CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 590	**Date: April 24, 2015**
	Change Request 9120

SUBJECT: Update of CMS-855A, Physician-Owned Hospital Reporting Via the CMS-855POH and Indirect Payment Procedure Registration Via the CMS-855C in Chapter 15 of Pub. 100-08

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to update CMS-855 application instructions in chapter 15 of Pub. 100-08.

EFFECTIVE DATE: May 25, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 25, 2015

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	15/15.4.1.8 - Hospitals and Hospital Units
R	15/15.7.9.2 - Submission of Registration Applications
R	15/15.7.9.3 – Processing of Registration Applications
R	15/15.7.9.4 – Disposition of Registration Applications
R	15/15.7.9.6 – Changes of Information and Other Registration Transactions
R	15/15.7.9.7 - Registration 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: 590	Date: April 24, 2015	Change Request: 9120

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EFFECTIVE DATE: May 25, 2015
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IMPLEMENTATION DATE: May 25, 2015

I. GENERAL INFORMATION

A. Background: This CR updates chapter 15 of Pub. 100-08 with CMS-855 application instructions. Since the last update to this chapter, there have been two Office of Management and Budget (OMB) approved CMS-855 forms. The first form, CMS-855C, is solely for Indirect Payment Plan billers. The second form, CMS-855POH, is solely for physician-owned hospitals to report ownership and investment interest, regardless of the percentage. The CMS-855POH replaces Attachment 1 of the CMS-855A application. This update replaces all reference to the CMS-855A Attachment 1 and adds references to the CMS-855C.

B. Policy: The OMB approved two CMS-855 forms, the CMS-855C, solely used by Indirect Payment Plan (IPP) billers for Medicare registration and the CMS-855POH, used solely by physician-owned hospitals for reporting hospital ownership and investment interest. This CR updates all references in chapter 15 of Pub. 100-08 to use the CMS-855C for IPP billers and updates all references to the CMS-855A Attachment 1 to the CMS-855POH for physician-owned hospitals.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9120.1.	The contractor shall observe the instructions in section 15.4.1.8 concerning the CMS-855POH	X								
9120.2.	The contractor shall observe the instructions in sections 15.7.9.2, 15.7.9.3, 15.7.9.4, 15.7.9.6, 15.7.9.7 concerning the CMS-855C		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility		
		A/B MAC	DME MAC	CEDI

		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Kimberly McPhillips, 410-786-5374 or kimberly.mcphillips@cms.hhs.gov, Andrew Stouder, 410-786-0222 or andrew.stouder@cms.hhs.gov

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

VI. FUNDING

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

ATTACHMENTS: 0

15.4.1.8 - Hospitals and Hospital Units

(Rev.590, Issued: 04-24-15, Effective: 05-25-15, Implementation: 05-25-15)

A. Swing-Bed Designation

A "swing-bed" hospital is one that is approved by CMS to furnish post-hospital skilled nursing facility (SNF) services. That is, hospital (or critical access hospital (CAH)) patients' beds can "swing" from furnishing hospital services to providing SNF care without the patient necessarily being moved to another part of the building. It receives a separate survey and certification from that of the hospital. Thus, if swing-bed designation is terminated, the hospital still maintains its certification. In addition, the hospital is given an additional CMS Certification Number (CCN) to bill for swing-bed services. (The third digit of the CCN will be the letter U, W, Y or Z.)

As stated in 42 CFR §482.66, in order to obtain swing-bed status the hospital – among other things – must: (1) have a Medicare provider agreement, (2) be located in a rural area, and (3) have fewer than 100 non-newborn or intensive care beds. Swing-bed hospitals, therefore, are generally small hospitals in rural areas where there may not be enough SNFs. The hospital is thus used to furnish SNF services.

A separate provider agreement and enrollment for the swing-bed unit is not required. (The hospital's provider agreement incorporates the swing-bed services.) The hospital can add the swing-bed unit as a practice location via the Form CMS-855A.

Additional data on "swing-bed" units can be found in Pub. 100-07, State Operations Manual, chapter 7, sections 2036 – 2040.

B. Psychiatric and Rehabilitation Units

Though these units receive a State survey, a separate provider agreement and enrollment is not required. (The hospital's provider agreement incorporates these units.) The hospital can add the unit as a practice location to the Form CMS-855A.

C. Multi-Campus Hospitals

A multi-campus hospital (MCH) has two or more hospital campuses operating under one CCN number. The MCH would report its various units/campuses as practice locations on the Form CMS-855A. A hospital that has its own main campus but also occupies space in another hospital has a "satellite facility" in that other hospital.

For additional information on multi-campus hospitals, see Pub. 100-07, chapter 2, section 2024.

D. Physician-Owned Hospitals

A physician-owned hospital means any participating hospital (as defined in 42 CFR §489.24) in which a physician, or an immediate family member of a physician has an ownership or investment interest in the hospital. The ownership or investment interest may be through equity, debt, or other means, and includes an interest in an entity that holds an ownership or investment interest in the hospital. (This definition does not include a hospital with physician ownership or investment interests that satisfy the requirements at 42 CFR §411.356(a) or (b).

Section 2(A)(4) of the Form CMS-855A asks the applicant to identify whether it is a physician-owned hospital. If the applicant indicates in section 2(A)(2) that it is a hospital, it must complete section 2(A)(4). Applicants that are not hospitals need not complete section 2(A)(4).

- *CMS-855POH* must be completed if the applicant is a physician-owned hospital – even if it furnishes similar information in section 5 and/or 6 of the Form CMS-855A.

15.7.9.2 - Submission of Registration Applications

(Rev.590, Issued: 04-24-15, Effective: 05-25-15, Implementation: 05-25-15)

A. Jurisdiction

An IPP entity's registration application must be submitted to each Medicare claims administration contractor to which the IPP entity will be submitting claims. Claims for all Part B items and services – other than for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) – must be submitted to the A/B Medicare Administrative Contractor (MAC) or carrier based on where the service was performed or the item was furnished. Almost all claims for DMEPOS must be submitted to the DME MAC based on where the beneficiary resides. However, claims for Medicare-covered implantable devices, although classified as DME, are submitted to the A/B MACs or carriers based on where the implant surgery was performed. These jurisdictional rules for claim submission apply to submission of registration applications. As such, the IPP entity must complete and submit:

(1) Form CMS-855C and Form CMS-588 to each applicable A/B MAC to which the plan will be submitting its non-DMEPOS claims; and/or

(2) Form CMS-855C and Form CMS-588 to the National Supplier Clearinghouse (NSC).

With respect to (1) – and consistent with section 15.5.4.2(D) of this chapter - the IPP entity need only submit one Form CMS-855*C* application and one Form CMS-588 per contractor jurisdiction.

B. Form Completion

The IPP entity:

(1) Must use the paper version of the Form CMS-855 application.

(2) Must – in light of its ineligibility for an NPI - apply for and receive either a Health Plan Identifier (HPID) or an Other Entity Identifier (OEID) in accordance with 45 CFR §162. This is to facilitate the entity's submission of claims under the IPP. The entity must furnish its HPID or OEID in the appropriate place on the Form CMS-855. It shall also list the HPID or OEID on the Form CMS-855 and Form CMS-588 and furnish documentation evidencing the issuance of the number (e.g., a notice from the HPID or OEID issuer identifying the number).

(3) Need not submit licensure or certification information.

(4) Shall list its main business address (e.g., its headquarters) and resident agent address (if applicable) as practice locations.

(5) Need not report medical record storage information.

(6) Need not pay an application fee (as it is not an "institutional provider" under 42 CFR §424.502), although it must receive payments via electronic funds transfer (EFT).

(7) Need not submit a Form CMS-460. Because §1842(h)(1) of the Social Security Act only permits "physicians and suppliers" to enter into participation agreements and because IPP entities do not meet the definition of a "supplier" at § 400.202, IPP entities cannot enter into a participation agreement (Form CMS-460) with Medicare. The IPP entity shall therefore be treated as "non-participating."

(8) Need not meet the applicable (a) supplier standards, (b) accreditation requirements, (c) surety bond requirements, and (d) liability insurance requirements if the IPP entity is a DMEPOS supplier. (The NSC may need to relax certain edits in the Provider Enrollment, Chain and Ownership System (PECOS).) Moreover, the contractor need not perform a site visit.

(9) Meet the attestation requirements in subsection (C) below.

C. Attestation

1. Contents

The IPP entity must submit with each registration application a signed attestation statement certifying that for each claim it submits, all of the following requirements in 42 CFR §424.66 are met:

(1) The entity provides coverage of the service under a complementary health benefit plan and covers only the amount by which the Part B payment falls short of the approved charge for the service under the plan.

(2) The entity has paid the person (i.e., the physician or other supplier) who provided the service (including the amount payable under the Medicare program) an amount that the physician or other supplier accepts as full payment.

(3) The entity has the written authorization of the beneficiary (or other person authorized to sign claims on the beneficiary's behalf under 42 CFR §424.36) to receive the Part B payment for the services paid by the entity.

(4) The entity relieves the beneficiary of liability for payment for the service and will not seek any reimbursement from the beneficiary, the beneficiary's survivors, or the beneficiary's estate.

(5) The entity agrees to submit any information requested by CMS or by a Medicare contractor, including an itemized physician or supplier bill, in order to apply the requirements under the Medicare program.

(6) The entity agrees to identify and exclude from its requests for payment all services for which Medicare is the secondary payer.

This attestation is necessary to help ensure that the entity is in compliance with the provisions of §424.66. As already stated, compliance with § 424.66 is a prerequisite for initial and continued registration as an IPP entity.

Since the IPP entity may be submitting applications in multiple jurisdictions, it is acceptable for the entity to submit a photocopy of a signed attestation rather than an originally signed attestation.

2. Signature

An "authorized official" - as that term is defined in 42 CFR §424.502 – must sign all attestations, though the same authorized official need not sign all attestations.

The certification statement on the Form CMS-855*C* supplements - and does not supplant - the attestation referred to above. The IPP entity is bound by the terms of the certification statement to the same extent as it is bound by the attestation's terms.

15.7.9.3 – Processing of Registration Applications

(Rev.590, Issued: 04-24-15, Effective: 05-25-15, Implementation: 05-25-15)

A. Basic Requirements

Upon receipt of a Form CMS-855*C* registration application from an IPP entity, the contractor shall begin processing the application. This includes:

- Ensuring that the application is complete (see section D(1) below for additional information).

- Creating a logging & tracking (L & T) record and entering the IPP entity's information in the Provider Enrollment, Chain and Ownership System (PECOS).

- Verifying the information on the application in accordance with (1) the "limited" category of screening (see section 15.19.2.1(A) of this chapter for more information), and (2) existing processing guidelines (e.g., reviewing all entities and individuals listed on the Form CMS-855 against the Medicare Exclusion Database and General Services Administration Excluded Parties List System).

- Ensuring that the attestation identified in section 15.7.9.2 above is submitted, signed by an authorized official, and contains the required language.

- As needed, asking the entity for additional or clarifying information using the procedures outlined in this chapter and other applicable CMS directives; this may include information – beyond the attestation itself – that is necessary to determine whether the entity is indeed in compliance with the provisions of 42 CFR §424.66.

- Assigning specialty code C2.

- Assigning a Provider Transaction Access Number (PTAN) (if the application is approved).

B. Prescreening

The contractor need not "prescreen" (as that term is described in section 15.7.1.1 of this chapter) the registration application.

C. Returns

Section 15.8.1 of this chapter outlines the reasons for which the contractor may immediately return a Form CMS-855*C*. If the contractor determines that one or more of these reasons applies, it shall return the registration application in accordance with the instructions outlined in that section.

D. Development Issues

If, in response to a development request, the IPP entity indicates that it is unable to furnish certain data elements because said elements do not apply to it, the contractor shall contact its Provider Enrollment Operations Group Business Function Lead (PEOG BFL) for guidance.

E. Timeliness and Accuracy Standards

The timeliness and accuracy standards in sections 15.6.1.1.3, 15.6.1.2, 15.6.2.1, and 15.6.2.2 of this chapter apply to the processing of IPP initial applications and changes of information. Should the contractor exceed timeliness standards due to the requirements of sections 15.7.9.1 through 15.7.9.7, the contractor shall note the provider file in accordance with section 15.7.3 of this chapter.

F. HPID/OEID

The algorithm for the HPID/OEID is similar to that of the National Provider Identifier in that it will be 10 digits in length and will begin with either a "7" (HPID) or a "6" (OEID). The HPID/OEID will replace the placeholder NPI for IPP entities only.

15.7.9.4 – Disposition of Registration Applications

(Rev.590, Issued: 04-24-15, Effective: 05-25-15, Implementation: 05-25-15)

A. Approval

If the contractor determines that the IPP entity meets all necessary requirements, it shall send an e-mail to its Provider Enrollment Operations Group Business Function Lead (PEOG BFL) that contains: (1) the entity's legal business name, "doing business as" name (if applicable) and HPID or OEID; (2) a draft approval letter patterned after the applicable model letter in section 15.7.9.7; and (3) any issues the contractor encountered in its review. The PEOG BFL will review the matter and advise the contractor as to how to proceed.

If PEOG authorizes the approval, the contractor shall (1) switch the Provider Enrollment, Chain and Ownership System (PECOS) record to "Approved," (2) establish an effective date that is the date on which the contractor approved the application, (3) assign a Provider Transaction Access Number (PTAN) or National Supplier Clearinghouse number (as applicable), and (4) send the approval letter via regular mail or e-mail to the entity no later than 5 business days after the contractor received authorization of the approval from PEOG.

After the entity is registered, the contractor (consistent with §424.66(a)(5)) may request additional information in order to confirm the entity's continued compliance with 42 CFR §424.66.

B. Denial

If the contractor determines that the entity does not meet all necessary requirements, it shall send an e-mail to its PEOG BFL that contains: (1) the entity's legal business name, "doing business as" name (if applicable), and HPID or OEID; (2) a draft denial letter patterned after the applicable model letter in section 15.7.9.7; and (3) the contractor's rationale for proposing to deny the application. The PEOG BFL will review the matter and advise the contractor as to how to proceed.

Grounds for denial include, but are not limited to, the following:

(1) The entity does not comply with all applicable registration requirements.

(2) The entity does not satisfy all of the requirements described in 42 CFR §424.66. (The contractor can contact its PEOG BFL for assistance on this issue.)

(3) The entity or any of its 5 percent or greater direct or indirect owners, managing employees, corporate officers, or corporate directors - or any entity or individual with a general partnership interest or a 10 percent or greater limited partnership interest in the entity - is excluded or debarred per the Medicare Exclusion Database (MED) and/or the General Services Administration Excluded Parties List System.

If the contractor believes that any other ground for denial exists, it shall include this in its e-mail to its PEOG BFL.

If PEOG authorizes the denial, the contractor shall (1) switch the PECOS record to "Denied," and (2) send the denial letter via certified mail to the entity no later than 5 business days after the contractor received authorization of the denial from PEOG.

As indicated in the model denial letter in section 15.7.9.7, an entity may appeal the denial of its IPP registration application. Although IPP entities are neither providers nor suppliers, the procedures in sections 15.25.2 through 15.25.2.3 of this chapter shall apply to IPP appeals.

C. Rejection

The Form CMS-855*C* shall be rejected if (1) the entity fails to furnish all required information on the form within 30 calendar days of the contractor's request to do so, or (2) the entity fails to timely submit new or corrected information in the scenarios described in section 15.8.2 of this chapter. (This includes situations in which information was submitted, but could not be verified.) The basis for rejection shall be 42 CFR §424.525(a). The rejection letter shall follow the format of the applicable letter in section 15.7.9.7 and shall be sent via regular mail no later than 5 business days after the contractor determines that the application should be rejected.

Prior PEOG approval of the rejection is unnecessary. However, as stated earlier, if the entity indicates that it is unable to furnish certain data elements because said elements do not apply to it, the contractor shall contact its PEOG BFL for guidance.

15.7.9.6 – Changes of Information and Other Registration Transactions

(Rev.590, Issued: 04-24-15, Effective: 05-25-15, Implementation: 05-25-15)

A. Changes of Information

An IPP entity is required to submit changes to its Form CMS-855*C* information in accordance with the terms of its signed Form CMS-855*C* certification statement. The contractor shall process such changes in accordance with existing instructions.

B. Other Transactions

1. Deactivations – The contractor shall not deactivate an entity's IPP registration for any reason unless CMS instructs the contractor to do so.

2. Voluntary Terminations – If an IPP entity submits a voluntary termination application, the contractor shall process it in accordance with existing instructions.

15.7.9.7 – Registration Letters

(Rev.590, Issued: 04-24-15, Effective: 05-25-15, Implementation: 05-25-15)

The contractor shall use the following letters when approving, denying, or rejecting an application, or when revoking an entity's registration.

A. Approval

CMS alpha representation
Contractor

[Month Day & Year]

[Entity Name]
[Address]
[City, State & zip code]

Dear [Entity name]:

We are pleased to inform you that your Medicare Form CMS-855*C* registration application as an Indirect Payment Procedure (IPP) entity has been approved. Listed below is the information reflected in your Medicare Form CMS-855*C* record, including your Provider Transaction Access Number (PTAN).

For more information on how to bill Medicare, please contact our XXXXXXXX department at [insert phone number].

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 related transactions. Please keep your PTAN secure.

Medicare Information

Entity name:	[Insert name]
Business address:	[Insert address]

PTAN: [Insert PTAN]
Status: IPP Entity

Please verify the accuracy of this information. If you disagree with this initial determination or have any questions regarding the information above, call [insert applicable Medicare contractor name] at [insert Medicare contractor phone number] between the hours of [insert hours of operation].

Consistent with 42 CFR §424.516, you must submit updates and changes to your Form CMS-855*C* 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) business address, and (3) payment information (such as changes in electronic funds transfer information). To download the CMS-855 applications, go to http://www.cms.hhs.gov/MedicareProviderSupEnroll.

Additional information about the Medicare program, including billing, fee schedules, and Medicare policies 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]

B. Denial

CMS alpha representation
Contractor

[Month Day & Year]

[Entity name]
[Address]
[City, State & zip code]

RE: [insert decision]

Dear [Entity name]:

We have received and reviewed your Form CMS-855*C* registration application as an Indirect Payment Procedure (IPP) entity. Your application is denied. We have determined that you do not meet the conditions necessary to bill Medicare as an IPP entity.

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 bill Medicare as an IPP entity, 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 the necessary registration requirements and must be signed and dated by an authorized official of the entity. CAP requests should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment Operations Group

Mail Stop AR-18-50
7500 Security Boulevard
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 the office listed below 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 an authorized official of 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
Provider Enrollment Operations Group
Mail Stop AR-18-50
7500 Security Boulevard
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]

C. Rejection

CMS alpha representation
Contractor

[Month Day & Year]

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

Dear [Entity name]:

We received your Medicare Form CMS-855*C* registration application on [insert date]. We are rejecting your application and returning it to you for the following reason(s):

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

(Repeat for multiple, if necessary)

Consistent with 42 CFR §424.525, prospective Indirect Payment Procedure (IPP) entities are required to submit a complete registration application and all necessary supporting documentation within 30 calendar days from the date of the contractor's request for missing/incomplete/clarifying information. If you would

like to resubmit your registration application, please make sure to address the issues stated above and to sign and date the new certification statement page on your resubmitted application.

To submit a new registration application, you may download and complete the application from the Centers for Medicare & Medicaid Services (CMS) Web site at http://www.cms.hhs.gov/MedicareProviderSupEnroll.

You should return the complete application 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]

D. Revocation

CMS alpha representation
Contractor

[Month Day & Year]

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

[RE:]

Dear [Entity name]:

This is to inform you that your Medicare registration as an Indirect Payment Procedure (IPP) entity is being revoked effective [insert effective date of revocation].

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 re-establish your eligibility to be registered as an IPP entity, 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 all registration requirements. The CAP request must be signed and dated by an authorized official of the entity. . CAP requests should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment Operations Group
7500 Security Blvd.
Mailstop: AR-18-50
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 the office listed below 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 an authorized official of 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 revocation 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
Provider Enrollment Operations Group
7500 Security Blvd.
Mailstop: AR-18-50
Baltimore, MD 21244-1850

Consistent with 42 CFR §424.535(c), [insert contractor name] is establishing a re-registration bar for a period of [insert amount of time]. This bar only applies to your registration in the Medicare program. In order to re-register, you must meet all registration requirements.

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]