Chapter 6 - Other requirements and timeliness standards

Provider enrollment

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6.1 Provider enrollment and NPI

The NPI is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). On May 23, 2007 (May 23, 2008, for small health plans), the NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

Reminder: The NPI is assigned by National Plan and Provider Enumeration System (NPPES), which is a separate process from applying for Medicare enrollment. You must obtain your NPI prior to enrolling in Medicare. You may apply for an NPI online through the [NPPES](https://nppes.cms.hhs.gov/#/) website.

If you are newly enrolling or are already enrolled and are requesting any change to existing Medicare enrollment information, you are required to supply your NPI(s) in conjunction with your Medicare Enrollment Application - (CMS-855). Medicare Enrollment Application - Physician and Non-Physician Practitioners (CMS-855I) will require the listed NPI information for both the individual reassigning and the group. Once you have reported your NPI(s) to us via the CMS-855 process, “linkages” are created in our claims processing system between the NPI(s) provided on your CMS-855 and:

* Any newly assigned identifier(s) PTAN/ correspondence control number (CCN)), or
* Legacy identifier(s) (PTAN/CCN).

It is crucial that once these linkages are established, you consistently report the same NPI-PTAN / CCN relationships on future CMS-855 applications. If the same relationships are not consistently reported, any established linkages could be altered (changed / removed), which could cause serious impacts to your claims processing.

Obtaining additional NPIs to resolve claim issues - groups / organizations only

This instruction is only relevant to groups and organizations that are in the process of obtaining additional NPIs in response to:

* Development letters sent by us indicating they have one NPI corresponding to more than one Medicare provider identification number (PIN): or
* Claim processing issues related to invalid NPI/PIN combinations

If you have experienced either situation identified above, follow these steps to take corrective action:

* If you are eligible to obtain additional NPIs and wish to do so, please visit the [National Plan & Provider Enumeration System](https://nppes.cms.hhs.gov/#/) website and click on the NPI link to apply.
* Confirm whether the provider/supplier has been loaded into the national provider enrollment database, PECOS, by calling the [provider enrollment helpdesk](ddocname:00162101).
* If the provider is not in PECOS, additional NPIs will only be cross-walked to existing PINs if the data provided to NPPES matches Medicare PIN data (e.g., provider PTAN/CCN, legal business name, tax ID, practice address and zip code, type of NPI). If you need to verify information contained within your PIN file prior to submitting an NPPES application, contact the [provider enrollment helpdesk](ddocname:00162101).
* If the provider / supplier is in PECOS, additional NPIs can only be cross walked to PINs through an update to PECOS. The update must be requested via a CMS-855 application.

CMS NPI links

Important enrollment information includes a link to these CMS documents:

* [Enrollment and NPI Information](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/enrollmentNPI.pdf" \t "_blank)
* [The who, what, when, why & how of NPI](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/enrollmentsheet_wwwwh.pdf" \t "_blank)
* [CMS NPI website](https://npiregistry.cms.hhs.gov/)

6.2 Processing timeframes

Please visit our [CMS-855 Enrollment Application Processing Timeframes](ddocname:00131972) article for specific information.

6.3 Application returns

Contractors may immediately return an enrollment application to the provider or supplier in the instances described below without requesting additional information. This policy applies to initial applications, change requests, form Medicare Enrollment Application - Ordering and Referring Physicians and Non-Physician Practitioners (CMS-855O) applications, and Medicare Enrollment Application - Electronic Funds Transfer Agreement (CMS-588) submissions, change of ownership (CHOW) applications, revalidations and reactivations.

* The provider/supplier sent its paper form CMS-855 form Electronic Funds Transfer Agreement (CMS-588), or Medicare Enrollment Application - Medicare Diabetes Prevention Program (MDPP) Suppliers (CMS-20134) to the incorrect contractor for processing (e.g., the application was sent to contractor X instead of contractor Y).
* The contractor received the application more than 60 days prior to the effective date listed on the application.
* This does not apply to initial Medicare Enrollment Application - Institutional Providers (CMS-855A) and ambulatory surgical centers and portable x-ray suppliers submitting an initial Medicare Enrollment Application - Clinics/Group Practices and Other Suppliers (CMS-855B).
* The seller or buyer in a CHOW submitted its Institutional Providers (CMS-855A) form or Clinics/Group Practices and Other Suppliers (CMS-855B) more than 90 days prior to the anticipated date of sale.
* The contractor received an initial application more than 180 days prior to the effective date listed on an application from an ambulatory surgical center, a portable x-ray supplier, or a provider/supplier submitting an Institutional Providers (CMS-855A) application.
* The contractor confirms that the provider/supplier submitted an initial enrollment application prior to the expiration of the time period in which it is entitled to appeal the denial of its previously submitted application.
* The provider or supplier submitted an initial application prior to the expiration of their existing re-enrollment bar or reapplication bar.
* The application is not needed for the transaction in question. Two common examples include:
* A rebuttal decision has been issued (therefore, the submitted form CMS-855, form Electronic Funds Transfer Agreement (CMS-588), or form Medicare Diabetes Prevention Program (MDPP) Suppliers (CMS-20134) is not needed.
* The application is to be returned per [CMS IOM Pub. 100-08 Medicare Program Integrity Manual, Chapter 10, Medicare Enrollment](https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/pim83c10.pdf), section 10.6.1.1.3.1.1.
* The provider or supplier submitted a revalidation application more than seven months prior to their revalidation due date.
* The Medicare diabetes prevention program supplier submitted an application with a coach start date more than 30 days in the future.
* A provider/supplier requests that their application be withdrawn prior to or during processing.
* A provider/supplier submits an application that is an exact duplicate of an application that has already been processed or is currently being processed or is pending processing.
* A provider or supplier submits a paper form CMS-855 or Medicare Diabetes Prevention Program (MDPP) Suppliers (CMS-20134) enrollment application that is outdated or has been superseded by a revised version.
* The provider/supplier submits a form Institutional Providers (CMS-855A) or form Clinics/Group Practices and Other Suppliers (CMS-855B) initial application followed by an Institutional Providers (CMS-855A) form or Clinics/Group Practices and Other Suppliers (CMS-855B) form change of ownership application. If the Medicare contractor:
* Has not yet made a recommendation for approval concerning the initial application, both applications may be returned.
* Has made a recommendation for approval concerning the initial application, the Medicare contractor may return the change of ownership application. If, per the Medicare contractor's written request, the provider or supplier fails to submit a new initial Institutional Providers (CMS-855A) form or Clinics/Group Practices and Other Suppliers (CMS-855B) form containing the new owner's information within 30 days of the date of the letter, the Medicare contractor may return the originally submitted initial Institutional Providers (CMS-855A) form or Clinics/Group Practices and Other Suppliers (CMS-855B) form.

6.4 Development / Requests for additional information

When additional information is needed to complete the enrollment/change process, practitioners / suppliers will receive written notification specifying the information required to continue processing the CMS-855 application. We will make every attempt to request all additional information at one time. Contractors will accept information via fax and mail. If you need access to a blank CMS-855 form, visit the [CMS web site](https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List) to obtain a copy.

Any additional information supplied in writing must be accompanied by a newly signed and dated certification statement which can be faxed or mailed.

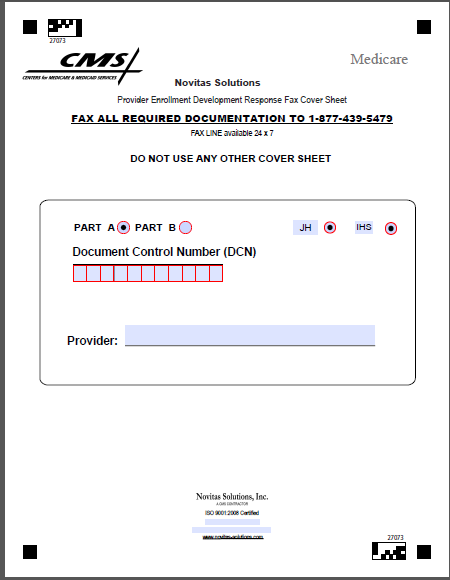
Additional information regarding development

We have completed analysis of the development data and trends for provider enrollment. Whether enrollment applications are submitted via a paper application or the CMS’ internet-based application process, we have found that the Physicians and Non-Physician Practitioners (CMS-855I) application has the highest percentage of development. Additionally, most of the development is the result of missing, incorrect, or incomplete information in Section 2 – Identifying Information of the application and/or not receiving the associated supporting documentation.

Please take a few moments to review the top reasons for development noted below in order of highest to lowest, and ensure the appropriate steps are taken and/or information is provided in order to reduce the amount of time your office spends responding to development requests.

To better facilitate the processing of applications that require development, a provider enrollment development response cover sheet is included with the development letter. This process improves the timeframe associated with delivery of development responses to Novitas provider enrollment representatives and lessens the likelihood of misplaced documents.

The majority of our requests for development, whether faxed, emailed, or mailed to customers will include the following form; the form cannot be downloaded. This form will be pre-populated with key identifiers that we will utilize to electronically route development responses to PE representatives.



If you received a cover sheet to fax your information, the development response information must be faxed to the toll-free number, 877-439-5479 with the Provider enrollment development response fax cover sheet as page 1 of the response within 30 days.

|  |  |
| --- | --- |
| Jurisdiction | Address |
| Jurisdiction L (JL): Delaware, Maryland, New Jersey, Pennsylvania and Washington, D.C. | Provider Enrollment Services Novitas Solutions PO Box 3157 Mechanicsburg, PA 17055-1836 |
| Jurisdiction H (JH): Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma and Texas | Provider Enrollment Services Novitas Solutions PO Box 3095 Mechanicsburg, Pa 17055-1813 |
| Indian Health Service / Tribal providers | Provider Enrollment Services Novitas Solutions PO Box 3115 Mechanicsburg, PA 17055-1858 |

To allow for additional efficiency in the CMS-855 development process, we request that you supply an email address, if available, for either the contact person or correspondence address. This will allow us to email development requests to appropriate designated persons.

Top reasons for development – Paper applications (Institutional Providers (CMS-855A), Clinics/Group Practices and Other Suppliers (CMS-855B), and Physicians and Non-Physician Practitioners (CMS-855I))

* Section 1 – Basic information / NPI
* Missing, incorrect, or incomplete NPI and Medicare identification number, if previously issued.
* Section 2 – Identifying information
* Missing, incorrect, or incomplete license, certification, or accreditation information.
* Missing, incorrect, or incomplete date of incorporation (Institutional Providers (CMS-855A) and Clinics/Group Practices and Other Suppliers (CMS-855B)).
* Section 3 – Adverse legal actions
* No indication on whether adverse legal actions have ever been imposed.
* Missing or incomplete documentation on resolution of adverse legal action.
* Missing or conflicting information on adverse legal actions.

Note: If you are uncertain as to whether an action falls into one of the adverse legal action categories (conviction, exclusion, revocation, or suspension), or whether a name on this application has an adverse legal action, you can query the [National Practitioner Data Bank](https://www.npdb.hrsa.gov/) or you can call 800-767-6732.

* Section 4 – Practice location information
* Missing, incorrect, or incomplete location information.
* Missing date you saw your first Medicare patient
* Required Electronic Funds Transfer Agreement (CMS-588) form not on file or submitted with enrollment application.
* Section 15 – Certification statement
* All signatures must be handwritten or an eligible digital signature (e.g., DocuSign, AdobeSign). Stamped signatures are not acceptable.

Top reasons for development - PECOS web applications (Institutional Providers (CMS-855A), Clinics/Group Practices and Other Suppliers (CMS-855B), and Physicians and Non-Physician Practitioners (CMS-855I))

* Section 2 – Identifying information
* Missing, incorrect, or incomplete license, certification, or accreditation information.
* Missing, incorrect, or incomplete date of incorporation (Institutional Providers (CMS-855A) and Clinics/Group Practices and Other Suppliers (CMS-855B)).
* Section 4 – Practice location information
* Missing, incorrect, or incomplete location information.
* Missing date you saw your first Medicare patient
* Required Electronic Funds Transfer Agreement (CMS-588) form not on file or submitted with enrollment application.

Additional development information that can be requested based on type of transaction

In accordance with CMS instruction, we will request additional information in conjunction with the following types of transactions:

Physicians, non-physician practitioners, groups, organizations, institutional providers

Change in practice location address

* We will have to ask for section 6 of the Institutional Providers (CMS-855A) or Clinics/Group Practices and Other Suppliers (CMS-855B) if an authorized/delegated official is not on file.
* We will call the location currently on file to verify the provider is no longer practicing at that address.

Change in correspondence or special payments address or change in EFT information

* We will have to ask for section 6 of the Institutional Providers (CMS-855A) or Clinics/Group Practices and Other Suppliers (CMS-855B) if an authorized / delegated official is not on file.
* We will be calling the provider (or authorized / delegated official) to verify the change.

Reactivations and revalidations

* If the practice location address on the application is different than that which is currently associated with the provider, we will follow the requirements for practice location address changes noted above.
* If the correspondence/special payment address on the application is different than that which is currently associated with the provider, we will follow the requirements for correspondence/special payment address changes noted above.

Physicians and non-physician practitioners

Reassignment of all benefits

If a physician or non-physician practitioner who is currently reassigning all of his or her benefits attempts to enroll as a sole proprietorship or as the sole owner of his or her professional corporation, association or LLC:

* We will verify the request to enroll a sole proprietorship or a professional corporation is valid by calling the old practice location to determine if the physician or non-physician is still employed there and if not, calling the practitioner to verify that he or she is indeed attempting to enroll as a sole proprietorship or sole owner.

Application rejections

In accordance with 42 CFR § 424.525(a)(1) and (2), contractors may reject an application if the provider/supplier fails to furnish complete information on the enrollment application - including all necessary documentation - within 30 calendar days from the date the missing information or documentation was requested. This includes situations in which the provider/supplier submits an application that falls into one of the following categories and, upon the contractor’s request to submit a new or corrected complete application, the provider failed to do so within 30 days of the request:

* The form CMS-855 or internet-based (PECOS) certification statement:
* Is unsigned;
* Is undated;
* Contains a copied or stamped signature;
* Required certification statement is missing (paper applications);
* Application is signed more than 120 days prior to the date on which the contractor received the application; or
* The application is signed by a person unauthorized to do so
* The form CMS-855 was completed in pencil.
* The application is submitted via fax or email when the provider or supplier was not otherwise permitted to do so.
* The wrong application was submitted (e.g., a Clinics/Group Practices and Other Suppliers (CMS-855B) form was submitted for Part A enrollment).

The applications described above shall be developed, rather than returned. For instance, if the provider submits an application completed in pencil, the contractor shall request the provider to submit a new application, either in ink or via Internet-based PECOS.

6.5 Effective billing date for physicians, non-physician practitioners, and physician or non-physician practitioner organizations

* Physicians
* Physician assistants
* Nurse practitioners
* Clinical nurse specialists
* Certified registered nurse anesthetists
* Certified nurse-midwives
* Clinical social workers
* Clinical psychologists
* Registered dietitians or nutrition professionals
* Anesthesiologist assistants
* Physical therapists
* Occupational therapists
* Audiologists
* Independent psychologists
* Speech language pathologist
* Marriage and family therapist
* Mental health counselor
* Physician and non-physician practitioner organizations (e.g., group practices) consisting of any of the categories of individuals identified above
* Ambulance service supplier
* Part B hospital departments
* CLIA labs
* Opioid treatment programs
* Mammography centers
* Mass immunizers/pharmacies
* Radiation therapy centers
* Home infusion therapy (HIT) suppliers

In accordance with 42 CFR §424.520(d)(1), the effective date for the individuals and organizations identified above is the later of the date of filing or the date they first began furnishing services at a new practice location. The date of filing for form CMS-855 applications is the date on which the contractor received the application, regardless of whether the application was submitted via paper or Internet-based PECOS.

In accordance with 42 CFR §424.521(a)(1), the individuals and organizations identified above may, however, retrospectively bill for services when:

* The supplier has met all program requirements, including State licensure requirements, and
* The services were provided at the enrolled practice location for up to—
* 30 days prior to their effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries, or
* 90 days prior to their effective date if a Presidentially declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§5121-5206 (Stafford Act) precluded enrollment in advance of providing services to Medicare beneficiaries.

The effective date of billing for a physician/non-physician practitioner and physician/non-physician practitioner’s organization is the later of the date of filing or the date the physician or non-physician practitioner began furnishing services at the practice location (the physician/non-physician must have met all program requirements including licensure/certification requirements at the time of the effective date).

Effective date of reassignment

The effective date of the reassignment is 30 days before the Physicians and Non-Physician Practitioners (CMS-855I) form is submitted if all applicable requirements during that period were otherwise met:

* Physicians and Non-Physician Practitioners (CMS-855I) form submitted with Clinics/Group Practices and Other Suppliers (CMS-855B) form either simultaneously or as part of development:
* The contractor shall apply the Clinics/Group Practices and Other Suppliers (CMS-855B) effective date to the Physicians and Non-Physician Practitioners (CMS-855I) form. When one or both of these forms requires the contractor to develop for information, and for purpose of establishing the §§ 424.520(d)/424.521(d) effective date, the contractor may apply the receipt date of the first application that is submitted as complete.

Reactivation effective date

The effective date of a reactivation of billing privileges is the date on which the contractor received the provider's or supplier's reactivation submission that the contractor processed to approval.

For more information regarding effective dates, please refer to the [[CMS IOM Pub. 100-08 Medicare Program Integrity Manual, Chapter 10, Medicare Enrollment, section 10.6.2](https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/pim83c10.pdf)](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c10.pdf).

6.6 Effective billing date for all other providers / suppliers not defined in section 6.5

The effective date for all other providers/suppliers not defined in section 6.5 is the date the provider/supplier first began furnishing services at a new practice location (the provider/supplier has met all program requirements including licensure / certification requirements at the time of the effective date). For non-certified supplier reactivations, the effective date shall be the date the contractor received the application.

Exceptions include:

* Independent diagnostic testing facilities (IDTF): The filing date of an IDTF Medicare enrollment application is the date that the contractor receives a signed application that it is able to process to approval. (See 42 CFR §410.33(i).) The effective date of billing privileges for a newly enrolled IDTF is the later of the following:
* The filing date of the Medicare enrollment application that was subsequently approved by a MAC; or
* The date the IDTF first started furnishing services at its new practice location.
* Medicare diabetes prevention program (MDPP): In accordance with 42 CFR §424.205(f), the effective date for billing privileges for MDPP suppliers is the later of:
* The date the supplier filed an enrollment application that was subsequently approved,
* The date the supplier filed a corrective action plan that was subsequently approved by a Medicare contractor, or
* The date the supplier first began furnishing services at a new administrative location that resulted in a new enrollment record or PTAN.
* CMS certified providers – effective date established per the CMS / State agency

6.7 Additional screening requirements, application fees and temporary moratoria

Additional screening requirements

On March 25, 2011, Medicare will place newly enrolling and existing providers and suppliers in one of three levels of categorical screening:

* Limited
* Moderate
* High

The risk levels denote the level of the contractor’s screening of the provider or supplier when it initially enrolls in Medicare, adds a new practice location, or revalidates its enrollment information, or, in certain circumstances, changes all or part of its ownership.

* Providers/suppliers in the “limited” screening category includes:
* Physicians
* Non-physician practitioners other than physical therapists
* Physician group practices
* Non-physician group practices other than physical therapist group practices
* Ambulatory surgical centers
* Competitive acquisition program/Part B vendors
* End-stage renal disease facilities
* Federally qualified health centers
* Histocompatibility laboratories
* Home infusion therapy suppliers
* Hospitals (including critical access hospitals, rural emergency hospitals, Department of Veterans Affairs hospitals, and other federally owned hospital facilities.)
* Health programs operated by an Indian Health Program (as defined in section 4(12) of the Indian Health Care Improvement Act) or an urban Indian organization (as defined in section 4(29) of the Indian Health Care Improvement Act) that receives funding from the Indian Health Service pursuant to Title V of the Indian Health Care Improvement Act
* Mammography screening centers
* Mass immunization roster billers
* Organ procurement organizations
* Outpatient physical therapy/outpatient speech pathology providers enrolling via the Institutional Providers (CMS-855A) form
* Pharmacies that are newly enrolling or revalidating via the Clinics/Group Practices and Other Suppliers (CMS-855B) application
* Radiation therapy centers
* Religious non-medical health care institutions
* Rural health clinics
* Providers in the “moderate” screening category includes:
* Ambulance service suppliers
* Community mental health centers (CMHCs)
* Comprehensive outpatient rehabilitation facilities (CORFs)
* Independent clinical laboratories
* Independent diagnostic testing facilities
* Physical therapists enrolling as individuals or as group practices
* Portable x-ray suppliers (PXRSs)
* Newly enrolling opioid treatment program (OTP) that were SAMHSA certified prior to October 24, 2018
* Revalidating home health agencies (HHA)
* Revalidating hospices
* Revalidating DMEPOS suppliers
* Revalidating MDPP suppliers
* Revalidating OTP providers
* Revalidating SNFs
* Providers in the “high” screening category includes:
* Newly enrolling DMEPOS suppliers
* Newly enrolling HHAs (including HHAs that must submit an initial enrollment application pursuant to § 424.550(b)(1))
* Newly enrolling hospices
* Newly enrolling MDPP suppliers
* Newly enrolling OTP providers that were SAMHSA certified after October 24, 2018
* Newly enrolling SNFs
* DMEPOS suppliers, HHAs, Hospices, MDPP suppliers, OTP providers that were SAMHSA certified after October 24, 2018, and SNFs submitting either: (i) a change of ownership application pursuant to 42 CFR § 489.18; or (ii) an application to report any new owner (regardless of ownership percentage, though consistent with the definition of owner in section 10.1.1 of the PIM) pursuance to a change of information or other enrollment transaction under title 42.
* DMEPOS suppliers, HHAs, Hospices, MDPP suppliers, OTP providers that have not been fully and continuously SAMHSA certified since October 24, 2018, and SNFs submitting a revalidation application where the CMS waived the fingerprinting requirements pursuant to applicable legal authority due to a national, state, or local emergency declared under existing law for their new/initial enrollment.

The enrollment screening procedures will vary depending upon the categories described above.

Screening procedures for the “limited” screening category will largely be the same as those currently in use.

Screening procedures for the “moderate” screening category will include all current screening measures, as well as a site visit.

Screening procedures for the “high” screening category will include all current screening measures, as well as a site visit and a fingerprint-based criminal background check for 5 percent or greater direct and indirect owners.

CMS will continuously evaluate whether we need to change the assignment of categories of providers and suppliers to the various risk categories. If CMS assigns certain groups of providers and/or suppliers to a different category, this change will be proposed in the Federal Register. However, CMS will not publish a notice or a proposed rule in the Federal Register that would include instances in which an individual provider/supplier is reassigned based upon meeting one or more of the triggering events.

Application fees

With the exception of physicians, non-physician practitioners, physician group practices and non-physician group practices, and Medicare Diabetes Prevention Program (MDPP), institutional providers and suppliers that are (1) initially enrolling in Medicare, (2) adding a practice location, or (3) revalidating their enrollment information, must submit with their application:

* An application fee in an amount prescribed by CMS, and/or
* A request for a hardship exception to the application fee

This requirement applies to applications received on or after March 25, 2011.

Note: A physician, non-physician practitioner, physician group, or non-physician practitioner group that is enrolling as a DMEPOS supplier via the Durable Medical Equipment, Prosthetics, Orthotics, and Suppliers (DMEPOS) Suppliers (CMS-855S) application must pay the required application fee.

The application fee must be in the amount prescribed by CMS for the calendar year in which the application is submitted.

* The fee for January 1, 2023 through December 31, 2023 is $688.00.
* The fee for January 1, 2022 through December 31, 2022 is $631.00.
* The fee for January 1, 2021 through December 31, 2021 is $599.00.
* The fee for January 1, 2020 through December 31, 2020 is $595.00.
* The fee for January 1, 2019 through December 31, 2019 is $586.00.
* The fee for January 1, 2018 through December 31, 2018 is $569.00.
* The fee for January 1, 2017 through December 31, 2017 is $560.00.
* The fee for January 1, 2016 through December 31, 2016 is $554.00.
* The fee for January 1, 2015 through December 31, 2015 is $553.00.
* The fee for January 1, 2014 through December 31, 2014 is $542.00.
* The fee for January 1, 2013 through December 31, 2013 is $532.00.
* The fee for January 1, 2012 through December 31, 2012 is $523.00.
* The fee for March 25, 2011 through December 31, 2011 is $505.00.

Fee amounts for future years will be adjusted by the percentage change in the consumer price index (for all urban consumers) for the 12-month period ending on June 30 of the prior year. CMS will give Medicare contractors and the public advance notice of any change in the fee amount for the coming calendar year.

The application fee is non-refundable, except if it was submitted with one of the following:

* A hardship exception request that is subsequently approved;
* An application that was rejected prior to the Medicare contractor’s initiation of the screening process; or
* An application that is subsequently denied as a result of the imposition of a temporary moratorium as described in 42 CFR § 424.570.

For providers who submit applications online via the PECOS website (also referred to as PECOS Provider Interface (or PECOS PI)), you will no longer have to separately access Pay.gov to make your application fee payments. Instead, as you proceed through the Internet based PECOS application process, if a fee is required, you will be prompted to submit your payment by credit card or ACH debit card. Once your payment transaction is complete, you will be automatically returned to the PECOS website to complete the remaining part of your application. PECOS will track the collection transaction and will update payment status, allowing your application to be processed.

For providers who continue to use the CMS-855 paper enrollment application, please submit your application fee by completing the [Medicare Application Fee form](https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do#headingLv1) and click the ‘PAY NOW’ button. You will be redirected to enter and submit payment collection information. At the conclusion of the collection process, you will receive a receipt indicating the status of your payment. Please print a copy for your records. We strongly recommend that you attach this receipt to the completed CMS-855 application submitted to your Medicare contractor.

Hardship exception

A provider or supplier requesting a hardship exception from the application fee must include with its enrollment application a letter (and supporting documentation) that describes the hardship and why the hardship justifies an exception. If a paper CMS-855 application is submitted, the hardship exception letter must accompany the application. If the application is submitted via the Internet-based PECOS, the hardship exception letter must accompany the certification statement. Hardship exception letters will not be considered if they were submitted separately from the application or certification statement, as applicable. If your Medicare contractor receives a hardship exception request separately from the application or certification statement, we will:

* Return it to you, or
* Notify you via letter, e-mail, or telephone, that it will not be considered.

Upon receipt of a hardship exception request with the application or certification statement, the contractor will send the request and all documentation accompanying the request to CMS. CMS will determine if the request should be approved. During this review period, the contractor will not begin processing the provider’s application. CMS will communicate its decision to the institutional provider and the contractor via letter.

Important: In addition, the contractor will not begin to process the provider’s application until the:

* Fee has been paid, or
* Hardship exception request has been approved.

Once processing commences, the application will be processed in the order in which it was received.

Review of hardship exception request

The application fees are noted above. This fee should not represent a significant burden for an adequately capitalized provider or supplier. It is not enough for the provider to simply assert that the imposition of the application fee represents a financial hardship. The provider must instead make a strong argument to support its request, including providing comprehensive documentation (which may include, without limitation, historical cost reports, recent financial reports such as balance sheets and income statements, cash flow statements, tax returns, etc.).

Other factors that may suggest that a hardship exception is appropriate include the following:

* Considerable bad debt expenses,
* Significant amount of charity care/financial assistance furnished to patients,
* Presence of substantive partnerships (whereby clinical, financial integration are present) with those who furnish medical care to a disproportionately low-income population;
* Whether an institutional provider receives considerable amounts of funding through disproportionate share hospital payments, or
* Whether the provider is enrolling in a geographic area that is a presidentially declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121-5206 (Stafford Act).

Note: If the provider fails to submit appropriate documentation to support its hardship exception request, the contractor is not required to contact the provider to request it. Ultimately, it is the provider’s responsibility to furnish the necessary supporting evidence at the time it submits its hardship exception request.

Appeal of the denial of hardship exception decision

If the provider or supplier is dissatisfied with CMS's decision, it may file a written reconsideration request with CMS within 60 calendar days from receipt of the notice of initial determination. The request must be signed by the individual provider or supplier, a legal representative, or any authorized official within the entity. Failure to file a reconsideration request within this timeframe is deemed a waiver of all rights to further administrative review. To file a reconsideration request, providers and suppliers should follow the procedures outlined in [CMS IOM Pub. 100-08 Medicare Program Integrity Manual, Chapter 10, Medicare Enrollment](https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/pim83c10.pdf).

Temporary moratoria

CMS may impose a moratorium on the enrollment of new Medicare providers and suppliers of a particular type or the establishment of new practice locations of a particular type in a particular geographic area.

The announcement of a moratorium will be made via the Federal Register. For initial and new location applications involving the affected provider and supplier type, the moratorium:

* Will not apply to applications for which an approval or a recommendation for approval has been made as of the effective date of the moratorium, even if the contractor has not yet formally granted Medicare billing privileges. Such applications can continue to be processed to completion.
* Will apply to applications that are pending as of the effective date of the moratorium and for which the contractor has not yet made a final approval/denial decision or recommendation for approval. The contractor will deny such applications and will return the application fee if it was submitted with the application.
* Will apply to initial applications that the contractor receives on or after the effective date of the moratorium, and for as long as the moratorium is in effect. The contractor will deny such applications and will return the application fee if it was submitted with the application.

If a particular moratorium is lifted, all applications pending with the contractor as of the effective date of the moratorium’s cessation are no longer subject to the moratorium and may be processed. However, such applications will be processed in accordance with the “high” level of categorical screening. In addition, any initial application received from a provider or supplier: (a) that is of a provider or supplier type that was subject to a moratorium, and (b) within 6 months after the applicable moratorium was lifted, the contractor will process the application using the “high” level of categorical screening.

Refer to [CMS IOM Pub. 100-08 Medicare Program Integrity Manual, Chapter 10, Medicare Enrollment](https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/pim83c10.pdf), for more information on the additional screening requirements, the application fees and the temporary moratoria.

6.8 Change of information

If an enrolled provider/supplier is adding, deleting, or changing information under its existing tax identification number, it must report this change using the applicable CMS-855 form. Letterhead is not permitted.

The timeframes for providers to report changes to their CMS-855 information are as follows:

* For physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, registered dietitians or nutrition professionals, speech language pathologists, marriage and family therapists, mental health counselors, and organizations (e.g., group practices) consisting of any of the categories of individuals identified in this paragraph. The following changes must be reported within 30 days:
* A change of ownership.
* A change in practice location (including additions and deletions).
* A final adverse action which means one or more of the following actions:
* A Medicare-imposed revocation of any Medicare billing privileges;
* Suspension or revocation of a license to provide health care by any State licensing authority;
* Revocation or suspension by an accreditation organization;
* A conviction of a Federal or State felony offense (as defined in §424.535(a)(3)(i)) within the last 10 years preceding enrollment, revalidation, or re-enrollment; or
* An exclusion or debarment from participation in a Federal or State health care program.
* For IDTFs, the following must be reported in 30 days:
* A change in adverse legal action
* A change in ownership
* A change in practice location (including additions and deletions)
* A change in general supervision
* For MDPP suppliers, the following must be reported in 30 days:
* A change in ownership
* A change in practice location (including additions and deletions)
* A change to its coach roster (including due to coach ineligibility or because the coach is no longer an employee, contractor, or volunteer of the MDPP supplier
* A change in final adverse legal action
* For air ambulance suppliers, the following must be reported in 30 days:
* A revocation or suspension of its license or certification
* The following FAA certifications must be reported:
* Specific pilot certifications including, but not limited to, instrument and medical certifications; and airworthiness certification
* All other provider/supplier types not mentioned above must report the following in 30 days:
* A change in ownership or control (including changes in authorized official(s) or delegated officials)
* Change of practice location (including additions and deletions)

All other informational changes involving the providers listed above must be reported within 90 days.

If the individuals or organizations listed above fail to:

* Comply with the reporting requirement specific to changes in adverse actions, billing privileges will be revoked.

In addition, if the individuals or organizations identified above, or IDTFs who/that are revoked from the Medicare program must, within 60 calendar days of the effective date of the revocation, submit all claims for items and services furnished.

* Comply with the reporting requirements related to final adverse actions and practice location changes, an overpayment will be assessed back to the date of the final adverse action or change in practice location; although no earlier than January 1, 2009.

If a change of ownership, or any change not otherwise specified above, is not timely reported, we may deactivate billing privileges. In order to reactivate privileges, a complete CMS-855 application must be submitted.

For any provider/supplier: If a timely request for a change of information/ownership / control (including changes to EFT) is received, and we do not yet have a record established in the national provider database, the PECOS, we are required to request a complete CMS-855 application. We are also required to request a complete CMS-855 application if you are reactivating your file. You have 30 days to submit the solicited data, meaning you have 30 calendar days from the date of our request to furnish the complete CMS-855 application. During this period, the change request initially submitted is “held” (not processed) until the complete application arrives. If the complete application is not submitted within the aforementioned 30-day period, we are mandated to take steps to revoke your billing privileges.

6.9 Change requests submitted on letterhead

Novitas cannot accept requests for changes to your provider file on letterhead. Any request for updates to your provider file must be submitted on the appropriate [CMS-855 form](ddocname:00004821).

6.10 Voluntary terminations / deactivations

If an enrolled provider/supplier will no longer be rendering services to Medicare patients or is planning to cease (or have ceased) operations, it must report this change using the applicable CMS-855 form to voluntarily terminate / deactivate their Medicare enrollment.

Complete the appropriate paper application sections listed below or go to the [Internet-based PECOS](https://pecos.cms.hhs.gov/pecos/login.do#headingLv1) to submit the electronic application.

* Physicians and Non-Physician Practitioners (CMS-855I):
* Individuals must complete Sections 1A, 2A, 13 and 15
* For reassignment terminations (including physician assistants):
* Complete sections 1A, 2A, 4F, 13, and either 15B (individual signature) or 15C (authorized or delegated signature)
* Clinics/Group Practices and Other Suppliers (CMS-855B):
* Complete sections 1, 2A1, 13 and 15
* Institutional Providers (CMS-855A):
* Complete sections 1, 2B1, 13 and either 15 or 16.

Note: Voluntarily terminating/deactivating your Medicare enrollment is not the same as “opting out” of the Medicare program. There are physicians and other individual practitioners who do not wish to enroll in the Medicare program.

Physicians and practitioners (but not organizations) can “opt-out” of Medicare. This means that neither the physician nor the beneficiary submits the bill to Medicare for services performed. Instead, the beneficiary pays the physician out-of-pocket and neither party is reimbursed by Medicare.

The difference between opting-out and not accepting assignment is relatively straightforward. If the practitioner opts-out, neither he/she nor the beneficiary can bill Medicare. If the practitioner chooses not to accept assignment, he/she must still enroll in Medicare and must submit the bill to the carrier.

Refer to [Chapter 4 of the Enrollment Reference Guide](dDocName:00093111) for more information on Medicare participation.

Refer to [Chapter 9 of the Enrollment Reference Guide](dDocName:00093112) for more information on opting out.

6.11 Revocations

Contractors, or CMS, may revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement or supplier agreement if the provider or supplier, or in some cases any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider / supplier is determined to have committed any of the transgressions outlined in 42CFR § 424.535.

Providers and suppliers may submit a corrective action plan (CAP) within 30 days of revocation to the contractor if the deficiencies resulting in the revocation have been corrected. Details on how to develop and submit a CAP are outlined in the revocation letter. If dissatisfied with the results of the review of the CAP, a written request may be submitted within 60 days of revocation for reconsideration before a contractor hearing officer. Once the corrective action plan and reconsideration options have been exhausted, or if neither is pursued, the revoked provider/supplier is barred from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar. The re-enrollment bar is a minimum of 1 year, but not greater than 3 years depending on the severity of the basis for revocation. The re-enrollment bar will be defined in the notice of revocation.

6.12 Do not forward initiative (Part B only)

CMS has mandated that all contractors use “Return service requested” envelopes for all Medicare Part B provider checks and/or hard copy standard paper remittance (SPR) notices. All Medicare Part B provider SPRs produced by us are issued in the new envelope.

As a result, provider checks and SPRs are no longer forwarded by the post office to a last known address. Instead, checks and SPRs are returned to the contractor for follow up. This results in an interruption of Medicare payment(s) until an address correction is performed on the provider’s file.

To prevent a potential delay in Medicare payment, ensure we have your correct mailing address on file. If you have recently changed your address or are planning to change your address in the near future, please remember to complete the appropriate CMS-855I or CMS-855B form with a handwritten signature and mail it to the addresses located in 'Where to Send Paper Enrollment Applications' of this enrollment guide.

6.13 Electronic funds transfer (EFT)

Claim payment is your "paycheck" from Medicare, and we want to help get those funds to you as easily and quickly as possible. That's what Electronic Funds Transfer, or EFT, is all about. EFT is the direct deposit of your Medicare payments, and is available to electronic and paper billers. Here's how it works:

* EFT is free and no software changes are required.
* You complete an Electronic Funds Transfer Agreement (CMS-588) form and return it to us at the addresses provided Where to Send Paper Enrollment Applications of this enrollment guide.
* We conduct a stringent test between your bank and the Medicare Bank.
* After approval, we directly deposit your Medicare payments into your bank account within three bank working days. This means that you do not have to wait for the mail and spend time visiting the bank to deposit your money.
* And, an optional electronic remittance advice (ERA, which is an electronic version of your paper voucher) eliminates the need for the bulky, cumbersome SPR.

If you are a new enrollee, or are already enrolled and are requesting any change to existing Medicare enrollment information, you are required to submit an Electronic Funds Transfer Agreement (CMS-588) form to receive your Medicare payments via EFT, in conjunction with your CMS-855 enrollment application, unless you are already receiving your payments via EFT.

The statute requiring all Federal payments be made via EFT can be found at [42 CFR 424.510(d)(iv) and 424.510(e)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-P/section-424.510). An Electronic Funds Transfer Agreement (CMS-588) form can be downloaded from the CMS website. Once a provider begins to receive Medicare payments via EFT, we are not permitted to issue any routine, ongoing payments via paper checks.

Payments may be sent to a bank for deposit in the provider/supplier’s account so long as the following requirements are met:

* The bank may provide financing to the provider/supplier, as long as the bank states in writing, in the loan agreement, that it waives its right of offset. Therefore, the bank may have a lending relationship with the provider/supplier and may also be the depository for Medicare receivables; and
* The account is in the provider/supplier’s name only and only the provider / supplier may issue any instructions on that account. The bank shall be bound by only the provider/supplier’s instructions. No other agreement that the provider/supplier has with a third party shall have any influence on the account. In other words, if a bank is under a standing order from the provider/supplier to transfer funds from the provider/supplier’s account to the account of a financing entity in the same or another bank and the provider/supplier rescinds that order, the bank honors this rescission notwithstanding the fact that it is a breach of the provider/supplier’s agreement with the financing entity.
* Irrespective of the language in any agreement a provider/supplier has with a third party that is providing financing, that third party cannot purchase the provider/supplier’s Medicare receivables.

Note: All payments must be made to a banking institution. EFT payments to non-banking institutions (e.g., brokerage houses, mutual fund families) are not permitted. If the bank of choice does not or will not participate in the proposed EFT transaction, another financial institution must be selected.

6.14 Deactivation for inactivity / reactivation (Part B only)

Contractors are instructed by CMS to routinely search their files to identify providers that have not billed the Medicare program in the prescribed time frame and to deactivate the provider’s billing status. Per [CMS IOM Pub. 100-08 Medicare Program Integrity Manual, Chapter 10, Medicare Enrollment](https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/pim83c10.pdf), an inactive provider is one who has not billed the Medicare program for 12 consecutive months. Effective January 1, 2010, Part B Medicare providers will receive an auto-generated notification of non-billing for 12 consecutive months and the deactivation of billing privileges.

Providers deactivated for non-submission of a claim are required to complete and submit a Medicare enrollment application to recertify that the enrollment information currently on file with Medicare is correct and must furnish any missing information as appropriate. The provider must meet all current Medicare requirements in place at the time of reactivation. As of January 2009, providers will receive a new PTAN when being reactivated. Providers that have been deactivated and bill electronically will also need to reactivate for electronic billing by completing the electronic billing enrollment forms (8292).

The provider enrollment services department will then notify the provider by letter once the provider is eligible to bill, and EDI will notify the provider by letter once the provider is eligible to begin electronic billing again (if applicable). Failure to reactivate in the program will result in claim denials.

For individual and organizational suppliers other than those identified in the beginning of the previous paragraph, the contractor shall enter the effective date as either: (a) the date the supplier first saw a Medicare patient at the location indicated on the CMS-855, or (b) the same date as the non-billing end-date in Multi-Carrier System, whichever is later.