

(A) Be assigned by the authorized official currently on file with CMS;
 (B) Be submitted to CMS via the CMS 855;

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

(D) Include the SSN of the delegated individual where that individual 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.

(1) *Verification of information.* The information submitted by the provider or supplier on the applicable CMS 855 must be such that CMS can validate it for accuracy as of the time of submission.

(2) *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.

(3) *Ability to furnish Medicare covered services or supplies.* The provider or supplier must be operational to furnish Medicare covered services and/or supplies before being granted Medicare billing privileges.

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

(5) *On-site inspections.* CMS reserves the right, when we deem 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 will not affect those site visits performed for establishing conditions of participation.

(b) [Reserved]

§ 424.515 Requirements for reporting changes and updates to, and the periodic revalidation of, Medicare enrollment information.

To maintain Medicare billing privileges a provider or supplier must resubmit and re-certify as to the accuracy via an authorized signature, its enrollment information for validation no more than once every 3 years.

Initially, all providers and suppliers currently in or initially enrolling in the Medicare program will be required to complete the applicable CMS 855 at least once. The provider or supplier will enter the three-year revalidation cycle once a completed CMS 855 has been submitted and validated. (Ambulance service providers will continue to resubmit enrollment information in accordance with § 410.41(c)(2) and DME suppliers will continue to renew enrollment in accordance with § 424.57(e) of this chapter). The requirements for the resubmission, recertification and reverification of enrollment information include the following:

(a) *Submission of form CMS 855 and supporting documentation.* The provider or supplier must meet the submission, content, signature, verification, operational, inspection, and other requirements outlined in § 424.510.

(b) *Processing time.* A provider or supplier must submit to us the applicable CMS 855 with complete and accurate information and applicable supporting documentation within 60 calendar days of our notification to resubmit and certify to the accuracy of its enrollment information.

(c) *Completion of any applicable State surveys, certifications and provider agreements.* A new survey and certification and a new provider agreement are not required for the purpose of resubmission and certification for revalidation of enrollment information. Providers and suppliers must continue to meet the requirements of parts 488 and 489 of this subchapter, if applicable.

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

(e) *Adjustments to 3-year revalidation cycle and non-routine revalidations.* (1) Revalidation of enrollment information will occur no more than once every 3 years. CMS reserves the right to adjust this schedule if it is determined that revalidation should occur on a more frequent basis due to complaints or evidence received indicating non-compliance with the Medicare statute or regulations by specific provider or supplier types. The schedule may also be on a less frequent basis if it is determined that the integrity of and compliance with the

Medicare statute and regulations by specific provider or supplier types indicate that less frequent validation is justified. CMS will continue to revalidate enrollment information for Ambulance Service Suppliers in accordance with regulations set forth at § 410.41(c)(2) of this chapter (Requirements for ambulance suppliers), and DME suppliers will continue to renew enrollment in accordance with regulations set forth at § 424.57(e) (Special payment rules for items furnished by DMEPOS suppliers and issuance of DMEPOS supplier billing numbers).

(2) CMS also reserves the right to perform non-routine revalidation and request the provider or supplier to recertify as to the accuracy of the enrollment information when warranted to assess and confirm the validity of the enrollment information. Non-routine revalidation may be triggered as a result of random checks, information indicating local problems, national initiatives, complaints, or other reasons that cause CMS to question the integrity of the provider or supplier in its relationship with the Medicare program. Like routine revalidation, non-routine revalidation may or may not be accompanied by site visits.

§ 424.520 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare program.

(a) *Certifying compliance.* CMS enrolls and maintains an active enrollment status for a provider or supplier when that provider or supplier certifies that it meets, and continues to meet, and CMS verifies that it meets, and continues to meet, all of the following requirements:

(1) Compliance with Title XVIII of the Social Security Act and applicable Medicare regulations.

(2) Compliance with Federal and State licensure, certification and regulatory requirements, as required, based on the type of services or supplies the provider or supplier type will furnish and bill Medicare.

(3) Not employing or contracting with individuals or entities—

(i) Excluded from participation in any Federal health care programs, for the provision of items and services covered under the programs, in violation of section 1128A(a)(6) of the Act; or

(ii) Debarred by the General Services Administration (GSA) from any other Executive Branch procurement or non-procurement programs or activities, in accordance with the Federal Acquisition and Streamlining Act of 1994, and with