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| CMS Manual System | Department of Health & Human Services (DHHS) |
| Pub 100-08 Medicare Program Integrity | Centers for Medicare & Medicaid Services (CMS) |
| Transmittal 11139 | Date: November 23, 2021 |
| | Change Request 12431 |

Transmittal 11040, dated October 14, 2021, is being rescinded and replaced by Transmittal 11139, dated November 23, 2021, to delay the implementation date to January 3, 2022. All other information remains the same.

SUBJECT: Revisions to Certified Provider/Supplier Model Letters and Instructions for Processing Initial Skilled Nursing Facility (SNF) Enrollment Applications

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to---(1) Revise the model letters that contractors use when processing certified provider and certified supplier enrollment applications; and (2) Instruct contractors on the processing of initial SNF Form CMS-855A enrollment applications.

EFFECTIVE DATE: October 15, 2021

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: January 3, 2022

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|--------------|---|
| R | 10/Table of Contents |
| R | 10/10.2/10.2.1/Certified Providers and Certified Suppliers That Enroll Via the Form CMS-855A |
| R | 10/10.2/10.2.1.14/Skilled Nursing Facilities (SNFs) |
| N | 10/10.7/10.7.5.1/ Part A/B Certified Provider and Supplier Letter Templates – Post-Transition |

III. FUNDING:

For Medicare Administrative Contractors (MACs):

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

directions regarding continued performance requirements.

IV. ATTACHMENTS:

**Business Requirements
Manual Instruction**

Attachment - Business Requirements

| | | | |
|-------------|--------------------|-------------------------|-----------------------|
| Pub. 100-08 | Transmittal: 11139 | Date: November 23, 2021 | Change Request: 12431 |
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I. GENERAL INFORMATION

A. Background: The CMS is transitioning certain administrative functions involving certified provider/supplier enrollment transactions from CMS Survey & Operations Group Locations to the MACs. To help facilitate this transition, this CR has two purposes. First, it revises the model letters that MACs utilize when processing various certified provider/supplier enrollment applications. Second, it updates the instructions for processing initial Form CMS-855A submissions involving SNFs. Revised initial application guidance involving additional certified provider/supplier types will be furnished in future CRs.

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

II. BUSINESS REQUIREMENTS TABLE

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

| Number | Requirement | Responsibility | | | | | | | | |
|---------|--|----------------|---|-----|------------|---------------------------|-----|-----|-----|-------|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| 12431.1 | The contractor shall follow the instructions in Section 10.2.1.14(B) in Chapter 10 of Publication (Pub.) 100-08 when processing initial Form CMS-855A applications involving SNFs. | X | | | | | | | | |
| 12431.2 | The contractor shall follow the instructions in the "Background" | X | X | X | | | | | | |

| Number | Requirement | Responsibility | | | | | | | | |
|--------|--|----------------|---|-----|------------|---------------------------|-----|-----|-----|-------|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | subsection of Section 10.7.5.1 in Chapter 10 of Pub. 100-08 when using the applicable model letters contained therein. | | | | | | | | | |

III. PROVIDER EDUCATION TABLE

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

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

| X-Ref Requirement Number | Recommendations or other supporting information: |
|--------------------------|--|
| | |

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

V. CONTACTS

Pre-Implementation Contact(s): Frank Whelan, 410-786-1302 or frank.whelan@cms.hhs.gov

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts

allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Program Integrity Manual

Chapter 10 – Medicare Enrollment

Table of Contents
(Rev. 11139; Issued: 11-23-21)

Transmittals for Chapter 10

10.7.5.1 – Part A/B Certified Provider and Supplier Letter Templates – Post-Transition

10.2.1 – Certified Providers and Certified Suppliers That Enroll Via the Form CMS-855A

(Rev. 11139; Issued: 11-23-21; Effective: 10-15-21; Implementation: 01-03-22)

(For purposes of sections 10.2.1.1 through 10.2.1.14, the term “SOG Locations” refers to CMS Survey & Operations Group (SOG) Locations (formerly CMS Regional Offices)).

Sections 10.2.1.1 through 10.2.1.14 address the specific types of providers and suppliers that complete the Form CMS-855A. *While these sections mostly address the unique statutory and regulatory requirements for these types, some of them also contain detailed application processing instructions, which the contractor shall follow.*

10.2.1.14 - Skilled Nursing Facilities (SNFs)

(Rev. 11139; Issued: 11-23-21; Effective: 10-15-21; Implementation: 01-03-22)

A. General Background Information

As stated in Pub. 100-07, chapter 7, section 7004.2, a SNF is a facility that:

- Is primarily engaged in providing to residents skilled nursing care and related services for residents who require medical or nursing care; or
- Is primarily engaged in providing to residents skilled rehabilitation services for the rehabilitation of injured, disabled, or sick persons; while the care and treatment of mental disease is not the primary action of SNFs, the ability to provide appropriate resources and support for these beneficiaries is necessary;
- Has in effect a transfer agreement (meeting the requirements of §1861(1) of the Social Security Act with one or more hospitals having agreements in effect under § 1866 of the Social Security Act); and
- Meets the requirements for a skilled nursing facility described in subsections (b), (c), and (d) of §1819 of the Social Security Act.

Like other certified providers, SNFs receive a state survey and sign a provider agreement.

SNFs cannot have multiple practice locations under one Form CMS-855A enrollment.

B. Processing Instructions for SNF Initial Form CMS-855A Applications

(This section 10.2.1.14(B) only applies to the processing of SNF initial enrollment applications. See section 10.6.1 et seq. for information on SNF CHOWs, changes of information, and certain other transactions.)

In the past, the SOG Location had vital functions in reviewing SNF requests for Medicare participation and finalizing CMS’ decision. With the transition of certain SOG activities to the state agencies, the contractors, and CMS PEOG, however, the operational process of reviewing SNF requests for participation and enrollment now generally involves (and with exceptions) the following:

- *The contractor sends the enrollment application (and all supporting documentation) and its recommendation for approval to the state for review*
- *The state notifies the contractor of its recommendation*
- *The contractor notifies PEOG of the recommendation. If applicable, PEOG signs the provider agreement and performs other administrative functions pertaining to the enrollment*
- *Once PEOG completes the required administrative actions, PEOG will notify the contractor thereof*

- The contractor completes processing and notifies the provider of the approval of the transaction using the appropriate model letter (sending a copy thereof to the state (and, if applicable, accrediting organization)).

(Thus, and except as otherwise stated in this section 10.2.1.14, SOG Locations are no longer involved in the SNF initial application process for Form CMS-855As received on or after MMDDYY.)

Specific details on these steps are outlined in this section 10.2.1.14(B). Said instructions take precedence over any conflicting processing directives in this chapter.

1. Receipt of Application

Upon receipt of a SNF initial Form CMS-855A application, the contractor shall undertake the following (in whichever order the contractor prefers unless directed otherwise in this chapter):

(i) Perform all data validations otherwise required per this chapter.

(ii) Ensure that the application(s) is complete consistent with the instructions in this chapter.

(iii) Ensure that the SNF has submitted all documentation otherwise required per this chapter. For SNF initial enrollment, this also includes the following:

- Form CMS-1561 (Health Insurance Benefit Agreement, also known as a “provider agreement”)
- Evidence of successful electronic submission of the Form HHS-690 through the Office of Civil Rights (OCR) portal, as applicable. (Evidence should be either written or electronic documentation.) (See <https://www.hhs.gov/sites/default/files/forms/hhs-690.pdf> for more information.)
- A signed SNF patient transfer agreement. (See <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/Facility-Transfer-Agreement-Example.pdf> for an example.)

(The SNF must complete, sign, date, and include the Form CMS-1561 and transfer agreement described above, though the SNF need not complete those sections of the forms reserved for CMS. For organizational SNFs, an authorized official (as defined in § 424.502) must sign the forms; for sole proprietorships, the sole proprietor must sign.)

If any of the required documents are missing, unsigned, undated, or otherwise incomplete, the contractor shall develop for the form(s) or the information thereon using the procedures outlined in this chapter. (Examples of when development would be necessary include, but are not limited to: (1) an incorrect signatory signed the form or the signatory failed to furnish his/her title (if required by the form); or (2) the SNF did not list its DBA name (if required by the form).) If the SNF fails to fully comply with the contractor’s request, the contractor shall reject the application pursuant to 42 CFR § 424.525 and the instructions in this chapter. (Rejection is proper even if only one of the required documents is missing or incomplete and the SNF did not respond to the contractor’s request.)

2. Conclusion of Initial Contractor Review

(Nothing in this section 10.2.1.14(B) prohibits the contractor from returning or rejecting the SNF application if otherwise permitted to do so per this chapter. When returning or rejecting the application, the contractor shall follow this chapter's procedures for doing so.)

a. Approval Recommendation

If, consistent with the instructions in section 10.2.1.14(B) and this chapter, the contractor believes an approval recommendation is warranted, the contractor shall send the recommendation to the state pursuant to existing practice and this chapter's instructions. (This includes sending recommendations via hard copy mail if the state only accepts this method of transmission.) The contractor need not copy the SOG Location or PEOG on the recommendation. Unless CMS directs otherwise, the contractor shall also send to the provider the notification letter in section 10.7.5.1(E) of this chapter.

The state will: (1) review the recommendation package for completeness; (2) review the contractor's recommendation for approval; (3) perform any state-specific functions; and (4) contact the contractor with any questions. The contractor shall respond to any state inquiry in Item (4) within 5 business days. If the inquiry involves the need for the contractor to obtain additional data, documentation, or clarification from the SNF, however, the timeframe is 15 business days; if the provider fails to respond to the contractor within this timeframe, it shall notify the state thereof. The contractor may always contact its PEOG BFL should it need the latter's assistance with a particular state inquiry.

b. Denial

If the contractor determines that a denial is warranted, it shall follow the denial procedures outlined in this chapter. This includes: (1) using the appropriate denial letter format in section 10.7.5.1 of this chapter; and (2) if required under section 10.6.6 (or another CMS directive) of this chapter, referring the matter to PEOG for review prior to denying the application.

3. Completion of State Review

The state will notify the contractor once it has completed its review. There are two potential outcomes:

a. Approval Not Recommended

If the state does not recommend approval, it will notify the contractor thereof. (The contractor may accept any notification that is in writing (e-mail is fine).) No later than 5 business days after receiving this notification, therefore, the contractor shall commence the actions described in section 10.2.1.14(B)(2)(b) above.

b. Approval Recommended

If the state recommends approval, it will typically (though not always) do so via a Form CMS-1539; the contractor may accept any documentation from the state signifying that the latter recommends approval. (Note that the contractor will not receive a formal tie-in notice.)

No later than 5 business days after receipt of the recommendation from the state, the contractor shall send an e-mail to MedicareProviderEnrollment@cms.hhs.gov with the following information and documents:

- *The Form CMS-855 application or PECOS Application Data Report*

- *A copy of the Form CMS-1539 or similar documentation received from the state*
- *A copy of the provider-signed Form CMS-1561*
- *A copy of the provider-signed SNF transfer agreement.*

PEOG will countersign the provider agreement. Based on the information received from the contractor, PEOG will also (1) assign an effective date, (2) assign a CCN, and (3) enter the applicable data into ASPEN. Within 5 business days of receiving from PEOG the signed provider agreement, transfer agreement, effective date, and CCN, the contractor shall: (1) send the approval letter (see section 10.7.5.1(D)) and a copy of the CMS-countersigned provider agreement to the SNF; (2) switch the PECOS record from “approval recommended” to “approved” consistent with existing instructions; and (3) retain the provider-signed transfer agreement (which CMS does not counter-sign) on file.

C. SNF Distinct Parts

A SNF can be a separate institution or a “distinct part” of an institution. The term “distinct part” means an area or portion of an institution (e.g., a hospital) that is certified to furnish SNF services. The hospital and the SNF distinct part will each receive a separate CCN. Also:

- A hospital may have only one SNF distinct part.
- “Distinct part” designation is not equivalent to being “provider-based.”

A SNF distinct part unit must enroll separately (i.e., it cannot be listed as a practice location on the hospital’s Form CMS-855A), be separately surveyed, and sign a separate provider agreement. (Note how this is different from “swing-bed” units, which do not enroll separately and do not sign separate provider agreements.)

D. Additional Information

For more information on SNFs, refer to:

- Section 1819 of the Social Security Act
- Pub. 100-07, chapter 7
- Pub. 100-02, chapter 8

10.7.5.1 – Part A/B Certified Provider and Supplier Letter Templates – Post-Transition (Rev. 11139; Issued: 11-23-21; Effective: 10-15-21; Implementation: 01-03-22)

The model letters in this section 10.7.5.1 pertain to certain enrollment transactions involving certified providers and certified suppliers. Except as otherwise stated, the contractor shall begin utilizing these letters (instead of those in section 10.7.5) upon completion of the transition (of which CMS will notify the contractors) of the applicable CMS Survey & Operations Group (SOG) function to the state agency and the CMS Provider Enrollment & Oversight Group (PEOG). In other words, once a transaction type (for example, CHOWs) has been transitioned, the contractor shall commence using the section 10.7.5.1 letter(s) pertaining to said transaction. CMS will notify contractors once a particular transition has occurred.

For certified provider/supplier transactions (and transaction outcomes) not specifically addressed in this section 10.7.5.1, the contractor shall continue to use the existing model letters in section 10.7 et seq. (even after the aforementioned transition).

In addition:

(i) The contractor shall continue to use the letter identified in section 10.7.19 of this chapter after the transition.

(ii) Most of the documents in this section 10.7.5.1 identify parties that must receive a copy of the letter in question. If an inconsistency exists between said copied parties and those listed elsewhere in this chapter concerning a particular letter, the parties identified in this section 10.7.5.1 take precedence. To illustrate, suppose another section of this chapter requires X, Y, and Z to be copied on a certain letter while section 10.7.5.1 only requires X to be copied. The contractor in this situation need only copy X.

(iii) The contractor need only copy an accrediting organization (AO) on a particular letter if the provider/supplier has an AO. The contractor can typically ascertain this by checking PECOS (for currently enrolled providers/suppliers) or reviewing the application (for initial enrollments) to see if an AO is disclosed. Also, PEOG will often identify an AO (if one exists) in cases where it must review the transaction before notifying the contractor of its final approval (e.g., CHOWs, certain changes of information).

(iv) See section 10.7.5.1(M) below for the applicable e-mail addresses of the SOG Locations. The contractor shall insert the relevant e-mail address into any letter in section 10.7.5.1 that addresses the provider/supplier's right to a reconsideration of a provider agreement determination.

(v) Any data element boxes that the contractor cannot complete because the information is unavailable or inapplicable (e.g., CMS Certification Number (CCN) in certain instances) can be: (1) left blank; (2) denoted with "N/A," "Not applicable," or any similar term; or (3) removed altogether.

(vi) The Provider Transaction Access Number (PTAN) box should contain the CCN for all provider/supplier types other than ASCs and PXRSSs; the PTAN for the latter two supplier types will be that which the contractor assigns or has assigned.

(vii) The Primary Practice Location Address box shall include the suite number if one was/is listed on the application.

(viii) For the Denial letter in section 15.7.1(H), the contractor shall indicate (in any manner it chooses) whether the denial pertains to the buyer's or the seller's application if a prospective CHOW was involved.

A. Approval – Change of Information (Part A/B Certified Org; No Recommendation to State Was Required)

[Month, Day, Year]

[Provider/Supplier Name]

[Address]

[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

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

| Medicare Enrollment Information | |
|---|--|
| Legal Business Name (LBN) | |
| Doing Business As Name | |
| Primary Practice Location Address | |
| Provider/Supplier Type | |
| National Provider Identifier (NPI) | |
| Provider Transaction Access Number (PTAN) | |
| Changed Information | Include detailed changes or section titles, as applicable. |
| Effective Date of Change | |

| Provider/Supplier Agreement-Specific Information | |
|---|--|
| CMS Certification Number (CCN) | |
| CCN Effective Date | |

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

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

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

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

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

Sincerely,

[Name]

[Title]

[Company]

CC: State Agency [& Accrediting Organization (AO), if applicable]

B. Approval - State Agency Approved Change of Information (Part A/B Certified; Recommendation to State Was Required)

[Month, Day, Year]

[Provider/Supplier Name]

[Address]

[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and Contractor number]] has received a response from the Medicare State Agency. Your change of information application is now approved.

| Medicare Enrollment Information | |
|---|---|
| Legal Business Name (LBN) | |
| Doing Business As Name | |
| Primary Practice Location Address | |
| Provider/Supplier Type | |
| National Provider Identifier (NPI) | |
| Provider Transaction Access Number (PTAN) | |
| Changed Information | Include detailed changes or section titles, as applicable |
| Effective Date of Change | |

| Provider/Supplier Agreement Specific Information | |
|---|--|
| CMS Certification Number (CCN) | |
| CCN Effective Date | |

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

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

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

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

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

Sincerely,

[Name]

[Title]

[Company]

CC: State Agency [& AO, if applicable]

C. Approval - State Agency Approved Change of Ownership (Part A/B Certified)

[Month, Day, Year]

[Provider/Supplier Name]

[Address]

[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and Contractor number]] has received a response from the State Agency. Your change of ownership application is now approved. The corresponding executed [insert provider/supplier agreement type] is enclosed/attached. Your enrollment and [provider/supplier agreement-specific] information is outlined below:

| Medicare Enrollment Information | |
|---|--|
| Legal Business Name (LBN) | |
| Doing Business As Name | |
| Primary Practice Location Address | |
| Provider/Supplier Type | |
| National Provider Identifier (NPI) | |
| Provider Transaction Access Number (PTAN) | |

| Provider/Supplier Agreement Specific Information | |
|---|--|
| CMS Certification Number (CCN) | |
| CCN Effective Date (use effective date of seller's CCN) | |
| CHOW Effective Date | |

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

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

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

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

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

Right to Submit a Reconsideration Request:

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

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.

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

Providers and suppliers may:

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

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

The reconsideration request should be sent to:

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

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

And

If you are also requesting a reconsideration of the provider/supplier agreement determination, you must submit a separate Reconsideration Request. Your requests must be e-mailed to: [Insert: Name and e-mail address of CMS Location Office]

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

Sincerely,

*[Name]
[Title]
[Company]*

CC: State Agency [and AO, if applicable]

Attachments: [Include any attachments that the contractor must send to the provider/supplier, the state agency, and/or the AO per the instructions in this chapter 10.]

D. Approval - State Agency Approved Initial (Part A/B Certified)

[Month, Day, Year]

[Provider/Supplier Name]

[Address]

[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and Contractor number]] received a response from the Medicare State Agency. Your initial enrollment application and [provider/supplier agreement] is approved. Your executed [insert provider/supplier agreement name] is enclosed/attached. The effective date is the date you met all federal requirements.

Medicare Enrollment and Provider/Supplier Specific Participation Agreement Information

| Medicare Enrollment Information | |
|---|--|
| Legal Business Name (LBN) | |
| Doing Business As Name | |
| Primary Practice Location Address | |
| Provider/Supplier Type | |
| National Provider Identifier (NPI) | |
| Provider Transaction Access Number (PTAN) | |
| Enrollment Effective Date | |

| Provider/Supplier Agreement Specific Information | |
|---|--|
| CMS Certification Number (CCN) | |
| CCN Effective Date | |
| Medicare Year-End Cost Report Date | |

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

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

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

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

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

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Reconsideration requests must:

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

Providers and suppliers may:

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

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

The reconsideration request should be sent to:

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

Or emailed to: ProviderEnrollmentAppeals@cms.hhs.gov

And

If you are also requesting a provider/supplier agreement reconsideration, you must submit a separate Reconsideration Request. Your requests must be e-mailed to:

Medicare Provider/Supplier Agreement:

[Insert: Name and e-mail address of CMS Location Office]

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

Sincerely,

[Name]

[Title]

[Company]

CC: State Agency [and AO, if applicable]

Attachments: [Include any attachments that the contractor must send to the provider/supplier, the state agency, and/or the AO per the instructions in this chapter 10.]

E. Approval Recommended - Initial (Part A/B Certified)

[Month, Day, Year]

[Provider/Supplier Name]

[Address]

[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and Contractor number]] assessed your initial Medicare enrollment application and your request for participation in the Medicare program as a [insert provider/supplier type] provider/supplier. A recommendation for approval has been forwarded to the [enter name of State Agency], which will review this application for further compliance. A survey may be conducted by a State Survey Agency or deemed accrediting organization approved by CMS.

We will contact you when we have a decision.

| Medicare Enrollment Information | |
|--|---|
| Legal Business Name (LBN) | |
| Doing Business As Name | |
| Primary Practice Location Address | |
| Provider/Supplier Type | |
| National Provider Identifier (NPI) | |
| Medicare Year-End Cost Report Date | Date that the provider/supplier requested (delete if not applicable) |

For questions concerning the application, contact [Insert State] at [contact information].

Sincerely,

[Name]

[Title]

[Company]

CC: State Agency [and AO, if applicable]

F. Approval Recommended – Change of Information, Change of Ownership, or Revalidation Containing Changed New/Changed Data that the State Must Review (if applicable) (Part A/B Certified)

[Month, Day, Year]

[Provider/Supplier Name]

[Address]

[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and Contractor number]] assessed your [change of information, change of ownership, or revalidation] Medicare enrollment application. A recommendation of approval has been sent to [name of State Agency], which will conduct a review for further compliance.

A survey may be conducted by a State Survey Agency or deemed accrediting organization approved by CMS to ensure compliance.

We will contact you when we have a decision.

| Medicare Enrollment Information | |
|---|--|
| Legal Business Name (LBN) | |
| Doing Business As Name | |
| Primary Practice Location Address | |
| Provider/Supplier Type | |
| National Provider Identifier (NPI) | |
| Provider Transaction Access Number (PTAN) | |

| Provider/Supplier Agreement Information | | |
|---|----------------|--------|
| CMS Certification Number (CCN) | | |
| Requested Changes (applicable to COI, CHOW, or Revalidation); remove if inapplicable) | Existing | Seller |
| | New | Buyer |
| | Effective Date | |

For questions concerning the recommended application, contact [Insert State] at [contact information].

Sincerely,

[Name]

[Title]
[Company]

CC: State Agency [and AO, if applicable]

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

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and add Contractor number]] has [approved your revalidation application/assessed your revalidation] application and forwarded it to the State Agency.

Medicare Enrollment Information

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

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

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

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

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

Right to Submit a Reconsideration Request:

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

Reconsideration requests must:

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

Providers and suppliers may:

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

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

The reconsideration request should be sent to:

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

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

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

Sincerely,

*[Name]
[Title]*

[Company]

CC: State Agency [and AO, if applicable]

H. Denial Letter – Post-1539 (Or Other Similar Notice) Received from State Agency for the following application types—Initials, COIs, CHOWs, revalidations, and reactivations)

(This letter only applies in cases where:

- (1) A recommendation to the state was required per the instructions in this chapter (e.g., the particular revalidation application contained information/changes requiring state review), and
- (2) The state sends notification to the contractor (e.g., via the 1539 or other notice) that the application should be denied and/or, if applicable, the provider/supplier agreement should be terminated.

As explained in this chapter, certain changes of information and revalidation applications can result in an enrollment revocation and provider agreement termination, though most do not. Accordingly, the contractor shall insert the applicable review result language (e.g., see bracketed options below) in the first paragraph of the letter.)

[Month, Day, Year]

[Provider/Supplier Name]

[Address]

[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[The [insert name of State Agency] completed its evaluation of your [initial application] or [change of information] or [change of ownership] or [revalidation] or [reactivation].
[Insert the following language based on the situation involved and the specific result of the state's review:

[INITIAL ENROLLMENT: Your participation in the Medicare Program and your enrollment in the Medicare Program is [denied] for the following reasons]:

[NO REVOCATION AND/OR PROVIDER AGREEMENT TERMINATION INVOLVED: Your application for [insert] is denied for the following reasons]:

[REVOCATION AND/OR PROVIDER AGREEMENT TERMINATION RESULTING FROM THE APPLICATION SUBMISSION. As a result of the state's review, your participation in the Medicare program is terminated and your enrollment in the Medicare program is revoked for the following reason(s):

[INSERT DENIAL OR TERMINATION REASON GIVEN BY THE STATE AGENCY]

Information about your provider/supplier agreement and your Medicare enrollment are outlined in the text box below.

| | |
|---|--|
| Medicare Administrative Contractor Name & | |
|---|--|

| | |
|---|--------------------------------------|
| <i>Contractor Number</i> | |
| | |
| <i>Medicare Enrollment Determination</i> | |
| <i>Status</i> | <i>DENIED [OR REVOKED]</i> |
| <i>Legal Business Name (LBN)</i> | |
| <i>Doing Business As Name</i> | |
| <i>Primary Practice Location Address</i> | |
| <i>National Provider Identifier (NPI)</i> | |
| <i>Provider Transaction Access Number (PTAN)</i> | |
| | |
| <i>Provider/Supplier Agreement Determination</i> | |
| <i>Provider/Supplier Agreement</i> | <i>DENIED [OR TERMINATED]</i> |
| <i>CMS Certification Number (CCN)</i> | |

Right to Submit a Reconsideration Request:

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

Reconsideration requests must:

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

Providers and suppliers may:

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

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

RECONSIDERATIONS REQUESTS—MAILING ADDRESSES:

Requests for Reconsideration: Medicare Provider Enrollment: The reconsideration request regarding your Medicare enrollment may be submitted electronically via e-mail to: ProviderEnrollmentAppeals@cms.hhs.gov or addressed as follows:

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

And

Requests for Reconsideration: Medicare Provider/Supplier Agreement: For reconsideration of the Provider/Supplier Agreement determination, you must submit a separate Reconsideration Request. Your requests must be e-mailed to:

Medicare Provider/Supplier Agreement:
[Insert: Name and e-mail address of CMS Location Office]

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

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

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

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and Contractor number]] has received notification from the State Agency that you are voluntarily terminating your provider/supplier agreement **or** [Insert Contractor name [and Contractor number]] has completed processing your application [or letter] to voluntarily disenroll from the Medicare program. Therefore, your provider

agreement has been terminated and your Medicare provider enrollment deactivated effective on the dates shown below.

Medicare Enrollment and Provider Agreement Termination Information

| Medicare Enrollment Termination | |
|--|--|
| <i>Legal Business Name (LBN)</i> | |
| <i>Doing Business As Name</i> | |
| <i>Primary Practice Location Address</i> | |
| <i>Provider/Supplier Type</i> | |
| <i>National Provider Identifier (NPI)</i> | |
| <i>Provider Transaction Access Number (PTAN)</i> | |
| <i>Effective Date of Enrollment Deactivation</i> | |

| Provider/Supplier Agreement Termination | |
|--|--|
| <i>CMS Certification Number (CCN)</i> | |
| <i>Effective Date of CCN Termination</i> | |
| <i>Reason for Termination</i> | |

In accordance with 42 CFR § 489.52, Medicare will not reimburse you for any claims with dates of service on or after your effective date of termination.

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

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

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

(This letter should be used for reactivation approvals regardless of whether the application was referred to the state agency for review.)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and add Contractor number]] has approved your reactivation enrollment application.

Medicare Enrollment Information

| | |
|----------------------------------|--|
| <i>Legal Business Name (LBN)</i> | |
|----------------------------------|--|

| | |
|--|--|
| <i>Doing Business As Name</i> | |
| <i>Primary Practice Location Address</i> | |
| <i>Provider/Supplier Type</i> | |
| <i>National Provider Identifier (NPI)</i> | |
| <i>Provider Transaction Access Number (PTAN)</i> | |
| <i>PTAN Effective Date</i> | |

| <i>Provider/Supplier Agreement Specific Information</i> | |
|--|--|
| <i>CMS Certification Number (CCN)</i> | |
| <i>CCN Effective Date</i> | |

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

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

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

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

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

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

Right to Submit a Reconsideration Request:

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

Reconsideration requests must:

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

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

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

Providers and suppliers may:

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

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

The reconsideration request should be sent to:

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

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

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

Sincerely,

[Name]

[Title]

[Company]

(Note: No CC: to State Agency/AO required. Deactivations do not impact certified provider CCN participation status.)

K. Voluntary Termination: Failure to Respond to Request for Information

Month, Day, Year

PROVIDER/SUPPLIER NAME
ADDRESS
CITY, STATE, ZIP

Reference # Application ID

Dear Provider Name (LBN),

[Insert Contractor name [and Contractor number]] has received notification from the State Agency that you are no longer operational. We have not received a response to the request sent on Month DD, YYYY to update your enrollment information. Therefore, we have disenrolled you from the Medicare program. Your [provider/supplier agreement] has also been terminated.

Medicare Enrollment and Provider Agreement Termination Information

| Medicare Enrollment Termination Information | |
|--|--|
| Legal Business Name (LBN) | |
| Doing Business As Name | |
| Primary Practice Location Address | |
| Provider/Supplier Type/Specialty | |
| National Provider Identifier (NPI) | |
| Provider Transaction Access Number (PTAN) | |
| Effective Date of Enrollment Termination | |

| Provider/Supplier Agreement Termination Information | |
|--|--|
| CMS Certification Number (CCN) | |
| Effective Date of CCN Termination | |

In accordance with 42 CFR § 489.52, Medicare will not reimburse you for any claims with dates of service on or after your effective date of termination.

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

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

L. Voluntary Termination Cessation of Business

[Month, Day, Year]

PROVIDER/SUPPLIER NAME

ADDRESS
CITY, STATE, ZIP

Reference Number:

Dear Provider/Supplier Name:

[Insert Contractor name [and Contractor number]] was notified by State Agency Name that on MONTH DD, YYYY, the State Agency attempted to verify if your Type of Provider is operational. The State Agency has reported that your facility was closed, not operational, and/or ceased business at your address of record.

Pursuant to 42 CFR § 489.52(b)(3), CMS considers a cessation of business and providing services to the community to constitute a voluntary withdrawal from the Medicare program.

If you believe that our determination is incorrect and your Type of Provider facility remains operational, you must notify the State Agency and copy this office within 10 days from your receipt of this notice that your facility is still operational and participating in the Medicare program. You must provide the State Agency and this office with information to clarify why your facility was not functional at the address of record at the time the State Agency performed the site survey.

STATE AGENCY NAME
ADDRESS
CITY, STATE, ZIP

We request that you complete and submit a CMS-855 or an application via the Internet-Based Provider Enrollment Chain and Ownership System (PECOS) for a change of information to indicate that your facility/practice location remains open and operational or to request a voluntary termination of your enrollment.

If we do not hear from you, your Medicare enrollment and corresponding Provider Agreement will be terminated, pursuant to 42 CFR § 489.52(b)(3).

If you have any questions, please contact our office at:

Sincerely,

[Name]
[Title]
[Company]

M. Applicable SOG Location E-mail Boxes

| CMS Locations Corporate Email Addresses | | |
|--|----------------------|--|
| CMS LOCATION | BRANCH | EMAIL Address |
| CMS Boston Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont | ACC & LTC | BostonRO-DSC@cms.hhs.gov |

CMS Philadelphia ACC & LTC ROPHIDSC@cms.hhs.gov

*Delaware, District of Columbia, Maryland,
Pennsylvania, Virginia, West Virginia*

CMS New York ACC & LTC RONYdsc@cms.hhs.gov

*New Jersey, New York, Puerto Rico, Virgin
Islands*

CMS Atlanta ACC & LTC ROATLHSO@cms.hhs.gov

*Alabama, Florida, Georgia, Kentucky,
Mississippi, North Carolina, South Carolina,
Tennessee*

CMS Chicago ACC & LTC ROCHISC@cms.hhs.gov

*Illinois, Indiana, Michigan, Minnesota, Ohio,
Wisconsin*

CMS Kansas City ACC & LTC ROkcmSCB@cms.hhs.gov

Iowa, Kansas, Missouri, Nebraska

CMS Denver ACC & LTC DenverMAC@cms.hhs.gov

*Colorado, Montana, North Dakota,
South Dakota, Utah, Wyoming*

CMS Dallas ACC & LTC RODALDSC@cms.hhs.gov

*Arkansas, Louisiana, New Mexico, Oklahoma
Texas*

CMS San Francisco ACC & LTC ROSFOSO@cms.hhs.gov

*Arizona, California, Hawaii, Nevada, Pacific
Territories*

CMS Seattle ACCB CMS_RO10_CEB@cms.hhs.gov

Alaska, Idaho, Oregon, Washington LTC Seattle_LTC@cms.hhs.gov