA's *or hospice's* current name] provider agreement [will be/has been] voluntarily terminated and its Medicare billing privileges [will be/have been] deactivated pursuant to 42 C.F.R § 424.540(a)(8) effective [Insert date(s)].

Medicare Enrollment and Provider Agreement Information

Medicare Enrollment Deactivation	
Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Effective Date of Enrollment Deactivation	

Provider/Supplier Agreement Termination	
CMS Certification Number (CCN)	
Effective Date of CCN Termination	
Reason for Termination	

In accordance with 42 CFR § 489.52, Medicare will not reimburse you for any claims with dates of service on or after your effective date of termination.

REBUTTAL RIGHTS:

If you believe that this deactivation 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 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. 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]

CC: State Agency [and AO, if applicable]

Q. Applicable SOG Location E-mail Boxes

CMS Locations Corporate Email Addresses

CMS LOCATION	BRANCH	EMAIL Address
CMS Boston	ACC & LTC	BostonRO-DSC@cms.hhs.gov
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont		
CMS Philadelphia	ACC & LTC	ROPHIDSC@cms.hhs.gov

Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia		
CMS New York	ACC & LTC	RONYdsc@cms.hhs.gov
New Jersey, New York, Puerto Rico, Virgin Islands		
CMS Atlanta	ACC & LTC	ROATLHSQ@cms.hhs.gov
Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee		
CMS Chicago	ACC & LTC	ROCHISC@cms.hhs.gov
Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin		
CMS Kansas City	ACC & LTC	ROkcmSCB@cms.hhs.gov
Iowa, Kansas, Missouri, Nebraska		
CMS Denver	ACC & LTC	DenverMAC@cms.hhs.gov
Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming		
CMS Dallas	ACC & LTC	RODALDSC@cms.hhs.gov
Arkansas, Louisiana, New Mexico, Oklahoma, Texas		
CMS San Francisco	ACC & LTC	ROSFOSO@cms.hhs.gov
Arizona, California, Hawaii, Nevada, Pacific Territories		
CMS Seattle	ACCB	CMS_RO10_CEB@cms.hhs.gov
Alaska, Idaho, Oregon, Washington	LTC	Seattle_LTC@cms.hhs.gov

10.7.9 – Revocation Letters

(Rev. 12550; Issued: 03-21-24; Effective: 04-21-24; Implementation: 04-21-24)

A. Revocation Letter Guidance

The contractor--

- Must submit one or more of the Primary Revocation Reasons as found in section 10.4.7.3 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 DMEPOS Suppliers

[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]*, Medicare enrollment, and Medicare billing privileges* for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS),

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

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

[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)]

[[Contractor Name] 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.]

[[Contractor Name] 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 Form CMS-855S enrollment application. The 30-day 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 *c*ivil *money* penalties.

Pursuant to 42 CFR § 424.535(c), you are barred from reenrolling in the Medicare program for a period of [number of years] year(s) from the effective date of the revocation. To reenroll after the reenrollment bar has expired, you must meet all requirements for your supplier type. In addition, if submitting a Form CMS-855S application after the reenrollment bar's expiration, 42 C.F.R. § 424.57(d)(3)(ii) states that suppliers are required to maintain an elevated surety bond amount of $50,000 for each final adverse action (which includes a Medicare revocation) imposed. Therefore, if you do not request a reconsideration of this revocation decision or receive an unfavorable decision through the administrative review process, you must submit an elevated surety bond with any application to reenroll in Medicare. Please note that this amount is in addition to, and not in lieu of, the base $50,000 amount that must be maintained.

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 the entity* responsible for reviewing the CAP)

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

or

Chags Health Information Technology LLC
P.O. Box 45266
Jacksonville, FL 32232

Or emailed to:

[Insert MAC email address] or [*PEARC@c-hit.com*]

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	*Chags Health Information Technology LLC* *P.O. Box 45266* *Jacksonville, FL 32232*

Or emailed to:

[Insert MAC email address] or [*PEARC@c-hit.com*]

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 enrollment and Medicare billing 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.)

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.

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]

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 enrollment and Medicare billing 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.

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.

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]

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], *Medicare enrollment, and Medicare billing privileges* for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) issued by [Contractor name) 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 [Contractor name] 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 billing 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 reenrollment bar established.)[Pursuant to 42 C.F.R. § 424.535(c), CMS is establishing a reenrollment bar for a period of [Insert amount of time] that shall begin 30 days after the postmark date of this letter. This reenrollment bar only applies to your ability to submit a new enrollment application to the Medicare program. In order to reenroll, you must meet all requirements for your provider or supplier type.]

In addition, if submitting a Form CMS-855S application after the reenrollment bar's expiration, 42 C.F.R. § 424.57(d)(3)(ii) states that suppliers are required to maintain an elevated surety bond amount of $50,000 for each final adverse action (which includes a Medicare revocation) imposed. Therefore, if you do not request a reconsideration of this revocation decision or receive an unfavorable decision through the administrative review process, you must submit an elevated surety bond with any application to reenroll in Medicare. Please note that 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:

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

or

Chags Health Information Technology LLC
P.O. Box 45266
Jacksonville, FL 32232

Or emailed to:

[Insert MAC email address] or [*PEARC@c-hit.com*]

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 by [Contractor name] prior to this timeframe will be returned.

If you have any questions, please contact our office at [Contractor 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 enrollment and Medicare billing* 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.

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.

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]

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]

10.7.14 – Model Opt-out Letters

(Rev. 12550; Issued: 03-21-24; Effective: 04-21-24; Implementation: 04-21-24)

The Contractors 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 Contractors shall not use these model letters to respond to Medicare enrollment applications or other correspondence. The Contractors 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

If 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

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

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

We Can't Cancel Your Medicare Opt-Out Status

Dear [Eligible Practitioner Name]:

We can't cancel the automatic renewal of your Medicare opt-out status because we didn't get your cancellation request in time. Your opt-out status automatically renewed for 2 years on [Month] [DD], [YYYY].

To properly cancel your opt-out status, you needed to submit your request by [Month] [DD], [YYYY], which was at least 30 days before your automatic opt-out renewal. [Contractor Name] is returning your written request, which they got on [Month] [DD], [YYYY].

Next Steps

If you don't request reconsideration, your next chance to cancel the automatic renewal of your Medicare opt-out status is prior to [Month] [DD], [YYYY] for the renewal that will occur on [Month] [DD], [YYYY].

If you believe you submitted a proper cancellation request before [Month] [DD], [YYYY], you can submit a reconsideration request to appeal the determination that you didn't timely or properly cancel your opt-out status. CMS (or a contractor) will review your request to see if we made an error in determining that you didn't cancel your opt-out status in a proper or timely manner. We'll base this decision on the information you include in your reconsideration request, CMS and contractor documents, and applicable regulations in 42 C.F.R. §§ 405.400-405.455. Submitting a reconsideration request doesn't allow you to submit (or allow us to accept) an untimely request to cancel your opt-out status.

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

[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]:

[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 Contractors 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]:

You've Successfully Opted Out of Medicare

Opt-out Affidavit Information:

Practitioner Name:	[Name]
Address:	[Address, City, State, Zip]
NPI:	[NPI]
Specialty:	[Specialty]
Ordering and Referring:	You're eligible to Order and Refer
Effective Date:	[Effective date]

[Contractor Name] approved your Medicare opt-out affidavit. **You don't need to take additional action at this time.** However, since you're opting out of Medicare for the first time, you have a one-time, 90-day period to change your mind about opting out. If you decide to terminate your opt-out status during this 90-day period, submit your written request by [Month] [DD], [YYYY]. After this 90-day period ends, you can cancel your opt-out status at the end of the 2 year opt-out period only. Your opt-out status will automatically renew every 2 years.

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

If you believe you submitted a proper termination request within 90 days of the effective date above, you can submit a reconsideration request. A reconsideration request allows you to appeal the determination that you didn't timely and properly terminate your opt-out status. CMS (or a contractor) will review your request to see if we made an error in determining that you didn't terminate your opt-out status in a proper or timely manner. We'll base this decision on the information you include in your reconsideration request, CMS and contractor documents, and applicable regulations 42 C.F.R. §§ 405.400-405.455. Submitting a reconsideration request doesn't allow you to submit (or allow us to accept) an untimely request to terminate your opt-out status. **You may submit a reconsideration request by [Month] [DD], [YYYY] (65 days after the 90-day termination period ends).).**

<u>Right to Submit a Reconsideration Request:</u>

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 by the date indicated above 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]

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]	OR	Centers for Medicare & Medicaid Services
[Address]		Provider Enrollment & Oversight Group
[City], [ST] [Zip]		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*; and*
- 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*; and*
- 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*; and*
- 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*; and*
- 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*; and*
- 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*; and*
- 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*; and*
- 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 shall issue the following letter to inform 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]

Action Needed to Cancel Your Medicare Opt-Out Status

Dear [Eligible Practitioner Name]:

Your Medicare opt-out status will be automatically renewed for a new 2-year opt-out period on [Month] [DD], [YYYY]. You don't need to take additional action at this time.

However, if you would like to cancel your opt-out status, submit a written cancellation request by [Month] [DD], [YYYY], which is at least 30 days before the end of your current opt-out period.

If you believe you submitted a proper cancellation request by [Month] [DD], [YYYY], you can submit a reconsideration request. A reconsideration request allows you to appeal the determination that you didn't timely and properly terminate your opt-out status. CMS (or a contractor) will review your request to see if we made an error in determining that you didn't cancel your opt-out status in a proper or timely manner. We'll base this decision on the information you include in your reconsideration request, CMS and contractor documents, and applicable regulations 42 C.F.R. §§ 405.400-405.455. Submitting a reconsideration request doesn't allow you to submit (or allow us to accept) an untimely request to cancel your opt-out status. ***You may submit a reconsideration request by [Month] [DD], [YYYY] (65 days after the last day to cancel the current opt-out period).***

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 by the date indicated above 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; and*
    - *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; and*

- *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 Contractors shall acknowledge this action by using this model letter. If the eligible practitioner requests a cancellation, the Contractors shall indicate the date of the cancellation and remove the following paragraph regarding termination. If the eligible practitioner terminates the opt-out, the Contractors 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*; and*
- 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*; and*
- 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 Contractors 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*; and*
- 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*; and*
- 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]