



Medicare Physician Services Version

KEY CONCEPTS OUTLINE

Module 2: To Be or Not to Be Participating with Medicare; Pros and Cons of Medicare Participation

I. National Provider Identifiers (NPIs)

A. What are NPIs?

1. NPIs are a set of identification numbers implemented as a part of HIPAA. NPIs replaced former Provider Identification Numbers (PINs) and Unique Provider Identification Numbers (UPINs).
2. Under HIPAA, private insurance companies are also required to recognize NPIs. This means that instead of having a different provider number for each health plan, physicians/practitioners will use a single unique provider number (the NPI) for all health plans. <MLN Booklet: NPI What You Need to Know>
3. CMS refers to this company as the "NPI Enumerator."

B. Obtaining an NPI

1. Physicians/practitioners can apply for an NPI in one of three ways:
 - a. Apply through National Plan and Provider Enumeration System (NPPES) with a web-based application;
 - b. Complete, sign, and mail a paper application Form CMS-10114, NPI Application/Update Form to the NPI enumerator address listed on the form; or
 - c. Give permission to an Electronic File Interchange Organization (EFIO) to send application data through bulk enumeration process.
2. The process of applying for and receiving an NPI is completely distinct from the enrollment process – physicians/practitioners must still separately enroll in the Medicare program as discussed above. <Tips to Facilitate the Medicare Enrollment Process: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/enrollmenttips.pdf>>

C. Finding NPIs of Other Practitioners

1. NPIs of other practitioners may be accessed via the online NPI Registry.
<https://npiregistry.cms.hhs.gov/>

II. Enrollment

A. What is "Enrollment"

1. Enrollment is Medicare's version of "credentialing."
 - a. Physicians, practitioners, and other healthcare "suppliers" must enroll in the Medicare program to be eligible to receive Medicare payment for covered services. <Medicare Program Integrity Manual, Chapter 15 § 15.1>
2. Among other things, enrollment serves a program integrity function.
 - a. Enrollment provides a way for Medicare to "checkup" on a physician/practitioner to make sure that the physician/practitioner is qualified to furnish services to Medicare beneficiaries. <Medicare Program Integrity Manual, Chapter 15 § 1.2>
3. "Enrollment" is different than "participation."
 - a. As discussed below, a physician/practitioner may enroll in the Medicare program but elect to be non-participating.

B. The Enrollment Process

1. Obtain National Provider Identifier (NPI) prior to enrollment.
 - a. CMS requires that you obtain an NPI before you enroll for the first time or make a change to your existing enrollment information. <Tips to Facilitate the Medicare Enrollment Process:
www.cms.hhs.gov/MedicareProviderSupEnroll/>
2. To enroll, the appropriate Medicare enrollment form(s) must be submitted to the appropriate Medicare contractor. Enrollment decisions are made by the contractor, not CMS.
 - a. CMS encourages enrollment to be completed electronically, although the paper-based application process can still be used.

- b. Electronic Enrollment Applications are completed through the Internet-based Provider Enrollment, Chain and Ownership System (PECOS). <<https://pecos.cms.hhs.gov>>
 - (i) CMS encourages the use of PECOS indicating the following benefits for providers and suppliers:
 - (a) All information is submitted electronically (paperless), and
 - (b) Stating PECOS applications tend to process faster than paper applications.
3. Accessing the Enrollment Forms/Instructions
- a. CMS maintains a series of web pages (accessible at hcprobootcamps.com "links" page) devoted to provider enrollment forms, instructions and other information relating to enrollment.
4. The Forms
- a. CMS-855I
 - (i) Used for individual physicians/practitioners. This form must be completed to initiate the enrollment process, reassign benefit, and/or terminate current reassignment. <See Consolidated CMS-855I/CMS 855R Enrollment Applications Bulletin>
 - (ii) CMS merged the CMS-855I and the CMS-855R paper enrollment application.
 - (a) The CMS-855I now includes all data previously captured data on the CMS-855R.
 - (b) There is no change in reassignments in PECOS.
 - b. CMS-855B
 - (i) Used for clinics, group practices, and suppliers other than individual physicians/practitioners (e.g. laboratory companies).

c. CMS 8550

(i) Used for Physicians and eligible professionals can apply to enroll for the sole purpose of ordering and certifying items and/or services to beneficiaries, and prescribing Part D drugs in the Medicare program.

(a) With the implementation of Section 6405 of the Affordable Care Act, CMS requires certain physicians and eligible professionals to enroll in the Medicare program for the sole purpose of ordering or certifying items or services for Medicare beneficiaries, and prescribing Part D drugs.

1. These physicians and eligible professionals do not and will not send claims to a Medicare Administrative Contractor (MAC) for the services they furnish.

a. Examples:

- i. Employed by the Department of Veterans Affairs (DVA)
- ii. Employed by the Public Health Service (PHS)
- iii. Employed by the Department of Defense (DOD)/Tricare
- iv. Dentists, including oral surgeons
- v. Pediatricians
- vi. Retired physicians who are licensed

d. CMS-855S

(i) Used for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers. This form must be completed in order to initiate the enrollment process.

(ii) DMEPOS suppliers submit the 855S applications and related forms to the regional enrollment contractor.

(a) DMEPOS regional enrollment contractors can be found in the CMS Medicare-Fee-for-Services Provider Enrollment Contact List.

Medicare Fee-for-Service Enrollment Contact List URL:

https://www.cms.gov/medicare/provider-enrollment-and-certification/medicareprovidersupenroll/downloads/contact_list.pdf

e. CMS-20134

- (i) Used for organizations, including those with existing enrollments, who wish to furnish Medicare Diabetes Prevention Program services (*to be discussed in a later module*).

C. Obligation to Report Changes

1. Physicians/practitioners must notify their Contractor whenever there is a change in the information submitted in any of the forms listed above. Changes of information are submitted on the same forms that are used for initial enrollment.
 - a. Changes must be made in a timely manner. <42 CFR 424.516>
 - (i) If the change involves a change of ownership, a final adverse action, or a change in practice location, then timely is defined within 30 days of the change.
 - (ii) All other informational changes must be within 90 days of the change.
2. Revalidation of Enrollment Information
 - a. Medicare Contractors generally revalidate enrollment information for providers and suppliers every five years. <*Medicare Program Integrity Manual*, Chapter 10 § 10.4.5; >
 - (i) For DMEPOS Suppliers are revalidated every three years.
 - b. Under Section 6401 (a) of the Affordable Care Act, CMS is under obligation to perform revalidation under new screening criteria beginning in 2016. ALL providers and suppliers are being required to revalidate their enrollment through these new criteria, and must submit their information through the PECOS systems at the various appropriate timeframes as noted in the revalidation letters received from their MAC.< See *Medicare Program Integrity Manual*, Chapter 10 § 10.4.45; >>
 - (i) These revalidations are suggested to be performed through the PECOS system for efficiency.
 - (ii) Revalidation is generally initiated by the MAC. However, providers can check their revalidation status in this process at <https://data.cms.gov/revalidation>

- (iii) Revalidation information can be found at:
<http://go.cms.gov/MedicareRevalidation> for more information on this topic

III. Railroad Medicare

A. Medicare Benefits for Railroad Workers

1. Railroad Medicare is Medicare coverage for railroad workers and their families. Railroad Medicare is administered through the "Railroad Retirement Board."

B. Enrollment

1. The Railroad Retirement Board has contracted with Palmetto GBA to act as the Railroad Specialty Administrative Contractor (RRB SMAC). Palmetto GBA processes all Medicare Part B Claims for Railroad Retirement beneficiaries, nationwide. <Railroad Medicare – Quick Reference Guide, page 2, January, 2024>
 - a. The practitioner must first be enrolled with the local MAC before requesting a Railroad Medicare Provider Transaction Access Number (PTAN). <Railroad Medicare – Quick Reference Guide, page 3, January, 2024>
 - (i) The first time a practitioner has a Railroad Medicare claim pending, a Request for a Railroad Medicare PTAN form can be submitted to Palmetto. The information on the Railroad Medicare PTAN form must match the local MAC's information. <Railroad Medicare – Quick Reference Guide, page 4, January 2024>

IV. Provider Transaction Access Numbers (PTANs)

A. Formerly the Provider Identification Number (PIN) or Legacy Number

1. Initially, the PTAN shall be the legacy number for currently enrolled providers. <MLN Matters SE1216>
2. Newly enrolled and re-enrolled providers will be assigned a PTAN. The PTAN will be included in the provider enrollment letters. <MLN Matters SE1216>
3. Practitioners will use their PTAN for authentication when using self-help tools with the contractor, such as the Interaction Voice Response (IVR) phone system, internet portals, and other various online and telephone self-help tools. <MLN Matters SE1216>

V. Participation versus Non-Participation

A. What is Participation?

1. "Participation" means that a physician/practitioner agrees to always "accept assignment" for all claims for services furnished to Medicare beneficiaries. <Medicare Claims Processing Manual, Chapter 1 § 30.3>
 - a. What is Assignment?
 - (i) In general, for any claim billed on an "assigned" basis, the physician/practitioner is prohibited from collecting any amount from the beneficiary in excess of the applicable Medicare deductible and coinsurance. <Medicare Claims Processing Manual, Chapter 1 § 30.3>
 - (a) Assignment is discussed in more detail in the "Claims" module.
 - b. Unassigned Claims Submitted by a Participating Physician/Practitioner
 - (i) If a participating physician/practitioner inadvertently submits an unassigned claim, the Contractor is supposed to automatically process the claim as an assigned claim. <Medicare Claims Processing Manual, Chapter 1 § 30.3.1.1>

B. National Participation Rates

1. For 2023, 98% of physicians/practitioners and other suppliers elected to participate. <CMS Announcement About Medicare Participation for Calendar Year 2024>

C. Advantages and Disadvantages of Participation

1. Advantages of Participation

a. Higher Fee Schedule Amounts

- (i) For participating physicians/practitioners, the Medicare allowable is based on the full Physician Fee Schedule amount. <Medicare Claims Processing Manual, Chapter 1 § 30.3>

b. Automatic Medigap Crossover

- (i) For services furnished to beneficiaries who have Medigap coverage and who accept assignment on both their Medicare and Medigap claims, Medicare automatically sends the claim on to the Medigap insurer. <CMS Announcement About Medicare Participation>

- c. Claim Payment Goes to Practitioner
 - (i) Because participating practitioners have agreed to accept Medicare's allowed amount as payment in full, payment is made to the practitioner who furnished the service. <Medicare Claims Processing Manual, Chapter 1 § 30.3.9>
- 2. Disadvantage of Participation
 - a. Payment Limited to the Allowable
 - (i) As discussed above, participating physicians/practitioners must accept assignment on all claims. They may not collect any amount of money above and beyond the Medicare allowed amount. <Medicare Claims Processing Manual, Chapter 1 § 30.3>
- D. Non-Participating Physicians/Practitioners
 - 1. Lower Fee Schedule Amounts
 - a. For non-participating physicians/practitioners, the Medicare allowable is based on 95% of the Physician Fee Schedule amount, regardless of whether the claim is submitted assigned or unassigned. <Medicare Claims Processing Manual, Chapter 1 § 30.3>
 - 2. The Limiting Charge
 - a. If a claim is filed on an unassigned basis, non-participating physicians/practitioners are permitted to bill (and attempt to collect from the beneficiary) an amount in excess of the allowable, subject to the "limiting charge." <42 CFR § 414.48(a)>
 - b. Calculation of the Limiting Charge <42 CFR § 414.48(b); Medicare Claims Processing Manual, Chapter 1 § 30.3.12.3>
 - (i) For items or services paid under the Physician Fee Schedule, the Limiting Charge is 115 percent of the non-participating Physician Fee Schedule amount.
 - (a) Example – Assume the participating Physician Fee Schedule amount for a particular service is \$100. The non-participating Physician Fee Schedule amount for the same service will be \$95 (95% x \$100) and the Limiting Charge for this service will be \$109.25 (1.15 x \$95).

Result – if a claim for this service was billed on an unassigned basis by a non-participating physician/practitioner, he or she can potentially collect \$9.25 more than a participating physician/practitioner could collect for the same service.

3. Claim Payment <Medicare Claims Processing Manual, Chapter 1 § 30.3.9>
 - a. Assigned claims – Payment is made to the practitioner who provided the service.
 - b. Non-assigned claims – Payment is made to the beneficiary.
4. Practitioners Subject to Mandatory Assignment
 - a. Physician assistant
 - b. Nurse practitioners
 - c. Clinical nurse specialists
 - d. Certified registered nurse anesthetists
 - e. Certified nurse midwives
 - f. Clinical social workers
 - g. Clinical psychologists
 - h. Registered dietitians
 - i. Anesthesiologist assistants
 - j. Marriage and family therapists
 - k. Mental health counselors
 - l. Mass immunization roster billers
 - m. Ambulatory surgical center

5. Mandatory Assignment for Certain Services

- a. Even if non-participating, assignment must be accepted for claims for the following items/services: <Medicare Claims Processing Manual, Chapter 1 § 30.3.1>
 - (i) Clinical diagnostic laboratory services and physician lab services;
 - (ii) Physician services to individuals dually entitled to Medicare and Medicaid;
 - (iii) Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, clinical social workers, medical nutritional therapists.
 - (iv) Ambulatory surgical center services;
 - (v) Home dialysis supplies and equipment paid under Method II;
 - (vi) Drugs; and
 - (vii) Ambulance services;

6. Possible State Law Restrictions on Balance Billing

- a. At least one state, Pennsylvania, has enacted a state law prohibiting physicians/practitioners from billing Medicare beneficiaries more than the Medicare allowable amount. <See Health Care Practitioners Medicare Fee Control Act, 35 P. S. § 449.31 - 449.36.>
 - (i) These types of state Medicare “balance billing” prohibitions, in essence, eliminate any possible benefit to being non-participating.

E. Electing to Participate

1. Submitting a Participation Agreement

- a. A physician/practitioner who desires to participate must complete a “Participating Physician or Supplier Agreement” (Form CMS-460) and mail it (or a copy) to each Contractor to which claims will be submitted. <CMS Announcement About Medicare Participation>

(i) Open Enrollment

(a) Subject to certain exceptions for new physicians/practitioners (and new physician/practitioner offices) the Contractors will only accept a participation agreement during the annual "open enrollment" period. <CMS Announcement About Medicare Participation>

1. The open enrollment period generally runs from mid-November through the end of December. <CMS Announcement About Medicare Participation; Medicare Claims Processing Manual, Chapter 1 § 30.3.12.1A>

a. CMS requires Contractors to produce a postcard reminding providers about the annual open participation enrollment period and to view the Contractor's web site regarding information for the upcoming open participation enrollment period. Providers are to be advised when the new MPFS update is posted. <Medicare Claims Processing Manual, Chapter 1 § 30.3.12.1(B1)>

i. Providers that do not have access to the internet must be educated to contact their local contractors to request a hard copy disclosure package.

(ii) New Physicians/Practitioners

(a) A new physician/practitioner may submit a participation agreement at any time within 90 days of:

1. The date the physician/practitioner became licensed, or
2. The date the physician/practitioner first opened an office in the particular Contractor locality. <Medicare Claims Processing Manual, Chapter 1 § 30.3.12 (J)>

2. Term of the Participation Agreement

a. One Year Term

(i) Each participation agreement is in effect for one year (January through December) and may not be revoked by the physician/practitioner during that period. <Medicare Claims Processing Manual, Chapter 1 § 30.3.12 (I)>

b. Automatically Renews Unless Notice Provided

- (i) At the end of each term of the participation agreement, the agreement automatically renews for an additional one-year term unless the physician/practitioner provided written notice of non-renewal to each Contractor that received a copy of the participation agreement. <Medicare Claims Processing Manual, Chapter 1 § 30.3.12 (I)>

c. Termination by CMS

- (i) CMS may terminate a physician/practitioner's participation agreement for "substantial" failure to comply with the agreement. <Medicare Claims Processing Manual, Chapter 1 § 30.3.12 (I)>

Version 04/25/2024
Check for Updates



NPI: What You Need to Know



What's Changed?

Note: No substantive content updates.

This booklet teaches providers about the National Provider Identifier (NPI), who must get an NPI, and how to apply.

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Background

The NPI is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Standard. An NPI is a unique identification number for covered health care providers, created to help send health information electronically more quickly and effectively. Covered health care providers, all health plans, and health care clearinghouses must use NPIs in their administrative and financial transactions.

The HIPAA Administrative Simplification provisions required the use of a standard, unique health identifier for each health care provider. The 2004 NPI Final Rule made NPIs the standard.

CMS developed the National Plan and Provider Enumeration System (NPPES) to assign NPIs. For more information on how to apply for an NPI, visit the [NPPES](#) webpage.

This booklet answers the following questions to help you understand the NPI:

- What's an NPI?
- Who may get an NPI?
- Who must get an NPI?
- Who may not get an NPI?
- What are the health care provider NPI categories?
- How do you apply for an NPI?
- Where can you find resources with more information?

What's an NPI?

An NPI is a 10-digit numeric identifier. It doesn't have information about you, like the state where you practice, your provider type, or your specialization. Your NPI won't change, even if your name, address, taxonomy, or other information changes.

In HIPAA standard transactions, providers must use the NPI instead of other provider identifiers, like a Provider Transaction Access Number (PTAN), Quality Improvement Evaluation System (QIES), Certification and Survey Provider Enhanced Reporting (CASPER), and National Supplier Clearinghouse (NSC).

What are HIPAA Standard Transactions?

HIPAA standard transactions are exchanges involving the transfer of information between 2 parties for specific purposes. HIPAA regulations set up the following standard transactions for Electronic Data Interchange (EDI) of health care data:

- Claims and encounter information
- Claims status
- Coordination of benefits and premium payment
- Eligibility, enrollment, and disenrollment

- Payment and remittance advice
- Referrals and authorizations

For more information, refer to the [Transactions Overview](#) webpage.

Benefits of an NPI

Benefits of an NPI include:

- Simple electronic transmission of HIPAA standard transactions
- Standard unique health identifiers for health care providers, health care plans, and employers
- Efficient coordination of benefit transactions

What an NPI Doesn't Do

Getting an NPI won't:

- Change or replace your current Medicare enrollment or certification process
- Enroll you in a health plan
- Make sure you're licensed or credentialed
- Guarantee health plan payment
- Require you to conduct HIPAA transactions

How Do You Find an NPI?

The National Plan and Provider Enumeration System (NPPES):

- Assigns NPIs
- Keeps and updates information about health care providers with NPIs
- Issues the NPI Registry and NPPES Downloadable File

CMS discloses NPPES health care provider data under the Freedom of Information Act (FOIA). This data is disclosed in the NPI Registry and the NPI Downloadable File. Find more information on the [NPI Data Dissemination](#) webpage.

The [NPI Registry](#) is an online query system that allows users to search for a health care provider's information.

The [NPPES Downloadable File](#) has disclosable information about health care providers with NPIs.

Who May Get an NPI?

All health care providers (physicians, suppliers, hospitals, and others) may get an NPI. Health care providers are individuals or organizations that render health care as defined in [45 Code of Federal Regulations \(CFR\) 160.103](#).

Who Must Get an NPI?

All health care providers who are HIPAA-covered entities, whether individuals or organizations, must get an NPI.

A HIPAA-covered entity is a:

- Health care provider that conducts certain transactions in electronic form
- Health care clearinghouse
- Health plan (including commercial plans, Medicare, and Medicaid)

Under HIPAA, you're a covered health care provider if you electronically transmit health information in connection with a HIPAA standard transaction, even if you use a business associate to do so.

For more information, refer to the CMS [Are You a Covered Entity?](#) webpage.

Do You Need an NPI to Enroll in Medicare?

Yes. If you apply for enrollment in Medicare, you must have an NPI and put it on your enrollment application. The NPI Enumerator will reject enrollment applications without an NPI.

Health Care Providers Who are HIPAA-Covered Entities

Individuals	Organizations
<p>Examples of individual HIPAA-covered entity health care providers include:</p> <ul style="list-style-type: none"> • Chiropractors • Dentists • Nurses • Pharmacists • Physical Therapists • Physicians • Psychologists 	<p>Examples of organization HIPAA-covered entity health care providers include:</p> <ul style="list-style-type: none"> • Ambulance Companies • Clinics • Group Practices • Health Maintenance Organizations (HMOs) • Home Health Agencies (HHAs) • Hospitals • Laboratories • Nursing Homes • Pharmacies • Residential Treatment Centers • Suppliers of Durable Medical Equipment (DME)

Who May Not Get an NPI?

Any entity that doesn't meet the definition of a health care provider as defined in [45 CFR 160.103](#) may not apply for an NPI. Such entities include

- Billing services
- Value-added networks
- Repricers
- Health plans
- Health care clearinghouses
- Non-emergency transportation services

What are the Health Care Provider NPI Categories?

Two categories of health care providers exist for NPI enumeration purposes: Entity Type 1 (Individual) and Entity Type 2 (Organization).

Entity Type 1: Individual Health Care Providers, Including Sole Proprietors

Individual health care providers may get NPIs as Entity Type 1. As a sole proprietor, you must apply for the NPI using your own SSN, not an Employer Identification Number (EIN) even if you have an EIN.

As a sole proprietor, you may get only 1 NPI, just like any other individual. For example, if a physician is a sole proprietor, the physician may get only 1 NPI (the individual's NPI). The following factors don't affect whether a sole proprietor is an Entity Type 1:

- Number of different office locations
- Whether you've employees
- Whether the IRS issued an EIN to you so your employees' W-2 forms can show the EIN instead of your Taxpayer Identification Number (which is your SSN)

Note: An incorporated individual is a single health care provider who forms and conducts business under a corporation. A sole proprietor isn't an incorporated individual because the sole proprietor didn't form a corporation. If you're a sole practitioner or solo practitioner, it doesn't necessarily mean you're a sole proprietor, and vice versa.

Entity Type 2: Organization Health Care Providers

Organization health care providers are group health care providers eligible for NPIs as Entity Type 2.

Organization health care providers may have a single employee or thousands of employees. An example is an incorporated individual who is an organization's only employee.

Some organization health care providers are made up of parts that work somewhat independently from their parent organization. These parts may offer different types of health care or offer health care in separate physical locations. These parts and their physical locations aren't themselves legal entities but are part of the organization health care provider (which is a legal entity). The NPI Final Rule refers to the parts and locations as subparts.

An organization health care provider can get its subparts their own NPIs. If a subpart conducts any HIPAA standard transactions on its own (separately from its parent), it must get its own NPI.

Subpart determination makes sure that entities within a covered organization are uniquely identified in HIPAA standard transactions they conduct with Medicare and other covered entities. For example, a hospital offers acute care, laboratory, pharmacy, and rehabilitation services. Each of these subparts may need its own NPI because each sends its own standard transactions to 1 or more health plans.

What If You're an Individual, Incorporated Health Care Provider?

If you're an individual health care provider who's incorporated, you may need to get an NPI for yourself (Entity Type 1) and an NPI for your corporation or LLC (Entity Type 2).

Note: Subpart delegation doesn't affect Entity Type 1 health care providers. As individuals, these health care providers can't choose subparts and are not subparts.

How Do You Apply for an NPI?

You can apply for an NPI in 1 of 3 ways:

Choice 1: Apply through [National Plan and Provider Enumeration System \(NPPES\)](#) with a web-based application. Individual providers must create a username and password through the Identity & Access Management (I&A) System and log in to NPPES using that username and password.

Choice 2: Complete, sign, and mail a paper application Form [CMS-10114, NPI Application/Update Form](#) to the NPI Enumerator address listed on the form. To ask for a hard copy application through the NPI Enumerator, call 800-465-3203 or TTY 800-692-2326, or send an email to customerservice@npienumerator.com.

Choice 3: Give permission to an [Electronic File Interchange Organization \(EFIO\)](#) to send application data through bulk enumeration process.

What Must Covered Organizations Do When Applying for an NPI?

An organization health care provider that's a HIPAA-covered health care provider must:

- Get an NPI
- Decide if it has subparts and if those subparts need their own NPIs
- Make sure its subparts that need to have their own NPIs do so by either getting the NPIs for them or instructing the subparts to get their NPIs themselves
- Make sure the subparts follow the NPI Final Rule requirements placed on HIPAA-covered health care providers

Organizations Applying for NPIs on Behalf of Employed Providers

The steps below guide organization health care providers who want to apply for NPIs or send updates to the NPPES on behalf of their employed health care providers.

Note: The process described below isn't the process for Electronic File Interchange (EFI) for bulk enumeration. Instead, an organization that's a health care provider should follow these steps when applying for an employee's NPI on an individual record-by-record basis.

1. Confirm Employees' Current NPI Status

Make sure the health care providers, for whom the organization will apply, don't already have NPIs.

2. Verify Agreement with Health Care Provider Employees

Find out if you have a legal agreement with your health care provider employees that allows your organization to act on their behalf. The agreement should allow actions such as completing NPI applications and updating transactions on their behalf. You may need legal counsel to decide if an existing agreement covers these actions. If you have such an agreement, you may not need the actions described in items 3-5 below.

3. Tell Health Care Provider Employees About Collected Information

Make sure the health care providers know about the information collected on the [NPI Application/Update Form \(CMS-10114\)](#). Make sure they read the Penalties for Falsifying Information on the National Provider Identifier (NPI) Application/Update Form, Certification Statement, and Privacy Act Statement sections of that form and agree to all relevant requirements.

4. Confirm NPI Application Data

Share the NPI application data with the health care providers represented in the application to make sure of complete and correct data. The same applies to updating information.

5. Keep NPI Documents

Ask the health care providers to sign a document indicating that you took the above actions and keep those documents as proof the health care providers knew about the actions taken on their behalf.

6. Choose A Contact Person for NPI Confirmation

The NPPES sends an email to the Contact Person entered on a health care provider's NPI application. This email informs the Contact Person of the enumerated health care provider's NPI and has some of the identifying information about the health care provider (including provider name, address, and Healthcare Provider Taxonomy Code and description).

If the organization sends an NPI application on behalf of a health care provider employee, the Contact Person the organization chooses gets the NPI notification email from the NPPES. The Contact Person must send that NPI notification (or a copy) to the health care provider employee. This notification confirms that the NPPES assigned the health care provider employee an NPI and has the NPI.

Ask your legal counsel to review this process as well.

Electronic File Interchange (EFI)

You can also apply for an NPI using EFI. Each EFIO can send NPI application information for hundreds or even thousands of health care providers all at once in a single electronic file or in a series of electronic files.

EFI helps both the health care providers and CMS. By allowing an EFIO to apply on its behalf, a health care provider doesn't have to apply for an NPI. This saves the health care provider time and resources. EFI also helps CMS by saving the time and resources CMS would have spent if the NPI Enumerator (contractor that processes NPI applications) and the web-based system had to process NPI applications 1 at a time.

Besides getting NPIs for health care providers, some EFIOs may also send changes or updates to the NPPES on behalf of enumerated health care providers to keep the providers' NPPES records current. To send changes or updates, the EFIO needs the health care providers' permission. An EFIO and its associated health care providers should decide together whether to make changes or updates to a provider's NPPES record.

Important!

If you decide to let the EFIO send future changes on your behalf, you're still responsible to ensure the NPI Enumerator gets the updates.

Resources

For more information about the NPI, refer to the [National Provider Identifier \(NPI\) Standard](#) webpage.

- [Are You a Covered Entity?](#)
- [Data Dissemination](#)
- [EFI](#)
- [I&A System](#)
- [Medicare NPI Implementation](#)
- [NPPES](#)

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KNOWLEDGE • RESOURCES • TRAINING

Medicare Provider Enrollment



What's Changed?

- Updated the enrollment application fee amount for 2024
- Added marriage and family therapists, mental health counselors, and certain dental specialties to the Part B suppliers list
- Merged Form CMS-855R into the CMS-855I paper enrollment application
- Added new provider specialty code information for dentists

Substantive content changes are in dark red.

[Print](#)

Application Fee

Physicians, non-physician practitioners, physician organizations, non-physician organizations, and Medicare Diabetes Prevention Program suppliers don't pay a Medicare enrollment application fee.

Generally, institutional providers and suppliers like DMEPOS suppliers and opioid treatment programs pay an [application fee](https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do#headingLv1) when enrolling, re-enrolling, revalidating, or adding a new practice location.

Enrollment Application Fee

The 2024 enrollment application fee (<https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do>) is \$709.

How to Pay the Application Fee ↗

Whether you apply for Medicare enrollment online or use the paper application, you can pay the Medicare application fee online through:

- **PECOS:** During the application process, PECOS prompts you to pay the application fee
- **CMS Paper Application:** Go to [PECOS Application Fee Information](https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do) (<https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do>) to submit the application fee

Hardship Exception ↗

A [hardship exception](https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R371PI.pdf#page=18) (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R371PI.pdf#page=18>) exempts you from paying a current application's fee. If you request a hardship exception, submit a written request and supporting documentation describing the hardship and justifying an exception to paying the application fee with your PECOS or CMS paper application. We grant exceptions on a case-by-case basis.

Medicare Administrative Contractors (MACs) will only process applications with the proper application fee payment or an approved hardship exception.

If you don't pay the fee or submit a hardship exception request, your MAC will send a letter allowing you 30 days to pay the fee. If you don't pay the fee on time, the MAC may reject or deny your application or revoke your existing billing privileges, as appropriate.

[Print](#)

Enrollment

Providers must enroll in the Medicare Program to get paid for providing covered services to Medicare patients. Determine if you're eligible to enroll and how to complete enrollment.

Who Are Institutional Providers? ↗

We list institutional providers on the [Medicare Enrollment Application: Institutional Providers \(CMS-855A\)](https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855a.pdf) (<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855a.pdf>), which include:

- Community mental health centers
- Comprehensive outpatient rehabilitation facilities
- Critical access hospitals
- ESRD facilities
- Federally Qualified Health Centers
- Histocompatibility labs
- Home health agencies
- Hospice organizations
- Hospitals
- Indian Health Service facilities
- Organ procurement organizations
- Opioid treatment programs
- Outpatient physical therapy, occupational therapy, speech pathology services
- Religious nonmedical health care institutions
- Rural emergency hospitals
- Rural health clinics
- Skilled nursing facilities (SNFs)

Who Are Part B Suppliers? ↗

Physicians, non-physician practitioners (NPPs), clinics or group practices, and specific suppliers who can enroll as Medicare Part B providers are defined in enrollment forms [Medicare Enrollment Application: Physicians and Non-Physician Practitioners \(CMS-855I\)](https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855i.pdf) (<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855i.pdf>) and [Medicare Enrollment Application:](#)

[Clinics/Group Practices and Other Suppliers \(CMS-855B\)](https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855b.pdf) (<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855b.pdf>).

Who's an NPP?

NPPs include nurse practitioners, clinical nurse specialists, and physician assistants who practice with or under a physician's supervision.

Physicians, NPPs, & Suppliers (CMS-855I)

Clinics, Group Practices, & Specific Suppliers (CMS-855B)

- Ambulatory surgical centers (ASCs)
- Clinics and group practices
- Home infusion therapy suppliers
- Hospital departments
- Independent clinical labs
- Independent diagnostic testing facilities
- Intensive cardiac rehabilitation suppliers
- Mammography centers
- Mass immunization roster billers (entities)
- Opioid treatment programs
- Pharmacies
- Physical or occupational therapy groups in private practice
- Portable X-ray suppliers
- Radiation therapy centers

Version 04/23/24
Check for updates

- Anesthesiology assistants
- Audiologists
- Certified nurse-midwives
- Certified registered nurse anesthetists
- Clinical nurse specialists
- Clinical psychologists
- Clinical social workers
- **Marriage and family therapists**
- Mass immunization roster billers (individuals)
- **Mental health counselors**
- Nurse practitioners
- Occupational or physical therapists in private practice
- Physicians (Doctors of Medicine or Osteopathy, [Doctors of Dental Medicine or Dental Surgery](https://www.cms.gov/medicare/coverage/dental) (<https://www.cms.gov/medicare/coverage/dental>), Podiatric Medicine, Chiropractic Medicine, or Optometry) **and these dental specialties:**
 - **Dental anesthesiology**
 - **Dental public health**
 - **Endodontics**
 - **Oral and maxillofacial surgery**
 - **Oral and maxillofacial pathology**
 - **Oral and maxillofacial radiology**
 - **Oral medicine**
 - **Orofacial pain**
 - **Orthodontics and dentofacial orthopedics**
 - **Pediatric dentistry**
 - **Periodontics**
 - **Prosthodontics**
- Physician assistants
- Psychologists billing independently
- Registered dietitians or nutrition professionals
- Speech-language pathologists

Medicare Diabetes Prevention Program Suppliers

Potential suppliers must use [Medicare Enrollment Application: Medicare Diabetes Prevention Program \(MDPP\) Suppliers \(CMS-20134\)](https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS20134.pdf) (<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS20134.pdf>) to enroll in the Medicare Program.

Beginning January 1, 2024, we established new provider [specialty codes](https://www.cms.gov/files/document/r12231cp.pdf) (<https://www.cms.gov/files/document/r12231cp.pdf>) for dentists.

If you don't see your provider type listed, contact your [MAC's provider enrollment center](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf) (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf) before submitting a Medicare enrollment application.

Provider & Supplier Organizations ↪

Medicare provider and supplier organizations have business structures, like corporations, partnerships, professional associations, or limited liability companies, which meet the **provider** and **supplier** definitions. Provider and supplier organizations don't include organizations the IRS defines as sole proprietorships.

Provider and supplier organizations include:

- ASCs
- Hospices
- Hospitals
- Medical group practices and clinics
- Portable X-ray suppliers
- SNFs

You must have a provider or supplier employer identification number (EIN) to enroll in Medicare. An EIN is the same as the provider or supplier organization's IRS-issued tax identification number (TIN).

Sole Proprietorships & Disregarded Entities

[Sections 10.6.4](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c10.pdf#page=451) (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c10.pdf#page=451>) and [10.6.7.1\(D\)\(5\) of Medicare Program Integrity Manual, Chapter 10](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c10.pdf#page=504) (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c10.pdf#page=504>) have more information about sole proprietorships and disregarded entities.

Decide If You Want to Be a Medicare Part B Participating Provider ↪

Medicare **participation** means you agree to accept claims assignment for all covered patient services. By accepting assignment, you agree to accept Medicare-allowed amounts as payment in full. You can't collect more from the patient than the [deductible and coinsurance or copayment \(https://www.medicare.gov/basics/costs/medicare-costs\)](https://www.medicare.gov/basics/costs/medicare-costs). The [Social Security Act \(https://www.ssa.gov/OP_Home/ssact/title18/1848.htm#act-1848-g-4\)](https://www.ssa.gov/OP_Home/ssact/title18/1848.htm#act-1848-g-4) says you must submit patient Medicare claims whether or not you participate.

You have 90 days after we send your initial enrollment approval letter to decide if you want to be a participating provider or supplier. To participate as a Medicare Program provider or supplier, submit the [Medicare Participating Physician or Supplier Agreement \(CMS-460\) \(https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS460.pdf\)](https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS460.pdf) upon initial enrollment. The only other time you may change your participation status is during the open enrollment period, generally from mid-November–December 31 each year.

Participating Provider or Supplier

- We pay 5% more to participating physicians and other suppliers
- Because these are assigned claims, we pay you directly
- We forward claim information to [Medigap \(Medicare supplement coverage\) \(https://www.cms.gov/medicare/health-drug-plans/medigap\)](https://www.cms.gov/medicare/health-drug-plans/medigap) insurers

Non-Participating Provider or Supplier

- We pay 5% less to non-participating physicians and other suppliers
- You can't charge patients more than the limiting charge, 115% of the Medicare Physician Fee Schedule amount
- You may accept assignment on a case-by-case basis
- You have limited appeal rights

[Medicare Claims Processing Manual, Chapter 12 \(https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf\)](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf) has more information.

Step 1: Get an NPI

To enroll in the Medicare Program, get an NPI through:

- **Online Application:** Get an [Identity & Access Management \(I&A\) System](https://nppes.cms.hhs.gov/IAWeb) (<https://nppes.cms.hhs.gov/IAWeb>) user account. Then apply for an NPI in [NPPES](https://nppes.cms.hhs.gov) (<https://nppes.cms.hhs.gov>).
- **Paper Application:** Complete, sign, and mail the [NPI Application/Update Form \(CMS-10114\)](https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS10114.pdf) (<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS10114.pdf>) paper application to the address on the NPI Enumerator form. To request a hard copy application:
 - Call 1-800-465-3203 (TTY 1-800-692-2326)
 - Email customerservice@npienumerator.com (<mailto:customerservice@npienumerator.com>)
- **Bulk Enumeration:** Apply for [Electronic File Interchange](https://nppes.cms.hhs.gov/webhelp/nppeshelp/EFI%20HELP%20PAGE.html) (<https://nppes.cms.hhs.gov/webhelp/nppeshelp/EFI%20HELP%20PAGE.html>) access and upload your own CSV or XML files.

Not Sure If You Have an NPI?

Search for your NPI on the [NPPES NPI Registry](https://npiregistry.cms.hhs.gov/search) (<https://npiregistry.cms.hhs.gov/search>).

CMS Provider Enrollment Systems:

- [I&A System](https://nppes.cms.hhs.gov/IAWeb) (<https://nppes.cms.hhs.gov/IAWeb>)
- [NPPES](https://nppes.cms.hhs.gov) (<https://nppes.cms.hhs.gov>)
- [PECOS](https://pecos.cms.hhs.gov) (<https://pecos.cms.hhs.gov>)
- [Electronic Health Record \(EHR\) Incentive Payments](https://www.cms.gov/medicare/regulations-guidance/promoting-interopability-programs) (<https://www.cms.gov/medicare/regulations-guidance/promoting-interopability-programs>)

Multi-Factor Authentication

To better protect your information, we implemented I&A System multi-factor authentication for the provider enrollment systems listed above.

Step 2: Complete Proper Medicare Enrollment Application

After you get an NPI, you can complete Medicare Program enrollment, revalidate your enrollment, or change your enrollment information. Before applying, get the [necessary enrollment information](https://pecos.cms.hhs.gov/pecos/help-main/checklists.jsp) (<https://pecos.cms.hhs.gov/pecos/help-main/checklists.jsp>), and complete the actions using PECOS or the paper enrollment form.

A. Online PECOS Application

After we approve your I&A System registration, submit your PECOS application.

PECOS offers a scenario-driven application, asking questions to recover the information for your specific enrollment scenario. You can use PECOS to submit all supporting documentation. Follow these instructions:

1. Log in to [PECOS](https://nppes.cms.hhs.gov) (<https://nppes.cms.hhs.gov>)

1. Log in to [PECOS \(https://pecos.cms.hhs.gov/\)](https://pecos.cms.hhs.gov/).
2. Continue with an existing enrollment or create a new application.
3. When PECOS determines your enrollment scenario and you confirm it's correct, you'll see the topics for submitting your application. To complete each topic, enter the necessary information.
4. At the end of your data entry process, PECOS:
 - Confirms you entered all necessary data
 - Lists MAC documents to submit for review
 - Gives the option to electronically sign and certify
 - Shows your MAC's name and mailing address
 - Lets you print your enrollment application for your records (don't submit a paper copy to your MAC)
 - Sends the application electronically to your MAC
 - Emails you to confirm your MAC got the application

PECOS 2.0 Enhancements

PECOS will have enhanced features to better meet your needs. Watch this 2-minute [video \(https://www.youtube.com/watch?v=P9ee_yWrsGU\)](https://www.youtube.com/watch?v=P9ee_yWrsGU) or read these [FAQs \(https://www.cms.gov/files/document/pecos-20-faqs.pdf\)](https://www.cms.gov/files/document/pecos-20-faqs.pdf) to learn more about:

- A single application for multiple enrollments
- Data pre-population and an application that's tailored to you
- Enhanced capability to add or delete group members
- Real-time processing checks and status updates
- Revalidation reminders

Visit [Introducing PECOS 2.0 \(https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/provider-enrollment-chain-ownership-system-pecos/introducing-pecos-20\)](https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/provider-enrollment-chain-ownership-system-pecos/introducing-pecos-20) for more information.

PECOS Scroll Functionality

PECOS validates that you've read and acknowledged certification terms and conditions before you electronically submit your Medicare enrollment application. Review and scroll through each text box with certification requirements before you can select **accept** on these pages:

- Submission
- Home
- Remote E-sign

[Physicians, Non-Physician Practitioners, & Other Part B Suppliers ↪](#)

Enrolling physicians, NPPs, or other Part B suppliers must choose 1 of the application descriptions below.

- **Sole Owner of a Professional Association (PA), Professional Corporation (PC), or Limited Liability Company (LLC):**
 - You're the only owner of a business, set up as a corporation, where you provide health care services
 - Your business is legally separate from your personal assets
- **Self-Employed or Sole Proprietor:**
 - You provide all health care services from a facility you own, lease, or rent
 - You're the only owner of a business that provides health care services
 - You and your business are legally 1 and the same
 - You're personally responsible for the business' financial obligations, and you report business income and losses on your personal tax return
- **Group Member Only:**
 - You provide all health care services as an employee of a group practice or clinic
 - You arrange with your employer to submit claims and get paid for your services
 - Choose **Group Member Only** if you're reassigning all your benefits to a group practice or clinic
- **Group Member and Self-Employed:**
 - You provide health care services as a group practice or clinic employee
 - You agree with your employer to submit claims and get paid for your services
 - You also provide health care services from a facility that you own, lease, or rent
 - Your income through self-employment is part of your personal assets
- **Disregarded Entity:**
 - You're the only owner of a business, set up as a corporation, where you provide health care services
 - Your corporation doesn't file taxes; instead, you file corporate taxes on your personal tax filing

B. Paper Medicare Enrollment Applications

Submit the appropriate paper enrollment application if you're unable to use PECOS. Carefully review the paper application instructions to decide which form is right for your practice. The paper enrollment application collects your information, including documentation verifying your Medicare Program enrollment eligibility.

If you submit a paper application, your MAC processes your application and creates a Medicare enrollment record by entering the data into PECOS.

[Institutional Providers ↗](#)

Medicare Enrollment Application: Institutional Providers (CMS-855A) (<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855a.pdf>): Institutional providers use this form to begin the Medicare enrollment or revalidation process or to change enrollment information.

Physicians, NPPs, & Other Part B Suppliers, Including Opioid Treatment Programs ↪

- **Medicare Enrollment Application: Physicians and Non-Physician Practitioners (CMS-855I)** (<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855i.pdf>): Individual physicians or NPPs, as well as individual physicians and NPPs that are sole proprietors or sole owners of a corporation that provides services, use this form to begin the Medicare enrollment or revalidation process or to change enrollment information.

Most physicians and NPPs complete the **CMS-855I** (<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855i.pdf>) to begin the enrollment process. You can also use the CMS-855I if you reassign your benefits to another entity, like a medical group or group practice that gets paid for your services. We've merged (<https://www.cms.gov/files/document/consolidated-cms-8551-bulletin.pdf>) the CMS-855R into the CMS-855I paper enrollment application.

- **Medicare Enrollment Application: Clinics/Group Practices and Other Suppliers (CMS-855B)** (<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855b.pdf>): Group practices and other organizational suppliers, except DMEPOS suppliers, use this form to begin the Medicare enrollment or revalidation process or to change enrollment information.
- **Medicare Enrollment Application: Enrollment for Eligible Ordering/Certifying Physicians and Other Eligible Professionals (CMS-855O)** (<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855o.pdf>): Physicians and other eligible NPPs use this form to enroll in Medicare solely to order or certify items or services for Medicare patients. **This includes those physicians and other eligible NPPs who don't send billed services claims to a MAC.**
- **Medicare Enrollment Application: Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers (CMS-855S)** (<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855s.pdf>): DMEPOS suppliers use this form to begin the Medicare enrollment or revalidation process or to change enrollment information.
- **Medicare Enrollment Application: Medicare Diabetes Prevention Program (MDPP) Suppliers (CMS-20134)** (<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS20134.pdf>): MDPP suppliers use this form to begin the Medicare enrollment or revalidation process or to change enrollment information.

Certified Providers & State Survey Agency ↪

After you submit an enrollment application and all required supporting documentation to your MAC, they'll send their recommendations to the **State Survey Agency** (<https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/contact-information>). The State Survey Agency then decides if specific providers meet Medicare enrollment conditions.

After a MAC makes a recommendation, the State Survey Agency or a CMS-recognized accrediting organization conducts a survey. Based on the survey results, the agency or

organization recommends that we approve or [deny](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-P/section-424.530) (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-P/section-424.530) the enrollment (certification of compliance or non-compliance).

Certain institutional provider types may elect voluntary accreditation by a CMS-recognized accrediting organization instead of a State Survey Agency. The accrediting organization will notify the State Survey Agency of their decision.

The State Survey Agency forwards us the survey results. We assign the CMS Certification Number and effective date, sign the provider agreement, and update the certification database. Your MAC will issue your final approval or denial letter.

If approved, you'll get a fully executed provider agreement.

Electronic Funds Transfer

If enrolling in Medicare, revalidating, or making certain changes to your enrollment, we require you to set up an electronic funds transfer (EFT). Enroll in EFT by completing the PECOS EFT information section. When submitting a PECOS application:

- Complete the EFT information for your organization (if appropriate) or yourself
- Include a copy of a voided check or bank letter that has your individual or business legal name and applicable account and routing numbers

Step 3: Respond to Requests for More Information

MACs pre-screen and verify enrollment applications for completeness. If the MAC needs more information, respond to information requests within 30 days. If you don't, the MAC may [reject your enrollment](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-P/section-424.525) (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-P/section-424.525).

Your MAC won't fully process your PECOS enrollment application without your electronic or uploaded signature, application fee (if applicable), and necessary supporting documentation. The enrollment application filing date is when the MAC gets your enrollment application.

You can check your PECOS enrollment application status 2 ways:

- Log in to [PECOS](https://pecos.cms.hhs.gov) (https://pecos.cms.hhs.gov) and select the **View Enrollments** link. In the **Existing Enrollments** section, find the application. The system shows the application status.
- To see your enrollment status without logging in, go to [PECOS](https://pecos.cms.hhs.gov) (https://pecos.cms.hhs.gov) and, under **Helpful Links**, select **Application Status**.

When your MAC approves your application, it switches the PECOS record to an approved status and sends you an approval letter.

Provider Enrollment Site Visits

We conduct a [site visit](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c10.pdf#page=23) (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c10.pdf#page=23>) verification process using National Site Visit Contractors (NSVCs). A site visit helps prevent questionable providers and suppliers from enrolling or staying enrolled in the Medicare Program.

The NSVCs conduct unannounced site visits for all Medicare Part A and B providers and suppliers, including DMEPOS suppliers. The NSVCs may conduct an observational site visit or a detailed review to verify enrollment-related information and collect other details based on pre-defined CMS checklists and procedures.

During an observational visit, the inspector has minimal contact with the provider or supplier and doesn't hinder the facility's daily activities. The inspector will take facility photos as part of the site visit. During a detailed review, the inspector enters the facility, speaks with staff, and collects information to confirm the provider's or supplier's compliance with our standards.

Inspectors performing site visits will carry a photo ID and a CMS-issued, signed authorization letter the provider or supplier may review. If the provider or its staff want to verify we ordered a site visit, [contact your MAC](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf) (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf).

Make your office staff aware of the site visit verification process. An inspector's inability to perform a site visit may result in denial of your Medicare enrollment application or revocation of your Medicare billing privileges.

Step 4: Use PECOS to Keep Enrollment Information Current

Report a Medicare enrollment change using PECOS. Physicians, NPPs, and physician and NPP organizations must report a [change of ownership or control](https://www.ecfr.gov/current/title-42/chapter-I/subchapter-G/part-489/subpart-A/section-489.18) (<https://www.ecfr.gov/current/title-42/chapter-I/subchapter-G/part-489/subpart-A/section-489.18>) (including a change in authorized or delegated official), a change in practice location, and any final adverse legal actions (like a felony or suspension of a federal or state license) within 30 days of the change and report all other changes within 90 days of the change.

DMEPOS suppliers must report changes in their enrollment application information within 30 days of the change.

Independent diagnostic testing facilities must report changes in ownership, location, general supervision, and adverse legal actions within 30 days of the change and report all other changes within 90 days of the change.

Medicare Diabetes Prevention Program suppliers must report changes in ownership, including AO or Access Manager; location; coach roster; and adverse legal actions within 30 days of the change and report all other changes within 90 days of the change.

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PECOS Users

We allow various organizations and users to work in our systems. The type of user depends on their relationship with you and the duties they perform in your practice.

You may choose other users to act for your organization to manage connections and staff, including appointing and approving other system-authorized users. Depending on your professional relationships with other providers, the CMS External User Services Help Desk may ask you for additional validation information.

One Account, Multiple Systems

We use several provider enrollment systems. Organizational providers and suppliers must use the [Identity & Access Management \(I&A\) System](https://nppes.cms.hhs.gov/IAWeb) (<https://nppes.cms.hhs.gov/IAWeb>) to name an AO to work in CMS systems. The I&A System allows you to:

- Use [NPPES](https://nppes.cms.hhs.gov) (<https://nppes.cms.hhs.gov>) to apply for and manage NPIs
- Use [PECOS](https://pecos.cms.hhs.gov) (<https://pecos.cms.hhs.gov>) to enroll in Medicare or update or revalidate your current enrollment information
- Register to get [electronic health record \(EHR\) incentive payments](https://www.cms.gov/medicare/regulations-guidance/promoting-interoperability-programs) (<https://www.cms.gov/medicare/regulations-guidance/promoting-interoperability-programs>) for eligible professionals and hospitals that adopt, use and upgrade, or show meaningful use of EHR technology

Authorized Officials, Access Managers, Staff End Users, & Surrogates

Organizational providers or suppliers must appoint and authenticate an **Authorized Official (AO)** through the I&A System to work in PECOS for them. That person must meet the AO regulatory definition. For example, an AO is a chief executive officer, chief financial officer, general partner, chair of the board, or direct owner who can legally enroll in the Medicare Program.

Respond to your employer's AO invitation or initiate the request yourself. After you're the confirmed AO, use PECOS for your provider or supplier organization. As an AO, you're responsible for approving PECOS user system requests to work on behalf of the provider or supplier organization. Regularly check your email and take the requested actions.

AOs may delegate their responsibilities to an **Access Manager** who can also initiate or accept connections and manage staff for their organizations.

AOs or Access Managers may invite a **Staff End User (SEU)** or **Surrogate** to access PECOS for their organization. Once registered, an SEU or Surrogate may log in to access, view, and

modify CMS system information, but they can't represent the practice, manage staff, sign enrollment applications, or initiate or accept connections.

Table 1. User Roles & Responsibilities

Role	Represent an Organization	Manage Staff	Approve or Manage Connections	Act on Behalf of Provider in CMS Systems
Individual Provider	Yes	Yes	Yes	Yes
AO	Yes	Yes	Yes	Yes
Access Manager	Yes	Yes	Yes	Yes
SEU	No	No	No	Yes
Surrogate	No	No	No	Yes

We recommend using the same I&A System-appointed AO and PECOS Access Managers. The assigned AO and Access Managers must have the right to legally bind the company and be responsible for approving the system staff and be CMS-approved in the I&A System.

Only AOs can sign an initial organization enrollment application. An Access Manager can sign changes, updates, and revalidations.

The [I&A System Quick Reference Guide](https://nppes.cms.hhs.gov/IAWebContent/Quick_Reference_Guide.pdf) (https://nppes.cms.hhs.gov/IAWebContent/Quick_Reference_Guide.pdf) has detailed instructions on managing system users.

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PECOS Technical Help

Using [PECOS](https://pecos.cms.hhs.gov) (<https://pecos.cms.hhs.gov>) may require technical support. The first step toward a solution is knowing which CMS contractor to contact.

Common Problems & Who to Contact

Problem: Navigating or Accessing PECOS Website ↗

You experience system-generated error messages, have trouble navigating through or accessing PECOS screens, encounter printing problems, or your valid I&A System user ID and password won't allow PECOS access because of a malfunction (for example, the website operates slowly or not at all or a system-generated error message prevents you from entering data).

A system-generated error message doesn't include messages created when you enter data incorrectly or ignore system prompts.

Solution: Contact the CMS External User Services Help Desk

The [External User Services \(https://eus.custhelp.com\)](https://eus.custhelp.com) website has information on common problems and allows you to ask questions, chat live with a support team member, or look up previous support history.

Phone: 1-866-484-8049 (TTY 1-866-523-4759)

Email: EUSSupport@cgi.com (<mailto:EUSSupport@cgi.com>)

EUS Hours of Operation:

- Monday–Friday: 6 am–6 pm CT
- Saturday–Sunday: Closed

Problem: Accessing PECOS ↗

Before you log in to PECOS, you need a valid [I&A System \(https://nppes.cms.hhs.gov/IAWeb\)](https://nppes.cms.hhs.gov/IAWeb) user ID and password.

Passwords expire every 60 days. The I&A System tells you the number of days until your password expires. If you attempt to log in to PECOS with an expired password, the system redirects you to the I&A System to reset it.

Solution: Access I&A System or Contact I&A System Help

The I&A System website lets you create an I&A System user ID and password, change your password, and recover forgotten login information. You can also access several resources:

- The [I&A FAQs](https://nppes.cms.hhs.gov/IAWebContent/FAQs.pdf) (https://nppes.cms.hhs.gov/IAWebContent/FAQs.pdf) helps you resolve common I&A System problems
- The [I&A System Quick Reference Guide](https://nppes.cms.hhs.gov/IAWebContent/Quick_Reference_Guide.pdf) (https://nppes.cms.hhs.gov/IAWebContent/Quick_Reference_Guide.pdf) provides step-by-step instructions, including screenshots, and information about I&A System features and tools

On the I&A System website, select the **Help** button in the upper right corner of any webpage for more information on that webpage's topic.

Problem: Enrolling in Medicare via PECOS (Non-Technical) ↪

While using PECOS, you may have questions, experience problems enrolling, or need help completing specific PECOS enrollment application sections.

Solution: Contact Your Medicare Enrollment Contractor

Find detailed enrollment contact information in the [Medicare Provider Enrollment Contact List](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf) (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf). If you have questions, find your [MAC's website](https://www.cms.gov/MAC-info) (https://www.cms.gov/MAC-info).

Problem: Not Sure Who to Call for a Particular Issue ↪

Solution: Refer to the CMS Provider Enrollment Assistance Guide

If you don't know who to call for help, refer to the ["Who should I call?" CMS Provider Enrollment Assistance Guide](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/CMSProviderEnrollmentAssistanceGuide.pdf) (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/CMSProviderEnrollmentAssistanceGuide.pdf).

Find detailed enrollment contact information in the [Medicare Provider Enrollment Contact List](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf) (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf).

PECOS FAQs

Print

Who can work in PECOS? ↪

Organizational providers and suppliers must designate a provider enrollment AO to work in CMS systems, including the [I&A System](https://nppes.cms.hhs.gov/IAWeb) (<https://nppes.cms.hhs.gov/IAWeb>), [NPPES](https://nppes.cms.hhs.gov) (<https://nppes.cms.hhs.gov>), and [PECOS](https://pecos.cms.hhs.gov) (<https://pecos.cms.hhs.gov>). The AO may also authorize Access Managers, Surrogates, and SEUs to use PECOS. Individual providers and suppliers don't require an AO but can authorize Surrogates and SEUs to work in PECOS. Refer to the [I&A System Quick Reference Guide](https://nppes.cms.hhs.gov/IAWebContent/Quick_Reference_Guide.pdf) (https://nppes.cms.hhs.gov/IAWebContent/Quick_Reference_Guide.pdf) and [I&A FAQs](https://nppes.cms.hhs.gov/IAWebContent/FAQs.pdf) (<https://nppes.cms.hhs.gov/IAWebContent/FAQs.pdf>) for more information on registering for an I&A System account or enrolling as an AO.

What login information do I need before accessing PECOS? ↪

We use several provider enrollment systems. Specifically, the [I&A System](https://nppes.cms.hhs.gov/IAWeb) (<https://nppes.cms.hhs.gov/IAWeb>) allows you to:

- Use [NPPES](https://nppes.cms.hhs.gov) (<https://nppes.cms.hhs.gov>) to apply for and manage NPIs
- Use [PECOS](https://pecos.cms.hhs.gov) (<https://pecos.cms.hhs.gov>) to enroll in Medicare or to update or revalidate your current enrollment information
- Register to get [EHR incentive payments](https://www.cms.gov/medicare/regulations-guidance/promoting-integratorability-programs) (<https://www.cms.gov/medicare/regulations-guidance/promoting-integratorability-programs>) for eligible professionals and hospitals that adopt, use and upgrade, or show meaningful use of certified EHR technology

Before completing PECOS enrollment, create an I&A System account. Organizational providers and suppliers must designate an AO to work in these systems.

What information do I need before I begin my enrollment in PECOS? ↪

Use the same information to enroll in Medicare using [PECOS](https://pecos.cms.hhs.gov) (<https://pecos.cms.hhs.gov>) as you would for a paper enrollment application.

- If you don't have an [I&A System](https://nppes.cms.hhs.gov/IAWeb) (<https://nppes.cms.hhs.gov/IAWeb>) account, create your username and password
- Use your username and password to log in to [NPPES](https://nppes.cms.hhs.gov) (<https://nppes.cms.hhs.gov>) to register for an NPI
- All Medicare provider enrollees must have an active NPI

Not Sure If You Have an NPI?

Search for your NPI on the [NPPES NPI Registry](https://npiregistry.cms.hhs.gov/search) (<https://npiregistry.cms.hhs.gov/search>).

Based on your provider type, you may also need this information:

- Personal identifying information, including your legal name on file with the Social Security Administration, date of birth, and SSN
- Legal business name of the provider or supplier organization
- Provider or supplier organization's TIN; if any person or organization has 5% or more partnership interest or ownership (direct or indirect), you must list them on all enrollment records under your TIN
 - Professional license information
 - School degrees
- Professional information, like
 - Certificates
- W-2 employees and contracted individuals and organizations with managerial control of the provider or supplier
- Accreditation information
- Surety bond information
- Specialty and secondary specialty information
 - Providers self-designate their Medicare specialty on the Medicare enrollment application (CMS 855-I or CMS 855-O) or PECOS when they enroll in the Medicare Program
 - **Beginning January 1, 2024, we established new provider [specialty codes](https://www.cms.gov/files/document/r12231cp.pdf) (<https://www.cms.gov/files/document/r12231cp.pdf>) for dentists**
- Practice location information, including:
 - Current medical practice location
 - Federal, state, and local (city or county) business and professional licenses, certificates, and registrations specifically required to operate as a health care facility
 - Medical record storage information
 - Special payment information
- Bank account information
- Information about relevant [final adverse actions](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-P#p-424.502(Final%20adverse%20action)) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-P#p-424.502\(Final%20adverse%20action\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-P#p-424.502(Final%20adverse%20action))) by a provider, supplier, owner, managing organization, officer, director, authorized or delegated official, medical director, supervising physician, or other health care or administrative or management services personnel, which may include:
 - Suspension, termination, or revocation of a license to provide health care by a state licensing authority or the Medicaid Program
 - Conviction of a federal or state felony within 10 years before enrollment, revalidation, or re-enrollment
 - Exclusion or debarment from federal or state health care program participation by the Office of Inspector General (OIG) or other federal or state offices with authority to exclude or sanction a provider (or those listed above)

What's the difference between an enrollment application and an enrollment record? ↗

An application is the paper or electronic form you submit for Medicare Program enrollment approval. After the MAC processes the application, PECOS keeps the enrollment record, which includes all your enrollment application data.

What enrollment changes can't you make through PECOS? ↪

You **can't** use PECOS to:

- Change your SSN
- Change a provider's or supplier's TIN
- Change an existing business structure, for example:
 - Solely owned PA, PC, or LLC can't be changed to a sole proprietorship
 - Sole proprietorship can't be changed to a PA, a PC, or an LLC

Submit changes noted above using the appropriate [paper Medicare enrollment application \(https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos/enrollment-applications\)](https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos/enrollment-applications).

Are any provider or supplier types restricted from using PECOS? ↪

No. All Fee-for-Service (FFS) providers can apply in PECOS.

When's PECOS available? ↪

PECOS is available 24 hours a day, Monday–Saturday, with scheduled downtime on Sunday. We offer technical support daily, 5 am–8 pm CT.

Am I required to complete and submit enrollment applications in PECOS? ↪

We encourage you to submit your enrollment application through [PECOS \(https://pecos.cms.hhs.gov\)](https://pecos.cms.hhs.gov) because it's faster and easier, but you may complete and mail the appropriate paper Medicare enrollment application to the address on the [Medicare Fee-for-Service Provider Enrollment Contact List \(https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf\)](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf):

- **Parts A and B Providers:** Send forms to your Part A or Part B MAC.
- **Home Health and Hospice Providers:** Send forms to the Home Health and Hospice Contractor.
- **DMEPOS Suppliers** Send forms to the National Provider Enrollment (NPE) DMEPOS contractor in your region. Find your [NPE contractor](https://www.cms.gov/medicare/provider-enrollment-and-certification/medicareprovidersupenroll/downloads/contact_list.pdf) (https://www.cms.gov/medicare/provider-enrollment-and-certification/medicareprovidersupenroll/downloads/contact_list.pdf).

Even if you submit your application on a paper form, your MAC creates an enrollment record in PECOS.

How will I know if I successfully submitted my electronic PECOS enrollment application?



When you electronically submit your Medicare enrollment application, you'll get a **Submission Confirmation** page, which will remind you that the individual provider, or the provider or supplier organization AO or Access Manager must electronically sign the application or upload their signature. You'll be able to see which MAC is processing your application, your unique application tracking number, and real-time information about your application.

PECOS emails the web tracking ID for the submitted application to each address in the **Contact Person** section of the application. Remember to verify all your completed signatures with either an electronic signature or uploading certification. Mail any required supporting documentation you didn't upload during submission to the MAC, and include the PECOS tracking ID.

How do I know when I need to create a new enrollment? →

Create a new enrollment:

- If you change your services, like changing specialties
- If you change your location, causing your MAC to need new state surveys and other documentation (your MAC can determine this)
- If you have a [change of ownership](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-489/subpart-A/section-489.18) (<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-489/subpart-A/section-489.18>)
- If a provider is creating a new TIN because of a change of ownership
- If you have provider-based vs. freestanding requirements (find your [MAC's website](https://www.cms.gov/MAC-info) (<https://www.cms.gov/MAC-info>) for more information)

Application Fee & Supporting Documentation

Am I required to pay an application fee? →

Generally, institutional providers and suppliers, like DMEPOS suppliers and opioid treatment programs, pay an [application fee](https://www.cms.gov/files/document/applicationfeerequisitepdf.pdf) (<https://www.cms.gov/files/document/applicationfeerequisitepdf.pdf>) when enrolling, re-enrolling, revalidating, or adding a new practice location.

What's the hardship exception to the application fee? ↪

A [hardship exception](https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R371PI.pdf#page=18) (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R371PI.pdf#page=18>) exempts you from paying a current application's fee. If you request a hardship exception, submit a written request and supporting documentation describing the hardship and justifying an exception to paying the application fee with your PECOS or CMS paper application. We grant exceptions on a case-by-case basis.

MACs will only process applications with the proper application fee payment or an approved hardship exception.

What happens if I don't submit the fee or hardship exception request? ↪

If you don't pay the fee or submit a hardship exception request, your MAC will send a letter allowing you 30 days to pay the fee. If you don't pay the fee on time, the MAC may reject or deny your application or revoke your existing billing privileges, as appropriate.

If you pay the fee during the 30-day period, the MAC processes the application in the usual manner.

Do I need to submit additional information outside PECOS to complete the application? ↪

No. When you electronically submit the Medicare enrollment application, a page appears that lists the supporting documentation to complete the enrollment. You can submit all this documentation electronically through PECOS.

Do I need to confirm my account information using bank letterhead or a voided check if I electronically submit and sign the Electronic Funds Transfer (EFT) Agreement (CMS-588)?



Yes, either is acceptable. You must send this information electronically (as supporting documentation uploaded into PECOS).

What are the penalties for falsifying information when using PECOS? ↗

During the PECOS application process, the **Penalties for Falsifying Information** page has the same text as the [paper Medicare enrollment application \(https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos/enrollment-applications\)](https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos/enrollment-applications) and lists the consequences for providing false information. These consequences include criminal and civil penalties, fines, civil monetary penalties, exclusion from federal health care programs, and imprisonment, among others. You must acknowledge this page by selecting the Next Page button before continuing the PECOS submission process.

Enrollment Application Issues

I'm a physician or NPP. What should I do if PECOS doesn't find my SSN? ↗

First, make sure you entered your correct SSN, legal name, and date of birth. If you believe you entered the correct information but PECOS doesn't accept this information, contact the [Social Security Administration \(https://www.ssa.gov/agency/contact\)](https://www.ssa.gov/agency/contact).

I'm a physician or NPP. What should I do if I don't have an SSN or don't want to use my SSN in a web transaction? ↗

You must report an SSN to enroll in Medicare. If you don't want to report your SSN over the web, use the appropriate [paper Medicare enrollment application \(https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos/enrollment-applications\)](https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos/enrollment-applications).

I see an Invalid Address error. How do I resolve this? ↗

An Invalid Address error indicates the address entered doesn't comply with the U.S. Postal Service address standards. This page lets you continue by either saving the address you entered or selecting the address PECOS displays.

When using PECOS, will the system time me out? ↗

As a security feature, PECOS will time out if you're inactive (you don't hit any keys on your computer keyboard) for 15 minutes. The system warns you of inactivity after 10 minutes. If it gets no response after 5 additional minutes, the system automatically times you out. Save your

work if you anticipate inactivity while applying in PECOS. If you don't save your work and the system times out, you must start from the beginning.

Submitting Reportable Events

Do I have to fill out the entire section if I'm just changing 1 field? ↗

No. If you report a change to existing information, check **Change**, include the effective date of change, and complete the appropriate fields in the impacted sections.

My information changed. Do I have to update my Medicare enrollment information? ↗

Yes. Following your initial enrollment, report certain changes (reportable events) to your MAC within 30 calendar days of the change. Report all other changes to your MAC within 90 days.

What's a reportable event? ↗

Report a Medicare enrollment change using PECOS. Physicians and NPPs must report a [change of ownership or control](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-489/subpart-A/section-489.18) (including a change in authorized or delegated official), a change in practice location, and any final adverse legal actions (like a felony or suspension of a federal or state license) within 30 days of the change and report all other changes within 90 days of the change.

DMEPOS suppliers must report changes in their enrollment application information within 30 days of the change.

Independent diagnostic testing facilities must report changes in ownership, location, general supervision, and adverse legal actions within 30 days of the change and report all other changes within 90 days of the change.

Medicare Diabetes Prevention Program suppliers must report changes in ownership, including AO or Access Manager; location; coach roster; and adverse legal actions within 30 days of the change and report all other changes within 90 days of the change.

What's the Special Payments address? ↗

Since Medicare pays claims by EFT, the Special Payments address should indicate where all other payment information must go (for example, paper remittance notices or special payments).

How do I change provider enrollment information? ↪

Providers and suppliers should report most changes using [PECOS](https://pecos.cms.hhs.gov) (<https://pecos.cms.hhs.gov>) or the applicable [paper Medicare enrollment application](https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos/enrollment-applications) (<https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos/enrollment-applications>).

I'm a DMEPOS supplier, and I have a new business location. Can I add this location to an existing PECOS enrollment? ↪

No. If you have a new business location, complete a new PECOS or paper application. Each DMEPOS enrollment record can only have 1 current business location.

Revalidations

Revalidation means resubmitting and recertifying your enrollment information.

My MAC requested I revalidate my enrollment information. What does this mean? Can I complete the action using PECOS? ↪

DMEPOS suppliers must revalidate every 3 years, while all other providers and suppliers generally revalidate every 5 years. We can also conduct [off-cycle revalidations](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-P#p-424.515(d)) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-P#p-424.515\(d\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-P#p-424.515(d))). You can revalidate using [PECOS](https://pecos.cms.hhs.gov) (<https://pecos.cms.hhs.gov>) or by submitting the appropriate [paper Medicare enrollment application](https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos/enrollment-applications) (<https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos/enrollment-applications>).

When do I revalidate? ↪

If you're currently enrolled, check the [Medicare Revalidation List](https://data.cms.gov/tools/medicare-revalidation-list) (<https://data.cms.gov/tools/medicare-revalidation-list>) to find your revalidation due date. If you see a due date, submit your revalidation before that date. Your MAC will also send you a revalidation notice.

Due dates are:

- Updated in the Medicare Revalidation List every 60 days at the beginning of the month
- Listed up to 7 months in advance or listed as to be determined (TBD) if the due date is more than 7 months away

Will I still get a revalidation notification from my MAC? ↪

Yes. Your MAC will send a revalidation notice 90–120 days before your revalidation due date.

Should I submit my revalidation if I don't have a notice from my MAC? ↪

If there's no due date listed on the [Medicare Revalidation List](https://data.cms.gov/tools/medicare-revalidation-list) (<https://data.cms.gov/tools/medicare-revalidation-list>) or you didn't get a MAC letter requesting revalidation, don't submit your revalidation application. Your MAC will return it to you.

However, if you're within 2 months of the due date listed on the Medicare Revalidation List and didn't get a MAC notice to revalidate, submit your revalidation application.

Can I revalidate without completing the entire enrollment application again? ↪

Yes. PECOS lets you review information on file and update and electronically submit your revalidation. If you use PECOS, you need to update only changed information.

What will happen if I don't submit my revalidation by the due date? ↪

If you submit your revalidation after its due date, your MAC may place a hold on your Medicare payments or deactivate your Medicare billing privileges. If the MAC requests additional documentation, respond within 30 days. If you don't, they may [deactivate](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-P/section-424.540) (<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-P/section-424.540>) your Medicare billing privileges.

If the information in my revalidation is different than what CMS has on file about my practice location, authorized representatives, or other pertinent information, will I get penalized for not reporting the change within the required time frames? ↪

Revalidation ensures all provider enrollment records are accurate and current. Generally, we don't take administrative action against a provider or supplier for updating their records even though it wasn't timely. However, we could take administrative actions, including recovering previous Medicare payments, when a provider or supplier that fails to report the change causes their Medicare enrollment to become ineligible.

PECOS users can't mail documents that require a signature. When submitting your application, be prepared to send an e-signature or upload your signed documents.

Version 04/25/2024
Check for Updates

Print

Protect Your Identity & Privacy

You can help protect your professional medical identifiers from identity thieves attempting to defraud the Medicare Program.

Keep PECOS Enrollment Information Current

Log in to PECOS and review your Medicare enrollment information several times a year to ensure no unauthorized changes were made.

PECOS Provides Security

Only you, authorized surrogates, authorized CMS officials, and MACs may enter and view your Medicare PECOS enrollment information. CMS officials and MACs get security standards training and must protect your information. We don't disclose your Medicare enrollment information to anyone, except when authorized or required by law.

Review & Protect Enrollment Information

Review your Medicare enrollment information in PECOS frequently to ensure it's accurate, current, and unaltered.

Use your [I&A System \(https://nppes.cms.hhs.gov/IAWeb\)](https://nppes.cms.hhs.gov/IAWeb) user ID and password to access PECOS. Keep your ID and password secure.

Protect Yourself & CMS Programs from Fraud

Your NPI and TIN are publicly available information. Use extra caution to monitor and protect your professional and personal information to help prevent fraud and abuse. Also ensure your patients' personal health information is secure. Refer to these resources:

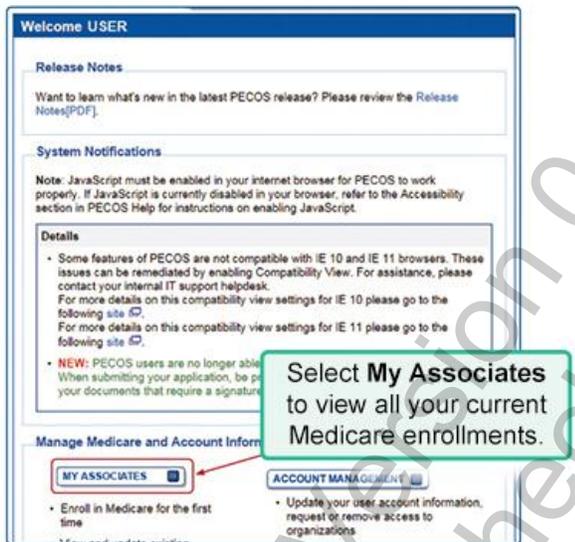
- [Medicare Fraud & Abuse: Prevent, Detect, Report \(https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf\)](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf)
- [Office of Inspector General \(https://oig.hhs.gov\)](https://oig.hhs.gov)
- [Reporting Medicare fraud & abuse \(https://www.medicare.gov/basics/reporting-medicare-fraud-and-abuse\)](https://www.medicare.gov/basics/reporting-medicare-fraud-and-abuse)

Take these steps to verify your Medicare enrollment information:

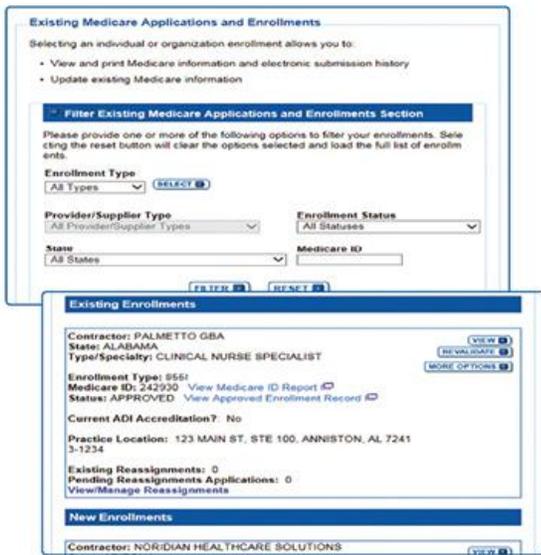
Step 1: Log in to [PECOS \(https://pecos.cms.hhs.gov\)](https://pecos.cms.hhs.gov)



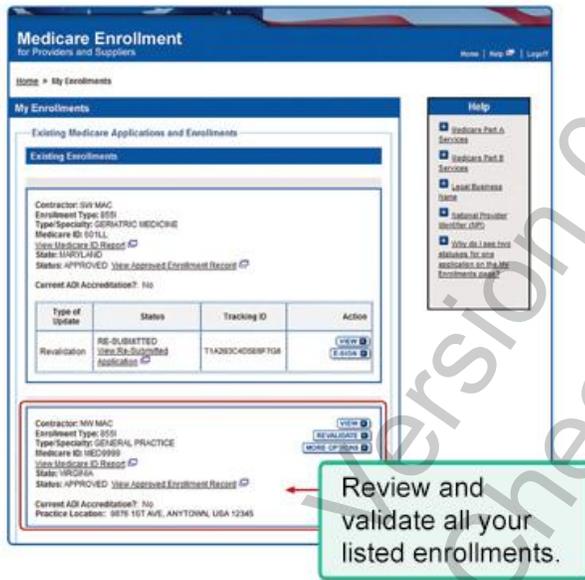
Step 2: View Your Medicare Account



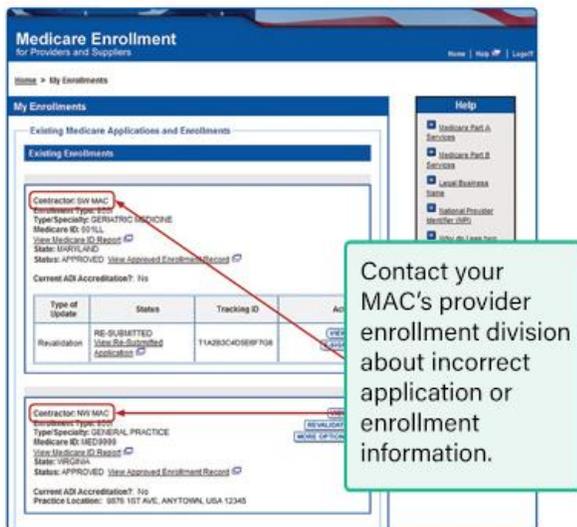
Step 3: View Existing Enrollments



Step 4: Check for False Applications & Enrollments



Step 5: Report Identity Theft, if Needed



If you suspect your PECOS profile is incorrect due to unauthorized account access, contact your MAC, law enforcement authorities, and your bank. Your MAC and bank can flag your respective accounts for possible fraudulent activity, and law enforcement can begin investigating if and how your accounts were compromised.

Additional Privacy Tips

Take these additional actions to protect your Medicare enrollment information:

- **Change your password in the I&A System before accessing PECOS the first time.** You can't change your user ID, but you must change your password every 60 days.
- **Review your Medicare enrollment information several times a year to ensure no one changed information without your knowledge.** Immediately report changes you didn't submit.
- **Maintain your Medicare enrollment record.** Report Medicare enrollment changes known as reportable events, including [change of ownership or control \(https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-489/subpart-A/section-489.18\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-489/subpart-A/section-489.18), change in practice location, banking arrangements, and any final adverse legal actions.
- **Store PECOS copies or paper enrollment applications in a secure location.** Don't allow others access to this information as it contains your personal information, including your date of birth and SSN. Don't leave copies in a public workspace.
- **Enroll in electronic Medicare payments, and ensure they deposit directly into your bank account.** We require all providers to use electronic funds transfer (EFT) when enrolling in Medicare, revalidating, or making changes to their enrollment. The most efficient way to enroll in EFT is to complete the EFT information section in PECOS and provide the required supporting documentation. Using EFT allows us to send payments directly to your bank account.

[Print](#)

DMEPOS Supplier Requirements

DMEPOS Supplier Standards, Accreditation, & Surety Bond

To enroll or keep your Medicare billing privileges, all [DMEPOS suppliers](https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/durable-medical-equipment-prosthetics-orthotics-supplies-dmepos) (except certain exempted professionals) must meet supplier and [DMEPOS Quality Standards](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/DMEPOSQuality/DMEPOSQualBooklet-905709.html) to become accredited. Certain DMEPOS suppliers must also submit a [surety bond](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424#p-424.57(d)).

DMEPOS suppliers (except those exempted eligible professionals and other persons) must be [accredited](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/DMEPOS_Basics_FactSheet_ICN905710.pdf) by a CMS-approved accrediting organization before submitting a Medicare enrollment application to the [National Provider Enrollment \(NPE\) DMEPOS contractors](#).

Each enrolled DMEPOS supplier covered under the Health Insurance Portability and Accountability Act (HIPAA) must name each practice location (if it has more than 1) as a sub-part and make sure each sub-part gets its own NPI.

Individual DMEPOS Suppliers (for example, sole proprietorships)

Physicians, NPPs, and DMEPOS suppliers may use their [I&A System](https://nppes.cms.hhs.gov/IAWeb) user ID and password to access [PECOS](https://pecos.cms.hhs.gov). If you don't already have an I&A System account, refer to the [I&A System User Registration](https://nppes.cms.hhs.gov/IAWeb) page and enter the information to open an account. For help, refer to the **How to Setup Your Account if you are a Sole Owner** section in the [I&A System Quick Reference Guide](https://nppes.cms.hhs.gov/IAWebContent/Quick_Reference_Guide.pdf).

As an individual DMEPOS supplier, you don't need an AO or another authorized user.

Organizational DMEPOS Suppliers System Users

A DMEPOS supplier organization must appoint an AO to manage connections and staff, including appointing and approving other authorized PECOS users. The organization must identify the AO in the enrollment application. The AO must have ownership or managing control in the DMEPOS supplier organization.

[Print](#)

Providers Who Solely Order or Certify

Physicians and other eligible professionals must enroll in the Medicare Program or have a valid opt-out affidavit on file to solely order or certify Medicare patient items or services.

Those physicians and other eligible professionals enrolled solely as ordering/certifying providers **don't** send billed service claims to a MAC.

Ordering/Certifying Terms

Part B claims use the term ordering/certifying provider to identify the professional who orders or certifies an item or service reported in a claim. These are technically correct terms:

- Providers **order** non-physician patient items or services, like DMEPOS, clinical lab services, or imaging services
- Providers **certify** patient home health services

The health care industry uses the terms **ordered**, **referred**, and **certified** [interchangeably](https://www.federalregister.gov/d/2012-9994/p-94) (<https://www.federalregister.gov/d/2012-9994/p-94>).

Who Are Eligible Ordering/Certifying Providers?

Physicians or eligible professionals who order or certify Part A or Part B services but don't want to submit Medicare claims are eligible ordering/certifying providers.

A person already enrolled as a Part B provider may submit claims listing themselves as the ordering/certifying provider without re-enrolling using [Medicare Enrollment Application: Enrollment for Eligible Ordering/Certifying Physicians and Other Eligible Professionals \(CMS-855O\)](https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855o.pdf) (<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855o.pdf>).

Note: Those who enroll as eligible providers using CMS-855O can't bill Medicare, and we can't pay for their services because they have no Medicare billing privileges.

Organizational NPIs don't qualify, and you can't use them to order or certify.

Eligible providers must meet these basic conditions:

- Have an individual NPI
- Be enrolled in Medicare in either an approved or opt-out status
- Be an eligible specialty type to order or certify

Denial of Ordering/Certifying Claims

If claims lack a valid individual NPI, MACs deny them if they're from:

- Clinical labs for ordered tests
- Imaging centers for ordered imaging procedures
- DMEPOS suppliers for ordered DMEPOS
- Part A home health agencies that aren't ordered or certified by a Doctor of Medicine, Osteopathy, or Podiatric Medicine

If you bill a service that needs an eligible provider and they aren't on the claim, the MAC will deny the claim. The claim must have a valid NPI and the eligible provider's name as it appears in PECOS.

If a provider who's on the [Preclusion List](https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos/preclusion-list) (<https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos/preclusion-list>) prescribes a Medicare Part D drug, drug plans will deny it.

Requirement 1: Get an Individual NPI

The 2 types of NPIs are: Type 1 (individual) and Type 2 (organizational). **Medicare allows only Type 1 NPIs to solely order items or certify services.** Apply for an NPI through:

- **Online Application:** Get an [I&A System](https://nppes.cms.hhs.gov/IAWeb) (<https://nppes.cms.hhs.gov/IAWeb>) user account. Then apply for an NPI in [NPPES](https://nppes.cms.hhs.gov) (<https://nppes.cms.hhs.gov>).
- **Paper Application:** Complete, sign, and mail the [NPI Application/Update Form \(CMS-10114\)](https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS10114.pdf) (<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS10114.pdf>) paper application to the address on the NPI Enumerator form. To request a hard copy application:
 - Call 1-800-465-3203 (TTY 1-800-692-2326)
 - Email customerservice@npienumerator.com (<mailto:customerservice@npienumerator.com>)
- **Bulk Enumeration:** Apply for [Electronic File Interchange](https://nppes.cms.hhs.gov/webhelp/nppeshelp/EFI%20HELP%20PAGE.html) (<https://nppes.cms.hhs.gov/webhelp/nppeshelp/EFI%20HELP%20PAGE.html>) access and upload your own CSV or XML files.

Requirement 2: Enroll in Medicare in an Approved or Opt-Out Status

Once you have an NPI, use PECOS to verify current Medicare enrollment record information, including your NPI and that you're approved, or go to the [Opt Out Affidavits list](https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment/opt-out-affidavits) (<https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment/opt-out-affidavits>) to check your status. To opt out of Medicare, [submit an affidavit](https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos/manage-your-enrollment#opt-out) (<https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos/manage-your-enrollment#opt-out>) expressing your decision to opt out of the program.

Part C and Part D providers don't have to enroll in Medicare in an approved or opt-out status.

Table 2. Options to Verify Your Current Enrollment Record Exists in PECOS

Verification Option	Enrollment Record Is Current If:
Go to the Order and Referring (https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment/order-and-referring) datasets.*	You're on 1 of these reports.
Go to PECOS (https://pecos.cms.hhs.gov) to find your enrollment record.	Your enrollment record displays an approved status.
If you submitted an enrollment application as 1 of the eligible provider types on paper (CMS-855O) or using PECOS and want to check the status, go to the Pending Initial Logging and Tracking Non Physicians (https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment/pending-initial-logging-and-tracking-non-physicians) and Pending Initial Logging and Tracking Physicians (https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment/pending-initial-logging-and-tracking-physicians) datasets.	Your enrollment application is pending contractor review if you're on 1 of these reports.

*We deny certain power mobility device claims if the ordering provider isn't on our eligible providers list.

Requirement 3: Be Eligible to Order or Certify

The physicians and eligible professionals who may enroll in Medicare solely for ordering or certifying include, but aren't limited to, physicians and eligible professionals who are:

- Department of Veterans Affairs employees
- Public Health Service employees
- Department of Defense or TRICARE employees
- Indian Health Service or Tribal Organization employees
- Federally Qualified Health Center, Rural Health Clinic, or Critical Access Hospital employees
- Licensed Residents in an approved medical residency program defined in [42 CFR 413.75\(b\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413/subpart-F/section-413.75#p-413.75(b)) ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413/subpart-F/section-413.75#p-413.75\(b\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413/subpart-F/section-413.75#p-413.75(b)))
- Dentists, including oral surgeons
- Pediatricians
- Retired, licensed physicians

If you're unsure whether your specific provider specialty qualifies to enroll as an ordering/certifying provider, refer to Section 4 of [CMS-855O](https://www.cms.gov/Medicare/CMS-Forms/) (<https://www.cms.gov/Medicare/CMS-Forms/>)

[CMS-Forms/Downloads/cms855o.pdf](#)) or find your **MAC's website** (<https://www.cms.gov/MAC-info>) before submitting a Medicare enrollment application.

Beginning January 1, 2024, we established new provider **specialty codes** (<https://www.cms.gov/files/document/r12231cp.pdf>) for dentists.

Interns & Residents

Claims for items or services ordered or certified by licensed or unlicensed interns and residents must specify a teaching physician's NPI and name. State-licensed residents may enroll to order or certify and can be listed on claims. If states offer provisional licenses or otherwise permit residents to order/certify, we allow interns and residents to enroll consistent with state law.

Requirement 4: Respond to Requests for More Information

MACs pre-screen and verify enrollment applications for completeness. If the MAC needs more information, respond to information requests within 30 days. If you don't, the MAC may **reject your enrollment** (<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-P/section-424.525>).

Your MAC won't fully process your PECOS enrollment application without your electronic or uploaded signature, application fee (if applicable), and necessary supporting documentation. The enrollment application filing date is when the MAC gets your enrollment application.

You can check your PECOS enrollment application status 2 ways:

- Log in to **PECOS** (<https://pecos.cms.hhs.gov>) and select the **View Enrollments** link. In the **Existing Enrollments** section, find the application. The system shows the application status.
- To see your enrollment status without logging in, go to PECOS and, under **Helpful Links**, select **Application Status**.

When your MAC approves your application, it switches the PECOS record to an approved status and sends you an approval letter.

Requirement 5: Use PECOS to Keep Enrollment Information Current

Report a Medicare enrollment change using PECOS. Providers and suppliers must report a **change of ownership or control** (<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-489/subpart-A/section-489.18>) (including a change in authorized or delegated official), a change in practice location, and any final adverse legal actions (like revocation or suspension of a federal or state license) within 30 days of the change and must report all other changes within 90 days of the change.

DMEPOS suppliers must report changes in their enrollment application information within 30 days of the change.

Independent diagnostic testing facilities must report changes in ownership, location, general supervision, and adverse legal actions within 30 days of the change and report all other changes within 90 days of the change.

Medicare Diabetes Prevention Program suppliers must report changes in ownership, including AO or Access Manager; location; coach roster; and adverse legal actions within 30 days of the change and report all other changes within 90 days of the change.

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Revalidation

Revalidation, or re-submitting and recertifying your enrollment information accuracy, is an important anti-fraud tool. All Medicare-enrolled providers and suppliers must periodically [revalidate their enrollment information](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/RevalidationChecklist.pdf) (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/RevalidationChecklist.pdf).

Generally, physicians, including physician organizations, opioid treatment programs, Medicare Diabetes Prevention Program suppliers, and institutional providers, revalidate enrollment every 5 years or when we request it. DMEPOS suppliers must revalidate their enrollment information every 3 years.

PECOS is the most efficient way to revalidate information.

If you're actively enrolled, go to the [Medicare Revalidation List](https://data.cms.gov/tools/medicare-revalidation-list) (https://data.cms.gov/tools/medicare-revalidation-list) to find your revalidation due date. If you see a due date, submit your revalidation before that date. Your MAC notifies you when it's time to revalidate. If you submit your revalidation application after the due date, your MAC may hold your Medicare payments or [deactivate](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-P#p-424.540(a)) (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-P#p-424.540(a)) your billing privileges.

Rebuttal Process

MACs issue Medicare billing privilege deactivations. We permit providers and suppliers to [file a rebuttal](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-P#p-424.546(a)) (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-P#p-424.546(a)).

Get more information:

- [42 CFR 424.515](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-P/section-424.515) (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-P/section-424.515)
- [Provider Enrollment Revalidation Cycle 2 FAQs](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/Reval_Cycle2_FAQs.pdf) (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/Reval_Cycle2_FAQs.pdf)
- [Revalidations \(Renewing Your Enrollment\)](https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/revalidations) (https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/revalidations)

Large Group Coordination

Groups with more than 200 members can use the [Medicare Revalidation List](https://data.cms.gov/tools/medicare-revalidation-list) (https://data.cms.gov/tools/medicare-revalidation-list) and search by their organization's name to download group information. Their MAC will send them a letter and spreadsheet that lists the providers linked to their group who must revalidate within 6 months. Large groups should work together to ensure they submit only 1 application from each provider or supplier.

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Resources

Use these resources to learn how to enroll in the Medicare Program, revalidate your enrollment, or change your enrollment information. Enroll in the Medicare Program to get paid for providing covered patient services. Enroll if you solely order items or certify services.

You can enroll online by using PECOS or the appropriate paper enrollment application you submit to your MAC.

- Get an [I&A System \(https://nppes.cms.hhs.gov/IAWeb\)](https://nppes.cms.hhs.gov/IAWeb) user account
- Apply for your NPI in the [NPPES \(https://nppes.cms.hhs.gov\)](https://nppes.cms.hhs.gov)
- Enroll in [PECOS \(https://pecos.cms.hhs.gov\)](https://pecos.cms.hhs.gov)

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Table 3. Learn About Medicare Enrollment

Topic	Title
Application fee	Application Fee Information (Application Fee Requirements for Institutional Providers (https://www.cms.gov/files/document/applicationfeerequirementmatrixpdf))
Provider-supplier general information	Become a Medicare Provider or Supplier (https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers)

Table 4. Revalidation Information

Topic	Title
Revalidation due dates	Medicare Revalidation List (https://data.cms.gov/tools/medicare-revalidation-list)
Revalidation overview	Revalidations (Renewing Your Enrollment) (https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/revalidations) Provider Enrollment Revalidation Cycle 2 FAQs (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/Reval_Cycle2_FAQs.pdf)

Table 5. Enrollment Help

Topic	Title
FAQs	PECOS FAQs (https://pecos.cms.hhs.gov/pecos/help-main/faq.jsp)
Get an NPI	NPPES Registered User Sign In (https://nppes.cms.hhs.gov) What's New in NPPES 3.0 (https://www.youtube.com/embed/BOJCAj1P2u8) (video)
Online enrollment system	PECOS (https://pecos.cms.hhs.gov)
PECOS tutorials	PECOS Enrollment Tutorial Videos (https://www.youtube.com/playlist?list=PLaV7m2-zFKpia1McB1WKKkw2esAdiZRem)
Register for usernames and passwords to access NPPES, PECOS, and the EHR incentive program	I&A System (https://nppes.cms.hhs.gov/IAWeb) I&A System Quick Reference Guide (https://nppes.cms.hhs.gov/IAWebContent/Quick_Reference_Guide.pdf) I&A FAQs (https://nppes.cms.hhs.gov/IAWebContent/FAQs.pdf)
Search NPI records, including the provider's name, specialty, and practice address	NPPES NPI Registry (https://npiregistry.cms.hhs.gov/search)

Submit provider NPI applications and update information electronically in NPES	Electronic File Management Main Page (https://nppes.cms.hhs.gov/webhelp/nppeshelp/EFI%20HELP%20PAGE.html)
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Table 6. Medicare Contractors That Can Help with Problems

Topic	Contact
All other enrollment-related questions	Find your MAC's website (https://www.cms.gov/MAC-info)
Application for NPI	NPES Home Page/Sign In Page Help (https://nppes.cms.hhs.gov/webhelp/nppeshelp/HOME%20PAGE-SIGN%20IN%20PAGE.html)
Institutional and other providers state survey	State Survey Agency Contact Information (https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/contact-information)
Navigating and accessing PECOS website	CMS EUS Help Desk (https://eus.custhelp.com) "Who should I call?" CMS Provider Enrollment Assistance Guide (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/CMSProviderEnrollmentAssistanceGuide.pdf)
Paper applications	Medicare Fee-for-Service Provider Enrollment Contact List (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf)
Provider site visit	Become an Institutional Provider (https://www.cms.gov/medicare/provider-enrollment-and-certification/enroll-as-an-institutional-provider)

Enrollment Forms

If you enroll using a paper application instead of [PECOS \(https://pecos.cms.hhs.gov\)](https://pecos.cms.hhs.gov), search the [CMS Forms List \(https://www.cms.gov/medicare/forms-notice/cms-forms-list\)](https://www.cms.gov/medicare/forms-notice/cms-forms-list) to find the form you need and read on page 1, **Who Should Submit This Application.**

Table 7. CMS Enrollment Forms

Form	Form Number
Electronic Funds Transfer (EFT) Authorization Agreement	CMS-588 (https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS588.pdf)
Health Insurance Benefit Agreement	CMS-1561 (https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1561.pdf)
Medicare Enrollment Application: Clinics/Group Practices and Other Suppliers	CMS-855B (https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855b.pdf)
Medicare Enrollment Application: Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers	CMS-855S (https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855s.pdf)

Medicare Enrollment Application: Enrollment for Eligible Ordering/Certifying Physicians and Other Eligible Professionals	CMS-855O (https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855o.pdf)
Medicare Enrollment Application: Institutional Providers	CMS-855A (https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855a.pdf)
Medicare Enrollment Application: Medicare Diabetes Prevention Program (MDPP) Suppliers	CMS-20134 (https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS20134.pdf)
Medicare Enrollment Application: Physicians and Non-Physician Practitioners	CMS-855I (https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855i.pdf)
Medicare Participating Physician or Supplier Agreement	CMS-460 (https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS460.pdf)
National Provider Identifier (NPI) Application/Update Form	CMS-10114 (https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS10114.pdf)

Commonly Used Terms

CMS

CMS is the federal agency that administers the Medicare, Medicaid, Children’s Health Insurance Program (CHIP), HIPAA, Clinical Laboratory Improvement Amendments (CLIA), and several other health-related programs.

CMS-460

The Medicare Participating Physician or Supplier Agreement describes your willingness to accept assignment for all covered services you provide to patients. If you participate, we pay 5% more, and participating providers get timely, direct payment.

CMS-588

The Electronic Funds Transfer (EFT) Authorization Agreement tells you how to get electronic payments or update existing banking information.

CMS-855A

The Medicare enrollment application institutional providers use to enroll, revalidate enrollment, or change enrollment information.

CMS-855B

The Medicare enrollment application clinics or group practices and other suppliers (except DMEPOS suppliers) use to enroll, revalidate enrollment, or change enrollment information.

CMS-855I

The Medicare enrollment application physicians and non-physician practitioners (NPPs) (individual physicians or NPPs) use to enroll, revalidate enrollment, or change enrollment information. **Physicians and NPPs can also reassign their right to bill the Medicare Program, terminate a current reassignment of Medicare benefits, or make a change in their reassignment of Medicare benefit information using the CMS-855I.**

CMS-855O

The Medicare enrollment application eligible ordering, certifying, and prescribing physicians and other eligible professionals (physicians, including dentists and other eligible NPPs) use to enroll to order items or certify patient services. This includes those physicians and other eligible NPPs who don't and won't send patient service claims to a MAC.

CMS-855S

The Medicare enrollment application DMEPOS suppliers use to enroll, revalidate enrollment, or change enrollment information.

CMS-1561

The Health Insurance Benefit Agreement is an agreement between a provider and CMS to get Medicare payments.

CMS-10114

This form tells you how to apply or submit NPI updates.

CMS-20134

The Medicare enrollment application Medicare Diabetes Prevention Program suppliers use to enroll, revalidate enrollment, or change enrollment information.

Director

A director of a corporation, even when the provider or supplier is a non-profit entity. This includes any member of the corporation's governing body regardless of the board's or member's specific title. The body could be a board of directors, board of trustees, or something similar.

DMEPOS Suppliers

Entities or persons, including physicians or Part A providers, who sell or rent Medicare Part B covered items to patients and meet the DMEPOS supplier standards.

Electronic File Interchange (EFI)

The EFI process lets CMS-approved EFI Organizations electronically submit provider NPI applications and update NPES information with minimal manual intervention.

Electronic Funds Transfer (EFT)

We directly pay EFT providers by sending payments to the provider's financial institution whether they file claims electronically or on paper. All our providers must apply for EFT.

Electronic Health Record (EHR)

An EHR is an electronic version of a patient's medical history.

External User Services (EUS) Help Desk

EUS is a dedicated CMS online support site offering help, including, but not limited to, the Identity & Access Management (I&A) System, PECOS, and NPES.

Identity & Access Management (I&A) System

Users register for usernames and passwords to access PECOS, NPES, and the EHR Incentive Program.

Institutional Provider

These are providers or suppliers that submit a [CMS-855A](https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855a.pdf) (<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855a.pdf>), [CMS-855B](https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855b.pdf) (<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855b.pdf>) (except physician and NPP organizations), or [CMS-855S](https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855s.pdf) (<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855s.pdf>) form. See page 1 of the respective provider-type forms about who should use them.

Managing Organization

An entity that exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operations of the provider or supplier, either under contract or through some other arrangement.

Medicare Administrative Contractor (MAC)

A private company that contracts with us to process and pay Fee-for-Service patient Part A and Part B medical or DME claims.

Medicare Application Fee

Institutional providers and suppliers must pay an application fee when they initially enroll in Medicare, add a practice location, or revalidate their enrollment information. We define an institutional provider as any provider or supplier that submits a CMS-855A, CMS-855B (except physician and NPP organizations), or CMS-855S form.

NPPES

NPPES assigns unique NPIs to Medicare providers and health plans to improve the efficiency and effectiveness of electronically submitting health information.

National Site Visit Contractor (NSVC)

The NSVC performs a site visit to screen and stop questionable providers and suppliers from enrolling or maintaining enrollment.

NPI Enumerator

The NPI Enumerator helps Medicare providers apply for NPIs and update their information in NPPES.

NPI Registry

The NPI Registry is a directory of all active NPI records that displays relevant public portions of the record, including the provider's name, specialty, and practice address.

Officer

An officer of a corporation, regardless of whether the provider or supplier is a non-profit entity.

Participating Physician or Supplier

Participating physicians or suppliers agree to accept patient assignment on Medicare service claims. They agree to accept allowed amounts as payment in full and to collect only the [deductible and coinsurance or copayment](https://www.medicare.gov/basics/costs/medicare-costs) (<https://www.medicare.gov/basics/costs/medicare-costs>). See [CMS-460 \(#460\)](#).

PECOS

PECOS is CMS's online provider enrollment system allowing registered users to securely and electronically submit and manage enrollment information. You can use PECOS instead of paper enrollment forms.

Reassignment of Medicare Benefits

Reassigning your Medicare benefits lets an eligible organization or group submit claims and get payment for Part B services you provide as a member of an organization or group. See [CMS-855l \(#855\)](#).

Revalidation

A provider and supplier mandatory resubmission and recertification process to maintain enrollment information accuracy and Medicare billing privileges. The process ensures enrollment information on file remains complete and current and helps fight health care fraud.

State Survey Agency

They perform initial surveys and periodic resurveys of all institutional providers (including labs) and certain kinds of suppliers. These surveys determine if a provider or supplier meets the conditions to participate in the Medicare Program and evaluates their performance and quality of care.

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Consolidated CMS-855I/CMS-855R Enrollment Applications

What Has Changed?

Medicare has merged the CMS-855R into the CMS-855I paper enrollment application. Physicians and non-physician practitioners can reassign your right to bill the Medicare program and receive Medicare payments for some or all the services you render to Medicare beneficiaries terminate a current reassignment of Medicare benefits or make a change in their reassignment of Medicare benefit information using the CMS-855I. All data previously collected on CMS-855R and used to report reassignment information is now captured on the CMS-855I. The CMS-855R will no longer be used to report reassignment information.

Organizations/groups accepting a new reassignment of Medicare benefits terminating a currently established reassignment of benefits or making a change in reassignment of Medicare benefit information, should also submit the 855I to report these changes. The CMS-855B will be updated to include reassignment information in a future form update.

What Does It Mean to Reassign Your Benefits?

Reassigning your Medicare benefits allows an eligible organization/group to submit claims and receive payment for Medicare Part B services that you have provided as a member of the organization/group. Such an eligible organization/group may be an individual, a clinic/group practice or other health care organization.

How to Submit Reassignment of Benefits Using the Revised CMS-855I

Physicians and non-physician practitioners can enroll and report reassignments using either:

- *The Provider Enrollment, Chain and Ownership System (PECOS), or*
- *The Paper CMS-855I Application*

PECOS Submissions

There is no change in how physicians, non-physician practitioners or organizations/groups report reassignments in PECOS. Within the Reassignment Topic of your PECOS application, you can add a new reassignment, terminate an existing reassignment or make a change to your reassignment information. All existing signatures are required to be submitted. For step-by-step enrollment tutorials refer to: <https://pecos.cms.hhs.gov/pecos/login.do#headingLv1>.

Paper Submissions

Adding a Reassignment with Your Initial Enrollment

1. Check the "You are a new enrollee in Medicare" box in Section 1A.
2. Complete all applicable sections.
3. In Section 4F, check "Add", furnish the effective date and complete the appropriate fields in this section
4. If you reassign benefits to more than one organization/group, copy and complete the page.
5. If applicable, in Section 4F3, identify the primary and/or secondary location of the organization/group where the practitioner will render in-person services most of the time.

Adding a New Reassignment as a Change of Information

1. Check the "You are reporting a change to your Medicare enrollment information" in Section 1A.
2. In Section 1B select "Reassignment of Benefit Information."
3. Complete Sections 1, 2A, 3, 4F, 12, 13 (optional) and 15.
4. In Section 4F, check "Add", furnish the effective date, and complete the appropriate fields in this section
5. If applicable, in Section 4F3, identify the primary and/or secondary location of the organization/group where the practitioner will render in-person services most of the time.
6. The practitioner must sign Section 15B.
7. The Authorized or Delegated Official of the organization/group must sign Section 15C.

Changing Existing Reassignment Information (Primary/Secondary Location(s))

1. Check the "You are reporting a change to your Medicare enrollment information" in Section 1(A).
2. In Section 1(B) select "Reassignment of Benefit Information."
3. Complete Sections 1, 2A, 3, 4F, 12, 13 (optional) and 15.
4. In Section 4F3, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.
5. The certification statement must be signed by either the practitioner (Section 15B) or the Authorized or Delegated Official (Section 15C) of the organization/group.

Terminating an Existing Reassignment

1. Check the "You are reporting a change to your Medicare enrollment information" in Section 1(A).
2. In Section 1(B) select "Reassignment of Benefit Information."
3. Complete Sections 1, 2A, 3, 4F, 12, 13 (optional) and 15.
4. In Section 4F, check "Terminate", furnish the effective date, and complete the appropriate fields in this section
5. The certification statement must be signed by either the practitioner (Section 15B) or the Authorized or Delegated Official (Section 15C) of the organization/group.

When are these Changes Effective?

Medicare Administrative Contractors (MACs) will begin to accept the revised version of the CMS-855I (05/23) on September 1, 2023. Refer to: <https://www.cms.gov/medicare/provider-enrollment-and-certification/enrollment-applications> for the revised form.

MACs will continue to accept the 12/21 version of the CMS-855I and the 01/20 version of the CMS-855R through October 30, 2023. After November 1, 2023, MACs will return any newly submitted CMS-855I and CMS-855R applications on the previous versions to the provider/supplier with a letter explaining that the CMS-855I has been updated and the CMS-855R discontinued and the current version of the CMS-855I (05/23) must be submitted.

Identify Your MAC

MACs process all Medicare enrollment applications for Part A and B providers and suppliers. MACs serve as the primary avenue of communication between health care providers and the CMS Medicare Fee-For-Service program.

Find and contact your MAC (PDF).

HEALTH CARE PRACTITIONERS MEDICARE FEE CONTROL ACT
Act of Jul. 10, 1990, P.L. 352, No. 81
AN ACT

Cl. 63

Prohibiting health care practitioners from balance billing for services to certain patients.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Short title.

This act shall be known and may be cited as the Health Care Practitioners Medicare Fee Control Act.

Section 2. Purposes.

(a) Legislative finding.--The General Assembly finds that there exists in this Commonwealth a major crisis because of the continuing escalation of costs for health care services. Because of the continuing escalation of costs, an increasingly large number of Pennsylvania citizens have severely limited access to appropriate and timely health care. Senior citizens and the disabled are disadvantaged by the continuing escalation of costs for health care services. Increasing costs are also undermining the quality of health care services currently being provided. Further, the continuing escalation is negatively affecting the economy of this Commonwealth and is restricting new economic growth and impeding the creation of new job opportunities in this Commonwealth.

(b) Declaration of policy.--The General Assembly declares its policy to be that, in accordance with the provisions of this act, providers of health care services should not charge or collect from a beneficiary of health insurance under Title XVIII of the Social Security Act (Public Law 74-271, 42 U.S.C. § 301 et seq.), known as the Medicare Program, an amount in excess of the reasonable charge for the service provided, as determined by the United States Secretary of Health and Human Services.

Section 3. Definitions.

The following words and phrases when used in this act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Balance billing." To charge or collect from a beneficiary of health insurance under Title XVIII of the Social Security Act (Public Law 74-271, 42 U.S.C. § 301 et seq.), known as the Medicare Program, an amount in excess of the reasonable charge for the service provided, as determined by the United States Secretary of Health and Human Services.

"Healing arts." The science and skill of diagnosis, prevention or treatment, in any manner whatsoever, of disease or any ailment of the human body.

"Health care practitioner." An individual who is authorized to practice some component of the healing arts by a license, permit, certificate or registration issued by a Commonwealth licensing agency or board. The term includes, but is not limited to, a medical doctor, an osteopathic physician, a chiropractor,

a dentist, an optometrist, a pharmacist, a physical therapist, a podiatrist, a professional nurse and a psychologist.

Section 4. Balance billing by health care practitioners prohibited.

It shall be unlawful for any health care practitioner, or any primary health center, corporation, facility, institution or other entity that employs a health care practitioner, to balance bill.

Section 5. Penalties and procedure.

(a) General penalties.--If a person violates section 4, the licensing board of the Bureau of Professional and Occupational Affairs under which the violator is licensed shall do the following:

(1) Publicly reprimand the violator.

(2) Order the violator to repay the victim the amount of excess payments made and received, plus interest on that amount at the maximum legal rate from the date payment was made until the date repayment is made.

(b) Additional violations.--If a person violates section 4 more than once, the penalties set forth in subsection (a) shall again be ordered. In addition, the following penalties shall be imposed:

(1) For a second violation, a fine of \$2,000.

(2) For a third violation, a fine of \$5,000.

(3) For a fourth or subsequent violation, a fine of \$1,000 more than the last fine imposed.

(c) Disposition of fines collected.--Fines collected under this section shall be deposited into the General Fund.

(d) Procedure.--Before a penalty may be imposed under this section, a complaint shall be filed against the health care practitioner and notice of and an opportunity for a hearing shall be given. Either party to the complaint may appeal to the Commonwealth Court from an adjudication of the licensing board under 2 Pa.C.S. (relating to administrative law and procedure).

(e) Exceptions.--No penalty imposed under this section shall be considered cause to withhold, suspend or revoke the license of a health care practitioner by a licensing board.

Section 6. Notice to Medicare beneficiaries.

(a) Practitioner's duty.--A sign which sets forth the following shall be posted by licensed health care practitioners who treat Medicare beneficiaries:

(1) The rights of Medicare patients under this act.

(2) The identification of the Department of State as the proper State agency to receive patients' complaints relating to balance billing prohibited under this act.

(3) The address and telephone number of the Department of State.

(b) Distribution of signs.--The signs posted by licensed health care practitioners, in accordance with subsection (a), shall be composed, printed and distributed by the Bureau of Professional and Occupational Affairs of the Department of State. Distribution shall be to all health practitioners who treat Medicare beneficiaries.

(c) Duty in the case of bilingual patients.--If a health

care practitioner treats Medicare beneficiaries whose primary language skill is in a language other than English, the practitioner shall notify the Bureau of Professional and Occupational Affairs, which shall provide the practitioner with a sign setting forth the information required under subsection (a) in the appropriate language.

Section 7. Effective date.

This act shall take effect in 60 days.

Version 04/25/2024
Check for Updates

regulatory authority, or under the Paperwork Reduction Act of 1995 to establish the provider or supplier's eligibility to furnish items or services to beneficiaries in the Medicare program (for example, a medical license or business license).

In § 424.515, we are adopting a 5-year revalidation cycle. In adopting a 5-year revalidation cycle, we believe that we can address the concerns raised during the public comment process about fee-for-service contractor's ability to continue to process new enrollments while also conducting revalidation activities. Moreover, we believe that extending the revalidation cycle from 3 years to 5 years will significantly decrease the burden on providers and suppliers.

We will contact all providers and suppliers directly as to when their 5-year revalidation cycle starts beginning with those providers and suppliers currently enrolled in the Medicare program but that have not submitted a completed enrollment application. The revalidation process would ensure that we collect and maintain complete and current information on all Medicare providers and suppliers and ensure continued compliance with Medicare requirements. In addition, this process further ensures that Medicare beneficiaries are receiving items or services furnished only by legitimate providers and suppliers, and strengthens our ability to protect the Medicare Trust Funds.

We will reserve the right to perform off cycle (non-routine) revalidations and request a provider or supplier to recertify as to the accuracy of the enrollment information when warranted to assess and confirm the validity of the enrollment information. Off cycle revalidations may be triggered as a result of information indicating local health care fraud problems, national initiatives, fraud investigations, complaints from beneficiaries, or other reasons that cause us to question the integrity of the provider or supplier in its relationship with the Medicare program. Like routine revalidations, off cycle revalidations may or may not be accompanied by site visits.

In § 424.520(b), we are adopting a policy that individuals and organizations are responsible for updating their enrollment information to reflect any changes in a timely manner. We would define timely as meaning within 90 days, with the exception of DMEPOS suppliers which are currently required to report changes of enrollment information within 30 days, or a change in ownership or control of any provider or supplier

which also must be reported within 30 days. Failure to do so may result in deactivation or even revocation of their billing privileges.

In § 424.525, we are adopting a position that if a provider or supplier enrolling in the Medicare program for the first time fails to furnish complete information on the enrollment application, or fails to furnish missing information or any necessary supporting documentation as required by CMS under this or other statutory or regulatory authority within 60 calendar days of our request to furnish the information, we would reject the provider or supplier's enrollment application. Rejection would not occur if the provider or supplier is actively communicating with us to resolve any issues regardless of any timeframes.

Upon notification of a rejected enrollment application, if the provider or supplier still wishes to enroll in the Medicare program, they must begin the enrollment process over by completing and submitting a new enrollment application and all applicable documentation. Since CMS cannot process an incomplete enrollment application, we must reject the application. Further, we clarify that applications that are rejected are not afforded appeal rights.

In § 424.530(a)(2) and § 424.535(a)(2), we clarify that no payments will be made to any providers or suppliers who are excluded from participation in the Medicare program under authorities found in sections 1128, 1128A, 1156, 1862, 1867, and 1892 of the Act, or who are debarred, suspended or otherwise excluded as authorized by the FASA. This includes any individual, entity, or any provider or supplier that arranges or contracts with (by employment or otherwise) an individual or entity that the provider or supplier knows or should know is excluded from participation in a Federal health care program for the provision of items or services for which payment may be made under such a program (section 1128A(a)(6) of the Act), and any provider or supplier that has been debarred, suspended, or otherwise excluded from participation in any other Executive Branch procurement or nonprocurement programs or activity (FASA, section 2455).

In § 424.530(a)(3), we are adopting the position that we may deny enrollment in the Medicare program if the provider or supplier, or any owner of the provider or supplier has been convicted of a Federal or State felony offense that we determine to be detrimental to the best interests of the Medicare program or its beneficiaries. This authority is

afforded to us in many of the HIPAA fraud and abuse provisions and section 4302 of the BBA. In making assessments, we are stating that any felony convictions within the last 10 years preceding enrollment or revalidation of enrollment. In addition, we would consider the severity of the underlying offense.

Felonies that we determine to be detrimental to the best interests of the Medicare program or its beneficiaries include the following:

- Within the last 10 years preceding enrollment or revalidation of enrollment, crimes against persons, such as murder, kidnapping, rape, assault and battery, robbery, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions. We believe it is reasonable for the Medicare program to question the ability of the individual or entity with such a history to respect the life and property of program beneficiaries.
- Within the last 10 years preceding enrollment or revalidation of enrollment, financial crimes, such as extortion, embezzlement, income tax evasion, making false statements, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions. We believe it is reasonable for the Medicare program to question the honesty and integrity of the individual or entity with such a history in providing services and claiming payment under the Medicare program.
- Within the last 10 years preceding enrollment or revalidation of enrollment, any felony that placed the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that resulted in a conviction of criminal neglect or misconduct.
- Any felonies referred to in section 1128 of the Act.

In § 424.530(a)(5), we are adopting a position that we may deny enrollment when, upon on-site review or other reliable evidence, we determine that the provider or supplier is not operational to furnish Medicare covered items or services or is not meeting these Medicare enrollment requirements or the requirements set forth in the enrollment application.

As outlined in § 424.530(b), if the denied provider or supplier appeals the decision, and the denial is upheld, that provider or supplier may submit a new enrollment application after we notify it that the original determination was upheld. If the provider or supplier did not appeal the determination, it may submit a new enrollment application

Regulations found at 42 CFR § 485.610(e)(2) and in the State Operations Manual state that the CAH's provider-based location must meet certain distance requirements from the main campus of another hospital or CAH.

The contractor shall contact the appropriate SOG Location while processing the Form CMS-855A to verify that the CAH's new provider-based location is more than 35 miles (15 miles in the case of mountainous terrain or an area with only secondary roads) from the main campus of another hospital or CAH. The contractor may not make a recommendation for approval without receiving a response from the SOG Location.

If the SOG Location finds that CAH's new provider-based location meets the distance requirements, the contractor shall continue processing the application normally. If the SOG Location determines that the location does not meet the distance requirements, the contractor shall reject the application and issue to the CAH the applicable rejection letter outlined in section 10.7 et seq.

The SOG Location will provide the CAH with three options if the location does not meet the distance requirements:

1. The CAH keeps the new provider-based location, which will cause an involuntary termination in 90 days (as outlined in the Pub. 100-07, chapter 3, section 3012).
2. The CAH terminates the new provider-based location and continue its enrollment as a CAH.
3. The CAH keeps the new provider-based location but converts to a hospital (as outlined in Pub. 100-07, chapter 2, sections 2256G and 2256H).

For each option, the contractor shall keep the CAH's enrollment in an approved status in PECOS. For Option #1 above, the contractor will receive notice from the SOG Location of the termination, which will lead to revocation of the CAH's enrollment. For Option #2, the CAH's enrollment remains approved and the contractor shall expect no further communication from the SOG Location. If the CAH chooses Option #3 to convert to a hospital, the contractor will receive a Form CMS-855A to terminate the CAH's enrollment and a new Form CMS-855A to enroll as a hospital.

10.4.5 – Revalidations

(Rev. 11891; Issued: 03-09-23; Effective: 04-21-23; Implementation: 06-19-23)

Consistent with section 6401(a) of the Patient Protection and the Affordable Care Act (ACA), all existing providers and suppliers are required to revalidate their enrollment information under new enrollment screening criteria. Providers and suppliers are normally required to revalidate their Medicare enrollment every 5 years (every 3 years for DMEPOS suppliers). However, CMS reserves the right to perform off-cycle revalidations as deemed necessary.

Except as otherwise stated in this chapter or another CMS directive, the contractor shall follow the guidance in sections 10.4.5 through 10.4.5.3 of this chapter when processing revalidation applications. This guidance takes precedence over all other instructions in this chapter concerning revalidation processing unless, again, another CMS directive specifies otherwise. The contractor shall note, however, that some of the instructions in section 10.4.5 et seq. may not

apply to PECOS revalidation applications. This is because, as stated in section 10.3(C) of this chapter:

- (1) PECOS automatically handles revalidation tracking and revalidation requests and prevents the submission of PECOS revalidation applications outside of the revalidation window.
- (2) PECOS establishes timeframes and then queues mailings based on revalidation history and enrollment dates (although CMS can modify timeframes and request off-cycle revalidations at any time; this includes those for large group revalidations.) All PECOS revalidation requests will be staggered so that revalidations are submitted and processed within 7 months of the provider's due date. This will eliminate the potential for unsolicited revalidation applications submitted outside of the 7-month window and permit a more structured and streamlined revalidation process.
- (3) Failure to respond to a revalidation request would result in an automatic pend, deactivation, etc.

Accordingly, the contractor can disregard those instructions in section 10.4.5 et seq. that obviously do not apply to a particular situation.

10.4.5.1 – Revalidation Solicitations

(Rev. 11891; Issued: 03-09-23; Effective: 04-21-23; Implementation: 06-19-23)

A. Background

Under previous practice, CMS identified the providers and suppliers required to revalidate during each cycle. CMS communicated when new lists became available through the appropriate channels, at which time the contractor obtained the list from the CGI Share Point Ensemble website. With the advent of PECOS 2.0, PECOS will automatically: (i) determine when a provider/supplier is due to periodically revalidate its enrollment; and (ii) send a revalidation notice to the provider/supplier. Note that this new process of revalidation solicitation applies both to providers/suppliers that currently submit applications via (or otherwise utilize) PECOS or via paper. For the former group, solicitations will be sent via the PCV. For the latter, solicitations will be e-mailed via PECOS, and the affected provider/supplier may submit its revalidation application via paper; it is not required to use PECOS.

B. Sending Revalidation Letters

Based on the due date identified in PECOS, PECOS will send a revalidation notice (using the applicable letter in section 10.7 et seq. of this chapter) between 90 to 105 days prior to the provider/supplier's revalidation due date. The initial revalidation letter will include a generic provider enrollment signature.

C. Interaction with Change Request

If the contractor receives a change of information (COI) application from the provider after PECOS has mailed to the provider a revalidation notice, the contractor shall ensure that the received revalidation application contains the changed information.

If the contractor receives paper revalidation and COI applications concurrently, the contractor shall merge the two applications and process accordingly. If the two applications were PECOS applications, they should be processed as two separate transactions.

If the provider submits an application marked as a revalidation but that only includes enough information to be considered a COI, the contractor shall (1) develop for a complete application containing the missing data elements and (2) treat it as a revalidation.

D. Interaction with a Change of Ownership (CHOW)

PECOS will not commence revalidation action regarding a provider/supplier that is undergoing a CHOW that: (1) the contractor is currently processing; or (2) is pending review with the state agency.

E. Reassignment Applications Received After Revalidation Letter Mailed

If a reassignment application has been received after a revalidation letter has been sent to the affected provider/supplier, the contractor shall process the reassignment application. The supplier need not report the newly established reassignment/employment arrangement on the revalidation application, and the contractor shall not develop for this information; this is because the arrangement was established after the revalidation notice was issued. However, the contractor shall maintain the reassignment/employment arrangement information in the enrollment record when processing the revalidation application; this information shall not be overridden. If the supplier fails to respond to the revalidation request, all reassignments shall be end-dated, including the newly established reassignment. Consider the following illustration:

EXAMPLE: Dr. Doe submits a Form CMS-855R application to add a new reassignment to Browns Medical Center after receiving a revalidation request. He submits his revalidation application to his contractor but does not include the reassignment for Browns Medical Center because the contractor is still processing the Form CMS-855R and has not yet approved the reassignment. The contractor finalizes the reassignment changes and then proceeds with processing the revalidation application. The contractor shall not develop for the new reassignment to Browns Medical Center and shall maintain the reassignment in the provider's enrollment record when processing the revalidation application.

F. Revalidation Extension Requests

The contractor shall only accept extension requests from a provider that was not given the full 7 months' advance notice prior to their revalidation due date. The contractor shall not accept extension requests from providers for any other reason.

The provider/supplier may submit its request in writing (fax/e-mail/PCV permissible) or via phone, though the individual provider, authorized/delegated official, or appropriate contact person shall make the request. (See section 10.3 of this chapter for information regarding contact persons for PECOS applications.)

G. Additional Letter Data

In addition to the PCV e-mailing revalidation correspondence, the contractor – in any circumstance required per this chapter -- shall print and mail the following PCV-generated letters: (1) revalidation notification letters (e.g., the first letter came back as undeliverable (see subsection (B)(2) above)); (2) pend letters; and (3) deactivation letters.

(NOTE: As a general rule, the PCV can, among other things: (1) automatically send emails (e.g., revalidation); (2) send e-mails upon request (e.g., development); (3) generate letters/store letters; (4) send letters to a print queue; and (5) accept document uploads,)

10.4.5.2 – Non-Responses to Revalidation and Extension Requests (Rev. 11891; Issued: 03-09-23; Effective: 04-21-23; Implementation: 06-19-23)

A. Phone Calls

The contractor may (but is not required to) continue to contact providers via telephone, e-mail, or the PCV to communicate non-receipt of revalidation applications. The contractor shall document in PECOS all such communications with the provider.

B. Pend Status and Deactivation Actions

PECOS will automatically pend (i.e., hold payment to) a provider/supplier that fails to respond to a revalidation request within the required timeframe. The pend will last until the final disposition of the application, and PECOS will notify the provider/supplier of the pend. If the provider does not submit the revalidation within this period, PECOS will automatically deactivate the provider and notify the contractor thereof. Within 10 business days of receiving this notification, the contractor shall send the appropriate deactivation letter to the provider using the procedures in this chapter. The deactivation basis is 42 CFR § 424.540(a)(3). Per § 424.540(d)(1)(ii)(A), the deactivation effective date shall be the date on which PECOS deactivated the provider (that is, the date on which the provider became non-compliant).

No later than 5 business days after sending the aforementioned deactivation letter --- and if the deactivated supplier is a physician – the contractor shall search his/her associate record to determine if he/she serves as a supervising physician on any independent diagnostic testing facility (IDTF) enrollment. If he/she does, the contractor shall disassociate him/her as the supervising physician for that entity. If he/she is the only supervising physician on file for the IDTF, the contractor shall develop for an active supervising physician to bring the IDTF into compliance. The contractor shall give the IDTF 30 days to respond. Failure to provide an active supervising physician in the designated timeframe shall result in revocation of the IDTF's billing privileges for non-compliance with the IDTF standards.

10.4.5.3 – Receipt and Processing of Revalidation Applications (Rev. 11891; Issued: 03-09-23; Effective: 04-21-23; Implementation: 06-19-23)

The provider may submit its revalidation application via paper or PECOS, though the latter is encouraged so as to allow for more expedited processing.

For paper applications, the contractor shall input the relevant data in PECOS consistent with longstanding practice and with the policies in this chapter, including those in section 10.3.

Note that some of the instructions in this section 10.4.5.3 et seq. may be inapplicable to PECOS (e.g., developing for missing sections of the Form CMS-855 revalidation application).

A. General Situations

1. Unsolicited Applications

An unsolicited revalidation application is one received outside of the PECOS revalidation request addressed in section 10.4.5.1. The contractor shall return such applications using the applicable sample return letter in section 10.7 et seq. within 20 business days of receipt. If the application was received more than 7 months prior to the provider/supplier's revalidation due date, the contractor shall use § 424.526(a)(8) as the return basis. If § 424.526(a)(8) does not apply to the situation, the contractor shall use § 424.526(a)(7) as the basis, for the application was inapplicable to or not needed for the transaction involved.

If applicable, the contractor shall also submit a request to CMS to have the application fee returned to the provider.

2. Signatures

The contractor may only accept revalidation applications signed by the individual provider or the authorized or delegated official.

3. Sub-Units

Any certified provider sub-unit that has a separate provider agreement must revalidate on a separate Form CMS-855A. It cannot revalidate via the main provider's Form CMS-855A. If the sub-unit has a separate CMS Certification Number (CCN) but not a separate provider agreement (e.g., hospital psychiatric unit, HHA branch), the sub-unit can disclose the revalidation on the main provider's Form CMS-855A; this is because the sub-unit is a practice location of the main provider and not a separately enrolled entity. Separate fees, too, are not required.

4. Collapse of PTANs

If the provider requests to collapse its PTANs per a revalidation, the contractor shall process said requests if appropriate (based on payment localities, etc.).

5. Voluntary Withdrawal

(This subsection (A)(5) does not apply to certified providers/suppliers. See section 10.6.1.3 of this chapter for instructions concerning certified provider/supplier voluntary terminations.)

If a non-certified supplier wishes to voluntarily withdraw from Medicare (including deactivating all active PTANs), the contractor shall accept this request via phone, U.S. mail, or fax from the

individual supplier or the authorized/delegated official (on letterhead); the contractor shall not require the non-certified supplier to complete a Form CMS-855 or CMS-20134 application. If the contractor makes the request via telephone, the contractor shall document the telephone conversation in PECOS and take the appropriate action in PECOS.

B. Development Required

(Note that some of the instructions in this subsection (B) will be inapplicable to PECOS applications. See section 10.3 for more information.)

1. General Instructions

If a revalidation application requires development (e.g., missing application fee, clarification or documentation needed, missing reassignments), the contractor shall notify the provider via mail, telephone, the PCV, fax, or e-mail. The contractor shall develop for all of the required information in one development request. The provider has 30 days to respond to the contractor's request. For paper applications, the provider may submit the information via mail, fax, or e-mail containing scanned documentation; this includes missing signatures and dates. For PECOS applications, the provider must submit the information via PECOS. (Note that the provider may submit a full Form CMS-855I or Sections 1, 2, 4, & 15 of the Form CMS-855I to report missing reassignments any time prior to their revalidation due date; this includes post-revalidation application approval.)

If the contractor can verify licensure and/or educational requirements (e.g., non-physician practitioner's degree or diploma) online, the contractor shall not require the provider to submit this documentation. If the supporting documentation currently exists in the provider's file, the provider need not submit that documentation again with their revalidation application; the contractor may utilize the existing documentation for verification. Residency information is not required as part of a revalidation. In addition, the contractor need not develop for data that is missing or needs clarification on the provider's revalidation application if the provider accurately disclosed (meaning no clarification is needed) the information (1) elsewhere on the application or (2) in the supporting documentation submitted with the application, though with the exception of the following items:

- (i) Adverse legal action data
- (ii) LBN
- (iii) Tax identification number (TIN)
- (iv) NPI-legacy number combinations
- (v) Supplier/Practitioner type
- (vi) DBA name
- (vii) Effective dates of sale/transfer/consolidation or indication of acceptance of assets/liabilities

The contractor shall not require providers to include the PTAN(s) in Section 2 or 4 of the revalidation application--provided that the provider included the information needed (NPI, TIN, LBN, DBA, etc.) for the contractor to appropriately make the association. If the PTAN was not submitted but is needed to make the connection, the contractor shall use the shared systems, PECOS, or its provider file(s) as a resource before developing with the provider.

The contractor shall not develop for the EFT form if the provider has the 05/10 or 09/13 version of the Form CMS-588 on file. If provider submits an EFT form with a bank letter or voided check, the contractor may verify that the LBN matches and develop to process the application accordingly. Note that the instructions in section 10.6.23 apply to revalidations.

If the supporting documentation currently exists in the provider's file, the provider need not submit that documentation again during the enrollment process. The contractor shall utilize the existing documentation for verification. Documentation submitted with a previously submitted enrollment application (or documentation currently uploaded in PECOS) qualifies as a processing alternative, unless stated otherwise in this chapter or any CMS directive. In addition, per the instructions in this chapter, the contractor shall document in PECOS that it found the missing information elsewhere in the enrollment package, with previously submitted applications, or with documentation currently uploaded in PECOS. (This excludes information that the contractor must verify at the current point in time (e.g., a license without a primary source verification method).) In addition, the contractor shall not utilize information submitted along with opt-out applications for enrollment application processing or vice-versa.

If a revalidation response is received for a single reassignment within an enrollment record that has multiple reassignments, the contractor shall develop with the contact person (or the individual provider if a contact is not listed) for the remaining reassignments not accounted for. If no response is received within 30 days, the contractor shall revalidate the single reassignment and deactivate the reassignments within the enrollment records that were not revalidated.

If other missing information is not received within 30 days, the contractor shall deactivate the provider within 25 days after the development due date and notify the provider of the deactivation using the applicable sample letter in section 10.7 et seq. of this chapter. After deactivation, the provider must submit an entirely new application in order to reactivate their PTANs. The contractor may use any supporting documentation received (if needed) for subsequent application submissions.

The deactivation date shall be consistent with the latter of: (1) the revalidation due date; or (2) the date on which the deactivation occurred due to non-response or incomplete response to a development request for all provider business structures (e.g., organizations, sole proprietors, sole owners, etc.).

2. Illustrations

Consider the following examples that address the instructions in section 10.4.5.3(B)(1):

SCENARIO #1 - PECOS issues a revalidation notice to the provider and includes reassignments and/or employment arrangements for Groups A, B & C. The provider submits the revalidation application but only addresses the reassignment for Group A. The contractor develops with the contact person for the missing reassignments and/or employment arrangements for Groups B & C. The provider responds with the reassignment information for Groups B & C prior to the development due date. Since the revalidation application remains in progress, the provider may submit a full Form CMS-855I or Sections 1, 2, 4, & 15 of the Form CMS-855I to report the missing reassignment information (even post-revalidation application approval). Here, the

contractor processes the revalidation application to completion, and the provider experiences no break in billing.

SCENARIO #2 - The contractor issues a revalidation notice to the provider and includes reassignments and/or employment arrangements for Groups A, B & C. The provider submits the revalidation application to the contractor but only addresses the reassignment for Group A. The contractor develops with the contact person for the missing reassignments and/or employment arrangements for Groups B & C. No response is received within 30 days, and the revalidation due date has passed. In this situation, Group A's reassignment is revalidated, and the contractor shall deactivate Group B & C's reassignments and/or employment arrangements effective with the date on which the contractor took deactivation action due to non-response or incomplete response to a development request. The approval letter shall identify the reassignments and/or employment arrangements that were revalidated and those that were terminated with the effective date of the reassignment or termination. The provider must submit a full application (Form CMS-855R) to reactivate the reassignment. The reactivation effective date is based on the receipt date of the CMS-855R.

In Scenario #2, therefore: (i) the provider experiences a break in billing but the contractor only deactivates the non-response reassignments and/or employment arrangements; and (ii) the contractor revalidates the other reassignments and/or employment arrangements.)

Contractor-initiated development letters, however, shall include a provider enrollment analyst's name and phone number for provider contacts.

C. Revalidation Received after a Pend is Applied

If the contractor receives a revalidation application after applying a pend, it shall remove the pend within 15 business days of receiving the revalidation application, even though the submitted application has not been processed to completion. This will release all held paper checks, SPRs, and EFT payments.

The contractor shall process the revalidation application using current processing instructions and mail, fax, or e-mail (via the PCV for PECOS applications) a decision letter to the provider to notify the latter that the contractor has processed the revalidation application.

D. Revalidation Received After a Deactivation Occurs

1. General Guidance

The contractor shall require a deactivated provider to submit a new, full application to reactivate their enrollment record. The contractor shall process the application as a reactivation. The provider shall maintain their original PTAN; however, the contractor shall reflect a gap in coverage (between the deactivation and the reactivation) on the existing PTAN using A/R codes in MCS and based on the application's receipt date. The provider will not receive reimbursement for dates of service in which they were non-compliant with Medicare requirements (deactivated for non-response to revalidation). The contractor shall reactivate group members (with the group enrollment) who had their reassignment associations terminated when the contractor deactivated

the group. The effective dates assigned to the reassigned providers should align with the group's effective date per standard reactivation instructions.

2. Certified Providers and Certified Suppliers

Unless CMS instructs otherwise, the contractor shall allow a certified provider/supplier to maintain its original PTAN and effective date when the reactivation application is processed. (As stated in § 424.540(c), a deactivation does not terminate a certified provider/supplier agreement.) In addition, when processing the revalidation application after a deactivation occurs, the contractor shall not require the deactivated certified provider/supplier to obtain a new state survey or accreditation as a condition of revalidation.

E. Finalizing the Revalidation Application

Prior to processing the revalidation application to completion, the contractor shall:

- (i) Ensure that a site visit (if applicable to the provider in question) occurs.
- (ii) Ensure that the provider meets all applicable federal regulatory requirements regarding licensure, certification, and/or educational requirements.
- (iii) Revalidate the provider's information based on the data in PECOS.
- (iv) Verify the practice locations, although the contractor need not contact each location separately. The contractor shall: (1) verify the location(s) by contacting the contact person listed on the application; and (2) note the validation accordingly in the contractor's verification documentation per the instructions in this chapter.
- (v) Ensure that the appropriate record type and finalization status are identified in PECOS.
- (vi) Ensure that an enrollment record is not marked as revalidated in PECOS if responses have been received for some PTANs but not all PTANs have been addressed (meaning that no action has been taken on the non-response PTANs, e.g., end-dated). If all PTANs have been addressed (e.g., revalidated, end-dated), the enrollment can be marked as revalidated.
- (vii) Ensure that PECOS and the claims systems remain consistent. The contractor shall not directly update the shared systems without first updating PECOS when processing a revalidation (unless instructed otherwise in another CMS directive).
- (viii) When processing is complete, issue an approval letter to the contact person (or the provider if no contact person is listed) via mail, fax, the PCV, or e-mail. (For PECOS If the provider has reassignments that were terminated due to non-response, the approval letter shall contain the reassignments that were terminated due to non-response and the effective date of termination (i.e., the revalidation due date or the development due date).

F. Revalidation Reporting

Unless CMS requests it, the contractor need no longer submit reports to CMS regarding its revalidation activities, for the revalidation data is captured in PECOS.

10.4.6 – Reactivations

(Rev. 11891; Issued: 03-09-23; Effective: 04-21-23; Implementation: 06-19-23)

A. Form CMS-855 or CMS-20134 Reactivations – Screening Levels

1. Limited

The contractor shall process reactivation applications from providers in the “limited” level of categorical screening in accordance with existing instructions.

2. Moderate

The contractor shall process reactivation applications from providers in the “moderate” level of categorical screening (including existing HHAs and DMEPOS suppliers) in accordance with the screening procedures for this category. A site visit is thus needed prior to the contractor’s final decision regarding the application.

3. High

The contractor shall process reactivation applications from providers in the “high” level of categorical screening in accordance with the screening procedures for this category. A site visit is thus needed prior to the contractor’s final decision regarding the application.

B. Form CMS-855B and CMS-855I Non-Certified Supplier Reactivations

If the contractor approves a Part B non-certified supplier’s reactivation application, the reactivation effective date shall be the date the contractor received the application that was processed to approval. In addition, upon reactivating a Part B non-certified supplier, the contractor shall issue a new PTAN; for PECOS applications (and as indicated in section 10.3 of this chapter), PECOS will automatically issue a new PTAN.

C. Form CMS-855A or CMS-855B Certified Provider or Supplier Reactivations

With the exception of HHAs, reactivation of a certified provider/supplier does not require a new state survey, provider agreement, or participation agreement. Per 42 CFR § 424.540(b)(3)(i), an HHA must undergo a new state survey or obtain accreditation by an approved accreditation organization before it can be reactivated.

D. Reactivations - Deactivation for Reasons Other Than Non-Submission of a Claim