

information from a provider or supplier before payment is authorized. Our issuance of an identification number to a provider or supplier does not automatically convey the privilege to bill Medicare. There must be a corresponding approval of the provider or supplier as meeting all Federal requirements to bill Medicare for the number to be an approved and active Medicare billing number.

In new § 424.510 (Form CMS 855), we propose that a provider or supplier must submit to us the appropriate completed form CMS 855—Provider/Supplier Enrollment Application based on the type of provider or supplier enrolling. As part of our continuing efforts to improve the enrollment process, the series of CMS 855 enrollment forms with proposed revisions are being submitted with this proposed rule, to be published in the **Federal Register** concurrently for review and public comment. Some of the proposed revisions are the removal of certain data collections from all forms in the series such as information on clearinghouses used in claims submission, practice locations from the CMS 855R, and a shortened attachment for ambulance companies in the CMS 855B. We have also simplified the sections for reporting owners and managers and added instructional clarifications. The forms are identified as follows:

- Form CMS 855A—For providers billing fiscal intermediaries.
- Form CMS 855B—For supplier organizations billing carriers.
- Form CMS 855I—For individual health care practitioners billing carriers.
- Form CMS 855R—For individual health care practitioners to reassign benefits to an organization.
- Form CMS 855S—For DMEPOS Suppliers billing the NSC.

The CMS 855 applications will be used to gather information on providers and suppliers for the purpose of authorizing billing numbers and establishing eligibility to furnish services to Medicare beneficiaries. The information submitted will also uniquely identify the providers and suppliers for the purpose of enumeration and payment. OMB has approved the CMS 855 for these purposes (OMB approval number 0938–0685).

At proposed § 424.510(a)(1) we are requiring that a provider or supplier submit the following on its CMS 855: Complete and accurate responses to all information requested within each section as applicable to the provider or supplier type.

- Any documentation currently required by CMS under this or other

statutory or regulatory authority to uniquely identify the provider or supplier (for example, a social security number (SSN) or a tax identification number (TIN)).

- Any documentation currently required by CMS under this or other statutory or regulatory authority to establish the provider or supplier's eligibility to furnish services to beneficiaries in the Medicare program (for example, a medical license or business license).

Under the authorities mentioned earlier in this preamble all providers, suppliers, and other health care related individuals and entities who will receive Medicare reimbursements, either directly or indirectly as a result of enrolling in the Medicare program, must furnish their SSN and/or TIN as a condition of maintaining an active enrollment status and billing privileges. We also maintain the right to require persons with ownership or control interests (as that term is defined in section 1124(a)(3) of the Act) in such providers and suppliers, and of all managing employees (as that term is defined in section 1126(b) of the Act and at 42 CFR 420.201) of such providers and suppliers to also furnish their SSN and/or TIN as a condition of enrollment.

We are proposing that providers and suppliers must certify that all the information furnished on the CMS 855 is accurate, complete, truthful, and verifiable. Any concealment or misrepresentation of material information in these applications constitutes a violation of this regulation and may result in the rejection, denial, or revocation of the provider or supplier's enrollment and billing privileges. In addition, such concealment or misrepresentation will be referred to the Office of Inspector General for investigation and appropriate criminal, civil or administrative action.

In § 424.510(a)(2), we propose that the CMS 855 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 subpart P. This person must be the individual practitioner or 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, be the provider's or supplier's 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 would attest that the information

submitted is accurate, complete, and truthful, and the provider or supplier is aware of, and will abide by, Medicare rules and regulations.

To ensure that the individual signing the form can bind the enrollee from a financial and legal standpoint, we would require the following persons to sign the enrollment form:

- In the case of an individual practitioner, the applying practitioner.
- In the case of a sole proprietorship, the applying sole proprietor.

- In the case of a corporation, partnership, group, limited liability company (LLC), or other organization, an authorized official, as defined in § 424.502. When an authorized official signs the application, the signed application is considered binding upon the corporation partnership, organization, group, or LLC (hereafter referred to in this section as an organization), as applicable. This requirement establishes accountability for the accuracy of the information on the CMS 855 and ensures that the provider or supplier is committed to taking the necessary steps to comply with these requirements. In addition to the signature requirements, we are establishing a delegation of authority. As required above, the original and all subsequent revalidation CMS 855s submitted by an organization to enroll or maintain enrollment in the Medicare program must have certification statements signed by the current authorized official on file with Medicare. Any subsequent updates or changes made outside the enrollment or revalidation process may be signed by a delegated official of the enrolled organization.

The delegated official must be a W–2 managing employee of the provider or supplier who is enrolling in, or currently enrolled in, the Medicare program, or be an individual with ownership or control interest in the provider or supplier.

The delegation of signature authority will not apply for individual practitioners and sole proprietors. All CMS 855s submitted by individual practitioners or sole proprietors must be signed by the enrolling/enrolled individual.

As proposed in § 424.510(a)(2)(ii), the delegation of authority must be assigned by the authorized official currently on file with us or the authorized official who has signed the CMS 855 currently being submitted to us. All delegations of authority must be submitted via the CMS 855 and must include the title of each person delegated authority to update or change the organization's enrollment information. The assignment