

accreditation from an outside organization authorizing the release of the survey to us or our agents. By adding this language to the certification statement, the current CMS 1514 form will be eliminated for Medicare purposes.

#### 16. Delegated Official (Optional)

The signature(s) obtained in sections 15 and 16 would attest that the provider or supplier has submitted accurate, complete, and truthful information as required by sections 1814(a) and 1833(e) of the Act, and that the person the provider or supplier has authorized to sign for the provider or supplier attests on behalf of the provider or supplier to having read and understood the information furnished and collected in the CMS 855, and that the information is accurate, complete, and truthful. By signing the certification statement, the provider or supplier, or the authorized or delegated official signing on behalf of the provider or supplier, is attesting, among other things, that the provider or supplier is aware of and will abide by all applicable Medicare laws and regulations.

#### 17. Attachments

This section is a checklist of possible documents that should be submitted with the enrollment application. These documents are used as evidence or proof of the validity of the information furnished through the CMS 855.

#### *B. Information Pertaining to Specific Provider and Supplier Types*

##### 1. Attachment 1 to Form CMS 855B—Ambulance Service Suppliers

We must collect specific information on ambulance service suppliers to verify their eligibility to receive payment for Medicare covered services. Section 410.41 (Requirements for ambulance suppliers) sets forth the requirements for ambulance service suppliers. An ambulance must be specially designed to respond to medical emergencies or provide acute medical care to transport the sick and injured and comply with all State and local laws governing an emergency transportation vehicle. We require that, at a minimum, an ambulance contain a stretcher, linens, emergency medical supplies, oxygen equipment, and other lifesaving emergency medical equipment as required by State or local laws, and be equipped with emergency warning lights, sirens, and two-way telecommunications.

**Note:** This attachment replaced the HCFA R-88 (OMB Approval Number 0938-0460).

##### 2. Attachment 2 to Form CMS 855B—Independent Diagnostic Testing Facilities (IDTFs)

IDTFs must submit specific information to us to justify their eligibility to receive payment for Medicare covered services. The information collected in this attachment allows us to assess compliance with 42 CFR § 410.33 (Independent diagnostic testing facility). In addition, 42 CFR § 440.30 (Other laboratory and x-ray services) defines laboratory and X-ray services. These services may be provided in an office or similar facility other than a hospital outpatient facility or clinic, and must be furnished by a laboratory that meets the requirements of Part 493 of chapter IV, 42 CFR.

#### *C. Supplemental Applications*

##### 1. Supplemental Application CMS 855S (DMEPOS Supplier Application)

The information collected in this iteration of the CMS 855 allows us to assess compliance with § 424.57 (Special payment rules for items furnished by DMEPOS suppliers and issuance of DMEPOS supplier billing numbers), which outlines specific standards that must be met for the enrollment and renewal of enrollment for DMEPOS suppliers. This collection was previously approved by OMB via the HCFA 192 (OMB Approval Number 0938-0594). The CMS 855S has replaced the HCFA 192.

**Note:** A DMEPOS supplier is not required to submit a CMS 855B form in addition to a CMS 855S.

##### 2. Supplemental Application CMS 855R (Individual Reassignment of Benefits Application)

The CMS 855R will be used to link individual Medicare suppliers with Medicare entities to whom the individual reassigns his or her benefits and is used in conjunction with the CMS 855I or the CMS 855B during initial enrollment into the Medicare program, or whenever an individual supplier wishes to, or is required to, reassign its benefits. The CMS 855R contains only the information needed to identify and link individual suppliers reassigning their benefits to the individuals and entities to whom their benefits are being reassigned.

#### **V. Sanctions and Penalties**

The CMS 855 states that the following penalties may be imposed:

- 18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United

States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes or uses any false, fictitious, or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry.

Individual offenders are subject to fines of up to \$250,000 and imprisonment for up to 5 years. Offenders that are organizations are subject to fines of up to \$500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender.

- Section 1128B(a)(1) of the Act authorizes criminal penalties against an individual who “knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program.” The offender is subject to fines of up to \$25,000 or imprisonment for up to 5 years, or both.

- The Civil False Claims Act, 31 U.S.C. 3729, imposes a civil penalty of \$5,000 to \$10,000 per violation, plus three times the amount of damages sustained by the Government and imposes civil liability, in part, on any person who—

- Knowingly presents, or causes to be presented, to an officer or an employee of the United States Government a false or fraudulent claim for payment or approval;

- Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or

- Conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

- Section 1128A(a)(1) of the Act imposes administrative sanctions on a person for the submission to a Federal health care program of false or otherwise improper claims.

These administrative sanctions include a civil monetary penalty of up to \$10,000 for each item or service falsely or fraudulently claimed an assessment of up to triple the amount claimed, and exclusion from participation in all Federal health care programs.

The government may assert common law claims such as “common law fraud,” “money paid by mistake,” and “unjust enrichment.” Remedies include compensatory and punitive damages, restitution, and recovery of the amount of the unjust profit.

In addition, the following two sanctions will be added to the CMS 855 form: