CMS Manual System

Pub. 100-08 Medicare Program Integrity

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 69 **Date: MARCH 26, 2004**

CHANGE REQUEST 3159

I. SUMMARY OF CHANGES: This instruction will revise requirements to help streamline the enrollment process and ultimately improve timeliness standards.

NEW/REVISED MATERIAL - EFFECTIVE DATE: March 26, 2004
***IMPLEMENTATION DATE: April 26, 2004**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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:

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	10/2.2 – Contractor Duties
R	10/3.1 – Processing the Application
R	10/3.2 - Identification
R	10/3.4 – Practice Location
R	10/3.6 – Ownership and Managing Control Information (Individuals)
R	10/4.3 – Qualification of Crew
R	10/5.2 – Review of Attachment 2, Independent Diagnostic Testing Facilities (IDTFs)
R	10/7 – Reassignment of Benefits
R	10/7.5 – Statement of Termination
R	10/7.6 – Reassignment of Benefits Statement
R	10/7.7 – Attestation Statement
R	10/10.4 – Practice Location
R	10/10.6 – Ownership and Managing Control Information (Individuals)
R	10/13 – Changes of Information – New Form CMS-855 Data
R	10/14.2 – Approval and Recommendations for Approval
R	10/15 – Time Frame for Application Processing

***III. FUNDING:**
These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-08	Transmittal: 69	Date: March 26, 2004	Change Request 3159

SUBJECT: Streamlining Enrollment Requirements

I. GENERAL INFORMATION

A. Background: This change request revises the instructions on enrollment.
A reference made to "those contractors without access to PECOS" was removed because everyone is now using PECOS.

Removed a sentence that discusses a non-physician practitioner who has more than one specialty since a non-physician practitioner cannot have more than one specialty per application.

We removed the sentence that refers to "certified true" or notarized license since this is no longer a requirement

The requirement to verify reassignments with they reach 5 or more reassignments was removed.

References to the HIPDB have been removed since contractors are no longer required to use it.

Decrease the number of times an intermediary is required to send a copy of the CMS-855A to the regional office and State agency.

Removed the requirement for deactivating a billing number. Requirements regarding this initiative will follow in a Joint Signature Memorandum

B. Policy:
With recent changes to the enrollment process, contractors are struggling to meet the timeliness standards for processing enrollment applications. In order to streamline the process, we have reviewed policies to change or eliminate items that are non-critical to the enrollment process.

C. Provider Education:
A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
3159.1 Section 2.2 Section 4	Contractors shall continue to check original signatures when a request to change a pay-to-address, however, for all other changes, contractors can forgo this requirement.	Contractors
3159.2 Section 3.1 Section 6 Section 10.6	When PECOS shows a no match for a SSN, contractors shall work with the applicant to determine the cause of the rejection. Provides additional guidance on how to proceed when a no match is indicated.	Contractors
3159.3 Section 3.2	For non-physician practitioners who list more than one supervising and/or collaborating physician, only one supervising and/or collaborating physician shall be listed unless the manual directs otherwise.	Carriers
3159.4 Section 3.2	When a supervisory physician is enrolled by another carrier, and the new carrier needs the carrier to create an enrollment record in PECOS, the old carrier shall enter the enrollment record within 30 days of the request.	Carrier
3159.5 Section 4 Section 10.4	For DNF mail, if the contractor has previous 855 changes in-house, the request to complete an entire 855 for changes to a pay-to-address was removed as long as the contractor can verify signatures from previous 855 changes.	Contractors
3159.6 Section 4 Section 10.4	For EFT mail, if the contractor has previous 855 changes in-house, the request to complete an entire 855 for changes to a pay-to-address was removed as long as the contractor can verify signatures from previous 855 changes.	Contractors
3159.7 Section 4.3	When information for crewmembers is missing, do not develop for this information. If you currently have information on file, continue to use the names previously submitted. You only need to add one name in PECOS for creating an enrollment record.	Carriers

3159.8 Section 5.2	Anytime an interpreting physician/supervising physician is enrolled with another carrier, and the new carrier needs to create an enrollment record in PECOS, the old carrier shall enter the enrollment record within 30 days of the request.	Carrier
3159.9 Section 7.5	Contractors shall verify that the names on the 855R form accurately reflect the designated parties.	Carrier
3159.10 Section 15	Prescreening should be started 15 days before the application is worked rather than 15 days after it is received.	Contractors

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: NA

D. Contractor Financial Reporting /Workload Impact:

E. Dependencies: NA

F. Testing Considerations: NA

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: March 26, 2004 **Implementation Date: April 26, 2004** **Pre-Implementation Contact(s): Patti Snyder 410-786-5991 or Barry Bromberg 410-786-5996** **Post-Implementation Contact(s): Same**	**These instructions shall be implemented within your current operating budget.**

2.2 - Contractor Duties –

(Rev. 69, 03-26-04)

As Part of the enrollment process, contractors must:

- Assign staff to the Provider/Supplier Enrollment (PSE) function corresponding with the enrollment workload in order to meet processing time requirements while still effectively screening applicants. Employees must receive formal training on enrollment requirements, procedures, and techniques. Staff must receive yearly refresher training. If there is not formal classroom training in this area, the following shall be done:

  - Provide each employee with a general review of the Medicare program.

  - Provide a minimum of one month side-by-side training with an experienced Provider Enrollment Analyst.

  - The supervisor/lead analyst shall test the employee to ensure that the analyst has been trained in the day-to-day operations of the unit.

  - The supervisor/lead analyst shall provide biweekly quality checks for the 1st 6 months of employment (in the provider enrollment section).

  - The employee must be competent in the review of applications. The contractor shall document why the employee is considered competent. An example would be when the employee is an auditor who has reviewed all of CMS's relevant manuals and procedures and attends the provider enrollment conference. Attendance at the yearly provider enrollment conference would meet the annual refresher training.

- Review each Form CMS-855 in its entirety before taking any action, including requesting additional information. Enter the data within the application in the Provider Enrollment and Chain Ownership System (PECOS) under logging and tracking. For those applications that are denied, and contractors were able to detect this in the prescreening phase, it is not necessary to continue to develop the application. For further information regarding denial, refer to §14.3. *All original applications (regardless if denied, approved, or returned for additional information*) must be retained on file according to the records retention requirements listed in §21.

- Review the application to determine that it is complete and that all information and supporting documentation required for the applicant's provider/supplier type has been submitted on and with the appropriate Form CMS-855.

- Verify and validate the information collected on the Form CMS-855 using Qualifier.net.

- Share information with other carriers and intermediaries concerning any experiences during the enrollment process to help identify potential program integrity issues affecting other jurisdictions.
- Coordinate with state survey/certification agencies and CMS Regional Offices (ROs), as needed.

- Capture and maintain the application's certification statement (in house) to verify and validate *changes to a pay-to-address.* The change request signature must be checked against the original signature to determine the validity of any *change to a pay-to-address.* This check can be made against a digital/photo image kept in-house.

- Keep all applications, related information, and documentation in a secure environment. For further clarification, see §24. Note that these instructions are in addition to, and not in lieu of, any other instructions issued by CMS regarding security.

- Confirm that the applicant, all names and entities listed on the application, and any names or entities ascertained through the use of an independent verification source, are not presently excluded from the Medicare program by the HHS Office of Inspector General (OIG). This query shall be done through the Medicare Exclusion Database (MED). The MED replaced the OIG file, Pub.69. (Contractors can access MED through Qualifier.net.)

- Confirm that the applicant, all names and entities listed on the application, and any names or entities ascertained through the use of an independent verification source do not appear on the "List of Parties Excluded from Federal Procurement and Nonprocurement Programs (List of Parties)." This must be accomplished by using Qualifier.net.

- Confirm that enrolled providers and suppliers are reviewed against periodically/monthly updated versions of the OIG/MED. This is to ensure that billing privileges are not retained by providers/suppliers that become excluded after enrollment.

- Check the applicant's name and all names and entities listed on the application that show they have a Medicare identification number (or had one) against the Fraud Investigation Database (FID). If during the review contractors find that a name/entity has (or had) a Medicare identification number and did not disclose it has or had a Medicare identification number, contractors must check the name against the FID.

- Process applications within the time frames described in §15.

- Coordinate with the Benefit Integrity/PSC to determine patterns and relationships among providers and suppliers.

- Maintain a Web site and have the ability to link to the CMS Web site to access the application forms that providers/suppliers may, at a minimum, complete on-line, print, and mail (via hard copy).

- The NSC shall maintain a national master file of all DME suppliers and share that information with the DMERCs.

- Enter/update data on individual practitioners and other suppliers as applicable in the UPIN Registry.

- Review and investigate billing agency agreements (if necessary) and provider/supplier reassignments of Medicare payments to ensure full compliance with operational guidelines.

- Enroll Managed Care Organizations (MCOs) and assign billing numbers to allow for fee-for-service payments. This includes all MCOs that have a contract with CMS, to include *Medicare Advantage*. See §9 for further information.

3.1 - Processing the Application –

(Rev. 69, 03-26-04)

Section 1: General Application Information - Form CMS-855I and/or Form CMS-855B

The applicant must state the reason for submitting the application.

A. Reason for Submittal of this Application

1. Check one:

If the applicant fails to check any of the boxes to indicate why the application is being submitted, review the application to determine the reason for submittal. If the *contractor can make that determination without contacting the applicant*, continue to process the application. If contractors cannot make a determination, contact the applicant by telephone for additional information, see §14.1.

Initial Enrollment--Any individual/supplier who: (1) is enrolling in the Medicare program for the first time with the carrier under this tax identification number or (2) has already enrolled with another carrier but needs to enroll in the contractor's jurisdiction, would check this box. Also, if an applicant is seeking to reestablish him/herself in the Medicare program after reinstatement from an exclusion, the applicant would enroll as if it were an initial enrollment. Although the application would be checked as an initial enrollment, the individual/supplier would retain his/her original billing number so that CMS can continue to monitor if he/she meets the conditions of enrollment. New hospitals that are requesting enrollment with the carrier to bill practitioner services for hospital departments, outpatient locations and/or hospital clinics must check this box.

Reactivation--An applicant would check this box to reestablish billing privileges after deactivation for non-billing.

NOTE: The fact that a number has been deactivated does not change the status of an individual/supplier to have Medicare privileges. Therefore, if contractors receive an inquiry from the Medicaid office asking whether the supplier has a Medicare number, state, "YES." Regardless of whether the number is deactivated, the individual/supplier is still considered as having Medicare privileges. Do not confuse the status of a deactivated individual/supplier with one who has been revoked or has been denied Medicare privileges.

Prior to reactivating a billing number, the individual/supplier must be able to submit a valid claim. (The claim need not have ultimately been paid.) He/she must also meet all current requirements for that individual/supplier type, regardless of when he/she was previously enrolled in the program (unless stated otherwise in CMS regulations). When the individual/supplier reactivates his/her billing privileges, he/she is required to verify that the information on the contractor's file is current. This can be done by printing out what is currently on file or photocopying a previous

application and have the applicant sign a certification statement to state that the information is still true and accurate. If the applicant has never completed the Form CMS-855I or Form CMS-855B, request that he/she do so now.

If contractors have various forms on file, i.e., a Form CMS-855 and changes, request that he/she submit an enrollment form and provide contractors with the pay-to-address and practice location on Form CMS-855 (with any changes) along with a signed certification statement. If the applicant provides contractors with any changed data, contractors must verify the new information. If the data is the same as previously recorded, and the contractor is not revalidating the information, do not verify/validate the information as it has already been verified previously.

Change of Information--Any time a currently enrolled provider or supplier is adding, deleting, or changing information under the same tax identification number, it must report this change using the Form CMS-855. The applicant should check the appropriate changed section on the application in Section 1A1 and identify him/herself. Only the reported changes need to be completed on the application. For example, if an applicant is changing his/her correspondence address and a contact person is not listed, assume that the contact person is the same person as identified in the initial enrollment. The applicant is not required to provide a new application. Always require that the certification statement in §15 be signed and dated.

All change of information certification statements must be signed. Make sure the designated person signed for the change, however, an actual verification of the original signature on file is not necessary unless the change is a change to a pay-to-address. When the contractors receive a request to change a pay-to-address, compare the signature on file. Contractors may check the original signature on file against a photo/digital image. If the certification statement is not signed by the supplier or the certification statement signature does not match the name, determine the appropriate action as necessary. If contractors must confirm who is the appropriate party signing the application, the contractor can request it be notarized. This should only happen if contractors encounter a problem.

If the applicant is making a change to his/her practice location, and that location is in another state within the contractor's jurisdiction, request the state license with that change. Contractors must validate any change to a Pay-to-Address. See §4C "Pay-to-Address" for further instructions.

Voluntary Deactivation of Billing Number - Effective Date (MM/DD/YYYY)--When a supplier will no longer submit claims to the Medicare program, the individual/supplier closes its business or leaves a group practice, etc., it should voluntarily deactivate its number. This is to prevent any fraudulent abuse of the number. The applicant must provide the contractor with the date it stopped practicing under this number. This deactivation is different from an applicant who has not billed the program for 4 consecutive quarters. Any individual/supplier who is placed on a corrective action plan cannot deactivate its billing number to circumvent its agreement with Medicare.

Hospital Only - Change of Ownership--If a hospital is undergoing a formal CHOW in accordance with 42 C.F.R. 489.18 and the hospital desires to continue billing for practitioner services, then they should complete this box. The hospital is required to submit a separate Form CMS-855A to the intermediary. If as a result of a CHOW, the hospital desires to deactivate its billing number with the carrier, it should check voluntary deactivation of billing number.

If a Portable X-ray Facility or Ambulatory Surgical Center is undergoing a change of ownership in accordance with the general principles outlined in 42 CFR 489.18, it should check this box. See §8 of these instructions (enrolling certified suppliers who enroll with the carrier) for more information.

2. Social Security Number (SSN)/Tax Identification Number (TIN)

If contractors discover that an applicant has used a different SSN/TIN in the past, or is identified by a different number, deny the application; see §14.3, Denial 6. An application cannot be approved until all SSNs/TINs have been appropriately supplied and approved. Section 1124(a)(1) and 1124A(a)(3) of the Social Security Act require both SSNs and EINs on the Form CMS-855. The Social Security Administration (SSA) and the Secretary of the Treasury, through the IRS, verify that the SSNs and EINs collected match the disclosing individual/entity on the application. *An automatic verification occurs during data entry in PECOS. If during data entry the SSN shows that your record does not match what is on file, you must reconcile this with the applicant.*

If the SSN in PECOS shows "The SSN unverified", you will need to contact the applicant to discuss. If you can determine a number was transposed, or receive a rational reason for the number not matching, obtain the correct SSN and continue processing the application. One common reason a SSN does not match is because the SSA may not have the correct surname. In situations where a woman has changed her surname but has not contacted the SSA, PECOS will not validate the information. Determine if this is the cause for the error message. If the applicant can provide you a surname used previously, check to see if PECOS will accept the surname. Also, look at Qualifier.net to determine if this surname was used previously. (It is not a requirement to have the name shown on Qualifier.net but this may be a useful tool.) If yes, continue processing the application using the previously used surname. However, the name is still required to be matched in PECOS and the matching surname must be the one listed on the Form CMS 855. This may require a new certification statement. Inform the applicant that he/she must change his/her name with the SSA. When this has been accomplished, the Form CMS 855 must be updated to reflect the SSA change.

In situations where you cannot resolve the case, the person must be referred to the SSA. You should close the application until the situation is resolved. If you find an applicant with several surnames, SSN, and DOBs and it doesn't appear to be legitimate, deny the application based on your findings.

Contractors must also use Qualifier.net to identify any SSNs that may have been used previously. If a number is found in Qualifier.net that differs from the number on the application you must reconcile this issue. If contractors determine that this appears to be fraudulent, refer this to Benefit Integrity/PSC. For example, if the executive summary shows a different name and SSN than that associated with the applicant, this would be cause for referral. If an applicant does not provide a SSN/TIN as requested, request additional information and inform the applicant that steps can be taken to terminate the Medicare relationship. If all means to collect this information fail, deny the application. See §14.3-Denial 6. For those individuals who use a SSN as a tax identification number, validate the number as stated below.

Tax Identification Number (TIN)-31 U.S.C. 7701 requires that all individuals and entities doing business with the United States provide their TIN. The TIN can be either the SSN or an EIN, and appears with the legal business name used when reporting taxes to the IRS. Validate the TIN against IRS paperwork, such as a CP575 (a computer-generated form), a form 990, a quarterly tax payment coupon, or other IRS correspondence that contains the applicant's name and the TIN. Note that the documentation must come from the IRS. An application for a TIN is not acceptable. If an applicant cannot obtain the required IRS document, then an explanation must be given in a separate attachment and evidence provided that links the business name with the TIN listed. An applicant may request a verification letter (IRS 147c) from the IRS of their TIN and legal business name. For example, if a supplier changes its name and the IRS does not send an updated document, the supplier may then submit the old IRS document with the old name, as well as a copy of documentation filed with the state or IRS concerning the name change with an explanation of the situation. If the applicant fails to provide the contractor with this information, or it does not match, deny the application; see §14.3, Denial 6.

If an individual is using his/her own SSN to report earnings, the only validation that would need to be made is to confirm that the SSN belongs to that person. This should be done through *PECOS*. Therefore, no other Tax ID documentation is necessary when individuals use their own SSN for tax purposes. Carriers should not require additional tax documentation or social security cards in this situation. Additional documentation should only be submitted when an individual or entity doing business is using a number other than its SSN. *For example, an individual that forms a professional corporation or association or a sole proprietor requesting to use their employer identification number to receive Medicare payment.*

3. Is the supplier currently enrolled in the Medicare program?

This section will indicate if the applicant is currently enrolled in another carrier's jurisdiction. If yes, the applicant must list the name of the carrier and its assigned billing number. The applicant does not need to list prior numbers that are no longer active. Verify that the Medicare identification number is correct if reported.

If contractors find a number that was not reported, and it is active, request that the applicant provide additional information, see §14.1.

In some instances, contractors may need to contact other Medicare contractors for information regarding the supplier's status with that contractor; i.e., overpayments, pending adverse action or existing adverse action against the supplier, owner, or managing employee. Any carrier who receives this request must respond to the carrier's inquiry within five days absent extenuating circumstances. If the other carrier indicates suspicion or existence of fraud or other problems, alert Benefit Integrity/PSC and pend the application until directed otherwise. Contact the OIG if necessary.

3.2. - Identification

(Rev. 69, 03-26-04)

Section 2: Practitioner Identification - Form CMS-855I

A. Personal Information

Check each section to see whether the applicant is changing previous information. If yes, verify that the effective date is listed. If the applicant fails to provide contractors with an effective date, request additional information, see §14.1.

1-2. Contractors must verify that the applicant has completed the requested information and that the name on the license matches the name in this section. If for some reason the name does not match, and the contractor cannot verify that this is the same person, deny the application; see §14.3, denial.

2. If an applicant fails to list his/her middle initial, yet it is on the license, it is not necessary to request additional information. However, if a surname differs, and the applicant hasn't provided the contractor with proof of a name change (such as a marriage license, etc), the contractor shall request additional information; see §14.1. If contractors determine that the applicant does not have a license or is not authorized by the Federal/State/local government, deny the application; see §14.3, denial 2.

3. The applicant's date of birth, State, and country is used to uniquely identify the individual. If contractors discover that a date of birth does not match, by using Qualifier.net, contact the applicant, see §14.1. If the contractor finds any information that appears to be suspicious, contact Benefit Integrity/PSC and pend the application until directed otherwise.

4. Gender information is to assist in uniquely identifying the applicant. If the applicant fails to provide this information, contact the applicant by telephone, see §14.1.

5. Year of Graduation and Medical School. Verify this information with Qualifier.net. A physician does not need to provide a copy of his/her diploma unless the contractor requests it.

B - Correspondence Address

Check to see whether the applicant is changing previous information. If yes, make sure that the effective date is listed. If the applicant fails to provide an effective date, request additional information; see §14.1.

This section is to assist contractors in contacting the applicant with any questions or concerns you have with the application, such as fraud or abuse. This must be an address where the contractor can directly contact the applicant to resolve any issues that may arise as a result of his/her enrollment in the Medicare program. It cannot be an address of a billing agency, management services organization, or staffing company. It can be the individual's home address and telephone number.

Verify that the telephone number on the application is a number where the contractor can directly contact the applicant. Call the number on the application to verify that this is the applicant's personal number. If it is an answering service and the contractor can identify it as the applicant's personal service, it is not necessary to talk directly to the applicant. Contractors only need to verify, if necessary, that you are able to directly contact the applicant. If the applicant has not provided the contractor with this information, attempt to contact the person by telephone at

his/her practice location. If contractors cannot make contact with the applicant, request additional information; see §14.1. If contractors find that the applicant has noted a billing agency's address, attempt to contact the applicant at the practice location. If contractors are unable to reach the applicant directly, request additional information; see §14.1.

C - Residency Status

Check to see whether the applicant is changing previous information. If yes, make sure that the effective date is listed. If the applicant fails to provide the contractor with an effective date, request additional information; see §14.1.

1. If the applicant checks the box "resident" or "intern" or "fellowship program" at a hospital, refer to Part 3 MCM, §2020.8 for further instructions. If this is missing, continue to process the application under the assumption that it does not apply, unless there is a reason to question the data. If contractors believe that there is reason to question the information, request additional information; see §14.1.

2. If the applicant responded "Yes" to question 1, the applicant must answer the questions in this section.

3. If the applicant responded "Yes" to question 1, the applicant must answer the questions in this section.

4. If the applicant responded "Yes" to question 1, the applicant must answer the questions in this section.

D - Business Information (if applicable)

Check to see whether the applicant is changing previous information. If yes, make sure that the effective date is listed. If the applicant fails to provide contractors with an effective date, request additional information; see §14.1.

This section only needs to be completed if the applicant is practicing business under a name different from his/her individual name. If the information is missing, assume this does not pertain to the applicant.

1. If the applicant checks this section, continue to process the application.
2. Contractors need not verify the Legal Business Name and Tax Identification Number, as this data will be captured on the Form CMS-855B.

3. If an applicant indicates that he/she is incorporated, ask the applicant to complete the Form CMS-855B. This is the form used to enroll the individual's business. The applicant must also complete a Form CMS-855R to reassign his/her benefits to the business. Failure to complete the Form CMS-855B and Form CMS-855R will require contractors to enroll the applicant as an individual only. The business will not receive its own group number. If the applicant indicates that he/she is NOT incorporated but is a sole-proprietor, he/she only needs to indicate the business name on the Form CMS-855I. A sole proprietor does not need to complete the ownership portion

of the application nor does it need to complete the Form CMS-855B form and Form CMS-855R. Verify that the entity is not incorporated if it is listed as a sole-proprietor.

NOTE: For purposes of this question, limited liability companies and limited liability corporations shall be treated as corporations.

E - Medical Specialty(s)

Check to see whether the applicant is changing previous information. If yes, make sure that the effective date is listed. If the applicant fails to provide contractors with an effective date, request additional information; see §14.1.

Verify that the applicant is licensed to practice in all States/counties for which a business/practice location is shown. This also includes medical and professional licenses, as well as Federal/State/local business requirements, if applicable *through Qualifier.net*. For a non-physician practitioner who is not required to be licensed in the state for whom CMS has additional requirements, instruct the applicant of the necessary documentation required. Failure to meet the licensing or documentation requirements will result in a denial; see § 14.3, denial 2. For those specialties that require special educational requirements that the applicant does not meet, deny the application; see §14.3, denial 4.

All applicable business and professional licenses must be submitted and verified as valid, as well as Federal/State/local business requirements, if applicable. Note that if Qualifier.net verified the applicant's licensure, contractors need not obtain a copy of the applicant's license. The Qualifier.net verification is sufficient. If the state has a licensing body that issued the applicant a certificate of good standing, contractors can recognize it as adequate proof that an individual has received the license. However, the certificate of good standing cannot be older than 30 days.

If the applicant had a previously revoked or suspended license, certification or registration reinstated, require that the applicant submit a copy of the reinstatement notice(s) with the application. If a supplier submits a temporary license, note the expiration date. If the applicant fails to submit the permanent license after the temporary license expiration date, request additional information. Inactivate the billing number until all the required licenses are obtained and notify the supplier of this action.

Professional School Degrees or Certificates--Verify all the required educational information to ensure that it is complete and accurate for non-physician practitioners. The non-physician practitioner must meet all CMS requirements for education and must provide documentation of courses or degrees taken to satisfy Medicare requirements. If contractors find that the applicant does not meet educational requirements, deny the application; see §14.3, denial 2. A physician's state medical license is acceptable proof of meeting educational requirements.

1. Physician Specialty - Check to see whether the applicant is changing previous information. If yes, make sure that the effective date is listed. If the applicant fails to provide contractors with an effective date, request additional information; see §14.1. The physician must indicate his/her supplier specialty, showing "P" for primary and "S" for secondary. The physician must meet the requirements of the specialty indicated on the Form. If needed, instructions can be found in Part 3-MCM, §2207. If the applicant fails to provide contractors with a supplier specialty, continue to

process the application but request additional information if contractors are unable to determine the correct specialty code; see §14.1. Any time the individual does not meet the requirements of the specialty indicated on this form, deny the application; see §14.3, denial 2.

2. Non-Physician Specialty - Check to see whether the applicant is changing previous information. If yes, make sure that the effective date is listed. *If the applicant fails to provide contractors with an effective date, request additional information; see §14.1*. If the applicant fails to provide contractors with a supplier specialty, continue to process the application but request additional information if contractors are unable to determine the correct specialty code. See §14.1. Anytime the individual does not meet the requirements of the specialty indicated on this form, deny the application; see §14.3, denial 2.

A Nurse Practitioner (NP) who applies for a Medicare billing number for the first time on or after January 1, 2001, must be a registered professional nurse who is authorized by the state in which services are furnished to practice as a NP in accordance with state law and must be certified as a NP by a recognized national certifying body that has established standards for NPs. A NP who applies for a Medicare billing number for the first time on or after January 1, 2003, must meet the requirements stated in the previous sentence and must possess a Master's degree in nursing.

Enhanced qualifications for NPs only apply to those NPs applying for Medicare numbers for the first time on or after their effective date. Enhanced qualifications will not be required for NPs already enrolled in the Medicare program on the effective date of that enhanced qualification. For NPs previously enrolled in another carrier's jurisdiction, contractors must check the UPIN registry to verify their initial enrollment date prior to requiring they meet any of the enhanced qualification.

Diabetes Education, also known as Diabetes Self-Management Training or DSMT

Carriers are instructed that any provider/supplier already enrolled with them that wishes to bill for DSMT need not submit a new Form CMS-855B. Rather the provider/supplier need only submit the American Diabetes Association (ADA) certificate (or other CMS-recognized certification). If the provider/supplier is not enrolled with contractors (e.g., is a DMEPOS supplier only; is a supplier enrolled only with another carrier), it must complete a new Form CMS-855B.

Since DMERCs cannot pay DSMT claims, a DMEPOS supplier must separately enroll with its local Part B carrier, even if it has already completed a Form CMS-855S and is enrolled in the Medicare program. In order to file claims for diabetes education services, a DMEPOS supplier must also be certified by a CMS-approved national accreditation organization, or during the first 18 months after the effective date of the final rule, recognized by the ADA as meeting the national standards for DSMT as published in Diabetes Care, Volume 23, Number 5.

If contractors receive an application from a DMEPOS supplier that would like to bill for DMST, verify with the National Supplier Clearinghouse (NSC) that the applicant is currently enrolled and eligible to bill the Medicare program. Contractors can do this through Email using the following address: Medicare.nsc@palmettogba.com. Provide the contractor's Email address, the supplier's name, National Supplier Clearinghouse number, and tax identification number. Once the information is confirmed, contractors will receive a response from the NSC. If the applicant is an approved supplier and enrolled with the NSC, process the application in accordance with Chapter 10. Enroll the DMEPOS supplier using specialty code 87 to allow claims to be processed.

F - Supervising and/or Collaborating Physician

For those specialties that require a supervising and/or collaborating physician to qualify to bill the Medicare program, the applicant must list the physician(s) in this section. Verify that any physician shown has not been sanctioned/excluded from the Medicare program through Qualifier.net. If the supervising and/or collaborating physician is excluded, deny the application; see § 14.3, Denial 1. All supervising and/or collaborating physicians must be enrolled individually.

For non-physician practitioners who list more than one supervising and/or collaborating physician, only one supervising/collaborating physician will need to be captured in PECOS (note that physician assistants are required to furnish their services under the general supervision of a physician and that nurse practitioners and clinical nurse specialists are required to furnish their services in collaboration with a physician). Ask the applicant to provide his/her primary physician to create an enrollment record. For any other physicians listed, maintain the application to use for future reference if needed.

An exception to the rule above will be for anesthesiologist assistants (AAs). Because an AA requires direct supervision, all names listed on the application will need to be captured in PECOS. Any specialty that requires direct supervision will need to list all the physicians and all of the physicians will need to have an enrollment record established in PECOS.

For initial enrollments, revalidation of IDTFs, or changes, all supervising physicians must have a current enrollment record in PECOS.

When a service is furnished incident to the service of an ordering physician (or non-physician practitioner when allowed (NPP), and that ordering physician or NPP is not in the office suite, a physician or NPP in the same group must supervise the service. Because an incident to service requires direct supervision, all names listed on the application will need to be captured in PECOS. For incident to settings, all supervising physicians and NPP will need to have an enrollment record established in PECOS.

G - Clinical Psychologist – Questionnaire

All questions must be answered to determine the applicant's eligibility to bill Medicare.

1. If the applicant does not hold a doctoral degree in psychology, deny the application; see §14.3, Denial 4.

There are three different types of doctoral degrees in psychology that meet Medicare's requirements.

The first and most common is the Ph.D. or doctorate of philosophy degree. The critical factor is that the Ph.D. must be in psychology (as opposed to any other subject area). If this is the case, contractors may accept the diploma as sufficient evidence. If the diploma does not state "Doctor of Philosophy" followed by some specific subject area of psychology, follow instructions regarding contact with state licensing board or collect transcript information from the applicant.

The second type of doctoral degree that meets Medicare's requirement is the Psy.D. or doctorate of psychology degree. This degree is granted by programs that lean more heavily towards preparing students for clinical practice rather than research or teaching.

The third doctoral degree that would qualify as a doctoral degree in psychology for Medicare enrollment is the Ed.D. or doctorate of education degree. Again, the critical factor is that the person's Ed.D. must be in psychology. To illustrate, having an Ed.D. in counseling psychology would qualify someone to seek CP status, but having an Ed.D. in educational administration or curriculum design would not. If the diploma does not state “Doctor of Education” followed by some specific subject area of psychology, follow instructions regarding contact with state licensing board or collect transcript information from the applicant.

If the diploma does not indicate the specialty, there are two ways that contractors can verify that the individual's doctorate is in psychology.

The first way is to check with the licensing board in each state to determine whether a doctorate in psychology is required to obtain a license to practice as a clinical psychologist. The majority of states require this level of education in order to practice psychology independently. If you find that the state does require a doctorate in psychology as a requirement for licensure as a Clinical Psychologist, contractors may take the fact that the applicant has a license, along with the copy of the diploma, as sufficient evidence that the applicant meets Medicare’s educational requirements for a clinical psychologist. This is the preferred method to verify that the applicant meets Medicare’s educational requirements. If contractors choose this method of verification, each carrier must document in its procedures that the state licensure requirements for clinical psychologist require a doctorate in psychology. This way contractors do not need to develop for this additional information each time contractors receive a diploma that does not clearly state the area of study.

The second way is to request the applicant submit a graduate school transcript showing the concentration of study. The carrier must then review the transcript and make a subjective decision as to whether the program of study is focused in psychology. This is the least preferred method of verifying the applicant’s education as it requires review of the academic transcript and determination of a field of study for each doctoral degree diploma which does not identify the specialty area.

2. If the applicant does not agree to inform each Medicare beneficiary of the desirability to confer with the beneficiary’s primary care physician regarding the beneficiary’s medical condition, deny the application; see §14.3, Denial 4.

3. If the Medicare beneficiary assents to the consultation and the applicant does not agree to consult with the beneficiary’s primary care physician in accordance with accepted professional ethical norms, deny the application; see §14.3, Denial 4.

4. If the Medicare beneficiary assents to the consultation and the applicant does not agree to consult with the beneficiary’s primary care physician within a reasonable time, deny the application; see §14.3, Denial 4.

H. - Psychologists Billing Independently

Questionnaire--All questions must be answered in this section to determine the applicant's eligibility to bill Medicare.

1. If the Psychologist indicates that he/she does not render services free of the professional control of an employer such as a physician, institution or agency, deny the application; see §14.3, Denial 4.

2. If the applicant does not treat his/her own patients deny the application; see §14.3, Denial 4.

3. If the Psychologist indicates that he/she does not have the right to collect fees for the service rendered, deny the application; see §14.3, Denial 4.

4. If the Psychologist's private practice is located in an institution and he/she does not furnish services to patients in private office space maintained at his/her own expense, deny the application; see §14.3, Denial 4.

If the Psychologist submits changes to add a practice location(s), he/she must complete the Questionnaire.

5. If the Psychologist's private practice is located in an institution and he/she does not furnish services to patients other than the institution's patients, deny the application; see §14.3, Denial 4.

I - Occupational/Physical Therapist in Private Practice (OT/PT)

If the OT/PT submits changes to add a practice location(s), he/she must complete the questionnaire.

Questionnaire--If the applicant indicates that this is his/her specialty, he/she must respond to these questions. However, if an OT/PT plans to provide his/her services as a member of an established OT/PT group, an employee of a physician directed group, or as an employee of a non-professional corporation, and reassigns his/her benefits to that group, this section does not apply. This information will be established through the group application.

1. If the OT/PT checks that he/she renders all of his/her services in patients' homes, verify that he/she has an established private practice where he/she can be contacted directly and where he/she maintains patient records. Also, §4E of the Form CMS-855 should indicate where services are rendered (e.g., county, State, city of the patients' homes). Post office boxes are not acceptable.

2. If an applicant indicates that he/she does not maintain private office space, deny the application; see §14.3, Denial 4.

3. If the OT/PT does not own/rent/lease his/her space, deny the application; see §14.3, Denial 4.

4. If the OT/PT checks "No" that office space is not used exclusively for its private practice deny the application; see §14.3, Denial 4.

5. If the OT/PT checks "Yes" that he/she does provide services outside of his/her office or outside of a patient's home, e.g., health club, public pool, verify that the OT/PT has a copy of a lease agreement giving him/her the exclusive use of that facility to treat Medicare patients. If it does not, deny the application; see §14.3, Denial 4.

J. - Physician Assistants (PA) Only

Section 2F of Form CMS-855I addresses Supervising and/or Collaborating Physicians and pertains to all non-physicians practitioner (excluding PAs) who require a supervising and/or collaborating physician to qualify for Medicare billing privileges. Any reference to PAs in Section 2F Supervising and/or Collaborating Physician is incorrect. The reason Section 2F excludes PAs is because Section 2J has been designed to capture information regarding the physician identified on the PA's license or degree. Since not all States require the name, SSN and date of birth on the PA's license, this information is not readily available. Also, a PA may not be aware who would be supervising/directing him/her. Therefore, we are not requiring that it be submitted on Form CMS-855I. If the applicant submits the information, determine if the name(s) appears on *Qualifier.net*. However, it is not necessary to develop for the information.

If the applicant indicates that this is his/her specialty, the PA must provide all employer Medicare billing number(s) that will bill Medicare for his/her services. Review the section that shows who plans to bill for the PA services. Any entity or individual who bills for the PA services must be a supplier and must be enrolled with the carrier.

A PA cannot bill the program. Therefore, a PA has no benefits to reassign. In order to reassign, contractors must be able to receive the payment directly. Only employers who are entitled to enroll as a supplier can receive the payment for a PA.

Section 2: Supplier Identification - Form CMS-855B

A. Type of Supplier

1. Check One

Verify that the supplier is licensed to practice, as the supplier type checked, in all States/counties in which it lists a business/practice location. This includes medical and professional licenses, as well as Federal/State/local business requirements, if applicable. The supplier must meet the requirements of the specialty indicated on the application, i.e., a professional medical license must match the specialty type chosen. If the supplier does not have the appropriate license, deny the application; see §14.3, Denial 2.

If the applicant submits the license without its being notarized or "certified true," contractors must verify the license with the appropriate state agency. Contractors must use Qualifier.net if this is available for the supplier type. All applicable business and professional licenses must be submitted and verified as valid, as well as Federal/State/local business requirements, if applicable. If the state has a licensing body that issued the applicant a certificate of good standing, contractors can recognize it as adequate proof that it has received the license. However, the certificate of good standing cannot be older than 30 days.

If the applicant had a previously revoked or suspended license, certification or registration reinstated, require that the applicant submit a copy of the reinstatement notice(s) with the application.

If a supplier submits a temporary license, note the expiration date in the data system. If the applicant fails to submit the permanent license after the temporary license expiration date, request additional information and inactivate the billing number until all the required licenses are obtained. Notify the applicant of this action.

Radiology Offices--Prior to enrolling a radiology group practice, see the enrollment section for IDTFs. The carrier shall determine that the radiology group practice qualifies as a radiologist's office. This is necessary to allow the group practice of radiologists to bill for the technical component (TC) of diagnostic tests. A discussion of the criteria for distinguishing between an IDTF and a radiologist's office is shown in the IDTF section of the manual.

Hospitals that are applying for billing numbers for practitioner services must check the appropriate box. The carrier shall follow the guidance provided in the section entitled, "Processing Hospital Form CMS-855s." The carrier does not have to obtain a copy of the state license of the hospital. Notification that the hospital has received a provider agreement is adequate.

2. OT/PT Groups Questionnaire--If the therapy group, physician directed group, or non-professional corporation indicates that this is its specialty, it must respond to these questions. When OT/PTs are enrolled in groups, the group must complete the Questionnaire when submitting a change to add Practice Location(s).

a. If the group checks it renders services in a patient's home, verify that it has an established private practice where it can be contacted directly and where it maintains patients' records. Also, section 4E of Form CMS-855B must indicate where services are rendered; i.e., counties, states, city of the patients' homes.

b. When a group states that it does not maintain a private practice, deny the application; see §14.3, Denial 4.

c. Indicate if the group owns/rents/leases the space. If no, deny the application; see §14.3, Denial 4.

d. If the group checks “No” that office space is not used exclusively for its private practice deny the application; see §14.3, Denial 4.

e. If the group checks "Yes" that he/she does provide services outside of his/her office or outside of a patient's home, i.e., health club, public pool, verify that the OT/PT has a copy of a lease agreement giving him/her the exclusive use of that facility to treat Medicare patients.

3. If the supplier indicates that it will be receiving reassigned benefits from individual practitioners, verify that contractors have received a Form CMS-855R from each practitioner. Make sure that each practitioner has completed his/her own Form CMS-855I. If the supplier indicates "Yes" and a separate form is not received, continue to process the application but do not

allow the entity to receive reassigned benefits from an individual until all the appropriate forms are completed.

4. Hospitals Only - A hospital enrolling with the carrier to bill for practitioner services must complete this section.

B. Supplier Identification Information

1. Verify that the legal business name reported is the same name reported on the IRS documentation that was submitted with the application. If the legal business name is different than what is reported to the IRS, request additional information for clarification after contractors have finished reviewing it; see §14.1. Verify the date the business started. If contractors find a discrepancy, contact the applicant for additional information; see §14.1.

2. Capture the "doing business as" name as reported and the county/parish where the name is registered (if applicable).

3. Note the organizational structure for this supplier in the contractor's system.

4. Verify the incorporation date. Contractors can do this using Qualifier.net. If contractors find a discrepancy, contact the applicant for additional information; see §14.1. Contractors may request a copy of the supplier's "Articles of Incorporation" for validation purposes if contractors uncover a discrepancy.

C. Correspondence Address

This section is to assist contractors in contacting the applicant with any questions or concerns about the application. This must be an address where contractors can directly contact the applicant to resolve any issues that may arise as a result of its enrollment in the Medicare program. It cannot be an address of a billing agency, management services organization, or staffing company.

Verify that the telephone number on the application is a number where contractors can directly contact the applicant. Call the number on the application to verify that this is the applicant's personal number. If it is an answering service, and the contractor can identify it as the applicant's personal service, it is not necessary to talk directly to the applicant. Contractors only need to verify, if necessary, that contractors are able to directly contact the applicant. If the applicant has not provided contractors with this information, attempt to contact the person by telephone at his/her practice location. If the contractor cannot make contact with the applicant, request additional information; see §14.1. If contractors find that the applicant has supplied a billing agency's address, try to contact the applicant at the practice location. If the contractor is unable to reach the applicant directly, request additional information.

D. Accreditation (Ambulatory Surgical Centers (ASCs) Only)

Check to see whether the applicant is changing previous information. If yes, make sure that the effective date is listed. If the applicant fails to provide contractors with an effective date, request additional information; see §14.1.

1. Note if the ASC has been approved by an accredited organization in lieu of a state Agency.

2. Annotate the date accreditation was received. If this date is after the date it started business, notify the claims department. No claims can be paid prior to the date the entity received its accreditation.

3. Note the name of the accrediting body or organization.

3.4 - Practice Location

(Rev. 69, 03-26-04)

Section 4: Practice Location - Form CMS-855I

Verify that the practice locations listed on the application actually exist. Contractors must use Qualifier.net to verify if the information on the application is a good address. If for some reason the information is not shown on the executive summary, the contractor can make a telephone call directly to the applicant requesting additional information. For example, the carrier could request that the applicant provide letterhead showing the appropriate address if it wasn't available in Qualifier.net. If the address does not exist, deny the application; see §14.3, Denial 3, Individual Application

A. Group Practice Information

This section is used to determine if the individual plans to render services in a group setting. If yes, make sure that the applicant has provided the contractor with a Form CMS-855R for every group to which the individual plans to reassign benefits. Also, verify that the group has been enrolled in the Medicare program.

1. If an individual plans to render all of his/her services in a group setting, he/she must check this section. Also, the individual must provide the name of the group (a) and the group's Medicare number in the space provided. If the individual is affiliated with more than three groups, he/she must copy this page to list any additional group affiliations. If the group has not yet been enrolled, contractors must first enroll the group prior to approving the reassignment. Once the applicant has provided the contractor with this information, he/she must complete §15.

2. If an individual is only rendering Part of his/her services in a group setting, he/she would complete this section. The applicant would list the group's name (a) that he/she has an affiliation with and its Medicare number in the space provided. Require that the applicant provide a Form CMS-855R for every group to which he/she plans to reassign benefits. Verify that the group has been enrolled in the Medicare program. If the group has not been enrolled, contractors must first enroll the group prior to approving the reassignment.

B. Practice Location Information

Check to see whether the applicant is adding, deleting, or changing previous information. If he/she is, make sure that the effective date is listed. If the applicant fails to provide contractors with an effective date, request additional information; see §14.1.

1. Indicate where services are rendered, including all hospitals and/or other health care facilities in this section. The practice name can be a "Doing Business As Name".
   Date Started at this Location.--Use this date as the date the applicant can begin to bill the program following approval after determining the applicant had a license prior to that date. In situations where the date appears to be beyond a reasonable amount of time, such as older than 12 months, contact the applicant by telephone. Ask the applicant to provide contractors a date that he/she started seeing Medicare patients. Contractors need to ensure

the 12 month deactivation initiative will not remove the new applicant from the file for any date that is used. If this information is missing, request it in writing.

2. The applicant must list each address where services are rendered, including all hospitals and/or other health care facilities in this section. A practitioner who renders services only in patients' homes (house calls) must supply his/her home address in this section. If an individual practitioner renders services in a retirement or assisted living community, this section must be completed by using the names and addresses of those communities. Verify that these addresses are physical addresses. Post office boxes and drop boxes are not acceptable for these addresses. If contractors are unable to verify the address, deny the application according to §14.3, Denial. 3. If all the information is not provided, see procedures in §14.1 and request additional information. Verify this information through Qualifier.net. Also verify that the telephone number reported is operational and connects to the practice location/business that is listed on the application. The telephone number must be a number where patients and/or customers can reach the applicant to ask questions or register complaints. 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 practice locations are in the contractor's jurisdiction and he/she maintains no operable telephone number at those practice sites or if he/she operates a mobile Unit. Match the applicant's telephone number with known, in-service telephone numbers using Qualifier.net to correlate telephone numbers with addresses. If contractors cannot verify the telephone number, complete the application verification process and request corrected information. If contractors suspect fraud or abuse, contact Benefit Integrity/PSC. The inability to confirm a telephone number may be an indicator to do an onsite visit. If contractors have an applicant who is using a cell phone for their business, contractors must verify that this is a telephone connected directly to its business.

3. *For those individuals who are receiving reassigned benefits ensure that provisions in Publication 100-04, Chapter 1, Section 30.2 are met.*

4. Annotate if the practice location is any of the locations listed.

5. The applicant must list any CLIA or FDA Mammography Certification Numbers (if applicable). If the applicant fails to provide contractors with the certification number, and the contractor is aware that he/she does have one, request additional information. See §14.1. If the applicant provides contractors with an incorrect number request additional information/clarification.

C. Medicare Payment "Pay To" Address Information

If an applicant indicates that payments are going to an address other than the reported practice location address, update the system. This address may be a post office box. If payment is being made to an agent, verify that the billing agreement/contract information questions in Section 8C of Form CMS-855 are appropriately answered. If the response to questions in Section 8C give rise to questions or concerns, the contractor must request a copy of all agreements/contracts associated with this billing agency. If the payments are being sent electronically, verify that an Electronic Funds Transfer (EFT) Authorization Agreement has been signed. When an EFT

Authorization agreement is submitted, verify the bank account is in compliance with *Publication 100-04, Chapter 1, Section 30.2*. Anytime a change is made to the EFT Authorization agreement, the provider enrollment staff must review this change to verify it complies with *Publication 100-04, Chapter 1, Section 30.2*.

If a provider submits Form CMS-855 (along with Form CMS-588) and states he/she is using EFT and later notifies the contractor's accounting department that he/she is changing their account to a different bank, the provider enrollment staff would need to be involved. The accounting department must forward the new Form CMS-588 form to the provider enrollment staff. The PE staff must review Form CMS-588 to determine whether all banking information complies with *Publication 100-04, Chapter 1, Section 30.2*. We view a change to Form CMS-588 as a change to the pay-to-address. If the contractor's accounting department notifies PE staff that they received a Form CMS-588, and the supplier has never completed an enrollment application, he/she must complete one. Although Form CMS-855 may not reflect the above change in the pay-to-address section of the form, as this address may be used for hardcopy checks and remittance advices, contractors must verify/validate the managers/owners, legal business name, signatures, etc. Therefore, it is necessary to obtain a new Form CMS-855. If, however, the supplier has completed an enrollment form, the contractor must check the signature on Form CMS-588 form against signatures on the Form CMS-855 on file. A new Form CMS-855 is not necessary. All the validation requirements as listed below must be followed. Once verifications are complete, a copy of the Form CMS-588 must be attached to the existing (or new) Form CMS-855 on file. The original Form CMS-588 can be maintained in accounting.

For those applicants who request a change to the "Pay To" address, we are requiring carriers to examine closely any request for an address change to ensure that the request is from the supplier in question. For a change to a "Pay To" address, the carrier must follow these procedures:

1. If the applicant has never completed an entire Form CMS-855 (or had previously submitted Form CMS-855s on file) the contractor shall develop for an entire Form CMS-855 reflecting the request to change the "Pay To" address. Verify and validate all the information provided. If, however, the carrier has on file previous Form CMS-855 changes from this entity/individual, and this entity has an authorized official/delegated official signature on file, do not develop for an entire application. You shall, however, compare signatures from your files against the request for a pay-to-address change.

2. *Anytime you are suspicious of a change to a pay-to-address,* check billing records to determine if the supplier has billed the program within 3 months. If the supplier has billed the program, continue with the next step. If the supplier has had no billing activity within 3 months, contact Benefit Integrity/Program Safeguard Center (PSC) to determine if there has been any suspicious conduct or activity. The Benefit Integrity/PSC must verify that this is an appropriate change. If it is determined that this request appears to be legitimate, continue with the processing of the application. Of course if the change appears to be suspicious, the Benefit Integrity/PSC will pursue as necessary and pend the application. Any time a supplier has been deactivated for-nonbilling, he/she will be required to verify that the enrollment data on file is still current/valid.

If the applicant was previously enrolled using Form CMS-855, verify the signature on the Form CMS-855 reflecting the change in the "Pay To" address against the existing signature to make

sure that they match. When the applicant requests a telephone number change at the practice location with a change to the "Pay To" address, call the number listed on the contractor's supplier file first. If the number on file is still active, attempt to speak with the supplier/authorized representative/delegated official who requested the change to verify the validity of the change. If contractors receive a directory assistance message changing the old number to a new number, and that number matches the supplier's request for change, contact the supplier at the new number. Inform the supplier you are making sure that this is a legitimate request for change. Although the enrollment unit may not always be able to reach the supplier directly, make every attempt to speak with the supplier/authorized representative/delegated official and not a staff member. If the supplier cannot be reached or a telephone number change seems suspicious, annotate the file and contact Benefit Integrity/PSC. If the change appears to be legitimate, continue with the update.

The carrier must follow the Do Not Forward initiative instructions as written in Pub. 100.4, Chapter 1, Section 80.5. Returned mail in the form of remittance advices and checks should be flagged if returned from the post office. Returned mail that is received from the post office box that is not a remittance advice or a check should not be considered DNF mail.

Returned mail in the form of remittance advices and checks indicates a change of a pay-to-address has been made. If the entity/individual has never completed the Form CMS-855I/B, one must be completed. If, however, the carrier has on file previous Form CMS-855 changes from this entity/individual, and this entity has designated an authorized official/delegated official signature on file, do not develop for an entire application. You shall, however, compare signatures from your files against the request for a pay-to-address change. Do not develop for an entire application in these cases where a certification statement is on file.

In situations where a provider/supplier is closing his/her business and has a termination date, i.e., he/she is retiring, the contractor will still need to make payment for prior services rendered. Since the practice location has been terminated, *and a request to change where the check should be sent*, the contractor may encounter a DNF message. In these situations, contractors can request the retired physician to complete the Pay-to-address section of the Form CMS-855 along with the certification statement. Do not collect any other information unless you have a need to do so.

D. Location of Patient Records.

Check to see whether the applicant is changing previous information. If yes, make sure that the effective date is listed. If the applicant fails to provide contractors with an effective date, request additional information; see §14.1.

The applicant must report where records are kept for each practice location. If the records are kept at the practice location shown in §4B, the applicant can skip this section. If the address is different than that of a practice location, indicate where the records are stored.

If the applicant does not have a place where he/she stores records, the application must be denied according to §14.3, Denial 3. Records kept at a storage location must be indicated. If the applicant leaves this section blank, see procedures in §14.1 and request additional information. Post office boxes and drop boxes are not acceptable as the physical address where patient records are maintained.

E. Comments

This section is used to capture any unique or unusual circumstances concerning the supplier's practice location(s) or the method by which the supplier renders health care services. Contractors must determine that the information provided is acceptable under current Medicare rules and is accurate.

Section 4: Practice Location - Form CMS-855B

A. Practice Location

Check to see whether the applicant is adding, deleting, or changing previous information. If yes, make sure that the effective date is listed. If the applicant fails to provide contractors with an effective date, request additional information; see §14.1.

1. The applicant must list each location where services are rendered, including all hospitals and/or other health care facilities in this section. The practice name can be the "Doing Business As Name."

Date Started at this Location. --Use this date as the date the applicant can begin to bill the program following approval. Be sure to determine, however, that the applicant had a license prior to that date. In situations where the date appears to be beyond a reasonable amount of time, such as older than 12 months, contact the applicant by telephone. Ask the applicant to provide a date that he/she started seeing Medicare patients. Contractors need to ensure the 12-month deactivation initiative will not remove the new applicant from the file for any date that is used. If this information is missing, request it in writing.

2. Verify that the address(es) listed is/are physical addresses. Post office boxes and drop boxes are not acceptable for those addresses. Contractors cannot just make a telephone call to validate this information. At the very least, use Qualifier.net to verify a good address to help make this determination--as well as telephone the applicant's number. If contractors are unable to verify the address, deny the application according to §14.3, Denial 3. If information is not provided, see procedures in §14.1 and request additional information. Match the applicant address with known addresses using Qualifier.net.

NOTE: For Ambulatory Surgical Centers (ASCs) and Portable X-ray suppliers if the applicant's address and or telephone number cannot be verified by use of Qualifier.net, then contact the applicant. If they advise that the facility and its phone number have not yet been completed, continue processing the application and annotate the file. However, a note shall be placed on any recommendation for approval that the address and the telephone number of the facility could not be verified pending completion of the facility. In this case, the Date Started at this Location item can also be left blank. For PECOS entry, when available, put in the date that the Certification Statement was signed, for the practice location start date. Don't pay claims until the notification that the supplier meets the certification requirements have been received. For IDTFs if the applicant's address and or telephone number cannot be verified by use of Qualifier.net, then contact the applicant. If they advise that the facility and its phone number have not yet been

completed, continue processing the application. These items shall be checked at the required site visit. The same guidance concerning address and telephone number verifications for ASCs, portable-x-ray suppliers, and IDTFs stated above shall apply if the applicant utilizes a Base of Operations for its practice location information.

Contractors can verify through contact with the appropriate state agency or Qualifier.net, if needed, the date incorporated or established as identified by the supplier on the application. Match the applicant's telephone number with known, in-service telephone numbers using industry-recognized software. The software must correlate telephone numbers with addresses. The telephone number must be a number where patients and/or customers can reach the applicant to ask questions or register complaints. 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 practice locations are in the contractor's jurisdiction and he/she maintains no operable telephone number at those practice sites. If contractors cannot verify the telephone number, complete the application verification process and request corrected information.

If the group is using a cell phone, contractors must conduct further investigations as to why it would conduct business this way. If contractors need further guidance, contact the RO.

3. For an entity that is receiving reassigned benefits from contractors, determine if the entity owns or leases the practice location. For those who received reassigned benefits from independent contractors, determine it meets criteria as instructed in *the Publication 100.04, Chapter 1, Section 30.2*.

4. The applicant must list any CLIA or FDA Mammography Certification Numbers (if applicable).

B. Mobile Facility and/or Portable Units

Check to see whether the applicant is changing previous information. If yes, make sure that the effective date is listed. If the applicant fails to provide contractors with an effective date, request additional information; see §14.1.

If the applicant indicates that it is providing services from a mobile facility or portable unit, it must complete section 4C through 4E about the mobile/portable services on the Form CMS-855B. If the applicant fails to check this box, continue to process the application and assume it does not operate services from a mobile facility or portable unit. However, if contractors suspect something different, contact the applicant for additional information; see §14.1.

C. Base of Operations Address

Check to see whether the applicant is changing, adding, or deleting previous information. If yes, make sure that the effective date is listed. If the applicant fails to provide contractors with an effective date, request additional information; see §14.1.

1. If the supplier answered "yes" in B, the base of operations name and the date the supplier started practicing at this location must be captured in this section. If the applicant fails to provide contractors with this information, request additional information; see §14.1.

2. This address must be one from where the personnel are dispatched, where the mobile/portable equipment is stored and when applicable, where vehicles are parked when not in use. The telephone number, fax number and applicable E-mail address must be captured for the base of operations. If the applicant fails to provide contractors with this information, deny the application according to §14.3, Denial 3.

D. Vehicle Information

Check to see whether the applicant is changing previous information. If yes, make sure that the effective date is listed. If the applicant fails to provide contractors with an effective date, request additional information; see §14.1.

This section captures information about the mobile unit when services are rendered in the vehicle. For portable services (e.g., where the equipment is removed from a van, etc., and is used in a fixed setting), information concerning how the equipment was transported would not be captured in this space. If this section is blank, assume that the services are not rendered inside a vehicle unless contractors have data that shows that they are providing medical services inside a vehicle. If contractors find this, request additional information. If none is forthcoming, deny the application according to §14.3. Denial 3.

1-3. Capture the vehicle information. A copy of all health care related permit(s), license(s), and registration(s) must be submitted for each vehicle reported. If the applicant fails to provide contractors with this information, deny the application according to §14.3, Denial 3 unless contractors are able to verify this information through Qualifier.net (See §14 for additional information.)

E. Geographic Location where the Base of Operations and/or Vehicle Renders Services

Check to see whether the applicant is changing previous information. If yes, make sure that the effective date is listed. If the applicant fails to provide contractors with an effective date, request additional information; see §14.1.

1. Initial Reporting and/or Additions

This section captures where the supplier renders services to Medicare beneficiaries in its mobile unit. For those mobile units that cross state lines, the supplier must complete a separate Form CMS-855 enrollment application for each carrier jurisdiction in which it provides services. If the applicant fails to provide contractors with this information, request additional information.

2. Deletions

The applicant would provide contractors this information if it is deleting a location where mobile or portable services were provided.

F. Pay-to-Address

If an applicant indicates that payments are going to an address other than the reported practice location mailing address, place that information into PECOS. This address may be a post office box. If contractors determine that contractors are making payment to an agent, (See Section 8 of the application) determine that billing agreement follows all the requirements outlined in the *Publication 100-04, chapter 1, Section 30.2*. If the payments are being sent electronically, verify that an EFT agreement has been signed by the appropriate official shown on Form CMS-855B. When an EFT agreement is submitted, verify the bank account is in compliance with the *Publication 100-04, Chapter 1, Section 30.2.*

Electronic Funds Transfer Changes

If a supplier submits Form CMS-855 (along with Form CMS-588) and states he/she is using EFT and later notifies the contractor's accounting department that he/she is changing their account to a different bank, the provider enrollment staff would need to be involved. The accounting department must forward the new Form CMS-588 to the provider enrollment staff. The PE staff must review the Form CMS-588 to determine whether all banking information complies with the *Publication 100-04, Chapter 1, Section 30-2*. We view a change to Form CMS-588 as a change to the pay-to-address. If the contractor's accounting department notifies PE staff that they received a Form CMS-588, and the supplier has never completed an enrollment application, he/she must complete one.

When completing a Form CMS-855, the EFT address may not be reflected in the pay-to-address section of the form, as this address may be used for hardcopy checks and remittance advices. However, contractors must verify/validate the managers/owners, legal business name, signatures, etc. Therefore, it is required to obtain a new Form CMS-855. If, however, the supplier has completed an enrollment form, the contractor need only to check the signature on the Form CMS-588 against signatures on the Form CMS-855 on file. A new Form CMS-855 is not necessary. All the validation requirements listed below must be followed. Once verifications are complete, a copy of the Form CMS-588 must be attached to the existing (or new) Form CMS-855 on file. The original Form CMS-588 can be maintained in accounting.

For those applicants who request a change to the "Pay To" address, we are requiring carriers to examine closely any request for an address change to ensure that the request is from the supplier in question. For a change to a "Pay To" address, the carrier must follow these procedures:

1. *If the applicant has never completed an entire Form CMS-855 (or had previously submitted Form CMS-855s on file) the contractor shall develop for an entire Form CMS-855 reflecting the request to change the "Pay To" address. Verify and validate all the information provided. If, however, the carrier has on file previous Form CMS-855 changes from this entity/individual, and this entity has an authorized official/delegated official signature on file, do not develop for an entire application. You shall, however, compare signatures from your files against the request for a pay-to-address change.*

2. *If the carrier is suspicious of the request for a pay-to-address,* check billing records to determine if the supplier has billed the program within 3 months. If the supplier has billed the program, continue with the next step. If the supplier has had no billing activity within 3 months, contact Benefit Integrity/PSC to determine if there has been any suspicious conduct or activity.

The Benefit Integrity/PSC must verify that this is an appropriate change. If it is determined that this request appears to be legitimate, continue with the processing of the application. Of course if the change appears to be suspicious, the Benefit Integrity/PSC will pursue as necessary and pend the application. Any time a supplier has been deactivated for-nonbilling, he/she will be required to verify that the enrollment data on file is still current/valid.

If the applicant was previously enrolled using Form CMS-855, verify the signature on Form CMS-855 reflecting the change in the "Pay To" address against the existing signature to make sure that they match. When the applicant requests a telephone number change at the practice location with a change to the "Pay To" address, call the number listed on the contractor's supplier file first. If the number on file is still active, attempt to speak with the supplier/authorized representative/delegated official who requested the change to verify the validity of the change. If the contractor receives a directory assistance message changing the old number to a new number, and that number matches the supplier's request for change, contact the supplier at the new number. Inform the supplier you are making sure that this is a legitimate request for change. Although the enrollment unit may not always be able to reach the supplier directly, make every attempt to speak with the supplier/authorized representative/delegated official and not a staff member. If the supplier cannot be reached or a telephone number change seems suspicious, annotate the file and contact Benefit Integrity/PSC. If the change appears to be legitimate, continue with the update.

The carrier must follow the Do Not Forward initiative instructions as written in Pub. 100.4, Chapter 1, Section 80.5. Returned mail in the form of remittance advices and checks should be flagged if returned from the post office. Returned mail that is received from the post office box that is not a remittance advice or a check should not be considered DNF mail.

Returned mail in the form of remittance advices and checks indicates a change of a pay-to-address has been made. Procedures for pay-to-address requests should be followed.

In situations where a provider/supplier is closing his/her business and has a termination date, i.e., he/she is retiring, the contractor will still need to make payment for prior services rendered. Since the practice location has been terminated, and a request to change where the check should be sent, the contractor may encounter a DNF message.

G. Location of Patient Records

1. The applicant must report where records are kept for each practice location. If the records are kept at the practice location shown in Section 4Aor 4C, the applicant can skip this section.

2. If the address is different than that of a practice location, indicate where the records are stored.

If applicant does not have a place where it stores records, the application must be denied according to §14.3, Denial 3. Records kept at a storage location must be indicated. If the applicant leaves this section blank, request additional information. Post office boxes and drop boxes are not acceptable as the physician address where patient records are maintained. All record requirements must be in conformance with Medicare regulations governing the reopening of a claim/cost report, etc.

H. Comments

This section is used to capture any unique or unusual circumstances concerning the supplier's practice location(s) or the method by which the supplier renders health care services. Contractors must determine that the information provided is acceptable under current Medicare rules.

3.6 - Ownership and Managing Control Information (Individuals) –

(Rev. 69, 03-26-04)

Section 6: Managing Employee Information - Form CMS-855I

The individual practitioner must furnish information about any and all managing employees. For purposes of this section, a managing employee is defined as any individual, including a general manager, business manager, office manager or administrator, who exercises operational or managerial control over the applicant's business/practice, or who conducts the day-to-day operations of the business/practice. For Medicare enrollment purposes, a managing employee also includes any individual who is not an actual employee but who, either under contract or through some other arrangement, manages the day-to-day operations of the practice/business.

NOTE: No information on ownership should be reported in this section.

All managing employees at any of the applicant's practice locations listed in Section 4B must be reported. However, individuals who (1) are employed by hospitals, health care facilities, or other organizations shown in Section 4B (e.g., the CEO of a hospital listed in Section 4B) or (2) are managing employees of any group/organization to which the practitioner will be reassigning his/her benefits, should not be reported.

A. Check Box

This box should be checked if there are no managing employees. If the applicant fails to check the box and no managing employees are listed, contact the applicant to request additional information; see §14.1.

B. Identifying Information

Check to see whether the applicant is adding, deleting, or changing information on an existing managing employee. If one of these boxes is checked, make sure that an effective date for the change is listed. If the boxes for effective date of Ownership or Effective Date of Control have not or cannot be completed, the application can be processed without further discussion with the applicant.

The name, Social Security Number (SSN), date of birth, and Medicare identification number of the employee must be provided. Section 1124(a)(1) and §1124A(a)(3) of the Social Security Act requires that the supplier furnishes the individual's SSN. If the applicant fails to provide this information, deny the application; see §14.3, Denial 6.

An automatic verification occurs during data entry in PECOS. If during data entry the SSN shows that your record does not match what is on file, you must reconcile this with the applicant.

If the SSN in PECOS shows "The SSN unverified", you will need to contact the applicant to discuss. If you can determine a number was transposed, or receive a rational reason for the number not matching, obtain the correct SSN and continue processing the application. One

common reason a SSN does not match is because the SSA may not have the correct surname. In situations where a woman has changed her surname but has not contacted the SSA, PECOS will not validate the information. Determine if this is the cause for the error message. If the applicant can provide you a surname used previously, check to see if PECOS will accept the surname. Also, look at Qualifier.net to determine if this surname was used previously. (It is not a requirement to have the name shown on Qualifier.net but this may be a useful tool.) If yes, continue processing the application using the previously used surname. However, the name is still required to be matched in PECOS and the matching surname must be the one listed on the Form CMS 855. This may require a new certification statement. Inform the applicant that he/she must change his/her name with the SSA. When this has been accomplished, the Form CMS 855 must be updated to reflect the SSA change.

In situations where you cannot resolve the case, the person must be referred to the SSA. You should close the application until the situation is resolved. If you find an applicant with several surnames, SSN, and DOBs and it doesn't appear to be legitimate, deny the application based on your findings.

The practitioner should also indicate whether the managing employee is actually employed by him/her (e.g., W-2 employee). It is within the carrier's discretion to obtain a copy of the W-2 to verify employment. The contractor may request a copy of a pay stub, or any other validation source that shows employment in situations that are suspect.

C. Adverse Legal History

See Section 5B for general instructions concerning this section. Note that Section 6C would only need to be completed by actual W2 employees of the supplier. Those managing employees that have a contractual relationship with the supplier must, of course, be reported in Section 6B, but would not need to furnish data in Section 6C.

D-E. Identifying Information

This is to allow the applicant to identify more than one managing employee.

Section 6: Ownership and/or Managing Control Information (Individuals) - Form CMS-855B

Before proceeding with the instructions for Section 6, you may wish to review the explanation of the term "ownership" listed in Section 5. Although the explanation there refers to the applicant as the "enrolling supplier," the definitions and explanations for ownership have the same applicability to individuals.

For purposes of this application, the terms "officer," "director," and "managing employee" are defined as follows:

- Officer--any person whose position is listed as being that of an officer in the supplier's "Articles of Incorporation" or "Corporate Bylaws," OR anyone who is appointed by the board of directors as an officer in accordance with the supplier's corporate bylaws.
- Director--a member of the supplier's "Board of Directors." It does not include a person who

may have the word "Director" in his/her job title (e.g., Departmental Director, Director of Operations). Note, however, that a person who has the word "Director" in his/her job title may be a "managing employee," as defined below. Moreover, where a supplier has a governing body that does not use the term "Board of Directors," the members of that governing body will still be considered "Directors." Thus, if the supplier has a governing body titled "Board of Trustees" (as opposed to "Board of Directors"), the individual trustees are considered "Directors" for Medicare enrollment purposes.

- Managing Employee--Any individual, including a general manager, business manager, or administrator, who exercises operational or managerial control over the supplier, or who conducts the day-to-day operations of the supplier. For purposes of this section, "managing employee" also includes individuals who are not actual employees of the supplier but who, either under contract or through some other arrangement, manage the day-to-day operations of the supplier.

The following individuals must be reported in §6A:

- All persons with 5 percent or more ownership (direct or indirect) of the enrolling supplier,
- If (and only if) the supplier is a corporation (whether for-profit or non-profit), all officers and directors of the supplier,
- All managing employees of the supplier, and
- All individuals with a Partnership interest in the supplier, regardless of the percentage of ownership the Partner has.

NOTE: All Partners within a Partnership must be reported on the application. This applies to general and limited Partnerships. For instance, if a limited Partnership has several limited Partners and each of them only has a 1 percent interest in the entity, each limited Partner would have to be listed on the application, even though each owns less than 5 percent. The 5 percent ownership threshold primarily applies to corporations and other organizations that are not Partnerships.

Contractors must use Qualifier.net to identify individuals who may have this type of relationship with the applicant. If during a managing employee's search, a name appears that was not listed on the application, query that name against Qualifier.net (for MED/GSA data), the *FID (if applicable)*. If the contractor finds that this person was excluded or debarred, deny the application; see §14.3, Denial 1. If this person is on the *FID*, process according to §16.1 and §16.2, respectively. If contractors find a name that was otherwise not reported, request additional information.

A. Individual with Ownership and/or Managing Control-Identification Information

Check to see whether the applicant is adding, deleting, or changing information on an individual in this section. If the boxes for effective date of Ownership or Effective Date of Control have not or cannot be completed, the application can be processed without further discussion with the applicant.

Remember that individuals must be listed here in Section 6. No organizations should be listed in this section. If the applicant fails to check the box and there are no managing individuals listed, contact the applicant to request additional information; see §14.1.

Note that there must be at least one managing employee listed in this section.

1. The name, SSN, date of birth, and Medicare identification number of the individual must be provided. §1124(a)(1) and §1124A(a)(3) of the Social Security Act require that the supplier furnish us with the individual's SSN. If the applicant fails to provide the contractor with this information, deny the application; see §14.3, Denial 6. Should the supplier list an owning/managing individual in 6A1, it must also complete either 6A2, or 6A3 and 6A4. If the applicant fails to indicate in these sections which organization the individual is associated with, and what role that person has in the organization, verify this data with the applicant.

2. If the individual listed in Section 6A is directly associated with the enrolling supplier, the supplier should indicate this in this section.

3. If the individual listed in Section 6A is directly associated with an organization listed in Section 5B (e.g., the owning/managing organization), the legal business name of that organization the individual is associated with should be listed.

4. If the applicant lists the legal business name of the owning/managing organization in Section 6A3, it should also indicate in 6A4 the relationship that individual has with that organization.

B. Adverse Legal History

1. For each individual listed in this section, check the name and SSN or Medicare/Medicaid numbers against Qualifier.net (which contains *MED and GSA data)*. The individual must be checked against the aforementioned database(s) regardless of whether the enrolling supplier states in this section that the individual has never had an adverse legal action imposed against him/her. If the individual is excluded or debarred, deny the application and explain the reason(s) for denial; see §14.3, Denial 1. If the applicant indicates that the individual has had an adverse legal action imposed against it but Qualifier.net does not report this, contact the OIG and/or Benefit Integrity/PSC to determine whether this can and should form the basis of an exclusion. Hold (but continue processing) the application until the OIG decides whether the adverse legal action should result in an exclusion. If the OIG imposes an exclusion, deny the application. If not, continue processing the application.

If the individual appears on the FID, process the application according to §16.1.

An automatic verification occurs during data entry in PECOS. If during data entry the SSN shows that your record does not match what is on file, you must reconcile this with the applicant.

If the SSN in PECOS shows "The SSN unverified", you will need to contact the applicant to discuss. If you can determine a number was transposed, or receive a rational reason for the number not matching, obtain the correct SSN and continue processing the application. One common reason a SSN does not match is because the SSA may not have the correct surname. In situations where a woman has changed her surname but has not contacted the SSA, PECOS will not validate the information. Determine if this is the cause for the error message. If the applicant

can provide you a surname used previously, check to see if PECOS will accept the surname. Also, look at Qualifier.net to determine if this surname was used previously. (It is not a requirement to have the name shown on Qualifier.net but this may be a useful tool.) If yes, continue processing the application using the previously used surname. However, the name is still required to be matched in PECOS and the matching surname must be the one listed on the Form CMS 855. This may require a new certification statement. Inform the applicant that he/she must change his/her name with the SSA. When this has been accomplished, the Form CMS 855 must be updated to reflect the SSA change.

In situations where you cannot resolve the case, the person must be referred to the SSA. You should close the application until the situation is resolved. If you find an applicant with several surnames, SSN, and DOBs and it doesn't appear to be legitimate, deny the application based on your findings.

2. If the applicant indicates that the individual has had an adverse legal action imposed against him/her, make sure that the applicant provides information concerning the type and date of the action, and what court(s) and law enforcement authorities were involved. Also, documentation that evidences the imposition/notification and resolution of the adverse action must be submitted (e.g., notification of disciplinary action, criminal court documents). If the individual was excluded but has since been reinstated, verify this through the OIG and ask the applicant to submit written proof (e.g., reinstatement letter) indicating that such reinstatement has in fact taken place.

4.3 - Qualification of Crew

(Rev. 69, 03-26-04)

3. Qualification of Crew

Check whether the applicant is adding, deleting, or changing information pertaining to a crewmember. If so, an effective date must be listed.

Information identifying each crewmember must be submitted *for initial applications*. *However, for PECOS purposes, do not develop for this information if you currently have this ambulance company enrolled. If you currently have information on file, continue to use the names previously submitted. You only need to add one name in PECOS for creating an enrollment record.*

1. The applicant must list the training completed by each crewmember and attach copies of all/any certificates verifying such training. If the crewmember does not meet Federal, State, and local training requirements, the applicant cannot bill for services furnished by the crewmember. Contractors must check each crewmember's name and SSN against Qualifier.net, FID (If applicable). If the crewmember is excluded/debarred deny the application and explain the reason(s) for denial. (See §14.3, Denial 1). If the applicant appears on the FID (If applicable), process the application according to §16.1 and 16.2, respectively. *If the applicant does not list or attach his/her training certificate(s) during the initial enrollment, do not develop for it. We will assume the ambulance company has checked its members prior to hiring them.*

NOTE: Crewmembers need not submit recertification documentation unless specifically requested to do so by the carrier, (i.e., on an "as needed" basis).

5.2 - Review of Attachment 2, Independent Diagnostic Testing Facility (IDTFs)

(Rev. 69, 03-26-04)

1. Service Performance

A - Standards Qualifications

The applicant must complete this item. If they have not, contact the applicant for additional information. An IDTF applicant can back bill (the same as any other supplier) from the date that they actually met all the supplier qualifications for their supplier type. Therefore, if an applicant is determined to have met the IDTF requirements and is granted a billing number, it can back bill from the date where they can provide reasonable evidence that they met the IDTF requirements. An example would be where the applicant is granted an IDTF number in July 1, 2000, but had the same acceptable, 1) properly calibrated equipment, 2) qualified technician(s), and 3) qualified supervisory physician(s), as of May 1, 2000. That applicant can back bill for services on or after May 1, 2000 for IDTF services based upon evidence, such as payroll records, personnel records, contracts, equipment purchase records, etc., that they met the standards as of May 1, 2000. The carrier, when necessary, shall request confirming documents from the applicant or review such documents as Part of the site visit. The applicable personnel and equipment do not have to be the same as those provided as of July 1, 2000. However, use of the same personnel and equipment will facilitate this process. The carrier shall document the file with the method used for determining when the applicant is entitled to bill for services. An applicant who has purchased the assets of an existing IDTF is not automatically allowed to continue billing. It must apply as a new IDTF and may back bill once enrolled. Use of the same personnel and equipment as the previously enrolled IDTF can facilitate the determination that the new IDTF can bill as of the date of the sale.

B - CPT-4 and HCPCS Codes

The applicant must complete this section. The codes listed should reflect all procedure codes which the applicant will perform and bill as an IDTF. If an applicant does not list what contractors consider to be relevant codes then make a request for additional information.

The applicant must list all equipment it will use to perform the listed tests. The carrier shall determine if the equipment list provided is adequate for the tests which the applicant will perform. If the equipment list is considered incomplete, then make a request for and review additional information.

The carrier shall confirm that the equipment is properly calibrated and maintained by requesting and reviewing any relevant documents or other evidence on the matter. This information can be obtained before, during or after a site visit. The carrier shall document the method and result of the calibration and maintenance confirmation.

If an enrolled IDTF desires to perform additional CPT or HCPCS code tests not originally specified on its CMS-855B, which are for procedure types and supervision levels similar to its previously allowed codes, the carrier shall follow the following procedures. Have the IDTF

amend its CMS-855B to add the additional codes and equipment listing. A new site visit is not required. However, if an enrolled IDTF will now be performing CPT codes for different types of procedures, or with different supervision levels, then a new site visit is required. Examples are as follows: a) If a sleep laboratory is adding CPT codes for MRIs, a site visit is required, and b) If an existing imaging center is doing MRIs for knees starts doing MRIs for shoulders, a new site visit is not required.

For new applicants the carrier shall use carrier edits to restrict the IDTF billings to the CPT and HCPCS codes listed on the CMS-855B, which have been reviewed by the carrier. The use of carrier edits shall apply to all IDTFs that are not already enrolled as of the effective date of this change. The IDTFs, which have already been enrolled, previously do not require updated carrier edits. Carriers are strongly encouraged to (but are not required to) enter carrier edits for existing enrolled IDTFs as time and resource constraints permit. However, if an enrolled IDTF is performing additional CPT codes, the carrier shall enter carrier edits for all codes previously disclosed and the new ones cited.

2. Interpreting Physician Information

The applicant shall list all physicians whose diagnostic test interpretations it will bill. This includes physicians who are providing purchased interpretations (which shall be in accordance with the *Publication 100-04, Chapter 1, Section 30.2*) to the IDTF as well as physicians who are reassigning their benefits to the IDTF. The carrier shall review and document that all physicians listed are Medicare enrolled. The carrier shall review that all interpreting physicians who are reassigning their benefits to the IDTF have the right to do so. The carrier shall review and document that any reassignment of benefits forms required have been submitted. The carrier shall also review and document that the interpreting physician(s) listed are qualified to interpret the types of tests (codes) listed. Sometimes it may be necessary for the carrier to contact another carrier to obtain required information. The carrier should document the file if it has obtained the required information from another carrier. If the applicant does not list any interpreting physicians, do not request additional information because the applicant may not be billing for the interpretations (the physicians may be billing for themselves). However, the applicant cannot bill globally for interpreting physicians not listed. *For all new enrollments and revalidations, all interpreting physicians are required to be entered into the PECOS system. If the interpreting physician's enrollment is only with another carrier, and they are not already entered into PECOS, the carrier shall request that the other carrier enter the interpreting physician into PECOS. The request can be made by telephone, electronically, or by letter. The request shall be documented. The other carrier who is making the PECOS entry shall accomplish the PECOS entry within 30 calendar days of the request. The carrier making the IDTF enrollment shall be automatically granted a processing time extension equal to the number of days it takes the other carrier to establish the PECOS record for the interpreting physician. The carrier enrolling the IDTF shall document the automatic extension granted by this means.*

3. Non-Physician Personnel (Technicians) who Perform Tests

Each non-physician who performs the diagnostic tests must be listed. These persons are often referred to as technicians.

A. If the non-physician person is state licensed or certified, the applicable license and/or certification should be attached and reviewed by the carrier. A notarized or certified true copy can be accepted with no further checks. A non-notarized or non-certified true copy should be checked with the applicable licensing authority. Not all states have licensing requirements for all diagnostic tests. In those instances, checking "No" in block 2 is acceptable. The carrier is responsible for knowing and ascertaining if there are specific state licensing requirements for the tests, which the technician will perform. The carrier shall maintain documentation to substantiate this.

B. If the technician is certified by a national credentialing body then the applicable certification should be attached and reviewed by the carrier. A notarized or certified true copy can be accepted with no further checks. A non-notarized or non-certified true copy should be checked with the applicable credentialing authority. The carrier shall decide which organization(s) constitute a national credentialing body for the tests the technician will perform. However, if the credentialing body is not one that is generally recognized as acceptable for the tests being performed, then the carrier should refer the issue to the IDTF Carrier Medical Director (CMD) workgroup for their opinion. The carrier's own CMD should facilitate this action.

All technicians must meet the standard of a state license or certification, or national credentialing body. The only exception to this is when a Medicare payable diagnostic test is not subject to state license or certification of the technician performing the test, and no generally accepted national credentialing body exists. In that instance, the technician should be listed and the IDTF should submit as an attachment any educational/credentialing and/or experience that the person has and fully justify why the individual should be considered qualified to perform the test(s) cited. The carrier shall use its judgment as to whether the technician is qualified to perform the diagnostic tests the IDTF is performing.

The IDTF technicians do not have to be employees of the IDTF. They can be contracted by the IDTF. The carrier shall document how it determined that the technicians listed met the licensing or credentialing requirements. All enrolling IDTFs must meet the technician licensing or credentialing requirements at the time of their enrollment. Carriers may no longer grant temporary exemptions from licensing and certification requirements.

Hospital Employment - This block should be completed with a yes or no. The technician can be employed by both an IDTF and a hospital (or other entity, including a physician practice), but he or she cannot be scheduled to perform services for both entities at the same time. If the technician is employed by a hospital, the carrier should notify the FI who is assigned to the hospital, so that the FI can confirm that the hospital is properly allocating the appropriate portion of all direct and indirect costs associated with the technician. A technician who is employed by a hospital or physician's office does not automatically qualify as being properly credentialed to perform services for an IDTF.

4. Supervisory Physician(s)

According to 42 CFR 410.33 (b)(1) an IDTF must have one or more supervising physicians who are responsible for the direct and ongoing oversight of the quality of the testing performed, the proper operation and calibration of equipment used to perform tests, and the qualifications of nonphysician IDTF personnel who use the equipment. Not every supervising physician has to be

responsible for all of these functions. One supervising physician could be responsible for operation and calibration of equipment, while other physicians are responsible for test supervision and the qualifications of nonphysician personnel. The basic requirement is that all the supervisory physician functions be properly met at each location, regardless of the number of physicians involved. This is particularly applicable to mobile IDTF units which are allowed to use different supervisory physicians at differing locations. They may have a different physician supervise the test at each location. The physicians used have to meet only the proficiency standards for the tests they are supervising. The carrier shall use its discretion to determine if the supervisory physician(s) meet the proficiency standards stated in 42 CFR 410.33(b)(2). Supervisory physicians do not have to be employees of the IDTF. They can be contracted physicians for each location serviced by an IDTF.

A - Supervisory Physician Information

1. Supervising Physician Information - This block must be completed by furnishing all the required identifying information about all supervisory physicians. The carrier shall check and document that each supervisory physician is licensed to practice in the State(s) where the diagnostic tests he or she supervises will be performed and that the physician is Medicare enrolled. The physician(s) does not have to be Medicare enrolled in the state where the IDTF is enrolled. *For all new enrollments and revalidations, all supervisory physicians are required to be entered into the PECOS system. If the supervisory physician's enrollment is only with another carrier, and they are not already entered into PECOS, the carrier shall request that the other carrier enter the supervisory physician into PECOS. The request can be made by telephone, electronically, or by letter. The request shall be documented. The other carrier who is making the PECOS entry shall accomplish the PECOS entry within 30 calendar days of the request. The carrier making the IDTF enrollment shall be automatically granted a processing time extension equal to the number of days it takes the other carrier to establish the PECOS record for the supervisory physician. The carrier enrolling the IDTF shall document the automatic extension granted by this means. The carrier shall verify the licensing for the State where the IDTF is being enrolled for* each supervisory physician enrolled with another carrier based upon the physician's license submission and discussions with the carrier where they are enrolled. A physician group practice cannot be considered a supervisory physician. Each physician of the group who actually performs an IDTF supervisory function must be listed. If a supervisory physician has been recently added or changed, the updated information is required to be reported via Form CMS-855 as a Change of Information. However, the new supervisory physician is required to have met all the supervisory physician requirements at the time any tests were performed. The carrier shall review the new physician(s) using the procedures in this manual section. If a supervisory physician is listed, whom the carrier knows has been listed with several IDTFs, then the carrier should check with the physician to determine that the physician is still acting as supervisory physician for the previously enrolled IDTFs. If the carrier is aware that a supervisory physician is listed as a supervisory physician for more than 5 IDTFs, then the carrier should refer the matter to their benefit integrity unit for further investigation.

2. General Supervision (For Overall IDTF Operation) - In accordance with 42 CFR 410.33(b), all IDTFs must have one or more supervisory physicians who are responsible for the direct and ongoing oversight of the quality of the testing performed, the proper operation and calibration of the equipment used to perform tests, and the qualification of non-physician personnel who use the

equipment. In applying this definition we cannot impose a physical distance limit between where the test is performed and where the supervisory physician is located. If the carrier question(s) whether a remote supervisory physician is actually performing this general supervision function, it should ask for specific written procedures or other documentation which the IDTF may have in place. Although, specific written procedures are not specifically required, a satisfactory written response to carrier questions is.

All the check boxes in block 2 must be checked. However, they can be checked through use of more than one physician. The carrier shall review that all three general supervision requirements have been checked.

1. Type of Supervision Provided in Accordance with 42 CFR 410.32(b)(3) - According to 42 CFR 410.33(b)(2), in the case of a procedure requiring the direct or personal supervision of a physician as set forth in 42 CFR 410.32(b)(3), the IDTF's supervisory physician must furnish this level of supervision. The carrier enrollment reviewer shall be familiar with the definitions of personal, direct and general supervision set forth at 42 CFR 410.32(b)(3). The carrier shall document that all reviewers of IDTF applications are familiar with said regulation section.

The carrier shall check and document that the applicant has checked the highest required level of supervision for the tests being performed. At least one supervisory physician must check a box in item 4A3 of Attachment 2 of Form CMS-855B, at the highest supervision level required for the tests to be performed.

B - Attestation Statement for Supervising Physician

1. Acknowledgement of Codes Supervised - This statement must be completed and signed by all supervisory physicians listed.

2. Disclosure of Codes Not Supervised - This block may not need to be completed. If it is not completed it is assumed that the supervisory physician(s) listed supervise for all codes listed. If this block is filled in, then the carrier must ensure that all codes listed in 1B are covered through the use of multiple supervisory physicians.

3. Physician Signature - The carrier shall check the signature against the signature of the enrolled physician. This should be documented. If the physician is enrolled at a different carrier, contractors should call the applicable carrier and obtain the listed telephone number of the physician. Call the listed telephone number to determine that the physician acknowledges that he or she has signed the attestation statement. In all cases the carrier shall contact the supervisory physician(s) by telephone or as Part of the required site visit. In Particular, the carrier should ascertain and document that each supervisory physician listed actually exists (i.e. a phony or inactive physician number is not being used) and that the physician is aware of his or her responsibilities. For general supervision of IDTF operations, these responsibilities are outlined in 42 CFR 410.33.

7 - Reassignment of Benefits - Form CMS-855R

(Rev. 69, 03-26-04)

Form CMS-855R is to be completed for any individual who will reassign his/her benefits to an eligible entity. The form must be completed for the following situations:

a. An individual practitioner is currently enrolled in Medicare and will reassign benefits to an entity that is currently enrolled;

b. An individual has been reassigning benefits to an entity and is terminating the reassignment; and

c. An individual reporting a change in the type of income tax withholding.

If the individual supplier wants to reassign his or her benefits and has not been enrolled, the applicant must complete Form CMS-855I as well as Form CMS-855R. (Form CMS-855I and Form CMS-855R can be submitted concurrently.) The newly enrolling entity that is going to receive benefits must complete Form CMS-855B.

NOTE ABOUT REASSIGNMENT

It is important to remember that benefits *are* reassigned to a provider/supplier (hereinafter referred to as "supplier"), not to the practice location(s) of that supplier. For instance, suppose Dr. X works for Smith Medical Group (SMG), which is a corporation. SMG has *5* practice locations. Dr. X, *however, reassigns* his benefits to the group. He *does not* reassign benefits to *all 5* practice locations, since practice locations are ineligible to receive reassigned benefits.

With this in mind, carriers should not require each practitioner in a group to submit a Form CMS-855R each time the group adds a practice location. Suppose Smith Medical Group had three physicians - X, Y, and Z - and six practice locations. All three doctors have reassigned their benefits to SMG. Now, SMG wants to add a seventh practice location. X, Y, and Z do not have to submit Form CMS-855Rs for this seventh location because, as stated before, they do not reassign their benefits to practice locations - only to the supplier itself, which they have already done. Of course, if the group practice as well as X, Y, and Z are all enrolling for the first time, and the doctors want to reassign their benefits to the group, each doctor would list each of the group's practice locations on his/her Form CMS-855R. But once they have reassigned their benefits to the group, the doctors need not submit Form CMS-855Rs each time the group adds a practice location. In situations that have large # of practitioners in a group, it is appropriate to request a list of those who will be joining the additional location as to avoid assigning new numbers to every physician.

7.5 – Statement of Termination

(Rev. 69, 03-26-04)

5. Statement of Termination

This section allows the individual practitioner to terminate his/her previous authorized reassignment of benefits. *Both the contractor's system and UPIN registry must be updated to show the termination.*

7.6 - Reassignment of Benefits Statement –

(Rev. 69, 03-26-04)

6. Reassignment of Benefits Statement

The individual practitioner must complete this section to reassign his/her benefits. Follow instructions in *Publication 100-04, Chapter 1, Section 30.2 to ensure that the group is eligible to receive payment. The group must provide a copy of the reassignment of benefits statement for each physician in order to receive benefits.*

7.7 - Attestation Statement

(Rev. 69, 03-26-04)

7. Attestation Statement

The applicant must sign the attestation statement. If the attestation statement is not signed, return the application. A photocopy or fax signature is not accepted. *File the signature copy with the original. The requirements to be an authorized official are defined in §3.15 of this manual. Verify the name to make sure it is the same name of the authorized/delegated official declared on the Form CMS-855B. An actual comparison of the signature is not necessary.* The effective date of a reassignment is the date that the individual began or will start rendering services with the group. This information is listed in Section 4 of the Form CMS-855R.

10.4 - Practice Location

(Rev. 69, 03-26-04)

Section 4. Practice Location

The intermediary should consider the following special situations:

Home Health Agencies (HHAs) should complete Section 4A with their administrative address.

Mobile and portable units should not be listed in this section.

CMHCs must list all alternative sites where core services are provided as practice locations (proposed alternative sites for initial applicants and actual alternative sites for those CMHCs already Participating in Medicare). In accordance with provisions of the Public Health Service Act, a CMHC is required to provide mental health services principally to individuals who reside in a defined geographic area (service area). Therefore, CMHCs must service a distinct and definable community. Those CMHCs operating or proposing to operate outside this specific community must have a separate provider agreement/number and enrollment, and must individually meet the requirements to participate. CMS will determine if the alternative site is permissible or whether the site must have a separate agreement/number. CMS will consider the actual demonstrated transportation pattern of CMHC clients within the community to ensure that all core services and Partial hospitalization are available from each location within the community.

A CMHC patient must be able to access and receive services he/she needs at the parent CMHC site or the alternative site that is the distinct and definable community served by the parent.

A. Practice Location Information

Hospitals must list all addresses where they (not a separately enrolled provider/supplier type, such as a nursing home) provide services which are being billed as provider-based (inpatient and outpatient services). All the locations the hospital lists must be able to qualify as provider-based in accordance with current regulations. The intermediary should not hold up processing of any additional practice locations pending receipt of provider-based attestations or RO concurrence of provider-based status for the practice location(s) being added. The practice location(s) should be listed on Form CMS-855A Change of Information. An exception is when CMS RO specifically requests that the enrollment change be delayed pending final determination of provider-based status.

Check to see whether the applicant is adding, deleting, or changing previous information. If yes, make sure that the effective date is listed. If the applicant fails to provide you with an effective date, request additional information; see §14.1.

1. The applicant must list each name where services are rendered, including all hospitals and/or other health care facilities in this section. The practice name can be the "Doing Business As Name". The applicant should also provide you the date it started at this location.

2. The provider shall list the complete address of all practice locations where it renders services as its provider type. If the applicant's address and or telephone number cannot be verified by use of Qualifier.net then contact the applicant. If they advise that the facility and its phone number have not yet been completed, continue processing the application and annotate the file. However, a note shall be placed on any recommendation for approval that the address and telephone number of the facility could not be verified pending completion of the facility. In this case, the Date Started at this location item can also be left blank. For PECOS entry use the date the Certification Statement was signed.

3. For those providers who are receiving reassigned benefits from contractors, indicate if the provider owns or leases the practice location. For those who received reassigned benefits from independent contractors--the contractor must provide the service on-site that the provider owns or leases. For clarification of reassigned benefits, see *Publication No. 100-04, Section 30.2.5.*

4. The applicant must list any CLIA or FDA Mammography Certification Numbers (if applicable).

B. Mobile Facility and/or Portable Units

If the applicant indicates that it is providing services from a mobile facility or portable unit, it should complete §4C through 4E about the mobile/portable services on Form CMS-855A. If the applicant fails to check this box, continue to process the application and assume it does not operate services from a mobile facility or portable unit. However, if you suspect something different, contact the applicant for additional information; see §14.1.

C. Base of Operations Address

1. The base of operations name and the date the provider started practicing at this location should be captured in this section. If the provider fails to provide this information, request additional information; see §14.1.

2. This address should be one where the personnel are dispatched, where the mobile/portable equipment is stored and, when applicable, where vehicles are parked when not in use. The telephone number, fax number and E-mail address should be captured for the base of operations. If the applicant fails to provide this information, recommend denial to the RO according to §14.3, Denial 3.

If the applicant's address and or telephone number cannot be verified by use of Qualifier.net then contact the applicant. If they advise that the facility and its phone number have not yet been completed, continue processing the application and annotate the file. However, a note shall be placed on any recommendation for approval that the address and telephone number of the facility could not be verified pending completion of the facility. In this case, the Date Started at this Location item can also be left blank.

D. Vehicle Information

This section captures information about the mobile unit when the services are rendered in the vehicle. For portable services (e.g., where the equipment is removed from a van, etc., and is used in a fixed setting), information concerning how the equipment was transported would not be captured in this space. If this section is blank, assume that the services are not rendered inside a vehicle unless there is data that shows otherwise. If this is found, recommend denial to the RO according to §14.3, Denial 3.

1-3. Capture the vehicle information. A copy of all health care related permit(s), license(s), and registration(s) must be submitted for each vehicle reported. If the applicant fails to provide this information, recommend denial to the RO according to §14.3, Denial 3.

E. Geographic Location where the Base of Operations and/or Vehicle Renders Services

1. Initial Listing and/or Additions

This section is to capture where the provider renders services to Medicare beneficiaries from or in its mobile unit. For those mobile units that cross state lines, the provider must complete a separate Form CMS-855A enrollment application for each State. If the applicant fails to provide this information, request additional information.

2. Deletions

The applicant would provide information if it were deleting a location where mobile or portable services were provided.

F. Pay-to-Address

If an applicant indicates that payments are going to an address other than the reported practice location mailing address, update the system. This address may be a post office box. If it is determined that payment is being made to an agent, (see Section 8 of the application) determine that the billing agreement follows all the requirements outlined in the MIM §3488. If the payments are being sent electronically, verify that an EFT agreement has been signed by the appropriate official listed on Form CMS-855A. When an EFT agreement is submitted, verify the bank account is in compliance with the MIM §3488, Payment to Bank.

Electric Funds Transfer Changes

If an enrolled provider notifies the *contractor* that he/she is changing their account to a different bank, the provider enrollment staff would need to be involved. The PE staff must review Form CMS-588 to determine whether all banking information complies with *Publication No. 100-04, Section 30.2.5, Section 30.2.5, Payment to Bank*. We view a change to Form CMS-588 as a change to the pay-to-address. *Therefore the procedures for processing a "Pay To" change shall be followed.*

When completing a Form CMS-855, the EFT address may not be reflected in the pay-to-address section of the Form CMS-855A, as this address may be used for hardcopy checks and remittance advices. The intermediary must obtain a complete initial Form CMS-855A. The initial Form CMS-855A must be completely revised/revalidated. The signature on the Form CMS-588 should note that of the authorized official/delegated official on the Form CMS –855A. Therefore, it is required to obtain a complete initial Form CMS-855. If however, the provider has previously completed an enrollment form, the intermediary need only to check the signature on the Form CMS-588 against signatures on the Form CMS-855 on file. This information does not require a "change of information" or a skeletal record for PECOS on the Form CMS-855A. All the validation *requirements* listed below for a pay-to-address change must be followed. Once verifications are complete, a copy of the Form CMS-588 must be attached to the existing (or initial) Form CMS-855. The original Form CMS-588 can be maintained in accounting. Processing time for an initial Form CMS-855A shall be the same as any other change. An initial logging and tracking (L & T) PECOS record is required for this change.

Pay To Changes

For those enrolled providers who request a change to Section 4 "Pay To" address, we are requiring intermediaries to examine closely any request for a "Pay To" address change to ensure that the request is from the provider. For change of "Pay To" address, the intermediary must follow these procedures:

1. *If the applicant has never completed an entire Form CMS-855 (or had previously submitted Form CMS-855s on file) the contractor shall develop for an entire Form CMS-855 reflecting the request to change the "Pay To" address. Verify and validate all the information provided. If, however, the contractor has on file previous Form CMS-855 changes from this entity/individual, and this entity has an authorized official/delegated official signature on file, do not develop for an entire application. You shall, however, compare signatures from your files against the request for a pay-to-address change.*

2. *If the intermediary is suspicious, check billing records to determine if the provider has billed* the program within 3 months. If the provider has billed the program, continue with the next step. If the provider has had no billing activity within 3 months, contact Benefit Integrity/PSC to determine if there has been any suspicious conduct. The Benefit Integrity/PSC must verify that this is an appropriate change. If it is determined that this request appears to be legitimate, continue with the processing of the application under *3* below. Of course if the change appears to be suspicious, the Benefit Integrity/PSC will pursue as necessary. Anytime a provider requesting a "Pay To" change has not billed for four consecutive quarters it is required to verify that the provider is still actually in existence. For a CMHC which has been deactivated, it is necessary to verify that the enrollment data on file is still valid.

3. If the enrolled provider has completed Form CMS-855A on file, verify Form CMS-855A change request signature against the existing signature to make sure that they match. When the applicant requests a telephone number change in the practice location section with a change to the pay-to-address, call the number listed on the provider file first. If the number on record is still active, attempt to speak with the authorized representative/delegated official who requested the change to verify the validity of the change. If you receive a directory assistance message

changing the old number to a new number, and that number matches the provider's request for change, accept that change and contact the provider at the new number. Inform the provider you are making sure that this is a legitimate request for change. If the provider cannot be reached or a telephone number change seems suspicious, annotate the file and contact Benefit Integrity/PSC. If the change appears to be legitimate, continue with the update.

4. *If the enrolled provider does not have Form CMS-855A* on file, the contractor shall request that they complete an entire Form CMS-855A based on these changes. Verify and validate all the information provided. If the provider has already established its EDI agreement, article of incorporations, billing agreements, etc., it is not necessary to obtain the attachments unless for some reason the contractors has reason to do so. Handle this Form CMS-855A as a change for processing time purposes. However, it is considered and handled as an initial application for PECOS purposes.

Do Not Forward Initiative

The intermediary must follow the Do Not Forward initiative. Returned mail in the form of remittance advices and checks should be flagged if returned from the post office. Returned mail that is received from the post office box that is not a remittance advice or a check should not be considered DNF mail.

Returned mail in the form of remittance advices and checks indicates a change of a pay-to-address has been made. Therefore, the procedures for processing a "Pay To" change shall be followed.

These changes require Form CMS-855A be submitted reflecting a change to the 'Pay To" address (a complete Form CMS-855A if none is on file) and should not be processed based solely upon a letter from the enrolled entity requesting a change to the "Pay To" address. Note that the Do Not Forward initiative cannot be implemented for Fiscal Intermediary Standard System (FISS) users until a later date to be communicated by CMS.

Post Office Box Change Only

When an enrolled provider changes their "Pay To" address from a post office box to a previously identified primary practice location a complete Form CMS-855A is not required. This applies even if there is no Form CMS-855 on file. The change should be reported as a change on a Form CMS-855A. However, the intermediary should perform a Qualifier.net verification that the current "Pay To" address is still a valid address.

G. Location of Patient Records

1. The applicant should report where records are kept for each practice location. If the records are kept at the practice location shown in Section 4A or 4C, the applicant can skip this section. However, indicate that address in the system if the system allows you to do so.

2. If the address is different than that of a practice location, the applicant must indicate where the records are stored. If applicant does not have a place where it stores records, issue a

recommendation for denial; see §14.3., Denial 3. Records kept at a storage location must be indicated.

Post office boxes and drop boxes are not acceptable as the address where patient records are maintained. If any of the above information is incomplete, continue the application verification process and request additional information. (See §14.1, request for additional information.)

H. Comments

This section is used to capture any unique or unusual circumstances concerning the provider's practice location(s) or the method by which the provider renders health care services. You must determine that the information provided is legal and accurate.

10.6 - Ownership and Managing Control Information (Individuals)

(Rev. 69, 03-26-04)

Section 6. Ownership and Managing Control Information (Individuals)

Before proceeding with the instructions for Section 6, review the explanation of the term "ownership" in Section 5. Although the explanation there refers to the applicant as the "enrolling provider," the definitions and explanations have the same applicability to individuals.

For purposes of this application, the terms "officer," "director," and "managing employee" are defined as follows:

- Officer--any person whose position is listed as being that of an officer in the provider's "Articles of Incorporation" or "Corporate Bylaws," OR anyone who is appointed by the board of directors as an officer in accordance with the provider's corporate bylaws.
- Director--a member of the provider's "Board of Directors." It does not include a person who may have the word "Director" in his/her job title (e.g., Departmental Director, Director of Operations). Note, however, that a person who has the word "Director" in his/her job title may be a "managing employee," as defined below. Moreover, where a provider has a governing body that does not use the term "Board of Directors," the members of that governing body will still be considered "Directors." Thus, if the provider has a governing body titled "Board of Trustees" (as opposed to "Board of Directors"), the individual trustees are considered "Directors" for Medicare enrollment purposes.
- Managing Employee--Any individual, including a general manager, business manager, or administrator, who exercises operational or managerial control over the provider, or who conducts the day-to-day operations of the provider. For Medicare enrollment purposes, "managing employee" also includes individuals who are not actual employees of the provider but who, either under contract or through some other arrangement, manage the day-to-day operations of the provider."

  Use Qualifier.net to identify other individuals who may have this type of relationship with the applicant. If during a Particular search, a name appears that was not listed on the application, query that name against Qualifier.net (for MED and GSA data), the FID (If applicable). If you find that this person was excluded or debarred, deny the application; see §14.3, denial 1. If found on the FID, process according to §16.1 and 16.2, respectively. If a name was found that was not otherwise reported, request additional information.

A. Individual with Ownership and/or Managing Control--Identification Information

Check to see whether the provider is adding, deleting, or changing information on an individual in this section. If one of these boxes is checked, make sure that an effective date for the change is listed. If the boxes for Effective Date of Ownership or Effective Date of Control have not or cannot be completed, the application can still be processed without further discussion with the applicant. A potential, recommendation for approval or denial, can still be made. For PECOS

entry the contractor can enter the date of the signature on the certification statement. Remember that individuals must be listed here in Section 6. No organizations should be listed in this section.

B. Adverse Legal History

1. For each individual listed in this section, check the name and SSN or Medicare/Medicaid numbers against Qualifier.net (which contains MED and GSA data) and FID (if applicable). The individual must be checked against the aforementioned database(s) regardless of whether the enrolling provider states in this section that the individual has never had an adverse legal action imposed against him/her. If the individual is excluded or debarred, recommend denial to the RO and explain the reason(s) for denial; see §14.3, Denial 1. If the provider indicates that the individual has had an adverse legal action imposed against him/her but Qualifier.net does not report this, contact the OIG and/or Benefit Integrity/PSC to determine whether this can and should form the basis of an exclusion. Hold the application until the OIG decides whether the adverse legal action should result in an exclusion. If the OIG imposes an exclusion, recommend denial to the RO. If not, continue to process the application normally.

An automatic verification occurs during data entry in PECOS. If during data entry the SSN shows that your record does not match what is on file, you must reconcile this with the applicant.

If the SSN in PECOS shows "no match", you will need to contact the applicant to discuss. If you can determine a number was transposed, or receive a rational reason for the number not matching, obtain the correct SSN and continue processing the application. One common reason a SSN does not match is because the SSA may not have the correct surname. In situations where a woman has changed her surname but has not contacted the SSA, PECOS will not validate the information. Determine if this is the cause for the error message. If the applicant can provide you a surname used previously, check to see if PECOS will accept the surname. Also, look at Qualifier.net to determine if this surname was used previously. (It is not a requirement to have the name shown on Qualifier.net but this may be a useful tool.) If yes, continue processing the application using the previously used surname. However, the name is still required to be matched in PECOS and the matching surname must be the one listed on the Form CMS 855. This may require a new certification statement. Inform the applicant that he/she must change his/her name with the SSA. When this has been accomplished, the Form CMS 855 must be updated to reflect the SSA change.

In situations where you cannot resolve the case, the person must be referred to the SSA. You should close the application until the situation is resolved. If you find an applicant with several surnames, SSN, and DOBs and it doesn't appear to be legitimate, deny the application based on your findings.

If the individual appears on the FID, process the application according to §16.1

2. If the provider indicates that the individual has had an adverse legal action imposed against him/her, make sure that the provider furnishes information concerning the type and date of the action, and what court(s) and law enforcement authorities were involved. Also, documentation that evidences the imposition/notification and resolution of the adverse action must be submitted

(e.g., notification of disciplinary action, criminal court documents). If the organization was excluded but has since been reinstated, verify this through the OIG and ask the provider to submit written proof (e.g., reinstatement letter) indicating that such reinstatement has in fact taken place.

13 - Changes of Information-New Form CMS-855 Data

(Rev. 69, 03-26-04)

Anytime a provider or supplier is adding, deleting, or changing information under the same tax identification number, it must report this change using the appropriate Form CMS-855. The applicant should check the changed section on the application in Section 1A1 and identify itself. Only the reported changes need to be completed on the application. For example, if an applicant is changing its correspondence address and a contact person is not listed, assume that the contact person is the same person as identified in the initial enrollment. Do not require the applicant to provide a new one. However, with any written change, always require that the certification statement in Section 15 be signed and dated. All signed certification statements must be kept -in-house (either photo imaged or original) to verify the signatures against the original Form CMS-855 *for a change to a pay-to-address*. The initial application's certification statement is a verification tool and must be checked with any change request *for a change to a pay-to-address*. If the contractor has any reason to question the validity of the certification statement, alert your Benefit Integrity/PSC for further action.

Previously we allowed certain changes to be communicated by letterhead. This practice is no longer acceptable. All changes must be provided on the appropriate Form CMS-855.

Enrolled providers/suppliers who do not have an application on file can make a change (except for "Pay To" changes) by submitting just the changed item on an application. Do not request a complete Form CMS-855. Do not request enough information to form a skeletal record for PECOS. They should complete the following.

1. Check the Change of Information block on item 1A1 of the application and fill in information for items 2 and 3 for the Tax identification Number and the Medicare Identification Number.

2. Make the applicable requested change in only the applicable section of the form.

3. Complete the entire block 15.B of the form.

4. In 6.A.1 complete only the name, social security number, date of birth and credentials for the individual who is listed in the certification statement (block 15.B.).

The contractor shall check the individual listed in block 6.A.1 against all required databases and make a record that this was performed in the enrollment file. We understand that it is not possible to compare signatures since the enrolled provider/supplier does not have an application on file. Therefore, the only required check should be that of the appropriate databases. If the contractor has enough information from the Change of Information, Form CMS-855 and information it has on file then a skeletal record in PECOS should be made. Otherwise the change action should just receive a logging and tracking action in PECOS.

The contractor shall basically use the above guidance for enrolled providers and suppliers who have a Form CMS-855 on file. However, block 6.A.1 of the Form CMS-855 does not require completion.

If contacted by a group who states that it is voluntarily terminating its billing number, make sure that the reassignments attached to the group member is deleted.

If the applicant makes a change to its practice location, and that location is within the same carrier's jurisdiction but within another State, it must provide the state license with that change. (Not applicable for intermediaries.)

Any change to a Pay-to-Address requires the contractor to verify/validate this request. See section "Pay-to-Address" for further instructions.

Processing the Change of Information

The contractor must process 90 percent of applications that are requesting a change of information within 45 days or sooner. *Ninety-nine* percent of applications must be processed within 60 days. This process includes:

- Receipt of the application in the mailroom and forwarding the application to the appropriate office for review,
- Contractor's review and verification of the requested change,
- Any request or contact needed with the applicant, and
- The requested change updated in both the contractor's system and UPIN registry.

Anytime a request for change is received, provide written (or via Email) confirmation that the change has been made. This also may be accomplished by telephone. Document (per Section 25 of this manual) in the file the date and time the confirmation was made. In certain situations the contractor has discretion when making this contact. For example, where an area code/zip code has been changed for the entire community, it is not necessary to send confirmation that this change has been made to the provider/supplier's file.

If a hospital is adding a practice location make the confirmation to the provider in writing with the disclaimer, “We have added the practice location to our records in accordance with your request. However, this does not constitute approval of the facility as provider-based under section 413.65 of the code of Federal Regulations.”

14.2 - Approval and Recommendations for Approval

(Rev. 69, 03-26-04)

The carrier should notify the applicant that it has been enrolled as a Medicare supplier and forward to the applicant a Medicare billing number. Except for DMEPOS suppliers, pay all supplier claims that satisfy existing Medicare requirements including, when permissible, claims for services furnished prior to the enrollment date. For claims submitted prior to enrollment for physicians and non-physician practitioners, see MCM §3004 for the claim filing limit. Payment cannot be made for services prior to the date the applicant is appropriately licensed. For initial enrollment, the carrier should use the date that the supplier started practicing at the practice location as the date it can begin submitting claims.

NOTE: A DMEPOS supplier, however, can be paid only for claims furnished after the enrollment process has been completed and a supplier number has been assigned.

Carriers enrolling a certified supplier (portable X-ray or ASC), will send the RO a copy of their recommendation for approval of denial notification. In addition to the standard notification language, a statement including the type of enrollment transaction and other additional information that the contractor believes is relevant to the State agency and Regional office shall be included. Contractors will no longer send the RO the Form CMS-855. Instead, they will send the State survey agency copies of the recommendation for approval notification and the final completed application (Form CMS-855 with any updated pages, explanatory information, and any relevant correspondence or documents, including any final sales agreements). After the State survey agency reviews the information, it will either forward the Form CMS-855 to the regional office as part of the certification packet or take action as required and notify the regional office and the contractor. The notification can be accomplished via CMS Forms 1539 and/or 2007, e-mail, telephone message, a letter, or sending back a copy of the recommendation for approval notification with a stamp citing approval. This process will be followed for all Form CMS-855 submissions (e.g., initial enrollment applications, changes of ownership, etc). A Change of Information, or a CHOW application from the outgoing old owner where the new owner has submitted its CHOW application, does not require a recommendation for approval.

The recommendation should include the following information:

State Agency or RO Control Number (if available)
Supplier/Provider NPI Number (if available)
OSCAR Number (if available)
Carrier/Intermediary Number
Carrier/Intermediary Contact Name
Carrier/Intermediary Contact Phone Number
Date Application Recommended for Denial/Approval
Reason for Recommendation for Denial cite one of the reasons listed in section 14.3)/recommendation for approval.

Upon issuance of a recommendation for approval, or acceptance of a Change of Information after any required verification, the applicant should be informed that the intermediary/carrier has

completed its initial review of the application. This information can be provided orally or in writing. Except if must be in writing, in accordance with the §13 disclaimer, when a hospital is adding a practice location. If this is performed orally, annotate the file. When applicable, the applicant should be advised that the next step of the enrollment process involves a site visit, survey or other information reviews, conducted by the state survey agency, the CMS RO, or by a contractor, to determine the applicant's compliance with state and Federal participation requirements. Provide the applicant with a phone number for the organization that is involved with the next enrollment step. If the applicant calls the FI or carrier after the recommendation for approval, have the customer service representative or provider enrollment staff advise them to discuss their status with the organization that performs the next step in the enrollment process.

15 - Time Frame for Application Processing

(Rev. 69, 03-26-04)

Timeliness expectations are not paramount over development and detecting fraud or abuse. If an application requires developmental procedures not outlined in this manual, document and support any action you made within the file. In those few situations where an extension is needed for investigative purposes, contact the RO provider enrollment contact person to request an extension. Intermediaries will not need to make this request in the following situations, but should always document the file accordingly:

- CHOW determination to RO after 10 days at RO (if rest of the intermediary processing is done in 60 days);
- A waiting provider-based decision from the RO, only when specifically required or requested by the RO. Extension time starts after 10 days at RO (if rest of the intermediary processing is done in 60 days.);
- Waiting for a sales agreement in future (if rest of the intermediary processing is done in 60 days); and
- Waiting for RO on capitalization after 10 days at RO (if rest of the intermediary processing is done in 60 days)

If an application is pended for further investigation by Benefit Integrity/PSC, annotate this action in the file. The Benefit Integrity has 10 days to process the provider enrollment unit's request. If the timeframe cannot be met, Benefit Integrity must call the RO provider enrollment contact person to request an extension for this particular case. These actions must be documented. Contractors that use a PSC for the investigation will be granted an automatic processing time extension for any PSC processing time beyond 10 calendar days. The days for PSC processing shall be calculated from the date of the request to the PSC until receipt of the PSC reply. The contractor must document the request date to the PSC and the reply date. Upon receipt of the action required by Benefit Integrity/PSC, immediately begin processing the application based on the recommendation.

Processing the Initial Application (Including CHOWS, Acquisitions, Mergers and Consolidations for FIs)

Process 90 percent of applications within 60 calendar days of receipt or sooner. Process 99 percent of applications within 120 calendar days of receipt. This process includes:

- Receipt of the application in mailroom and forward to appropriate office for review;
- Prescreen the application in its entirety, as outlined in this section;
- Enter the information into PECOS (if applicable);

- Contact with the applicant (first by telephone and when necessary in writing);

- Verification of the application;

- The time it takes for the applicant to respond;

- Mailing/handling time to receive the requested information;

- The time (10 days to process) for Benefit Integrity/PSC to respond to a provider enrollment's request;

- Making a decision (or recommendation) to assign or deny a billing number;

- Formal notification of the carrier's decision (and provide the appropriate appeal rights (see section 13), as necessary); and

- Supplier site visit--an extension may be given if it is a site visit to a remote location. To obtain this extension, contact your RO.

Certified providers are considered closed after the recommendation for approval/denial.

<u>Date Stamping</u>

As a general rule, all incoming correspondence must be date-stamped. This includes, but is not limited to:

- Initial Forms CMS-855A, 855B, 855I and 855R applications. The first page must be date stamped.
- Letters from providers/suppliers. The first page must be date stamped.
- Articles of Incorporation/Partnership agreements, billing agreements, etc. The first page of the document or the envelope must be date stamped.
- When a provider/supplier submits a change and does not have a Form CMS-855 on file. The first page of the changed information must be date stamped.
- Once an initial (first submission) of Form CMS-855 changes are on file, any new additional changes received must have all pages date stamped.
- Additional Information received based on your request. All pages must be date stamped.

CMS is distinguishing from an initial (first submission) application from one that is being submitted for changes. Because most contractors interleaf the changed pages with the original application, it is necessary to determine the sequence in which the application/pages were received. Therefore, when the contractor received an initial application, it is only necessary to date stamp the first page of the application. However, in situations where the contractor requests additional information and additional pages are submitted, all the resubmitted pages must be date stamped. The rules for changes of information apply the same as that of requests for additional information.

The first page of the above documents and envelopes must be date-stamped in the mailroom. If the mailroom has a difficult time distinguishing a request for change from an initial application, the Provider Enrollment unit can date stamp the additional pages. However, long time lapses shouldn't be noticed from the time it was received in the mailroom until the time the Provider Enrollment Unit date stamps the pages.

Processing Times for Form CMS-855Rs, Changes and Reactivations

Process any Form CMS-855R, request for change, and reactivation that is not with an initial enrollment within 45 calendar days of receipt or sooner 90 percent of the time. Process 99 percent of these type of applications within 60 days of receipt.

This process includes:

- Receipt of the application in mailroom and forward to appropriate office for review;
- Review and verification of the changed information;
- Entering the information into PECOS (if applicable);
- Contact with the applicant (first by telephone or when necessary in writing) for clarification or additional information;
- The time it takes for the applicant to respond;
- Mailing/handling time to receive any requested information;
- An onsite visit for suppliers who may require one;
- The time (10 days to process) for Benefit Integrity/PSC to respond; and
- Updating the system

Prescreening

To better manage workloads, a prescreen of the application must be made within 15 calendar days *of working* an initial Form CMS-855I, Form CMS-855B, or Form CMS-855A. *If the contractor is meeting timeliness standards, it is not necessary to prescreen.* As Part of this process, analyze the application for any missing information (e.g., no phone number; lack of documentation). The point of prescreening is to find any obviously missing data elements. The contractor is not required to begin the verification process during the 15-day period, although they may do so.

If information is missing, make an initial contact by telephone, E-mail or send a corresponding letter for additional information within 15 days of *working the application.* Sending out a letter or making a telephone call is sufficient to satisfy this requirement. (Carriers: When making this initial contact, you must also ask the supplier whether he/she wishes to be Participating or non-participating if the application does not indicate so.) It is not necessary to actually talk to or

receive a written reply from the applicant within the 15-day period. For instance, if the contractor telephones the applicant on the 12th day, this requirement is met, even if the applicant did not return the call until the 17th day. Do not hold up the application for verification while waiting for the additional information. If ready, begin the verification process while waiting for the missing information.

For intermediaries the prescreening process should be used to determine when information is actually required based upon: 1) The type of transaction the applicant is requesting (CHOW from old owner, CHOW from new owner, Merger, Acquisition, Consolidation, initial application, etc., 2) The information that the intermediary already has in its records about the provider/facility, and 3) Information obtained from the other Party in a sales transaction. In conjunction with the above, the reviewer shall review Form CMS-855A completion instructions and manual instructions. The same considerations should be applied when performing verification and obtaining information not provided on an application.

Verification

The verification process may begin at any time during the processing timeline. The purpose of the verification process is to determine if any of the information received conflicts with the executive summary prepared by Qualifier.net, the attached supporting documentation, or other information present in the records. At any time during the verification phase, the contractor can contact the applicant orally for clarification/information. If additional data is needed in writing that was not previously requested during the prescreening phase, allow the applicant 14 days to respond to this request. Note that all Qualifier.net executive summaries are valid for 120 days.

Process an application without contact

Review the application in its entirety. If the contractor finds data elements that are missing and can validate the data from a valid source (including the contractor's records) or confirm them from supporting documentation submitted with the application, continue to process the application without contacting the applicant directly. We have determined that just because information is missing or this information is unable to be verified, it doesn't necessarily require that you make a request for additional information. However, data requirements, that do not require oral confirmation, are few.

Oral information or clarification

After the completion of the prescreen review of the application in its entirety, annotate what type of information is missing or needs clarification. Immediately contact the applicant for the missing information, as it will be used during the verification phase of the enrollment process. If the applicant has not provided supporting documentation (such as a license), it is not necessary to request this information in a written letter. If for some reason the contractor has been unsuccessful in its attempt to contact the applicant directly, follow procedures for written requests. Allow 1-week to connect with the applicant by telephone. Do not return the original application. If unable to connect with the applicant by telephone, request the information in writing. Retain a copy of the developmental letter on file as well as the validation it developed from the data validation sources.

Upon receipt of the written information, and since you developed the application in its entirety and have retained the data validation documentation on file, only validate the new information. Any time a file is closed, document the reason for closing the file. If an applicant returns the requested information late, indicate this in the file. If the information verified in the closed folder is less than 60 days old, verify the requested information and do not treat the application as a new one. Always accommodate the applicant to the best of your ability.

In situations where you have made at least three attempts to contact the applicant for information, and the applicant is not responding to those requests, close the application after 120 days. The first request happens in the prescreening phase when the contractor makes the telephone call to the applicant to request information. A second request could be made during the verification phase, either as a follow-up from the prescreening phase or a request for additional information not previously requested. This request/clarification can be made by telephone, and when necessary, in writing. If after 14 days the applicant has not responded, you must contact the applicant once more for the information. If the applicant fails to provide any of the required data within 7 days, close the file after 120 days. Anytime the information is received during the 120-day cycle, process it even if the delay in processing was not caused by the contractor. Therefore, if the applicant waited until the 99th day to send the information, the contractor is required to process it, and take one count.

At this time we do not have a way to track those applications that are late based on the applicant being delinquent. Therefore, if the contractor has the ability to track this data, and would like to submit it to the RO to consider for timeliness purposes, do so.

After closing the application, contact the applicant using the following draft language:

> "Dear Entity:
>
> We received your enrollment application on ____________. We have tried to reach you several times to request additional information that is required to process your application. Unfortunately, you did not respond or only sent a portion of the requested information. Therefore, we are closing your application at this time. If at a later date you want to enroll in the Medicare program, you will need to resubmit your application."

Request for Written Information

Certain documentation is critical in the pursuit of legal issues. The applicant must document and certify certain data elements, and therefore, missing information or clarification must be submitted on a revised application to Medicare. All changed/missing data elements must be accompanied with a signed/dated certification statement. Such examples include the name, sanction information, and adverse legal information. Always retain the original application on file. The reason to do so is to make sure that the information validated through Qualifier.net is not compromised. Send the applicant a blank application and send a letter annotating what data fields are missing or need clarification. Also when a blank application is returned for additional information, always attempt to make a telephone call to the applicant/contact person to discuss the reason for the return. The telephone call is to alert the supplier/contact person what additional information is required and to help facilitate the processing of the application. We also suggest that you mail the request for the additional information and make the telephone call concurrently.

It is suggested to allow 7 days for the contact to be made. Allow the applicant at a minimum 14 days to submit the requested information. You can also inform the applicant that the applicable section(s) of the 855 forms can be downloaded from our Web site. In those situations where the applicant has the capability to do so, instruct the applicant to download the file and complete the data element you need. Remind the applicant that it must also provide a signed certification statement or the application will be returned.

For situations when both data requirements fall under two headings "Request verbal information or clarification" and "written information required," follow the procedures as a written request.

NOTE: Do not pay claims until the application is complete and the provider/supplier is enrolled. This is not for fiscal intermediaries on CHOWS, Acquisitions/Mergers and Consolidations, as special instructions should be followed to stop payment only when required.

Clarifications

Review of the application may result in questions or a need for information from the *applicant*, which may not result in an actual change to the application. If this is the situation, make a telephone call to request clarification. The determination to request additional information with a formal letter, or a telephone request, as appropriate, is within your discretion.