CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 299	Date: August 28, 2009
	Change Request 6527

SUBJECT: Updates to Model Rejection, Returned Application, Revalidation, Approval, Denial/Revocation Letters and Identity Theft Prevention Letter

I. SUMMARY OF CHANGES: Updates the rejection, returned application, revalidation, three model approval letters to include appeal rights, changes the address where the certified provider/supplier denial and revocation letters are sent and adds instructions for the Model Identity Theft Prevention Letter.

NEW / REVISED MATERIAL
EFFECTIVE DATE: September 28, 2009
IMPLEMENTATION DATE: September 28, 2009

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/14.3/Model Rejection Letter
R	10/14.4/Model Returned Application Letter
R	10/14.5/Model Revalidation Letter
R	10/14.7/Model Approval Letter for Initial Enrollment
R	10/14.8/Model Approval Letter for Change of Information
R	10/14.9/Model Revalidation Approval Letter
R	10/14.10/Model Denial Letter for Certified Providers & Suppliers: Denial Based on a Condition of Participation
R	10/14.11/Model Denial Letter for Certified Providers & Suppliers: Denial Based on Enrollment Reason(s)
R	10/14.14/Model Revocation Letter for Certified Providers & Suppliers: Revocation Based on a Condition of Participation
R	10/14.15/Model Revocation Letter for Certified Providers & Suppliers: Revocation Based on Enrollment Reason(s)

R	10/14.17/Model Revocation Letter for OIG Sanctioned Provider/Suppliers
R	10/14.20/Model Identity Theft Prevention Letter

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: 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

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 299	Date: August 28, 2009	Change Request: 6527

SUBJECT: Updates to Model Rejection, Returned Application, Revalidation, Approval, Denial/Revocation Letters and Identity Theft Prevention Letter

Effective Date: September 28, 2009

Implementation Date: September 28, 2009

I. GENERAL INFORMATION

A. Background: This change request (CR) revises existing model provider enrollment language and adds appeal rights to the model rejection letter, returned application letter, revalidation letter and the three model approval letters. This CR also changes the address where the certified provider/supplier denial and revocation letters are sent to and adds instructions for the Model Identity Theft Prevention Letter.

B. Policy: Contractors shall establish and use model provider enrollment correspondence that clearly informs an applicant about the status or disposition of an enrollment action.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6527.1	Contractors shall establish and use model provider enrollment correspondence that clearly informs an applicant about the status or disposition of an enrollment action. As necessary, contractors may revise the model language contained in section 14 for grammatical changes.	X		X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	None

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Ann Marie Reimer (Vale) Annmarie.reimer@cms.hhs.gov (410) 786-4898
Post-Implementation Contact(s): Ann Marie Reimer (Vale) Annmarie.reimer@cms.hhs.gov (410) 786-4898

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers and Regional Home Health Intermediaries (RHHIs),* use the following statement:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs),* use the following statement:

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.

14.3 – Model Rejection Letter

(Rev.299, Issued: 08-28-09, Effective: 09-28-09, Implementation: 09-28-09)

See section 3.1 of this manual and/or 42 CFR 424.525 for specific reasons when a contractor shall reject the provider or supplier's enrollment application(s). This policy applies to all applications identified in sections 2.1 and 2.2 of this manual.

CMS alpha representation
Contractor

[Month Day & Year]

[Provider/Supplier Name]
[Address]
[City, State & ZIP Code]

Dear [Insert Provider/Suppler name]:

We received your Medicare enrollment application(s) on [insert date]. We are rejecting your Medicare enrollment application(s) and returning your application(s) for the following reason(s):

FACTS: [Insert ALL rejection reason(s) and cite the applicable regulatory authority]

(Repeat for multiple, if necessary)

In compliance with Federal regulations found at 42 CFR 424.525, providers and suppliers are required to submit complete application(s) and all supporting documentation within 30 calendar days from the postmark date of the contractor request for missing/incomplete information. If you would like to resubmit an application, you must complete a new Medicare enrollment application(s). Please make sure to address the issues stated above as well as sign and date the new certification statement page on your resubmitted application(s).

Providers and suppliers (except DMEPOS suppliers) can enroll in the Medicare program using either the:

1. Internet-based Provider Enrollment, Chain and Organization System (PECOS). To apply via the Internet-based PECOS, go to http://www.cms.hhs.gov/MedicareProviderSupEnroll.

2. Paper application process. To apply by paper, download and complete the Medicare enrollment application(s) from the Centers for Medicare & Medicaid Services (CMS) Web site at http://www.cms.hhs.gov/MedicareProviderSupEnroll. DMEPOS suppliers that would like to apply should download and complete the paper application(s) and sent to the National Supplier Clearinghouse (NSC).

You should return the complete application(s) to the address listed below:

[Insert contact address]

If you have any questions regarding this letter, please call [phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]
[Title]

14.4 – Model Returned Application Letter

(Rev.299, Issued: 08-28-09, Effective: 09-28-09, Implementation: 09-28-09)

See section 3.2 of this manual for information on when a contractor shall return the enrollment application(s) to the provider or supplier. This policy applies to all applications identified in sections 2.1 and 2.2 of this manual.

CMS alpha representation
Contractor

[Month Day & Year]

[Provider/Supplier Name]
[Address]
[City, State & ZIP Code]

[Insert application reference number]

Dear [Insert Provider/Suppler name]:

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

FACTS: [Insert ALL return reason(s) and cite the applicable regulatory authority, if applicable]

In order to resubmit your application(s) you must complete the [insert application type] application(s) with an original signature and date before we can begin processing your application(s). Please make sure to address the issues stated above on your resubmitted application(s).

Providers and suppliers (except DMEPOS suppliers) can enroll in the Medicare program using either the:

1. Internet-based Provider Enrollment, Chain and Organization System (PECOS). To apply via the Internet-based PECOS, go to http://www.cms.hhs.gov/MedicareProviderSupEnroll.

2. Paper application process. To apply by paper, download and complete the Medicare enrollment application(s) from the Centers for Medicare & Medicaid Services (CMS) Web site at http://www.cms.hhs.gov/MedicareProviderSupEnroll. DMEPOS suppliers that would like to apply should download and complete the paper application(s) and sent to the National Supplier Clearinghouse (NSC).

You should return the complete application(s) to the address listed below:

[Insert contact address]

If you have any questions regarding this letter, please call [insert phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]
[Title]

14.5 – Model Revalidation Letter

(Rev.299, Issued: 08-28-09, Effective: 09-28-09, Implementation: 09-28-09)

See section 9 of this manual for information regarding revalidation.

CMS alpha representation
Contractor

[Month Day & Year]

[Provider/Supplier Name]
[Address]
[City, State & ZIP Code]

Dear [Insert Provider/Suppler name]:

Consistent with Medicare regulations found at 42 CFR 424.515, [insert contractor name], a Medicare contractor, requires that you complete and submit a Medicare enrollment application(s) and submit all applicable supporting documentation within 60 calendar days of the postmark date of this letter.

Providers and suppliers (except DMEPOS suppliers) can enroll in the Medicare program using either the:

1. Internet-based Provider Enrollment, Chain and Organization System (PECOS). To apply via the Internet-based PECOS, go to http://www.cms.hhs.gov/MedicareProviderSupEnroll.

2. Paper application process. To apply by paper, download and complete the Medicare enrollment application(s) from the Centers for Medicare & Medicaid Services (CMS) Web site at http://www.cms.hhs.gov/MedicareProviderSupEnroll. DMEPOS suppliers that would like to apply should download and complete the paper application(s) and sent to the National Supplier Clearinghouse (NSC).

While the submission of your Medicare enrollment application(s) will start your 5-year revalidation cycle, you are required by regulations found at 42 CFR 424.516 to submit updates and changes to your enrollment information in accordance with specified timeframes. Reportable changes include, but are not limited to changes in: (1) legal business name (LBN)/tax identification number (TIN), (2) practice location, (3) ownership, (4) authorized/delegated officials, (5) changes in payment information such as changes in electronic funds transfer information and (6) final adverse legal actions, including felony convictions, license suspensions or revocations of a health care license, an exclusion or debarment from participation in Federal or State health care program, or a Medicare revocation by a different Medicare contractor.

Failure to submit complete enrollment application(s) and all supporting documentation within 60 calendar days of the postmark date of this letter may result in your Medicare billing privileges being revoked.

Please return the completed application(s) to:

[Insert application return address]

If you have any questions regarding this letter, please call [insert phone number] between the hours of [insert office hours] or visit our Web site at [insert Web site] for additional information regarding the enrollment process or the [insert application type].

Sincerely,

[Your Name]
[Title]

[Enclosure]

14.7 – Model Approval Letter for Initial Enrollment

(Rev.299, Issued: 08-28-09, Effective: 09-28-09, Implementation: 09-28-09)

CMS alpha representation
Contractor

[Month Day & Year]

[Provider/Supplier Name]
[Address]
[City, State & ZIP Code]

Dear [Insert Provider/Suppler name]:

We are pleased to inform you that your Medicare enrollment application is approved. Listed below is the information reflected in your Medicare enrollment record, including your National Provider Identifier (NPI) and Provider Transaction Access Number (PTAN).

If you are an existing Medicare provider and currently do not submit claims electronically, or are new to the Medicare program and plan on filing claims electronically, please contact our EDI department at [insert phone number]. To start billing the Medicare program, you must use your NPI on all Medicare claim submissions. Your PTAN is also activated for use and will be the required authentication element for all inquiries to customer service representatives (CSRs), written inquiry units and the Interactive Voice Response (IVR) system for inquiries concerning claims status, beneficiary eligibility and to check status or other supplier related transactions, therefore keep your PTAN secure. Because the PTAN is not considered a Medicare legacy identifier, do not report this identifier to the National Plan and Provider Enumeration System (NPPES) as an "other" provider identification number.

Medicare Enrollment Information

Provider \ Supplier name:	[Insert name]
Practice location:	[Insert address]
National Provider Identifier (NPI):	[Insert NPI]
Provider Transaction Access Number (PTAN):	[Insert PTAN]
Specialty:	[Insert provider/supplier specialty]
You are a:	[Insert participating or non-participating]
Effective date [Insert "of termination" if the applicant is voluntarily terminating Medicare participation]	[Insert effective date or effective date of termination]

(Repeat for multiple, if necessary, for each additional location and NPI/PTAN combination)

Please verify the accuracy of your enrollment information. If you disagree with any portion of this initial determination*, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person who was not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The request for reconsideration*

must state the issues, or the findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration request that you believe may have a bearing on the decision. The reconsideration request must be signed and dated by the physician, non-physician practitioner or any responsible authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review. The request for reconsideration should be sent to:

[Insert applicable Medicare contractor address]
You are required by regulations found at 42 CFR 424.516 to submit updates and changes to your enrollment information in accordance with specified timeframes. Reportable changes include, but are not limited to changes in: (1) legal business name (LBN)/tax identification number (TIN), (2) practice location, (3) ownership, (4) authorized/delegated officials, (5) changes in payment information such as changes in electronic funds transfer information and (6) final adverse legal actions, including felony convictions, license suspensions or revocations of a health care license, an exclusion or debarment from participation in Federal or State health care program, or a Medicare revocation by a different Medicare contractor.

Providers and suppliers may enroll or make changes to their existing enrollment in the Medicare program using the Internet-based Provider Enrollment, Chain and Organization System (PECOS). To apply via the Internet-based PECOS or to download the CMS-855 enrollment applications, go to http://www.cms.hhs.gov/MedicareProviderSupEnroll.

Additional information about the Medicare program, including billing, fee schedules, and Medicare polices and regulations can be found at our Web site at [insert Web site address] or the Centers for Medicare & Medicaid Services' (CMS) Web site at *http://*www.cms.hhs.gov/home/medicare.asp.

Sincerely,

[Your Name]
[Title]

14.8 – Model Approval Letter for Change of Information

(Rev.299, Issued: 08-28-09, Effective: 09-28-09, Implementation: 09-28-09)

CMS alpha representation
Contractor

[Month Day & Year]

[Provider/Supplier Name]
[Address]
[City, State & ZIP Code]

Dear [Insert Provider/Suppler name]:

We have approved your information change request. Listed below is the [insert "new" or "updated"] information reflected in your Medicare enrollment record.

Medicare Enrollment Information

Provider \ Supplier name:	[Insert name]
[Insert revised item on the application]:	[Insert updated or changed item on the application]
National Provider Identifier (NPI):	[Insert NPI]
Provider Transaction Access Number (PTAN):	[Insert active or inactive PTAN]
Specialty:	[Insert provider/supplier specialty]
You are a:	[Insert participating or non-participating]
Effective date [Insert "of termination" if the applicant is voluntarily terminating Medicare participation]	[Insert effective date or effective date of termination]
If a Change of Ownership (CHOW, insert Medicare Year-End Cost Report date:	[Insert Month and Day]

(Repeat for multiple, if necessary, for each additional location and NPI/PTAN combination)

Please verify the accuracy of your enrollment information. If you disagree with any portion of this initial determination*, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person who was not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The request for reconsideration must state the issues, or the findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration request that you believe may have a bearing on the decision. The reconsideration request must be signed and dated by the physician, non-physician practitioner or any responsible authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review. The request for reconsideration should be sent to:*

[Insert applicable Medicare contractor address]

ADDITIONAL INFORMATION

If you are an existing Medicare provider and currently do not submit claims electronically, or are new to the Medicare program and plan on filing claims electronically, please contact our EDI department at [insert phone number]. To start billing the Medicare program, you must use your

NPI on all Medicare claims submissions. Your PTAN will be the required authentication element for all inquiries to customer service representatives (CSRs), written inquiry units and the interactive voice response (IVR) system for inquiries concerning claims status, beneficiary eligibility and to check status or other supplier related transactions, therefore keep your PTAN secure.

To maintain an active enrollment status in the Medicare Program, regulations found at 42 CFR 424.516 require that you submit updates and changes to your enrollment information in accordance with specified timeframes. Reportable changes include, but are not limited to changes in: (1) legal business name (LBN)/tax identification number (TIN), (2) practice location, (3) ownership, (4) authorized/delegated officials, (5) changes in payment information such as changes in electronic funds transfer information and (6) final adverse legal actions, including felony convictions, license suspensions or revocations of a health care license, an exclusion or debarment from participation in Federal or State health care program, or a Medicare revocation by a different Medicare contractor.

Providers and suppliers may enroll or make changes to their existing enrollment in the Medicare program using the Internet-based Provider Enrollment, Chain and Organization System (PECOS). To apply via the Internet-based PECOS or to download the CMS-855 enrollment applications, go to http://www.cms.hhs.gov/MedicareProviderSupEnroll.

Sincerely,

[Your Name]
[Title]

14.9 – Model Revalidation Approval Letter

(Rev.299, Issued: 08-28-09, Effective: 09-28-09, Implementation: 09-28-09)

CMS alpha representation
Contractor

[Month Day & Year]

[Provider/Supplier Name]
[Address]
[City, State & ZIP Code]

Dear [Insert Provider/Suppler name]:

We have processed your Medicare enrollment application(s) to revalidate your Medicare enrollment information.

Listed below is the information reflected in your Medicare enrollment record.

Medicare Enrollment Information:

Provider Name:	[Insert name]
Practice Location:	[Insert address]
National Provider Identifier (NPI):	[Insert NPI]
Provider Transaction Access Number (PTAN):	[Insert PTAN]
You are a:	[Insert participating or non-participating]
Effective Date:	[Insert month day, year]
If a Change of Ownership (CHOW), insert Medicare Year-End Cost Report date:	[Insert Month and Day]

(Repeat for multiple, if necessary, for each additional location and NPI/PTAN combination)

Please verify the accuracy of your enrollment information. If you disagree with any portion of this initial determination, *you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person who was not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The request for reconsideration must state the issues, or the findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration request that you believe may have a bearing on the decision. The reconsideration request must be signed and dated by the physician, non-physician practitioner or any responsible authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review. The request for reconsideration should be sent to:*

[For Part B Supplier, insert contractor address]
[For Certified Providers/Suppliers, insert CMS address]

To maintain an active enrollment status in the Medicare program, regulations found at 42 CFR 424.516 require that you submit updates and changes to your enrollment information in accordance with specified timeframes. Reportable changes include, but are not limited to changes in: (1) legal business name (LBN)/tax identification number (TIN), (2) practice location, (3) ownership, (4) authorized/delegated officials, (5) changes in payment information such as changes in electronic funds transfer information and (6) final adverse legal actions, including felony convictions, license suspensions or revocations of a health care license, an exclusion or debarment from participation in Federal or State health care program, or a Medicare revocation by a different Medicare contractor.

Providers and suppliers may enroll or make changes to their existing enrollment in the Medicare program using the Internet-based Provider Enrollment, Chain and Organization System

(PECOS). To apply via the Internet-based PECOS or to download the CM-855 enrollment applications, go to http://www.cms.hhs.gov/MedicareProviderSupEnroll.

Sincerely,

[Your Name]
[Title]

14.10 – Model Denial Letter for Certified Providers & Suppliers: Denial Based on a Condition of Participation

(Rev.299, Issued: 08-28-09, Effective: 09-28-09, Implementation: 09-28-09)

See section 6.2 of this manual and/or 42 CFR 424.530 to view circumstances that warrant a fee-for-service contractor to deny a provider or supplier's enrollment in the Medicare program. If the *certified* provider or *certified* supplier *(i.e., ambulatory surgery center (ASC) and portable x-ray)* is denied based on a condition of participation, then the applicant or enrolled entity must submit a reconsideration or a corrective action plan *with CMS.*

CMS alpha representation
Contractor

[Month Day & Year]

[Provider/Supplier Name]
[Address]
[City, State & ZIP Code]

RE: Notice of Denial

Dear [Insert Provider/Suppler name]:

We have received your request to enroll in the Medicare program. However, your application request to receive Medicare payment is denied. After reviewing the submitted Medicare enrollment application(s), it was determined that you do not meet the conditions of enrollment or meet the requirement to qualify as a [insert provider or supplier type e.g., hospital, skilled nursing facility, hospice]

FACTS: [Insert ALL the reason(s) for denial and cite the applicable regulatory authority]

(Repeat for multiple, if necessary)

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30

calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. *The reconsideration request must be signed by the authorized or delegated official within the entity.* CAP requests should be sent to:

Centers for Medicare & Medicaid Services
Division of Provider & Supplier Enrollment
7500 Security Blvd.
Mailstop: C3-02-16
Baltimore, MD 21244-1850

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person who was not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The request for reconsideration must state the issues, or the findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration request that you believe may have a bearing on the decision. *The reconsideration request must be signed and dated by the authorized or delegated official within the entity.* Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review. [The following statement should only be used if the denial involves exclusions or sanction: 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]. The request for reconsideration should be sent to:

Centers for Medicare & Medicaid Services
Division of Provider & Supplier Enrollment
7500 Security Blvd.
Mailstop: C3-02-16
Baltimore, MD 21244-1850

If you have any questions regarding this letter, please call [phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]
[Title]

14.11 – Model Denial Letter for Certified Providers & Suppliers: Denial Based on an Enrollment Reason(s)

(Rev.299, Issued: 08-28-09, Effective: 09-28-09, Implementation: 09-28-09)

See section 6.2 of this manual and/or 42 CFR 424.530 to view circumstances that warrant a fee-for-service contractor to deny a provider or supplier's enrollment in the Medicare program. If the *certified* provider or *certified* supplier is denied *(i.e., ambulatory surgery center (ASC) and portable x-ray)* based on an enrollment reason(s), then the applicant or enrolled entity must file a reconsideration with *CMS*.

CMS alpha representation
Contractor

[Month Day & Year]

[Provider/Supplier Name]
[Address]
[City, State & ZIP Code]

RE: Notice of Denial

Dear [Insert Provider/Suppler name]:

We have received your request to enroll in the Medicare program. However, your application request to receive Medicare payment is denied. After reviewing the submitted Medicare enrollment application(s), it was determined that you do not meet the conditions of enrollment or meet the requirement to qualify as a [insert provider or supplier type e.g., hospital, skilled nursing facility, hospice].

FACTS: [Insert ALL the reason(s) for denial and cite the applicable regulatory authority]

(Repeat for multiple, if necessary)

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. *The reconsideration request must be signed and dated by the individual provider or the authorized or delegated official within the entity.* CAP requests should be sent to:

Centers for Medicare & Medicaid Services
Division of Provider & Supplier Enrollment
7500 Security Blvd.
Mailstop: C3-02-16
Baltimore, MD 21244-1850

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person who was not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The request for reconsideration must state the issues, or the findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration request that you believe may have a bearing on the decision. *The reconsideration request must be signed and dated by the individual provider or authorized or delegated official within the entity.* Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review. [The following statement should only be used if the denial involves exclusions or sanction: 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]. The request for reconsideration should be sent to:

Centers for Medicare & Medicaid Services
Division of Provider & Supplier Enrollment
7500 Security Blvd.
Mailstop: C3-02-16
Baltimore, MD 21244-1850

If you have any questions regarding this letter, please call [phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]
[Title]

14.14 – Model Revocation Letter for Certified Providers & Suppliers: Revocation Based on a Condition of Participation

(Rev.299, Issued: 08-28-09, Effective: 09-28-09, Implementation: 09-28-09)

See section 13 of this manual and/or 42 CFR 424.535 to view the circumstances that warrant a fee-for-service contractor to revoke a provider or supplier's Medicare billing privileges. If the *certified* provider or *certified* supplier *(i.e., ambulatory surgery center (ASC) and portable x-ray)* is revoked based on a condition of participation, then the applicant or enrolled entity must submit a reconsideration or corrective action plan *with CMS.*

CMS alpha representation
Contractor

[Month Day & Year]

[Provider/Supplier Name]
[Address]
[City, State & ZIP Code]

RE: Notice of Revocation of Medicare Billing Privileges

Dear [Insert Provider/Suppler name]:

This is to inform you that your Medicare privileges are being revoked effective [insert effective date of revocation]. Pursuant to 42 CFR 424.545(a), this action will also terminate your corresponding provider agreement.

FACTS: [Insert ALL reason(s) for revocation and cite the applicable regulatory authority]

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. *The reconsideration request must be signed and dated by the authorized or delegated official within the entity.* CAP requests should be sent to:

Centers for Medicare & Medicaid Services
Division of Provider & Supplier Enrollment
7500 Security Blvd.
Mailstop: C3-02-16
Baltimore, MD 21244-1850

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person who was not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The request for reconsideration must state the issues, or the findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration request that you believe may have a bearing on the decision. *The reconsideration request must be signed and dated by the authorized or delegated official within the entity.* Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review. [The following statement should only be used if the denial involves exclusions or sanction: 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.] The request for reconsideration should be sent to:

Centers for Medicare & Medicaid Services
Division of Provider & Supplier Enrollment
7500 Security Blvd.
Mailstop: C3-02-16
Baltimore, MD 21244-1850

Pursuant to 42 CFR 424.535(c), [insert contractor name] is establishing a re-enrollment bar for a period of [insert amount of time]. This enrollment bar only applies to your participation in the Medicare program. In order to re-enroll, you must meet all requirements for your provider or supplier type.

If you have any questions regarding this determination, please contact [insert contact name] at [insert phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]
[Title]

Enclosure [Attach a copy of the development letter if applicable]

14.15 – Model Revocation Letter for Certified Providers & Suppliers: Revocation Based on an Enrollment Reason(s)

(Rev.299, Issued: 08-28-09, Effective: 09-28-09, Implementation: 09-28-09)

See section 13 of this manual and/or 42 CFR 424.535 to view the circumstances that warrant a fee-for-service contractor to revoke a provider or supplier's Medicare billing privileges. If the *certified* provider or *certified* supplier *(i.e., ambulatory surgery center (ASC) and portable x-ray)* is revoked based on an enrollment reason(s), then the applicant or enrolled entity must file a reconsideration with *CMS*.

CMS alpha representation
Contractor

[Month Day & Year]

[Provider/Supplier Name]
[Address]
[City, State & ZIP Code]

RE: Notice of Revocation of Medicare Billing Privileges

Dear [Insert Provider/Suppler name]:

This is to inform you that your Medicare billing privileges are being revoked effective [insert effective date of revocation]. Pursuant to 42 CFR 424.545(a), this action will also terminate your corresponding provider agreement.

FACTS: [Insert ALL the reason(s) for revocation and cite the applicable regulatory authority]

(Repeat for multiple, if necessary)

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. *The reconsideration request must be signed and dated by the individual provider or authorized or delegated official within the entity.* CAP requests should be sent to:

Centers for Medicare & Medicaid Services
Division of Provider & Supplier Enrollment
7500 Security Blvd.
Mailstop: C3-02-16
Baltimore, MD 21244-1850

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person who was not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The request for reconsideration must state the issues, or the findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration request that you believe may have a bearing on the decision. *The reconsideration request must be signed and dated by the individual provider or authorized or delegated official within the entity.* Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review. [The following statement should only be used if the denial involves exclusions or sanction: 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]. The request for reconsideration should be sent to:

Centers for Medicare & Medicaid Services
Division of Provider & Supplier Enrollment
7500 Security Blvd.
Mailstop: C3-02-16
Baltimore, MD 21244-1850

Pursuant to 42 CFR 424.535(c), [insert contractor name] is establishing a re-enrollment bar for a period of [insert amount of time]. This enrollment bar only applies to your participation in the Medicare program. In order to re-enroll, you must meet all requirements for your provider or supplier type.

If you have any questions regarding this letter, please call [phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]
[Title]

14.17 – Model Revocation Letter for OIG Sanctioned Providers/Suppliers

(Rev.299, Issued: 08-28-09, Effective: 09-28-09, Implementation: 09-28-09)

[Month Day & Year]

[Provider/Supplier Name]
[Address]
[City, State & ZIP Code]

RE: Notice of Revocation of Medicare Billing Privileges

Dear [Insert Provider/Supplier name]:

This *letter* is to inform you that your Medicare *Provider Transaction Access Number (PTAN) [insert PTAN number] that is associated to the National Provider Identifier (NPI) [insert NPI number] has been* revoked effective [insert date of OIG debarment or exclusion].

According to federal regulations 42 CFR 424.535(a)(2), the provider or any owner, managing employee, authorized or delegated official, medical director, supervising physician or other health care personnel of the provider or supplier who has been debarred, suspended or excluded from the Medicare, Medicaid or any other Federal health care or other government program, cannot maintain enrollment in the Medicare program. According to information obtained from the U.S. Department of Health & Human Services (Office of Inspector General), [insert provider/supplier name] has been excluded from participating in the Medicare program.

FACTS: The Department of Health and Human Services, Office of Inspector General notified us that you are excluded from the Medicare, Medicaid, or any other Federal health care program as defined in 42 CFR 1001.2; in accordance with section 1128, 1128A, 1156, 1842, 1862, 1867 or 1892 of the Social Security Act. You are excluded as of [insert effective date of exclusion] for [Cite the regulatory basis for exclusion. For example: 1128(b)(14)-Default on health education loan and scholarship obligations].

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. However, if you believe that this revocation is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person who was not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The request for reconsideration must state the issues, or the findings of fact with which you disagree and the reasons for

disagreement. You may submit additional information with the reconsideration request that you believe may have a bearing on the decision. The reconsideration request must be signed and dated by the individual provider or authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review. [The following statement should only be used if the denial involves exclusions or sanction: 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]. The request for reconsideration should be sent to:

[For Part B Supplier, insert contractor address]
[For Certified Providers/Suppliers, insert CMS address]

Finally, in accordance with 42 CFR 424.565, [insert name of contractor] is assessing an overpayment in the amount of [insert dollar amount] because the physician or non-physician practitioner continued to furnish services to Medicare beneficiaries after a final adverse action precluded enrollment in the Medicare program.] [Note: As stated in 42 CFR 424.565, Medicare contractors should assess an overpayment back to January 1, 2009, not the date of the final adverse action if the adverse action occurred prior to January 1, 2009.]

If you have any questions regarding this letter, please call [insert phone number] between the hours of [insert office hours]

Sincerely,

[Your name]
[Title]

14.20 – Model Identity Theft Prevention Letter

(Rev.299, Issued: 08-28-09, Effective: 09-28-09, Implementation: 09-28-09)

The contractor shall use the following model letter for changes of information and reassignment enrollment applications received, paper and web-submitted, where suspicious provider/supplier enrollment activity may be suspected, except in circumstances where the application can be returned based on the manual instructions in section 3.2 of this chapter. This model letter shall be sent to the address previously established and on file.

CMS alpha representation
Contractor

[Month Day & Year]

[Provider/Supplier]

[Address]
[City, State & ZIP Code]

Dear [Insert Provider/Suppler]:

As a security precaution, we are writing to confirm that you submitted a Medicare enrollment application(s) to enroll or change an existing enrollment at the following address:

[Insert Provider/Supplier Address]

If this application was submitted without your authorization, please call the Medicare contractor that processes your claims. The Medicare Fee-For-Service contact information can be found at www.cms.hhs.gov/MedicareProviderSupEnroll.

We will process your application(s) according to The Centers for Medicare & Medicaid (CMS) timeliness standards and will contact you if there is a need for additional information. We will notify you once processing is complete.

Please contact our office with any questions at [insert phone number] between the hours of [insert office hours] and refer to your application(s) reference number [insert reference number].

Sincerely,

[Your Name]
[Title]