

*Operational* means the provider or supplier has a qualified physical practice location, is open to the public for the purpose of providing health care related services, is prepared to submit valid Medicare claims, and is properly staffed, equipped, and stocked (as applicable, based on the type of facility or organization, provider or supplier specialty, or the services or supplies being rendered), to furnish these services.

*Owner* means any individual or entity that has any partnership interest in, or that has 5 percent or more direct or indirect ownership of the provider or supplier as defined in section 1124A(a) of the Act.

*Reject/Rejected* means that the provider or supplier's enrollment application has not been processed due to incomplete information or that additional information or corrected information was not received from the provider or supplier within 60 days after it was requested.

*Revoke/Revocation* means that the provider or supplier's billing privileges have been terminated.

#### **§ 424.505 Basic enrollment requirement.**

To receive payment for covered Medicare services from either Medicare (in the case of assigned claims) or a Medicare beneficiary (in the case of unassigned claims), a provider or supplier must have a valid Medicare billing number and been granted billing privileges for the date the service or supplies were furnished.

#### **§ 424.510 Requirements for obtaining a billing number and Medicare billing privileges.**

Providers and suppliers must submit enrollment information via the applicable form CMS 855 for verification by the Medicare program to obtain a Medicare billing number and be granted billing privileges. Upon the provider or supplier's successful completion of the enrollment process, including State survey and certification, accreditation, and approval of the CMS 855, The Centers for Medicare & Medicaid Services (CMS) issues a billing number and grants billing privileges that enable the provider or supplier to bill the Medicare program or the Medicare beneficiaries for Medicare covered services. Currently, the effective dates for reimbursement can be found at § 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. For those

providers and suppliers seeking accreditation from a CMS approved accreditation organization, the effective date for reimbursement will be the later of the date accreditation was received or the final approval of the CMS 855. CMS will not issue Medicare billing numbers or grant Medicare billing privileges retroactive to the date that the provider or supplier received final approval of their enrollment application (CMS 855). To obtain a billing number and be granted billing privileges, the following enrollment requirements must be met:

(a) *Form CMS 855.* A provider or supplier must submit to CMS the applicable completed CMS 855—Medicare Health Care Provider/Supplier Enrollment Application. The completed form will provide information for the purpose of establishing eligibility to receive payment for covered services furnished to Medicare beneficiaries. The information obtained uniquely identifies the provider and supplier for the purpose of enumeration, and provides information to CMS necessary for CMS to verify that the provider or supplier is not, and should not be, excluded from participation in the Medicare program, and that it renders services covered by the Medicare program.

(1) *Content.* The submitted CMS 855 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) Any documentation required by CMS under this or other statutory or regulatory authority 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), and owners of the business.

(iii) Any documentation 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, including copies of pertinent licenses.

(2) *Signature(s).* The certification statement found on 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 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, be 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 will abide by, all applicable Medicare laws, regulations, and program instructions.

(i) *Requirements.* The signature requirements set forth below outline who must sign the CMS 855 for an enrolling provider or supplier:

(A) In the case of an individual practitioner, the applying practitioner.

(B) In the case of a sole proprietorship, the applying sole proprietor.

(C) In the case of 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 CMS 855 submitted for an organization's initial enrollment and all subsequent CMS 855s 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 CMS 855 to report updates or changes to the enrollment information will be 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 will be those of the authorized official and the person(s) to whom this authority has been delegated in accordance with the procedures detailed herein. Individual practitioners and sole proprietors can not delegate signature authority when submitting a CMS 855 for any reason. All CMS 855s submitted by individual practitioners and sole proprietors must be signed by the enrolling/enrolled individual. Each delegation of authority to a delegated official must—