

a physician or, when permitted, an eligible professional (as defined in § 424.506(a) of this part).

(ii) The claim must contain the legal name of the physician or the eligible professional (as defined in § 424.506(a) of this part) who ordered or referred.

(iii) The physician or the eligible professional who ordered or referred must have an approved enrollment record or a valid opt-out record in the Provider Enrollment, Chain and Ownership System (PECOS).

(iv) If the items or services were ordered or referred by a resident or an intern, the claim must identify the teaching physician as the ordering or referring supplier. The claim must identify the teaching physician by his or her legal name and he or she must have an approved enrollment record or a valid opt-out record in PECOS.

(b) *Conditions for payment of claims for ordered covered home health services.* (1) *Home health provider claims.* To receive payment for ordered, covered Part A or Part B home health services, a provider's home health services claim must meet all of the following requirements:

(i) The Part A or Part B home health services must have been ordered by a physician;

(ii) The claim from the provider of home health services must contain the legal name and the National Provider Identifier (NPI) of the ordering physician;

(iii) The ordering physician must have an approved enrollment record or a valid opt-out record in the Provider Enrollment, Chain, and Ownership System (PECOS); and

(iv) If the services were ordered by a resident or an intern, the claim must identify the teaching physician as the ordering or referring physician. The claim must identify the teaching physician by his or her legal name and NPI and he or she must have an approved enrollment record or a valid opt-out record in PECOS.

(2) *Home health beneficiary claims.* To receive payment for ordered covered Part A or Part B home health services, a beneficiary's home health services claim must meet all of the following requirements:

(i) The Part A or Part B home health services must have been ordered by a physician.

(ii) The claim from the provider of home health services must contain the legal name of the ordering physician.

(iii) The ordering physician must have an approved enrollment record or a valid opt-out record in the Provider Enrollment, Chain, and Ownership System (PECOS).

(iv) If the services were ordered by a resident or an intern, the claim must identify the teaching physician as the ordering or referring physician. The claim must identify the teaching physician by his or her legal name and he or she must have an approved enrollment record or a valid opt-out record in PECOS.

(c) A Medicare contractor will reject a claim from a provider or a supplier for covered services described in paragraphs (a) and (b) of this section if the claim does not meet the requirements of paragraph (a)(1) and (b)(1) of this section, respectively.

(d) A Medicare contractor may deny a claim from a Medicare beneficiary for covered items or services described in paragraphs (a) and (b) of this section if the claim does not meet the requirements of paragraphs (a)(2) and (b)(2) of this section, respectively.

[75 FR 24448, May 5, 2010]

§ 424.510 Requirements for enrolling in the Medicare program.

(a) Providers and suppliers must submit enrollment information on the applicable enrollment application. Once the provider or supplier successfully completes the enrollment process, including, if applicable, a State survey and certification or accreditation process, CMS enrolls the provider or supplier into the Medicare program. To be enrolled, a provider or supplier must meet enrollment requirements specified in paragraph (c) of this section.

(b) The effective dates for reimbursement are specified in § 489.13 of this chapter for providers and suppliers requiring State survey or certification or accreditation, § 424.5 and § 424.44 for non-surveyed or certified/accredited suppliers, and § 424.57 and section 1834(j)(1)(A) of the Act for DMEPOS suppliers.

(c) The effective date for reimbursement for providers and suppliers seeking accreditation from a CMS-approved accreditation organization as specified in § 489.13.

(d) Providers and suppliers must meet the following enrollment requirements:

(1) *Submittal of the enrollment application.* A provider or supplier must submit a complete enrollment application and supporting documentation to the designated Medicare fee-for-service contractor.

(2) *Content of the enrollment application.* Each submitted enrollment application must include the following:

(i) Complete, accurate, and truthful responses to all information requested within each section as applicable to the provider or supplier type.

(ii) Submission of all documentation required by CMS under this or other statutory or regulatory authority, or under the Paperwork Reduction Act of 1995, to uniquely identify the provider or supplier. This documentation may include, but is not limited to, proof of the legal business name, practice location, social security number (SSN), tax identification number (TIN), National Provider Identifier (NPI), if issued, and owners of the business.

(iii) Submission of all documentation, including all applicable Federal and State licensure and regulatory requirements that apply to the specific provider or supplier type that relate to providing health care services, required by CMS under this or other statutory or regulatory authority, or under the Paperwork Reduction Act of 1995, to establish the provider or supplier's eligibility to furnish Medicare covered items or services to beneficiaries in the Medicare program.

(iv) At the time of enrollment, an enrollment change request, revalidation or change of Medicare contractors where the provider or supplier was already receiving payments via EFT, providers and suppliers must agree to receive Medicare payments via EFT, if not already receiving payment through EFT. In order to receive Medicare payments via EFT, providers and suppliers must submit the CMS-588 form.

(3) *Signature(s) required on the enrollment application.* The certification

statement found on the enrollment application must be signed by an individual who has the authority to bind the provider or supplier, both legally and financially, to the requirements set forth in this chapter. This person must also have an ownership or control interest in the provider or supplier, as that term is defined in section 1124(a)(3) of the Act, such as, the general partner, chairman of the board, chief financial officer, chief executive officer, president, or hold a position of similar status and authority within the provider or supplier organization. The signature attests that the information submitted is accurate and that the provider or supplier is aware of, and abides by, all applicable statutes, regulations, and program instructions.

(i) *Requirements.* The signature requirements specified in paragraphs (d)(3)(i)(A) through (C) of this section outline who must sign the enrollment application for an enrolling provider or supplier. In the case of—

(A) An individual practitioner, the applying practitioner.

(B) A sole proprietorship, the applying sole proprietor.

(C) A corporation, partnership, group, limited liability company, or other organization (hereafter referred to collectively in this section as an organization), an authorized official, as defined in § 424.502. When an authorized official signs the certification statement on behalf of an organization, the signed statement is considered legally binding upon the organization.

(ii) *Delegation of authority.* The original enrollment application submitted for an organization's initial enrollment and all subsequent enrollment applications submitted for periodic revalidation of the organization's enrollment data (as required to maintain enrollment in the Medicare program) must be signed by an authorized official. Any updates or changes reported outside of the initial enrollment or periodic revalidation process may be signed by a delegated official(s) of the organization. The delegated official's signature binds the organization both legally and financially, as if the signature was that of the authorized official. Before the delegation of authority is established, the only acceptable signature on the

enrollment application to report updates or changes to the enrollment information is that of the authorized official currently on file with Medicare. Once the delegation of authority is established, the only acceptable signatures on correspondence to report updates or changes to the enrollment information are those of the authorized official and the person(s) to whom this authority is delegated in accordance with the requirements described in this section. Individual practitioners and sole proprietors cannot delegate signature authority when submitting an enrollment application for any reason. All enrollment applications submitted by individual practitioners and sole proprietors must be signed by the enrolling or enrolled individual. Each delegation of authority to a delegated official must—

(A) Be assigned by the authorized official currently on file with CMS;

(B) Be submitted to CMS using the appropriate enrollment application or CMS established electronic enrollment process;

(C) Include the title and SSN of each person delegated authority to update or change the organization's enrollment information;

(D) Be an individual that has an ownership or control interest in the organization or is a W-2 managing employee as defined in section 1126(b) of the Act; and

(E) Be signed by the authorized official and the delegated official(s) of the organization.

(4) *Verification of information.* The information submitted by the provider or supplier on the applicable enrollment application must be such that CMS can validate it for accuracy at the time of submission.

(5) *Completion of any applicable State surveys, certifications, and provider agreements.* The providers or suppliers who are mandated under the provision in part 488 of this chapter to be surveyed or certified by the State survey and certification agency, and to also enter into and sign a provider agreement as outlined in part 489 of this chapter, must also meet those requirements as part of the process to obtain Medicare billing privileges.

(6) *Ability to furnish Medicare covered items or services.* The provider or supplier must be operational to furnish Medicare covered items or services before being granted Medicare billing privileges.

(7) *Additional requirements.* Providers and suppliers must meet the provisions of § 424.520 regarding additional compliance and reporting requirements.

(8) *On-site review.* CMS reserves the right, when deemed necessary, to perform on-site inspections of a provider or supplier to verify that the enrollment information submitted to CMS or its agents is accurate and to determine compliance with Medicare enrollment requirements. Site visits for enrollment purposes do not affect those site visits performed for establishing compliance with conditions of participation.

(i) *Medicare Part A providers.* CMS determines, upon on-site review, that the provider is no longer operational to furnish Medicare covered items or services, or the provider fails to satisfy any of the Medicare enrollment requirements.

(ii) *Medicare Part B suppliers.* CMS determines, upon review that the supplier is no longer operational to furnish Medicare covered items or services, or the supplier has failed to satisfy any or all of the Medicare enrollment requirements, or has failed to furnish Medicare covered items or services as required by the statute or regulations.

(e) Providers and suppliers must—

(1) Agree to receive Medicare payment via electronic funds transfer (EFT) at the time of enrollment, revalidation, change of Medicare contractors where the provider or supplier was already receiving payments via EFT or submission of an enrollment change request; and

(2) Submit the CMS-588 form to receive Medicare payment via electronic funds transfer.

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