| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-08 Medicare Program Integrity | Centers for Medicare & Medicaid Services (CMS) |
| **Transmitta:12796** | **Date: August 15, 2024** |
| | **Change Request 13725** |

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

**I. SUMMARY OF CHANGES:** The purpose of this Change Request (CR) is to clarify certain Medicare provider enrollment policies in Chapter 10 of Pub. 100-08. These policies involve topics such as -- (1) Model letters; and (2) Various certified provider types.

**EFFECTIVE Date September 16, 2024**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: September 16, 2024**

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

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| R | 10/10.2/10.2.1.7/Hospices |
| R | 10/10.2/10.2.1.11/Outpatient Physical Therapy/Outpatient Speech Pathology Services (OPT/OSP) |
| R | 10/10.3/10.3.2.1/CMS-20134 (Section 1 - Basic Information) |
| R | 10/10.6/10.6.1.2/Changes of Information – Transitioned Certified Providers and Suppliers |
| R | 10/10.6/10.6.21.1/Additional Miscellaneous Enrollment Topics |
| R | 10/10.7/10.7.9/Revocation Letters |

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

**IV. ATTACHMENTS:**
**Business Requirements**
**Manual Instruction**

# Attachment - Business Requirements

| Pub. 100-08 | Transmittal: 12796 | Date: August 14, 2024 | Change Request: 13725 |
|---|---|---|---|

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

**EFFECTIVE DATE: September 16, 2024**

**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: September 16, 2024**

**I. SUMMARY OF CHANGES:** The purpose of this Change Request (CR) is to clarify certain Medicare provider enrollment policies in Chapter 10 of Pub. 100-08. These policies involve topics such as -- (1) Model letters; and (2) Various certified provider types.

## II. GENERAL INFORMATION

**A. Background:** The purpose of this CR is to clarify certain Medicare provider enrollment policies in Chapter 10 of Pub. 100-08. These policies involve topics such as -- (1) Model letters; and (2) Various certified provider types.

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

## III. BUSINESS REQUIREMENTS TABLE

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

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | MAC | FISS | MCS | VMS | CWF | |
| 13725.1 | The contractor shall observe and adhere to the applicable policy and operational changes outlined in this CR to the CMS Internet Only Manual (IOM) sections. | X | X | X | | | | | | NPEAST, NPWEST |
| 13725.2 | The contractor shall observe the edits to the various model letters | | | | | | | | | NPEAST, NPWEST |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | MAC | FISS | MCS | VMS | CWF | |
| | included in this CR to the CMS IOM sections. | | | | | | | | | |

## IV. PROVIDER EDUCATION TABLE

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

## V. 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

## VI. CONTACTS

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

## VII. 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. 12796; Issued: 08-15-24)*

## 10.2.1.7 - Hospices

*(Rev.: 12796; Issued: 08-15-24; Effective: 09-16-24; Implementation: 09-16-24)*

### A. General Background Information

A hospice is a public agency or private organization or subdivision of either of these that is primarily engaged in providing a comprehensive set of services such as the assessment and management of pain. Typically, the need for services is identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care.

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

1. Receipt of Application

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

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

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

(C) Ensure that the hospice has submitted all documentation otherwise required per this chapter. For hospice 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.)

*(T*he hospice must complete, sign, date, and include the Form CMS-1561, though the hospice need not complete those sections of the form reserved for CMS. *For organizational hospices, an authorized official (as defined in § 424.502) must sign the form; for sole proprietorships, the sole proprietor must sign.)*

Notwithstanding the foregoing, if the Form CMS-1561 or the Form HHS-690 evidence is missing, unsigned, undated, or otherwise incomplete, the contractor need not develop for the form(s) or the information thereon; the contractor shall instead notify the state in its recommendation letter which document(s) was/were missing or otherwise incomplete. For all other missing or incomplete required documentation, the contractor shall follow the normal development instructions in this chapter.

2. Conclusion of Initial Contractor Review

(Nothing in this section 10.2.1.7(B) prohibits the contractor from returning or rejecting the hospice 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 10.2.1.7(B)(2) 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. 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 hospice, 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).) The site visit described in subsection (D)(1) below need not be performed. No later than 5 business days after receiving this notification, the contractor shall commence the actions described in section 10.2.1.7(B)(2)(B) above.

(B) Approval Recommended

If the state recommends approval, it will typically do so via a Form CMS-1539; however, 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 order the site visit described in subsection (D)(1) below.

If the hospice fails the site visit, the contractor shall follow the denial procedures addressed in subsection (B)(2)(B) above. If the hospice passes the site visit, the contractor (within 3 business days of completing its review of the results) 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) and all application attachments.
- A copy of the Form CMS-1539 from the state or similar documentation received from the accrediting organization.
- A copy of the provider-signed Form CMS-1561.
- A copy of the draft approval letter, with the effective date shown on the Form CMS-1539 (or similar documentation) included in the draft letter. (See section 10.7.5.1 for the model approval letter.)

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, (3) enter the relevant data into the applicable national database, and (4) approve (with possible edits) the approval letter. Within 5 business days of receiving from PEOG the signed provider agreement, effective date, and CCN, the contractor shall: (1) send the approval letter and a copy of the CMS-countersigned provider agreement to the hospice; (2) send a copy of both the approval letter and the provider agreement to the state and/or accrediting organization (as applicable)); and (3) switch the PECOS record from "approval recommended" to "approved" consistent with existing instructions.

**C. Multiple Practice Locations**

Hospices are not precluded from having multiple practice locations if permitted by the state. If the state disapproves an additional practice location, the location must seek Medicare approval as a separate hospice with its own enrollment and provider agreement. (See Pub. 100-07, chapter 2, section 2088 for the policies regarding multiple hospice locations.)

If the hospice submits a change of information application to add or relocate a practice location, the contractor shall process the application consistent with section 10.6.1.2 of this chapter. The contractor should be aware, however, that the state may not approve the location addition/change.

**D. Site Visits**

1. Initial application - The scope of the site visit will be consistent with sections 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not convey Medicare billing privileges to the provider prior to the completion of the NSVC's site visit and the contractor's review of the results.

2. Revalidation – If a hospice submits a revalidation application, the contractor shall order a site visit through PECOS. This is to ensure that the provider is still in compliance with CMS's enrollment requirements. The scope of the site visit will be consistent with sections 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not make a final decision regarding the revalidation application prior to the completion of the NSVC's site visit and the contractor's review of the results.

3. New/changed location - If a hospice is (1) adding a new location or (2) changing the physical location of an existing location, the contractor shall order a site visit of the new/changed location through PECOS no later than 5 business days after the contractor receives the approval recommendation from the state but before the contractor sends to PEOG the applicable e-mail described in section 10.6.1.2(A)(3) of this chapter. (See the latter section for more information.) This is to ensure that the new/changed location complies with CMS's enrollment requirements. The scope of the site visit will be consistent with sections 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not make a final decision regarding the change of information application prior to the completion of the NSVC's site visit and the contractor's review of the results.

***E. Out-of-State Hospice Operations***

*Pub. 100-07, chapter 2, section 2085 states that when a hospice furnishes services across state lines:*

- *It must be certified by the state in which its CCN is based.*
- *The involved states must have a written reciprocal agreement permitting the hospice to provide services in this manner. In those states that have a reciprocal agreement, hospices need not be separately enrolled in each state; consequently, they would not have*

*to obtain a separate Medicare provider agreement/number in each state. Hospices residing in a state that does not have a written reciprocal survey agreement with a contiguous state are precluded from providing services across state lines; the hospice must establish a separate location in the state in which it wishes to provide services.*

*See section 10.3.1.1.4(D) of this chapter for additional information regarding the enrollment of out-of-state hospice locations. In the event of any inconsistency between the instructions in sections 10.3.1.1.4(D) and 10.2.1.7(E), the latter takes precedence.*

***F. Recommendation Before New Hospice Location Established***

*If a hospice is adding a new location or changing the site of an existing one, the contractor can make a recommendation for approval to the state prior to the establishment of the new/changed location (notwithstanding any other instruction in this chapter to the contrary) in accordance with Pub. 100-07, chapter 2, section 2088. If the contractor opts to make such a recommendation prior to the location's establishment or movement, it shall note in its recommendation letter that the location is not yet established or has not yet moved.*

***G. Practice Locations and Mergers/Acquisitions***

*Notwithstanding section 10.2.1.7(C) above, hospices cannot merge and allow the other locations to become multiple locations of the hospice because this hinders CMS and/or the state in evaluating compliance with 42 CFR § 418.100(f). The hospice will need to file a CHOW or a voluntary termination of the non-surviving site; the surviving hospice can then submit a Form CMS-855A to add a new multiple location in accordance with Pub. 100-07, chapter 2, section 2088.*

***H*. Additional Information:**

For more information on hospices, refer to:

- Sections 1861(u) and 1861(dd) of the Social Security Act
- 42 CFR Part 418
- Pub. 100-07, chapter 2, sections 2080 – 2089
- Pub. 100-04, chapter 11
- Pub. 100-02, chapter 9

## 10.2.1.11 - Outpatient Physical Therapy/Outpatient Speech Pathology Services (OPT/OSP)

***(Rev.: 12796; Issued: 08-15-24; Effective: 09-16-24; Implementation: 09-16-24)***

### A. General Background Information

Physical therapists and speech pathologists provide therapy targeting a person's ability to move and perform functional activities in their daily lives typically inhibited by illness or injury. Care is typically coordinated by therapists in conjunction with a physician and is based on an agreed upon plan of care.

As explained in Pub. 100-07, chapter 2 section 2292, there are three types of organizations that may qualify as providers of OPT and OSP services under 42 CFR Part 485, Subpart H: clinics, public health clinics, and rehabilitation agencies. However, rehabilitation agencies are the only organizations that are currently enrolled as a Medicare provider with a CCN. The primary purpose of a rehabilitation agency is to improve or rehabilitate an injury or disability and to tailor a rehabilitation program to meet the specific rehabilitation needs of each patient referred to the agency. A rehabilitation agency must provide, at a minimum, physical therapy and/or speech language pathology services to address those needs of the patients. Social/vocational services are no longer a requirement.

Note that:

- If an OPT/OSP provider elects to convert to a CORF, it must meet the CORF conditions of coverage and participation. An initial Form CMS-855A enrollment application, state survey, and CMS program approval are also required.

- Only those OTP/OSP providers covered under 42 CFR Part 485, Subpart H that furnish OPT/OSP services (as listed above) have provider agreements under 42 CFR § 489.2. Part B physician groups – the supplier type that most people normally associate with the term "clinics" – do not have certified provider or certified supplier agreements.

- Occupational therapy cannot be substituted for the physical therapy requirement. It may, however, be provided in addition to physical therapy or speech pathology services. (See Pub. 100-07, chapter 2, section 2292A.)

There is no prohibition against an organization operating on the premises of a supplier (e.g., physician or chiropractor) or another provider if they are not operating in the same space at the same time. (See Pub. 100-07, chapter 2, section 2304.)

**B. Processing Instructions for OPT/OSP Initial Form CMS-855A Applications**

1. Receipt of Application

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

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

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

(C) Ensure that the OPT/OSP has submitted all documentation otherwise required per this chapter. For OPT/OSP 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.)

(The OPT/OSP must complete, sign, date, and include the Form CMS-1561, though the OPT/OSP need not complete those sections of the form reserved for CMS. For organizational OPT/OSPs, an authorized official (as defined in § 424.502) must sign the form; for sole proprietorships, the sole proprietor must sign.)

Notwithstanding the foregoing, if the Form CMS-1561 or the Form HHS-690 evidence is missing, unsigned, undated, or otherwise incomplete, the contractor need not develop for the form(s) or the information thereon; the contractor shall instead notify the state in its recommendation letter which document(s) was/were missing or otherwise incomplete. For all other missing or incomplete required documentation, the contractor shall follow the normal development instructions in this chapter.

2. Conclusion of Initial Contractor Review

(Nothing in this section 10.2.1.11(B) prohibits the contractor from returning or rejecting the OPT/OSP 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 10.2.1.11(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. 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 OPT/OSP, 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 10.7.8 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 the contractor shall commence the actions described in section 10.2.1.11(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) and all application attachments
- 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 draft approval letter, with the effective date shown on the Form CMS-1539 (or similar documentation) included in the draft letter. (See section 10.7.5.1 for the model

approval letter.)

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, and (4) approve (with possible edits) the approval letter.

Within 5 business days of receiving from PEOG the signed provider agreement, effective date, and CCN, the contractor shall: (1) send the approval letter and a copy of the CMS-countersigned provider agreement to the OPT/OSP; (2) send a copy of both the approval letter and the provider agreement to the state and/or AO (as applicable)); and (3) switch the PECOS record from "approval recommended" to "approved" consistent with existing instructions.

## C. Extension Locations

### *1. Background*

As discussed in Pub. 100-07, chapter 2, sections 2298 and 2298A, an OPT/OSP provider can, in certain instances, furnish services from locations other than its primary site. (The provider must designate one location as its primary location on the Form CMS-855A, however.) These sites are called extension locations. An extension location is defined at 42 CFR § 485.703 as "a location or site from which a rehabilitation agency provides services within a portion of the total geographic area served by the primary site. The extension location is part of the agency. The extension location should be located sufficiently close to share administration, supervision, and services in a manner that renders it unnecessary for the extension location to independently meet the conditions of participation as a rehabilitation agency." Per Pub. 100-07, chapter 2, section 2298A, only rehabilitation agencies are permitted to have extension locations. The clinics operated by physicians and public health clinics are not permitted extension locations. These two providers must provide outpatient therapy services at their Medicare approved location.

An OPT/OSP provider may also furnish therapy services in a patient's home or in a patient's room in a SNF. (See Pub. 100-07, chapter 2, section 2300. Note that when the OPT provides services away from the primary site or extension location(s), this is referred to as "off-premises activity" at other locations. Section 2300 (referenced) above discusses such activities.) Because these are not considered extension locations, neither the home nor the patient's room need be listed as a practice location on the provider's Form CMS-855A. (See Pub. 100-07, chapter 2, section 2298B.)

OPT/OSP extension sites fall under the parent's Medicare provider agreement and CCN. They are assigned and identified by a unique 10-digit alphanumeric identification number (also sometimes referred to as a "Medicare Branch ID") linked to the parent CCN. PEOG is responsible for the assignment or termination of OPT/OSP extension site identifiers and for updating ASPEN accordingly.

### 2. Extension Site Changes

All extension site additions, deletions, changes, and relocations require a Form CMS-855A change of information application.

#### a. Additions

*An* addition *or relocation/change* of an extension site requires a referral to the state and thereafter to PEOG to review for final determination prior to approval. The approval letter sent to the OPT/OSP provider, with a copy to the state and/or AO, should include the assigned Medicare Branch ID and the effective date of the added *or relocated* extension site. The effective date of coverage for services provided from the extension site is the date CMS determines that the extension site meets all applicable federal requirements.

b. Deletions

Deletions do not require a referral to the state but do require post approval correspondence with PEOG and the state (and, if applicable, the accrediting organization) per section 10.6.1.2(B) of this chapter.

**D. CHOWs**

For OPT/OSP CHOWs, the contractor shall follow the instructions in section 10.6.1.1 of this chapter.

**E. Additional Information**

For more information on OPT/OSP providers, refer to:

- Section 1861(p) of the Social Security Act
- 42 CFR Part 485, subpart H
- Pub. 100-07, chapter 2, sections 2290 – 2308
- Pub. 100-07, Appendix E

## 10.3.2.1 – CMS-20134 (Section 1 - Basic Information)

***(Rev.: 12796; Issued: 08-15-24; Effective: 09-16-24; Implementation: 09-16-24)***

*(See section 10.2.6 of this chapter for more information on Medicare Diabetes Prevention Programs.)*

**A. Reason for Submittal**

In this section, the supplier indicates the reason for submittal of the application. Unless otherwise stated in this chapter, in another CMS directive, or as permitted by PECOS, the supplier may only check one reason for submittal. For example, suppose a supplier is changing its tax identification number (TIN). The supplier must submit two applications: (1) an initial Form CMS-20134 as a new supplier; and (2) a Form CMS-20134 voluntary termination. Both transactions cannot be reported on the same application.

Excluding (1) the voluntary termination checkbox and (2) the effective date of termination data in the Basic Information section of the Form CMS-20134, any blank data/checkboxes in the Basic Information section can be verified through any means the contractor chooses (e.g., e-mail, telephone, the PCV, fax).

**B. Centers for Disease Control (CDC) Diabetes Prevention Recognition Program (DPRP)**

To be eligible to enroll as an MDPP supplier, an entity must have either:

- MDPP preliminary recognition or
- DPRP full recognition

Note that MDPP preliminary recognition includes both interim preliminary recognition as designated by CMS as well as preliminary DPRP recognition as designated by the CDC.

Organizations with preliminary or full CDC DPRP recognition must submit to CMS a copy of its recognition letter provided by CDC. To verify the applicant's eligibility, the contractor shall:

- Verify that a letter has been submitted for each organizational code provided in Sections 2 and 4 of the Form CMS-20134
- Verify that (1) any letters provided have appropriate letterhead from CDC and (2) each reflects that the organization has met either preliminary or full recognition with an expiration date that has not passed.
- Verify that the organization code or codes provided in Sections 2 and 4 of the Form CMS-20134 matches both the organization code on the letter(s) and the organization code on CDC's online registry, which is updated just-in-time and can be found at https://dprp.cdc.gov/cms/download.
- Verify that the CDC's online registry or any list provided by CMS indicates that the entity associated with that organization code is associated with *either* an in-person *or in-person with a distance learning component* delivery mode and that a delivery mode of in-person *or in-person with a distance learning component* is noted in the letter's letterhead.
- Verify that CDC's online registry indicates that the entity associated with that organization code has met either preliminary or full recognition.
- Verify that the name associated with the organization code on CDC's online registry is consistent with what is listed on the letter, as well as what is provided in Sections 2 or 4 of the Form CMS-20134

Certificates or letters of the above recognitions are the only eligibility documents required by Medicare to function as the supplier type in question. Any other licenses, certificates, and permits that (1) are not of a medical nature or (2) are of a medical nature but unrelated to MDPP are not required.

**C. Recognition Status**

In situations where an MDPP supplier is required to submit a copy of its CDC recognition but fails to do so, the contractor need not obtain such documentation from the supplier if the contractor can verify the information independently. This may be done by: (1) reviewing and printing (or electronically saving in PECOS) confirming pages from the Centers for Disease Control and Prevention Web site; (2) requesting and receiving from the CDC written confirmation of the supplier's status therewith; or (3) utilizing another third-party verification source. Similarly, if the supplier submits a copy of the applicable recognition but fails to complete the applicable section of the form, the section need not be completed if the data in question can be verified on the recognition itself or via any of the three mechanisms described above in this paragraph. The contractor shall not develop for a correction to the form if the recognition information can be verified as described above.

The above-referenced written confirmation of the supplier's status can be in the form of a letter, fax, or email, but it must be in writing. Documentation of a verbal conversation between the contractor and the body in question does not qualify as appropriate confirmation.

## 10.6.1.2 – Changes of Information – Transitioned Certified Providers and Suppliers

***(Rev.: 12796; Issued: 08-15-24; Effective: 09-16-24; Implementation: 09-16-24)***

**(Until further notice from CMS, the instructions in this section 10.6.1.2 apply only to certified provider and certified supplier types that have officially "transitioned" as part of the transition of various certification activities from the SOG Location to the states, the contractors, and PEOG. These provider/supplier types include SNFs, HHAs, CMHCs, CORFs, FQHCs, Part A OPT/OSP providers, ASCs, PXRSs, hospitals,**

**hospices, and ESRD facilities. The contractor shall continue to use the existing change of information instructions--now in section 10.6.22.1 of this chapter--for all non-transitioned certified provider/supplier types.**

**When executing the instructions in this section 10.6.1.2, the contractor can disregard directives that obviously do not apply to the transitioned provider/supplier type in question (e.g., references to hospitals).**

All references to the SOG Location (formerly the "RO") in this section 10.6.1.2 refer to the applicable CMS Regional Office's Survey & Operations Group (SOG) Location. Also, and except as otherwise indicated, all references to "provider" include certified suppliers (e.g., ambulatory surgical centers, portable x-ray suppliers).

The instructions in this section 10.6.1.2 address the handling of changes of information involving certified providers and certified suppliers. With the transition of certain functions from the SOG Locations to the contractors and the Provider Enrollment & Oversight Group (PEOG), the processing instructions for these changes of information are slightly different from previous guidance. In particular: (1) the SOG Locations will be much less involved in the process; (2) tie-in and tie-out notices will no longer be issued; (3) the contractor will be responsible for finalizing changes previously requiring SOG Location approval; and (4) recommendations of approval will be made to (and reviewed by) the state agency (hereafter occasionally referenced simply as "state") only and not the SOG Location.

Except as stated otherwise:

(1) Any provider-specific instructions in section 10.2.1 et seq. of this chapter pertaining to changes of information (e.g., relocation of a federally qualified health clinic site; addition or deletion of an OPT/OSP extension site) take precedence over those in this section 10.6.1.2.

(2) Any instructions pertaining to ownership changes in section 10.6.1.1 et seq. of this chapter take precedence over those in this section 10.6.1.2.

(3) Any instructions pertaining to voluntary terminations of entire enrollments and/or provider agreements in section 10.6.1.3 of this chapter take precedence over those in this section 10.6.1.2.

(4) Any instructions in this section 10.6.1.2 concerning the voluntary termination of a branch, sub-unit, or other practice location that does not involve the termination of the entire enrollment and/or provider agreement take precedence over those in section 10.6.1.3. For instance, suppose a certified provider's Form CMS-855A enrollment has three practice locations and/or sub-units. The provider is voluntarily terminating one of them. Here, the contractor shall use the instructions in section 10.6.1.2 when processing this transaction. Now assume that a provider is of a type that must individually and separately enroll each location. The provider has three separately enrolled locations with three separate provider agreements. The provider seeks to terminate one of these locations. Since this will involve the termination of an individual/entire enrollment and corresponding provider agreement, the instructions in section 10.6.1.3 apply.

**A. Changes of Information Requiring Recommendation to the State**

**1. Types**

The following Form CMS-855 transactions require an approval recommendation to (and review by) the state prior to approval:

- Addition *or relocation/change* of outpatient physical therapy/outpatient speech pathology extension site

- Addition of HHA branch

- Addition or deletion of a prospective payment system (PPS)-excluded psychiatric unit, rehabilitation unit, or transplant program.

- Addition or deletion of swing-bed approval (see Section 2A2 of the Form CMS-855A)

- Conversion of a hospital from one type to another (e.g., acute care to psychiatric)

- Addition, deletion, or relocation of a hospice practice location

- Addition, change, and/or relocation of a hospital practice location when a survey of the new site may be required. (If the contractor is uncertain as to whether the state will perform a survey, it may (1) contact the state for guidance or (2) make the referral based on the contractor's experience with these types of changes and with the practices of the state in question. Note that a survey often may be required if the location is shifting outside of the existing geographic area.)

- Addition of PXRS practice location

**2. Initial Contractor Review and Recommendation**

The contractor shall process the change request consistent with the instructions in this chapter (e.g., verification of data, developing for missing or conflicting data). If the contractor determines that the change/addition should be approved, it shall send the appropriate recommendation letter (see section 10.7 et seq.) to the state with all applicable documentation that the contractor currently sends in such situations. The SOG Location need not be copied on the letter.

Nothing in this section 10.6.1.2(A)(2):

- Prohibits the contractor from returning or rejecting the application if grounds for doing so exist.
- Supersedes any applicable requirement for performing a site visit (including the timing of such visits).

**3. State Review and Contractor Receipt of Recommendation**

The state will review the recommendation of approval, the application, and any other pertinent information. If the state decides to perform a survey, it will do so and notify the contractor thereof.

**a. State Recommends Approval**

If the state concludes that the change/addition should be approved, it will make a recommendation to this effect to the contractor, typically via a Form CMS-1539 and/or similar confirming documentation. No later than 5 business days after receipt of the recommendation, the contractor shall send an e-mail to MedicareProviderEnrollment@cms.hhs.gov containing general identifying data about the provider (including LBN, NPI, CCN, specialty, facility name and address), a copy of the Form CMS-1539 (or other similar documentation evidencing the state's approval recommendation, if available), the draft provider approval letter, and a description of the change to be made. If, to the contractor's knowledge, a new CCN is required, the name and address of the new entity requiring the CCN should be furnished along with the effective date. If a termination is involved (e.g., HHA branch), the contractor shall include the old CCN and the termination date in the e-mail.

Once PEOG responds to the contractor, the latter may finalize its processing of the application (e.g., sending copies of the provider notification of approval to the state and, if applicable, accrediting organization; switching the PECOS record from "approval recommended" to "approved").

**b. State Does Not Recommend Approval**

If the state does not recommend approval, the contractor shall refer the matter to MedicareProviderEnrollment@cms.hhs.gov for guidance. The e-mail to him/her shall contain (1) the identifying data described in (3)(a) above; (2) a copy of the notification from the state declining to recommend approval; and (3) any other information the contractor deems pertinent. PEOG will review the matter and furnish the contractor additional instructions, which the contractor shall follow.

**4. Additional Policies**

**a. Post-Recommendation Inquiries** - Once the contractor has made its recommendation for approval to the state, any inquiry the contractor receives from the provider regarding the status of its change request shall be referred to the state.

**b. Pending State Recommendation** - So as not to keep the PECOS record in "approval recommended" status interminably, if the contractor does not receive the state's recommendation after 120 days, it may contact the state to see if its recommendation is forthcoming. The contractor may contact the state every 30 days thereafter to ascertain the recommendation's status.

**c. State Practice -** The PECOS record should not be switched to "Approved" until the contractor receives the state's approval recommendation. However, if the contractor knows that the state in question generally does not review this type of transaction, the contractor need not send the transaction to the state and shall instead follow the instructions in section 10.6.1.2(B) below.

**B. Post-Approval State Notification Required**

Form CMS-855 changes that do not mandate a recommendation to the state but do require post-approval correspondence with PEOG and the state (and, if applicable, the accrediting organization) include:

- Except as described in section 10.6.1.2(A), deletions/voluntary terminations of practice locations or hospital subunits. (Note that this scenario is different from cases where the provider is voluntary terminating its enrollment as a whole (per section 10.6.1.3 of this chapter) rather than simply terminating a single location or subunit within its enrollment.)

- LBN, TIN, or "doing business as name" changes that do not involve a CHOW.

- Except as described in section 10.6.1.2(A), address changes that generally do not require a survey of the new location.

- Addition, change, and/or relocation of a hospital practice location (including physician/practitioner group practice locations) for which a survey is not required.

- *Deletion of an OPT/OSP extension site or practice location.*

- Ownership changes that involve neither a 42 CFR § 489.18 CHOW nor a § 424.550(b) exempt or non-exempt change in HHA majority ownership (e.g., a 15 percent owner of a hospice sells her ownership stake).

The contractor shall:

(1) Inform PEOG, the state, and the AO (if appropriate) of the changed information (via any mechanism it chooses, including copying PEOG/state/AO on the notification letter or e-mail to the provider) no later than 10 calendar days after it has completed processing the transaction. Such notice to the PEOG/state/AO shall specify the type of information that is changing. (Prior PEOG approval of the change is not required, though PEOG will update applicable national database as needed.)

(2) Switch the PECOS record to "Approved."

**C. All Other Changes of Information**

**1. General Principle**

For all Form CMS-855 change requests not identified in section 10.6.1.2(A)(1) and (B) above (and except as stated in subsection (C)(2) below), the contractor shall: (1) notify the provider via letter, fax, e-mail, or telephone that the change has been made; and (2) switch the PECOS record to "Approved." The contractor need not notify the state, SOG Location, or PEOG of the change.

**2. FQHCs**

If an FQHC is adding, deleting, or changing a Section 13 contact person , the contractor shall send an approval letter via e-mail and copy the MedicareProviderEnrollment@cms.hhs.gov mailbox (with "FQHC COI" in the subject line) thereon. (Aside from this exception, all other instructions in subsection (C)(1) apply to this scenario.) See section 10.2.1.4(D) of this chapter for more information on FQHC changes of information.

**D. Revalidations, Reactivations, and Complete Form CMS-855 Applications**

**1. When Referral Required** - In situations where the provider submits a (1) Form CMS-855 reactivation, (2) Form CMS-855 revalidation, or (3) full Form CMS-855 as part of a change of information (i.e., the provider has no enrollment record in PECOS), the contractor shall make a recommendation to the state and switch the PECOS record to "approval recommended" only if the application contains new/changed data falling within one of the categories in section 10.6.1.2(A)(1). For instance, if a revalidation application reveals a new hospital psychiatric unit that was never reported to CMS via the Form CMS-855, the contractor shall make a recommendation to the state and await the state's approval recommendation before switching the record to "Approved." In this situation, the contractor should forward the application to the state with a note explaining that the only matter the state needs to consider is the new hospital unit.

**2. No Referral Required** - If the application contains new/changed data falling within one of the categories in section 10.6.1.2(B), the contractor can switch the PECOS record to "Approved." It shall also inform the state of the changed information (via any mechanism it chooses, including copying the state on the notification letter or e-mail to the provider) no later than 10 calendar days after it has completed processing the transaction.

**E. Unsolicited Notifications from State**

If the contractor receives notice of a provider's change of information from the state but the provider never submitted the required Form CMS-855 change request to the contractor, the contractor shall: (1) alert the state of the situation; and (2) contact the provider and have it complete and submit the change request. However, if the data in question is not collected on the Form CMS-855, the contractor need not make this request.

**F. Special ESRD Instructions**

Notwithstanding any other contrary instruction in this chapter, if an ESRD change of information application results in the issuance of a new or additional CCN, the contractor shall copy the ESRD Network on the approval letter it sends to the provider. The contact information for the ESRD Network can be found at https://esrdnetworks.org/membership/esrd-networks-contact-information/.

**G. Clock Stoppages and Processing Alternatives**

While awaiting PEOG's reply on any matter in this section 10.6.1.2 in which the contractor is required to refer a matter to PEOG - and beginning on the date following the sending of the e-mail referenced therein - the application processing time clock is stopped. It resumes on the date on which the contractor receives PEOG's final response. Communication between the contractor and PEOG during this "waiting period" (e.g., PEOG request for additional information from the contractor) does not restart the clock.

In addition, nothing in this section 10.6.1.2 negates other permissible clock stoppages and processing alternatives outlined in this chapter that can apply to the applications addressed in this section 10.6.1.2.

## 10.6.21.1 – Additional Miscellaneous Enrollment Topics

***(Rev.: 12796; Issued: 08-15-24; Effective: 09-16-24; Implementation: 09-16-24)***

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

**A. Type of Practice Location**

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

**B. Voluntary Terminations for Non-Certified Suppliers**

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

**C. Initial Enrollments with Multiple Locations**

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

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

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

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

**D. Verification of Telephone Numbers**

Except when the provider or supplier has a regulatory supplier standard regarding maintenance of a telephone number (e.g., § 410.33(g)(5) for IDTFs), the contractor need not verify the provider's or supplier's phone number listed on the application, *though the provider or supplier must report one. If it does not, the contractor shall develop for a phone number using the procedures outlined in this chapter.*

If a regularly supplier standard concerning telephone numbers is implicated, the contractor shall not call the supplier's phone number as a means of verification. However, all other applicable means of validating the phone number remain intact.

**E. Sales Agreement**

For any reported direct ownership change in Section 5 or 6 of the Form CMS-855A – and except as otherwise directed by CMS -- the provider must submit a copy of the legal document(s) that governed the transaction, such as a sales agreement, bill of sale, or transfer agreement. (See section 10.6.1.1.3.1.1(B) of chapter 10 for more information on such documents.) This requirement, however, does not apply to: (1) indirect ownership changes; and (2) ownership changes that are not otherwise required to be reported (e.g., less than 5 percent owner of a corporation).

***F. Survey and Certification Application Referrals to PEOG***

*Per existing guidance and as required, the contractor shall complete and submit the Survey and Certification Checklist with survey and certification applications referred to PEOG for accuracy and completion (e.g., in the instance described in section 10.2.1.7(B)(3)). This is in addition to, and not in lieu of, all other documents the contractor is required to submit with the application (e.g., Form CMS-855A, provider-signed Form CMS-1561) per this chapter or other CMS directive.*

## 10.7.9 – Revocation Letters

***(Rev.: 12796; Issued: 08-15-24; Effective: 09-16-24; Implementation: 09-16-24)***

**A. Revocation Letter Guidance**

The contractor--

- Must submit one or more of the Primary Revocation Reasons as found in section 10.4.7.3 into the appropriate section on the specific Revocation Letter. Only the CFR citation and a short heading shall be cited for the primary revocation reason.

- Shall include sufficient details to support the reason for the provider or supplier's revocation;

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

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

**B. Model Revocation Letters**

**1. Revocation Example - Letter for DMEPOS Suppliers**

[month] [day], [year]

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

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

Certified mail number: [number]
Returned receipt requested

Dear [Supplier Name]:

The purpose of this letter is to inform you that pursuant to 42 CFR §§ 405.800, 424.57(x), 424.535(g), and 424.535(a)[(x)], your Medicare supplier number [xxxxxxxxxx], Medicare enrollment, and Medicare billing privileges for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS),

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

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

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

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

[[Contractor Name] has not received a response to the developmental letter sent to you on [date] informing you that the request for a hardship exception for the required application fee was denied. The notification afforded you the opportunity to pay the mandatory application fee for processing your enrollment application and an appeal period which you did not select.]

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

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

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

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

Pursuant to 42 CFR § 424.535(c), you are barred from reenrolling in the Medicare program for a period of [number of years] year(s) from the effective date of the revocation. To reenroll after the reenrollment bar has expired, you must meet all requirements for your supplier type. In addition, if submitting a Form CMS-855S application after the reenrollment bar's expiration, 42 C.F.R. § 424.57(d)(3)(ii) states that suppliers are required to maintain an elevated surety bond amount of $50,000 for each final adverse action (which includes a Medicare revocation) imposed. Therefore, if you do not request a reconsideration of this revocation decision or receive an unfavorable decision through the administrative review process, you must submit an elevated surety bond with any application to reenroll in Medicare. Please note that this amount is in addition to, and not in lieu of, the base $50,000 amount that must be maintained.

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

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

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

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

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

- Be received in writing within 35 calendar days of the date of this letter and mailed to the address below or emailed to the address below;
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

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

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

Chags Health Information Technology LLC
P.O. Box 45266

or

*Centers for Medicare & Medicaid Services*
*Center for Program Integrity*
*Provider Enrollment & Oversight Group*

Jacksonville, FL 32232

*Attn: Division of Provider Enrollment Appeals*
*7500 Security Boulevard*
*Mailstop AR-19-51*
*Baltimore, MD 21244-1850*

Or emailed to:

[PEARC@c-hit.com] or [*ProviderEnrollmentAppeals@cms.hhs.gov*]

**Reconsideration Request:**

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

Reconsideration requests must--

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

Providers and suppliers may--

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

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

The reconsideration request should be sent to:

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

Chags Health Information
Technology LLC
P.O. Box 45266
Jacksonville, FL 32232

or

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

Or emailed to:

[PEARC@c-hit.com] or [*ProviderEnrollmentAppeals@cms.hhs.gov*]

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

Sincerely,

[Name]
[Title]
[Company]

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

[Month] [day], [year]

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

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The CAP should be sent to:

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

Or

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

Or emailed to:

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

**Reconsideration Request:**

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

Reconsideration requests must--

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

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

Providers and suppliers may--

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

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

The reconsideration request should be sent to:

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

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

or

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

Or emailed to:

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

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

Sincerely,

[Name]
[Title]
[Company]

**C. Revocation Letter Examples**

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

**1. Abuse of Billing Revocation Letter Example**

[month] [day], [year]

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

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

Dear [Provider/Supplier Name]:

Your Medicare enrollment and Medicare billing privileges are being revoked effective June 16, 2022 for the following reasons:

Revocation reason: 42 CFR § 424.535(a)(8)

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

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

**Right to Submit a Reconsideration Request:**

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

Reconsideration requests must--

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

reported within your Medicare enrollment record, or an authorized representative.

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

Providers and suppliers may--

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

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

The reconsideration request should be sent to:

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

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

or

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

Or emailed to:

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

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

Sincerely,

[Name]

[Title]
[Company]

**2. DMEPOS Supplier Revocation Letter Example**

[month] [day], [year]

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

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

Dear [Supplier Name]:

The purpose of this letter is to inform you that pursuant to 42 C.F.R. § 405.800, 42 C.F.R. §424.57(e), and 42 C.F.R. § 424.535(a)(5), your Medicare supplier number [xxxxxxxxxx], Medicare enrollment, and Medicare billing privileges for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) issued by [Contractor name) is revoked. The effective date of this revocation has been made retroactive to April 26, 2012, which is the date the Centers for Medicare & Medicaid Services (CMS) determined that your practice location is not operational.

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

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

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

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

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

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

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

In addition, if submitting a Form CMS-855S application after the reenrollment bar's expiration, 42 C.F.R. § 424.57(d)(3)(ii) states that suppliers are required to maintain an elevated surety bond amount of $50,000 for each final adverse action (which includes a Medicare revocation) imposed. Therefore, if you do not request a reconsideration of this revocation decision or receive an unfavorable decision through the administrative review process, you must submit an elevated surety bond with any application to reenroll in Medicare. Please note that this amount is in addition to, and not in lieu of, the base $50,000 amount that must be maintained.

**Right to Submit a Reconsideration Request:**

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

Reconsideration requests must--

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

Providers and suppliers may--

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

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

The reconsideration request should be sent to:

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

Chags Health Information
Technology LLC
P.O. Box 45266
Jacksonville, FL 32232

or

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

Or emailed to:

[PEARC@c-hit.com] or [*ProviderEnrollmentAppeals@cms.hhs.gov*]

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

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

Sincerely,

[Name]
[Title]
[Company]

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

[month] [day], [year]

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

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

Dear [MDPP Supplier Name]:

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

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

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

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

Specifically, you were notified on April 1, 2018 that John Doe was ineligible to serve as an MDPP coach due to an assault conviction in June 2015. On April 15, 2018, you submitted a corrective action plan (CAP), which removed John Doe from Section 7 of your Form CMS-

20134. On June 1, 2018, you submitted a claim with the NPI of John Doe for services rendered May 1st, after he was removed from your coach roster. This indicates knowingly use of an ineligible MDPP coach.

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

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

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

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

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

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

- Be received in writing within 35 calendar days of the date of this letter and mailed or emailed to the address below;
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.
- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

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

| | | |
|---|---|---|
| [Name of MAC]<br>[Address]<br>[City], [ST] [Zip] | or | Centers for Medicare & Medicaid Services<br>Center for Program Integrity |

Provider Enrollment & Oversight Group
Attn: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

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

**Reconsideration Request:**

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

Reconsideration requests must--

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

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

Providers and suppliers may--

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

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

The reconsideration request should be sent to:

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

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

or

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

Or emailed to:

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

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

Sincerely,

[Name]
[Title]
[Company]